

**Victimization, Trauma, and Mental Health:  
Women's Recovery at the Interface of the  
Criminal Justice and Mental Health Systems**

by

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## ABSTRACT

There is substantial evidence that women in psychiatric and correctional settings constitute severely traumatized populations, and that women's experiences of victimization and trauma are intricately connected to their mental health and substance use problems, and their pathways to crime. Yet, little research has focused on victimization and trauma in the lives of women at the interface of the criminal justice and mental health systems. This study explored the trauma-related experiences and needs of women receiving forensic mental health treatment services in British Columbia, Canada, and the challenges faced by forensic mental health professionals in addressing trauma-related issues with their female clients.

The study was grounded in feminist criminological theories, and employed feminist qualitative interview methods. Semi-structured interviews were conducted with 16 women receiving forensic mental health treatment services throughout the province, on an inpatient or outpatient basis, and 13 forensic mental health treatment staff. Women clients also completed a quantitative questionnaire, the *Reactions to Research Participation Questionnaire*, to explore their experiences as research participants and the ethics of trauma-focused research with a vulnerable population of women.

Findings from the study revealed that the lives of women receiving forensic psychiatric services are replete with experiences of victimization and trauma, which are closely linked to their mental health, substance use, and criminal behaviour. Yet, interviews with both clients and staff suggested that little is being done in the forensic mental health system to address victimization and trauma. This finding centred around 3 emergent themes: (1) women's experiences of victimization and trauma remain largely invisible owing to a lack of awareness and training among forensic staff; (2) women clients do not feel that they can open up to staff because they lack a voice and confidentiality in the forensic system; and (3) the forensic mental health system operates under a medical model, where trauma is considered to be neither legitimate nor particularly relevant to treatment. The dissertation explores opportunities for moving toward more trauma-informed approaches in the forensic mental health system, and

provides empirical evidence on the ethics of trauma-focused research with women in inpatient and outpatient forensic mental health settings.

**Keywords:** violence against women; victimization; mental illness; forensic mental health; forensic psychiatry; trauma-informed; feminist criminology; intersectionality; ethics; trauma-focused research

D is for... Dissertation.

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# 1: INTRODUCTION

There is substantial evidence indicating that women in psychiatric and correctional settings constitute severely traumatized populations (Gearon, Kaltman, Brown, & Bellack, 2003; Moloney, van den Bergh, & Moller, 2009; Mueser, Rosenberg, Goodman, & Trumbetta, 2002; Task Force on Federally Sentenced Women, 1990), and that women's experiences of victimization and trauma are intricately connected to their mental health and substance use (Morrow, 2002; Moses, Reed, Mazelis, & D'Ambrosio, 2003), and their pathways to crime (Comack, 1996; Dirks, 2004; Gilfus, 1992). Attending to gender differences, and differences among women based on other social categories, is critically important in the delivery of effective mental health and criminal justice services in order to promote gender equality and reduce health inequities.

Persons with serious mental illness, including psychiatric inpatients, report high rates of childhood abuse and victimization, which have been found to affect both the onset and course of mental illness (Goodman, Rosenberg, Mueser, & Drake, 1997; Hiday, Swartz, Swanson, Borum, & Wagner, 1999; Mueser et al., 1998; Mueser et al., 2002). Indeed, according to Herman (1992b), "the mental health system is filled with survivors of prolonged, repeated childhood trauma" (p. 122). Research with girls and women in the criminal justice system, and particularly in prisons, has documented similarly high rates of physical and sexual victimization in childhood, adolescence, and adulthood (Chesney-Lind, 1989; Comack, 1996; McDaniels-Wilson & Belknap, 2008).

A landmark report from the Task Force on Federally Sentenced Women (1990) revealed that approximately 60-90% of federally sentenced women in Canada had been physically abused, and approximately 50-60% had been sexually abused during their lifetime, with higher rates reported among Aboriginal women. Similar patterns of victimization and trauma have been reported by women in prisons throughout the United States, England, and Australia (Chesney-Lind, 2002; Easteal, 2001; McDaniels-Wilson & Belknap, 2008; Morris & Wilkinson, 1995; Owen & Bloom, 1995; Warren et al., 2002; Zlotnick, 1997).

Psychiatric deinstitutionalization policies of the late 20<sup>th</sup> century, driven by humanistic goals to improve the living conditions and quality of life of individuals suffering from serious mental illness (Bachrach, 1984; Halpern, Sackett, Binner, & Mohr, 1980), have had significant implications for the criminal justice system. These policies involved a multi-pronged approach of trans-institutionalization (e.g., the transfer of patients from tertiary psychiatric institutions to psychiatric units in general hospitals), de-hospitalization (i.e., the relocation of psychiatric inpatients to community-based settings), and non-institutionalization (Sealy & Whitehead, 2004).

There is little doubt that the vast majority of former psychiatric inpatients have been well served by community-based services and supports, and have gone on to live meaningful lives in the community (Standing Senate Committee on Social Affairs Science and Technology, 2006; Torrey, 1997; Wilson-Bates, 2008). Deinstitutionalization to other care facilities has similarly led to many positive outcomes including improved quality of life for persons living with mental illness<sup>1</sup> (Hamden, Newton, McCauley-Elsom, & Cross, 2011). However, in British Columbia, community-based mental health services and supports continue to struggle to deliver recovery-oriented and gender-informed care that is attentive to the intersections of gender and other social inequities (Morrow et al., 2010).

For a minority of individuals with severe and chronic mental illness, deinstitutionalization policies have not fulfilled their promise and have been described as a failed social experiment (Gilligan, 2001), a 'psychiatric titanic' (Torrey, 1997), and an 'ill-advised' political movement (Clarke, 1979). For some individuals suffering from mental illness, deinstitutionalization policies have led them to the streets or unstable and unsafe living conditions, where they are more vulnerable to victimization and exploitation (Bachrach, 1984; Lamb, 2001; Rose, 1979; Torrey, 1997). These conditions also increase the likelihood that these individuals will come to the attention of law enforcement agents and be criminalized. Indeed, it is well known that one of the unintended consequences of deinstitutionalization policies has been a notable increase in the number of persons with mental illness who come into contact with the criminal justice system (Bachrach, 1984; Halpern et al., 1980).

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<sup>1</sup> Quality of life has been conceptualized as a reflection of an individual's independence (including self-determination), social participation (including social inclusion, and human and legal rights), and emotional, physical and material well-being (Schallock, Bonham, & Verdugo, 2008).



Police departments and criminal courts are struggling today to deal with a growing number of cases involving persons who suffer from mental health and/or substance use problems (Peters & Bekman, 2007; Wilson-Bates, 2008). In Canada, the majority of individuals who are charged with criminal offences are tried in the provincial courts (e.g., the Provincial Court of British Columbia), though cases involving serious indictable offences may be tried in the superior courts (e.g., the Supreme Court of British Columbia) (Griffiths & Verdun-Jones, 1994). Those individuals who plead or are found guilty and convicted may be given a custodial sentence or community disposition. Custodial sentences of two years or more are administered by the *Correctional Service of Canada* (CSC), and are served in federal correctional institutions.<sup>2</sup> Sentences of less than two years, on the other hand, are served in provincial correctional facilities. In British Columbia, correctional services are delivered in nine correctional centres<sup>3</sup> and 55 community corrections offices throughout the province.

Over the past decade or more, correctional institutions have witnessed a dramatic increase in the proportion of prisoners, particularly women, who are identified as having mental health and/or substance use issues upon admission (Correctional Service of Canada, 2006; Glube, Audette, Henriksen, & Stobbe, 2006). Federally sentenced women in Canada are twice as likely as their male counterparts to have a mental health diagnosis upon admission, and women with a mental health diagnosis comprise nearly 30% of federally sentenced women (over 50% of female prisoners in some regions) (Correctional Investigator, 2010, 2011). In British Columbia, more than 55% of individuals in the correctional system have a mental health and/or substance use diagnosis upon admission. In light of this “changing offender profile” (BC Ministry of Public Safety and Solicitor General, 2010, p. 14), it has been argued that prisons now serve as ‘de facto’ or ‘surrogate’ mental hospitals (Grant, 2007; Torrey, 1997) and that they are, in essence, ‘the last mental hospital’ (Gilligan, 2001).

Of course, not all individuals with mental illness who come into conflict with the law end up in correctional service settings. The *Criminal Code of Canada* (herein ‘*Criminal Code*’) includes mental disorder provisions that may be applied to mentally

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<sup>2</sup> Federally sentenced women serving custodial sentences in British Columbia are held at Fraser Valley Institution (FVI) in Abbotsford, a multi-level facility for women.

<sup>3</sup> Provincially sentenced women serving custodial sentences in British Columbia are held at Alouette Correctional Centre for Women (ACCW) in Maple Ridge, a medium security facility for women.

disordered accused, including individuals who were suffering from a mental disorder, at the time they committed an offence, that interfered with their capacity to distinguish between right and wrong. This is particularly important in a legal system that is premised on the notion that individuals who lack the necessary *mens rea*, or 'guilty mind,' are not morally blameworthy and should not be held responsible for their criminal behaviour. The mental disorder provisions also apply to individuals who have a mental disorder that interferes with their right to a fair trial when they are brought before the courts (Verdun-Jones, 2011).

Where an accused person's mental health is called into question in the course of a prosecution, the court may order a psychiatric assessment in the forensic mental health system. This system is best described as a 'hybrid' of the criminal justice and mental health systems, and a sub-specialty of general psychiatry (Johnson, 1990; Pouncey & Lukens, 2010). 'Forensic,' in this context, means "connected to the law or the courts" (Bettridge & Barbaree, 2008, p. 2). Unlike the regular criminal justice system, which focuses on punishment (and, to a lesser extent, rehabilitation), the forensic mental health system focuses specifically on reducing the risk of recidivism, particularly the risk of violence, through the treatment of serious mental health and substance use disorders. British Columbia's forensic mental health system is regulated by the mental disorder provisions (s. 672) of the *Criminal Code*, and the province's *Mental Health Act* (1996) and *Forensic Psychiatry Act* (1996).

British Columbia's forensic mental health (or forensic psychiatric) services are responsible for providing specialized assessment, treatment, and clinical case management services to a small proportion of individuals with mental health issues who come into conflict with the law.<sup>4</sup> Mentally disordered individuals may enter the forensic

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<sup>4</sup> Note that the vast majority of individuals with mental health and substance use problems who come into conflict with the law do not receive services in the forensic mental health system.

mental health system in a variety of ways. For example, some individuals come to forensic services directly, as a result of a court order, for psychiatric assessments pertaining to their fitness to stand trial or criminal responsibility,<sup>5</sup> or for the purposes of a pre-sentence report (J. Livingston, Researcher, Forensic Psychiatric Services Commission, personal communication, August 8, 2012). Alternatively, persons with mental illnesses may be referred to forensic services as a condition of a probation order or community disposition. In British Columbia, the majority of forensic clients are individuals who are found to be not criminally responsible and individuals serving probation orders in the community<sup>6</sup> (J. Livingston, Researcher, Forensic Psychiatric Services Commission, personal communication, August 8, 2012).

A fitness assessment determines if the accused is 'fit to stand trial;' that is, whether an individual with a mental health diagnosis is capable of understanding the nature of the court proceedings and the possible consequences of these proceedings, and capable of communicating with counsel (Davis, 1994). If the accused is found to be fit,<sup>7</sup> then the court proceedings continue; if the accused is found to be unfit, then the individual typically receives forensic inpatient or outpatient treatment, which often includes medication, until fitness is restored, at which point the accused is returned to the courts to stand trial<sup>8</sup> (Newby & Faltin, 2008).

If an individual is fit to stand trial, but there are questions pertaining to the individual's mental health at the time the crime was committed, then the individual may be assessed by forensic psychiatric professionals to inform the court's determination of criminal responsibility; that is, whether, at the time of the offence, the person was able to appreciate the nature or quality of the act committed, or know that it was wrong (Verdun-Jones, 2011). In this way, the mental disorder provisions of the *Criminal Code* have "helped to mobilise the entry of psychiatric power into the legal arena" (Kendall, 2006, p. 53). If an individual is found to be criminally responsible, then the court proceedings

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<sup>5</sup> Fitness and criminal responsibility are often assessed concurrently in British Columbia's forensic mental health system (J. Livingston, Researcher, Forensic Psychiatric Services Commission, personal communication, August 8, 2012).

<sup>6</sup> Most other forensic mental health services in Canadian provinces do not provide treatment services to probation clients (J. Livingston, Researcher, Forensic Psychiatric Services Commission, personal communication, August 8, 2012).

<sup>7</sup> The *Criminal Code* indicates that accused are presumed to be fit to stand trial.

<sup>8</sup> In cases where the mental state of an accused does not improve with treatment, and they are considered 'permanently unfit,' the court may enter a stay of proceedings or otherwise resolve the charges (Newby & Faltin, 2008).

continue. If not, then the person may be adjudicated 'Not Criminally Responsible on account of Mental Disorder' (NCRMD, and referred to as 'NCR-accused'). Importantly, NCR-accused have not been found guilty, and are not considered criminal offenders, though they often face the dual stigma associated with the labels 'mentally disordered' and 'criminal,' – 'triple stigma' for those who have concurrent mental health and substance use disorders (Hartwell, 2004; Livingston, Rossiter, & Verdun-Jones, 2011). NCR-accused are transferred to the forensic mental health system, and come under the jurisdiction of a Criminal Code Review Board, an independent tribunal established under the *Criminal Code*.<sup>9</sup>

Review Boards are quasi-judicial panels normally comprised of five members,<sup>10</sup> including a Superior Court judge or person qualified to be appointed to this position, a psychiatrist, and other qualified professionals (e.g., psychologist, social worker, criminologist). These Review Boards are responsible for determining the degree of freedom granted to persons adjudicated NCRMD by the courts. The boards must balance the rights of the individual and society and, must impose the least onerous and least restrictive conditions on the accused without compromising public safety. NCR-accused are entitled to an annual Review Board hearing, where the board determines whether an individual continues to pose a "significant threat to the safety of the public" (*Winko v. British Columbia*, 1999).

The Review Board may order one of three dispositions: (1) custody in a forensic psychiatric hospital, (2) a conditional discharge to the community, or (3) an absolute discharge, where the person is no longer under any jurisdiction. Individuals who are detained in custody typically receive inpatient forensic services in a secure hospital or ward, whereas individuals on conditional discharge are required to attend treatment services at a designated forensic outpatient clinic in the community. These outpatient clinics also provide treatment services to individuals who are referred to forensic mental health services as a condition of probation or parole.

Women comprise only a small proportion of forensic mental health clients. In light of the evidence that women in contact with mental health and correctional services have high rates of past victimization and trauma, it is not surprising that women who come into

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<sup>9</sup> The trial court may make a disposition, but does so only in a small minority of cases.

<sup>10</sup> In British Columbia, Review Boards usually include three members (J. Livingston, Researcher, Forensic Psychiatric Services Commission, personal communication, August 8, 2012).

contact with forensic mental health services also have extensive histories of victimization and abuse. Indeed, the scant research on victimization and trauma in forensic populations supports this assumption that forensic mental health clients are likely to have experienced trauma in childhood and/or adulthood (Simpson & Penney, 2011).

Studies of men and women in inpatient forensic psychiatric populations in the UK, Germany, and The Netherlands, have revealed rates of childhood physical and sexual abuse between 15% and 81% (Adshead, 1994; Bland, Mezey, & Dolan, 1999; Spitzer, Chevalier, Gillner, Freyberger, & Barnow, 2006; Timmerman & Emmelkamp, 2001). Yet, to date, little research has focused on victimization and trauma in the lives of women receiving forensic services (Bland et al., 1999). One study involving 100 girls aged 11-17 who were referred to adolescent forensic mental health services found that most of the girls had experienced multiple forms of abuse in childhood (Jasper, Smith, & Bailey, 1998). One researcher (Adshead, 1994) noted that not a single woman, of the 16 women included in her study, had reported her adult experiences of victimization to the police.

Individuals who suffer from mental illness and who come into contact with helping professionals may not report experiences of victimization and trauma for a variety of reasons, including that they do not think they will be believed, owing to the stigma associated with mental illness, and professionals' assumptions that their reports may be inaccurate or unreliable (Bachrach, 1984; Lloyd, 2006; Marley & Buila, 2001). There is no doubt that "the status of psychiatric inpatient reduces [survivors'] credibility" (Heney & Kristiansen, 1998, p. 33) and their behaviours are often interpreted as symptoms of their psychiatric illness. However, some studies have found the reports of individuals with mental illness concerning their histories of victimization and abuse to be reliable and consistent, with respect to the frequency and severity of abuse, and valid, especially in the case of past sexual abuse (Goodman et al., 1999; Meyer, Muenzenmaier, Cancienne, & Struening, 1996).

Not only may women with mental illnesses (and women, generally) be reluctant to report their experiences of victimization, but mental health professionals may also hesitate to inquire about victimization and trauma among individuals suffering from mental illness, due to limited resources, competing priorities, organizational mandates, limited knowledge and training in victimization and trauma, and concerns about managing the emotional and behavioural difficulties that may accompany discussions of

victimization and trauma with clients (Goodman et al., 1999; Lloyd, 2006; Morrow, 2002). In forensic settings, the additional label of 'criminal' or 'offender' may also direct attention away from issues of victimization and trauma. For example, Adshead (1994) has suggested that Post-traumatic Stress Disorder (PTSD) "is not a diagnosis commonly made within forensic populations, perhaps because it is associated with 'victims' rather than 'perpetrators'" (p. 245).

In fact, a small body of research suggests that the perpetration of an offence may lead to the development of PTSD, a phenomenon described as 'perpetration-induced' PTSD or, simply, 'perpetrator PTSD' (Byrne, 2003; Friel, White, & Hull, 2008; Harry & Resnick, 1986; Papanastassiou, Waldron, & Boyle, 2004; Pollock, 1999). The suggestion that perpetrators of violence may be traumatized as a result of violence perpetration is controversial; yet, Pollock (1999) argues that this scenario fits within the DSM-IV criteria for a PTSD diagnosis and that it may be quite common in forensic settings. Emerging evidence suggests that characteristics of the offence (i.e., type of violence) and the perpetrator (i.e., type of offender) are associated with traumatic responses following the perpetration of violence (Pollock, 1999). Perpetration-induced PTSD is an important consideration in forensic populations, given the significant implications for criminal responsibility, mental health recovery, and community reintegration (Friel et al., 2008).

Although there is evidence that forensic psychiatric patients may be severely traumatized, their histories of victimization and trauma are unlikely to be assessed, and their reports are unlikely to be believed or taken seriously (Lloyd, 2006). It is clear that if women's experiences of victimization and trauma remain unknown to mental health professionals, these issues are unlikely to be properly assessed and treated (Brunet, Akerib, & Birmes, 2007; Eilenberg, Fullilove, Goldman, & Mellman, 1996; Frueh et al., 2000; Mueser et al., 1998). Indeed, trauma-related disorders, such as PTSD, remain severely under-diagnosed in mental health and criminal justice settings, and are frequently misdiagnosed, particularly when women present with concurrent substance use disorders (Brunet et al., 2007; Frueh et al., 2000; Morrow, 2002; Mueser et al., 1998; Mueser et al., 2002; Walsh et al., 2003). As a result, few efforts have been made to address victimization and trauma, promote trauma recovery, and reduce women's risk of re-victimization or re-traumatization in these systems.

This lack of attention to victimization and trauma is even more troubling given that coercive and punitive settings have been identified as sites where the dynamics of abusive relationships may be reproduced, contributing to women's sense of powerlessness (Bill, 1998; Dirks, 2004; Girshick, 2003). Powerlessness is a common experience in forensic mental health settings, where clients have limited autonomy and where staff may have power over decisions concerning clients' legal status and freedom (Livingston & Rossiter, 2011; Livingston et al., 2011). Paradoxically, for some women, punitive or coercive environments, such as prisons and forensic psychiatric hospitals, may be experienced as safer than the community, offering women an opportunity to address issues of victimization and abuse for the first time in their lives and begin the process of trauma recovery (Bradley & Davino, 2002; Miller & Najavits, 2012).

As evidence emerges about victimization and trauma among women in the forensic mental health system, questions arise about the role of forensic mental health professionals in addressing these issues, and the potential for developing trauma-informed forensic services to better meet the needs of women with co-occurring experiences of trauma, mental illness, and substance use, who come into conflict with the law.

Research on victimization and trauma within forensic psychiatric populations has, to date, been conducted in inpatient settings, using structured interviews, self-report questionnaires, and/or information collected from hospital records and case notes, often reflecting the perspectives of staff rather than those of women clients themselves. Feminist scholars conducting research with women in forensic mental health settings in the UK noted a lack of research that "asked women themselves how they come to 'end up' in secure mental health services" (Williams, Scott, & Bressington, 2004, p. 35). The paucity of qualitative trauma-focused research in inpatient and outpatient forensic mental health settings has meant that the voices of women at the interface of the criminal justice and mental health systems have not been heard. The gap in knowledge is particularly evident in the Canadian context, where little research has been conducted on the intersection of women, trauma, mental health, and criminal justice.

## **1.1 The Trauma Recovery Study**

The present study (the Trauma Recovery Study) employed a feminist approach and qualitative interview methods to address some of the gaps in the literature, and

consider challenges and opportunities in the development of trauma-informed forensic mental health services in British Columbia. The research explored the victimization and trauma experiences of women receiving forensic mental health treatment services in British Columbia, Canada, and the perspectives of forensic treatment staff with respect to the challenges and opportunities in addressing trauma-related issues with their female clients. The study addressed three research questions:

- (1) What are the experiences of victimization and trauma of women in contact with the forensic mental health system? What are their needs for trauma recovery?
- (2) What challenges do forensic mental health professionals face in addressing issues of victimization and trauma in the lives of their clients? What supports are in place to assist them in addressing these issues and reduce the risk of secondary traumatic stress?
- (3) What are the reactions of women forensic mental health clients to participation in trauma-focused research?

In light of evidence on the gendered nature of victimization and trauma, and differences between women's and men's experiences of mental health and pathways to crime, the research focused on women clients only. Studies have shown that women and men are exposed to different types of trauma, with women more likely than men to be the victims of sexual and intimate partner violence (Finkelhor, 2007). Women are also more likely to be re-victimized throughout the life course, and are more likely to develop PTSD following trauma exposure, given the types of trauma to which they are exposed and the cumulative nature of trauma (Brewin, Andrews, & Valentine, 2000; Kilpatrick & Acierno, 2003; Marley & Buila, 2001; Miller & Najavits, 2012). A recent study of forensic psychiatric clients in British Columbia – the same population from which participants were drawn for the Trauma Recovery Study – found that women clients were more likely than their male counterparts both to have a history of victimization (38% versus 20%) and to be at risk of further victimization (10% versus 4% at high risk), signifying gender differences in both trauma-related experiences and needs (Nicholls, Petersen, & Brink, 2011).

There are important differences in the ways that men and women experience and express mental health problems, including responses to trauma, as well as their coping strategies and help-seeking behaviours (Green & Diaz, 2008; Morrow, 2007b; Rossiter &



Morrow, 2011). As well, women's pathways to crime differ from those of men, and are often closely linked to their histories of victimization and trauma (Comack, 1996; Gilfus, 1992; Moloney et al., 2009). Research has also revealed differences *among* women, as well, where gender intersects with other social inequities and exacerbates vulnerability to victimization. For example, homeless women with mental health and/or substance use disorders report especially high rates of victimization and trauma (Christensen et al., 2005; Goodman, Dutton, & Harris, 1995; Stermac & Paradis, 2001).

Client participants in the Trauma Recovery Study were women with mental health issues who had come into conflict with the law, and were receiving inpatient or outpatient forensic psychiatric services as a condition of a probation order or a disposition order following an NCRMD adjudication by the courts. Staff participants in the study were forensic mental health service providers (e.g., psychiatrists, psychologists, social workers, nurses) who had experience working with women clients in British Columbia's forensic mental health system.

The study used trauma theory as a foundation for understanding the effects of victimization and trauma (van der Kolk, McFarlane, & Weisaeth, 1996), the process and principles of trauma recovery (Herman, 1992b), and the relevance and importance of trauma theory in the design and delivery of services (Bloom, 1997; Harris & Fallot, 2001d). The study was also grounded in feminist criminological theories, building, in particular, on the work of Chesney-Lind (1989), Daly (1992), Gilfus (1992), and Comack (1996), whose research contributed to the development of a feminist or gendered 'pathways' to crime perspective. This pathways approach was the first to draw connections between women's victimization and criminalization, theorizing that girls' and women's survival strategies are often the very behaviours that bring them into contact with the criminal justice system (Gilfus, 1992). Finally, intersectional feminist frameworks were used to explore and highlight the diverse experiences and needs of women clients, and staff responses to women's trauma-related needs in the forensic mental health system.

I conducted qualitative feminist interviews to elicit rich narratives about a complex and layered issue that has not yet been explored in the literature. Qualitative methods are particularly well suited to feminist research, but also to research on sensitive topics and vulnerable populations (Lee, 1993). This qualitative feminist approach gave voice to a group of silenced and disempowered women about their lived experiences of

victimization and trauma, and in so doing, sought to empower them and improve the situation of women in the forensic mental health system. I employed semi-structured interviews with female forensic clients as well as with forensic treatment staff, to learn from their experiences and perspectives about the role of forensic mental health services in attending to the trauma-related needs of female clients.

Feminist scholars are particularly attentive to ethical issues in research, as the ethical principle of justice is at the core of the feminist project, which seeks to reduce gender inequalities and promote social justice. These ethical considerations also extend to research interviews, where feminist interviewers seek to equalize power imbalances between researchers and research participants in the research process itself (Preissle, 2007). The women clients involved in the study can be considered multiply disadvantaged and extremely vulnerable given that they were survivors of trauma who had mental health and/or substance use problems and had come into conflict with the law. Their vulnerability, and the trauma-focused nature of the research, raised a number of significant ethical issues, including the risk that they may be re-traumatized in the course of research participation. Yet, these ethical issues and the potential harm that may be caused to research participants are often presumed, and are rarely determined with evidence from research participants themselves.

In order to determine the benefits and harms of trauma-focused research with women in forensic mental health settings, from the perspective of the women affected, I included an empirical assessment of women's reactions to research participation in the Trauma Recovery Study. For this component of the research, I employed both qualitative and quantitative methods, which included semi-structured interview questions and the *Reactions to Research Participation Questionnaire* (RRPQ) (Newman, Willard, Sinclair, & Kaloupek, 2001). This component of the research gave the women in the study a voice not only with respect to their histories of victimization and trauma, and how forensic mental health professionals address these issues, but also with respect to the research process itself.

## **1.2 Chapter Summaries**

This dissertation consists of nine chapters. In Chapter 2, I introduce trauma theory and discuss how the term 'trauma' has been used by researchers and practitioners approaching the issue from different theoretical perspectives. I then outline

the biological, psychological, and social effects of victimization and trauma, and discuss Post-traumatic Stress Disorder, pointing to evidence that victimization and trauma, mental health, and substance use are intricately connected for women. I then describe mental health and trauma recovery, and differentiate between trauma-specific treatment models and techniques, and trauma-informed approaches across service systems. I conclude with a brief discussion of secondary traumatic stress with a particular focus on mental health professionals, victims' service workers, and researchers.

In Chapter 3, I articulate the feminist theoretical framework within which the study is rooted, and describe the feminist or gendered 'pathways' perspective, which first theorized a link between women's victimization and criminalization. I also introduce intersectionality, a theoretical framework that interrogates interlocking forms of oppression that sustain gender and other social inequities and shape women's experiences of victimization and trauma. This theoretical framework was used to identify and extract examples of women's diversity with respect to their trauma-related experiences and needs, in order to avoid essentializing a diverse group of women survivors.

Chapter 4 focuses on the ethics of trauma-focused research, including a brief overview of the history of research ethics and policy, and the need for special protections for vulnerable populations. I identify core principles in research ethics policy, and examine the relationship between risk and harm, outlining the steps researchers may take to minimize the risk of harm to research participants. I also discuss the key ethical issues in research involving prisoners, women, and individuals with mental illness – all vulnerable populations that have relevance for the current research project. I introduce the concept of evidence-based ethical decision-making, summarize the research evidence on the ethics of trauma-focused research, and discuss the importance of gathering evidence on the benefits and harms of trauma-focused research with vulnerable populations, from the perspective of research participants themselves.

In Chapter 5, I describe the qualitative feminist approach employed in the study, and include a detailed description of the research protocol, including the purpose of the study and research questions. I describe the research sites and population, and discuss how I negotiated access to the organization within which the research was conducted. I then describe the sampling strategy and participant recruitment process, including the challenges associated with the recruitment of clients and staff in the forensic mental

health system, and discuss how the findings of the study were reflected in the research process itself. Finally, I describe the data collection and analysis procedures, and the strategies employed to enhance the quality and trustworthiness of the findings.

The main findings of the study are reported and discussed in three separate chapters. The first, Chapter 6, focuses on the women clients' experiences of victimization and trauma, and the role of these experiences in their pathways to (and through) forensic mental health services. The chapter begins with a description of the sample of female forensic clients who participated in the study, and the female forensic client population more generally, from the perspectives of client and staff participants. In this chapter, I describe the women's layered experiences of victimization and trauma, and draw connections to their mental health, substance use, and criminal behaviour, from their own perspectives and in their own words. I also explore the ways in which their experiences in the criminal justice and forensic mental health systems have been re-traumatizing.

The second findings chapter, Chapter 7, focuses on the challenges faced by forensic mental health professionals in responding to women's experiences of victimization and trauma. In this chapter, I discuss the three main themes that emerged with respect to addressing trauma in the forensic mental health system: (1) 'the elephant in the forensic mental health worker's office,' which speaks to the invisibility of trauma in the forensic mental health system, and the fear surrounding trauma-related issues; (2) 'speaking (her) truth to power,' which reflects the power and control of forensic mental health professionals, particularly psychiatrists, that serves to silence women survivors; and (3) 'fitting a square peg in a round hole,' which explores the place of trauma and trauma-informed approaches within the medical model, where trauma is delegitimized and alternative approaches to trauma recovery are under-valued. At the end of the chapter, I report on client and staff participants' own reflections about 'trauma-informed' forensic mental health services.

Chapter 8, the third findings chapter, focuses on the ethical aspects of trauma-focused research in a vulnerable population of women at the interface of the criminal justice and mental health systems. In this chapter, I report on the quantitative and qualitative findings of the ethics inquiry of the study, and discuss the importance of evidence-based ethical decision-making in trauma-focused research with vulnerable populations.

In Chapter 9, I make meaning of the evidence on women's pathways to (and through) forensic mental health services, and draw conclusions about trauma-informed forensic mental health services and trauma-focused research with women receiving forensic mental health services. This discussion centres on key issues emerging from the research concerning women's powerlessness and the silencing of their voices in the forensic mental health system. I discuss how the research process and the ethics component of the study gave these women an opportunity to have their voices heard. The chapter concludes with a discussion of the strengths and limitations of the study, and directions for future research in this area.

## **2: THEORETICAL FRAMEWORK I: TRAUMA AND RECOVERY**

The Trauma Recovery Study drew upon trauma theory to understand the impact of victimization and trauma on women's mental health and their pathways to crime. The process and principles of trauma recovery, advanced by Judith Lewis Herman (1992b), were also central to the analysis of the challenges in adopting trauma-informed approaches in the forensic mental health system. Indeed, the concept of trauma-informed care (and integrated trauma-specific treatment), that is currently gaining popularity in a variety of service systems and settings throughout the United States and Canada, is based in trauma theory and the principles of trauma recovery (Clark & Power, 2005; Elliott, Bjelajac, Falot, Markoff, & Reed, 2005; Harner & Burgess, 2011; Harris & Falot, 2001d; Jennings, 2004; Clinic Community Health Centre, 2008; Ko et al., 2008; Miller & Najavits, 2012).

### **2.1 Understanding Trauma**

The term 'trauma' originates from the Greek word for 'wound,' and has been used to describe both overwhelming experiences and psychological responses to traumatic events or stressors (Covington & Bloom, 2006). The field of traumatic stress studies has grown substantially over the past 25 years, with the development of trauma theory, and advancements in the assessment and treatment of psychological responses to trauma. However, despite a large body of knowledge on the subject of victimization and trauma, and its biological, psychological, and social sequelae, the literature is replete with debates about what constitutes 'trauma.'

At the centre of these debates are questions pertaining to the nature of trauma, its causes, and the processes by which it is resolved – answers to which depend on one's theoretical orientation, or paradigm. As with the mental health field in general, the field of traumatic stress studies is dominated by biomedical research that focuses on the biological and psychological responses to trauma, and the assessment and treatment of trauma-related disorders such as PTSD. Yet, there is a growing literature, rooted in critical and feminist perspectives, that emphasizes the social and structural factors that

shape women's lived experiences of victimization and trauma, and seeks to advance social justice and gender equality in order to reduce, prevent, and ultimately eliminate, violence against women.

Researchers and practitioners approaching the problem of victimization and trauma from feminist and other critical perspectives refocus discussions of trauma to the problem of male violence against women, and seek to increase women's empowerment. Feminist scholars and practitioners have also sought to challenge the dominance of the biomedical perspective in the mental health field, and the resultant pathologization and medicalization of women (Rossiter & Morrow, 2011). However, challenging biomedical and psychiatric perspectives has not always required feminists to abandon the medicalized language of 'trauma;' in fact, some feminist scholars and clinicians – myself included – have adopted this term in psychiatric research settings for strategic reasons (Morrow, 2008).

In her foundational text on trauma and recovery, feminist psychiatrist Judith Lewis Herman (1992b) reviewed the 'forgotten history' of trauma, in which she described three distinct waves of interest in the study of psychological trauma, each supported by a political movement: the first in late nineteenth century France during what is now described as the 'age of hysteria'<sup>11</sup> the second following World War I and continuing through to the end of the Vietnam War, bolstered by the anti-war movement; and the third during the women's liberation movement of the 1970s, when feminists first named and brought public awareness to the problem of sexual and domestic violence against women (Herman, 1992b). Today, there is renewed interest in the concept of trauma among women's health researchers and practitioners whose work focuses on the integration of trauma in the treatment of women's mental health and substance use issues, and the development of trauma-informed approaches across service systems (Covington, 2008; Elliott et al., 2005; Harris & Fallot, 2001d; Clinic Community Health Centre, 2008; Ko et al., 2008; Miller & Najavits, 2012; Poole & Urquhart, 2009).

Psychological trauma was formally recognized by the medical profession in 1980, with the inclusion of Post-Traumatic Stress Disorder in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III, American

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<sup>11</sup> The social implications of the connection between hysteria and trauma led Freud to deny the reality of women's experiences of childhood sexual abuse, effectively silencing women survivors of sexual abuse (Herman, 1992a; van der Kolk, Weisaeth, & van der Hart, 1996).

Psychiatric Association, 1980). This development significantly advanced the field of traumatic stress studies; however, diagnostic criteria for the disorder have been the subject of significant debate since its emergence as a psychiatric construct (Figley, 1988; Lasiuk & Hegadoren, 2006a; MacIntosh & Whiffen, 2005). Much of this controversy has focused on Criterion A, or what qualifies as a ‘traumatic stressor’.<sup>12</sup>

Stressful events exist along a continuum from non-traumatic to extremely traumatic, depending on their frequency, duration, severity, complexity, predictability, and controllability (Weathers & Keane, 2007). For example, stress related to a divorce may be considered non-traumatic, whereas the stress associated with a violent sexual assault could be considered extremely traumatic. It is important to recognize, however, that an event that is considered to be traumatic to one person may not be experienced as such by other individuals.

When PTSD first appeared in psychiatric nomenclature, a traumatic stressor was defined as an event that was “outside the range of usual human experience” (American Psychiatric Association, 1980, p. 50) and “would evoke significant symptoms of distress in most people” (American Psychiatric Association, 1980). This definition suggested that traumatic stressors were rare and/or extreme events, and that responses to these events could be compared to some normative standard (Weathers & Keane, 2007). However, scholars have noted that the “perception of an event as stressful depends on subjective appraisal, making it difficult to define stressors objectively, and independent of personal meaning making” (Weathers & Keane, 2007, p. 108).

Examples of traumatic stressors in the DSM-III included rape, military combat, torture, car accidents, and floods, most of which reflect single or isolated events. Common or everyday experiences, such as intimate partner violence against women, were explicitly excluded as potentially traumatic events that could give rise to a PTSD diagnosis, sparking responses from feminist scholars, clinicians, and activists. The argument that was made was that, despite the fact that intimate partner violence was a common experience for women, and therefore not ‘outside the range of usual human

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<sup>12</sup> PTSD is the only psychiatric disorder appearing in the DSM-IV for which a cause is specified. For a PTSD diagnosis, both Criterion A1 and A2 must be met. Criterion A1 describes the type of traumatic stressors that may qualify an individual for a diagnosis, whereas Criterion A2 describes the response to the traumatic stressor or event experienced. An individual must react with “intense fear, helplessness, or horror” in order to meet this diagnostic criterion.



experience,' it could still lead to the development of post-traumatic stress (Herman, 1992b).

Despite feminist critiques, the definition of a traumatic stressor in the next edition of the DSM (DSM-III-R) remained an event 'outside the range of usual human experience' and, again, explicitly excluded intimate partner violence. However, traumatic stressors were described, in this edition, as events that would be considered "markedly distressing to almost anyone" (American Psychiatric Association, 1987) *and* produce feelings of "intense fear, terror, and helplessness" (American Psychiatric Association, 1987). Notably, the net of trauma was also cast wider, to include *indirect* experiences of traumatic events (e.g., learning about serious bodily injury or harm to a close friend or relative).

This expansion of the diagnostic criteria to include individuals who were not the primary, or direct, victims of a traumatic experience marked a particularly significant development in the history of post-traumatic stress disorder, as it formally recognized the secondary effects of traumatic stress on witnesses, families and friends of victims, communities, and professionals who work with trauma survivors<sup>13</sup> (Buchanan, Anderson, Uhlemann, & Horwitz, 2006; Yoder, 2005).

The DSM-IV saw a further broadening of the definition of trauma,<sup>14</sup> with the shift from an objective, or normative, standard to a more subjective response (Weathers & Keane, 2007). Criterion A now requires that an individual have experienced, witnessed, or otherwise been confronted with an "extreme traumatic stressor," or life-threatening event, that produces "intense fear, helplessness or horror" (American Psychiatric Association, 2000). The category also lists many more traumatic stressors, including being diagnosed with (or learning that your child has been diagnosed with) a life-threatening illness (Lasiuk & Hegadoren, 2006a, 2006b; Weathers & Keane, 2007).

The gradual expansion of the diagnostic criteria for PTSD, since its inception, has led some scholars to suggest that the diagnosis suffers from "conceptual bracket creep" (McNally, 2003) or 'criterion creep,' which threaten its legitimacy and value as a psychiatric construct. Certainly, it is possible that overly broad definitions of trauma

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<sup>13</sup> The concepts of 'secondary traumatic stress' and 'vicarious traumatization' are discussed in further detail at the end of this chapter.

<sup>14</sup> Others have suggested that the DSM-IV criteria are, in fact, stricter than those of previous editions, due to the requirement that both criterion A1 *and* A2 be met (Brunet et al., 2007).

minimize the experiences of individuals who have been exposed to extreme traumatic events (Weathers & Keane, 2007). However, individual responses to traumatic events and stressors vary widely, and feminist scholars and clinicians have criticized PTSD for its narrow scope and failure to adequately capture the broad array of psychological responses to trauma.

Herman (1992b), for example, argued that 'classic' or 'simple' PTSD, a construct that may adequately explain psychological responses to combat and rape, inadequately reflects the psychological suffering of individuals exposed to prolonged or repeated victimization. She argued that psychological responses to trauma cannot be conceived of as a single psychiatric disorder, but should instead be considered as a 'spectrum of conditions.' Based on her work with survivors of prolonged and repeated abuse, she proposed a 'complex' PTSD to describe the clinical presentation of survivors of ongoing childhood sexual abuse and intimate partner violence<sup>15</sup> (Herman, 1992b).

Feminist and critical scholars have continued to advance broader conceptualizations of what constitutes 'trauma,' that extend beyond PTSD and other psychiatric labels. These include concepts such as 'intergenerational trauma',<sup>16</sup> which has been used to describe the legacy of Indian residential schools for Aboriginal peoples in Canada (Bombay, Matheson, & Anisman, 2009), 'collective' or 'cultural' trauma, which has been used to explain the impact of slavery on African-American cultural identity (Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004; Kansteiner, 2004), and 'insidious trauma,' which describes the impact of sexism, racism, classism, and ableism on marginalized groups (Burstow, 2003).

Other critical feminist scholars have altogether rejected the medical profession's tendency to individualize and pathologize women's behaviours and responses to victimization and trauma<sup>17</sup> (Kilty, 2006; Morrow, 2007a). Feminist scholars and activists have framed women's responses to victimization and trauma not as symptoms of psychopathology, but as coping behaviours and survival strategies – that is, as 'normal'

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<sup>15</sup> Complex PTSD was included in the fourth edition of the DSM (American Psychiatric Association, 2000) under the diagnostic category Disorders of Extreme Stress not Otherwise Specified (Hegadoren, Lasiuk, & Coupland, 2006).

<sup>16</sup> Complex PTSD has also been used to explain the effects of intergenerational trauma, which often compound the impact of individual trauma.

<sup>17</sup> The feminist literature on Lenore Walker's (2000) 'Battered Woman Syndrome' serves as a good example of the feminist community's simultaneous praise and criticism of psychological explanations of women's responses to male violence (see, for example, Shaffer, 1997).

responses to abnormal circumstances. Furthermore, feminists place women's experiences of victimization and trauma within a wider social context, drawing attention to social and structural factors that produce gender inequalities and impact women's vulnerability to, experiences of, and responses to victimization and trauma.

In my own work, I have approached the concept of trauma broadly, calling for women with experiences of 'violent victimization, trauma or abuse' but asking them to speak about 'victimization and trauma,' rather than specific types of experiences predetermined to be 'traumatic' (for example, traumatic stressors that would qualify for a PTSD diagnosis) or specific trauma-related symptoms (e.g., flashbacks associated with traumatic events). This approach allowed women participating in the study to define trauma in their own ways, describing events in their lives that they themselves experienced as traumatic, and the impact of these experiences on the course of their lives. Although my use of the term 'trauma' may contribute to the medicalization and pathologization of women's experiences of victimization and trauma, I anticipated that this language would facilitate access to the forensic mental health system and increase the likelihood that the research would inform forensic mental health service delivery.

### **2.1.1 The Impact of Trauma**

Individuals who are exposed to violence and trauma in the course of their lives may experience a single traumatic event (e.g., sexual assault, terrorist attack, witnessing a murder, learning about the unexpected death of a family member) or repeated traumatic events over a longer period (e.g., years of childhood sexual abuse or intimate partner violence). Individual responses to these experiences are as varied as are the victims themselves (Weathers & Keane, 2007). Responses may be instantaneous, occurring during or immediately following a traumatic event, or they may develop long after the traumatic incident has taken place. For others, problems may develop more gradually over time, especially in the case of chronic or repeated victimization (Bloom, 1997; van der Kolk, McFarlane et al., 1996).

Responses to trauma depend on a combination of factors, including the nature of the traumatic event or stressor itself, characteristics of the victim and, in the case of interpersonal violence, the characteristics of the perpetrator (Briere & Scott, 2006; Verdun-Jones & Rossiter, 2010). While some victims appear to cope well in the aftermath of traumatic experiences, and demonstrate enormous resilience, for others,

the psychological impact of trauma may be utterly devastating and potentially life-altering. The cumulative nature of trauma suggests that individuals who are exposed to multiple traumatic events or ongoing trauma may also experience more negative outcomes (Follette, Polusny, Bechtle, & Naugle, 1996). In the following sections, I describe the biological, psychological, and social sequelae of trauma, demonstrating how traumatic experiences can affect every aspect of victims' lives, forever changing who they are and how they live.

### **2.1.1.1 Biological Sequelae**

Psychological trauma, or post-traumatic stress, can be distinguished from physical forms of trauma in the medical field (e.g., traumatic brain injury, traumatic spinal cord injury). Yet, it is well known that victimization and trauma have a significant impact on the human body, from immediate and relatively short-lived physiological responses to longer-lasting injuries and chronic health problems (Banyard, Edwards, & Kendall-Tackett, 2009; Romans, Belaise, Martin, Morris, & Raffi, 2002; Schnurr & Jankowski, 1999; Weissbecker & Clark, 2007). Indeed, as van der Kolk has noted, when it comes to trauma, “the body keeps the score” (van der Kolk, 1996a, p. 214).

The immediate physiological response to trauma has been described as a “rapid-fire, automatic, total body response” (Bloom, 1997, p. 18), which reflects the body's natural ‘fight-or-flight’ response to danger. Individuals who have been exposed to trauma may experience chronic hyper-arousal, meaning they have a lower startle response threshold and their bodies are regularly ‘on guard,’ in constant anticipation of danger (van der Kolk, 1996a). As a result, they often take great care to avoid stimuli (e.g., sounds, images, locations, thoughts) that are associated with arousal and may trigger physiological reactions, such as increased heart rate and blood pressure (van der Kolk, 1996a). In the case of post-traumatic stress, even minor stimulation or arousal may lead to extreme fight-or-flight responses that appear to be disproportionate to the stimuli that initially triggered the response. This type of response has significant implications for survivors in institutional settings where the everyday conditions of these environments may trigger trauma responses (Williams & Paul, 2008).

Chronic physiological arousal and the ‘fight-or-flight’ response also have implications for emotional regulation, resulting in extreme emotional reactions, such as fear and anger (Bloom, 1997; van der Kolk, 1996a). Trauma survivors may have great

difficulty identifying, expressing, and controlling their emotions, causing them to engage in emotional-numbing and avoidance strategies (Bloom, 1997). Emotional inhibition may, in turn, affect survivors' mental and physical health and well-being (Bloom, 1997). The wide range of emotional and psychological difficulties experienced in the aftermath of victimization and trauma are described in further detail below.

Victimization and trauma can also contribute to long-term physical illnesses and health problems, including hypertension, headaches, chronic fatigue, asthma, and disease (Banyard et al., 2009; Bloom, 1997; Keeshin, Cronholm, & Strawn, 2012; Romans et al., 2002; Zoellner, Goodwin, & Foa, 2000). Individuals who are exposed to trauma are also more likely to report poor overall health status, greater use of health services, and higher health-care costs (Frayne et al., 2004; Larson et al., 2005; Schnurr & Jankowski, 1999; Walker et al., 2003). As is the case with research on the relationship between psychological trauma and mental health, findings on the association between trauma symptoms and physical health complaints suggest important implications for the delivery of health-care services to trauma survivors (Weissbecker & Clark, 2007).

Trauma exposure may also cause significant damage to the brain, especially if it occurs in early childhood when the brain has not yet fully developed (Heide & Solomon, 2006; Solomon & Heide, 2005). Research shows that children who are exposed to repeated abuse may develop neurobiological abnormalities, leading to permanent brain damage and dysfunction (van der Kolk, 1996a). Traumatic stress also leads to impairments in memory and decision-making functions, through its effects on the hippocampus and amygdala (Bloom, 1997; Goodman & Dutton, 1996; Hill, 2003; Wang & Xiao, 2010; Weber & Reynolds, 2004; Yoder, 2005). Traumatic experiences become 'engraved' as vivid yet fragmented memories that, when triggered, intrude upon survivors' consciousness in the form of flashbacks and nightmares, which can cause sleep disturbances, among other difficulties (Bloom, 1997; Herman, 1992b). Traumatic memories may also be forgotten, a phenomenon known as 'traumatic amnesia,' which has been framed as a survival strategy and "adaptive response to childhood abuse" (Freyd, 1994, p. 307). The possible forgetting of traumatic experiences has important implications for settings where universal screening for trauma is routine, as a failure to identify trauma does not necessarily mean the absence of trauma. The same is true in cases where trauma is not detected because a survivor chooses not to report it or where

staff lack corroborative evidence to support a survivor's self-reported history of victimization and trauma.

### **2.1.1.2 Psychological Sequelae**

The psychological effects of victimization and trauma range from relatively mild emotional distress to serious and debilitating mental health problems (Verdun-Jones & Rossiter, 2010). The adverse psychological effects of trauma may be particularly pronounced for women whose lives have been characterized by discrimination, disability, poverty, homelessness, and/or addiction (Lam & Rosenheck, 1998; Sells, Rowe, Fisk, & Davidson, 2003). Survivors may experience feelings of sadness, grief, guilt, shame, and fear, all of which may interfere with their day-to-day functioning. However, as indicated above, survivors may also have great difficulty identifying, naming, and regulating emotions (Bloom, 1997).

Serious mental health problems commonly linked to traumatic experiences include anxiety, phobia, depression, dissociation, disordered eating, self-injury, substance abuse, and personality disorders (Brady, 2008; Briere & Scott, 2006). Depression is a common psychological response to victimization and trauma, often developing alongside other psychiatric disorders (Briere & Scott, 2006; Verdun-Jones & Rossiter, 2010). In some cases, depression may be linked to traumatic grief, particularly when the survivor has experienced a significant loss (Briere & Scott, 2006; Jacobs, 1999; Regehr & Sussman, 2004).

Experiences of childhood trauma, particularly sexual abuse, dramatically increase women's risk of suffering depression, thereby increasing the risk of suicide and deliberate self-harm (Gladstone et al., 2004; Gratz, 2003; Hegadoren et al., 2006; Santa Mina & Gallop, 1998). Self-injurious behaviour has been linked to childhood abuse, often serving as a coping mechanism to deal with the psychological sequelae of trauma, and is itself associated with other mental health problems, including dissociative and personality disorders (Connors, 1996; Dubo, Zanarini, Lewis, & Williams, 1997; Low, Jones, MacLeod, Power, & Duggan, 2000; Weierich & Nock, 2008).

Dissociation is commonly linked to trauma exposure, particularly abuse in childhood, and severe physical and sexual violence in adulthood (Briere & Scott, 2006; Neumann, Houskamp, Pollock, & Briere, 1996). Dissociation serves as a "built-in 'safety valve'" (Bloom, 1997, p. 33) to protect the body when it is in a state of extreme hyper-

arousal. Its underlying mechanism involves “separating thoughts from feelings, feelings from memory, or thoughts from memory” (Bloom, 1997, p. 34) to defend against overwhelming stress. In some cases, dissociation may develop into Dissociative Identity Disorder<sup>18</sup> (DID), which is characterized by identity fragmentation resulting in two or more personality states (American Psychiatric Association, 2000). DID involves disconnection or detachment, which serves as a protective mechanism to avoid a full realization of the trauma that is currently happening or has previously occurred (van der Kolk, 1996b). While co-morbid DID and PTSD diagnoses have been found to be associated with reduced amygdala and hippocampus size, these areas of the brain have been found to be intact among trauma-exposed individuals without co-morbid PTSD, suggesting that structural abnormalities in the brain are related to post-traumatic stress responses rather than dissociative responses to trauma (Weniger, Lange, Saschsse, & Irle, 2008).

Survivors of victimization and trauma may be diagnosed with Borderline Personality Disorder (BPD), a disorder characterized by difficulties with regulating emotions, impulsive behaviour, poor self-image, and unstable interpersonal relationships (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). The label ‘borderline’ is disproportionately applied to women, and is one of the most highly stigmatized psychiatric diagnoses (Morrow, 2008). The stigma associated with this label has been found to affect access to mental health services and care, as well as service providers’ perceptions of those diagnosed with the disorder (Nehls, 1998, 1999). For example, mental health nurses consider BPD patients to be more dangerous, and hold less sympathetic and less optimistic views of them, compared with other mental health patients (Markham, 2003; Markham & Trower, 2003). Individuals with BPD are typically considered difficult to treat, though Dialectical Behavior Therapy (DBT), a form of cognitive behaviour therapy developed specifically for BPD patients, has been found to be effective (Herman, Perry, & van der Kolk, 1989; Nehls, 1998).

BPD has been linked to childhood trauma, with approximately 60-70% of individuals, particularly women, with BPD meeting the criteria for a PTSD diagnosis (Herman et al., 1989; Nehls, 1998; Zanarini et al., 1998). Individuals diagnosed with BPD are at least four times as likely as those without a BPD diagnosis to have a concurrent PTSD diagnosis (Zimmerman & Mattia, 1999). As with DID, research has

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<sup>18</sup> Formerly Multiple Personality Disorder.

found reductions in hippocampal volume among individuals diagnosed with BPD, particularly those with co-morbid PTSD (Rodrigues et al., 2011).

Individuals with BPD are at much greater risk of committing suicide or engaging in self-harm, as a way to express or relieve emotions, and to distract or punish the self (Brown, Comtois, & Linehan, 2002; Gunderson & Ridolfi, 2001). Concerns have been raised that, given the similarities between symptoms of BPD and PTSD, women may be mistakenly diagnosed with the former or diagnosed with both disorders. Given the stigma associated with BPD, Hodges (2003) has called for an integration of the two diagnostic categories under the label of PTSD. Becker (2000), on the other hand, has concluded that “the promised land of PTSD has turned out to be a wasteland, most particularly so for the ‘bad girl’ borderline client” (p. 430). Expectations about socially acceptable behaviour for women are closely tied to women’s mental health diagnoses, with women who deviate from these expectations often constructed as ‘bad’ or ‘mad’ by experts who hold the power to define women’s behaviours (and responses to violence) as ‘pathological’ or ‘disordered,’ and in need of ‘taming’ (Pollack, 2005; Robillard, 2010; Ussher, 2011).

Post-traumatic Stress Disorder is the psychiatric diagnosis most closely associated with trauma, and the response to trauma most commonly cited in the literature (Verdun-Jones & Rossiter, 2010). It is classified in the DSM-IV-TR as an anxiety disorder and is characterized by the following symptoms: re-experiencing of the trauma (e.g., nightmares, flashbacks), avoidance of stimuli associated with the traumatic experience (e.g., thoughts, activities, locations, people) as well as emotional numbing (e.g., sense of detachment, lack of interest in activities), and increased arousal (e.g., irritability, hypervigilance, exaggerated startle response), all of which must persist for longer than one month and cause functional impairment<sup>19</sup>.

While men are more likely than women to experience victimization, women are more likely to be exposed to certain types of trauma, including sexual abuse and intimate partner violence (Hegadoren et al., 2006). Research shows that women are also twice as likely as their male counterparts to develop PTSD following trauma exposure (Brewin et al., 2000; Kilpatrick & Acierno, 2003), though this gender difference can be

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<sup>19</sup> PTSD may be specified as *acute* if symptoms last less than three months, *chronic* if symptoms last longer than three months, or *with delayed onset* if at least six months pass between the traumatic event and the onset of symptoms (American Psychiatric Association, 2000).



explained by women's greater risk of exposure to the types of trauma associated with PTSD (Hegadoren et al., 2006; Stein, Walker, & Forde, 2000). Other risk factors for the development of PTSD include younger and older age, genetic predisposition, lower socioeconomic status, previous history of victimization, and pre-existing mental health problems (Briere & Scott, 2006).

Persons suffering from severe mental illness are more likely than individuals without mental health problems to experience victimization and trauma, and to develop PTSD (Goodman et al., 1999; Hiday, Swanson, Swartz, Borum, & Wagner, 2001; Hiday et al., 1999; Silver, 2002). The relationship between mental illness and victimization can be explained, in part, by the fact that individuals with mental illness are more likely to be homeless, living in socially disorganized areas, and/or engaging in substance use (Hiday, 1997, 2006; Sells et al., 2003; Silver, 2006; Sirotych, 2008; White, Chafetz, Collins-Bride, & Nickens, 2006).

Hiday (1997) has suggested that psychiatric symptoms that are sufficiently intrusive or threatening to override self-control may create tense situations with others that, in turn, lead to violence perpetrated by individuals with mental illness. Such tension may also result from suspicion and mistrust resulting from violent victimization, which is more likely to occur among individuals with increased psychiatric symptomatology and in communities characterized by social disorganization and poverty (Hiday, 1997, 2006; Silver, Piquero, Jennings, Piquero, & Leiber, 2011). Social disorganization itself has been linked to violence perpetrated by individuals with mental illness as well (Silver, 2000).

Homeless women with mental health and substance use problems are especially vulnerable to physical and sexual violence on the streets, where victimization is so common that it is considered normative (Brunette & Drake, 1998; Goodman et al., 1995; Lam & Rosenheck, 1998; Padgett, Hawkins, Abrams, & Davis, 2006; Padgett & Struening, 1992; Wenzel, Koegel, & Gelberg, 2000). Trauma and PTSD may, in turn, exacerbate the symptoms of mental illness, either directly, as a result of PTSD symptoms, or indirectly, as a result of other problems such as increased substance use (Mueser et al., 2002).

Substance use is closely associated with victimization and trauma, with research suggesting that a history of trauma increases women's risk for alcohol and drug use (Covington, 2008; Stewart, 2007). For example, women may use substances to cope

with PTSD symptoms, numbing the emotional pain and managing intrusive thoughts related to trauma (Harris & FalLOT, 2001a). Substance use also increases women's risk of victimization and trauma. For example, women may end up in dangerous or unsafe situations in the course of accessing or using drugs, or their judgment may be impaired as a direct result of substance use, thereby increasing their risk of further victimization (Mueser et al., 2002).

There is strong evidence to suggest that experiences of victimization and trauma, substance use, and mental illness are intricately connected for women, particularly women involved in the criminal justice system (Covington & Bloom, 2006). For example, trauma plays an important role in the onset of mental health and substance use problems (Poole & Greaves, 2007). Substance use is also strongly connected to mental health problems, such as PTSD and other anxiety disorders, which may develop secondary to substance use or may lead women to engage in substance use as a form of self-medication (Kang, 2007). Findings from research on the co-occurrence of victimization and trauma, mental illness, and substance use have significant implications for treatment and recovery, as discussed in the recovery section below.

Though controversial, emerging evidence suggests that there is also a link between trauma and psychosis (Krabbendam, 2008). Research indicates that a history of victimization and trauma may be a risk factor for psychotic symptoms, particularly among those with a genetic predisposition for psychosis, suggesting that some psychotic disorders may be trauma-induced (Larkin & Read, 2008; Manning & Stickley, 2009; Spauwen, Krabbendam, Lieb, Wittchen, & van Os, 2006). For example, survivors of childhood abuse, particularly sexual abuse, may develop symptoms such as auditory command hallucinations (Morrison, Read, & Turkington, 2005; Read, Agar, Argyle, & Aderhold, 2003). A positive correlation has also been found between the severity of trauma and the severity of PTSD and psychotic symptoms, suggesting a dose-response relationship, with those exposed to more severe trauma likely to experience more severe psychiatric symptoms (Kilcommons & Morrison, 2005). Some scholars have even suggested that psychotic symptoms may themselves be traumatizing (Morrison et al., 2005).

### **2.1.1.3 Social Sequelae**

Victimization and trauma may profoundly affect victims' perceptions and beliefs about the world and the people around them, due to cognitive changes that occur in the aftermath of violence (Bloom, 1997; Goodman & Dutton, 1996; Hill, 2003; Yoder, 2005). Survivors are challenged to make meaning of their experiences in the aftermath of traumatic events that have shattered their assumptions that the world is benign or 'just' and that people are good. They often also feel a sense of guilt or shame about what has happened to them (Yoder, 2005).

When faced with danger, individuals seek attachment with others. This is especially true with children who have developed strong attachments with caregivers upon whom they are dependent for survival (Bloom, 1997). However, trauma interferes with the formation of secure and meaningful attachments, such that children who are abused and maltreated tend to form disorganized, insecure attachments with their caregivers (Heide & Solomon, 2006; van der Kolk, 1996b). Where interpersonal victimization and trauma is severe or prolonged, individuals may form attachments with perpetrators, a phenomenon known as 'trauma-bonding' (Bloom, 1997). In these cases, trauma survivors may consider unhealthy and harmful relationships to be 'normal.'

Traumatic experiences may also have a significant impact on social functioning and interpersonal relationships. Where personal boundaries are crossed in the course of interpersonal violence, victims may lack a sense of control and power (Hegadoren et al., 2006). The resulting sense of helplessness can damage victims' ability to trust others, especially when victimization involves secrecy or is perpetrated by individuals in positions of trust and authority (Bloom, 1997; van der Kolk, 1996b). Trauma survivors have been found to withdraw, socially, and avoid intimate relationships in an effort to maintain a sense of control and stability in their lives (van der Kolk, 1996b). It is therefore critically important that service providers recognize the importance of relationships and reconnecting with others in the trauma recovery process, and develop healing relationships with clients that promote and support their recovery (Herman, 1992b).

There is little doubt that "traumatized people tend to lead traumatizing and traumatized lives" (van der Kolk & McFarlane, 1996, p. 11). Although a causal relationship has yet to be established, victimization and trauma have been linked to future victimization and offending. Difficulties with early attachment and adult

interpersonal relationships increase the likelihood that trauma survivors will themselves engage in violent and antisocial behaviour (Heide & Solomon, 2006). Children who are abused or exposed to intimate partner violence in childhood, for example, may go on to perpetuate the cycle of violence, victimizing others in adolescence and adulthood (Bloom, 1997; van der Kolk, 1996b). Victims of interpersonal violence are also at increased risk of being re-victimized, with repeated victimization over the life course likely to have significant implications for trauma recovery, given the cumulative effects of trauma (Classen, Palesh, & Aggarwal, 2005; Follette et al., 1996; van der Kolk, 1996b).

Individuals who have experienced trauma may also engage in what is known as 'trauma reenactment' or 'compulsive reexposure,' which stems from a compulsion to repeat or relive traumatic experiences. This behaviour is often ignored and dismissed as 'attention-seeking' behaviour, though Bloom (1997) suggests that it more accurately signals a need for social connection.

Evidence on the biological, psychological, and social sequelae of victimization and trauma, and the vulnerability of women with mental health and substance use issues to victimization and re-victimization, have significant implications for the forensic mental health system, both in terms of reducing the risk of further victimization and trauma, and promoting trauma recovery. In the next section, I discuss mental health and trauma recovery, and describe trauma-specific and trauma-informed approaches to service delivery. I also show how re-framing assumptions about trauma survivors' behaviours, by adopting trauma-informed approaches, can support survivors in the trauma recovery process (Klinic Community Health Centre, 2008).

## **2.2 Understanding Recovery**

The concept of 'recovery' has multiple meanings depending on the context in which it is discussed. For example, recovery from physical illness, mental illness, psychological trauma, and addiction, all imply different processes and outcomes (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005). Recovery can also have different meanings within the same context. For example, in the substance use field, harm-reduction and abstinence-oriented approaches to recovery have remained the subject of significant debate, despite recent efforts to conceive of the two approaches as existing along a continuum (Kellogg, 2003). In the following sections, I describe perspectives on mental health and trauma recovery.

### **2.2.1 Mental Health Recovery**

The mental health field has seen a growing interest in the notion of ‘recovery’ over the past decade, a concept that emerged as a result of advances in anti-psychotic medications in the 1950s, psychiatric deinstitutionalization policies of the 1960s and 1970s, and the psychiatric survivor movements of the 1980s and 1990s (Livingston, Nijdam-Jones, & Brink, 2012; Morrow, Jamer, & Weisser, 2011; Starnino, 2009). In large part a reaction to the dominance of the medical model and the narrow view of recovery as the alleviation of symptoms through medication (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010), the survivor movement continues today through consumer- and peer-driven recovery-oriented approaches in mental health.

Recovery from mental illness, from the perspective of consumers and survivors, goes beyond symptom management and includes notions of hope, empowerment, autonomy, improved quality of life, and living a meaningful and purposeful life (Mental Health Commission of Canada, 2012). Canada’s mental health strategy defines recovery as “living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses” (Mental Health Commission of Canada, 2012, p. 15). Another key component of the recovery process is recovery from the stigma and discrimination associated with mental illness, which themselves may serve as barriers to recovery (Anthony, 1993; Corrigan, Markowitz, & Watson, 2004; Rossiter & Morrow, 2011).

Mental health recovery is neither straightforward nor linear, but instead a complex journey involving personal change and growth (Anthony, 1993). This process does not necessitate the involvement of professionals, though mental health service providers may play an important role in supporting individuals with mental illness in the recovery process (Anthony, 1993). In fact, the mental health system has seen a shift towards more recovery-oriented models of service delivery that emphasize therapeutic relationships between service providers and consumers, marked by shared power and control, and a holistic view of individuals with mental illnesses that extend beyond their illness (Livingston et al., 2012; Mead & Bower, 2000).

### **2.2.2 Trauma Recovery**

Recovery from psychological trauma is an extraordinarily complex, non-linear, and incomplete process (Herman, 1992b). Like recovery from mental illness, trauma

recovery does not imply a return to a 'normal' (i.e., pre-illness or pre-trauma) state, but rather making meaning of traumatic experiences, and moving from 'victim' to 'survivor' (Herman, 1992b). Herman describes trauma recovery as a process involving three stages<sup>20</sup>: (1) the establishment of safety (physical, psychological, and social), including the restoration of a sense of power and control; (2) remembrance and mourning, where survivors reconstruct the trauma by transforming fragmented traumatic memories into a coherent trauma story or narrative; and (3) reconnection with ordinary life, which may involve seeking justice through the legal system or alternative processes (Bloom, 1997; Herman, 1992b). Because the experience of trauma is one of disconnection and disempowerment, the recovery process involves reconnection, in the form of healing relationships, and empowerment of the survivor by restoring a sense of safety and control (Herman, 1992b).

As is the case with mental health recovery, trauma survivors may recover without formal treatment or interventions. Indeed, the vast majority of victims of crime choose not to access formal service systems, preferring to draw on informal supports to deal with the effects of trauma, particularly if they experience relatively low levels of distress (New & Berliner, 2000). However, for some, trauma recovery may require formal interventions, such as trauma therapy, or other professional supports.

Formal supports and service systems can address the trauma-related needs of survivors in three complementary ways: (1) by connecting clients to community-based victim services, (2) by offering *trauma-specific* services, which are designed to treat the immediate and long-term psychological sequelae of victimization and trauma, and (3) by adopting *trauma-informed* approaches, which integrate an awareness of the impact of victimization and trauma into all aspects of service delivery<sup>21</sup> (Harris & Fallot, 2001d; Jennings, 2004; Poole & Urquhart, 2009). In the following sections, I describe trauma-specific treatment techniques and models, and outline the fundamental principles of trauma-informed approaches, clearly distinguishing these two approaches to service delivery for trauma survivors. Although the Trauma Recovery Study focused on the challenges in developing trauma-*informed* forensic mental health services, the need for

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<sup>20</sup> Note that not all survivors will experience trauma recovery as a three-stage process, or move through the three stages in the order articulated by Herman.

<sup>21</sup> It is important to note that services may be *trauma-informed* even if they do not deliver *trauma-specific* services.

trauma-specific services (both in and outside the forensic mental health system) did emerge in interviews with client and staff participants.

### **2.2.2.1 Trauma-Specific Services**

Trauma-specific services involve direct interventions that assist trauma survivors in the healing and recovery process by addressing psychological, behavioural, and interpersonal issues (Salasin, 2005). Countless trauma-specific treatment techniques and models have been developed to treat the psychological effects of trauma. These include, but are not limited to, psycho-education (e.g., providing accurate information about trauma and its effects), affect regulation (e.g., grounding and relaxation), cognitive therapy (e.g., trauma-focused psychotherapy), techniques to improve emotional processing (e.g., exposure and desensitization<sup>22</sup>) and relational functioning (e.g., counterconditioning), and psychotropic medications (Briere & Scott, 2006; Davidson & van der Kolk, 1996; Scott & Briere, 2006). Medications that have been used in the treatment of PTSD include anti-depressants, benzodiazepines, mood stabilizers, adrenergic agents, and anti-psychotic medications, though these are unlikely to be effective in the absence of non-pharmacological interventions (Scott & Briere, 2006).

Trauma-specific treatment techniques and interventions should also be delivered by professionals who believe in trauma recovery and growth, and respect the basic principles of trauma therapy<sup>23</sup> (Briere & Scott, 2006). That is, they must establish safety (e.g., physical, psychological, emotional) and ensure stability (e.g., an individual's living conditions), treat victims with respect, foster a sense of hope, maintain a positive outlook, nurture the therapeutic relationship, remain sensitive to the diversity of trauma survivors, and tailor therapeutic interventions to victims' unique needs (Briere & Scott, 2006).

No one intervention or treatment technique will be suitable and effective for all trauma survivors, given the enormous variation in the nature, severity, and duration of

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<sup>22</sup> One of the most popular and controversial desensitization techniques, Eye Movement Desensitization and Reprocessing (EMDR), has been found to be no more effective than other exposure techniques, with eye movements found to be unnecessary (Davidson & Parker, 2001).

<sup>23</sup> The concept of Post-traumatic Growth (PTG) has emerged in the positive psychology movement, implying that traumatized individuals are able not only to recovery from trauma, but also grow and develop in positive ways following a traumatic incident (Ai & Park, 2005; Calhoun & Tedeschi, 1998; Joseph & Linley, 2008; Linley & Joseph, 2004; Tedeschi & Calhoun, 2004).

traumatic experiences, and the psychological responses of victims. It is therefore critical that interventions address the unique needs of trauma survivors (Verdun-Jones & Rossiter, 2010). In addition to differences in exposure and responses to trauma, men and women also “experience, communicate, and process the distress associated with traumatic events in different ways” (Briere & Scott, 2006, p. 79). Therefore, an important consideration in trauma treatment is the development of interventions designed to meet gender-specific needs and attend to issues of diversity.

Another important consideration in trauma-specific interventions is the co-occurrence of mental health and substance use problems. Despite a growing body of literature on the interconnection of women’s experiences of victimization and trauma, mental illness, and substance use, these concerns have often been addressed separately in treatment (Covington & Bloom, 2006; Poole & Greaves, 2007; Poole & Urquhart, 2009; Stewart, 2007). For example, women may be required to have abstained from substance use for a specified period, or be taking psychotropic medications, before they are accepted into trauma treatment. Yet, research has shown that integrated trauma-specific services that aim to treat victimization and trauma, substance use, and mental health issues together are more effective than services that attempt to treat these problems separately, where one problem is addressed before others are considered (Finkelstein et al., 2004, June; Gatz et al., 2007; Morrissey et al., 2005).

The Women, Co-occurring Disorders, and Violence Study (WCDVS) was the first large-scale quasi-experimental study to develop and evaluate the effectiveness of integrated trauma-specific and trauma-informed service delivery models in the mental health and substance use fields. The study involved the collection of baseline and 12-month follow-up data across nine sites in the United States, between 2001 and 2003. The participants were 2,729 women with co-occurring mental health and substance use disorders who had histories of victimization and trauma (Salasin, 2005). Findings indicated that women receiving integrated trauma-specific treatment services showed greater improvements than women in the treatment-as-usual comparison group (Morrissey et al., 2005).

A number of treatment models were used or developed in the course of the study, including the Trauma Recovery and Empowerment Model (Harris, 1998; Tremblay), the Addiction and Trauma Recovery Integration Model, the Triad model



(Clark & Fearday, 2003), and Seeking Safety (Najavits, 2001; Najavits, 2002). The latter is a present-focused, integrated treatment model that focuses on ideals and achieving interpersonal, cognitive, behavioural, and emotional safety. It is flexible and adaptable to various service systems, and has been adopted by a number of services, including the Victoria Women's Sexual Assault Centre in British Columbia. An evaluation of the adapted program<sup>24</sup> for women survivors of sexual violence found that women participants felt safe and grateful to have the opportunity to address both trauma and substance use issues, experienced reduced isolation and stigma, and gained a greater sense of self-acceptance, connection with others, and hope for the future (Gose & Jennings, 2007; Poole & Pearce, 2005).

Although not all mental health and addiction services are equipped with the resources and expertise required to provide trauma-specific treatment services to clients, all service systems have the potential to adopt *trauma-informed* approaches. In the following section, I describe the fundamental principles of trauma-informed approaches, and how they have been adapted to mental health, substance use, and criminal justice settings.

### **2.2.2.2 Trauma-Informed Approaches**

Trauma survivors may be re-traumatized as a result of interactions with service providers across service systems, including criminal justice, mental health, and addictions services. For example, research suggests that involvement in the legal system has the potential not only to re-victimize trauma survivors but also to impede the recovery process (Dylan, Regehr, & Alaggia, 2008; Herman, 2003; O'Sullivan & Fry, 2007). According to Herman (1992b), "if one set out by design to devise a system for provoking intrusive post-traumatic symptoms, one could do no better than a court of law" (p. 72).

Beyond the criminal courts, correctional facilities may be a site of potential re-traumatization for survivors, particularly because, "in addition to their legitimized power over inmates, prison officers have the prerogative and the duty to punish women who do not accept their control" (Heney & Kristiansen, 1998, p. 32). These settings are likely to

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<sup>24</sup> The adapted program involved two stages: (1) *Seeking Information*, a 3-week program focused on coping strategies, and (2) *Seeking Understanding*, a 12-week integrated trauma and substance use treatment program, for women who wished to delve further into these issues.

be traumatizing because they remove a sense of power and control from individuals who are already powerless and controlled.

In light of the traumatizing experiences of survivors accessing service systems, trauma researchers have called for a paradigm shift and the development of 'trauma-informed' systems of care, which demand shifts in organizational culture (Bloom, 1997; Harris & Fallot, 2001d). Trauma-informed services build on trauma theory by respecting the underlying principles of trauma therapy, recognizing the centrality of victimization and trauma in the lives of clients, and integrating this knowledge into service delivery (Harris & Fallot, 2001b). They are sensitive to the trauma-related experiences and needs of clients, and aim to reduce the risk of re-victimization, promote trauma recovery, and avoid blaming victims for their responses to trauma (Elliott et al., 2005; Harris & Fallot, 2001d; Jennings, 2004; Salasin, 2005).

According to Elliott and colleagues (2005), trauma-informed services: (1) validate clients' experiences by acknowledging the impact of trauma, and how it affects survivors' coping strategies, (2) focus on recovery through the provision of trauma-specific services or referrals to programs that offer these services, (3) emphasize women's empowerment, (4) offer women choices with respect to treatment and give women control over decisions that affect them, (5) attempt to foster safe, supportive, and therapeutic relationships between service providers and survivors, (6) provide women with a safe and respectful environment, (7) focus on women's strengths and recovery, rather than symptoms and pathology, (8) minimize the risk of re-traumatization in the course of service delivery, (9) strive for cultural competence and safety, and (10) involve survivors in the design and evaluation of services.

These principles have been condensed into four key principles for trauma-informed practice: (1) trauma awareness at all levels of an organization and embedded in the organization's culture, (2) emphasis on safety and trustworthiness in programming and the space where services are delivered, both for clients and staff, (3) choice, control, and collaboration in the delivery of services, and (4) emphasis on strengths, resilience, and coping skills (Poole, 2012).

Trauma-informed approaches have been successfully adopted in a variety of services and systems of care, including inpatient and outpatient mental health services (Bloom, 1997; Freeman, 2001; Harris & Fallot, 2001c), addictions services (Harris & Fallot, 2001a), correctional services (Covington & Bloom, 2006), residential housing

programs (Bebout, 2001), and services offered by a range of child-serving agencies (Ko et al., 2008). Trauma-informed approaches designed for one type of service may also be adapted and integrated into other types of programs and services.

Mental health and addiction services throughout the United States and Canada have been moving, in recent years, towards more trauma-informed models of service delivery. Highly acclaimed trauma-informed services in Canada include the Jean Tweed Centre in Toronto, Ontario, and the Victoria Women's Sexual Assault Centre in Victoria, British Columbia, both of which have adapted their organizations to provide trauma-specific and trauma-informed services (Gose & Jennings, 2007). The Jean Tweed Centre describes its approach as a 'braided' approach, which integrates trauma into the delivery of substance use services for women, including women who are pregnant and parenting (Hume, Grant, & Furlong, 2007).

The adoption of trauma-informed approaches in correctional environments is arguably more difficult than in mental health settings, given the conflicting correctional goals of rehabilitation and punishment (Miller & Najavits, 2012). Yet, some scholars have suggested that, despite the challenges of adopting trauma-informed approaches in prison settings, *trauma-informed correctional care* is possible (Harner & Burgess, 2011; Miller & Najavits, 2012). Similar challenges can be anticipated in the forensic mental health system, where there is an apparent conflict between the goals of recovery and risk management (Livingston et al., 2012; Mezey et al., 2010; Nijdam-Jones, 2012). Challenges and opportunities related to the adoption of trauma-informed approaches in forensic mental health services reflect those in mental health, addictions, and correctional services. As such, trauma-informed approaches have not yet been widely adopted in forensic mental health services, and the Trauma Recovery Study sought to explore some of the unique challenges associated with the adoption of trauma-informed approaches within forensic psychiatric settings.

Adopting trauma-informed approaches to service delivery does not necessarily mean that clients are required to disclose trauma histories. In fact, the shift towards trauma-informed services involves abandoning standardized trauma screening in favour of "creating a safe environment which would support women to tell their story in their own ways, in their own time" (Poole & Urquhart, 2009, p. 5). Additionally, trauma-informed approaches require organizations to shift the way they view clients; for example, by shifting the language and thinking from 'what is wrong with this woman?' to

‘what has happened to this woman?’ (Poole & Urquhart, 2009; Williams & Paul, 2008). In doing so, trauma-informed approaches shift the focus from individual survivors’ symptoms and behaviours to issues of violence against women in society more broadly. An understanding of the social context of women’s lives and the structural factors that shape their lived experiences of victimization and trauma means that trauma-informed approaches should also be attentive to issues of diversity. For example, responsive programming for Aboriginal women should not only be trauma-informed and women-centered, but also ‘culturally safe’ in order to be effective (Browne et al., 2009; Josewski, 2012).

Trauma-informed approaches focus not only on victimization and trauma in the lives of clients who access services. These approaches also highlight the fact that working with trauma survivors can have an impact on the mental health and well-being of service providers themselves. The next section considers the secondary effects of trauma on professionals who work with trauma survivors, an important consideration for staff in forensic mental health settings who work with women who have co-occurring experiences with victimization and trauma, mental illness, substance use, and crime.

## **2.3 Working with Trauma Survivors**

Service providers in the helping professions are regularly exposed to their clients’ stories of victimization and trauma, and general human suffering. Bearing witness to these experiences can be difficult, and has been found to have an effect on service providers’ own mental health and well-being. In some cases, service providers may develop symptoms of traumatic stress as a result. Remaining attentive to the ripple effects of trauma is an important consideration in working with trauma survivors because, according to Herman (1992b), “trauma is contagious” (p. 140).

The secondary effects of trauma have been variously described as ‘traumatic countertransference’ (Herman, 1992b), ‘vicarious traumatization’ (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), ‘secondary traumatic stress,’ ‘compassion fatigue’ (Figley, 1995), and ‘burnout’ (Pines & Maslach, 1978). Although these terms are often used interchangeably to describe a common phenomenon, there are subtle differences between the constructs (see, Collins & Long, 2003). As with the effects of traumatic stress on survivors, secondary traumatic stress has cognitive, emotional, behavioural, spiritual, interpersonal, and physical impacts, including increased self-doubt, survivors’

guilt, hypervigilance, feelings of hopelessness, isolation, and health problems (Yassen, 1995). Vicarious traumatization can affect professionals' sense of safety, trust, intimacy, esteem, and power (Pearlman & Mac Ian, 1995). It can also have an impact on professional functioning, affecting job performance (e.g., mistakes, avoidance of certain tasks), employee morale (e.g., demoralization, detachment), professional relationships (e.g., reduced communication, increased conflict), and job behaviour (e.g., absenteeism, staff turnover).

Factors associated with the development of secondary traumatic stress include degree of exposure, gender, age, education, history of trauma, mental health problems, current life stress, empathy with trauma survivors, negative coping strategies, and a lack of social supports (Gates & Gillespie, 2008; Huggard, 2003; Lerias & Byrne, 2003). As with post-traumatic stress, women are more likely than men to develop secondary traumatic stress (Lerias & Byrne, 2003). Younger persons are also more likely to experience negative effects from working with trauma survivors because they have less experience with, and exposure to, trauma and distress (Lerias & Byrne, 2003). Victim services workers and other helping professionals who themselves have a history of victimization may be particularly vulnerable to secondary traumatic stress (Lerias & Byrne, 2003).

Factors associated with the work itself are also relevant to the risk of experiencing secondary trauma. It is important for organizations and employers to recognize the potential for secondary traumatic stress and ensure that structures and supports are in place to assist staff in doing trauma work without compromising their own health and well-being (Hesse, 2002). This may include ensuring that workers are not overwhelmed with clients who have trauma-related issues, and allowing workers to organize their schedules and build in breaks when necessary to avoid burnout (Richardson, 2001). Research suggests that the likelihood of negative outcomes resulting from work with victims of crime can be reduced through trauma-specific training and the development of a strong network of personal and professional supports (McCann & Pearlman, 1990; Salston & Figley, 2003). Helping professionals should maintain a balance of professional and recreational activities, and seek meaningful connections with others (Richardson, 2001).

An awareness of the impact of trauma on mental health service providers is critical when considering the experiences and needs of women in the forensic mental

health system who have histories of victimization, because it informs discussions about the role of forensic mental health professionals in responding to trauma-related issues in the lives of their clients, and the supports that need to be in place for them to do so without suffering from the secondary effects of trauma.

The secondary effects of trauma are not limited to service providers, but also impact upon others involved in trauma-focused work, including researchers. Indeed, according to Herman (1992b), “to study psychological trauma means bearing witness to horrible events” (p. 7). Researchers, educators, and students whose work focuses on understanding the experience and impact of victimization and trauma are vulnerable to secondary traumatic stress. Exposure to human suffering in the course of research, but particularly in the data collection and analysis stages, can be emotionally draining for researchers. Some scholars have even suggested that transcribers working with graphic and emotional interview content be considered ‘vulnerable’ persons (Gregory, Russell, & Phillips, 1997). Increased awareness of the risks of psychological distress to researchers, and particularly graduate students undertaking trauma-focused research, is critical to reducing the impact of victimization and trauma. While carrying out the Trauma Recovery Study, I managed the effects of bearing witness to women’s traumatic experiences through the use of professional supports and maintaining a research journal where I wrote about and dealt with troubling experiences.

### **3: THEORETICAL FRAMEWORK II: PATHWAYS AND INTERSECTIONS**

Victimization and trauma are central to feminist theories of women's pathways to crime, which have mapped women's experiences along a continuum from victimization to criminalization, and blurred the boundaries between 'victim' and 'offender' (Comack, 1996, 2006). The Trauma Recovery Study drew heavily on feminist criminological theories – specifically, the feminist 'pathways' perspective – to explore the role of victimization and trauma in women's pathways to (and through) forensic mental health services. The study also employed intersectional feminist frameworks, which have gained popularity in criminological and mental health research, to reveal differences among women at the interface of the criminal justice and mental health systems, and to illustrate how the intersection of gender and other social inequities shapes women's trauma-related experiences and needs.

#### **3.1 Feminist Criminology**

Women have been largely ignored in the construction of criminological theory, with mainstream criminology focused on explaining men's criminality (Collins, 1999; Comack, 1990; Daly & Chesney-Lind, 1988; DeKeseredy, 2000; Milovanovic & Schwartz, 1996). Women's 'invisibility' in criminological theory can be explained in part by their tendency to commit fewer crimes than men, but also by women's invisibility in the academe, with theories of crime historically developed by male scholars (Einstadter & Henry, 2006). Early theories of women's criminality, too, were developed by men, and emphasized women's weakness and inferiority, attributing their criminal behaviour to biological features (e.g., Lombroso, 1895).

It was not until the 1960s and 1970s when feminism permeated the academe that a feminist criminology emerged to address the invisibility and misrepresentation of women in mainstream criminological theory, or what has been dubbed 'malestream'

criminology<sup>25</sup>. The influence of feminist thought in criminology marked an important shift in knowledge about women's criminality. Feminist criminological theories offered alternative explanations of women's crime from women's own perspectives, shifting the focus from biological explanations to social and structural factors that contributed to gender inequality.

In addition to uncovering the structural roots of women's law violations and exposing gender discrimination in the criminal justice system, feminist scholars and activists took on the important task of documenting and explaining male violence against women. In doing so, they framed this 'private' problem as an important social and criminal justice issue<sup>26</sup>, and drew important links between women's victimization and criminalization.

Although we often hear of a 'feminist criminology,' feminist theory does not consist of a single theory, but rather multiple feminist perspectives on the causes of gender inequality, the process of gender formation, and strategies for social change (Daly & Chesney-Lind, 1988; DeKeseredy, 2000). Feminist theory consists of five perspectives, each offering a unique explanation of the source of women's oppression and, in criminology, a different account of women's victimization and criminal behaviour (see, Comack, 1996; Daly, 1998; Burgess-Proctor, 2006).

According to *liberal feminists*, women commit fewer crimes than men because of gender role socialization and a lack of opportunities to engage in such behaviour (Burgess-Proctor, 2006). Other perspectives have sought to explain women's criminality, with *radical feminism* pointing to patriarchy and gender-based oppression, *Marxist feminism* pointing to class-based inequities and economic disparities, and *socialist feminism* examining the interaction of gender- and class-based inequities (Burgess-Proctor, 2006). *Postmodern feminists* explore multiple truths and perspectives, and the social construction of crime and justice (Balfour & Comack, 2006; Burgess-Proctor, 2006).

Feminist scholars are particularly attentive to the terms they employ in their work, remaining "sensitive to the ways in which language attributes meaning and structures

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<sup>25</sup> This term has also been employed in the mental health field, with feminist scholars arguing that women's mental health has been marginalized within 'malestream' psychiatry (Morrow, 2007a).

<sup>26</sup> The problem of violence against women has more recently been framed as a pressing public health issue (Garcia-Moreno & Watts, 2011).



our ways of knowing the world around us” (Comack, 1996, p. 10). Women who come into conflict with the law have been labelled as ‘female offenders/criminals,’ ‘unruly women’ (Faith, 1993), ‘women in trouble’ (Comack, 1996), and ‘criminalized women’ (Balfour & Comack, 2006; Faith, 1993). The phrase ‘women in conflict with the law’ is problematic, according to Faith (1993), because “it denies the fundamental inequality of the relationship... One cannot simply be ‘in conflict’ with power to which one is subordinate” (p. 58). Acknowledging unequal power is important to the feminist project, which seeks to invert unequal power structures and empower women. Comack (1996) adopted the phrase ‘women in trouble’ in an effort to find “a pathway out of this terminological muddle” (p. 11).

Contemporary and postmodern feminist criminologists prefer the term ‘criminalized women’ because it draws attention to the power of the law, and the selective process by which some women are labelled ‘criminal’ and others are not, a process that perpetuates social inequities (Balfour & Comack, 2006; Comack & Balfour, 2004; Daly, 1998). Indeed, as Faith (2006) notes, “all societies are selective about who is criminalized and sent to prison; the likelihood is not just a matter of who breaks the law, but also of one’s position on the social ladder” (p. 6).

In this dissertation, I refer to ‘women at the interface of the criminal justice and mental health systems’ and ‘women receiving forensic mental health treatment services.’ These terms do not draw attention to the unequal power relations in the forensic mental health system in the same way that the language of ‘criminalized and psychiatrized women’ would, but do still afford women some degree of resistance in that they are not characterized as seeking services voluntarily. I chose to employ less critical language for strategic reasons, aware that gatekeepers within the forensic mental health system were in positions of power and, in some cases, directly involved in the psychiatrization of the women clients whose perspectives the research sought to uncover. These gatekeepers had power over the research in the sense that they could deny access to the organization. Critical researchers may have difficulty gaining access to organizations that are concerned about having their services and organizational cultures evaluated and/or critiqued<sup>27</sup>. More critical language may also have suggested an allegiance to clients, and a lack of openness to staff perspectives, that may similarly raise concerns

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<sup>27</sup> Police agencies and correctional services may be especially wary of researchers, particularly researchers external to their organizations, for similar reasons. In fact, it is very difficult for researchers to gain access to these types of organizations.

among gatekeepers who are in positions of power and who view the research as critical of them (Liebling, 2001).

### **3.1.1 'Pathways' Perspective**

The Trauma Recovery Study was grounded in feminist criminological theories, building in particular on research conducted by Chesney-Lind (1989), Daly (1992), Gilfus (1992), and Comack (1996), whose work has mapped women's pathways from victimization to crime. This feminist 'pathways' perspective is fitting as it has drawn links between women's victimization and criminalization, and the ways in which women's survival strategies and responses to victimization are criminalized (Gilfus, 1992).

The connection between women's experiences of victimization and criminalization has been one of the most significant contributions of feminist criminology. Research in this area has illustrated how women's attempts to cope with victimization often lead them to engage in behaviours that are then criminalized. This 'pathways' perspective has mapped women's routes from victimization to criminal offending, and placed these connections within the social context of women's lives, drawing links to women's experiences of poverty, sexual exploitation, substance use, and mental illness, and the role of these experiences in women's pathways to crime (Comack, 1996; Daly, 1992, 1998; DeHart, 2004; Gilfus, 2002; McDaniels-Wilson & Belknap, 2008; Pollack, 2006).

Chesney-Lind (1989) first theorized the criminalization of girls' survival strategies, arguing that "many young women, then, are running away from profound sexual victimization at home, and once on the streets they are forced further into crime in order to survive" (p. 22). Gilfus (1992) drew similar conclusions from qualitative life history interviews with incarcerated women who described how running away from abuse in their homes led them to the streets where they experienced further victimization, and became involved in the sex and drug trades, activities that brought them into contact with the criminal justice system.

Based on her research, Daly (1992) advanced a number of different pathways to crime for women, which she compared to the 'leading feminist' or 'street woman' scenario described in Chesney-Lind's and Gilfus' work. The majority of the women in her sample were described as 'harmed-and-harming women' – women who experienced childhood abuse or neglect, were labelled as 'problematic' in adolescence, and

developed subsequent mental health and substance use problems. Many women did fit the 'street woman' scenario, while others were labelled as 'battered women,' 'drug-connected women,' and 'other,' a category for women whose crimes had been committed out of economic necessity or greed and who did not fit in any other category.

Feminist criminologists have continued to employ the pathways perspective in order to explain women's routes to criminal behaviour, probation, and incarceration. For example, researchers have extended this work beyond retrospective qualitative approaches and employed quantitative analyses that have found empirical support for gendered pathways to crime and the need for gender-responsive correctional services (Salisbury & Van Voorhis, 2009; Simpson, Yahner, & Dugan, 2008).

The pathways perspective, though a significant contribution to feminist criminology, has not been without criticism. Indeed, a simplistic construction of criminalized women as 'victims' has been criticized by mainstream criminologists for its over-simplification of women offenders as 'victims,' and problematized by feminist criminologists for its denial of women's agency, survival, and resistance (Comack, 1999b; Faith, 1993; Hannah-Moffat & Shaw, 2000). To overcome this problem, it is important to return to the notion of blurred boundaries and ensure that women who have committed crimes are not constructed as *only* victims, thereby excusing their criminal behaviour, but as women who have extensive histories of victimization and trauma that might explain their pathways to crime and imprisonment.

Although no causal relationship has been established between women's victimization and criminal behaviour, the feminist 'pathways' perspective has had an impact on social and criminal justice responses to women who come into conflict with the law (Comack, 1996; Pollack, 2006). Feminist explanations of women's pathways to crime have led to the development of women-centered, or gender-responsive, policies, programs, and services, that are tailored to the unique needs of women, and attend to the social and structural forces that shape their lives. For example, the Correctional Service of Canada has adopted a women-centered approach, though critical feminist scholars have argued that this concept has been redefined by correctional services and used to regulate rather than empower women in prison (Hannah-Moffat, 2000, 2001; Pollack, 2005)

Gender-informed approaches in the delivery of other services, outside of the criminal justice system, similarly consider women's experiences of victimization and

trauma in their pathways to those services. For example, gender-informed inpatient mental health services encourage staff to recognize that mental distress and illness may be rooted in childhood experiences of trauma and abuse, and rethink their relationships with clients to support mental health recovery (Williams & Paul, 2008). Women-centered, or gender-responsive, approaches require policy makers and service providers to acknowledge that gender matters, and to recognize that attending to gender differences in service delivery is critical if service goals are to be achieved.

Acknowledging the realities of victimization and trauma in women's and girls' lives suggests that being women-centered also requires services and systems to be trauma-informed. Services that are both women-centered and trauma-informed treat women, in all their diversity, as experts of their own experience and needs; promote recovery through respectful and collaborative relationships where power is shared equally; and empower women by focusing on their strengths and providing them with meaningful choices (Cory & Dechief, 2007; Harris & Fallot, 2001b; Williams & Paul, 2008).

The recognition of gender differences ultimately affects all aspects of service delivery, from intake procedures to case management, programming, and release planning. As with trauma-informed approaches, women-centered services involve “the creation of an environment – through site selection, staff selection, program development, and program content and materials – that reflects an understanding of the realities of women's and girls' lives and that addresses and responds to their challenges and strengths” (Covington, 2008, pp. 377-378). A focus on women's strengths and empowerment is especially important in criminal justice, mental health, and forensic mental health services where inherent power imbalances exist between clients and service providers. However, developing and implementing women-centered programming in a service system does not mean that the service system is ‘women-centered.’

### **3.2 Intersectional Frameworks**

Despite the contribution of feminist perspectives in criminology, early feminist theories have been criticized for reflecting the perspectives of White, middle-class, educated women and neglecting those of marginalized and minority women (Collins, 1999; Comack, 1990). Feminist essentialism led to the false belief that there was a

'universal' female experience (Grillo, 1995), and constructed women as "raceless, classless, albeit gendered human beings" (Collins, 1999, p. 276). This essentialism has meant that the voices of marginalized women, including racial and ethnic minority women, women living in poverty, and women living with mental illness, have not been heard. As bell hooks (2000) so eloquently stated:

Feminism in the United States has never emerged from the women who are most victimized by sexist oppression; women who are daily beaten down, mentally, physically, and spiritually – women who are powerless to change their condition in life. They are a silent majority.

Although the voices of marginalized and minority women have been muted within dominant feminist theories, Black feminist and anti-racist feminist writing that challenged feminist essentialism were some of the earliest writings that advanced an intersectionality framework (Dhamoon & Hankivsky, 2011). Women of colour argued that gender could not be experienced separately from race, and that forms of oppression were interlocking and mutually reinforcing. That is, the lived experiences of women of colour are simultaneously shaped by racism and sexism.

Intersectionality was more recently popularized by Kimberlé Crenshaw (1991) and Patricia Hill Collins (1999), and has sought to address the limitations of dominant feminist writings by giving voice to those silenced at the margins of feminist scholarship and activism (McCall, 2005). It has been heralded as one of the most important contributions to feminist theory and scholarship, and has been embraced by contemporary feminist criminologists and women's health researchers, among others (Burgess-Proctor, 2006; Davis, 2008; Dill, McLaughlin, & Nieves, 2007; Solokoff & Dupont, 2005; Varcoe, Hankivsky, & Morrow, 2007).

Intersectionality has been described as a research paradigm, a theoretical framework, a methodological approach, and a tool for achieving social justice (Symington, 2004). An intersectional lens allows for an understanding of the complex ways in which multiple identities, categories, or hierarchies (such as race, ethnicity, class, gender, and ability) intersect to produce unique experiences of relative privilege and subordination (Collins, 1999; Crenshaw, 1991; Symington, 2004). This framework conceives of individuals as being situated in a matrix, with each at a 'social location,' which refers to their "position within a social hierarchy conferred by multiple and

interconnected social statuses (such as race/culture/ethnicity, gender, class, ability/disability)” (Samuels-Dennis, Bailey, & Ford-Gilboe, 2011, p. 176).

Intersectional perspectives offer explanations of women’s experiences that move beyond gender as the primary focus of analysis, and instead explore intersecting inequalities, which are conceptualized as multiplicative rather than additive (Hancock, 2007). That is, intersectional analyses do not necessarily assume that gender will be the primary category of analysis but, rather, consider gender as an identity category inseparable from other identity categories and axes of inequality (Burman & Chantler, 2003; Solokoff & Dupont, 2005; Varcoe et al., 2007). This approach seeks to untangle the complex interactions among gender and other axes of inequality and understand women’s experiences at different social locations where systems of domination and oppression are experienced together rather than separately (Comack, 1999a; Monture-Angus, 1999; Price, 2005). That is, a woman with mental illness does not experience the world separately as a ‘woman’ and as a ‘person with mental illness’ but uniquely at the intersection of gender and mental disability.

Much intersectional scholarship has focused on the intersections of gender, race, and class (e.g., Comack, 1999a; Milovanovic & Schwartz, 1996; Solokoff & Dupont, 2005; Zawilski, 2010). However, contemporary feminists employing intersectional frameworks are beginning to move beyond the ‘trilogy’ of gender, race, and class, to explore other systems of inequality such as sexual orientation, ethnicity, religion, age, and disability (Comack, 1990, 2007; DeKeseredy, 2000; Symington, 2004).

In criminology, intersectionality has been used to explain how intersecting axes of inequality shape women’s experiences of victimization and criminalization (Burgess-Proctor, 2006). For example, in the area of violence against women, intersectional feminist scholars have explored how interlocking systems of domination and oppression create and perpetuate the social conditions that put women at risk of experiencing victimization and trauma; how victimization and trauma are experienced by women at different social locations; and the ways in which services and supports aimed at reducing and preventing violence against women may fail to meet the diverse needs of women survivors (Hankivsky & Cormier, 2009; Johnson & Dawson, 2011).

Intersectional frameworks have also expanded perspectives on women’s pathways to crime. For example, Richie (1996) examined the ways in which battered African American women are ‘compelled to crime’ through a process of ‘gender

entrapment' that is directly linked to their identities at the intersection of gender and race. As well, intersectional frameworks have been used to explain how women's experiences of victimization and trauma, which are often at the root of their pathways to crime and incarceration, are embedded in race-based, gender-based, and class-based inequities (Brown, 2006).

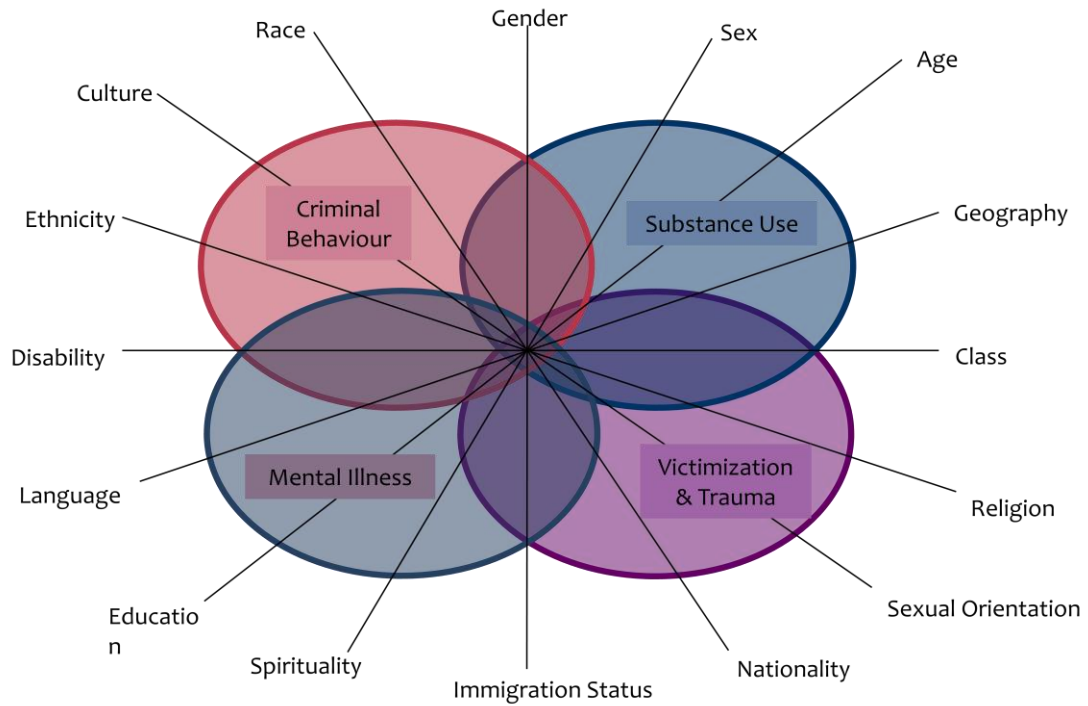
Finally, intersectionality has been used to explore social responses to crime, and to shed light on gender, class, and racial discrimination in the criminal justice system (Comack, 1999a, 2007). The impact of interlocking forms of oppression is particularly evident in the disproportionate overrepresentation of Aboriginal women in Canadian prisons – a consequence of colonization and the erosion of Aboriginal cultural identity (Martel & Brassard, 2008). In fact, Balfour (2008) has argued that feminist-inspired approaches to address violence against women have led to *increased* rates of victimization and incarceration among Aboriginal women, illustrating the importance of intersectional approaches in feminist criminological research.

In mental health services research, intersectionality has been used to explore the ways in which interlocking systems of domination and oppression influence women's relative risk of developing mental health problems, their access to mental health services, their experiences of stigmatization, and their responses to treatment (Chiu, Morrow, Ganesan, & Clark, 2005; Groh, 2007; Kohn & Hudson, 2002; O'Mahony & Donnelly, 2007). For example, immigrant women with mental health issues face multiple barriers in accessing culturally appropriate mental health services (Chiu et al., 2005). Similarly, poverty shapes women's experiences of mental illness and their access to treatment services (Groh, 2007). Yet, despite the value of intersectionality in the mental health field, intersectional approaches remain underdeveloped in mental health research, policy, and services (Morrow, 2007b).

Samuels-Dennis and colleagues (2011) recently proposed an 'intersectionality model of trauma and PTSD,' making an important feminist contribution to the field of traumatic stress studies. This model shifts the focus from an understanding of the individual biological and psychological responses to trauma, to one that explains how "neighbourhood structural and political intersectionality influences exposure to gender-based trauma, the response of self and others to violence, and access to community and institutional supports that facilitate recovery from PTSD" (Samuels-Dennis et al., 2011, p. 288). The Trauma Recovery Study employed intersectionality to explore and highlight

the diversity and complexity of women's trauma-related experiences and needs at the interface of the criminal justice and mental health systems (see Figure 1).

**Figure 1: Intersectional Framework of the Trauma Recovery Study**





## **4: THE ETHICS OF TRAUMA-FOCUSED RESEARCH**

In order to contribute to the growing literature on the ethics of trauma-focused research, and to assist in assessing the ethical impact of trauma-focused research on women who participated in the study, the Trauma Recovery Study included an ethics component in the research protocol. This inquiry involved gathering information about the experiences and reactions of individuals who participated in the study (the third focus of the study). This component also sought to give voice to these women regarding their experiences as research participants in a trauma-focused study, so that decisions about the participation of women in forensic psychiatric settings in sensitive research of this nature may be guided by women's own voices and perceptions of their vulnerability, rather than the perspectives and assumptions of those who have power over them.

Ethics are of paramount importance in research involving vulnerable populations and individuals whose circumstances render them vulnerable. In the context of research, individuals or groups may be considered vulnerable on the basis of gender (e.g., women, transgender persons), age (e.g., children, older adults), criminal justice or mental health status (e.g., individuals with mental health issues, psychiatric inpatients, prisoners), or disability (e.g., persons with diminished capacity for self-determination). In criminology, vulnerable populations may also include individuals who have low social status, are under court or correctional supervision, and are "unfamiliar with social research or otherwise occupy a position of unequal power with the researcher" (Academy of Criminal Justice Sciences, 2000, Article B17).

The Trauma Recovery Study involved sensitive research with a vulnerable population of women receiving forensic mental health treatment services. This population of women may be considered 'triple vulnerable' on account of their gender, mental health status, and legal status, and thus a number of important ethical considerations concerning vulnerable participants were relevant to the study. These ethical issues are historically rooted, and thus a review of historical abuses in research involving women, persons with mental illness, and prisoners is warranted.

Historical abuses in the use of humans as research subjects have led to concerns about the rights of research participants and the need to protect individuals who may be vulnerable to harm as a result of their particular circumstances. Vulnerable populations have historically been both ‘over-researched’ or exploited for research purposes (e.g., prisoners), and ‘under-researched’ or excluded from the benefits of research (e.g., women), a problem that research ethics codes have sought to resolve.<sup>28</sup> Yet, despite the codification of ethical standards for research, examples of unethical research conduct in the medical and social sciences abound,<sup>29,30</sup> and researchers continue to grapple with questions of how best to balance competing ethical principles and how to resolve ethical dilemmas in the field.

Canada’s overarching research ethics policy, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (TCPS2, Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010), sets out basic ethical principles for research involving human subjects and provides ethical guidance to investigators.<sup>31,32,33</sup> This ethics framework underscores the importance of respect for

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<sup>28</sup> Research ethics codes date back to the early 20<sup>th</sup> century; however, it was the Doctors’ Trial at the Nuremberg Trials, and the global condemnation of the exploitation of prisoners in the name of science, following the atrocities of medical research experimentation performed by Nazi doctors in concentration camps during the Second World War, that prompted the development of modern research ethics guidelines (Guillemin & Gillam, 2004; Seto & Barbaree, 1999). The *Nuremberg Code* of 1947, the *Declaration of Helsinki* of 1964, and the Belmont Report of 1979 were some of the earliest research ethics codes (Pont, 2008; Seto & Barbaree, 1999).

<sup>29</sup> For example, the Tuskegee Syphilis Study, carried out by the United States Public Health Service between 1932 and the 1970s, involved the withholding of treatment for syphilis from 400 infected African American men without their knowledge, in order to better understand the course of untreated syphilis; it was condemned as an example of racism and unethical conduct in science, and was followed by a formal apology from President Clinton in 1997.

<sup>30</sup> Well known cases of questionable ethics in psychological research include Milgram’s (1974) obedience experiment and the Stanford prison experiment (Haney, Banks, & Zimbardo, 1973).

<sup>31</sup> The first edition of the TCPS was published by the Interagency Advisory Panel on Research Ethics (PRE) in August 1998, and was amended in 2000, 2002, and 2005. A second edition (TCPS2) was published in August 2010 following a lengthy public consultation process.

<sup>32</sup> Researchers funded by one of Canada’s three national research agencies – the Canadian Institutes of Health Research (CIHR), the Natural Sciences and Engineering Research Council of Canada (NSERC), and the Social Sciences and Humanities Research Council of Canada (SSHRC) – must comply with the ethical guidelines articulated in the TCPS.

human dignity in research, which is reflected in three core principles: (1) respect for persons, (2) concern for welfare, and (3) justice.<sup>34</sup>

*Respect for persons* reflects a belief in the fundamental value of human life and the importance of respecting human dignity. It involves the “dual moral obligations to respect autonomy and to protect those with developing, impaired or diminished autonomy” (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010, p. 8). Respecting autonomy means acknowledging that individuals are able to reason and make decisions in their own interests. In research, autonomy is expressed through the provision of informed consent whereby research participants agree or refuse to participate after weighing the risks and benefits of their participation.

Consent to participate in research requires both voluntariness and competence. Voluntariness may be undermined in situations where potential research participants are subject to undue influence; for example, when persons in a position of authority are involved in participant recruitment, or when financial incentives are so high that participants disregard the risks of research participation. Participants may also be vulnerable to coercion, whereby they face threats of punishment or harm should they choose not to participate in research, especially when research is carried out with institutionalized populations, such as prisoners and psychiatric inpatients.

The notion of competence suggests that potential research participants must have the mental or intellectual capacity to consent to research participation. In the case that a potential participant’s capacity is diminished owing to cognitive impairment, ethical guidelines may allow for an authorized third party to provide consent on the individual’s behalf. However, it should be noted that it is possible for a participant to have “diminished capacity but still be able to decide whether to participate in certain types of research” (Canadian Institutes of Health Research et al., 2010, p. 41). It is also possible

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<sup>33</sup> Prior to the development of the TCPS, each of the three funding agencies (see footnote 31) had its own set of guidelines for ethical research. Medical research was governed by the *Guidelines for Research on Somatic Cell Gene Therapy in Humans* and the *Guidelines for Research Involving Humans*; social science research was governed by the *Ethics Guidelines for Research with Human Subjects*. The agencies came together in 1994 to develop a joint ethics framework for all research involving human subjects conducted under their auspices.

<sup>34</sup> These interrelated principles replaced the eight guiding ethical principles outlined in the first edition of the TCPS: respect for human dignity, respect for free and informed consent, respect for vulnerable persons, respect for privacy and confidentiality, respect for justice and inclusiveness, balancing harms and benefits, minimizing harm, and maximizing benefit.

that a participant could lose their capacity over the course of their involvement in a research project, due to mental deterioration, or regain capacity if, for example, they recover from a psychotic episode (Canadian Institutes of Health Research et al., 2010). Because an individual's particular circumstances may change at any time, affecting their voluntariness or competence, consent to participate in research should be regarded as an ongoing process, and sought on a continuous basis. Research participants must also be informed that they have the right to withdraw from a study or terminate study procedures at any time without penalty.

*Concern for welfare* is relevant to individual participants who may experience harm as a result of research participation, and the groups to which they belong who may indirectly benefit or suffer negative consequences as a result of research findings. According to the TCPS2, "welfare consists of the impact on individuals of factors such as their physical, mental and spiritual health, as well as their physical, economic, and social circumstances" (Canadian Institutes of Health Research et al., 2010, p. 9). For example, an individual participant may suffer great harm if their privacy is compromised. Similarly, a community or population may be subject to stigmatization and discrimination as a result of research findings. In order to demonstrate concern for welfare, researchers must maximize the benefits of research, minimize the risk of harm to participants, and protect participants from unnecessary risks.

The principle of *justice* reflects the belief that all persons should be treated fairly and that "no segment of the population is unduly burdened by the harms of research or denied the benefits of the knowledge generated from it" (Canadian Institutes of Health Research et al., 2010, p. 10). There are numerous historical examples of populations that were once considered to be 'vulnerable' and, as a result, were not afforded equitable treatment in research. According to the TCPS2, vulnerability may result from "limited capacity, or limited access to social goods, such as rights, opportunities and power" (Canadian Institutes of Health Research et al., 2010, p. 10). Researchers must be careful to avoid the automatic exclusion of vulnerable populations from research, particularly if the reason for their exclusion is unrelated to the research. This ethical issue is clearly articulated in TCPS2, which indicates that vulnerable populations should not be "inappropriately included or automatically excluded from participation in research on the basis of their circumstances" and "individuals should not automatically be considered vulnerable simply because of assumptions made about the vulnerability of

the group to which they belong” (Canadian Institutes of Health Research et al., 2010, p. 52). That is, the concept of ‘vulnerability’ should not be presumed and, if researchers choose to exclude certain populations from research, they must be able to justify their exclusion in order to satisfy the justice principle.

#### **4.1 Special Protections for Vulnerable Populations**

The core ethical principles outlined in the TCPS2 are not necessarily equally weighted in all research, but it is not always clear which principle(s) should prevail when they are in conflict. As such, ethical dilemmas are unlikely to have straightforward solutions, and may be resolved in different ways depending on the specific context and circumstances of the research<sup>35</sup> (Weinberg, 2002).

In research with vulnerable populations, as in all research, there may be situations when the core ethical principles of respect for persons, concern for welfare, and justice compete with one another. For example, “while autonomy may be considered a necessary condition for participation in research, involving those who lack capacity to make their own decisions to participate can be valuable, just and even necessary” (Canadian Institutes of Health Research et al., 2010, p. 8). Researchers must therefore carefully weigh these principles, as they have an ethical duty to protect vulnerable populations, and to ensure that vulnerable groups are not exploited for research purposes, excluded from research participation, harmed, or rendered more vulnerable as a result of research participation (Canadian Institutes of Health Research et al., 2010).

Ethical issues related to three vulnerable populations have particular relevance to the female forensic psychiatric population involved in the Trauma Recovery Study: (1) prisoners, (2) women, and (3) persons with mental illness. In the following sections, I highlight the key ethical issues in research with these populations, and place these issues in their historical context.

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<sup>35</sup> Various professional associations have also developed codes of ethics to guide investigators in ethical research conduct. Those most relevant to criminological research include the American Sociological Association (ASA) and the Academy of Criminal Justice Sciences (ACJS) in the United States, the British Society of Criminology, British Sociological Association, and Social Research Association (SRA) in the United Kingdom, and the Australian and New Zealand Society of Criminology.

### 4.1.1 Research Involving Prisoners

Prisoners are at risk of being exploited for research purposes because they represent a population that is relatively easy to access, inexpensive, willing to participate, and stable because they live in controlled environments (Osborne, 2006; Pont, 2008). However, the very nature of their incarceration means that their voluntariness and free will may be compromised – an important aspect of free and informed consent, which is an expression of autonomy. There is a high risk of coercion in research with prisoners because they are relatively powerless, and may be motivated to participate in research in order to appear ‘cooperative’ in the hopes that this will have a direct, positive impact on their situation (e.g., increased privileges or better treatment while in custody; reduced sentence length or early release). Like others in unequal power relationships, prisoners may experience undue influence when persons in positions of authority are involved in research recruitment (Canadian Institutes of Health Research et al., 2010). Additionally, because prisoners have little privacy and may face legal repercussions for disclosing certain information, confidentiality is critically important in research with this vulnerable population.

Historical examples of the exploitation of prisoners for research purposes abound, in the United States and Canada, despite the establishment of research ethics guidelines. For example, in the United States, until the mid-1970s, pharmaceutical companies relied heavily on prisoners to test new drugs (Pont, 2008; Regehr, Edwardh, & Bradford, 2000). In Canada, between 1955 and 1975, prisoners were used as “guinea pigs behind bars” (Osborne, 2006, p. 285) in sensory deprivation, behaviour modification, and therapeutic and non-therapeutic pharmacology research. As well, in the 1960s, women incarcerated in Kingston’s Prison for Women were the subjects of medical experiments designed to better understand the effects of LSD and electroconvulsive therapy (Hayman, 2006; Osborne, 2006; Regehr et al., 2000).

These examples of unethical medical experimentation involving prisoners as human subjects have since been condemned and served as the basis for the development of regulations restricting the participation of prisoners in research, or altogether prohibiting their inclusion in research. Pont (2008) notes that, “without any doubt, abolishing any research involving prisoners guarantees their protection against abuse and exploitation by researchers” (p. 191). Yet, there are also important ethical considerations concerning the *exclusion* of vulnerable populations from research,

especially when their exclusion means that they may be denied access to knowledge or treatment that could directly benefit them. This is an especially important consideration in research that focuses upon issues of particular relevance to prison populations, such as research on infectious diseases, mental illness, or the psychological effects of imprisonment (Pont, 2008).

For instance, Pasquerella (2002) makes a convincing argument that prisoners suffering from HIV/AIDS and Hepatitis C should be permitted to participate in clinical trials, despite their vulnerability, as they should reserve the right to participate in research involving potentially life-saving treatment. She suggests that, in the case of prisoners who have life-threatening illnesses, the principles of respect for persons and justice outweigh the principle of concern for welfare. Pont (2008) summarizes the controversy about research with prisoners:

...the more cautious, protective and restrictive the approval procedures are for research in prison, the greater the barriers to beneficial research as researchers are discouraged from including prisoners in studies, and prisoners are discouraged from participating in research. On the other hand, the less restrictive the protective measures, the greater the risk of the abuse of prisoners by research. (p. 191-192)

In order to ensure the ethical inclusion of prisoners in biomedical research, guidelines have been developed suggesting that research with prisoners should benefit individual participants directly, or prisoners as a group, and be minimal risk (Elger, 2008). However, there has been less discussion in the literature on ethical research involving prisoners in social and behavioural sciences – particularly whether such research should be subject to the same standards as biomedical research (Elger, 2008). Certainly, efforts to avoid exploiting prison populations have led some scholars to suggest that researchers have become overly cautious about conducting research with this vulnerable population, and that prisoners have become an “overprotected population” (Moser et al., 2004, p. 8).

#### **4.1.2 Research Involving Women**

Research in the medical and social sciences has historically been conducted by male researchers with male participants, with results inappropriately generalized to both men and women. Indeed, men have typically been considered the ‘norm,’ with women often constructed as ‘other,’ constituting a “special subgroup” (Merton, 1993, p. 374) or

“demographic sub-population” (Corrigan, 2002, p. 50). The key ethical issues concerning the inclusion or exclusion of women in research is that of fairness and equity, which are issues relevant to the principle of justice.

There are certainly examples of abuses resulting in harm to women research participants, though this has been a greater concern in biomedical research than in the social sciences. For example, in the 1960s, 76 minority women in Goldzieher’s study were unknowingly given placebos as part of an experiment on the side effects of oral contraceptives. Eleven women became pregnant during the course of the research, under the false belief that they were taking oral contraceptives, ten of whom were taking the placebo (Stevens & Pletsch, 2002). This and similar studies led to the classification of pregnant women as a ‘vulnerable population’ in research. This classification meant that researchers were reluctant to include pregnant women and women of childbearing years in clinical research, leading to the widespread exclusion of women from research.

Sex-based differences (e.g., hormonal differences, pregnancy) that were thought to complicate or interfere with the findings of clinical drug trials have often been cited as grounds for the exclusion of “pregnant, pregnable, and once-pregnable people (a.k.a., women)” (Merton, 1993, p. 369). Yet, some suggest that the ethical pendulum swung too far in the opposite direction, from the under-protection and harmful inclusion of women in research to a paternalistic overprotection of women. Indeed, women’s exclusion from research, especially biomedical research, meant that women were no longer afforded the benefits of research knowledge, and were, like prisoners, denied access to potentially life-saving therapeutic interventions in clinical trials on life-threatening illnesses, such as HIV/AIDS (Merton, 1993; Stevens & Pletsch, 2002).

There has been much less evidence on women’s health issues than men’s, and women may be at greater risk of harm if findings from clinical research conducted with men are inappropriately applied to women. This is critically important as emerging evidence in women’s health has shown significant sex and gender differences with respect to various health issues, including the course of mental illness, and the effects of alcohol consumption for men and women (Brady & Randall, 1999; Poole & Greaves, 2007).

In keeping with the principle of justice, contemporary ethics policy, including the TCPS2 (Canadian Institutes of Health Research et al., 2010), forbids the inappropriate exclusion of women from research, and “rejects discriminatory and unethical use of



inclusion or exclusion criteria that presumptively or inappropriately exclude women because of their gender or sex” (p. 49). However, the exclusion of women may be justified in some cases; therefore, researchers must carefully consider the welfare of women participants, and pregnant women in particular, in light of the potential benefits and foreseeable risks of a research project (Canadian Institutes of Health Research et al., 2010), and provide appropriate grounds for the exclusion of women.

Responding to the historical exclusion of women from research, many contemporary women’s health researchers argue that the inclusion of women in health research is insufficient for the advancement of knowledge on women’s health issues. Rather, they advocate for the use of a sex and gender lens or an intersectional approach to data analysis to enhance the accuracy, rigour, validity, and practical application of research findings (Hankivsky & Cormier, 2009; Johnson, Greaves, & Repta, 2007).

#### **4.1.3 Research Involving Individuals with Mental Illness**

Research on mental illness is critical in order to better understand its causes, the factors that determine its course, and how it can be prevented and treated (Tsao, Layde, & Roberts, 2008). However, persons who have severe mental illnesses constitute a vulnerable population whose inclusion in research has sparked significant debate among members of the scientific community (Roberts & Roberts, 1999). A key ethical concern in research with this population is the competence or capacity to provide informed consent, which is relevant to the issue of autonomy and the principle of respect for persons, as this may be compromised by mental illness or cognitive impairment.

Research on the decision-making capacity of individuals with mental illness has found that these individuals have more difficulty understanding information presented during the consent process than non-mentally ill persons (Roberts & Roberts, 1999). Individuals with mental illness are nevertheless capable of providing consent for research, a requirement according to most research ethics guidelines. Still, the decision-making capacity of persons with mental illness varies substantially, depending on the nature and severity of their illness, and may in fact fluctuate as their mental health improves or deteriorates (Roberts, Warner, Green Hammond, & Geppert, 2006; Tsao et al., 2008).

Questions about how decisional capacity is defined and assessed in the research context are particularly important for researchers to consider in psychiatric research

(Roberts, Geppert, & Brody, 2001). Special precautions are warranted to protect the interests of individuals with mental illness who participate in research, and it remains the responsibility of researchers to ensure that safeguards are built into research protocols to satisfy the ethical principle of concern for welfare. In cases where an individual lacks the capacity to provide consent, or their capacity is reasonably expected to fluctuate over the course of a research project, the TCPS2 (Canadian Institutes of Health Research et al., 2010) allows for an authorized third party to make a decision about the individual's participation.<sup>36</sup>

Authorized third parties include “any person with the necessary legal authority to make decisions on behalf of an individual who lacks the capacity to consent to participate or to continue to participate in a particular research project” (Canadian Institutes of Health Research et al., 2010, p. 27). Research on third party decision-making is scant, yet it is clear that the decisions of authorized third parties do not always reflect the true wishes of individuals who lack capacity to consent, as third parties may be overly conservative or protectionist in their decision-making (Roberts & Roberts, 1999). It is also possible that individuals with mental health diagnoses may be excluded from, or discouraged from participating in, research because of their mental status or assumptions about their capacity to consent, such that their perspectives and voices are not always heard in research.

The participation of mentally disordered individuals in research is particularly controversial in clinical research involving interventions that are not expected to provide any direct therapeutic benefit to participants. Of course, distinguishing between therapeutic and non-therapeutic interventions is not an easy task (Verdun-Jones & Weisstub, 1998). Historical abuses in experimental research involving individuals with mental retardation and mental illness have been well documented in the literature.<sup>37</sup>

Another contentious issue in research involving individuals with mental health and addictions problems concerns the provision of incentives for participation. Research participants are routinely financially compensated for their time and to offset any costs (e.g., transportation, child care) associated with research participation. However, it is

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<sup>36</sup> In most provinces/territories, there is no specific legal authority for third parties to consent to non-therapeutic research on behalf of a legally incompetent participant.

<sup>37</sup> For example, the Willowbrook Study involved the intentional infection of developmentally disabled children with hepatitis, and a study at the Brooklyn Jewish Chronic Disease Hospital involved the injection of cancer cells into individuals with dementia (Roberts & Roberts, 1999).

generally agreed that incentives should not be so excessive that they negate informed consent. Controversies surrounding the issue of research payment appear to be of greatest concern in research with illicit drug users and economically disadvantaged populations (Fry, Hall, Ritter, & Jenkinson, 2006; Stones & McMillan, 2010). While there is no consensus on whether or not research participants should be paid, or what constitutes reasonable compensation, a number of models and recommendations for the ethical payment of research participants have been published in the literature (Beckford & Broome, 2007; Grady, 2001). Some scholars have also advanced arguments to suggest that not paying participants for their research involvement constitutes unethical research practice. For example, Fry and colleagues (2006) argue that:

In the case of addictions research, denial of reward or fair recognition for research contributions based on negative assumptions about drug user motivations for research participation, their entitlement to such payments, and their use of research payments would seem to be inconsistent with the principles of respect for autonomy, distributive justice and beneficence. (p. 31)

As with prisoners and women, it is important to consider the ethical principle of justice when it comes to the inclusion of persons with mental illness in research. This is particularly true in clinical trials involving medications that hold promise for the treatment of mental illness, but the principle of justice is also important in social science research where individuals with mental illness may benefit from research participation, and persons with mental illness in general may benefit from the research findings. In general, researchers should avoid excluding mentally disordered participants in favour of more 'healthy' participants where their exclusion is not justified by the research questions.

## **4.2 Evidence-based Ethical Decision-making**

Researchers in academic institutions across Canada who are conducting studies involving human subjects must obtain approval from institutional Research Ethics Boards<sup>38</sup> (REBs). The role of the REB is to review research protocols and determine the "ethical acceptability of a research project through consideration of the foreseeable risks, the potential benefits and the ethical implications of the project" (Canadian Institutes of Health Research et al., 2010, p. 11). Ethics policy mandates that REBs adopt a

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<sup>38</sup> Also known as Institutional Review Boards (IRBs) in the United States, and Human Research Ethics Committees (HRECs) in Australia.

proportionate approach, whereby research projects posing greater risk are subject to greater REB scrutiny. In order to obtain REB approval, researchers must demonstrate that a proposed project has a favourable balance of foreseeable risks and potential benefits (Canadian Institutes of Health Research et al., 2010). Each research project reviewed is designated as 'minimal risk' or 'greater-than-minimal risk'.<sup>39,40</sup>

A determination of the risk associated with a particular research project involves an assessment of both the magnitude (i.e., seriousness) and probability (i.e., likelihood) of harm. According to Canadian research ethics policy, harm is defined as "anything that has a negative effect on the welfare of participants," which may be "social, behavioural, psychological, physical, or economic" in nature (Canadian Institutes of Health Research et al., 2010, p. 22). The potential harms associated with research participation range from relatively minor (e.g., inconvenience) to very serious (e.g., death), and from short-lived problems (e.g., temporary emotional distress) to long-term suffering (e.g., psychological trauma).

Researchers have an ethical duty to avoid exposing research participants to unnecessary risks, and to take steps to mitigate or reduce the likelihood of any foreseeable risks associated with participation in research. Still, "research is a step into the unknown" (Canadian Institutes of Health Research et al., 2010, p. 7), and researchers are not always able to protect participants from harm, especially when unanticipated problems are encountered in the course of research. There is always a risk that participants may experience an adverse reaction in the course of research participation. Such unanticipated reactions, incidents, experiences, or outcomes are collectively referred to as 'adverse events' and occur when the risk of harm translates into actual harm to research participants.<sup>41,42</sup> For example, in trauma-focused research,

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<sup>39</sup> The notion of 'minimal risk' is intended to serve as a measure of whether the risk of harm posed by the research is greater than that experienced by participants in their every day lives (Corbin & Morse, 2003; Newman & Kaloupek, 2004; Social Sciences and Humanities Research Ethics Special Working Committee, 2004). Research determined to be greater-than-minimal risk may be subject to increased REB scrutiny and monitoring throughout the life of the project, and the application of additional measures to protect participants.

<sup>40</sup> The Trauma Recovery Study was determined to be minimal risk.

<sup>41</sup> Simon Fraser University's internal REB policy defines an adverse event as "a serious consequence of participation in a research protocol that was not defined in the protocol and which may or may not be considered related to the research protocol." Serious adverse events include such incidents as unexpected death, serious injury, or a mental breakdown resulting in harm to the participant or to others, and may be classified as foreseen (anticipated) or unforeseen (unanticipated).

researchers may anticipate that some participants will experience mild psychological distress as a result of recalling and recounting traumatic events, and thus are required to outline the steps they will take to mitigate these risks and reduce the likelihood of such an event.<sup>43</sup>

Although all research has the potential to cause harm to participants, researchers must do all they can to ensure that participants do not leave the research in a worse state than when they entered it (Wengraf, 2001). Vulnerable populations and individuals whose circumstances put them at an increased risk of harm in their everyday lives are afforded special consideration in the review process, as ethics policy suggests that “their inclusion in research should not exacerbate their vulnerability” (Canadian Institutes of Health Research et al., 2010, p. 23). Although the TCPS2 indicates that fairness and equity in research participation can be threatened by “over-protectionist attitudes or practices of researchers and REBs” (p. 47), some scholars have expressed concern that REBs have a tendency to overestimate the risk of harm in social and behavioural science research (Social Sciences and Humanities Research Ethics Special Working Committee, 2004).

Indeed, these boards have been widely criticized by social science scholars generally, and qualitative researchers in particular. Some scholars have argued that the mere existence of REBs implies “institutionalized distrust” (Haggerty, 2004, p. 393) of researchers,<sup>44</sup> and that REB governance has inappropriately extended beyond ethics review to non-ethics issues such as institutional risk or liability management, a phenomenon known as ‘ethics drift’ (Social Sciences and Humanities Research Ethics

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<sup>42</sup> Compared to biomedical research, there has been much less discussion about adverse events in the social and behavioural sciences, where questions about how adverse events are defined, who decides whether an adverse reaction has occurred (i.e., researcher or participant), and how adverse events should be handled may be more complex (Boothroyd, 2000; McClain, Laughon, Steeves, & Parker, 2007). Researchers are offered little guidance with respect to managing adverse reactions in sensitive social research, where it is often difficult to determine a causal connection between a particular research protocol or condition and a specific adverse event. This is especially true when research involves vulnerable populations where there is a high rate of adverse events (e.g., suicides, overdoses) in the every day lives of participants.

<sup>43</sup> Researchers are required to report adverse events to the REB that approved the research. In these cases, the REB has the authority to suspend a research project or request that changes be made to the research protocol.

<sup>44</sup> Discipline-specific codes of ethics, because they are not enforced, are thought to restore trust in researchers and encourage ethical decision-making in the field, rather than simply promoting ‘bureaucratic rule-following’ and ‘procedural ethics’ (Clark & Sharf, 2007; Guillemin & Gillam, 2004; Haggerty, 2004).

Special Working Committee, 2004) or 'ethics creep' (Haggerty, 2004). Others have questioned the power of REBs to make decisions about what is considered 'research', what research is conducted, how it is conducted, and the type of knowledge that is produced as a result (Haggerty, 2004; Israel, 2004; Johnson & Altheide, 2002; Lowman & Palys, 1998; Social Sciences and Humanities Research Ethics Special Working Committee, 2004).

In order to assess the magnitude and probability of harm in research, REB members may draw on previous research experience, published literature on the harms reported in similar studies, or other empirical evidence. Yet, there is little empirical evidence in the published literature upon which to base such assessments. Researchers, research ethics boards, and participants alike are therefore often left to make important ethical decisions based on personal experiences, and assumptions about the risk of harm towards prospective participants, in the absence of reliable empirical evidence. For example, REBs may assume that trauma-focused research is particularly harmful to participants. When prospective participants include individuals with mental health problems, the assumed risk of harm may be even greater due to stigmatizing attitudes towards persons with mental illness and assumptions about their diminished capacity to consent.

Ethical decisions based on assumptions and anecdotal evidence, rather than empirical evidence, may lead not only to inconsistencies in decision-making among university and institutional research ethics boards, but also to inaccurate assessments of the risk posed to research participants, particularly in studies involving sensitive topics and vulnerable populations. Indeed, as Haggerty (Haggerty, 2004) argued:

...there is a tendency for REB members to perceive eventualities that others might see as innocuous as being sufficiently risky to necessitate some precautionary measures. With few constraints on the types of harms that can be imagined, a process is set in motion that has the potential to introduce ever more regulations to manage potentially undesirable eventualities, the true likelihood of which is routinely unknown. (p. 412)

According to the TCPS2, "researchers and REBs should attempt to assess the harm from the perspective of the participants" (Canadian Institutes of Health Research et al., 2010, p. 23) when assessing the probability and magnitude of harm. In light of this guideline, it may be useful for researchers to gather empirical evidence on the benefits

and harms of research participation, from the perspectives of participants themselves. In fact, there are instances in the literature in which assumptions about participants have been contradicted by research participants themselves. For example, researchers generally agree that prisoners may be vulnerable to coercion when it comes to research participation. However, a study of coercion and informed consent with prisoners found that, although mentally disordered prisoners may be motivated to participate in research to improve their circumstances and treatment in prison, they experience no more coercion than controls (Moser et al., 2004).

Certainly, knowledge about the capacity of persons with mental illness to provide research consent, and the effectiveness of ethical safeguards to protect their interests, would be greatly enhanced by research evidence so that researchers' and REB members' decisions are grounded in empirical evidence rather than simply "based on tradition and good intention" (Roberts & Roberts, 1999, p. 1036). Not only can evidence on the harms and benefits of research from the perspectives of research participants inform the decision-making of researchers and REBs, but it can also assist in the resolution of ethical dilemmas that emerge in the research context (Roberts, 2000). Additionally, potential participants may also benefit from knowledge about the benefits and harms associated with certain types of research when considering their own participation in research.

In the case of trauma-focused research, participants may be at risk of experiencing emotional distress or re-victimization as a result of research participation. Yet, assumptions about the potential harms associated with research participation may deny trauma survivors the opportunity to have their experiences heard and validated (Cromer, Freyd, Binder, DePrince, & Becker-Blease, 2006). In their work, Becker-Blease and Freyd (2006) questioned the ethics of *not* asking about trauma, based on assumptions about the vulnerability of trauma survivors, arguing that "silence impedes scientific discovery, helps abusers, and hurts victims" (p. 225).

To date, relatively little research has been conducted on research participants' reactions to research participation (Boothroyd, 2000). However, scholars have begun to build evidence on the perceptions and experiences of research participation from the perspectives of various vulnerable populations, including individuals with severe mental illness (see, Boothroyd, 2000; Roberts, Warner, Anderson, Smithpeter, & Rogers, 2004; Roberts, Warner, & Brody, 2000; Schafer et al., 2010), the bereaved (Cook & Bosley,

1995; Dyregrov, 2003; Eilegard, Steineck, Nyberg, & Kreicbergs, 2011), refugee families (Dyregrov, Dyregrov, & Raundalen, 2000), women receiving income assistance (Boothroyd & Best, 2003), and other vulnerable subgroups (Widom & Czaja, 2005). Cook and colleagues (2011) point to the value of this evidence, especially in research involving sensitive topics and vulnerable populations:

To enhance ethical decision making about human subjects research, institutional review boards, and researchers alike need systematic data on the emotional, social, and physical risks as well as benefits that may result from research participation. The need for data is particularly great for trauma-related research, which is likely to involve vulnerable populations, stigmatizing experiences or characteristics, and sensitive topics. (p. 316)

#### **4.2.1 Evidence on the Ethics of Trauma-focused Research**

Trauma-focused research may be considered 'sensitive' insofar as it focuses on emotionally distressing experiences, and may be considered particularly sensitive when it involves 'vulnerable' participants, such as individuals with mental illness and psychiatric inpatients. Sensitive research is defined according to the nature of the topic and type of data collected, the site or setting in which the research takes place, the specific characteristics of the population or participants involved, and/or the potential implications of the research for those involved, including individual participants, the groups to which those participants belong, and researchers themselves (Brannen, 1988; Johnson & Clarke, 2003; Lalor, Begley, & Devane, 2006; Liebling & Stanko, 2001; Sieber & Stanley, 1988).

Lee (1993) defines sensitive research as that which "potentially poses a threat to those who are or have been involved in it" (p.4). He articulates three types of threat: intrusive threat, threat of sanction, and political threat. (1) *Intrusive threat* occurs in research where participants may be asked to disclose private information (e.g., income) or personal experiences (e.g., sexual victimization) that may cause embarrassment or emotional distress. Trauma-focused research may pose an intrusive threat to participants by asking them to recall and disclose potentially distressing personal experiences of victimization and trauma. (2) *Threat of sanction* is particularly relevant in criminological research where participants may be asked to disclose potentially incriminating information pertaining to their own criminal involvement. Threat of sanction is also relevant to forensic mental health populations because of their involvement in the



criminal justice system. (3) *Political threat* occurs in research that threatens the culture of an organization, such as a law enforcement agency or correctional service, or threatens to exacerbate existing political conflict or the vulnerability of individuals or groups. It is important not to assume that all trauma-focused research is inherently sensitive, and therefore risky, but rather to appreciate that the potential harms and benefits of trauma-focused research depend largely on such factors as the research context, setting, methods, and individual participants.

A growing literature on the ethics of trauma-focused research has sought to assess the perceived costs and benefits of participation in trauma studies, and identify the characteristics associated with distress and regret about participating (DePrince & Chu, 2008). Much of the evidence on the ethics of trauma-focused research has been gathered using the *Reactions to Research Participation Questionnaire* (RRPQ) (Newman et al., 2001). Data gathered using this questionnaire suggest that most participants in trauma-focused research feel that the benefits of participation outweigh the harms. Research has shown that anywhere between 25-75% of participants report deriving some benefit from participation in trauma-focused research (Newman, Walker, & Gefland, 1999; Ruzek & Zatzick, 2003; Walker, Newman, Koss, & Bernstein, 1997). One study found that over 95% of participants felt that the benefits outweighed the harms, and agreed they would participate again (Ruzek & Zatzick, 2003). Another trauma-focused study found that over 75% of participants would agree to participate in the study again (Walker et al., 1997).

Although the evidence suggests that most participants in trauma-focused research derive some benefit from their participation, a minority of participants still report unexpected distress as a result of participating in such research. To date, empirical evidence suggests that approximately 10-13% of participants in trauma-focused research report being more upset than anticipated (Newman et al., 1999; Ruzek & Zatzick, 2003; Walker et al., 1997). One study with women who had recently experienced domestic violence found that 25% of the participants became more upset than expected, though the authors attribute this elevated number to the nature, recency, and chronicity of violence experienced by the women in the sample (Johnson & Benight, 2003).

Not only is it important to assess the benefits and harms of trauma-focused research; it is also helpful to identify the particular characteristics associated with

increased vulnerability among participants. The empirical evidence suggests that greater trauma-related symptoms are generally associated with increased distress and adverse reactions in trauma-focused research (DePrince & Chu, 2008; Ruzek & Zatzick, 2003; Walker et al., 1997), though some studies have found no association between trauma symptoms and distress resulting from trauma-focused research participation (Griffin, Resick, Waldrop, & Mechanic, 2003). Other factors that have been found to be associated with increased emotional distress among research participants in trauma-focused studies include depressive symptoms (Ruzek & Zatzick, 2003), female gender (Cromer et al., 2006), male gender (DePrince & Chu, 2008), older age (DePrince & Chu, 2008; Dyregrov et al., 2000), a history of sexual violence (Newman et al., 1999), and having experienced multiple traumas (DePrince & Chu, 2008).

Research comparing the impact of trauma-focused research and other types of studies suggests that trauma-focused interview or survey questions may result in greater distress than other questions, but that participants responding to trauma-focused questions are no less likely to report deriving some benefit from their participation and are equally likely to participate again (Cromer et al., 2006). Furthermore, participants may consider trauma-focused research to be more valuable than other types of sensitive research, resulting in more favourable cost-benefit ratings (Cromer et al., 2006). The only known experimental study of the impact of trauma-focused research concluded that this type of research is no more harmful than other types of research, and that participants' experiences are generally positive, contrary to assumptions that trauma-focused research is inherently harmful (Cook et al., 2011).

A number of conclusions can be drawn from this literature on the ethics of trauma-focused research. First, although some participants involved in trauma-focused research report adverse reactions, such as emotional distress, the majority of participants report deriving some benefit from their participation. Furthermore, participants generally feel that the benefits of trauma-focused research outweigh the harms associated with any unexpected distress or anxiety experienced in the course of the research project. Second, individuals with PTSD or other trauma-related symptoms may be at an increased risk of experiencing adverse reactions as a result of their participation in trauma-focused research, yet this type of research is generally well-tolerated and few participants regret having participated in this type of research. Finally,

trauma-focused research is not necessarily more distressing or harmful than other types of sensitive research, and participants generally consider such research to be of value.

Compared to the substantial literature on ethical issues in psychiatric research, there is relatively little discussion of ethics in the specific area of forensic psychiatric research (Munthe, Radovic, & Anckarsater, 2010). However, ethical considerations in research with prisoners and persons with mental illness can be extrapolated to the “especially vulnerable group” (Munthe et al., 2010, p. 43) of individuals involved in the forensic mental health system. The Trauma Recovery Study focused on women receiving treatment services in the forensic mental health system, who may be considered ‘triple vulnerable’ (Liamputtong, 2007) on account of their gender, mental health status, and criminal justice status, and adversely affected by the ‘layering’ of stigma resulting from involvement in both the criminal justice and mental health systems (Walkup, Cramer, & Yeras, 2004). The inclusion of the ethics component generated empirical evidence on the women’s experiences as research participants in the qualitative, trauma-focused study, which is described in detail in the next chapter.

## 5: METHODOLOGICAL APPROACH

### 5.1 Feminist Qualitative Research

Feminist epistemologies developed as a response to dominant positivist modes of inquiry that value objectivity, neutrality, distance, and universality, instead favouring women's ways of knowing and experiential knowledge (McCormack, 1989; Rubin & Rubin, 2005). Critical feminist research aims to shed light on social problems, give voice to powerless and silenced populations, and advocate for social change (Reinharz, 1992; Rubin & Rubin, 2005). Feminist and intersectional research critically examines the ways in which power is used to maintain the subordination of women and other oppressed groups, with the goal of advancing gender equality (Dhamoon & Hankivsky, 2011; Rubin & Rubin, 2005). Critical feminist approaches to research with women at the interface of the criminal justice and mental health systems, though not without difficulties, may be especially valuable given the sense of powerlessness expressed by forensic clients, and the devaluing of their experiences (Livingston & Rossiter, 2011)

According to Hesse-Biber (2007), feminist research can be described as

research that gets at an understanding of women's lives and those of other oppressed groups, research that promotes social justice and social change, and research that is mindful of the researcher-researched relationship and the power and authority imbued in the researcher's role. (p. 117)

Qualitative methods are particularly well suited to feminist research, as they provide researchers with an opportunity to conduct rich, textured analyses and better understand the context and complexities of women's lived experiences at the margins (Lynch, 1996; Rubin & Rubin, 2005; Symington, 2004). Qualitative interview methods are particularly suitable in research on sensitive topics with vulnerable populations, allowing researchers to hear and observe participants as they tell their stories, paying attention not only to what is said, but also to how it is said and what is left unsaid (Burman, Batchelor, & Brown, 2001; Lee, 1993; Rubin & Rubin, 2005). The qualitative interviews employed in the Trauma Recovery Study were particularly useful in this regard, giving women a voice concerning their experiences, with non-verbal cues

providing additional information about the impact of victimization and trauma, and the women's experiences as participants.

The Trauma Recovery Study was grounded in the feminist 'pathways' perspective and intersectional frameworks, and employed feminist qualitative interview methods to shed light on the trauma-related experiences and needs of women at the interface of the criminal justice and mental health systems, and the challenges faced by forensic mental health professionals in addressing trauma-related issues with their clients. In particular, through the perspectives of forensic clients and staff, the research sought to expose power imbalances that serve to hinder women's healing and recovery from trauma and mental illness in the forensic mental health system.

I employed open-ended, semi-structured interviews to gather information about victimization and trauma, the role of trauma in women's pathways to forensic mental health services, and the role of forensic mental health professionals in addressing trauma-related issues in the lives of their clients. Semi-structured interviews were flexible, allowing for an in-depth exploration of relevant issues, and probing to encourage women to elaborate on their diverse experiences as female survivors of trauma and mental illness.

Feminist interviewing provided women from this arguably 'vulnerable' and often silenced population an opportunity to have their voices heard and experiences made visible (DeVault & Gross, 2007; Legard, Keegan, & Ward, 2003). Participants were able to "define the problem in their own terms" (Brannen, 1988), describing what trauma meant for them, and how it impacted their lives. Client interviews for the Trauma Recovery Study began by inviting women to share information about themselves and how they came to be involved with forensic mental health services, giving them a sense of control over their stories of victimization and trauma, and privileging *their* perspectives on their pathways to forensic services, as opposed to the 'official' version documented in their forensic charts. The focus then shifted to how they had experienced victimization and trauma in their lives, as well as the context and meaning of those experiences.

According to Dhamoon and Hankivsky (2011), in intersectional scholarship, "it is important for researchers to be self-reflexive about their own positionality and their relationships of power to knowledge production and research subjects" (p. 30). Indeed, all feminist research requires a reflexive stance, where the researcher engages in critical self-reflection to articulate how their own assumptions, values, and identities influence

the research process and outcomes (Etherington, 2004; Hesse-Biber & Piatelli, 2007). Reflexivity asks researchers to reflect back on themselves to acknowledge and make explicit their influence on the research as well as the research on them (Dowling, 2006) and, in doing so, enhances the credibility and rigour of the research. Articulating my position in relation to the research and participants is helpful in this regard.

It was not until I was introduced to the concept of intersectionality that I began comfortably adopting the term ‘feminist’ to describe myself and my research. I had previously held the label at arm’s length, identifying my research as *grounded in feminist theory* but never *feminist* in its own right. As an educated, White, middle-class woman, I had rarely experienced (or perhaps, rarely acknowledged) sexism and gender inequality in my own life. But, more importantly, I could not pretend to relate to the experiences of more marginalized women, despite our shared gender. I was (and am) too keenly aware of my own privilege. I share little in the way of lived experience with the women whose worlds I pass through on my bus ride through Vancouver’s Downtown Eastside, as I make my way home from the university’s downtown campus – the women with substance use problems, selling their bodies on the street, who are vulnerable to victimization and criminalization in the course of their daily survival. The idea that gender intersects with other axes of inequality, and that individuals experience interlocking forms of oppression, seemed so incredibly intuitive that I immediately embraced the idea of intersectionality and, in turn, feminism.

I came to the research topic by way of an interest in women’s experiences with intimate partner violence and homicide, and the victimization–criminalization continuum.<sup>45</sup> I had initially been interested in conducting trauma-focused research with women in prison, but my interest in women’s mental health and illness, and my position as a research assistant for Forensic Psychiatric Services (see, Livingston & Rossiter, 2011; Livingston et al., 2011), led me to turn my attention instead to women in the forensic mental health system.<sup>46</sup> I recall women describing their experiences of victimization and trauma, and the difficulties they faced in accessing support and justice due to the stigma associated with the ‘mentally ill’ and ‘criminal’ labels that had been

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<sup>45</sup> This interest developed during my Master’s thesis research, which involved an examination of expert psychiatric testimony in a case of female-perpetrated intimate partner homicide.

<sup>46</sup> Note that when I began the Trauma Recovery Study, I had already left my research assistant position and was no longer affiliated with BC’s Forensic Psychiatric Services Commission.

applied to them.<sup>47</sup> I became curious about the experiences of other women situated at the interface of mental health and criminal justice, and wondered how staff addressed issues of victimization and trauma in the lives of female clients in the forensic mental health system. The Trauma Recovery Study, described in detail below, set out to explore these questions.

## **5.2 The Trauma Recovery Study**

### **5.2.1 Purpose and Research Questions**

The purpose of the Trauma Recovery Study was three-fold. First, it explored the trauma-related experiences and needs of women in contact with forensic mental health services in order to understand how they had experienced victimization and trauma in their lives, and how they had come to be involved in the criminal justice, mental health, and forensic mental health systems. Second, it sought to determine the role of forensic mental health professionals in addressing trauma-related issues in the lives of their female clients, and to identify both the challenges that staff faced and supports in place that affected their capacity to do so. These first two inquiries, together, informed a broader discussion about the need and potential for trauma-informed forensic mental health services in British Columbia.

The third purpose of the study was to better understand women forensic clients' experiences as participants in a trauma-focused study, in order to give voice to women concerning their experiences as research participants and contribute to the literature on the ethics of trauma-focused research with vulnerable populations. This ethics inquiry was designed, more specifically, to inform the decision-making of researchers who design trauma-focused studies, ethics review committees who assess the risks and benefits of research protocols, and individuals who are invited to consider participating in trauma-focused research. To achieve the three goals of the study, the study addressed three specific research questions:

- (1) What are the experiences of victimization and trauma of women in contact with the forensic mental health system? What are their needs for trauma recovery?

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<sup>47</sup> A qualitative study of 10 male and female forensic psychiatric inpatients' perceptions and experiences of mental health recovery found that the 'double stigma' of being labelled both 'mad' and 'bad' served as a barrier to recovery from mental illness (Mezey et al., 2010).

- (2) What challenges do forensic mental health professionals face in addressing issues of victimization and trauma in the lives of their clients? What supports are in place to assist them in addressing these issues and reduce the risk of secondary traumatic stress?
- (3) What are the reactions of women forensic mental health clients to participation in trauma-focused research?

### **5.2.2 Research Site and Population**

This study was conducted within British Columbia's forensic mental health system, a specialized mental health service, which can be distinguished from regular inpatient and outpatient mental health services delivered in the province. The Forensic Psychiatric Services Commission (FPSC) falls under British Columbia Mental Health and Addiction Services (BCMHAS), an agency of the Provincial Health Services Authority (PHSA), which is responsible for the delivery of province-wide health programs and services, and monitored by the BC Ministry of Health. British Columbia's health care system was regionalized in December 2001, which led to the creation of the PHSA and five geographically-based regional health authorities: Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Vancouver Island Health. In April 2002, shortly after the restructuring of health services, addiction services were transferred to health authorities, marking the integration of mental health and addiction services in the province, with significant implications for forensic mental health services.

The FPSC is responsible for the assessment, treatment, and clinical case management for a subset of individuals with mental illness who come into conflict with the law. Forensic psychiatric services are offered on both an inpatient (i.e., hospital) and outpatient (i.e., community) basis, by multi-disciplinary treatment teams of mental health professionals. Inpatient forensic services are delivered in a provincial Forensic Psychiatric Hospital (FPH), located in Port Coquitlam, while outpatient services are delivered in six forensic community clinics, located in Kamloops, Nanaimo, Prince George, Surrey, Vancouver, and Victoria. The FPSC works closely with criminal justice and mental health agencies, including the courts and correctional services, and the British Columbia Review Board. Together, these agencies work to support the reintegration of forensic patients and clients into the community (British Columbia Mental Health and Addiction Services, 2007).



The FPSC employs a wide range of professionals to support and facilitate the rehabilitation and reintegration of forensic clients. Upon admission to forensic services, clients are assigned a psychiatrist and a case manager, usually a nurse or social worker, who is responsible for managing the client's treatment, and who is a member of the client's multi-disciplinary treatment team.

Staffing information from the start of the data collection period for the study indicated that the majority of clinics employed greater numbers of case managers with a nursing background than social work.<sup>48</sup> Most of the regional clinics had psychiatrists and psychologists on site, though one geographically distant clinic relied on psychiatrists and psychologists from other regions to provide these core services to their clients. The forensic hospital generally employs a wider range of professionals on site than do the clinics, with far more psychiatrists than psychologists on staff. The greater number of psychiatrists on staff may be expected given the severity of mental illness among inpatient clients, compared to outpatient clients.

Client participants for the study were drawn from the population of women receiving forensic mental health treatment services in British Columbia, on an inpatient or outpatient basis. Data obtained directly from FPSC indicate that, during the year 2009/10, women comprised approximately 17% of all (inpatient and outpatient) FPSC admissions, for a total of 514 admissions. Of all female admissions, 71 women (13.8%) were admitted to custody at FPH, and 443 women (86.2%) were admitted to regional outpatient clinics throughout British Columbia. As for the purpose of admission, 217 women (42.2%) were admitted for assessment and 297 women (57.8%) were admitted for treatment. Of those women admitted for treatment purposes, 27 (9%) were admitted after being adjudicated by the courts as 'Not Criminally Responsible on account of Mental Disorder' (NCRMD), 133 (45%) were admitted as a condition of their probation order, and 137 (46%) were admitted on bail, non-adjudicated, or assigned an alternative treatment legal status.

### **5.2.3 Procedural Ethics and Negotiating Access**

I approached the Trauma Recovery Study from the perspective of an 'outsider' who had previously been an 'insider' as a research assistant with the Forensic Psychiatric Services Commission. I recognized that access to the organization was

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<sup>48</sup> I was unable to obtain information from one of the forensic regional outpatient clinics.

neither guaranteed nor static, and that challenging gatekeepers within the organization after gaining access could result in the subsequent denial of access, both for myself and for future researchers. I therefore struggled, like other feminist scholars before me, with how to conduct feminist research and challenge power imbalances within psychiatric settings (Morrow, 2008), in this case a forensic psychiatric service.

My research addressed victimization and trauma within a forensic psychiatric setting from a feminist perspective. Recognizing the power of language to name violence as a gendered problem (Nixon, 2007), I was conscious about the terminology I employed in carrying out the research. I intended to approach the research using the language of 'violence and trauma,' terms regularly employed in the literature on women's experiences with gender-based violence and trauma, mental illness, and substance use (e.g., Clark & Power, 2005; Morrow, 2002). However, it became clear in my discussions with other forensic psychiatric researchers that the term 'violence,' when employed in the context of forensic mental health, was often misinterpreted as violence perpetrated *by* rather than *against* women. I reluctantly chose to employ the term 'victimization,' rather than 'violence,' however imperfect the term may be, to avoid confusion and to specify my focus on violence *against* women.<sup>49</sup>

Like other feminist scholars and women with lived experiences of violence, I appreciate that the language of 'victimization' connotes passivity and powerlessness. Indeed, my research involved a disenfranchised group of women who were in circumstances where they were powerless to make meaningful choices for themselves. The term 'victim' suggests a permanent state of 'victimhood' whereas the shift from 'victim' to 'survivor' implies strength, and taking an active role in overcoming the effects of victimization and trauma. I have thus used the term 'survivor' where possible to overcome some of the problems associated with the term 'victim' but, like Herman (1992b), I use both terms throughout the dissertation.

The term 'trauma' is similarly problematic, as it draws on medical language, which may individualize the problem of violence against women and pathologize women's responses to victimization. For example, despite growing interest in 'trauma-informed' approaches, some feminist researchers and activists have preferred the

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<sup>49</sup> Feminist scholars prefer terms such as 'violence against women' and 'woman abuse' to gender-neutral terms such as 'domestic violence' and 'intimate partner violence' because the latter mask the gendered nature of violence against women (DeKeseredy, 2011; Johnson & Dawson, 2011; Nixon, 2007).

adoption of 'violence-informed' language in policy and practice (Cory, Godard, Abi-Jaoude, & Wallace, 2010). The argument is that this language de-medicalizes women's responses to violence and acknowledges both past *and* current violence in women's lives. This terminology cannot be easily transferred to forensic settings, however, given the tendency of forensic mental health professionals to focus on the perpetration of violence, rather than violent victimization.

My use of the phrase 'victimization and trauma' in the study was intentional. First, I sought to recruit women who had different kinds of experiences of victimization and trauma in order to understand the full range of experiences that women in the forensic mental health system consider to be traumatic. Second, I employed the language of 'trauma' for strategic reasons, as I anticipated that medicalized language would be more acceptable to forensic mental health professionals, and would facilitate access to the organization and support from staff who could assist with participant recruitment or participate themselves. I also anticipated that this language would improve the likelihood that the research findings would be used to inform service delivery, ultimately benefiting women forensic clients who have experienced victimization and trauma.

In my research proposal and applications for research approval, I employed gender-neutral language and omitted references to feminist theoretical and methodological approaches. Morrow and colleagues (2008) describe a similar experience with developing trauma-informed training within a psychiatric hospital, noting that "a feminist structural analysis must often be strategically attenuated in order to make small inroads into medical and psychiatric practice" (p. 158). Of course, this approach has drawbacks, as it silences feminist perspectives and reinforces the power of the medical and psychiatric professions.

In the Trauma Recovery Study, negotiating access to the organization, research sites, and prospective participants was an ongoing process, involving multiple gatekeepers at various levels of the organization. Before beginning the research, I completed the BCMHAS' institutional review process for research involving clients and staff, and obtained written approval to conduct the study.<sup>50</sup> This process also required me to have obtained ethics approval from the Simon Fraser University (SFU) Research

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<sup>50</sup> Approval was obtained from the Manager of the Policy and Research Department, the Director of Research, the President of Mental Health Services for PHSA, and the FPSC Research Advisory Committee (RAC).

Ethics Board (REB), and identify a BCMHAS contact person for the study. As I had been employed as a Research Assistant with Forensic Psychiatric Services during my doctoral studies, I had a colleague who was willing to take on this role and provide feedback on my application for approval to conduct research in the organization.

The study was approved by the SFU REB in October 2009 and by the FPSC RAC in November 2009, following some minor amendments to the research protocol, at the request of the institutional committee. The committee's suggestions included revising the staff recruitment protocol, including a definition of 'trauma-informed treatment' in the consent form and client interview preamble, revising the client questionnaire completion protocol, and agreeing to breach confidentiality in the event that a hospital client participant became distraught during the interview and refused to cooperate in informing staff.<sup>51</sup> The SFU REB reviewed these amendments and granted final ethics approval for the study in January 2010. One year later, a request was submitted to the FPSC RAC to extend the research agreement to the end of March 2011, and was approved.

#### **5.2.4 Sampling Strategy and Recruitment**

Recruitment and data collection for the study took place over a 14-month period, beginning in February 2010 and ending in March 2011. A purposive sampling strategy was employed for both the client and staff samples, as both have specialized knowledge and experience that contributed to an understanding of the trauma-related experiences of clients and how trauma-related issues and needs are addressed by forensic mental health professionals (Ritchie, Lewis, & Elam, 2003). Every effort was made to include participants from each of the seven research sites in order to strengthen the analysis of differences on the basis of facility type (i.e., inpatient and outpatient) and geographic location (i.e., large urban centres and small communities). Differences were anticipated along these dimensions with respect to the experience of trauma, the response to trauma-related needs, and the resources available to women survivors. Additional efforts were made to include a wide range of treatment staff, to uncover disciplinary differences in the response to gender-specific and trauma-related issues among women clients.

The majority of clients were recruited for the study using posters (see Appendix A), which were placed in visible locations (e.g., clinic waiting rooms, hospital ward) in all

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<sup>51</sup> This suggested revision was specific to hospital clients because it was thought that they may be at a 'more vulnerable stage of recovery' than clients in the community.

research sites. A minority of prospective participants were also made aware of the study through their case managers, or through the BC Mental Health and Addiction Research Network's (BCMARN) research participant portal.<sup>52</sup> Clients who were interested in participating in the study had to: (1) be women aged 19 years or older; (2) have self-identified experience of violent victimization, trauma, or abuse; (3) have come into conflict with the law; and (4) be receiving forensic mental health treatment services in British Columbia. Those who met the inclusion criteria were encouraged to contact the researcher by telephone or email to learn more about the project and decide if they would like to participate. Given that women comprise only 17% of forensic client admissions annually, the number of women who both met the inclusion criteria *and* were able and willing to discuss their experiences of victimization and trauma in a research context was relatively small.<sup>53</sup>

Women clients were offered a \$50 honorarium for participating in the study.<sup>54</sup> This amount was expected to pay women for their time and expertise, as well as cover any expenses associated with their participation (e.g., transportation, child care). Client recruitment posters indicated that they would be paid for participating in the study, but did not specify the amount. This decision was made deliberately to minimize the chance that clients, who would prefer not to disclose or discuss their experiences of victimization and trauma, should feel compelled to participate due to financial need. However, I felt it was important to compensate participants for sharing their time and experiential knowledge, despite the controversies surrounding payment of research participants<sup>55</sup> (see, Beckford & Broome, 2007; Fry et al., 2006; Grady, 2001; Stones & McMillan, 2010).

Prospective participants contacted me directly by telephone or email to inquire about the study, giving me an opportunity to confirm their eligibility, provide information

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<sup>52</sup> The BC Mental Health and Addiction Research Network was established with funding from the Michael Smith Foundation for Health Research (MSFHR). It was one of several such networks established, along with the Women's Health Research Network (WHRN).

<sup>53</sup> At several points during the recruitment period, there were regional clinics outside of the Lower Mainland that reported they had no female clients receiving treatment services.

<sup>54</sup> One client participant in custody refused the honorarium.

<sup>55</sup> There are some research contexts in which financial compensation for research participation may not be possible or desirable, because it endangers the health and well-being of participants (e.g., victims of bullying) or because organizational policies forbid financial compensation of some participant groups (e.g., prisoners). Alternative forms of payment, such as gift certificates or food stamps, may be preferred in research with marginalized populations.

about the study and the nature of the interview, and begin building rapport prior to meeting face-to-face. This initial contact also provided potential participants with an opportunity to ask questions or express any concerns prior to agreeing to participate in the study. For example, one client indicated that she still experienced social anxiety and that it would be helpful to have some advanced notice of the interview so that she could prepare herself.

A total of 40 women (14 women in custody at FPH and 26 women living in the community<sup>56</sup>) contacted me during the recruitment period. Of these 40 women, 16 (40%) participated in the study. The other 24 women were excluded for various reasons: 8 were excluded because they were not currently receiving forensic mental health services,<sup>57</sup> 6 were excluded because they were remand clients,<sup>58</sup> 4 could not be reached when contacted, 1 was excluded because of scheduling challenges due to full-time employment, and 1 was excluded because she had stopped attending forensic mental health services. Four other women were excluded after a member of their treatment team expressed reservations about their participation (either because they were unsuitable or unstable).

Prospective client participants were asked, at the first point of contact, for their permission to contact a member of their treatment team to confirm that they had the capacity to consent to research participation. Their case manager or attending psychiatrist was asked to provide a professional opinion and note anything (e.g., cognitive impairment) that would compromise the client's capacity to consent. In this way, psychiatrists and other treatment staff served as gatekeepers in my access to women clients, and were in a position to refuse access to women whom they did not

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<sup>56</sup> Not all of the women who contacted me were receiving treatment services in the forensic mental health system (e.g., some of the women in custody were remand clients and some of the women in the community were involved with community corrections and the Elizabeth Fry Society of Greater Vancouver).

<sup>57</sup> All of these women had seen the study poster at a drop-in centre run by the Elizabeth Fry Society of Greater Vancouver. Some were accessing civil mental health services, some had historical contact with the criminal justice and/or mental health systems, and others were fleeing intimate partner violence. Following a wave of calls from women who were ineligible for the study, but who were nevertheless eager to share their stories of trauma, I requested that the poster be removed. I briefly considered revising the research protocol to include a non-forensic group, but abandoned the idea because there were no common threads in their experiences with the criminal justice or mental health systems to serve as a comparison.

<sup>58</sup> Remand clients at FPH are admitted for assessment, rather than treatment services, and therefore were not included in the study, which focused on trauma-informed treatment services.

deem 'suitable' for participation in trauma-focused research. After obtaining approval that the client could consent to research participation, the client was contacted and arrangements were made for a face-to-face interview at the forensic facility where they were detained or attending treatment.

Staff participants were recruited for the study with an invitation letter (see Appendix B), distributed by email, with the assistance of management (e.g., clinic manager, staff supervisor) at each of the seven research sites. Managers and supervisors, the final gatekeepers in my access to treatment staff, were very supportive of the research and encouraged members of their teams to participate in the study.<sup>59</sup> However, some managers were incredibly busy and very slow to respond and assist with the recruitment of staff participants. The staff recruitment process required multiple requests and reminders over the course of the study period, and was as challenging as the client recruitment process, if not more so.

Forensic mental health professionals were invited to contact the researcher to learn about the study and/or make arrangements for a 30-60 minute face-to-face or telephone interview. They were required to have some experience working with women clients but were informed that they did not need to be informed about, or have experience dealing with, trauma-related issues. Staff participants were offered a \$5 coffee card for participating in the study.

While the majority of staff participants contacted me about the study, I also made a point of mentioning the staff component of the study to staff when I contacted them to confirm that one of their clients, a potential study participant, could provide research consent. As such, several client-staff dyads were included in the study; however, they were not 'matched' in the analysis, as the staff interviews did not focus on specific clients. Interviews were conducted with 13 forensic mental health professionals, including both clinical (e.g., psychiatrists, psychologists, counsellors) and case management (e.g., social workers, nurses) staff.

### **5.2.5 Ethics-in-practice**

There were several occasions during the client participant recruitment process where the core principles of respect for persons and concern for welfare were in conflict.

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<sup>59</sup> One gatekeeper at FPH was particularly enthusiastic about the research, and noted that a study of this nature was 'overdue' and would be a very valuable study in forensic services.

As a researcher, I found these ethical dilemmas to be both intellectually stimulating and emotionally distressing, particularly in cases where the resolution of ethical dilemmas was unsatisfactory. These ethical dilemmas uncovered some of the challenges in doing trauma-focused research and revealed the power of psychiatrists over clients and other professionals.

A number of cases involved women clients who contacted me to participate in the study but were discouraged from participating or denied the opportunity to participate by their treatment teams, for various reasons. In some cases, because of my ethics and research agreements, I felt I had no choice but to respect the opinion of the treatment team that the client should not participate in the study. Deference to psychiatric authority, combined with my commitment to ethical research practice in which harm to participants is minimized, led me to agree to exclude women in cases where the client's psychiatrist felt that participation in trauma-focused research might impede the woman's mental health recovery.

In other cases, I engaged in a dialogue with staff about the competing ethical issues in an effort to develop a process or reach a decision that would satisfy both the client and the treatment team. Regardless of the outcome, the process often placed me in a difficult position, where I felt torn between respecting the autonomy of the client who wished to participate and the professional opinion of their case manager or attending psychiatrist, a challenge that I had anticipated prior to recruiting participants for the study, and explored in at least one entry of my research journal:

*The inclusion in my research protocol of a process for ensuring that potential participants have the capacity to consent to research participation is problematic. On the one hand, this shows a concern for the mental health and well being of participants and an interest in high ethical standards to minimize harm. On the other hand, this limits the agency and choice of participants to make decisions for themselves and act with their best interests in mind, further perpetuating the paternalistic powers of the forensic psychiatric system, giving staff 'experts' the power in determining whether a client is 'well enough' to discuss issues of trauma in a research interview setting. The women clients are therefore not able, despite having contacted the researcher, to determine whether or not they are in a position to discuss their experiences of trauma for research purposes. This is an ethical dilemma where core principles of 'concern for welfare' and 'respect for autonomy' are at odds, and it is unclear which of the two principles should prevail (Reflexive research journal entry, October 16, 2009).*



One such case involved a woman who was considered by a member of her treatment team to be ‘too unreliable a historian’ to participate in the study. This comment gave the impression that the staff member was overstepping their role in an attempt to control the *quality* of the study rather than provide a professional opinion on the client’s *capacity* to provide research consent. In two other cases, a member of the treatment team had reservations about their client’s participation because they did not feel it was a good time for the client to discuss trauma-related issues. In one case, the staff thought it would be ‘a bit much’ for the client, given that she had only recently been admitted to FPH. The client expressed disappointment but indicated that she understood the treatment team’s reasoning. In the other case, the staff confirmed the client’s capacity to consent, but noted that the client’s life was ‘a bit unstable’ and that she was non-compliant and, therefore, difficult to follow up with for research purposes. Again, this comment reaches beyond the issue of the client’s capacity to consent, but is nevertheless an important consideration given the ethical duty to protect vulnerable participants.

The most complex ethical issue arose when I was contacted by a female forensic inpatient who wished to participate in the study. With her consent, I contacted her case manager about her capacity to provide consent to participate in the research. The case manager conferred with the client’s psychiatrist, and informed me that the treatment team thought it would be best for the client not to participate because she had delusional thoughts about past trauma. She noted that there was no collateral information or evidence to substantiate her claims of victimization and trauma. The team indicated that her progress in the hospital had not been very good, and that they did not want her to ‘dwell’ on her traumatic delusions. They were particularly concerned that her participation in the research would contribute to or validate her traumatic delusions, and so I was not able to interview her.

I struggled with the ethical issues presented in this case where the psychiatrist appeared to have answered a different question than the one asked – that pertaining to the client’s capacity to consent. Rather than commenting on whether or not the client *could* participate in the study, the staff seemed to be commenting on whether or not they thought the client *should* participate in the study. I found myself powerless and voiceless in the face of psychiatric authority, and silenced despite my efforts to express my views.

In reflecting on this case, I came to appreciate that, in some ways, my experiences with the forensic mental health system mirrored those of forensic clients:

*I ask staff if the client has the cognitive capacity to provide research consent. I don't ask if they think it would be good or bad for the client to talk about their trauma, real or perceived. That said, I have a duty not to harm the client, as an ethical researcher, so I don't want to do something that is anti-therapeutic. As a feminist, I do believe that the client should be able to express her concerns, have her experiences validated, and have a voice. I felt that I had to abandon/betray my beliefs when I told the case manager that I appreciated the concerns about the client's participation in the study. I can appreciate these concerns from a case management perspective, but not from a feminist perspective. [...] As someone who, in this situation, felt 'on the side of the client,' I also shared a feeling of powerlessness with the client about the decisions of staff. (Reflexive research journal entry, February 5, 2010)*

This case drew my attention to complexities that I had not fully appreciated and, because I was denied access to the client, I decided to invite the client's case manager to participate in a staff interview in order to shed light on this complex issue. The staff member refused to participate, but because the issue emerged early on in the research process, I was able to revise the staff interview guide to include a question about responses to trauma-related delusions and explore this issue with other staff participants. As a result, I was able to understand the challenges staff faced in addressing trauma-related issues when they appear to be entangled with psychotic symptoms. I also experienced this challenge first-hand when I interviewed another woman whose case manager had informed me that she had a history of trauma but also some delusions about her experiences. This was undoubtedly the most difficult interview to understand and make meaning of, as it was unclear if some parts of her story were based in reality or a delusion. Given my feminist orientation and position as a researcher rather than a clinician, I chose to believe women's accounts of victimization and trauma, or what Ann Oakley termed 'believing the interviewee' (Reinharz, 1992). These ethical dilemmas, and their at times unsatisfactory resolution, was illustrative of, and served to reinforce, the power of psychiatrists in the forensic mental health system – not only over forensic patients and clients, but also over the researcher and the research process.<sup>60</sup>

Another ethical dilemma involving the competing principles of 'respect for persons' and 'concern for welfare' revolved around issues of confidentiality and voice. In

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<sup>60</sup> None of these women were included in the study.

this case, ethical standards appeared to be at odds with feminist approaches.

Researchers have an ethical duty to maintain the confidentiality of research participants, which in research involving the collection of information in identifiable form, involves the 'de-identification' of data at the earliest opportunity, through the removal of directly (e.g., name, personal health number) and indirectly (e.g., place of residence, unique personal characteristic) identifying information. Women clients who participated in the study were given the opportunity to select a pseudonym for their story.<sup>61</sup> A few women selected pseudonyms, while a few others asked me to select a name for them. Yet several participants asked me to use their own names, saying: "It's my story!" (Patty, client) or "I am who I am" (Grace, client). This presented an ethical dilemma between my ethical duty to maintain confidentiality and my desire to respect the wishes and voices of the participants:

*I went to [a] symposium yesterday and had an opportunity to ask about how to resolve the confidentiality dilemma when a research participant elects not to choose a pseudonym (because they don't care, or aren't worried about treatment staff knowing what they've said) or insists on their own name being used because it is their story and they want their name associated with it. [My colleagues] agreed that, as researchers, we should probably err on the side of confidentiality and impose a pseudonym against their wishes because they (and we) may not be able to predict the potential long-term negative consequences of their decisions to waive confidentiality. This is my perspective too, especially when clients are involved in the criminal justice and mental health systems, and their words could be used against them at some point in the future, or they may not have considered the range of possible consequences. It doesn't feel right overriding, ignoring, or denying their requests to have their names associated with their stories, but I think it would feel worse to find out that they had suffered negative consequences down the road. I feel that the issue is complex, but that it is ultimately our responsibility as researchers to protect our participants. (Reflexive research journal entry, April 7, 2011)*

Scholars have pointed out that by silencing participants' voices in an effort to maintain confidentiality, despite a participant's expressed wishes, researchers take on a paternalistic role (Giordano, O'Reilly, Taylor, & Dogra, 2007). Yet, for several reasons, I chose to use pseudonyms, and thereby maintain confidentiality, for all research

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<sup>61</sup> During a discussion with some colleagues about this ethical dilemma, I came to realize that I had not afforded staff participants the opportunity to select a pseudonym. This discovery forced me to reflect on the question 'whose side are we on?' (Liebling, 2001). I chose to use female pseudonyms for all staff participants in order to maintain the confidentiality of male staff participants, who comprised a very small proportion of the staff sample.

participants. First, the consent form, which was signed by myself and the participant prior to the interview, included a statement of confidentiality that promised participants' names and contributions would be guaranteed to the full extent permitted by law. Second, it was impossible to predict the potential risks associated with participant identification, and my preference was therefore to err on the side of caution. Finally, the participants in the study were already in contact with the criminal justice system, and many had also had contact with the child welfare system; therefore, the potential consequences of identification with respect to stories of violence perpetrated by and against them, were deemed sufficiently significant to warrant protection of their identities in spite of their wishes to have themselves named. In an effort to protect the research participants, I denied the women a voice and the power to make choices for themselves, which paralleled the ethical issues that emerged with treatment staff who chose to err on the side of caution with respect to some women clients' involvement in the study and, in doing so, also silenced and disempowered them.

## **5.2.6 Data Collection Procedures**

The Trauma Recovery Study involved the gathering of information from clients and staff in the forensic mental health system. Data collection involved semi-structured interviews with women clients (see Appendix E) and treatment staff (see Appendix F), and a brief questionnaire for clients (see Appendix G).

### **5.2.6.1 Client Interviews**

Each research interview was preceded by an informed consent process, during which client participants were given a copy of the consent form (see Appendix C), and invited to follow along as the form was read aloud to them by the interviewer.<sup>62</sup> This step was taken to ensure that the risks, benefits, and limits to confidentiality were clearly communicated to prospective participants before they agreed to participate.<sup>63</sup> It also allowed prospective participants to ask questions of the researcher and clarify any points. Each participant gave written consent before proceeding with the interview, and was offered a copy of the signed consent form. As per Article 3.12 of the TCPS2 (2010), researchers are discouraged from leaving documentation about the study with

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<sup>62</sup> The client and staff consent forms are included below in Appendix C and D, respectively.

<sup>63</sup> This was particularly important for clients with poor literacy skills or English language proficiency, and those who may not have felt comfortable disclosing this to the researcher.

participants if it may put them at risk or otherwise compromise their safety. In light of these ethical guidelines, participants were given the choice to accept or refuse a copy of the consent form, based on their own assessment of their needs and safety.

Semi-structured interviews with women clients focused on their experiences of victimization and trauma, their recovery from the psychological effects of trauma, and their needs for trauma recovery, particularly in relation to forensic mental health services. The semi-structured nature of the interviews allowed for flexibility in the interview, affording participants greater control over both the form and content of the interview, which is particularly important in research on sensitive topics (Brannen, 1988; Corbin & Morse, 2003; Kavanaugh & Ayres, 1998). Greater control over the interview was expected to increase women's sense of safety in the research context. Flexibility in the interview process also allowed me to adapt the questions to explore different types of victimization and trauma, and to direct the interview away from particularly sensitive topics if participants became emotionally distressed, and return to these topics at a more appropriate time.

Interviews with women clients ranged from 53 minutes to 2.5 hours ( $x = 1.38$  hours). The interviews were conducted in forensic settings (e.g., hospital, regional clinic) because, as a Criminological researcher, I was neither qualified, nor in a position, to provide clinical support or crisis-intervention. These settings, while not the most comfortable or private, ensured that a mental health professional would be on hand so that if a participant became upset or anxious during the interview, they could be referred directly to a member of their treatment team. Client participants were also given information about community-based services that provide specialized support to women who have experienced violence and trauma, in case they needed support following the interview or did not feel comfortable seeking support from their treatment team.

Despite a lack of clinical or trauma-specific training, I felt sufficiently qualified to conduct trauma-focused interviews based on extensive interview experience with women and men on a number of related sensitive topics (e.g., victimization and trauma recovery, mental illness and stigmatization, imprisonment and reintegration) as well as crisis intervention training and volunteer experience in a variety of relevant settings (e.g., suicide hotline, distress centre, women's shelter, court, prison). Through the consent process and interviews with women clients, I articulated my role as a researcher, and emphasized that I did not have clinical experience or training in trauma therapy.

I also indicated that I was a graduate student, and was not employed by Forensic Psychiatric Services, in order to minimize my own power and authority, so that they could confide in me, and feel comfortable sharing both positive *and* negative experiences in the forensic mental health system. In some cases, clients explicitly stated that my position as a researcher, and the confidential nature of the research interview, were part of the reason they had decided to participate. For example, in the course of my interview with Lisa, she indicated that she was interested in participating in the study because, unlike forensic mental health services, the research was confidential: “*I don’t need it to get repeated and everything written down and... Oh, and then everyone else reads it. No. Don’t need that shit*” (Lisa, client). When I stressed my role as a researcher and not a trained counsellor or forensic mental health professional, she replied: “*Well that’s what I mean. That’s why I like you*” (Lisa, client).

Having no personal experience with the criminal justice system or psychiatric services,<sup>64</sup> I relied heavily on my gender when interviewing female forensic clients, and on my education when interviewing staff participants, to build rapport. My gender was particularly important, given that the research focused on victimization and trauma, and the majority of client participants (as expected) had lived experiences of male violence (Reinharz, 1992; Reissman, 1987). I did not disclose any personal experiences of victimization and trauma, but did share some personal information in the course of the interviews, to connect with research participants and establish trust.

#### **5.2.6.2 Client Questionnaire**

At the end of the trauma-focused semi-structured interview, client participants were asked several open-ended questions about their experiences as participants in the study (e.g., What would you consider to be the positive aspects, or benefits, of participating in trauma-focused research interviews like this one? Do you have any concerns about your participation in the research?). Client participants were then invited to complete the *Reactions to Research Participation Questionnaire* (Newman et al., 2001), to measure their experiences as participants in a trauma-focused study (see Appendix G).

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<sup>64</sup> My personal experience with the mental health system is limited to one or two years of family counselling during my adolescence. I have several years of volunteer experience with female survivors of intimate partner violence and women involved in the criminal justice system.

The RRPQ consists of 23 items, scored using a 5-point Likert scale (from *strongly agree* to *strongly disagree*), that load onto five factors: *Participation* (e.g., 'I felt I could stop participating at any time'), *Personal Benefits* (e.g., 'I gained something positive from participating'), *Emotional Reactions* (e.g., 'The research made me think about things I didn't want to think about'), *Perceived Drawbacks* (e.g., 'I found the questions too personal'), and *Global Evaluation* (e.g., 'I think this research is for a good cause'). The RRPQ initially consisted of 60 items, but was revised following exploratory and confirmatory analyses (Newman et al., 2001). The revised 23-item scale includes some negatively worded items that are reverse scored; however, because few items are negatively worded, there is a risk of response bias (Newman et al., 2001). The RRPQ was specifically developed to measure reactions to participation in trauma-focused research and is regularly cited in the literature on the ethics of trauma-focused research. The questionnaire also includes a question about the reasons participants decided to participate in the research.<sup>65</sup>

At the request of the Research Advisory Committee, client participants completed the paper-and-pencil RRPQ in privacy, after I had left the interview room.<sup>66</sup> Participants were asked to seal the completed questionnaire in an envelope labelled 'confidential,' and directed to return the envelope to me before leaving. When they returned the questionnaire, they were thanked for taking the time to share their stories and perspectives, and given an honorarium and information card with a list of names and phone numbers for several community-based support services located throughout the province. This information was provided in the event that participants became distressed following the interview but did not wish to (or were unable to) access support from forensic services.

### **5.2.6.3 Staff Interviews**

Interviews with forensic treatment staff focused on their perceived role in addressing issues of victimization and trauma in the lives of women clients, the challenges they face in addressing these issues, and the supports that are in place to

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<sup>65</sup> Early in the interview process, I revised the client interview guide to include an open-ended question about why the women had decided to participate in the study, to capture any responses that may not have been included in the fixed-response options of the RRPQ.

<sup>66</sup> A staff member working on the women's unit at the forensic psychiatric hospital provided assistance to one participant who had difficulty with English reading and comprehension.

assist them in doing so, while managing their own vulnerability to secondary traumatic stress. These interviews focused on female forensic clients in general, and did not inquire about specific clients.<sup>67</sup> As the research process unfolded, issues that had not previously been considered emerged, and the interview guide was revised to include a question about staff responses to women clients whose experiences of victimization and trauma were perceived or interpreted by treatment professionals as delusional beliefs. Staff were asked, at the end of the interview, if they had ever encountered a situation involving a woman whose trauma was thought to be delusional, and how they might approach or address the issue in the course of their work with the client.

Interviews were conducted with 13 forensic mental health professionals. Ten (76.9%) staff participants were working in one of the six community clinics, while the remaining three (23.1%) worked at FPH. Nine (69.2%) staff participants were based in the Lower Mainland (FPH, Vancouver FPS clinic, or Surrey FPS clinic), with four (30.8%) working in regional clinics outside the Lower Mainland. Ten (76.9%) staff participants were case managers (e.g., psychiatric nurses, social workers), while the remaining three (23.1%) were clinical and rehabilitation staff (e.g., psychiatrists, psychologists, counsellors). Staff participants' experience in the forensic mental health system ranged from a minimum of 2 to over 25 years (mean = 10.6 years).

Staff interviews ranged from 28 minutes to 1.25 hours ( $x = 53$  minutes). The majority of staff interviews were conducted face-to-face in the participants' offices. However, two staff interviews were conducted by phone due to geographic distance or scheduling problems.<sup>68</sup> All staff participants were required to sign a consent form (see Appendix D) prior to completing an interview.

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<sup>67</sup> Some staff did, of course, offer detailed information about specific clients, including clients who had participated in the study, to provide examples or illustrate their perspectives.

<sup>68</sup> The recruitment of forensic mental health staff proved to be as, if not more, difficult than the recruitment of clients, as treatment staff were extremely busy, and research is not always a priority when time and resources are limited.



## 5.2.7 Data Analysis and Interpretation

Notes were recorded during the interviews for the purposes of probing,<sup>69</sup> and further notes were taken following each interview, which included any observations of the participant's behaviour during the interview. Semi-structured interviews with clients and staff were recorded with a digital-voice recorder,<sup>70</sup> and transcribed verbatim. Transcribing the interviews was arguably the most emotionally challenging part of the research, as I listened to the women's stories again, repeatedly replaying the graphic details to ensure accuracy in the transcriptions.

*This has been such a grueling process, and very difficult, emotionally, at times. I've had to disconnect from the meaning of the words, at times, and just type out the words as meaningless letters on a page, to distance myself from them. I've had to take breaks outside and listen to music to drown out the thoughts and images associated with the words, as they play on repeat in my head. (Reflexive research journal entry, June 15, 2011)*

In some cases, transcripts were minimally altered to maintain the confidentiality of participants whose identities may have been revealed through quotes. As well, whereas involuntary vocalizations such as laughter were removed, as the meaning of these vocalizations could be misinterpreted, most instances of response tokens (e.g., um, uh) were included as they are typically intentional and may convey meaning to the reader (Oliver, Serovich, & Mason, 2005). Transcribed interview data were manually coded and analyzed using qualitative content analysis techniques.<sup>71</sup> Content analysis of the data was guided by the qualitative 'spiral model' articulated by Hesse-Biber and Leavy (2011), which sees the researcher "diving in and out of the data" (p. 236), throughout the process of generating and refining codes, generating meta-codes or broader themes, and interpreting the findings.

I began the inductive analysis process by reading through the transcripts, line-by-line, and coding the text. As I generated the initial codes, I inserted quotations from the

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<sup>69</sup> Few notes were taken during the interview itself, as extensive note taking could have disrupted the flow of the interview, and damaged rapport with the participant, especially if she was wary of note taking by treatment staff, knowing that those notes are recorded in her forensic chart and may follow her through services, or be used against her in the future.

<sup>70</sup> Verbal permission to digitally record the interview was sought from all participants during the consent process.

<sup>71</sup> I began the process using qualitative analysis software (NVivo8) but abandoned this as a tool for managing and analyzing the data, as the program created a 'barrier' between me and the data. Of course, electronic coding has many advantages in qualitative research (Basis, 2003).

text into cells in an Excel spreadsheet, with each participant listed in a separate column, and codes populating the rows as they were generated. In the process of coding the women clients' interview transcripts, my focus shifted from the women's stories to the electronic spreadsheet and I lost sight of the women's lived experiences. I concluded, like other feminist scholars, that "the best way to proceed was to simply become 'immersed' in the data" (Comack & Balfour, 2004, p. 183). I returned to the hard copies of the transcripts, and began highlighting the text with different colours according to four broad categories: victimization and trauma, mental health, substance use, and criminal justice. An additional category highlighted experiences related to foster care, education, sex work, parenting, racism, and other relevant experiences not captured in the four main categories. This process allowed me to reconnect with the women's voices and lived experiences of victimization and trauma, mental illness, substance use, and crime.

As I highlighted the text, I engaged in more focused coding (Charmaz, 2004) and wrote codes into the margins of the transcripts. I simultaneously condensed the data into one-page reference sheets for each woman, where I recorded basic demographic information and made notes about their experiences and needs. The women's experiences in the four main categories were described in a diagram, with arrows drawn in to indicate relationships between these four categories (e.g., using substances to cope with experiences of trauma or symptoms of severe mental illness; committing a crime to support a drug habit or while in a psychotic state; or experiencing violent victimization while intoxicated or as a result of involvement in the drug trade). I also identified the 'root' of each woman's story, based on their own descriptions or my interpretations of their pathways to forensic mental health services. Finally, I recorded descriptions of the women's self-reported needs for trauma recovery, and reflections on forensic mental health services, on each reference sheet. I referred to these sheets to look across the 16 cases and identify common experiences and patterns in their pathways to forensic mental health services.

I then returned to the Excel file to group the over 100 initial codes into broader categories, and identify emergent themes. Coding of the staff interviews followed a similar process, with the transcripts highlighted according to trauma-related issues, challenges in addressing clients' trauma-related needs, and opportunities or supports for this kind of work. Over 50 initial codes input into Excel were then collapsed into broader categories to identify emergent themes. Themes from the analyses of client and staff

interview transcripts were then integrated to tell the story of trauma in forensic mental health services.

The qualitative analysis paid special attention to gender and diversity, to ensure that women's experiences were continually contextualized in relation to their social locations. The analysis explored the complexity and diversity of women clients' lived experiences of victimization and trauma, mental health, and criminal justice involvement, as well as their needs for trauma recovery (Collins, 1999; Symington, 2004). Managing the complexity of an intersectional analysis can be challenging; however, every effort was made to fully explore this complexity rather than artificially separate identity categories for analytical purposes, a practice which clearly threatens the quality of the analysis (McCall, 2005). I attempted to contextualize the women's experiences of victimization and trauma, drawing attention to the unique vulnerabilities some of the women faced as women with mental health and/or substance use problems who were marginalized at the intersections of gender and other social inequities.

The quantitative questionnaire data were scored according to the scoring sheet provided by the authors of the instrument (Newman et al., 2001), and analyzed using Excel. I grouped items according to the five subscales and then calculated the percentage of respondents that endorsed each of the fixed choice responses for individual items, or aggregate frequencies for each item, and the mean scores for each subscale. I also examined individual scores to identify individuals who had particularly negative reactions, to explore potential common characteristics (e.g., trauma exposure, psychiatric diagnosis). Additionally, guided by the TCPS2 (Canadian Institutes of Health Research et al., 2010), I identified items that reflected the core ethical principles of research conduct, and those items that best captured notions of 'harm' and 'benefit.' I then calculated frequencies for clients' self-reported reasons for participating in the study.

### **5.3 Trustworthiness of the Research Findings**

Criteria traditionally used to evaluate quantitative research include reliability, validity, and generalizability (Palys & Atchison, 2007). Reliability is concerned with the consistency of the findings over time and across investigators, whereas validity is concerned with the accuracy or truthfulness of the data, assessing how well the research measured what it intended to measure (Kvale, 1996). Generalizability is concerned with

the extension of the findings to other, similar groups. Some postmodern scholars have outright rejected the notions of reliability and validity, which have been “discarded as leftovers from a modernist correspondence theory of truth” (Kvale, 1996, p. 231). Many qualitative researchers, however, have simply argued that these criteria are not suitable for evaluating qualitative research, instead proposing alternative criteria such as confirmability, dependability, credibility, transferability, and trustworthiness (Lincoln & Guba, 1985; Seale, 1999).

I employed three types of strategies to enhance the quality of the Trauma Recovery Study: reflexivity, as demonstrated through critical self-reflection throughout the research process, triangulation of data sources and research methods, and respondent validation. Reflexivity was employed to examine my own assumptions about the research topic and population, and to enhance the credibility, transparency, and rigour of the research (Dowling, 2006). In order to maintain a ‘reflexive stance’ throughout the research process, from the research design through to the writing stage, I kept a detailed research journal that documented the effect the research had on me, my influence on the research, and my thoughts as I grappled with difficult decisions and ethical dilemmas along the way. Excerpts from my research journal are included in the dissertation to illustrate some of the challenges I faced in conducting the research, particularly with respect to ethical issues encountered in the course of carrying out the study, and how I struggled to make meaning of these difficulties.

Triangulation of data (e.g., multiple sources), investigators (e.g., multiple coders), theories (e.g., multiple perspectives), and methods (e.g., multiple or mixed methods) also enhance the trustworthiness of research (Denzin & Lincoln, 2005; Maxwell, 1996). Methodological triangulation, particularly the combination of quantitative and qualitative approaches, or integration of “narratives and numbers” (Stewart & Cole, 2007, p. 330) is an especially common approach to improve the consistency of research findings (Patton, 1990). I employed two forms of triangulation in the Trauma Recovery Study: data triangulation, with the inclusion of both client and staff perspectives in the study, and methodological triangulation, with the inclusion of both qualitative interview and quantitative questionnaire methods in the ethics inquiry.

Interviews with clients and staff in the forensic mental health system ensured that the research findings were informed by different perspectives on trauma-related issues. These diverse perspectives were especially important given the power differential

between forensic clients and treatment staff, and the challenges faced by women trauma survivors, women with mental health and substance use problems, and criminalized women to be perceived as 'credible' sources. The ethics component of the study employed methodological triangulation, specifically between-method triangulation, using both qualitative interview and quantitative survey methods to investigate the reactions of participants to participation in trauma-focused research.

Another method to improve the credibility of qualitative research findings is to engage participants in *respondent validation* or *member checks* during analysis to ensure that the researcher's interpretations are accurate (Maxwell, 1996; Seale, 1999). Of course, despite its potential value, respondent validation may be distressing or traumatizing for participants involved in sensitive research (Campesino, 2007). Although I was unable to undertake respondent validation due to time limitations imposed on my post-interview contact with participants and the loss of participant contact information,<sup>72</sup> preliminary analyses were presented at a local conference for professionals working in the anti-violence and health care sectors (Rossiter, 2011). Discussions at this event served as an approximation of member checks, as those in attendance had extensive frontline experience in the delivery of trauma-informed services within the anti-violence, mental health, and criminal justice sectors. These conversations helped to enhance accuracy in the interpretation of the research findings.

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<sup>72</sup> At the request of the Forensic Psychiatric Services Commission, I selected December 31, 2010 as the date after which I would not follow-up with participants. This did not allow sufficient time to follow-up with clients, given that the recruitment and data collection process lasted longer than anticipated. As well, participant contact information was lost during data analysis.

## **6: WOMEN'S PATHWAYS TO FORENSIC SERVICES**

In the following three chapters, I report and discuss the findings of the Trauma Recovery Study. The first chapter explores women's pathways to forensic mental health services, and the role of victimization and trauma in the women's lives and their pathways to mental illness, substance use, and crime. I begin by providing a biographical profile of the women clients who participated in the study, drawing on demographic information shared in the course of the client interviews,<sup>73</sup> and juxtapose this profile with a general description of the female forensic client population, from the perspective of staff participants.

The next section, *Hearing Women's Voices*,<sup>74</sup> describes the women clients' lived experiences of victimization and trauma, honouring and privileging their voices, which are often silenced in the forensic mental health system. I then explore the connections between the women's experiences of victimization and trauma, mental health and substance use, and involvement in the criminal justice system, based on their own understandings of their pathways to (and through) forensic mental health services. These pathways are explored and discussed in relation to what is known about women's gendered pathways to crime, as articulated in the feminist criminological literature.

### **6.1 Profiles and Constructions of Female Forensic Clients**

The descriptions provided by clients of their lived experiences, and by staff who have worked with women in the forensic mental health system, both confirmed the gendered nature of women's trauma-related experiences and needs, and highlighted the diversity of the female forensic population.

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<sup>73</sup> Not all client participants provided detailed demographic information, nor were their forensic files reviewed to gather this type of information. The demographic data provided herein are self-reported and based on information revealed in the course of the women's interviews.

<sup>74</sup> This is the title of a report on women's mental health and mental health reform, published by the British Columbia Centre of Excellence for Women's Health (see Morrow & Chappell, 1999).

### 6.1.1 Profile of the Women Client Participants

The client participants' narratives revealed that they were a heterogeneous group with respect to their lived experiences of victimization and trauma, mental health and legal status, and their social locations (see Table 1). Women clients who participated in the study ranged in age from their early 20s to their early 60s (mean age = 42.4 years<sup>75</sup>). Four (25%) of the women indicated that they were Aboriginal, and two (12.5%) identified as immigrant women.<sup>76</sup> Nine (56.3%) of the women reported that they had dropped out of school, though two had later earned a GED, and three (18.8%) of the women reported having some post-secondary education. The women who had dropped out of school had done so for a variety of reasons, including having to care for younger siblings or struggling to cope with untreated psychiatric symptoms.

Many of the women indicated that they were struggling financially, receiving income assistance, and/or living in subsidized housing at the time of the interview. One third (31.2%) of the women reported having grown up in middle- or upper-class families, and having been financially secure themselves, owning property and vehicles. However, interestingly, all of these women reported having lost large sums of money or assets at some point in their lives (e.g., money was stolen or used to support a drug habit). Five (31.3%) of the women reported that they had run away from home during adolescence, and two (12.5%) of the women indicated that they had experience working in the sex trade.

Five (31.3%) of the women who participated in the study had been through the foster care system as children, and one woman was fairly sure she had been adopted. Twelve (75%) of the women had children of their own, with five (41.7%) of the women with children having had their first pregnancy before age 18. Some women had had children with multiple partners over the course of their lives, and at least one woman had a child that was the result of a sexual assault. Two women reported having had an abortion at some point, and at least five (41.7%) of the women who had children had either given their children up for adoption or had their children removed by child protection services.

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<sup>75</sup> Three client participants did not report their age.

<sup>76</sup> A study of British Columbia's NCRMD population found that 80% of the cohort identified as white (Livingston, Wilson, Tien, & Bond, 2003).

All of the women reported having been diagnosed with an Axis I disorder, with ten (62.5%) of the women indicating that they had been diagnosed with a mood disorder, such as Major Depressive Disorder, Bipolar Disorder, Social Phobia, or Generalized Anxiety Disorder. Five (31.3%) of the women reported having been diagnosed with Schizophrenia or another psychotic disorder, such as substance-induced psychosis. Twelve (75%) of the women revealed that they had engaged in problematic substance use; six (37.5%) women had problems with drugs, two (12.5%) women had problems with alcohol, and another four (25%) women reported problematic drug *and* alcohol use. With respect to Axis II disorders, only a few women reported having been diagnosed with a personality or developmental disorder. Two (12.5%) of the women acknowledged that they had been diagnosed with Borderline Personality Disorder, and one indicated she had received a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD). Only two (12.5%) of the women indicated that they had received a diagnosis of PTSD at some point in their lives.

A recent study involving participants from the same forensic population, and including 128 female clients, found that women were more likely than men to be diagnosed with a mood disorder (25% versus 14%), substance use disorder (12% versus 9%), anxiety disorder (8% versus 3%), or personality disorder (7% versus 2%), but that men were more likely than women to have a schizophrenia spectrum disorder diagnosis (54% versus 35%). The women who participated in the Trauma Recovery Study had more self-reported mood disorder diagnoses than the female forensic population, and more self-reported substance use problems, though these did not necessarily result in a substance use diagnosis.

The women's criminal profiles were slightly more varied than their clinical profiles. Eleven (68.8%) of the women reported having committed a violent offence (e.g., uttering threats, assault, arson, attempted murder, murder), with assault the most commonly reported such offences. Nine (56.3%) of the women reported having committed property offences (e.g., theft, fraud, forgery, breaking and entering, possession of stolen property), and three (18.8%) of the women had committed other offences, such as drug trafficking or possession.

Nine (56.3%) of the women were attending forensic mental health services as a condition of a probation order, while the other seven client participants (43.8%) had been adjudicated *Not Criminally Responsible on Account of Mental Disorder* (NCRMD). Given



that the proportion of women clients on probation exceeds that of female NCR-accused in British Columbia's forensic mental health system, it was not surprising that a majority of the study participants would be probation clients.

Four (57.1%) of the NCR-accused participants were in custody while the other three (42.9%) were on a conditional discharge order in the community, with a condition to attend treatment services at one of the six forensic outpatient clinics. Of the total sample, twelve participants (75.0%) were living in the community, receiving forensic services on an outpatient basis, while four (25.0%) were residing in custody, receiving forensic services as inpatients. Of those 12 participants who were attending forensic community clinics, six (50.0%) were located in the Lower Mainland while the other six (50.0%) were located outside of the Lower Mainland.

**Table 1: Demographic Profile of Female Forensic Client Participants**

Demographic Variable		N	%
Ethnic Minority Status	Aboriginal	4	25.0
	Immigrant	2	12.5
Education Status	Did not complete HS	9	56.3
	GED	2	12.5
	Some post-secondary	3	18.8
Mental Health Status	Mood disorder	10	62.5
	Psychotic disorder	5	31.3
	Personality disorder	2	12.5
	PTSD diagnosis	2	12.5
Substance Use	Drugs only	6	37.5
	Alcohol only	2	12.5
	Drugs & Alcohol	4	25.0
Criminal Offences	Violent offences	11	68.8
	Property offences	9	56.3
	Other offences	3	18.8
Legal Status	NCRMD	9	56.3
	Probation	7	43.8
Forensic Status	Outpatient	12	75.0
	Inpatient	4	25.0

### 6.1.2 Staff Descriptions of the Female Forensic Client Population

Staff participants were asked to describe the ‘typical’ female forensic client and the female forensic population as a whole. While some staff drew comparisons between male and female clients with respect to the nature of their crimes, the severity of their mental health and substance use problems, and their needs for recovery, staff made it clear that women comprised only a small proportion of forensic clients and that these women were not a homogenous group. Women clients in the forensic mental health system were described by treatment staff as an extremely diverse population with respect to their criminality, mental health, and level of functioning, making it very difficult to describe a ‘typical’ client. Instead, staff painted a complex picture of women at the interface of the criminal justice and mental health systems, which seemed to acknowledge both women clients’ agency and social disadvantage at the intersections of gender and other social inequities.

Female forensic clients were generally described as ‘disenfranchised,’ ‘marginalized,’ ‘vulnerable,’ ‘at-risk,’ ‘disadvantaged,’ ‘impoverished,’ ‘isolated,’ ‘underserved,’ and ‘prejudged.’ They were characterized as experiencing multiple disadvantages and barriers, such as limited education, poverty, homelessness, sex-trade involvement, serious health concerns, physical disabilities, intellectual or developmental disabilities, extreme isolation, and low self-esteem or sense of self-worth, which rendered them even more marginalized. From a treatment perspective, the women were considered to be ‘sicker’ and ‘harder to engage’ or ‘harder to treat’ than their male counterparts. They were also characterized as ‘angry,’ ‘verbally aggressive,’ ‘secretive,’ and ‘manipulative,’ making their cases more ‘complicated,’ ‘challenging,’ and ‘difficult.’<sup>77</sup>

*They often... serious psychiatric histories, serious substance misuse histories, tons and tons of trauma and abuse... often serious health problems as well. So yeah, they’re really kind of complicated. (Dawn, staff)*

*I think that women tend to be more verbal, more aggressive – verbally aggressive – and so... the challenge has been, for me, to try and help them reintegrate into society and it’s... I find it more challenging with women than with men. (Jeanette, staff)*

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<sup>77</sup> Terms that were used to describe individual female forensic clients included ‘feisty’ and ‘feral,’ though these were not intended to describe the female forensic population as a whole.

*Some people think they're sicker. They're definitely more marginalized. Because, you know, for the men that are here, they're very much marginalized, but the women are even more so. Multiple barriers, right? (Sam, staff)*

Staff participants' descriptions suggest complex views of clients, with female forensic clients simultaneously constructed as 'disadvantaged' and worthy of empathy, 'sick' and in need of care, and 'aggressive' and therefore more difficult to care for, especially in comparison to male forensic clients. Yet, negative views of women forensic clients, and the use of pejorative terms to describe them, serve as dehumanizing and 'othering' practices that ultimately impact the relationship between forensic staff and their clients (Jacob, Gagnon, & Holmes, 2009; Peternelj-Taylor, 2004). The use of judgmental terms has been challenged by proponents of gender-informed mental health care who argue that these terms can make women's needs invisible (Williams & Paul, 2008). Negative attitudes and language in forensic psychiatric settings may similarly affect how forensic treatment staff attend to the trauma-related needs of their female clients.

The clinical picture of female forensic clients provided by treatment staff reflected known gender differences in the prevalence of mental health problems and gendered application of psychiatric diagnoses. As with negative language, stereotypes and labels of women forensic clients may obscure their needs. According to staff, most female forensic clients have been diagnosed with mood disorders (e.g., bipolar disorder, depressive disorder), though some have been diagnosed with a psychotic disorder (e.g., schizophrenia, delusional disorder). Six (46.2%) staff participants mentioned personality disorders when characterizing female forensic clients, particularly Borderline Personality Disorder, which was described as a diagnosis commonly given to women. While women in the general population are at greater risk of developing PTSD (Finkelhor, 2007; Kilpatrick & Acierno, 2003; Stein et al., 2000), women in forensic populations are not likely to have a PTSD diagnosis; rather, one of Borderline Personality Disorder, which is a more highly stigmatized diagnosis (Herman et al., 1989; Nehls, 1998).

Nine (69.2%) staff participants indicated that substance use issues and substance-related disorders were common among women accessing forensic mental health services. Few staff mentioned other self-destructive behaviours, such as disordered eating, self-injury, and suicide. It was surprising that self-injurious behaviour and suicidal ideation did not feature more strongly in staff descriptions of the female forensic client population, given that self-injury has been linked to experiences of

childhood abuse and other mental health problems, and is a mental health concern for many women in prison (Brown et al., 2002; Kilty, 2006; Weierich & Nock, 2008). In the study published by Nicholls and colleagues (2011), 30% of female forensic inpatients were found to have a history of suicidal ideation or attempts, suggesting that self-injury is a concern in forensic mental health settings as well.

Women's crimes typically fall into three categories: property-related offences, drug-related offences, and prostitution-related offences (Barker, 2008). According to forensic treatment staff, the criminal profiles of female forensic clients do not reflect what are generally considered to be 'typical' women's crimes. This finding is perhaps not surprising in a forensic population, given the relationship between mental illness and criminal and violent behaviour (Silver, 2006). Staff indicated that, in contrast to the general population of women offenders, many female forensic clients had committed violent offences (e.g., assault, criminal harassment, attempted murder, murder), with several staff specifying that children, partners, and family members were often the targets. Although the female forensic population may be considered by staff to be more violent than the general female offender population, property crimes (e.g., theft, fraud, drug possession) were still common. A few staff also mentioned mischief and administrative offences (e.g., failure to comply) committed by women. It should be noted that, among forensic patients, women tend to have more extensive psychiatric than criminal backgrounds (Bland et al., 1999; Coid, Kahtan, Gault, & Jarman, 2000).

## **6.2 Hearing Women's Voices**

In this section of the findings, I honour women's voices, and describe their lived experiences of victimization and trauma, in their own words.<sup>78</sup> I draw connections between their experiences of victimization and trauma, mental health and substance use, and their involvement in the criminal justice system, based on their own descriptions of their pathways to forensic mental health services and trauma recovery, and situate these interconnected experiences within the social context of their lives. I have devoted this section to the women's voices, and deliberately excluded quotations from staff interviews, in order to give voice and space to the women clients, who are so often silenced in the forensic mental health system, and to treat them as 'experts' of their

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<sup>78</sup> All client and staff participants' names are pseudonyms.

own experience, in a system where they are often controlled by psychiatric and other professional 'experts.'

### 6.2.1 Layered Experiences of Victimization and Trauma

The overwhelming majority of women who participated in the Trauma Recovery Study had experienced multiple forms of victimization and trauma. Traumatic exposure included direct experiences of violence in childhood, adolescence, and adulthood, and witnessing violence committed towards others. Some of the women had been exposed to single incidents of horrific violence, while others had suffered repeated or chronic victimization over the course of their lives. Women had also been traumatized by their experiences of loss, perpetration of violence towards others, or their involvement in the criminal justice and forensic mental health systems. For many, violence was a constant, almost 'normal,' aspect of their life histories.

*I've had violence in the drug trade, the sex trade. I've been... I've been victimized all my life. That's why I'm here, eh? (Katrina, client)*

Women's experiences of victimization in childhood included physical, sexual, and emotional abuse at the hands of immediate and extended family members, family friends, and foster parents. Some of these experiences were severe or life-threatening, leading to serious injuries and bodily harm.

*My mom was violently physically abusive, emotionally and psychologically abusive from a very young age towards me. My brother experienced a fair bit but I seemed to get the brunt, most of it. (Corine, client)*

*We had got to fighting about this crayon... about the colour of this crayon. And that's all I really remember, but I do know my dad flew right into a blind rage. And he went absolutely just crazy on me. And my mom said all she basically remembers is there was blood everywhere. Yeah, and he just literally just mopped the floors with me. And there was blood everywhere. And there were strangle marks around my ankle and what have you. (Donna, client)*

*I think I went through about two or three foster homes. And then... [pause]... I can't really think right now, if it was two or three. But I was abused in both of them. Sexually abused. (Katrina, client)*

*My grandfather moved in with us, and decided to have his way with me for three years. It was awful. [...] Looking back, I... didn't know... I didn't know. You know? Like I knew it was wrong, but I didn't know. You know,*

*'cause I was his special girl and this and that. You know, like, he manipulated the whole situation, right? (Patty, client)*

Grace's experiences of childhood abuse at the hands of a female step-parent were linked to racial stereotypes about substance use among Aboriginal people, and illustrate how her intersecting identities as a young Aboriginal woman were tied to her experiences of victimization and trauma:

*...she used to throw me down the stairs. Every day when I got home, saying 'let me see your eyes, let me smell your breath,' thinking that I was smoking pot and drinking and everything. She had Natives all categorized and, you know, I was nothing but a no-good, low-down slut too... and this, that. At the age of 7, I didn't even understand the words she was talking about, but at the age of 12, I understood... (Grace, client)*

Another Aboriginal woman who participated in the study did not feel that her experiences of victimization and trauma were related to her identity as an Aboriginal woman, indicating that she had always been accepted by others. However, she attributed this to the fact that she did not conform to stereotypes of Aboriginal people. *"I've never been picked on because of my race [...] because they're like 'you don't look Native, you don't act Native.' It's like well, you don't gotta be a chunk to be an Indian"* (Faye, client). Her story illustrates how the *visibility* of identity categories that mark women as 'different' can affect their vulnerability to victimization and trauma.

Not all of the women who participated in the study had experienced childhood abuse, with several stating that there had never been violence in the home. Others indicated that they had been the targets of verbal and emotional abuse, but had never experienced physical or sexual violence growing up. The overwhelming majority of women, however, reported experiencing violence in adolescence and/or adulthood, including physical and sexual assault, at the hands of acquaintances, relatives, strangers, and police officers, and severe and ongoing intimate partner violence. One woman reported having been bullied by peers at school during her adolescence, an experience that had a lasting impact.

*My youngest baby's dad, when he was – he was an alcoholic – and he was very verbally abusive, and once in a while would get violent. And then my oldest kid's dad, he would get drunk and just kick the crap out of me. (Patty, client)*

*There was some physical violence between the two of us – equal. I can't say he was more than I was because it was very equal, but he was emotionally and psychologically very abusive. (Corine, client)*

*Two guys lived in the... across the alley from us and I guess they – I'm not sure if they lived with their parents or they just rented the house on their own. They were about 21 years old. And I was 13. And we always used to hang around them, you know? 'Cause they were older guys and I... I snuck out of the house and went to a party there the night that it happened. And I was raped by both – one guy and his brother. And I never told anyone 'cause I thought, you know, I was totally... in denial, I guess, huh? I hadn't really... I thought I was going to get in trouble for sneaking out at home. (Aja, client)*

Aja had experienced severe violence perpetrated by men at several points throughout her life, from childhood through adolescence and into adulthood. The sexual assault she describes above resulted in her first pregnancy. As a result of her pregnancy, she was sent away to a home for unwed mothers where her early traumatic experiences were compounded by stigmatizing and judgmental attitudes from staff: “...we were treated like criminals, you know? We were treated like we were really bad. And uh... that was... that was very traumatic for me” (Aja, client). This labelling and treatment of a young, unwed mother as ‘bad’ served both to reinforce ideas about what behaviour is deemed appropriate for young women and the notion that victims of sexual violence are somehow to blame for their victimization and its consequences.

Many of the women participants who had experienced intimate partner violence described being dependent on their partners, with some women having never been on their own or only recently becoming single for the first time in their lives. For example, Lisa had been alone for one month between relationships, and described it as “*pretty scary*” (Lisa, client). Another woman, Heather, who had similarly spent most of her adult life in relationships, saw this as a weakness, and explained that she was envious of women who were ‘strong enough’ to be alone:

*Like the whole dependency, the whole why would I, you know... what's crazy is I'm still I'm not single. [...] I would love to be strong. Like I watch women who are strong enough that can just go solo, you know? That it's okay going to bed alone at night or... I mean, it, yeah, so... I'm working on that. Yeah. It would be nice. (Heather, client)*

Another woman, Heather, looked to a potential FASD diagnosis to make her feel less down on herself for staying with her abusive partner:

*I don't know what that would mean. I don't know. It would maybe just take a load off. That maybe there's a reason why I think the way I think, and a reason why I kept doing things over and over when people are just going 'what the hell...' Usually when you get punched in the head and broken ribs, I mean... you would go! Not, you know, all he has to say is oh, he loves you... (Heather, client)*

This quote illustrates the way in which mental health diagnoses can at once alleviate women's self-blame for staying with an abusive partner, while at the same time reinforcing the notion that women who remain in abusive relationships are somehow 'mad,' with the problem located in the woman's psyche rather than with the men who perpetrate the violence. Heather felt that she would need to be incarcerated in order to get an FASD assessment, as she had been informed that obtaining an assessment in the community was costly.

Some participants had witnessed horrific violence during their lives, including physical and sexual violence towards others (e.g., a friend being physically assaulted, a family member being sexually assaulted, a mother being killed by the woman's father). These experiences, though not directed at the participants themselves, had had an enormous effect on the women.

*I witnessed my dad killing my mom, and that is a memory that I'll always have. And I was a young child and... I saw him raise his arm, and apparently he... he hit her on the head with some blunt object. And, um... killed her. And I was a witness to this. (Katrina, client)*

*I even witnessed my sister and brother gettin' raped by our neighbour. [...] Watching him do that to my brother and sister. [...] I was an emotional wreck because I couldn't do nothin'. (Lisa, client)*

*I've seen one guy almost beaten to death, I've seen one guy stabbed, I've seen a girl thrown in front of a bus... [...] they all had a... an effect. (Corine, client)*

One young woman who had left home, in an attempt to run away from her problems, had witnessed violence while living with a friend: "*I didn't enjoy it because her boyfriend was violent and... I had to live with him...*" (Jeopardy, client). Her experience illustrates how young women's lack of financial and other resources may place them in unsafe living conditions where they are exposed to victimization and trauma, either directly or indirectly.



While men are more likely to witness trauma than women in the general population, a study of women prisoners found that the women had witnessed trauma at levels comparable to men in the general population and that, in some cases, women identified witnessing violence as their most traumatic experience (Warren, Loper, & Komarovskaya, 2009). Hackett (2009) has suggested that witnessing violence may be particularly traumatic for individuals who have been exposed to multiple traumatic events, owing to the cumulative nature of trauma. Thus, forensic mental health professionals should be careful not to assume that witnessing victimization and trauma has been experienced by female clients as less traumatic than direct experiences of victimization and trauma. Staff must also be aware of the social contexts and realities of women's lives that may place them in situations where they are at risk of witnessing victimization and trauma.

Other traumatic experiences described by the women centered around loss. Women spoke about the trauma of losing their children to violence or having their children apprehended by child protection services. Some women who had given up their children voluntarily, or who had had an abortion, struggled to come to grips with these difficult decisions, though some still acknowledged that they had made the right decision. Others had lost a loved one in tragic circumstances such as a motor vehicle accident, or in unknown circumstances, where the person was missing and presumed murdered.

*I moved in with a man and I was four and a half months pregnant and he was high and drunk, and kicking me in the back. I lost the baby and everything. (Patty, client)*

*...when the Ministry took my children, because I was with an abusive man... he wasn't hitting the children. I know I can still, I'm still just, you know, but I guess they heard mommy at night getting beat, and that was... that was... not good I guess. But yeah, they removed my reason for waking up... (Heather, client)*

*And I will say this without any doubt in my mind, and I have no reservations about saying it today – I would... I would never [have an abortion] again. Never. Never. Never. Never. Probably the most foremost thing that causes me the most grief and pain and despair in my life is that. Is that one act. (Donna, client)*

*Oh, it was very hard. I didn't know if she was going to come back or not. I didn't know if she was just somewhere. So eventually somewhere became a month, two, three, four, five. (Erika, client)*

Ruth described how her social status had helped her to avoid losing her children, despite having been reported to child welfare services:

*[My husband and I] were in the process of trying to buy a second house. We had a \$10,000 down payment. The deal fell through, and for some reason we, uh, picked up heroin. And um... at the meantime, our kids went to like private school. You know, we were very middle-class, and uh... so we picked up heroin and ended up using that and blew our 10 grand. Um, after about 2 years of that, uh, took one call from social services. They found out that I was driving my kids to the private school on heroin, because the doctor... my doctor happened to have her kids at the same school, so she contacted social services. They called me and I cleaned up from that. Went on the methadone program. Never lost my children, and um... but then we ended up using, intravenously, using cocaine. (Ruth, client)*

Her story illustrates how women's relative privilege may allow them chances that are not afforded to other women at risk of losing their children. Another woman reported having fewer choices, and having to give up her child because she was struggling with drug addiction:

*He was healthy when he was born. I had to give him up. I did give him up. I didn't have to. [...] But I knew it was for the best being 'cause I couldn't even stay in the treatment for the required amount of time and do the work, so how am I supposed to be a full-time mother? (Erika, client)*

For another woman, Corine, the trauma of putting her child in foster care compounded her own traumatic experiences of being removed and placed in foster care:

*Because... the thing is when I was removed from my mom and my brother, the only thing I knew, put into that other – I call it hell – um, the idea of my own children having that was traumatizing back to my own stuff. So yeah, I... it's very connected. Of course, so I acted out, you know, tried to suppress everything so that I didn't feel, and I went back to survival mode. Because that's what I knew! Right? That's all I knew, so... once they were gone, I was gone. And it's only in the last year have I been trying to come out of that. So it's... it's a tough one. (Corine, client)*

In a few cases, women participants felt that they had been traumatized by their mental health symptoms and violence perpetrated towards others. For example, one woman felt that the paranoid delusions she experienced as part of her mental illness were traumatic, and one woman affirmed that she suffered from 'perpetration-induced trauma' as a result of committing a violent act against a close family member. For her,

the impact of the crime she had committed was so significant that she was unwilling or unable to discuss the circumstances surrounding the offence.

## **6.2.2 Connections to Mental Health, Substance Use, and Crime**

The women clients' pathways to forensic mental health services were extremely diverse, with various points of departure. Although not all of the women engaged in substance use, in many of the women's stories, drugs and alcohol featured prominently. And while all of the women had experienced victimization and trauma, in one form or another, trauma emerged and featured in different ways throughout the women's narratives of their pathways to forensic mental health services. Perhaps not surprisingly, the stories of most probation clients began with experiences of victimization and trauma, and/or substance use. The stories of women who had been adjudicated NCRMD, on the other hand, were more likely to begin with the symptoms or sequelae of major mental illness.

That is, for some women, trauma was understood as a root cause of their mental health and substance use problems, and their pathways to criminal behaviour. For other women, trauma emerged as a consequence of mental health symptoms, drug and alcohol addiction, criminal behaviour itself, and involvement with the criminal justice and forensic mental health systems. This means that forensic mental health service professionals need to consider not only historical experiences of victimization and trauma when dealing with women clients, but also current experiences of trauma, even within the forensic mental health system, and women's vulnerability to further victimization.

Regardless of where the women's stories began, the vast majority of client participants considered their experiences of victimization and trauma to be connected in some way to their mental health, substance use, and criminal justice problems.<sup>79</sup> Some of the women's stories reflected the 'leading feminist scenario' as described in the feminist criminological literature (Daly, 1992). However, women's pathways to forensic mental health services did not always reflect feminist 'pathways' to crime, especially

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<sup>79</sup> The importance of language emerged in the interview process: when I spoke about victimization and trauma, the women talked about getting screamed at and beat up; when I spoke about substances and substance use, the women spoke about drugs and addiction; when I spoke about criminal involvement, they spoke about getting into trouble.

when women were suffering from serious mental illnesses that were at the root of their pathways to crime.

Some of the women described trauma as the 'root' of their problems or starting point, whereas others thought of trauma as a point that marked a "fork in the road" (Ruth, client) of their pathways through life.

*It definitely did something to my mind because it started from there. It started from... from... the violence and the... I don't... [sigh]... I don't exactly know... I don't know exactly! All I know is that they're all linked. It started from the violence. (Heather, client)*

*I mean, that is the root. That is, you know, the A. You know, the A... the childhood plus all the drug abuse as equal this now, right? (Ruth, client)*

*...it's mostly because of the trauma, why I did what I did. Why I do what I do. So I know that it's deep-rooted issues that I need help with. (Faye, client)*

Of course, an acknowledgment that trauma and its effects were at the root of their problems did not necessarily negate women's agency or excuse their criminal behaviour in the same way that mental illness may be used to negate criminal responsibility in court. Patty recognized that she had made choices in her life, but did feel that childhood sexual abuse had shaped her life course.

*I do blame him [abuser], but I know I'm responsible for my own choices. If he wouldn't have done that, I think my life would have went in a different direction. (Patty, client)*

The impact of victimization and trauma was significant, affecting women's mental health and wellness, including their self-esteem, self-confidence, and sense of self-worth.

*I just feel like a fuck-up. A fall-down fuck-up that just can't get her shit together, and I don't get it. (Heather, client)*

*...I think I've got some real serious work to do. Personal work... to do... so that I don't attract abusers anymore. And that I feel like I deserve someone loving. And that's just as honest as I can get. Because there's gotta be a part of me that feels like I don't deserve it and that I'm worthless. (Iris, client)*

*Self-esteem's gone. Confidence in self is gone. Belief in self is gone. Surrendering your own power, unfortunately, becomes just a general day-*

*to-day thing. Whether you surrender it to a guy or you surrender it to a program or you surrender it to a counselor or you surrender it to your husband or your children, or... the ability to... yeah. It's just... it's affected in every area. (Corine, client)*

The women noted their roles as caretakers for their children, partners, and parents, even during their childhood years. One woman, Iris, described herself as a 'people-pleaser,' 'caretaker,' 'martyr,' 'doormat,' and 'protector,' but noted that these were "self-defeating behaviours" (Iris, client). For some women, low self-esteem and self-worth was also connected to their criminal behaviour, suggesting that improving self-esteem might reduce their likelihood to engage in criminal behaviour.

*So that is all related to the shoplifting as well, you know? If I allow myself to be okay, then I have no need to shoplift. I have no need to live on the edge there. (Aja, client)*

Victimization and trauma were also linked to more serious mental health problems, including depression, self-injurious behaviour, and suicide attempts. At times, the perceived inevitability of further victimization and trauma made suicide seem like a better option.

*I was really proud of myself that I got out of it [highly abusive relationship], but I really see the effect that it had on me after I got out of it. Because I... in it, I was always on guard and always like... you know, I couldn't let my guard down at all. And then once I did, it's like I almost feel apart, and went into depression. Because even though I'll end it, I'll take some kind of blame on... and that's just I guess part of, I don't know, being a victim. (Iris, client)*

*I had, um, a hard time with um... well, because of the abuse that happened to me all the way through. You know, first from [step-mother] and then from [ex-partner]. Um... yeah, I guess I... I swallowed pills. I... yeah. I tried to end it, just go to sleep a few times in my life, when things got tough. (Grace, client)*

*It's that severe when she [mother] gets going, that I would rather eat a bottle of pills and die than having to listen to her anymore. (Lisa, client)*

Victimization and trauma were also linked to substance use, which, for some, women served as a coping mechanism to deal with the impact of trauma. For example, substances could smother other emotions, such as sadness and shame that were associated with the effects of victimization and trauma.

*I was trying to cope any way I could. And I didn't... I still don't have the proper tools. [...] I was on crystal meth because, you know, I didn't want to sleep 'cause then I'd have to wake up and be me again. (Lisa, client)*

*Like I'd be... I remember being upset and I'd grab a pipe and I'd be about to cry and I'd just do a big hoot and it would just go away. (Faye, client)*

*...like that's when I lost the kids and I lost my purpose. I found that, uh, I really liked this drug called heroin because it uh... took all my thoughts away and made me so nice and warm, but I could handle everything when I was on heroin. (Grace, client)*

These findings are not surprising given that women with histories of victimization and trauma have been known to use substances to cope with the effects of their experiences. For example, drugs may be taken to reduce anxiety, avoid painful memories, improve moods, manage anger, connect with others, or end their suffering (Harris & Fallot, 2001a). Some of the women clients indicated that most people who had substance use problems had troubled lives. Drawing comparisons with other 'addicts' both normalized their own substance use, and served as an acknowledgement of their own traumatic histories.

*I don't think anybody that just decides they're going to pick up and be a drug addict. I'm pretty sure that they had to [have] had something significant happen before they did that. (Ruth, client)*

*'Cause it's mostly trauma... it's mostly trauma that does it. Like every addict that I've ever met – it's always because of their upbringing. Something happened to them, or their parents weren't there... (Faye, client)*

*Well, yeah, I think it all um... tends to be a snowball effect. Um...in a life where I had no purpose, um... anybody with no purpose eventually tends to feel like a waste of space. And that's when I find that they will use drugs and alcohol and whatever – something to make the time pass. (Grace, client)*

Women's pathways from victimization and trauma to substance use were sometimes mediated by promiscuity and sexually risky behaviours, which one woman suggested was just one of many types of careless behaviours.

*But that kind of, that one little incident [child molestation] there led to me being a promiscuous teenager. You know, um, having sex with just tons of different partners. Being careless, using drugs. [...] You got abused, so you just keep self-abusing. (Ruth, client)*

*Well 'cause I just felt... 'cause I mean the promiscuity and you just think about it and then you wanted something to cover the pain or whatever, so then you go to the drugs and... and you just stuff it and stuff it. But, you know, when you sober up it's still there. (Patty, client)*

Research has shown that childhood sexual abuse is linked to highly sexualized behaviours in adolescence and adulthood (Nixon, Tutty, Downe, Gorkoff, & Ursel, 2002), and that child maltreatment is related to women's pathways to sexual risk taking (Lopez et al., 2011). Indeed, both women whose stories included promiscuous and sexually risky behaviour were survivors of childhood sexual abuse perpetrated by older men related to or acquainted with their parents. Other women had become involved in the sex trade, which, in addition to increasing their risk of further victimization and trauma, also precipitated or exacerbated mental health symptoms. For example, Erika described dissociation as a survival strategy when working the streets.

*...and then with working [in the sex trade], I mean, well, we won't get into that. There's things that you do that you would... you wouldn't tell a soul. Um, requests that men have. But when you're surviving and that, you really don't have a choice, so you dissociate to the point where your body's there but your head's not... which has become a problem for me because, um, I can do it at a heartbeat's notice and people wouldn't even know it. (Corine, client)*

Women's substance use, and involvement in the drug trade, also put them at risk of further victimization and trauma, especially physical assault. Of course, victimization is more common among individuals with mental illness who also have substance use problems (Walsh et al., 2003).

*There was one time I was pregnant with my baby and I was downtown and I was smoking rock and there was this little punk kid and... [...] He just punched me so hard. I'd never had, had a punch that hard in my life. Boom! Into the face. (Erika, client)*

*Especially the couch-surfing thing. Staying in other people's houses, especially that off-beat, the scene. Well, I guess, drug houses, riff raff, and you know... ya owe a lot for sleeping on those couches. It costs a lot, emotionally, physically. I mean, I've been beat a couple of times pretty good 'cause they thought, you know, I stole their toilet paper or something... (Heather, client)*

*...you have to do something big to get that score, to pay off your... your debts. But me, I've always been lucky to the point where I didn't... ever want to face, you know, one of those people at the top that come in to beat me up or whatever. Due to a bill. So if I don't have the money, I*

*don't... I don't get myself in the hole. I learned to, at a very young age, from watching other people, that's not the way to go. (Grace, client)*

For some women, substance use and mental health problems were connected. For example, women used drugs to self-medicate and cope with psychiatric symptoms, while one woman described how her substance use had led directly to her mental health problems.

*I have drug-induced psychosis. Like if I'm not on drugs I'm... normal, fine, like I don't see things, hear things, think things, and when I was on drugs, like I'm a totally different person. Like it's like I'm one of those little crazy schizophrenic people. (Faye, client)*

Substance use was also connected, directly or indirectly, to violent and/or criminal behaviour for some women. For example, the physiological effects of drugs and alcohol led some women to engage in aggressive or violent acts (e.g., fighting while intoxicated). According to Lisa, “*Drugs make you violent. Alcohol makes you – Jekyll and Hyde*” (Lisa, client).<sup>80</sup> Other women committed violence and crime as a result of their involvement in the drug trade (e.g., committing violence on behalf of drug dealers) or to support an illicit drug habit or addiction to prescription medications (e.g., prostitution, theft).

*It's my addiction that keeps me committing offences. Like all the property thefts were to support my habits. The selling – the drug-dealing – was to support my habit so I didn't have to go out and do property thefts anymore. Like I just... my crimin... criminal pattern just escalated. (Faye, client)*

*...I stole my doctor's prescription pad and started writing my own prescriptions. [...] And I got charged with forgery. (Ruth, client)*

*...before you know it, if you're into the heavy drugs, um... sooner rather than later, you need money to support that habit. And it's expensive. Like damn expensive. And if you don't deal drugs – that's another charge I got, was trafficking, that led me to jail too – um, if you don't deal them, then uh... yeah, you've gotta find some other way to support your drug habit. [...] And so many people, myself included, turned to shoplifting because that's about the easiest way where you can do something alone, without having anybody help you. Because, right away, the second you have a partner in anything, there goes half you... and so you end up working so much harder just to support that other person. (Grace, client)*

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<sup>80</sup> Several references were made to Jekyll and Hyde when client participants described the effects of alcohol addiction on their parents, their intimate partners, and themselves.



For other women, criminal behaviour was directly linked to mental health problems, such as a psychotic episode or problems with impulse control. However, not all of these women were adjudicated NCRMD in the courts.

*I was starting to get sick in Grade 12 when I was – I think I was about 17. But I didn't know what was going on. Like I had no idea. I didn't know about mental illness and um... I was self-medicating with pot. [...] It continued to be untreated and undiagnosed, and... for several years. And it wasn't until the index offence when I was [early 20s] until I started to learn anything about mental illness and that was when I was at forensic. (Darlene, client)*

*I got really, really paranoid on a bus after work. I was heading home, and I stabbed two people. (Jeopardy, client)*

*I'm not doing this to, you know, like be a bad person or anything like that. I'm doing this for a high, obviously, because my brain has been trained to do this to get high. You know. And it's not like I want to do this, it's not like I want to hurt anybody. You know, it's a little bit more than just trying to go steal something to make money to buy drugs. It's... there's more to it. (Ruth, client)*

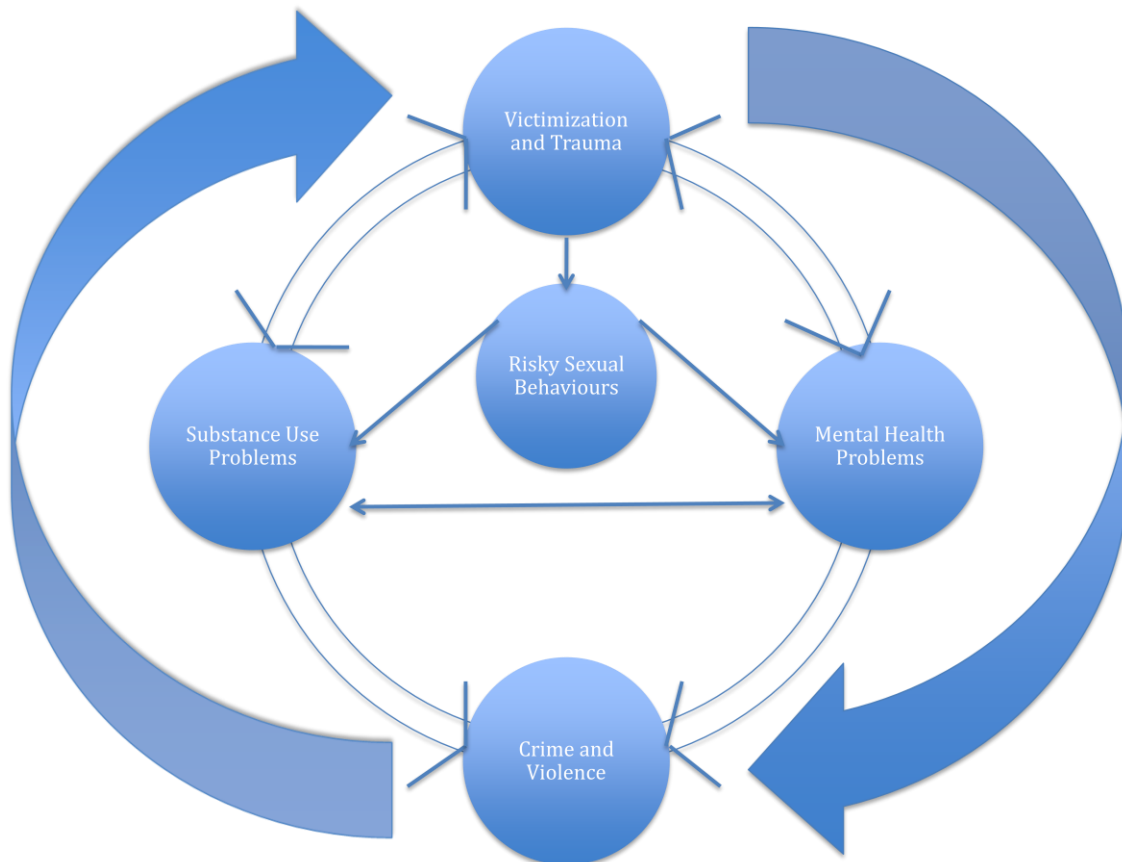
For other women, still, violence perpetration was linked to victimization and trauma, either as a direct response to victimization from a step-parent or intimate partner (e.g., hitting an abusive parent or partner back during an episode of abuse), or indirectly, with violence as a coping mechanism or form of emotional expression. Faye described how the emotional pain of her sister's death had led her to “act out aggressively ‘cause I didn't want to cry” (Faye, client).

*...you can't judge somebody and be so hard on them because obviously something went wrong in their lives and people cry out for help in many ways. (Hope, client)*

The women clients' narratives shed light on the extensive and layered experiences of victimization and trauma endured by women at the interface of the criminal justice and mental health systems, and the connections between their experiences of victimization and trauma, mental health, substance use, and crime. However, their stories of victimization and trauma, the impact of these experiences on their mental health and substance use, and the connections between these experiences and criminal behaviour, did not tell a single story of women's pathways to forensic mental health services.

Rather, victimization and trauma featured in different ways, with trauma appearing to be the root cause of several women's problems and pathways to forensic services, but mental illness appearing to be a stronger underlying factor for other women. Given that the feminist pathways literature has focused on women in correctional settings, it was not surprising that trauma emerged more often as a root problem among female probation clients, and that mental illness emerged more often as the root of their problems for female NCR-accused clients. However, it should be noted that a woman's legal status did not necessarily reveal their pathways to forensic mental health services; that is, there were some exceptions to this pattern in the data (see Figure 2).

**Figure 2: Women's Pathways to Forensic Mental Health Services**



Three composite sketches illustrate different pathways to forensic mental health services that emerged from the women's narratives. The first scenario is that of the woman whose pathway to forensic mental health services was rooted in childhood experiences of victimization and trauma. In this scenario, the woman experienced

physical and verbal abuse throughout her childhood at the hands of an alcoholic father, and witnessed severe violence against her mother at the hands of her father. The violence escalated and she ultimately witnessed her father kill her mother, leaving a horrific memory that remained with her. She was apprehended by social services and placed in foster care where she was sexually abused by one of her foster parents. When she ran away in her early adolescence, she became involved in the sex trade, where she experienced further victimization and trauma. She also began spending time with older men, using substances to cope with the impact of victimization and trauma in her life, and committing petty crimes to support her drug habit. She became pregnant at a young age, and had children with multiple partners, all of whom were violent towards her. Her children were eventually apprehended by social services, which brought back traumatic memories for her. She has a history of suicide attempts and has been diagnosed with Bipolar Disorder, Borderline Personality Disorder, and Substance Dependence. She was arrested on charges of theft and possession of property obtained by crime and is receiving forensic treatment services in the community.

This scenario reflects the experiences of more than half of the women client participants in the Trauma Recovery Study, though not all of the women's stories included all of these features. The scenario best reflects the stories of the women clients who were on a probation order in the community, and mirrors Daly's (1992) description of the 'street woman' scenario, or what she refers to as the "leading feminist scenario of women's lawbreaking" (p. 12). This pathway to forensic services also reflects Gilfus' (1992) descriptions of women's immersion into street crime, which involves a transition from 'victim' to 'survivor' to 'offender,' and Chesney-Lind's (1989) feminist account of female delinquency in which women's survival strategies are criminalized.

The second scenario is that of the woman whose pathway to forensic mental health services began with childhood abuse and neglect, but whose index offence was closely linked to the physiological effects of substance use. In this case, the woman suffered emotional abuse and neglect as a child, but did not experience physical violence until adolescence when she became involved in several abusive relationships. She married a man who was extremely controlling and abusive, and they had one child together. Over the course of their five-year marriage, she became isolated and depressed, and lost touch with her family and support system. She began drinking to cope with the effects of victimization and her depression, but was eventually able to

escape the abusive relationship. She never used any women's support services, but has been in and out of substance abuse treatment programs. She was doing well in the community and considered herself to be 'in recovery' when she relapsed and assaulted a stranger with a weapon while intoxicated. She was diagnosed with Major Depressive Disorder, incarcerated in a provincial jail, and is now receiving outpatient forensic treatment services as a condition of her probation order. Her experiences in the criminal justice and forensic mental health systems have been highly traumatizing.

This scenario describes the experience of a small minority of the women client participants. It does not differ drastically from the scenario above, though it involves a violent offence rather than property offences. The scenario fits most closely with the 'harmed-and-harming women' described by Daly (1992) in her research on women's pathways to felony court.

The third scenario is that of the woman whose criminal behaviour is directly linked to mental illness. In this scenario, the woman did not experience victimization and trauma in her childhood. She suffered from psychotic symptoms in her late adolescence, dropped out of school, and began using drugs to cope with the symptoms of her mental illness. Her mental health condition remained undiagnosed and untreated until she killed her young nephew while he was in her care and she was in a psychotic state and was brought into the forensic mental health system. She has never been married and has no children of her own. She was adjudicated 'Not Criminally Responsible on Account of Mental Disorder.' With medication, her mental health symptoms have improved but she continues to experience some delusional thoughts. She has been diagnosed with Schizophrenia, and remains in custody in the forensic psychiatric hospital. She describes her index offence as very traumatic.

This scenario bests reflect the experiences of women participants who were referred to forensic mental health services by the courts, after being adjudicated NCRMD. However, there were some probation clients whose pathways to forensic services were more reflective of this scenario.

These composite sketches serve as examples that illustrate the client participants' different pathways to forensic mental health services, and illustrate how victimization and trauma emerged in different ways in their journeys. In the first two scenarios, victimization and trauma were experienced in childhood and adulthood relationships, whereas the second and third scenarios also show how trauma emerged

as a result of criminal behaviour and involvement in the criminal justice and forensic mental health systems.

### 6.2.3 Re-victimization and Re-traumatization in Services

Victimization and trauma were experienced at many points in the lives of women who participated in the Trauma Recovery Study. Along their pathways to forensic mental health services, many of the women interacted with service providers in various service systems, some of which were characterized as traumatic. These experiences included being labeled a 'criminal' by the criminal justice system, losing their rights in the civil and forensic mental health systems, being treated with a lack of dignity and respect, or having to navigate service systems without adequate guidance or supports.

*I've been unfairly treated a lot, I think. I mean, I've been locked up, I've been thrown on the pavement and handcuffed, and it's like America's Most Wanted. (Aja, client)*

Hope explained how overwhelming the criminal justice process had been for her, beginning with the courts, which she described as a circus. She recalled being sent from one office (e.g., legal aid) to the next (e.g., probation), all new and unfamiliar spaces, and having to wait for hours to be seen at each one.

*You just feel like a Hansel and Gretel, but there's no trail of bread crumbs. You know, you're just sort of, you know... I mean, I was just horrified at the whole thing. (Hope, client)*

Another woman, Lisa, described an experience where her probation officer disclosed to her family that she had had a child as a result of a sexual assault committed by another family member. This experience was particularly traumatic for Lisa, who noted that *"it just flashed everything back and I started to cry [...] I had blocked that out for years. I forgot all about it"* (Lisa, client). This example illustrates that women's privacy and rights are easily overlooked when they have been labelled as 'criminal' or 'deviant.'

Women who had been held in custody in correctional, psychiatric, and forensic psychiatric institutions were especially troubled by their experiences.

*They threw me in there actually naked, naked. Uh, big glass door! You know, there's men on the other side, uh, cameras, you know... hmm... I was debating whether just to keep banging my head into that concrete wall because it would be better than lying here, naked, feeling this. Yeah, I think there's... it's really wrong on how they address people with*

*mental... uh, like if you're sad and whatnot, you don't strip somebody down and do... oh, something's so not right. Yeah. It's not right. [...] I mean, you're on this gross – the mats in there, the mats you sleep on are this thick [shows how thin the mats are], they're blue, they're rubber, they stink because, you know, there's been thousands of people on them. But no sheets, no nothing. They give you a mat and this concrete bed pan thing... you put it on, and with this lead jacket, uh blanket thing. Um... it's uh... I just cried, you know. I cried. I wished I was dead. And what did I do to deserve this karma, like... I mean, being a mom, I don't remember doing anything to anybody that... that would des... I don't know. Yeah, um, mentally it's... ugh... it's... it's an experience. (Heather, client)*

*...Authority again, with having to abide by whatever rules are or not. And if you don't, you're thrown into a cell. An empty cell. A cold cell. And when you have the traumas like I have, others like me have, being caged like that at the will of whoever and whatever is not really the best place for one of us to be. Um, two, the [prison] environment itself is very violent. Is very, uh, you are on high alert all the time. Like I, when I went in this time, I isolated severely. Um, I wouldn't come out of my cell very much. [...] Um, the only beneficial part of my prison time was the psychologist. Other than that it was nothing. Uh, being caged, um, for a person like me, uh, is very challenging. Uh, with impulsivity comes the get up and go, and having that taken away... [...] you don't have that safety or that coping mechanism, and you have to be there and you have to, you know, do or whatever they want, in the back of your head, you're always saying 'okay, who's coming in the door and what do they want?' or 'what are they going to do?' Even though it may not happen, but because of the trauma you're always thinking that. (Corine, client)*

Lisa reported being placed in segregation and heavily medicated, while in jail, after learning about the death of her son.

*Yeah, and they put me in seg for a week – in a rubber room. They put me in a rubber cell, in a straight jacket, 'cause I was nuts. They had me so drugged up, I couldn't lift my head. (Lisa, client)*

*Oh, it was terrifying. You're in the dark. You don't get light. It's 24-hour lock-up. You get one hour a day to take a shower and to eat and make your phone calls. That's it. But they had me in seg because I was...I ripped their toilet right out of... toilet and sink right out of the wall – out of a cement wall – and ripped the bunk beds right out of the cement, when I found out my son died. I went nuts. (Lisa, client)*

The institutional response to Lisa's behaviour is typical in corrections, where women in need of supports are constructed as 'risky' and 'dangerous,' and mental health issues are treated as security issues, with women isolated and punished (Kilty, 2006).

Two of the women clients who had been placed in seclusion (or the 'side room') in forensic mental health facilities were so mentally unwell that they found it humorous, suggesting that this response may not attend to their needs.

*I thought seclusion was really funny. Yeah. I thought it was funny. Yeah. And I also heard a guy's voice there, um... it's usually with the girls that are [city] pre... there's guys there too, but like I heard a different guy there, that phoned me from jail, that told the cops that the radio stations were talking about me. They followed me there. (Jeopardy, client)*

*Twice I had to go in the side room. [...] Both times I was so sick I thought it was funny. Yeah, just not even there at all. (Darlene, client)*

Some women also reported negative experiences with psychiatrists and psychologists in the forensic mental health system, where they felt they had been misunderstood, judged, or not taken seriously.

*[Psychiatrist] just hit a lot of spots that uh, you know, like 'oh so, if you want your children, you could have had them back.' Well, you know... uh... I'm the one who has to wake up every day and know that, so I don't think I should have to fucking say it out loud to you, who's somebody I don't know. You know? It's... hmm... yeah... I found her very judging. [...] And her words echo in my head off and on, you know? (Heather, client)*

*Well, I think [psychologists] should be more honest about what can happen to you, you know? Like he... he... it was... I should have brought the [pre-sentence] report with me. It was, um... [pause]... it was bordering on abuse. On emotional abuse. (Aja, client)*

*When I first came [to forensics] I was like totally traumatized, you know. Now I've been to court, I've got this not... this woman who doesn't work here anymore. She phoned and said, you know, 'and if you think about not coming, you're court-ordered to and I could have you arrested.' (Hope, client)*

It is important to note that not all of the women who participated in the Trauma Recovery Study reported traumatizing experiences in the criminal justice and forensic mental health systems. Several of the women described positive interactions with individual police officers, lawyers, probation officers, and administrative staff in the criminal justice system. For example, women described instances where child protection workers, mental health workers, and criminal justice personnel had treated them with dignity or helped them break free from abusive partners. One woman, Hope, described an experience with police officers who took her for coffee and treated her gently,

choosing not to handcuff her. When she had an opportunity to ask the officers why they had been so nice, one of the officers said “*because I could see you were traumatized enough*” (Hope, client). Another woman, Aja, had the financial resources to hire a good lawyer who was able to keep her out of jail after she had been caught shoplifting. Women remembered these experiences and interactions with supportive individuals, and described them as helpful in their recovery from victimization and trauma, mental health, and substance use, and desistance from crime.

Despite some positive interactions with supportive service providers, the forensic mental health system has the effect, for some women, of “deepening the psychological and emotional wounds they already carried and, quite possibly, creating new ones” (Lloyd, 2006, p. 229). That many of the women clients who participated in the Trauma Recovery Study reported traumatic experiences in the criminal justice, mental health, and forensic mental health systems suggests that forensic mental health services need to be attentive to the impact of victimization and trauma in women’s lives, and should aim to avoid further traumatizing them while addressing their trauma-related needs and supporting their recovery. The next chapter explores the barriers and opportunities for such ‘trauma-informed’ services in the forensic mental health system.



## **7: ADDRESSING TRAUMA IN FORENSIC SERVICES**

The previous section provided a space for women's voices to be heard. The following section, which contains the central analysis on trauma in the forensic mental health system, integrates the perspectives of women clients and treatment staff to gain insight into how trauma is dealt with in the forensic mental health system. It outlines several key challenges faced by staff in addressing trauma-related issues with female clients that centred around three emergent themes. The first theme, *The Elephant in the Forensic Mental Health Worker's Office*, suggests that women's experiences of victimization and trauma remain largely invisible in the forensic mental health system owing to a lack of awareness and training among treatment staff. The second theme, *Speaking (Her) Truth to Power*, explains how women clients often do not feel that they can trust forensic treatment staff owing to the effects of trauma, the lack of confidentiality, and women's lack of voice in the forensic mental health system. The third and final theme, *Fitting a Square Peg in a Round Hole*, suggests that, because forensic mental health services operate under a medical model, trauma is often not considered to be a 'legitimate' mental health concern or particularly relevant to forensic psychiatric treatment. Each of these three themes is discussed in detail, with direct quotations from client and staff interviews to illustrate sub-themes and paint a picture of trauma in the forensic mental health system. The final section, *Towards Healing and Recovery*, explores opportunities for the adoption of trauma-informed approaches in forensic mental health to support female forensic clients in the trauma recovery study.

### **7.1 The Elephant in the Forensic Mental Health Worker's Office**

The forensic clients' stories of victimization and trauma suggested that women who come into contact with forensic mental health services may be extremely traumatized, having experienced multiple forms of trauma over the course of their lives. From the women's perspectives, traumatic experiences had a significant impact, and were closely linked to their mental health, substance use, and criminality, thereby playing an important role in their pathways to forensic mental health services. Forensic treatment staff who participated in the study recognized that many, if not most, of their

female clients had experienced victimization and trauma. They understood that they were working with a traumatized population, and acknowledged that trauma played a role in women's pathways to the criminal justice system and forensic mental health services.

*All our clients experience extraordinary trauma. One thing I've sort of learned to believe is that every one of our clients, without exception, has a story, which if you have the time to sort of listen to and get to know... everything makes sense. And trauma is always a big part of it. (Dawn, staff)*

*I would think it would be at the root of their problems, the root of their issues, the root of their existence, where their path, you know, to... they're going along and they... that abuse happens, and I think it changes everything about their lives and how they view the world and where they carry on from that. (Pam, staff)*

*When I think of forensic and trauma, I just think of basically the walking wounded. People whose lives have been affected by the abuse that they've experienced or traumas that they've had and they're coping as best they can and wandering through services, or through life and end up in our service, as a result of either poor choices or looking for a way to escape where they're at, or substance use because of trying to cope with where they're at ineffectively. (Taryn, staff)*

Staff recognized that women had experienced victimization and trauma in a wide range of contexts, and that some clients had had an unbelievable number of traumatic experiences from their early childhood through to their adulthood. Some staff also understood the complexity of women's lives, and the role of trauma in women's pathways to forensic mental health services.

*I would say where there's been significant trauma, it's clearly a perpetuating factor for, you know, all the bad outcomes. Ongoing substance abuse, ongoing criminal behaviour, ongoing violence... (Sheila, staff)*

*I think a lot of people turn to substances to try and cope with what's going on or what has happened to them. I think depression, anxiety follows in with that. And I think as part of the substance use lifestyle, to support their habit, they end up getting into criminal activity to support their habits. (Taryn, staff)*

*"They're often pretty addicted, in the sex trade, have trauma histories, and I think are just living in that fight or flight kind of state. (Claire, staff)*

Several staff participants acknowledged that trauma could stem from the perpetration of a crime, particularly if the individual had committed a violent offence during a psychotic episode.<sup>81</sup> A few also recognized that being processed through the criminal justice and forensic mental systems could be traumatizing.

*Don't tell me that realizing, after you've been stabilized on meds, that you just killed your daughter?! 'Cause you got all delusional about being god-like?! Don't tell me that that doesn't haunt you every day. You know, so... I don't think that the violence has to come from someone else. I think that knowing you did the violence, and having to live with it, is trauma. (Kristen, staff)*

*Committing the crime can be traumatic. And the consequences – dealing with the legal system, although I don't think that would fit – it wouldn't allow you to get a diagnosis of PTSD, but it might... the whole system is traumatic as well. (Diane, staff)*

*For some of our clients, coming into our system is probably the first time they got into contact with the law – it's traumatizing, you know... that in itself is traumatizing 'cause there... there are a lot of our clients that I've dealt with who have been in the mental health system, but then all of a sudden they come into contact with the law, they had to be hauled off to the police, and they talk about how frightening that was, so that in itself is a trauma. (Jeanette, staff)*

*Just coming here can be really traumatizing for people. You know? They're sick or they committed a crime, and they're brought here and they can't manage on the unit, which, you know, is not surprising when someone's acutely ill. (Sam, staff)*

A large body of literature describes the re-traumatizing effects of involvement in the criminal justice system, for both victims and perpetrators of crime. Mentally disordered offenders may have an even more difficult time in the justice system, given their mental state and the effects of mental illness. Entering the forensic mental health system can also be traumatizing, especially if it involves a custodial disposition where the client becomes a psychiatric inpatient.

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<sup>81</sup> Three hospital staff hosted a Brown Bag Lunch, entitled 'When the violent perpetrator suffers: Trauma, treatment and tribulations,' at FPH on March 9, 2010, to discuss how perpetration of a violent offence may impact forensic clients and their recovery. This is an example of the ways in which professionals within the organization have encouraged greater attention to trauma-related issues. This Brown Bag was attended by approximately 10 staff.

### 7.1.1 Trauma as Invisible

Despite their own awareness of the prevalence and importance of trauma in forensic clients' lives, staff participants indicated that there was an enormous lack of awareness about victimization and trauma in the organization as a whole. They felt that the organization did not appreciate the potential relevance of trauma to the work undertaken by forensic mental health professionals, and described trauma as an issue that was often 'glossed over,' 'ignored,' or 'swept under the rug' in the forensic mental health system.

*I would just say that it isn't even, from my perspective or what I've seen, that it's not even on the table. I don't think people are even talking about it or considering it. (Claire, staff)*

*I would say that it's not even looked for, that it's not considered, and that that is another hole that we have. You know, ten years ago not considering substance misuse when they came through the door was the biggest hole we had because it affects so many of our people. But I think for women, and for the men, that we're not considering that they have been – even at their own hands, if you know what I mean – that they have been traumatized. (Kristen, staff)*

*It's just like not even on the radar. So I think we almost can do harm just from being ignorant. (Tammy, staff)*

Research suggests that the psychological sequelae of trauma, including PTSD, are regularly undetected and untreated in forensic mental health services, particularly if they are thought to stem from the perpetration of a violent offence (Friel et al., 2008). One staff participant felt that the general ignorance of victimization and trauma in forensic mental health services was not a problem specific to the forensic mental health system, but another instance of trauma being overlooked and ignored in society more broadly.

*I think in some ways too, our whole legal system minimizes trauma. I think our whole society does... [...] It's hard for survivors to get that validation and to get that help, and not get the message 'oh, just get over it – you know, this happened a long time ago...' (Annabel, staff)*

This perspective reinforces Herman's (1992b) argument that trauma has regularly been forgotten and minimized throughout history. Certainly, the criminal justice system is an offender-focused system with little attention paid to the experience and

needs of victims. However, “the fact that something is not talked about does not mean that it doesn’t exist” (Mezey & Robbins, 2001, p. 562).

Although the forensic mental health system is connected to the courts, it is intended to be a therapeutic system where individuals are treated as ‘patients,’ rather than ‘offenders.’ That is, while mental health Review Boards are still concerned with public safety, and professionals within the system regularly assess clients for their risk for violence and reoffending, the system is (at least, in theory) geared towards treatment rather than punishment. Yet, according to staff participants, forensic clients are nonetheless constructed as ‘criminals,’ a label that is often considered to be incompatible with that of ‘victim.’ The ‘offender’ status serves to overshadow and negate that of ‘victim,’ creating an additional barrier to acknowledging and addressing the trauma-related needs of individuals with mental health issues who have committed criminal offences.

*The reason they’re at the hospital is probably only indirectly because of trauma, because they’re offenders coming to us, they’re not seen as victims coming to us, even though they may have a history of victimization. So, when you’re looking at why they ended up in the hospital, it’s easier to say they have a major mental illness and they committed a crime than saying there’s trauma behind that. (Diane, staff)*

*I guess the trick is that our people have come here because they’ve done something, not because something was done to them. So I think it’s pretty easy to ignore that. (Kristen, staff)*

*I think that when you think about forensics, even though we work in the system, you still have this view of the clients, you know, kind of doing bad things, and doing it for a purposeful reason. And even, even the mental health behind it, I think, sometimes is overlooked. (Claire, staff)*

According to one staff participant, Tammy, the general invisibility of trauma in the forensic mental health system, combined with a view of forensic clients as ‘offenders,’ meant that perpetrator-induced trauma was even more invisible in the system than historical experiences of victimization and trauma.

*...they are told that they need to feel bad about this kind of thing. Like they committed it. They don’t even... like if you think they are not even able to talk about their past traumas, like the idea that someone even consider that they might be experiencing trauma because of the crime is so far off the radar. But they feel bad about it. I see it all the time. They get all teared up and then, but then there’s a stigma attached. Well, you*

*committed a crime, so – you did it. Too bad. Doesn't matter if you have nightmares or flashbacks about committing a crime. (Tammy, staff)*

The notion that forensic clients, including NCR-accused, should express guilt and remorse seems to be almost counter-intuitive, given that they have been found not criminally responsible by the courts. Despite the invisibility of trauma in the organization, and the view of forensic clients as 'offenders,' staff felt that some of their colleagues were aware of trauma. However, even if forensic treatment staff acknowledged clients' histories of victimization and trauma, they were thought to have little understanding of the impact of trauma on their clients' mental health and behaviour.

*I think a lot of the people [staff] that I deal with, yes, have that understanding. I'm not sure I can speak for the larger forensic system. I mean, for instance, I've never worked at the forensic hospital. So I don't know what the environment is like there. But I think at our clinic, there is that understanding. (Sheila, staff)*

*I'm sure that everyone knows and would acknowledge that trauma is an issue their clients face. (Claire, staff)*

*...it's acknowledged, but I don't think people understand or recognize the impact that it can have on someone. (Annabel, staff)*

One staff participant recognized the value in understanding the impact of trauma on clients, suggesting that awareness of trauma can help staff to anticipate emotional and behavioural difficulties.

*...that's another thing that's playing into their behaviour. It's their reaction to certain things that gives you, potentially, warning when something is about to go bad, you know, because it's their anniversary date or because a big redhead just came on, and that's who beat the crap out of them last time. Or whatever, right? Like you need to be aware of this stuff and... we're not. We just pretend, you know... so, we're not totally. I mean, we watch for some of the people, you know... with some of our women who have, you know, killed their own children. We know that that anniversary is going to be difficult. (Kristen, staff)*

Understanding why clients might be acting in certain ways, in light of their traumatic experiences, also benefits clients, as staff may be more understanding, responding to incidents with support services rather than security measures.

### 7.1.2 Trauma as Irrelevant

If trauma is not reported by clients or detected by staff, it is likely to remain untreated. When asked whether they routinely screen for trauma issues in clients' lives, staff responses were mixed, suggesting a lack of standardized intake procedures and comfort around asking clients about such sensitive issues. Whether staff inquired about trauma seemed to depend largely on the individual staff member conducting the intake interview.

*In the social history, you may find some stuff referring to it. Yeah, there's not like a section dedicated to that. Like you will get some reference to... it usually is like a line that says 'and reported went to foster care' or 'reported physical/sexual abuse, da, da, da, da, da...' So there is sometimes a mention of it. But not, it's never... explored. And it's not like a main focus. And I think it probably gets missed a lot of times. (Tammy, staff)*

*I mean our intake assessment's got these sort of typical categories, but there isn't a section for trauma. So it's... whether it could... I mean, potentially it could be discovered. But it would depend on the clinician who was doing the assessment... whether they were really interested in going there or not. Or had the skills to. Or whether it was appropriate even, as well... (Dawn, staff)*

*Well, you know, we kind of go through a little bit of everything, actually. Um... we talk to, 'cause it's about medical issues. It's about psychiatric issues, so it's 'okay, how did you get to where you were? What happened?' You know, and then we do go through the family stuff. Was there any kind of abuse when you were a kid? What was your childhood like? It's almost kind of too general... and it depends on the individual. (Sonya, staff)*

*...we have a... sort of an intake guideline that I follow. So I'm assuming that most people do follow a similar thing. I think some people might, depending on their comfort level, might delve into things a little bit more with the client, depending on where you're at. (Karen, staff)*

Some staff chose not to ask about or explore issues of victimization and trauma in the lives of their clients because they felt that doing so would be too intrusive, because they believed the information would emerge on its own, or because they felt that there was no benefit to asking or knowing this information.

*I would have to say no. Yeah, it's not really something I'm looking for when I do a chart audit. (Kristen, staff)*

*I specifically wouldn't ask them 'have you been traumatized or victimized?' or, you know, although I would ask – it's not really part of our brief intake, you know, 'have you been traumatized, have you been victimized, have you been abused?' But in gathering that information, usually at least a portion of that would come out – you're going to get some idea about that. But, but on the first intake, um... to me, that's pretty intrusive. And I don't know that... I mean, every interview could be different. If someone wants to talk about that, or tell you about that, I wouldn't stop that, but I also wouldn't go on and on about it... (Pam, staff)*

*I don't need to go on some wild goose chase, if you will, to find out what trauma this poor woman has been through. She's lived on the street for... I just... I well up when I think about it, right? It doesn't help me to see it. I know it's there, so it's just, you know, what can I possibly do to sort of try to make her life a little bit more comfortable and safe, in the short term. (Dawn, staff)*

Sometimes staff simply assumed that their clients had histories of trauma, and didn't feel it was necessary to inquire about this. Others regularly inquired about experiences of victimization and trauma during the intake process.

*I routinely ask about different types of abuse they may have experienced in childhood and then continue that up, we always... I always ask about their relationships. (Sheila, staff)*

*Like in the intake, I'll definitely try and ask about what their childhood was like growing up, how their relationships were with their different partners, you know, where they're living now, how they're feeling safe/unsafe, what their jail experience was like. Just to get an idea of what might be there. Um... but I don't think that I would dig or make it [trauma] an issue that we have to talk about or look at until I felt like the person was maybe ready to go there a bit. (Claire, staff)*

In some cases, clients had been asked about their experiences of victimization and trauma. Yet, several clients felt that even if it were brought up, it didn't seem to matter. Rather, it was just another piece of information that was noted in the client's file, a permanent record of the client's mental status, written from the perspective of medical (i.e., psychiatric) and other professionals.

*'Cause it's like they ask and nothing... doesn't seem important. [...] I think you can ask, but do something. (Patty, client)*

*Uh, actually, [psychologist] asked me, but it... it's still not something that seems to be of total importance." (Hope, client)*



*I think they are trauma-informed. They're just not trauma-centered. They're informed about it. You know, they have the education and the book smarts about it. But they're not actually doing anything physically to assist with it. It's kind of like 'oh, okay, that's part of the file.'* (Corine, client)

Staff agreed that trauma was not always seen as important, even when it was identified or emerged as an issue in the client's past or present. This disconnect between *asking* about trauma and *addressing* trauma was notable, and sent a strong message to clients about the (ir)relevance of trauma.

*Whether it's acknowledged or not, nothing's being done. Or very little is being done, I feel.* (Diane, staff)

*There's not much I can do about it. I don't have the particular skills either, in terms of counseling, to kind of... to go there. Or even if I got there with somebody, what the hell would I do about it, right?* (Dawn, staff)

*Well, I think we should address it. I think we need to recognize it, first off, would be a number one thing – just even recognizing the fact that this occurs would be a step in the right direction because right now people won't even... don't even think about it. And so I think awareness would be number one. And then I think we need to treat it, and do follow-up care.* (Tammy, staff)

*...but in terms of getting into their issues and helping them to resolve them, no. I don't do that. People here, as far as I know, don't do that.* (Pam, staff)

### **7.1.3 Fear of Re-traumatizing or De-stabilizing**

Many of the staff participants themselves recognized the value of addressing the trauma-related needs of their clients, but they expressed concern about re-victimizing their clients in the process.

*...bringing up people's past victimization and trauma... you know, that's not always a safe thing to do. And I think it's really important that there's supports in place for people. You know, that's why I wouldn't... I mean, that's not part of my role to do that. To do that, because that's almost like re-victimizing them.* (Pam, staff)

*There's trauma there. Not everybody, but a lot of people. And I don't want to do secondary harm... I don't want to re-traumatize. And sometimes you can do that when you don't know what you're doing."* (Annabel, staff)

*My concern is that I would do the wrong thing. And I would never... I don't... I wouldn't want to do that. I wouldn't want to be responsible for re-victimizing somebody; for opening up a wound that I couldn't help them clean and close. (Kristen, staff)*

The concern about potentially re-victimizing or re-traumatizing clients suggested that staff participants were genuinely concerned about the mental well-being of clients, and that they might be less fearful of broaching the subject of trauma if they had the tools to do so safely. I encountered a similar dilemma when a staff member at one of the clinics suggested a potential client participant who was described as highly traumatized but not currently safe, given that she was in a victim/witness protection program. I chose not to actively pursue the interview, and instead asked the case manager to contact me or have the client contact me if she was interested in participating in the study. I hoped this approach would reduce the risk that the client might have felt coerced to participate in the study, or that participation may have been re-traumatizing. Thus, this struggle to strike a balance between giving clients a voice and protecting them from further harm emerged in both the research and the treatment context, with the fear of causing harm resulting in inaction.

Intersecting experiences of trauma and mental illness made staff even more wary of addressing trauma, as they feared they could not only re-victimize but also destabilize their clients.

*...the other thing is you want them to be in a stable state before you start with that. (Sonya, staff)*

*...if they have the trauma stuff and then they've got all kinds of chaos in their life, we don't touch the trauma. We try to put everything else in place, and then if they're stable, then we would get into that. (Sonya, staff)*

One staff participant who had training in integrated trauma-specific treatment argued that the assumption among forensic staff that a client must be 'stable' before trauma-related issues could be safely addressed was not evidence-based.

*Yeah, the whole mentality has been, you know, we can't do trauma work until they're stable, which is actually not true. [...] they need to address both to get better. And so I think that a lot of times we're getting... we're helping them with their mental health stuff but they're, and we're not... we're totally ignoring the other side of things and then they just never get better. And then we wonder why they never get better and... they keep using drugs because they feel like shit once their symptoms have cleared*

*up and they haven't dealt with, you know, why they attacked their best friend or whatever, and then they get high. It makes perfect sense to me, but not to many other people. (Tammy, staff)*

*You didn't want to destabilize them. Right? So you didn't want to get them to talk about things that can be really upsetting because that can adversely affect their mental state. That's true! But not talking about [it] can also adversely affect their mental state. It's a... and this is even more complicated. We have trauma and we have people that have major mental illness. Why aren't we getting training on that? Because how do you work with the two together, or do you, or...? (Annabel, staff)*

Related to concerns about re-victimizing and de-stabilizing women clients, staff participants expressed a sense of fear about opening up trauma wounds because they did not know what might happen if they did. That is, they felt unprepared to deal with the emotional and behavioural issues that may arise.

*You know... it's ugly! It's murky. [...] just don't want to deal with it. (Annabel, staff)*

*They're probably scared to even ask because they're 'oh my god, what if I ask and then they're triggered and they do this...' (Tammy, staff)*

*You never know what will happen. Like people can, you know, keep anything hidden or buried or just pop out like... like it's a matter of course, you know, you just never know what will happen. (Sam, staff)*

At times, throughout the research process, I felt similarly unsure of how the women might react when recalling and disclosing their experiences of victimization and trauma, or how I might react to hearing their stories of trauma. The women managed their emotions in different ways, shifting the conversation towards less sensitive topics, asking to take breaks before talking about particularly difficult experiences, sharing positive experiences with abusers to deal with the guilt associated with identifying them as abusers, or simply crying to release their emotions. I was surprised to find that more women cried when talking about the loss of their children (as a result of violence or apprehension by child protection services) than when talking about victimization and trauma.<sup>82</sup>

Some staff were also sensitive to the fact that trauma survivors may be fragile and that, if they were going to address trauma-related issues, they would need to be

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<sup>82</sup> A few of the women even brought pictures of their children and grandchildren to the interview.

able to provide support to clients through the healing and recovery process, which some did not feel they had the skills to do.

*...it's pretty heavy issues to sort of unpack for somebody and then you'd have to kind of put them back together and hope that they're not going to do anything... any self-harming or anything like that... and that they have supports when they leave. (Karen, staff)*

*...for people to bring up their victimization and trauma and abuse in their life, there's risks associated with that and you have to be very trained to do that. (Pam, staff)*

*...after you've opened them up, you know, how long it would take for this client then to heal from the... the recreated trauma, because they've had to relive it. And just there isn't enough... unless we, you know, refer them on to [psychologist] early enough so that she's got enough time. (Jeanette, staff)*

Though well-intentioned, staff constructions of female forensic clients with histories of trauma as 'fragile' and their fear of addressing trauma-related issues, meant that women clients were unable to access trauma treatment to support them in the recovery process. One client, Corine, expressed enormous frustration because she had tried to access trauma-specific treatment services on multiple occasions, but had been turned away repeatedly owing to her mental health diagnosis. She similarly suggested that forensic mental health professionals were afraid of addressing trauma because they did not know what to expect or how to manage the potential emotional reactions of clients.

*I think they're afraid of reactions. And of course, when people... when you open that stuff, of course somebody's going to have some reactions. So, you know, you assist them with that. And then, you know, you open up them a little more, and you assist them, and then... because unless you, and they're just scared, really. It's too much work, it's too much paperwork. Uh, the person might go into crisis, so then you're going to have to be on call. Who has the money, the time, or the availability to help somebody who needs to go through what they need to go through? It's just not... it's not there. (Corine, client)*

*Trauma is not looked at. Trauma is not... nobody wants to open that, those wounds. Nobody wants to look under that scab because they don't know what's going to come out. Well, really? So you're going to leave that scab on all these people that have this stuff going on? Like, really? Try walking down [street] and you look around and see how many people actually have it. And then, then you wonder why they are the way they are – they're living with the choices they are – because there's... nobody*

*wants to help them! Nobody wants to help them even look at it and some of them don't even know how to even start. They just know it's there, and they want to bury it. Right? Because that's what we're told to do. Hide it. Bury it. It doesn't exist. (Corine, client)*

The concern expressed by staff participants about opening up wounds and causing further harm was not limited to clients, but extended to the staff themselves. Several staff participants described the impact of 'bearing witness' to victimization and trauma, and the suffering of their clients, which one participant suggested may add to the reluctance of staff to address trauma-related issues.

*I couldn't get it out of my head. It was awful. I couldn't stop thinking about it, I couldn't stop, you know, trying to sleep at night, getting to sleep at night was really hard, if that would infiltrate. (Sam, staff)*

*You know it gets... it gets to be a bit much. Especially, like their histories are very violent. (Tammy, staff)*

*I think you can't help but not be affected I would think. It's like it would be inhumane almost, like... which is why I think it is unfortunate that it isn't valued within the service and there isn't more opportunity for some formalized supervision around it 'cause vicarious trauma is huge in the field. And maybe that's why some people do avoid talking about it or don't consider it as a treatment issue. (Claire, staff)*

The risk to staff of developing symptoms of secondary traumatic stress, and the risks involved in addressing trauma-related issues with clients, point to a need for increased training and support for forensic mental health professionals.

#### **7.1.4 Training and Support**

Staff participants were asked about training opportunities around gender, diversity, and victimization/trauma. Not a single staff participant cited any gender-specific or women-centered training offered through the organization.<sup>83</sup> Some staff had previously acquired relevant training or experience through their degree programs, practicum placements, or other opportunities offered outside of the organization, though their experience and training were not extensive.

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<sup>83</sup> The majority of staff participants had taken cultural competency training through the PHSA's Indigenous cultural competence program, which is a relatively new self-paced, online course.

Some staff had acquired specialized knowledge and training around trauma and trauma-related disorders, such as PTSD, through participation in conference presentations/workshops, online seminars, and courses offered through other health services agencies (e.g., Vancouver Coastal Health) or educational institutions (e.g., Justice Institute of British Columbia). Some staff indicated that victimization and trauma had been discussed at grand rounds or other special events, but was not a part of their core or mandatory training. A lack of gender-specific and trauma-related training meant that staff did not have the competencies required to address trauma-related issues in the lives of clients.

*Nobody's trained in how to deal with this. (Tammy, staff)*

*...I know I'm not qualified to counsel them in that area or to try to bring them along, or to probe into that. (Pam, staff)*

*I'm not trained, and I don't need to deal with, you know, all the psychotherapy. (Jeanette, staff)*

*...as soon as I find out that there's been some trauma or victimization or stuff like that, then – because I don't feel that I'm trained to address the issue – then, at that point, we make a referral to a psychologist. (Jeanette, staff)*

It became clear in interviews with staff participants that few were aware of the difference between trauma-specific and trauma-informed approaches; that is, staff did not recognize that they could attend to trauma-related issues in forensic mental health service delivery without actually doing trauma treatment or therapy.

Despite their lack of training, staff appeared eager for more education and training around gender-specific and trauma-informed approaches in order to be better able to address trauma-related issues in the lives of their clients. They considered training in these areas to be of value to all forensic staff.

*...it would be great if there could be some kind of training so people could be aware of... of what trauma is and what's associated with trauma. What it looks like. What... how there's comorbidities – everything that trauma is. (Diane, staff)*

*Training staff. Even in basic 'what does it look like.' What is trauma symptoms, like just basic trauma-informed practice. [...] Even if they're not competent, at least they can be informed. (Tammy, staff)*

*They really do need to give us at least a little bit of training. Their focus is so much elsewhere. (Annabel, staff)*

*I think, as an organization, having more kind of workshops. Like we have workshops on motivational interviewing and those kinds of things and... and more training and on... what we might be seeing in our clients and how it is related to victimization and trauma. (Pam, staff)*

*I guess that people have to have some level of expertise in, you know, in both assessing that in clients – and not ignoring it – and then, once that's become clear, deciding how they're going to address it and, again, not just ignore it and hope it resolves. (Sheila, staff)*

Still, two staff participants indicated that training alone would not guarantee competence in addressing trauma-related issues. For them, the personalities and approaches of individual staff members mattered too, and they recognized that offering the same training to all staff did not mean that all staff would be equally aware and equally competent in addressing trauma-related issues. For example, one staff participant said “*I can think of a couple of people that I don't even... even if they were trained, I don't think they should ever have those discussions with a client*” (Karen, staff). This perspective supports the idea that training is not enough, and that it takes a commitment on the part of individual professionals and the organization as a whole to embrace the spirit of trauma-informed approaches and put their knowledge into practice. This was seen as a significant challenge in the forensic mental health system, where securing buy-in from the organization around trauma-related issues was difficult.

The findings suggest that trauma is the elephant in the forensic mental health worker's office; that is, although the majority of clients have histories of victimization and trauma, it is rarely discussed or addressed in the course of forensic mental health treatment. Staff participants, for the most part, seemed to recognize trauma and its importance in women's lives and their pathways to forensics. Many of them even recognized that trauma could stem from the perpetration of an offence, or processing through the criminal justice and forensic mental health systems. Yet, despite their individual awareness, they felt that the organization or the system lacked an awareness of trauma, in part because of the construction of clients as ‘offenders’ rather than ‘victims.’

That staff made a distinction between their own level of awareness about victimization and trauma and awareness of these issues in the organization and the

system as a whole suggests that they too felt constrained by the forensic mental health system and a lack of support within the organization for trauma-informed approaches. In some ways, it seemed that staff lacked the knowledge and power to address these issues with clients because of their lack of training, confidence, and experience with respect to trauma-related issues.

Whether clients are asked about trauma during the intake process (or anytime thereafter) seems to depend on the individual staff person. If it is queried, or comes up, it is typically documented in the client's file but rarely addressed. At the individual staff level, there is a notable fear of either re-traumatizing/victimizing the client, or destabilizing their mental health, by asking about trauma, which is compounded by concerns about their own reactions in doing trauma work, including secondary traumatic stress. These fears seem to be related to the fact that staff do not feel they have the proper training to address trauma, and the belief that if they are going to open those wounds, they must also be able to close them. Staff felt that gender-specific and trauma-informed training was desperately needed in the forensic mental health system, but indicated that it would be difficult to get the necessary buy-in from the organization to make this a reality.

## **7.2 Speaking (Her) Truth to Power**

Experiences of victimization and trauma can have an enormous impact on women's ability to trust others. This is especially true for survivors of childhood abuse involving perpetrators in positions of trust, such as adult caregivers, teachers, doctors and police officers. Trusting others was identified by several of the women clients as a significant challenge, given their histories of trauma.

*I have like such serious trust issues, it's not funny. (Ruth, client)*

*There is zero trust. I'm just starting to get some. Um, physical trust, absolutely not. Emotional trust, a little. I've been putting myself out there a bit more in the – lately – than I think I ever have. So in a sense, it's a form of emotional trust. Giving a little bit and then we'll see where that goes. Right? But physical, absolutely not. There is no physical trust with anybody. I don't... I don't like people to even touch me. (Corine, client)*

Difficulties trusting others sometimes extended to the women's relationships with forensic treatment staff, though many of the participants did indicate that they had good



relationships with their case managers. Still, not all of the women clients wished to open up to staff about their histories of victimization and trauma. One client noted that she was cautious about opening up to staff, especially when members of her treatment team changed frequently.

*...I'm sort of a little bit leery about getting close again, because of, you know, you go down the road of explaining yourself and explaining your story and it's not easy! And um... then it's just like they'll get you to know one doctor and then all of a sudden that doctor will go, or they'll give you one counselor and all of a sudden you gotta deal with another counselor. (Grace, client)*

*Like I don't know any of them! Why am I going to confide in them?! (Katrina, client)*

Staff participants also recognized that women clients were not necessarily open to sharing or discussing experiences of victimization and trauma with them, owing to the negative effects of interpersonal violence and previous experiences where trust had been broken.

*You know, you talk about trauma, I mean trust is... trust, safety, and security – that's all – that, internally, that's been ruined for the person, right? (Annabel, staff)*

*But there will be some people that won't trust. [...] They've had so much negative experience with trusting people, so that's going to be a real challenge for you. 'Cause they don't know who they can trust. (Annabel, staff)*

*And some people we suspect that there's stuff in their life that they simply won't tell us. And there's nothing we can do. (Sonya, staff)*

Some staff participants thought that clients might disclose trauma after some time in the forensic mental health system. Staff similarly suggested that they might broach the subject of trauma, but they would typically wait until they had established some rapport with the client. Yet, the structure of the forensic mental health system meant that they often did not have enough time to build trusting relationships, which they considered to be imperative before addressing issues of victimization and trauma.

*...just to build a trusting relationship and some rapport to get them to keep coming can be a challenge. (Claire, staff)*

*For initial intake it's kind of tough 'cause they're meeting you for the first time and, you know, they're hesitant and maybe a bit guarded, so... it's sort of... and it's a difficult thing to get into and you don't have that much time or you don't have the sort of therapeutic rapport with them already... (Karen, staff)*

*I don't know how to say this... maybe there's a gentler approach 'cause you realize there's something that they're covering and what you need to work on then is building trust. That's the bottom line. Trust and rapport, right? (Sonya, staff)*

The fact that forensic clients are only able to attend forensic services while on a legal order represented a greater barrier for probation clients, whose orders may last only a few months. However, it was also cited as an issue with NCR-accused persons, as their disposition orders are reviewed annually by the Review Board, at which point they may be granted an absolute discharge. One staff participant suggested that time constraints were not only a barrier to addressing trauma-related issues, but indeed all issues, stating that “*if they're only here for a short period of time, it's more difficult to help them*” (Sonya, staff).

Additionally, clients in the forensic mental health system are not there voluntarily, which means that they may be resistant to sharing information. Given the potential for treatment resistance, staff recognized the need to meet clients where they are, and not push them too hard, especially early in the treatment.

*I mean, sometimes people with trauma don't want to address it. And that's okay. (Annabel, staff)*

*So you can't press about that or you're going to lose them. You want to engage with them and, so that they access services so that they keep coming and you can refer them or, you know, whatever. (Pam, staff)*

### **7.2.1 Limited Confidentiality**

One of the biggest system-related barriers to addressing trauma was the lack of confidentiality in forensic mental health services. Forensic services are connected to the courts, and work closely with correctional services, where information is regularly shared and where files may be subject to subpoena. This lack of confidentiality compounded interpersonal trust issues, with women keenly aware that what they say may be used against them, with serious and sometimes permanent consequences. In light of these

realities, lack of confidentiality was cited as a significant barrier to addressing trauma-related issues, with client participants wary about opening up about their experiences.

*The only thing I don't like about this is it's not confidential. I hate it. I can't stand it. I didn't know they'd report everything that you say to your probation – that pisses me off. (Lisa, client)*

*Like a lot of the times you gotta be worried about who you let know about [being the victim of] violent incidents. Like especially when you got kids, because if the Ministry finds out, they get involved and then if it's like bad, they'll take your kids away! And like who wants their kids taken away trying to get help? (Faye, client)*

*Yeah, 'cause I now know the things not to say to people. I mean, the mental health... I know not to, if somebody asks you 'have you thought about how you will kill yourself? I now know you say nothing because it goes onto paper and they can use that against you at any time in your life. And I know that you never admit to kill... that you want to kill yourself. You never do it, because... yeah, there's just all these things that... that I've learned. (Heather, client)*

Clients felt that confidentiality was an important consideration for openness and disclosure of their circumstances, be it a history of trauma or ongoing involvement in the sex trade. Staff felt that encouraging clients to share personal information was particularly difficult if clients had had negative experiences with other service systems in the past, or if information that was previously shared with other service providers had been used against them.

*I think given their histories of a lot of them having childhood trauma, having recent traumas of being assaulted on the street, or whatever might be going on... being in jail, which is pretty traumatizing... going through the court system, knowing that we're connected to that in some way... I think that those are all barriers to feeling like you can trust anyone, and then to wanting to trust this person who's connected to a lot of that... is hard. (Claire, staff)*

*...when they come in here, they're not sure how much they can share with us because they know that, you know, people share information and then they don't know if it's going to get back to, you know, their social worker or their child welfare worker or whoever. So... it's sort of... yeah. It's... it's a hard thing to... to work through with them. And to get... and to establish that sort of trust. (Karen, staff)*

*...but there are challenges to that because we do have a limited confidentiality, so we do report back information to the probation. We can*

*also be called into court. Our files can be subpoenaed, so sometimes people are hesitant. (Taryn, staff)*

*...it's about giving somebody safety where they can talk about this [trauma]. And I don't think forensics, just because of the nature of our service, provides a lot of that. Because they know that anything they tell, their probation officer can call. I mean, there's not a confidentiality there, right? (Annabel, staff)*

*In terms of it being a safe place, one of the issues that does often come up is... [pause]... is concern, particularly when the person is not yet kind of post-sentencing, and sometimes even the... about whether there will be further legal ramifications for anything they tell us. So that's a barrier for some people. More often that's a barrier around things like whether they're still actively using substances and such – they do not want to tell us about that if that's contrary to their order. But sometimes even if, say they... they're in an abusive relationship and there's supposed to be no contact but they're back with that person. That may be something that they don't want to tell us because they're worried that that will get back to their supervising officer. Although, in fact, typically we don't do that. We don't give that information back to the supervising officer, but I think lots of people are concerned about that. Or if they're not supposed to be... involved with criminal activity, or the sex trade, but they are at this point. So I can see that there would be things like that that they wouldn't want to disclose. (Sheila, staff)*

Staff indicated that all the information provided by clients was written in their charts, and that this information could be used against them.

*...most of them wouldn't want all that crap written in there. And rightfully so. It gets used against them in [Review] Boards and things like that, so the confidentiality definitely puts a hamper on it. (Tammy, staff)*

It was, therefore, understandable that they might not want to disclose past and current experiences of victimization and trauma to forensic staff.

### **7.2.2 Power(less) and Control(led)**

Women who come into contact with the mental health, criminal justice, or forensic mental health systems often experience a loss of power and control over their own lives. These systems have been criticized for replicating the dynamics of power and control in abusive relationships and gender-based violence. For example, it has been argued that imprisonment, because of the inherent power imbalance between guards

and prisoners, may replicate the dynamics of child abuse and intimate partner violence for women survivors (Heney & Kristiansen, 1998).

Many client participants reported positive relationships with individual forensic treatment staff, such as their case managers. However, the system itself was still one that stripped clients of power, control, and a voice. Women clients described a loss of control and voice in the forensic mental health system, as decisions about their lives were made for them and their wishes were ignored.

*She [forensic nurse] just treated me appallingly, and I'm sitting there and there's this other person who's a student and she said 'do you mind if she hears' and I said 'yes I do!' But she stayed anyways. You know, that's horrible! Now I'm on display to this person, who I don't know, and I think that was really an invasion of privacy. [...] and I said 'well, why did you bother asking me then, if you're not going to abide by my wishes? And she said 'well, you're here, you're the criminal, and you have to do what we tell you.' I said 'when did civil rights go out the door?!' (Hope, client)*

This loss of control was especially difficult in light of their histories of victimization and trauma, with some feeling that they could not express their needs or make decisions for themselves.

*...even to set boundaries with her [case manager]. Well, I could say 'no' or 'yes' or, you know, 'I can't do that' or 'I don't want to do that.' I find it really uncomfortable when I first do it though, like I'm doing something wrong. (Donna, client)*

*These people are in control of the situation and you've got no control over your own life. I am not allowed to make any decisions here. [...] There's nothing you can do, without permission, or 10,000 eyeballs watching you. You're under scrutiny. Constantly. Daily. Every moment. Especially at [women's unit]. (Katrina, client)*

A lack of voice in the system simply compounded the lack of voice some women experienced in childhood and in their intimate relationships, contributing to their ongoing disempowerment. As one woman said, "where I come from, I didn't have a voice" (Iris, client).

Staff participants recognized the power and control exerted over clients in the system as well, largely due to their mental health and involuntary status. Staff also acknowledged that having a mental illness stripped clients of a voice in the forensic mental health system.

*I don't know why we sometimes treat mentally ill people like they don't have a voice... (Annabel, staff)*

*I think there's a lot of acting out, and there's... there's... a lot of times they don't feel like their voice is heard ever. They're... often you hear complaints that they don't like their psychiatrist, that they're being told what to do by their psych... they're being controlled by their psychiatrist, which is true in some sense, but they don't have any other outlet where they can deal with some of these issues. So that turns into acting out sometimes. (Diane, staff)*

*...other women who maybe just feel like all their power has been stripped from them, they've been stuck in this place, they've been injected against their will... and it's just felt really kind of lonely and frightening for them. (Claire, staff)*

One client, Hope, similarly noted that women's voices were often silenced in the forensic mental health system, where official accounts prevailed:

*Because we don't... people don't get to tell their story. Because people, it's... 'well this is what you did, this is on a piece of paper, I don't care what you thought of it, you know, let's shovel it along.' (Hope, client)*

This quote illustrates how women's own stories of their lived experiences may be undervalued and ignored, with official versions of their experiences, recorded by authorities, dominating criminal justice and mental health records. Information captured in permanent records follows women through services and often precedes them, such that staff may form judgments about women clients before they have had a chance to meet face-to-face (Williams et al., 2004). This reinforces the staff participants' earlier comments that women are often prejudged in the forensic mental health system. These labels and judgments may have a significant impact on women and on the attitudes of staff towards women clients.

Darlene described the process of becoming a 'mental patient' and how this process, and the stigma associated with the label itself, might be more difficult and damaging for women with histories of victimization and trauma:

*...you sort of just become a mental patient. And in a sense you lose your voice. You lose the fact that you're a person. Your individuality. And I think for someone that's been abused and victimized, they already feel like they're a non-person, so I think it would make it worse. (Darlene, client)*

Darlene's comments reflect Erving Goffman's writings on the 'career' of mental health patients (Goffman, 1961) and research on the stigma and powerlessness experienced by mental health patients (Livingston & Rossiter, 2011).

For women with histories of trauma, the power and control exerted by forensic mental health staff was thought not only to replicate abusive dynamics, but also to exacerbate pre-existing trauma and re-traumatize clients.

*For me it always... I bring it back to sort of the dynamics around power and control, and you know, some of these women have had... are in positions where they do have limited control over their lives, whether it's from the partner, whether it's from the system. And they... so it's sort of that... try to be that alliance with the client instead of being like 'you're going to do this, you're going to do that.' That's just my own personal approach in terms of the kind of balancing out that power. Because we are seen... and I mean they've... most of the women have dealt with a lot of authorities, whether it's the police, social services – they're all people that have the power to make huge decisions about their lives. (Karen, staff)*

*Well they control people. It's all about control and intimidation, and so people are totally alienated from anything that may have meaning to them. Unless they've been in there a whole bunch of times, in which case they're, you know, there's that group of sort of complacent, sort of passive participants in this hideous show. But you know, for... I'm imagining, and I don't know a lot about trauma, or treatment of trauma, or assessment of trauma, but I'm imagining that it's all about finding somebody being in a position where they're feeling a little bit more safe and... there's nothing safe at all... meetings, you know... they meet with their treatment team, it's a very intimidating process. There's the patient and there's this big collection of service providers who sit around and cross their legs and, you know... [...] everybody's posturing, trying to show off to the psychiatrist that they're smart or they've got something relevant to say, and the patients learn to quickly kind of come in and endure these bully-ish situations and move on. (Dawn, staff)*

*I'm not sure that the trauma they've been through is, for them, as big an issue as... or what you and I would consider the trauma they went through... is as big an issue as the trauma they see in their day-to-day having to be here. You know, the restrictions, I think they feel is, you know, the trauma. The injustice of the restrictions of being here, I think is that they consider we, you know, daily re-traumatize. (Kristen, staff)*

The forensic hospital setting, in particular, could be very traumatizing for women with histories of victimization and trauma. Staff described circumstances involving

intimidation and bullying at the hospital though, depending on where clients had come from, the hospital could be conceived of as 'safe.'

*I worked at the hospital for years, and it's a hideous, awful place. In fact, I think you probably couldn't be in a worse place if in fact you did have trauma issues. (Dawn, staff)*

*I think having people [new patients] come in that high and potentially that violent and that paranoid and that restless and that loud and that aggressive is, for some of these people [patients], traumatizing. You know, for some of them, they're very delicate and that's not something they're used to and it's something they would normally retreat back and far from, and they're not able to. (Kristen, staff)*

*I think there are aspects of the [forensic] hospital system which can be really re-traumatizing and traumatic too. [...] Some women, though, have an opposite experience, that I've worked with, coming from hospital where they feel like it has been one of the safest places they've been and um... has been somewhere where they've felt a bit nurtured, so I think, you know, everybody's experience with it is different. But just knowing, from them, how it was for them, and what their feelings are around it is... is good. (Claire, staff)*

Treatment planning conferences, where clients meet face-to-face with their entire treatment team, were highlighted as one instance where clients were easily bullied and controlled, which impeded the development of trust.<sup>84</sup>

*The treatment planning conferences are... well, I mean, you come in and you know, at minimum, you've got your social worker, you've got your case manager, you've got your... the psychiatrist, and you've got the staff person. And then sometimes you have a student or an OT. You know, like, I don't know how you're supposed to trust everybody! (Annabel, staff)*

*[The Treatment Planning Conference] is supposed to be her team meeting. Her chance to, you know, voice her opinions and her needs and her progress, and question the team about what they should be doing for her, but that's you know, obviously not what the psychiatrists think it is, but anyhow... and you know, patient-centered... really sort of a foreign concept still here. (Kristen, staff)*

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<sup>84</sup> At the end of the data collection period of the study, staff indicated that the forensic hospital was moving towards a new model involving 'integrated treatment teams,' which would include more service providers. That is, rather than holding 'treatment planning conferences' with the psychiatrist, social worker, and case manager, the team would be expanded to include the client's psychologist, drug and alcohol counselor, and occupational therapist, among others.



For women who were (or had been) in custody in the forensic psychiatric hospital, boundaries were regularly crossed by male co-patients. Some women clients reported experiences of sexual harassment and sexual exploitation during their hospitalization, which made them feel very uncomfortable.

*It makes me feel... oh god... um, very... nervous. To the point where you just, you don't want to go out. You don't want to... you don't want nothing to do with them. You don't want to talk to them. You don't want to see them. You don't want them looking at you, talking to you, talking about you. (Katrina, client)*

*The men were always hitting on the girls. Always just... yeah, it was... it was awful that way. (Darlene, client)*

*Some of them are kind of strange because I've been called sexy by them, and they're kind of old. So I think it's kind of creepy. [...] I just think it's creepy. I just... kinda... stay away from them. (Jeopardy, client)*

*They want to hug me but I said no, no. [...] I kind of protect myself. (Mallory, client)*

The women's vulnerability to further victimization and exploitation at the hands of male co-patients in the hospital setting was exacerbated by their mental health status, with the most mentally ill women most vulnerable to victimization.

*Well, there are people who are sick, mentally. They're not all there. And they often get preyed upon by other people there. (Darlene, client)*

*[Women's physical boundaries were crossed by men] all the time. Especially the ones that didn't understand boundaries. Especially the ones that were more mentally sick. (Darlene, client)*

While the separate women's ward in the forensic psychiatric hospital may protect women clients from victimization and exploitation, to some degree, there are still opportunities for women to interact with male co-patients in certain areas of the hospital. For vulnerable women to remain safe, they would need to stay on the women's ward, which limits opportunities to engage in other activities (e.g., recreational, vocational). Staff participants were not blind to the fact that female inpatients were exploited and at risk of further victimization at the hands of male co-patients in the hospital setting. However, some suggested that the women put themselves at risk through their involvement in interpersonal relationships and substance use.

*The men sometimes exploit the women, yeah. Like there was one guy that was pimping out the ladies not too long ago, and nothing was really getting done about it, which is kind of sad. And the women are often very ill and they'll go into the bathroom and do things for cigarettes or whatever it is... they get victimized here still by our... 'cause we have some like psychopathic predators that just wait for these girls to come in and just take total advantage of them. (Tammy, staff)*

*Sometimes the women... sometimes people [co-patients] just have relationships – all well and good. Officially we don't approve of it and it's against the rules to... well, I guess you can have a relationship, you just can't actually do anything about it. But, yeah, I mean, we've had... we've had women who've been victimized here [FPH]. (Sam, staff)*

*I mean it's hard sometimes with the women to see them, you know, get sexually exploited by guys, right? And you know it's happening. But if, you know, if they want their drugs, it's just what they do, right? (Annabel, staff)*

*They're at risk to be re-victimized from the guys [co-patients] here. And then their boundary issues and such. (Tammy, staff)*

Women who were experiencing more acute symptoms of mental illness, and had difficulty establishing boundaries due to a history of victimization and trauma, were even more vulnerable to victimization and exploitation in the forensic hospital setting. These intersecting experiences had an impact on their ability to manage difficult situations with male co-patients.

*Like people constantly trying to borrow money, constantly trying to ask for smokes, ask for your things, ask for favours... Yeah, even the guys try to ask for all those things from you too. So you have to have like your boundaries firmly established and, like I said, if you've experienced abuse, you are used to your boundaries being overtaken, right? [...] So many girls don't know how to say no. They don't even know they're allowed to say no! (Darlene, client)*

*I have boundary-setting issues. I have a lot of problems with that. Where other people begin and I end, I'm not really sure. I overstep boundaries, or I let other people step on mine, and I don't know when to say no. I don't know how to say no... (Donna, client)*

These findings contrast with those from a recent study on mixed-sex forensic hospital settings in which staff, despite recognizing the need for gender segregation to protect women from sexual violence and exploitation, described female patients as the

instigators of “sexually provocative and predatory behaviour”<sup>85</sup> (Mezey, Hassell, & Bartlett, 2005, p. 581). Still, the authors concluded that “it may be that the women who are most damaged may be least capable of protecting themselves, or recognizing and avoiding situations of greatest risk” (Mezey et al., 2005, p. 582). Women who have been traumatized, particularly those who have been repeatedly victimized, are so used to having their personal boundaries crossed that they often have a hard time establishing and maintaining appropriate boundaries. Yet, the onus remains on women to establish boundaries and take steps to protect themselves from sexual violence and exploitation. When they ‘fail’ to do so, they may be the ones who are blamed, rather than the men responsible for causing harm to them.

### 7.2.3 Silencing Survivors with Mental Illness

There are legitimate reasons to be wary of claims about PTSD in the criminal and civil courts. For individuals with severe mental illnesses who are in contact with the forensic mental health system, issues around the use of the PTSD label to justify or excuse criminal or violent behaviour may be less of a concern. In this context, questions are more likely to arise around the credibility of clients’ claims about having experienced trauma or suffering from PTSD, given the existence of co-occurring psychotic disorders. Women who suffer from mental illness and claim to be victims of sexual assault and other forms of interpersonal violence are especially likely to have their credibility questioned (Bachrach, 1984).

Forensic staff participants indicated that clients’ claims about victimization and trauma were sometimes questionable, and that this led them to try to determine whether their stories were ‘real’ by seeking collateral information. Of course, making this determination was not necessarily straightforward, and staff seemed to suggest that determining whether clients’ traumatic experiences were based in reality, or simply delusional, was a difficult task.

*It’s really hard for her – she’s so delusional – to know what’s true and what’s not true, so that’s an interesting piece there. [...] It could be a delusion, right? Like, you know, a sexual assault or being traumatized here, it’s like ‘did it really happen?’ (Sam, staff)*

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<sup>85</sup> Quotes provided by forensic staff to support this finding are indicative of a ‘victim-blaming’ perspective, where women are faulted for wearing revealing clothing or entering the bedrooms of male co-patients. In this sense, women are expected to avoid certain areas and dress in certain ways, or risk being blamed for the consequences of their choices and behaviours.

*...we do see more people coming through here with Post-traumatic stress stuff. And I don't know... some people I think it's clear cut. That's what they've got. Other people, I think they've heard it and go 'okay, well, let's just say that's what I have amongst all the drug stuff.' So sometimes you question whether they're... it's just something that they've heard and they're using. And you have to, you know, check out their background a little bit more to see what they've got in their past. (Sonya, staff)*

*I guess that, first of all, I would want to be very clear on the background. I tend to try and get a lot of background information on my clients, whether they're court-ordered assessments or not. You know, I try as much as possible to get their permission to contact collateral sources, get prior treatment records, and things like that. Because I think... I think sometimes things that are said to be delusional are not necessarily delusional. So I'd want to make sure that I was clear on that. (Sheila, staff)*

I, too, found myself questioning some clients' accounts of victimization and trauma, wondering how they could be true or whether they might be delusions. I chose to believe the women's stories because of my feminist orientation and my position as a researcher rather than a clinician. However, I struggled with the fact that I questioned the truth of some women's accounts of victimization and trauma, knowing that women's credibility when it comes to victimization and trauma is intricately connected to their mental health status and social location.

*Another woman asked if she could talk to me for money, but she thought I was the researcher for another study. I explained the inclusion criteria, and she came up with a story about being raped as a teenager. It was the first time that I wondered about the accuracy of the women's accounts of trauma. [...] It makes me want to check with staff about their accounts before including them, though I recognize that they may not have talked to their treatment team about these experiences. This is also in direct contrast to my earlier reaction to staff telling me women's experiences of trauma were not real, or that they were 'poor historians.' An interesting change on my part... not sure how I feel about this, but it definitely challenged me to think about it more today. (Reflexive research journal entry, August 19, 2010)*

Mental illness was not the only factor that determined whether a woman's stories of victimization and trauma were believed. In fact, substance use, homelessness, and involvement in the sex trade were seen as other factors that were 'strikes against' women's credibility as trauma survivors.

*She [client] said that she was raped and in a lot of people's eyes, because she was a prostitute and a drug addict, [she] couldn't be raped. (Sam, staff)*

*...when you have somebody who has a history of abuse and a history of abusing substances and a life on the street and some cognitive impairment and a severe mental illness and they're on medications... you know, sometimes what you get out of them is a bit garbled. (Kristen, staff)*

*...I think in general that's the problem with disclosure, is people are afraid that people aren't going to believe them. So if you already have a mental illness, and you say that maybe people won't think it's real. And it could be! (Annabel, staff)*

Yet, there may be truth behind women's stories of victimization and trauma, explaining their emotions and behaviours. For example, one staff member explained how a special request from a client might be trauma-based, but interpreted by treatment staff as delusion-based or manipulative behaviour.

*We have patients who say they prefer to be called this name and then we say 'well, we can't call you that.' And it's like, well, maybe [given name] is what their abuser called them. Maybe that's why they chose their own name. You know, like we don't... we don't look at any of those sort of things. We don't really give them options. And, unfortunately, sometimes they're too sick to be able to explain any of that to us. You know, we don't even assume that there might be a reason they want us to call them something different. We just assume they're delusional, you know, whacky-doodle, so who cares, or they're [personality disordered] or whatever. They're being difficult or manipulating. They're, you know, we sort of default on the side of 'they're just being difficult' instead of that there might be a reason. (Kristen, staff)*

Ignoring trauma in persons suffering from psychotic disorders could have a negative impact on the course of their mental illness, by contributing to substance use and social isolation (Kilcommons & Morrison, 2005). Some staff felt that, regardless of whether or not the trauma was delusional or based in reality, if it is experienced by the client as 'real,' then it must be addressed in treatment.

*...you kind of approach it with the... kind of the... the understanding that even if the report of trauma is a delusional belief, that likely is still difficult and traumatizing for them. So there's sort of an emotional reality there that you have to deal with. (Sheila, staff)*

*...I don't want to reinforce the delusion by doing talk therapy about it, so from what I learned, I just did therapy around the feelings, but not the*

*actual events and the actual specifics. So validating like 'you're feeling confused or you're feeling scared,' but not actually reinforcing the details... (Tammy, staff)*

*Whether or not it occurred, though, what it means to the client is what's important. So if they feel traumatized in some res... in some... to some extent, whether the event that they're describing actually happened or not, it's – I think it signifies something that's happening. So I'd have to figure out what that actually is, I guess, and then treat that, as opposed to what they're actually... [...] just not 'oh, It didn't happen – okay, we're not going to talk about it 'cause it didn't happen for real.' (Diane, staff)*

Some staff participants recognized that not addressing the trauma, and 'sweeping it under the rug' could significantly damage trust. They did not generally consider challenging clients' delusional beliefs to be their role.

*...their delusions aren't real, but the feelings they have about this are just as real as if it happened, so for you to ignore it, say 'oh, that's a delusion,' it's going to really destroy them and your relationship, so you have to validate how they're feeling. (Tammy, staff)*

*I never challenge somebody. I never tell somebody that... that, you know, if they're saying somebody used to beat them up, I never say 'well, you know, we have proof nobody ever beat you up.' Like I don't do that. That's not... that's not my job. You know, god did not make me in charge of somebody else's trauma. And they may have the time wrong. They may have the person wrong. But, for me, if somebody is doing that as a woman, then I have, you know, for me, at least 75% of the time it means that at some point, somebody did hit them... if they're telling me now that somebody hit them yesterday. [...] At what point, and when, do you call somebody on the 'well we have no proof of that.' You know, we think that's delusional, so we're going to increase your meds. Well, that's a doctor's job. I don't, you know, that's not my job. (Kristen, staff)*

#### **7.2.4 Survivor Empowerment**

Trauma-informed services seek to disrupt the power imbalance between clients and service providers, with the goal "to return a sense of control and autonomy to the consumer-survivor" (Harris & Fallot, 2001b, p. 16). Empowering clients within a system that disempowers them on a daily basis is challenging. Yet, staff sought to meet the needs of traumatized female clients in some minor ways, if only fulfilling the requests of women clients to work with female staff if they had histories of victimization and trauma at the hands of men.

*I think it could be intimidating for a woman who has been victimized or experienced trauma at the hand of males, if they do have a male psychiatrist and a male social worker. And if either one of them are kind or very gentle, or warm, or nurturing, I think that could be... I think she'd feel either intimidated or anxious or kind of scared or just... in some ways, I think almost re-victimized, depending on that interaction, if they're not sensitive to that. (Karen, staff)*

*She didn't want to work with a man, so I tried to get a female worker for her. (Pam, staff)*

*...she [client] wanted a female psychiatrist. So we were able to give that to her. And I think with somebody like that, even small things, however... choices. Whatever choices, how little or small they may be... to give her some of that so that she feels some power, that she has some control and right to make decisions. And people aren't just telling her that this is what she has to do. Plus she resisted it, right? But I think if somebody has a trauma history, I don't want to disempower them anymore. Try not to. I mean sometimes you have to draw boundaries, and limits. But... I think that's okay too, 'cause that can kind of model. But definitely treating them with respect and dignity and... warmth. (Annabel, staff)*

The only difficulty with requesting a different treatment team or worker, according to one client, is that *"the treatment team that you're asking to get rid of has to decide whether it's a valid reason or not"* (Darlene, client). Thus, the client would need to feel empowered enough to make a request, and may be in a position where, for example, they must ask their male psychiatrist if they can have a female psychiatrist, on account of the psychiatrist's gender. Women who do not feel comfortable working with male staff because of a history of victimization from male abusers may have great difficulty expressing their needs and feeling as though they had the power to make such a request.

Client participants articulated a broader need for gender-specific programming that attended to self-esteem, assertiveness, empowerment, and setting and maintaining boundaries, which had so often been crossed and ignored in the course of their experiences of victimization and trauma.

*There were programs to teach you about mental illness, which you know, is not gender-specific. There were programs about anger management. There were never any programs about assertiveness or boundaries or empowerment, which is typically women's issues, right? Nothing like that. (Darlene, client)*

Some staff also recognized the importance of restoring power and control to women survivors of victimization and trauma who also had mental illness, in order to assist them in the trauma recovery process. Yet, this was not always considered to be achievable in the forensic mental health system.

*[My priority is] patients. I mean, I know that sounds easy, but I often don't feel that that's other people's priorities. So their wellness and having them, take back some control of their lives and hopefully their mental health and to get back to a community and a level of functioning that they're happy with, so that they can get on and move on with their lives. (Kristen, staff)*

*I think that, on the face of it, that, you know, we try to have... we try to work on empowerment. But in practice... not always happening so much. (Sam, staff)*

The findings suggest that women clients face a number of barriers in speaking their truth about victimization and trauma to persons in positions of power and authority. Client participants indicated that they had difficulties trusting others, given their histories of victimization and trauma. These challenges extended to their relationships with forensic staff, particularly when their treatment teams consisted of multiple members who changed frequently. Staff agreed that it was difficult to discuss trauma without having developed rapport, but that building trust took time, of which they often have an insufficiency. Again, this speaks to the ways in which the constraints imposed by the forensic mental health system, and the inherent power imbalances within the system, limit the ability of staff to attend to issues perceived to be important in the lives of women.

Even when there was rapport between clients and staff, clients indicated that forensics was not a safe place in which to discuss trauma because the service was not confidential, and any information they shared would be included in their file and could be used against them. Clients and staff both recognized that the forensic system has a great deal of power and control over clients, and they have little voice. Empowering women in the forensic mental health system, and hearing their voices concerning victimization and trauma, is especially difficult given the stigma associated with mental illness that undermines women's credibility (Heney & Kristiansen, 1998) and the reluctance of clients to trust forensic staff who have power over their legal status, and who could use this information against them (Livingston & Rossiter, 2011).



The stigma around mental illness also means that clients who report victimization and trauma may not be believed, and their stories may instead be interpreted as delusions, with psychiatrists holding the power to define what is and is not real. Staff participants had not come across many such cases, but did sometimes find themselves questioning clients' reports of victimization and trauma, as I did in some cases. Some staff felt that it would be important to validate women's experiences, regardless of whether or not they were real, and that it was also important to give women choices and empower them in the forensic system. However, concerns about validating and reinforcing experiences of victimization and trauma that were considered to be delusional and inseparable from psychiatric symptoms, were used by some staff to justify women's exclusion from the Trauma Recovery Study, which had the effect of further silencing and disempowering them. This framing of women's experiences of victimization and trauma as psychiatric symptoms contributed to both the invisibilization of women's lived experiences of victimization and trauma, and the strengthening of the medical model in forensic psychiatric services (Maden, 1996).

### **7.3 Fitting a Square Peg in a Round Hole**

Power and authority are features of forensic staff-client relationships, but also of the medical model, which dominates the forensic mental health system as a whole. From the perspective of staff participants, the medical model contributes to the silencing of women clients and non-medical professional perspectives.

*This medical model, which is absolutely driving the ship, has all the power and authority. (Dawn, staff)*

*I mean, I think it is a medical model, so I don't think that their – women or clients in general's – voices are always valued. (Claire, staff)*

*It's hard to be in a medical model. It's very hard, and mental health and psychiatry, and in a hospital setting – a mental hospital – is pretty challenging because you can be... come from such a different outlook. (Sam, staff)*

Driven by the medical model, forensic mental health services focus on assessing, diagnosing, and treating major mental illness and substance use disorders. The mandate of forensic psychiatric services includes providing treatment and community case management services, and supporting the reintegration of forensic clients back to

the community (BC Mental Health and Addiction Services, 2011). Given the system's connection to the courts and corrections, and the need to ensure public safety, another major focus of forensic psychiatry is risk assessment and risk management. These two priorities mean that trauma is often not addressed in forensic mental health services.

*Our focus is on substances and major mental illnesses. That's what our focus is on. But we do not focus on trauma. (Annabel, staff)*

*Their focus is risk assessment. Their focus is diagnosis. It's a very medical-orienting organization. As much as there are [other professions], we work under a medical model. It's diagnose. It's prescribe meds. Let me know how you're feeling afterwards. There's not... there's not a lot of time spent on that kind of stuff. And because their focus is risk assessment, so it's, you know, okay this person's in the community or the person's in hospital – how can we manage them on medications? How can we get them to, you know, not be psychotic or keep them away from drugs? So it's... there's not a lot of time spent on trauma at all. (Karen, staff)*

*I think the focus is more on um... schizophrenic disorders and, so the symptoms... those symptoms are asked about. They're not asking about any PTSD symptoms, like I think, automatically. (Diane, staff)*

Client participants agreed that trauma was not a focus or priority in the forensic mental health system, and was secondary to mental illness.

*It's not addressed here. It isn't! It doesn't come up at all. (Katrina, client)*

*No, no, no. There hasn't been any discussion about trauma... the trauma, or all the crap that I've been through. I mean, 'cause obviously all that stuff that I've gone through is why I'm in this situation, right? 'Cause I've been dealing with a lot of baggage, a lot of trauma issues, right? (Ruth, client)*

*They don't. They don't address the trauma. They'll address your mental health, they'll address your behaviours... (Corine, client)*

Greater emphasis is placed in the forensic mental health system on managing current psychiatric symptoms and risk, than on understanding how clients came to be involved with forensic mental health services.

*...they may have developed a substance misuse issue because of the abuse they experienced. Or they could experience abuse within their addiction. SO, I think there needs to be something in place to sort of support... support the reasons why people are doing what they do, which*

*I don't think that we do here. We just sort of... we identify and we name it... (Karen, staff)*

*The issues that would help these individuals out the most aren't the ones that are being addressed when they're... when they're being treated. It's the symptoms of the mental illness, but not looking at why... why they're addicted to drugs or alcohol and what that stems from. And... and their mental illness, too. (Diane, staff)*

Yet, for Hope, understanding how and why people end up in forensic mental health services requires looking back at their histories: “*Why did somebody do what they did, well, maybe you should look at their background. Maybe you should see the brokenness of their life...*” (Hope, client). Client participants noted that staff focused much more on what was happening today, than what had happened in the past, during treatment appointments.

*They just talk about what happens currently. (Jeopardy, client)*

*They don't really talk about the past. It's all what's going on right now. (Faye, client)*

*But that's [trauma] not the issue in here. The issue in here is, like I said, day-to-day crap like 'what did you do today? How did that make you feel? Why are you feeling that way?' (Ruth, client)*

Staff agreed that the focus is on what is happening currently, and that staff rarely look back at the past, and clients' pathways to forensic mental health services.

*When we do connect... when they... when they go back and they come here for treatment, then we focus on here and now, and don't go back. (Jeanette, staff)*

*And the questions, I think, aren't being asked or are not of concern because it's sort of a 'today' model. Like how can we fix them today without addressing the issues from the past that may be causing some of the acting out or have contributed to poor coping skills or substance use, things like that, right? (Diane, staff)*

### **7.3.1 Under- and Mis-Diagnosis**

Despite the dominance of the medical model in forensic psychiatry, some staff participants were under the impression that psychiatrists did not consider PTSD to be a legitimate diagnosis, worthy of their attention.

*I think in terms of [forensics], which is much more of a medical model and psychiatry is there to diagnose and treat, I don't think that it's... it's almost not seen as a legitimate diagnosis. I don't think I've ever seen one person who's been given that diagnosis [PTSD] and I think that there's definitely a handful of people, men and women, that I see that deal with PTSD issues – not just depression, or anxiety, or whatever it might be. (Claire, staff)*

*I mean my experience with psychiatry has been that it's not... it's not really seen as, you know, a worthwhile diagnosis to give somebody. It's not considered... they don't take the time, for sure, to talk about those issues with clients. And maybe it is that – there's no magical pill that you can give to somebody for PTSD... (Claire, staff)*

*I think it [PTSD] could be probably diagnosed a lot more in people, but there are also people who have legitimate mental health issues – mood disorders or schizophrenia as well, so it would be kind of hard to determine... (Taryn, staff)*

In fact, the legitimacy of PTSD as a diagnostic category has been questioned since it was first included in the DSM in 1980 (Mezey & Robbins, 2001). These authors argue, however, that “dismissing post-traumatic stress disorder as a valid diagnosis denies the ongoing suffering of people who have been exposed to severe and life threatening trauma” (p. 563). Regardless of whether or not PTSD is considered to be a legitimate diagnosis, according to staff participants, it remains severely under-diagnosed (and in some cases, mis-diagnosed) in the forensic mental health system.

*I've probably literally gone through ever single file of every single person that's in this hospital, and I've never seen a PTSD diagnosis. Nor have I ever seen anything of... any sort of trauma history. (Tammy, staff)*

*I suspect it [PTSD] probably is under-diagnosed and sometimes mis-diagnosed. I don't have the impression it's over-diagnosed. Most of the women who come to us that I think have issues around Post-Traumatic Stress Disorder have not received that diagnosis in the past – some have, but most have not. (Sheila, staff)*

*Countless times I've seen like 'oh, history of trauma' but it's not even clear what that means when they write that. And I think PTSD is mis-diagnosed in some cases, where it's not... where it doesn't exist. And missed and under-diagnosed in many cases. So yeah, I don't think that those patients are getting the treatment they need or being, yeah... it's just kind of... stuck with all the other stuff, but it's not the priority, so it's not even addressed at all. I don't know if they would say 'this client has PTSD so we're going to give them medication.' I think it's more like 'they*

*have... okay, they have a history of trauma, but they have schizophrenia, so let's treat the schizophrenia.'* (Diane, staff)

Some of the women clients felt that they themselves had been mis-diagnosed or misunderstood by professionals in the forensic mental health system, with psychiatric labels assigned to them remaining through their interactions with multiple service systems over the course of their lives. And while mental health diagnoses allowed some clients to make meaning of their emotions and behaviours, others felt that 'normal' emotions had been defined as 'sick.'

*I think I'm actually mis-diagnosed. I really do. I really know I must be because they say I'm manic depressive. Well, I just think I'm a normal human being with tendencies to be happy, sad, irate, annoyed, whatever, depressed.* (Katrina, client)

*I don't think I'm sick. I just think I'm misunderstood.* (Jeopardy, client)

The perception of staff participants that PTSD and trauma-related disorders are likely under-diagnosed in the forensic mental health system is consistent with research that PTSD is generally not over-diagnosed (Brunet et al., 2007). Still, there may be concerns that the disorder will be over-diagnosed and presented as a mitigating factor, or to excuse violent or other criminal behaviour ('the abuse excuse'), with implications for criminal responsibility (Friel et al., 2008; Slovenko, 2004). The potential over-diagnosis of PTSD is also a significant concern in civil litigation, where false claims of PTSD, or malingering, may result in greater financial compensation for victims<sup>86</sup> (Mezey & Robbins, 2001).

Staff participants suggested that women with histories of trauma were sometimes mis-diagnosed with other disorders, including Borderline Personality Disorder, a diagnosis that is strongly associated with childhood trauma and more likely to be applied to women (Pollack, 2005). It is also a highly stigmatized disorder, as it has traditionally been considered 'untreatable.'

*More women here have borderline traits. It's not nil by any stretch for the men, but sometimes usually more antisocial for them. But because females tend to be more abused as children, then that's probably one of the reasons that they end up having more personality disorders.* (Sam, staff)

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<sup>86</sup> Because PTSD is the only psychiatric diagnosis in the DSM-IV that specifies a cause, it is also the only diagnosis for which victims can be financially compensated (Mezey & Robbins, 2001).

*I think that there's a lot of bias, there's a gender bias towards women that have been traumatized. Sometimes they get the diagnosis of Borderline Personality Disorder. And then that, in the system, carries a lot of stigma. And people will respond to them perhaps differently. (Annabel, staff)*

### **7.3.2 Treatment as Medication**

Staff participants suggested that, because the forensic mental health system operates under the medical model, the focus is on diagnosing psychiatric disorders and treating those disorders with medication.

*I just think it's like they just think that medication is the way to go, you just medicate everything. [...] Even if you're on the unit and someone comes up and says 'oh I'm upset because, I don't know, my mom was here and she said something really mean.' Instead of sitting down and talking with them, they give them a PRN [pro re nata] – like it's stupid! (Tammy, staff)*

*I think we want to treat people who we can give medication to and see an improvement in their symptoms, and that's easy and let's, you know, let's move on versus putting in some actual time and work and maybe offering more groups, offering more treatment services that might benefit clients. (Claire, staff)*

*Medication is one of the main things that people can provide here – the psychiatrists anyway. I don't know how many of them do much therapy. I hear that some do. The doctor I work with doesn't do much. He has good relationships with his patients, generally, but that part of it – not so much." (Sam, staff)*

Diagnosis and medication are central features of the medical model, where psychiatrists are considered 'experts' and have complete control over treatment decisions (Humphreys & Thiara, 2003). Some clients felt there was too much emphasis on medication, something they had very little control over.

*I keep telling [psychiatrist] to lower the doses, he keeps putting it up! I can't wait to get rid of him so I can get off this shit! Get this poison out of my body! I don't even have a period anymore, because of the stress and the hormones and all this shit. And... the poison that they're pumping into me. And the side effects of these things. And he... I had a meeting with him just today, and all it is one big joke. Oh yeah, he's in control, man. Yeah, he's in the driver's seat. And I have no... I can't stop him! (Katrina, client)*

*I don't know why people that aren't sick, that get misunderstood as being sick, have to take pills. [...] I have to take medications. And when they*

*increase it, I don't really like it 'cause I get fevers and even more side effects. (Jeopardy, client)*

Some clients resisted taking medications due to the side effects or because the medications were addictive, causing further problems. *"I threw it out. I just had enough. Made me like a zombie and very flippy"* (Lisa, client). One woman, who had had negative experiences with medication side effects in prison said *"I felt like I was being punished for being sick"* (Patty, client) while another, speaking about forensic mental health services, said *"I just always feel like the little science experiment when I come here"* (Hope, client). Others had become used to taking medications, and had given up fighting: *"I'm just so used to popping all these pills they give me. I just, you know... I just do it"* (Aja, client).

Not all clients had had negative experiences with medications. Some were grateful that they were able to *"stabilize mentally"* (Darlene, client) or stop using substances to self-medicate. One client participant even described medication as a *"saving grace"* (Patty, client). Still, both clients and staff participants also indicated that there was not enough offered in the way of other treatment services – counselling in particular.

*I didn't get any counselling at all [in the forensic hospital]. And I don't like that. I don't believe that people should be given medication – like I call it the 'here, take meds and get better' approach. I don't agree with that. I believe there should be some talk therapy, and there wasn't. At all. (Darlene, client)*

*I just try to connect with them more than anything and follow like an interpersonal model and support them through their time here [FPH] because they don't get any counseling... like at all. So just... like a lot of supportive counseling with them as well. (Tammy, staff)*

*...typically we don't do so much therapy here, especially if you're schizophrenic or schizoaffective because it just destabilizes... (Sonya, staff)*

### **7.3.3 Holistic Approaches**

Staff participants noted that because forensic mental health services follow a medical model, clients' emotions and behaviours are often interpreted as symptoms of mental illness, and little effort is made to understand the *person* behind the illness.

*They are very much dedicated to understanding a person through illness and treating the illness. And there's not a lot of attention or interest or dedication to getting to know a person and trying to sort of maybe understand why they're making some of the decisions they're making. (Dawn, staff)*

*Clients will do something and it's seen as manipulative or they're doing it on purpose to get to this person instead of, well, no, let's really look at like what actually happened and what that person may have been thinking and what is their background, like, and why might they have said that or reacted in that way, and how can we actually support them to learn about how they're reacting and to change that? To see how it's not serving them anymore even though it may have in the past... (Claire, staff)*

*I think someone who's had, you know, an incident may be able to withstand more. Someone who's had repeated abuse, by multiple people, is just going to have a much more challenging time working through it, and it... you know, the thing that is a little challenging here, and I... I don't blame people... working with someone with a personality disorder is very challenging, but that's how it tends to show up. Someone who's been abused as a child, they will often have these [personality disorder] traits that are very challenging to, I'm sure, the world in general. [...] Around here, people would rather deal with someone who has a mental illness and they can take meds and they can be... treated. (Sam, staff)*

Clients talked about the need to treat the whole person, not just their mental illness, and to consider issues in their lives beyond their criminal record. This requires staff to understand and treat their clients more holistically.

*You need a holistic, you know, like treating the whole person. You know, treat their head and their heart and that is how you get, you know their health and... it's a whole person approach. It isn't just looking at somebody's criminal record. You should look at what the hell they did and why! And a holistic approach – I really believe in that. You know, head, heart, and hand sort of approach. It's far more helpful. (Hope, client)*

Staff agreed that addressing trauma was a key component of a holistic treatment approach, and that it should be something that is addressed in the course of clients' treatment in the forensic mental health system.

*I mean, to me it seems almost unethical that we don't! I think that probably, I mean, I don't really... obviously there's no statistics around it, I have no idea, but I would say 80% of the people have some kind of trauma in their life, so to not be addressing this is crazy! Like how are you really providing treatment if you're not seeing the person holistically and talking about those issues which obviously are impacting them. (Claire, staff)*



*...we're getting more at looking at the holistic person, you know? The whole, not just a diagnosis – mental health diagnosis, right? We're looking at, you know, housing, income, relationships. We're looking more at the spiritual part of it. We're taking all that more... as a society, we're evolving. And I think we still have a long way to go though. (Pam, staff)*

*Whether it was the focus of treatment would depend on what the client's needs were, and like the goal... the objectives of treatment were. But I would think that they would become part of – at least part of – the objectives of treatment. (Diane, staff)*

For some staff, recognizing trauma and treating the client holistically also meant embracing complexity and working with clients to address multiple issues simultaneously. This perspective reflects an intersectional approach, which recognizes that multiple issues (e.g., violence, poverty, housing) co-occur, that problems in one area may compound problems in another, and that addressing issues that are experienced simultaneously together will be more effective.

Unfortunately, the calls of staff for more holistic approaches are not often heard in the forensic mental health system, where psychiatrists are at top of the 'professional hierarchy.' In some instances, the position of psychiatrists has caused tension with other treatment professionals – psychologists, in particular.

*Psychiatry is number one. That's like the 'report of reports.' [...] So, for example, I will often do some trauma work with a patient, and I'll chart about it, but the doctor will write the report and it's not even mentioned. So it doesn't necessarily make it in. (Tammy, staff)*

*...the psychiatrists are sort of seen as the number one priority. (Diane, staff)*

*...there was tension between psychology and psychiatry because psychologists' roles are dictated by psychiatrists. So I think that's... that's really hard because our role is defined by psychiatry instead of by psychology, by what we're trained to do than what we actually do. So it depends with which psychiatrist. Some psychiatrists understand psychology more, and get what we can do, and other psychiatrists never refer to us, and then other psychiatrists will refer to us as a last resort. [...] So... it's, yeah... it's sort of a power... not even a power struggle. It's a hierarchy, and psychologists are under psychiatrists... [...] It's usually a pattern of the same psychiatrists referring to psychologists because these are the ones who appreciate our work or understand or have had positive experiences with the psychologists in the past, that will invite them to come back or... they've seen success cases... (Diane, staff)*

Psychology does not seem to be valued in the forensic mental health system, except in carrying out psychological assessment duties. One staff participant suggested that even simply connecting with clients on a therapeutic level was not considered to be valuable in the organization: *“I don’t think that the organization values therapeutic rapport as much, or having that time to actually do some counseling with clients”* (Claire, staff). Staff participants felt that the service needed to increase its capacity to address clients’ trauma-related needs by increasing the number of psychologists in the service, and expanding psychologists’ role from conducting assessments to providing treatment.<sup>87</sup>

*I definitely think that forensics could utilize their psychologists to work through issues around trauma and victimization with women in our system. (Karen, staff)*

*Well, they [psychologists] are just so busy, on the one hand, doing court assessments that they haven’t got any time to do it [talk therapy]. And on the other hand, they’ve also been shut down so many times that the psychiatrists don’t see the need for psychotherapy. Like they’ve just undervalued the psychologist’s role for so long that they kind of gave up. (Tammy, staff)*

*...she’s swamped. And she’s a psychologist here, but doesn’t have time, so she does assessments and then she does treatment. So, only being here part-time, I think... she’s good, so I mean I would refer... but she doesn’t have a lot of time. Her waitlist is pretty... there is a waitlist. (Annabel, staff)*

Staff participants indicated that providing psychological treatment to supplement treatment in the form of psychotropic medications would require more psychologists on staff.

*...as a forensic psychiatric services not offering psychological treatment or psychotherapy is also not right. Whether it’s expressed by the clients or not, we think... we just thought that we should be offering some sort of treatment instead of just being an assessment machine. (Diane, staff)*

*I don’t think I’m trained to deal with, you know, treatment to do with trauma. But I think we could have more psychologists on staff to deal... you know, we need more specialists. So for me, that... that would be the avenue to go. (Jeanette, staff)*

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<sup>87</sup> A few psychologists in the service were providing treatment services at the time the study was conducted, but staff and clients alike noted that few forensic clients were receiving counseling or other treatment from psychologists in the forensic system.

*I think psychologists is a good start, but I don't think that would be enough either. (Diane, staff)*

Clients participants echoed the need for more counselling staff within forensic mental health services, arguing that counselling and talk therapy were desperately needed to support trauma recovery.

*More counselling. More counselling, specifically for trauma. Sure, because a lot of these girls are here for... because of battered, tough life. Yeah, somebody with real good training. (Katrina, client)*

*Well, I think they should offer more services. [...] Well, just like for the abuse or for sexual assault or... like some kind of counselling. (Patty, client)*

Because limited time and resources make it difficult to do one-on-one counselling with clients, some staff suggested having more groups for the women, something that had been offered in the forensic hospital setting, albeit on an inconsistent basis depending on the interest and availability of staff. One staff participant spoke about group therapy as something that could help manage clients in the hospital setting, but seemed reluctant that group therapy would be feasible with the female forensic population because she considered the inpatient population to be too low functioning.

*Groups would help, but whether it's psychoeducation or... I don't know if the clients at the hospital or at our clinic are high functioning enough to do groups... like psychotherapy groups. Support groups, yes, but therapy groups might be a bit of a stretch. (Diane, staff)*

*If we're just treating with medication, they stop taking their medication, they'll likely end up back at the hospital again – or in another mental health facility. So if we can help them understand why they need medication and help also provide other coping strategies and dealing with issues that maybe are causing substance abuse, which are... which is exacerbating symptoms. Yeah, it could help manage the clients while they're at the hospital. (Diane, staff)*

Several of the women clients, however, articulated a preference for one-on-one as opposed to group treatment. From the women clients' perspectives, psychotherapy focusing on trauma-related issues would ideally be delivered by female staff who had specific training in trauma therapy or who themselves had lived experiences with victimization and trauma, or substance use, if this was a co-occurring problem for the client.

*I would never talk with a guy. Not a way in hell I'd do that. (Lisa, client)*

*...with trauma, I would only work with a female. [...] Anything to do with sexual exploitation or sexual abuse would be female. Even some of the stuff working around being a child in care... female. Physical abuse, husband crap, you know, general... general trauma... I could. I don't like to work with men. Just because of my... I don't have respect for them. (Corine, client)*

*I don't know if I could talk to... like when drug and alcohol counselors, right? I've had a couple where... they've never done drugs! Alright, so like... I can't talk to you. 'Cause I'm laughing at you right now in my head. And I'm being really polite and I can't be really serious with somebody that doesn't know what the hell I'm talking about, right? (Heather, client)*

*And if she... if she was someone who had struggled with drugs in her lifetime, or struggled with trauma in her lifetime, or kind of had any inclination of where I'm at, she wouldn't have suggested those things. 'Cause she knows that it's not practical. (Ruth, client)*

This perspective echoes the findings of other research on services for marginalized women, with women expressing a desire for gender-specific programs, delivered by staff with lived experience (Nixon et al., 2002).

### **7.3.4 Beyond Forensic Services**

The focus of forensic mental health services is on treating major mental illnesses and substance use disorders, and assessing and managing the risk of recidivism. Some staff believed that addressing the trauma-related needs of their clients was absolutely a part of their work, given that trauma plays a role in women's pathways to forensic mental health services.

*I think the... [pause]... forensic has got a lot of roles that they don't... that they should assume and they don't. (Dawn, staff)*

*I think it is something that is our responsibility because sometimes people end up in our path because of their past – their history of abuse. (Taryn, staff)*

*I think it – like PTSD, and any history of trauma – should, like anything, be addressed in an intake interview. Because it's part of a person's history. And that... to determine whether it's causing clinically significant impairment, whether it reaches a diagnosis or not. If it's causing issues for them, essentially... so I think that... that's all of our roles. It's... I don't*

*know if it would take special priority, but it shouldn't be ignored either. It should be touched upon, especially knowing that so many offenders have a history of... and so many people with mental health issues have histories of trauma, and the comorbidity between histories of trauma and substance use and mental illnesses and all of that – I think it should be something that's touched upon just like depressive symptoms. Just like anything else. And then addressed if it's seen as something that's causing impair... causing problems. (Diane, staff)*

Some staff also saw the potential value of addressing trauma, particularly if trauma is considered to be a root cause or an experience that helps to explain why clients are in the forensic mental health system. In this case, addressing trauma may help to keep clients from returning to the criminal justice and forensic mental health systems.

*I mean, I just do really see it as pretty central and integral to treating them because with a lot of people when you talk to them about when symptoms started, it can be following a traumatic event, even if they've had a past history. Maybe there was something that really, you know, that was the turning point or the tipping point and it just seems like without going back to that, how do you really move forward and make some changes and work on improving their illness and mental health and mental stability and wellness and all of that? (Claire, staff)*

*I think it has to start with an understanding that that's the reality for most of our clients here. And that that has an influence on why they're here and why they may keep coming back here if we don't address it. (Sheila, staff)*

*...I see it as all connected so, you know, sometimes if they were either... victims of trauma and then got into drugs and alcohol, and then the drugs and alcohol got them to become involved in the criminal justice system, and then they come see us, and if in the process they become depressed or anxious, or, you know, had a psychotic episode [...] I mean, for most clients, if you can get to the core of what's causing them to use or to become involved with our system, I think that that is a good place to start. (Karen, staff)*

*They would vastly improve their substance use disorders. God, even just looking at the literature on getting better from psychosis and all their comorbid disorders, their rate of success just goes up exponentially. It's just... yeah, from a treatment perspective, they're gonna get medically stable, mentally stable... longer term, they're going to have less relapses. They're going to have less re-victimization later. They're going to have less risk because their mental status has improved, which is obviously directly related to their risk which is our big thing here. So it's always my argument, you know... look at it from a risk perspective! Treat the trauma, they're more likely to be mentally stable and not offend. (Tammy, staff)*

According to Friel and colleagues, (2008) PTSD should be addressed with clients in the forensic mental health system because it has significant implications “for the treatment of their PTSD, for the treatment of their comorbid illness, and for ongoing risk” (p. 81). Yet, some staff participants noted that addressing victimization and trauma with psychotherapy did not fit within the mandate or role of forensic mental health services. As Pam said: “*we’re not a counseling agency*” (Pam, staff). The reality is that there are often so many other pressing needs that, even if trauma did fall within the role or mandate of forensic mental health services, there would be little opportunity to address trauma given the number of competing priorities.

*I mean, the mandate is flexible enough, like I said, that you could... you could address some issues that you want to with your client. (Karen, staff)*

*I think it’s very... limited... very slim. Very, very slim. And part of that is because we get people that are in all kinds of chaos, right? They’re in trouble with the law, they got mental health issues... largely they don’t want to deal with their mental health issues. So just coming here, they don’t want to be here. Um... and, unfortunately, that puts us on a bad foot. So... our first big hurdle to overcome is ‘we’re here to help you.’ So trying to even just to get them through the front door. Uh... and sometimes people can be referred here multiple times before they actually get here. So again, it boils down to working with them on basic issues. ‘Do you got a place to live?’ Try to get them off the streets so that they’re not victimized anymore. If they got... if they’re using needles and they got abscesses all over, which happens in some places, then we have to deal with the immediate medical issues. Um... [sigh]... yeah, you know, and then you tend to... the problem is that every time they come here there seems to be more issues. So it’s just trying to balance it out. So, unfortunately, dealing with any kind of trauma is usually the last thing on the plate. And it’s because there’s so many more immediate concerns... (Sonya, staff)*

Whereas some staff did not consider trauma-related issues to be a part of their job, others simply felt that there were more immediate concerns (e.g., housing) or competing priorities (e.g., pre-sentence reports) that interfered with the prioritizing of trauma-related concerns. Rather than try to address trauma-related issues, some staff participants indicated that forensic staff would connect with community-based services and supports outside the forensic mental health system who had the mandate, staff, and training to address trauma. Yet, one staff participant indicated that connecting clients to community-based trauma therapy did not happen in practice.

In fact, staff argued that there was a lack of accessible and affordable community-based trauma services with qualified staff that would accept forensic clients. Barriers to services were especially problematic in smaller communities where fewer services were available and service providers were considered to be less qualified in some instances.

*I've referred them to mental health and they've said that they don't have counselors who are appropriate to deal with Post-traumatic Stress Disorder, so counseling in that area in this community is very limited, if at all. (Pam, staff)*

*...there's really not a lot of agencies, I guess, around trauma that you can liaise with in the community. (Jeanette, staff)*

Some Aboriginal women in the sample were also interested in accessing culturally appropriate services, such as First Nations treatment centres to support them in their healing and recovery. Other women were seeking religious services that were not offered through forensic services, limiting women's access to appropriate services to meet their spiritual and religious needs and support their recovery from trauma, mental illness, and addiction.

Where services were available in the community, the stigma associated with the 'forensic' label or particular mental health diagnosis served as a barrier, with service providers assuming that individuals involved with forensic mental health services are inherently more violent or dangerous than other individuals accessing community supports.

*...the community's quite closed to forensic patients – forensic clients. [...] They're afraid of forensic patients. And a lot of time they turn – they shy away and they don't include our patients. (Jeanette, staff)*

*Honestly, like if they were just strictly Post-Traumatic Stress Disorder, I don't really think they should be coming here. It would be nice if we had another agency for them to go to. And the reason I say that is because if they come here, they get the forensic label slapped on them and the second people hear that, it doesn't go well for them. (Sonya, staff)*

*...some of it has to do with just the risk issues. They sometimes think because they're a 'forensic' client that they are horrible and that their clinic can't support it. The unfortunate piece about it is that once people come here, are sort of painted with that forensic brush, and that label stays with them forever. [...] I think a lot of it is sort of fear-based and not*

*understanding that all of our clients are not mean and horrible. (Karen, staff)*

Corine, a woman client who had experienced multiple forms of victimization and trauma in her life, including physical and sexual abuse from a very young age at the hands of numerous caregivers, violence in adult intimate relationships and in the sex trade, witnessing severe violence, and the loss of her children to child protection services, had been given a diagnosis of Borderline Personality Disorder, among other mood and anxiety disorders. She described the significant impact this label had had on her ability to access community-based trauma-specific treatment services outside of the forensic mental health system, due to the stigma associated with the disorder.

*I was refused trauma counseling because of being Borderline mental health. Borderlines are difficult to treat, so I was rejected. [...] I was trying to be as forthcoming as possible and I know that Borderlines have a stigma. We have a... people will just turn away, without even looking at really what's behind it. What level the Borderline's at, are they medicated, are they not, are they stable, are they not. They don't even ask, they just... it's a blanket... done. [...] You would think a trauma counseling agency would be aware of that, and a little bit more understanding than closing the door just because 'well, your trauma's so bad now you have Borderline. Okay, we're not going to help you.' I was really frustrated with that. Because it's definitely something that I need... I need to work on to move on. (Corine, client)*

Another significant barrier, cited by the women clients themselves, was a lack of financial resources, given the costs of psychological therapy. Clients were all too aware of the individual financial constraints, and structural barriers such as resource allocation to psychology services, that stood in the way of treatment being offered to persons who had experienced victimization and trauma.

*If you really want to spend the money on... on good therapy and figure out what's all going on in your head, you gotta pay a lot of money for that. And criminals don't have money unless they go get money the criminal way. So it's like, totally doesn't make any sense. (Ruth, client)*

*So for trauma patients and people with post-traumatic stress [...] we need psychologists! Okay? We can't get them if we're in a lower income bracket. (Corine, client)*

*No, you can't do it in a week! No, it would take... trauma... minimum of a year. Who has the money and the availability for a year, for one patient, let alone how many are walking down [street], how many are walking [area]. (Corine, client)*



The research findings illustrate the many challenges of fitting a square peg (trauma) in a round hole (the medical model). Staff participants cited working within a medical model as a significant barrier to addressing trauma-related issues with forensic clients. The focus is on assessing, diagnosing, and treating major mental illness (primarily with medication), and PTSD is not always considered to be a 'legitimate' diagnosis. The mandate of the organization, and the legal framework within which forensic services are provided, appear to be at odds with approaches that focus on trauma recovery. However, research does suggest that recovery-oriented approaches may not be completely incompatible with the medical model (Livingston et al., 2012).

The focus is on the present, and there is little interest in understanding *how* the client ended up in forensic mental health services, or *why* the client is doing what they are doing. As a result, the role of trauma in clients' pathways to forensic services is often minimized, and their behaviours are interpreted through an illness lens rather than a trauma lens. This contributes to the invisibility of victimization and trauma in the forensic mental health system, and the further denial and silencing of women's experiences of victimization and trauma.

Within the medical model, psychiatrists have significant power, such that other perspectives in the professional hierarchy are less valued. The role of psychology is largely dictated by psychiatry, with psychologists spending most their time conducting assessments rather than providing treatment. This means that forensic clients receive little, if any, psychotherapy, even though staff and client participants both agreed that there was a significant need for counselling services to address trauma-related issues. Staff indicated that the role of psychologists in the forensic mental health system is shifting towards a greater emphasis on treatment, but that this remains a minor role. Referrals to community organizations continue to be one way that staff can support clients in accessing trauma-specific services. Unfortunately, accessing community-based trauma-specific services is difficult for forensic clients due to the double stigma of being labelled 'mentally ill' and 'criminal,' a lack of appropriate services with qualified staff, and limited financial resources.

While client and staff participants indicated that counselling, and a shift in the role of forensic psychologists from assessment to treatment, would benefit women who had experiences of victimization and trauma, it may not always be feasible to provide trauma-specific services in forensic settings. However, the development of more trauma-

informed approaches may be possible given the move towards more recovery-oriented approaches in forensic mental health services (Livingston et al., 2012).

## 7.4 Towards Healing and Recovery

Despite women clients' extensive and layered experiences of victimization and trauma, there were a number of significant barriers to addressing trauma-related needs in the forensic mental health system. Staff and client participants were asked to reflect on the notion of 'trauma-informed' forensic mental health services.

*For me, I think it would mean, like just having that awareness of how it's connected to... whether it's behaviours or patterns or just who that person is in front of you. Um... and... obviously understanding the impact of... of trauma. The different levels of trauma. I think... and... [long pause]... more understanding the 'why' – the prior stuff to why they... they have made the decisions they've made, or got involved in the lifestyles that they've gotten involved in. (Karen, staff)*

*I think that our clients' histories would be more forefront, and we would be talking about those issues and how they relate to the treatment we're providing. (Claire, staff)*

*We would have all our staff informed, and have like a baseline part of their training to be on trauma. [...] And then we would have a [integrated trauma-specific] group for the men, and one for the women. And we would incorporate that into their treatment plans. We wouldn't ignore it. We would give proper diagnosis when needed. We would give proper after-care and have more liaisons with community in terms of longer care trauma treatment. (Tammy, staff)*

For some participants, trauma-informed services did not only mean increased awareness about trauma and its effects, but also about the complexities and social realities of women's lives. Greater awareness of women's diversity would also mean that programs and services would be tailored to the unique needs of women clients, rather than reflecting a 'one-size-fits-all' approach.

*...if they were informed of trauma, then they would also be informed of a whole bunch of other things and it would look completely different. (Dawn, staff)*

*...all the females at FPH are on one unit so you get all this diversity of different levels of functioning and different diagnoses and, um... and cognitive levels of functioning. So you've got all this diversity, in that*

*sense, all grouped into one... all being treated the same way, which makes it really difficult... (Diane, staff)*

*So I think that it would be not necessarily that clients would also have to come in here. I mean, we can meet our clients in the community, but... for some women even to come... like to leave their home, or to come here, or to deal with all the other issues that come along with childcare or whatever their situation is, just to get here is... I think can be cumbersome, so something that's more... I guess more outreach focused around that area. (Karen, staff)*

A trauma-informed forensic mental health system would be kinder, gentler, more welcoming system that would view clients through a trauma lens rather than an 'illness' lens, as is typically the case in the medical model.

*I think that it starts with... with our whole process of people coming in. And that they're sort of stripped down, you know, literally stripped down, and while that's safety, and while they often come in quite high, mania, and/or on drugs – and I don't want to die 'cause somebody's brought a shank in – you know, whatever, right? You know, so I understand that, but there is sort of a process that could be perhaps done slightly more gently. (Kristen, staff)*

*I think that people would be kinder in the way that they think about our clients, and what they're currently dealing with and how they're presenting because their addiction and their behaviours, and their whole presentation would be viewed from a trauma perspective and trauma-focused lens. (Claire, staff)*

*I'm not saying that when somebody comes here you should have a welcoming party, but, you know, I think that... but there should be this understanding that somebody's just had... maybe for some people they don't care, but... for some of us that have never done this before, have just gone through one of the biggest traumas you're ever going to go through, and um... and have a little compassion. Try a little kindness, you know? (Hope, client)*

A trauma-informed system would also recognize that working with trauma survivors, and addressing trauma-related issues with forensic clients, may have a significant impact on professionals as well. The organization would support staff in doing this work, through supervision and peer support, practices that staff participants reported were already in place in the forensic mental health system.

*I think that within our clinic we're pretty good in terms of like peer supervision. Like you can always go to anyone and debrief and kind of talk about things. (Claire, staff)*

*This clinic, like... we're very good at going to each other if we have to debrief about a client or a frustration. (Annabel, staff)*

*We have a very supportive supervisor, and a fantastic group of employees that we can all debrief and discuss and just kind of get things out. (Taryn, staff)*

*I feel a lot of support from my peers, my colleagues, so I would go talk to them if I felt traumatized or, yeah, if I was really deeply affected by something. (Diane, staff)*

*...most of my colleagues... we are always a small and very close-knit offices. And so we always debrief with each other. We always pull ourselves and are there for each other, so... and that has been stressed out to us and... as a senior staff, that's something we're teaching our junior staff as well... (Jeanette, staff)*

Trauma-informed forensic mental health services would meet women where they are, adapting the *system* to meet the needs of the *clients*, rather than molding the clients to meet the needs of the system. Both client and staff participants pointed to the need to change or adapt the system itself.

*In practice, I find that there's often a push for me to get them to understand the system they're in, rather than advocate for them as individuals, or based on their needs. It's about getting – molding – them to the system, rather than advocating, you know, which is very strange at times and hard. (Sam, staff)*

*And having enough resources so that you can continually go back and check. And that you can keep, you know, that you can have time to establish a rapport with somebody so that when they're ready, you can move from a casual rapport to a therapeutic relationship and, you know, start some work. (Kristen, staff)*

*This heart-crunching system. The nice person just gets swallowed up alive by the system. But what do you change? The person or the system? Well, I'd say the system's gotta go. I mean, you've gotta make it – I mean, it should be about getting a better person going out the door than when they came in. And if you haven't done that, you've totally failed. (Hope, client)*

Some staff felt that it was time for the adoption of trauma-informed approaches in forensic mental health services, but noted that changing the system and shifting organizational culture would be both difficult and slow.

*I really think we have a Cadillac service, but it just doesn't have all... you know, an up-to-date model of the Cadillac. Doesn't have the power controls and everything else. (Jeanette, staff)*

*You know, getting people to buy into the need and then actually apply to their practice has been very, very difficult which, professionally, I'm embarrassed to have to say. (Kristen, staff)*

*It's so hard to do culture shift. So hard. Especially at forensics. We're the slowest moving culture place on the p-la-net. It's mind-boggling. (Tammy, staff)*

*And it certainly seems to be, you know, trauma-informed services, trauma-informed care, time... you know, well past time. (Kristen, staff)*

Yet, staff reflected on the benefits of addressing trauma in the lives of their clients, including greater awareness among clients of the role victimization and trauma have played in their lives so that they can improve their lives.

*Maybe people will make better choices for themselves. Maybe they would understand a little bit more of their triggers, so maybe they won't do drugs and then maybe they won't risk their mental state. Maybe they'll have better relationships, you know... Maybe they'll have more space for some of the positive things in life. (Annabel, staff)*

*Well, I think a lot of times people say well 'yeah, I had a tough life, but who cares,' you know, whatever, and they just continue on with their dysfunction. But I don't think a lot of them realize how much it's truly affected them. (Sonya, staff)*

*If we're not going to be addressing it specifically in a focused, ongoing way [...] I think that we should have something. We should have something that's able to address it. Right? And some way of being able to identify it and direct... direct a person with those needs to care. (Sam, staff)*

Client participants, too, talked about the importance of healing from experiences of victimization and trauma, in order to advance their mental health recovery, and avoid returning to the forensic mental health system. Several client participants expressed a desire and readiness to begin dealing with their histories of victimization and trauma, indicating that doing so might help them move forward with their lives.

*Secrets keep you sick. So if you've got secrets about sexual abuse, and you've got secrets about people you see murdered, and you've got*

*secrets about, you know, what your parents or child welfare or all these people did to you, it keeps you ill. (Corine, client)*

*I'm at a point that this trauma stuff needs to start being dealt with. I need to start letting some of it go. I need to stop harbouring it. Um, and I need to find a way to come to terms with it. (Corine, client)*

*I really want to try to stop this world of chaos. I mean, 7 years has gone by and it seems like yesterday. It's because I haven't dealt with anything – nothing. Nothing. (Heather, client)*

*...through healing a person, they are going to be better and they're going to be better armed to go out to the world and not come back... hopefully. (Hope, client)*

According to client and staff participants, trauma-informed forensic mental health services would require adapting the system to meet the diverse needs of clients. It would be a kinder, gentler system, and would help women recover from trauma and mental illness, and avoid returning to forensic mental health services. Staff would be informed about trauma, and supported by the organization in doing this kind of work to minimize the potential impact of secondary traumatic stress.

The next chapter explores the ethical issues involved in conducting trauma-focused research with a vulnerable population of women receiving services in a forensic mental health system, and reports on empirical evidence gathered in the ethics inquiry component of the study.

## **8: A VOICE THROUGH RESEARCH PARTICIPATION**

A third purpose of the Trauma Recovery Study focused on the ethics of trauma-focused research with a vulnerable population of women receiving forensic mental health services. To explore the impact of the research, client participants were invited to answer open-ended questions about their experiences as participants in the study and complete the *Reactions to Research Participation* (RRPQ) questionnaire. Information about clients' reactions to participating in the Trauma Recovery Study were also captured in field notes. This triangulated approach captured not only how participants felt about participating, but also the reasons underlying their reactions to participation in a trauma-focused study. It also allowed for triangulation of the results, shedding light on discrepancies between what participants reported to me verbally and what they reported on paper in my absence. The following sections explore client participants' perspectives regarding whether the core ethical principles of research were achieved in the Trauma Recovery Study, as well as their perspectives on the benefits and harms of the trauma-focused study.

The primary reasons for participating in the Trauma Recovery Study, as reported by the women involved in the study, included curiosity, wanting to help themselves, and wanting to help others. Some women indicated that they had participated because of financial incentives, while three women felt they had to or hoped that participating might improve their access to health care. These findings are important in that they underscore the vulnerability of women at the interface of the criminal justice and mental health systems, and the benefits anticipated by women who choose to participate in trauma-focused research.

### **8.1 Respecting Core Research Ethics Principles**

Several RRPQ items offered insight into participants' experiences with respect to the core ethical principles of research, as outlined in the TCPS2 (2010) – in particular, the principle of *respect for persons*, which involves respecting autonomy, achieved by seeking participants' free, ongoing, and informed consent. Article 3.1(a) in the TCPS2

(2010), which states that “consent shall be given voluntarily” (p. 28), is reflected in the RRPQ item: ‘Participation was a choice I freely made’ (item 21). All participants (n=16) in the Trauma Recovery Study either agreed (37.5%) or strongly agreed (62.5%) with this statement, suggesting that the consent process was sufficiently tailored to the needs of the population.

Article 3.1(b) in the TCPS2, which states that “consent can be withdrawn at any time” (p. 28), is reflected in the RRPQ item: ‘I felt I could stop participating at any time’ (item 17). While the majority of participants agreed (37.5%) or strongly agreed (43.75%) with this statement, a small proportion (18.75%) of participants reported a negative or neutral response.

Another important aspect of the consent process is reflected in Article 3.2 of the TCPS2, which states that “researchers shall provide to prospective participants, or authorized third parties, full disclosure of all information necessary for making an informed decision to participate in a research project” (p. 30). The notion that consent must be informed is captured by the RRPQ item: ‘I understood the consent form’ (item 23). All participants in the Trauma Recovery Study either agreed (50.0%) or strongly agreed (50.0%) with this statement.

Two additional RRPQ items reflect core ethical principles outlined in the TCPS2. The first item, ‘I trust that my replies will be kept private’ (item 9), reflects the level of trust and confidence participants have in researchers to uphold their fundamental right to privacy and maintain the confidentiality of their responses. The ethical duty of confidentiality is captured in Articles 5.1 and 5.2 of the TCPS2, and requires researchers to maintain confidentiality and to inform prospective participants, during the consent process, about the measures that will be undertaken to do so, and any foreseeable disclosure requirements. In the Trauma Recovery Study, prospective participants were informed that any threats of harm to themselves or others would be disclosed to their treatment team, and that any suspected abuse or neglect of a child under the age of 19 years would have to be legally reported to the Ministry of Children and Family Development, as per the *Child, Family and Community Service Act* (1996) of British Columbia.

The second item, ‘I was treated with respect and dignity’ (item 12), reflects the underlying value of ethics policy in Canada, *respect for human dignity*, and the first core principle in the TCPS2, *respect for persons*. All participants in the Trauma Recovery



Study either agreed (31.25%) or strongly agreed (68.75%) with the statement. Notably, this was the item with the highest proportion (68.75%) of participants who strongly agreed, with voluntary participation a close second (62.50%), suggesting that the fundamental principles of research ethics were achieved, from the perspective of participants involved in the study.

## **8.2 Harms of Trauma-focused Research**

The harms associated with research participation vary widely, from relatively minor (e.g., inconvenience) to significant (e.g., psychological trauma). The RRPQ captures a range of drawbacks and emotional responses associated with participation in research, with three items capturing relatively minor drawbacks that are not associated with the nature of the research topic. Most participants disagreed (50.0%) or strongly disagreed (43.75%) with the item 'I found participating boring' (item 18). Similarly, most disagreed (56.25%) or strongly disagreed (31.25%) with the item 'the study procedures took too long' (item 19). Finally, all participants disagreed (40.0%) or strongly disagreed (60.0%) with the item 'participating in this study was inconvenient for me' (item 20).

Other harms captured by the RRPQ were more specifically related to the nature of the research topic, and provided critical information about the emotional and psychological harms associated with participation in trauma-focused research. These items were those that comprised the questionnaire's 'Emotional Reactions' subscale. As a whole, the sample did not report becoming overly emotional during the interview, with the majority of participants selecting 'neutral' in response to the statement 'I was emotional during the research session' (item 16). And while only one quarter of the sample agreed (18.75%) or strongly agreed (6.25%) with the statement 'I experienced intense emotions during the research session and/or parts of the study' (item 10), almost one third of participants agreed (6.25%) or strongly agreed (25.0%) with the statement 'the research made me think about things I didn't want to think about' (item 5). Finally, over half of the sample agreed (43.75%) or strongly agreed (12.50%) with the statement 'the research raised emotional issues for me that I had not expected' (item 3).

The open-ended questions shed light on the subjective physical and psychological reactions of participants when recalling and describing traumatic events for research purposes, and how they managed those reactions during the interview.

*Well, I mean, if it was difficult, you'd see me going somewhere else without me even realizing it. Like I'll just go somewhere else. My brain'll just take me somewhere else if it's difficult. And then I'll come back and go 'I don't really want to talk about that.' [...] And that's what I learned... that's what I learned to do in situations like that – was pretend it wasn't really happening. Right? And go into denial and uh... so... 'cause it was just too much to bear! (Iris, client)*

*There was a few moments. It's okay. Uh, I was okay. I mean, I wasn't uh... I didn't feel unsafe in any way, it's just my body reacted. Tense back, you know. You just... you be aware of it and then you kind of either acknowledge it or stuff it back down. So I just kind of acknowledged it. Once I acknowledged it and once I stuffed it... (Corine, client)*

*It gets easier and easier. Like before I wouldn't have been able to talk about it without crying. Now I can talk, 'cause I've been... I've been... 'cause I've talked about it so many times, like, having to do these assessments over, and so... learned not to cry anymore. (Faye, client)*

*Through this whole, through this system that I've been kind of pushed and prodded through, I told my story a lot, so it becomes easier and easier every time I do it. (Ruth, client)*

Some women had more neutral experiences with the interview. Interestingly, Aja also noted that the methods mattered in trauma-focused research, with interview methods more appealing than survey methods.

*Nothing. I don't feel anything anymore. It's almost like it's... like an annal of history that's... it's just like reading it out of a book. It's almost – I'm so far detached from it, it doesn't even really feel like it's mine anymore. At first it used to make me cry and I would hurt – it would hurt, but it doesn't do that anymore. (Donna, client)*

*No good can come from bringing it back up again. Because I... I don't... it doesn't scare me anymore, it doesn't make me emotional anymore. It's just like I'm talking like a... a robot, you know, when I'm telling somebody about my past. Uh... I'm not afraid of anybody anymore, you know? I had a long time there where I was afraid of my own shadow, you know? But I'm not afraid of anyone anymore. Nobody's gonna get me now. [...] That part of my life's done. And I know it's necessary for you to hear it for your research, but other than that, it's just research. (Aja, client)*

*If I had to write it out, I wouldn't. You know? If I had to send in a survey where I had to write all of that... all that stuff out, I'd say forget it. You know, \$50 isn't enough money for that. But uh, being asked the questions is very... it's very interesting for me. (Aja, client)*

### 8.3 Benefits of Trauma-focused Research

Participants reported a number of benefits associated with participating in the Trauma Recovery Study. In terms of direct personal benefits, the majority of participants agreed or strongly agreed that they found participating beneficial to them (56.25% and 43.75%, respectively), that they gained something positive from participating in the study (50.0% and 43.75% respectively), that they found participating in the study to be personally meaningful (56.25% and 25.0%, respectively), and that they gained insight about their experiences (26.67% and 33.33%, respectively).

The open-ended ethics-related questions revealed that some participants felt it was good to talk about their experiences of trauma, in order to get it off their chest (i.e., releasing it) or make meaning of their experiences. They also emphasized the importance of having someone listen and acknowledge their experiences, with some reporting having been very excited about the interview.

*It makes me feel better by talking about it. I never told anybody else. (Lisa, client)*

*It helps me to talk about it when somebody's listening. (Katrina, client)*

*I feel better. Like just talking about all this, getting this off my chest. I'll feel better. Like it seems like it's more cleansing. (Faye, client)*

*Yeah, I feel better... about remembering it. (Erika, client)*

*I mean, it may not be a counseling session, but in a way it's still, uh, releasing it, and putting it out there and saying it happened. And acknowledging it, instead of hiding it for so long, or pretending like it doesn't exist. (Corine, client)*

*Just, it might clarify my own perspective on things. You know, to say it out loud. (Darlene, client)*

One of the case managers working in a clinic outside of the Lower Mainland informed me that she had received overwhelmingly positive feedback – what she described as ‘raving reviews’ – from her clients who had participated in the study. She indicated that it was rare for these women to find someone who wanted to listen to their stories and that participating in the study made them feel that their experiences were valuable. One client, in particular, said she could not believe that someone would travel

all the way from Vancouver just to talk to her. This speaks to importance for the women of having a voice and being heard, which is not always the case in their interactions with service providers in the criminal justice and mental health systems. These sentiments were also captured in the open-ended question included in the RRPQ.

*Thank-you for taking the time to fly up and meet me. (Grace, client)*

*Thank you, it feels good to think I might make a difference and have something worth listening to. (Heather, client)*

These findings on the personal benefits of participating in trauma-focused research are consistent with other research using the RRPQ, and support the notion that participating in trauma-focused research may empower individuals who are otherwise silenced (Newman, Risch, & Kassam-Adams, 2006). The findings are also consistent with anecdotal and empirical evidence from trauma-focused research involving individuals with mental health problems. In one study, the authors noted that they were “concerned that talking about victimization experiences would be distressing for participants, [but] most expressed gratitude at the opportunity to talk about their trauma histories” (Goodman et al., 1999, p. 595).

Of course, the benefits of research are not limited to direct benefits to participants, but also extend to others whose social locations are represented in the sample and to society at large, through the production of knowledge.

*I'm glad that there's somebody out there that knows a little bit more about my story, that somewhere along the line, someone will... it'll help somebody. (Katrina, client)*

*...just a chance that I may help someone in the future. In the forensic system. You know. 'Cause they're making a lot of changes down there, and I don't necessarily think it's good, but... I don't know... maybe they'll make some good changes later, who knows. (Darlene, client)*

*...anything that will help! Like I'm interested in anything that will help women. I believe that that's part of my purpose on earth. [...] So if there's any way of helping through anything that I can say or do, that's right up my alley. (Iris, client)*

*I thought 'yeah, maybe I could participate in that and see what I have to offer and be helpful.' (Patty, client)*

*If I could be of any assistance in any way at all to help anybody understand anything about any part of the system, I would be more than willing to help. (Donna, client)*

Three items on the RRPQ capture participants' thoughts about the importance of the research, which can be used as a measure of the broader benefits of the research. The first statement, 'I believe this study's results will be useful to others' (item 8), was endorsed by the majority of participants, with 43.75% agreeing and 50% strongly agreeing with the item. The second statement, 'I think this research is for a good cause' (item 11), was endorsed by the entire sample, with half (50.0%) of the participants agreeing and half (50.0%) strongly agreeing with the item. The third statement, 'I like the idea that I contributed to science' (item 15), was endorsed by all participants, with 43.75% agreeing and 56.25% strongly agreeing with the item. These findings clearly suggest that participants felt they were making an important contribution by participating in the study. Written comments on the RRPQ confirmed this: "*Great study!*" (Patty, client); "*I hope this will help women in the future!*" (Hope, client).

## **8.4 Balancing Harms and Benefits**

For research to be ethical, the potential benefits of the study must outweigh the risks. The balance of direct benefits to participants and harms experienced during the interview process were loosely captured in two similar RRPQ items: 'knowing what I know now, I would participate in this study if given the opportunity' (item 2) and 'had I known in advance what participating would be like I still would have agreed to participate' (item 22). These items are not a true reflection of the benefits and harms of the study, as they capture neither the benefits to society and the advancement of knowledge, nor the long-term and widespread harms associated with participation or the dissemination of the study's findings.

Yet, all participants in the study agreed (43.75%) or strongly agreed (56.25%) with the first statement, and most participants (87.5%) indicated a positive response to the second statement, suggesting that benefits of the study outweighed any potential discomfort, emotional distress, or other harm associated with participation in the study, from the perspective of participants. Additionally, all participants agreed (50.0%) or strongly agreed (50.0%) with the statement 'I was glad to be asked to participate' (item

14), a finding that implies an overall positive assessment of trauma-focused research participation for this vulnerable population of female forensic clients.

Much of the research on participants' reactions to trauma-focused research to date has been conducted with undergraduate and community samples (Cook et al., 2011; Cromer et al., 2006; DePrince & Chu, 2008). Some research has been conducted with survivors of physical and sexual violence (Griffin et al., 2003). In the Trauma Recovery Study, the RRPQ was used with a 'multiply vulnerable' population of women with mental health problems who have criminal justice involvement, some of whom were in custody. The ethics component of the study makes an important contribution to the literature on the ethics of trauma-focused research and serves to inform forensic mental health services as well, in that the women's positive experiences of telling their stories may alleviate concerns among staff that talking about victimization and trauma issues with clients may be re-traumatizing and de-stabilizing. In fact, acknowledging their stories and hearing their voices may be empowering and support them in the trauma recovery process.

## **9: CONCLUSIONS AND FUTURE RESEARCH**

The Trauma Recovery Study explored the victimization and trauma-related experiences and needs of women in the forensic mental health system, and the challenges faced by forensic mental health professionals in addressing these issues in the lives of female clients. Through this research, I mapped women's pathways to forensic mental health services and considered the possibilities for trauma-informed approaches in forensic mental health services. Trauma-focused research with vulnerable populations, including female forensic clients, raises a number of ethical issues, including concerns that participants may be re-traumatized as a result of their participation. Through the ethics component of the Trauma Recovery Study, women clients shared their experiences as research participants, and provided insight into the benefits and harms of participation in trauma-focused research from their own perspectives. This inquiry generated empirical evidence about the ethics of trauma-focused research with vulnerable populations, from the perspective of participants themselves, and illustrated how research participation may give a voice to women who are often silenced and disempowered.

The narratives of client participants revealed that the lives of women receiving forensic mental health services are replete with experiences of victimization and trauma. Some women described multiple and layered experiences of victimization and trauma throughout their lives, from childhood abuse to violence in adolescence and adulthood, especially in the context of intimate relationships, or as a result of involvement in the sex and drug trades. The women also described horrific stories of witnessing violence and death, and experiences of trauma stemming from the loss of their children, intrusive psychiatric symptoms, and the perpetration of violence. In some cases, having children apprehended by child protection services brought back traumatic memories of the women's own removals as children. The women also shared stories about their experiences in the criminal justice, mental health, and forensic mental health systems, which some considered to be traumatic.

The women conceptualized 'trauma' broadly, and their descriptions of traumatic experiences were more closely aligned with feminist understandings of trauma than

narrow medical definitions restricted to psychiatric symptoms and diagnostic categories, such as PTSD. In fact, very few of the women in the study reported having a PTSD diagnosis, a finding that was expected based on other research that has found PTSD to be under-diagnosed in the criminal justice, mental health, and forensic mental health systems (Brunet et al., 2007; Frueh et al., 2000; Morrow, 2002; Mueser et al., 1998; Mueser et al., 2002; Walsh et al., 2003). Findings from staff interviews provided further evidence that trauma-related symptoms are often under-diagnosed or mis-diagnosed in the forensic mental health system, and that PTSD is not always considered to be a 'legitimate' diagnosis in forensic psychiatry.

Staff participants, like the women clients themselves, considered trauma as broader than a PTSD diagnosis, with some staff recognizing that concerns around victimization and trauma were not limited to historical experiences of childhood abuse. Rather, they understood that trauma could stem from the perpetration of violence or experiences in the criminal justice and forensic mental health systems, and that vulnerability to victimization could be an ongoing concern for women in inpatient and outpatient forensic settings. These findings suggest that broad conceptualizations of trauma are more suitable than narrow medical definitions for a full recognition of the traumatic experiences of women receiving forensic mental health services, and their ongoing vulnerability to victimization and trauma.

Findings from the Trauma Recovery Study suggest that women who are the most mentally unwell may be at greater risk of further victimization and exploitation in forensic hospital settings, through interactions with male co-patients. Forensic psychiatric hospitals are also environments that may trigger trauma-related symptoms because clients are subject to greater power imbalances and their lives are more controlled. Women in the community may also have ongoing safety concerns, especially if they are experiencing psychotic symptoms, using substances, involved in the sex trade, or experiencing homelessness (White et al., 2006). These findings are consistent with research indicating that individuals, particularly women, with severe mental illness are at greater risk of being victimized than individuals without mental health issues (Teplin, McClelland, Abram, & Weiner, 2005; Walsh et al., 2003; Wood & Edwards, 2005). Some research suggests that outpatient psychiatric commitment may protect persons with mental illness from victimization in the community, by increasing medication compliance and reducing substance use (Hiday, Swartz, Swanson, Borum, & Wagner, 2002). Thus,



forensic treatment staff have an important role to play in addressing victimization and trauma-related issues in women's lives.

The impact of victimization and trauma on the lives of women in the forensic mental health system was significant. And while many women perceived their experiences of victimization and trauma to be at the root of their mental health and substance use issues, and their pathways to forensic mental health services, this was not the case for all women. In the Trauma Recovery Study, victimization and trauma emerged in a number of different ways in the women's lives. Some of the women's stories reflected the 'leading feminist scenario' (Daly, 1992) and provide further evidence that women's coping mechanisms and survival strategies following childhood abuse may be criminalized (Chesney-Lind, 1989).

For other women, however, trauma emerged not as a *root cause* of women's mental illness, substance use, and criminal behaviour, but rather as a *consequence* of their mental health symptoms, criminal behaviour, or involvement with the criminal justice and forensic mental health systems. In most of these cases, the women's criminal behaviours were directly linked to mental illness (e.g., committing a crime while in a psychotic state). Of course, these differences in women's pathways to (and through) forensic mental health services may be explained by the broad inclusion of both probation and NCR-accused clients in the sample, though the women's pathways were not necessarily related to their legal status.

It is clear from the stories of the women clients who participated in the study that female forensic clients are extremely diverse in terms of their experiences of victimization and trauma, mental health and substance use problems, and pathways to forensic mental health services. As the forensic staff themselves noted, describing the 'typical' female forensic client is a difficult, if not impossible, task. The women's lived experiences of victimization and trauma, and the role of trauma in their pathways to (and through) forensic mental health services were clearly shaped by their social locations at the intersections of gender and other identity categories (e.g., race, ethnicity, class, age, sexual orientation, education, religion, language, geography). While the women participants' narratives shed light on some of these intersections, the diversity of the sample meant that particular intersections emerged in only a small number of narratives, sometimes reflecting only a single woman's experience. However, differences among the women point to the need to move beyond gender-informed or women-centered

services, and towards a diversity or intersectional approach in forensic mental health services.

A few of the women clients who participated in the study reported positive interactions with individual service providers in the criminal justice and forensic mental health systems. However, many reported experiences in these systems that they considered to be traumatizing and disempowering. These findings support previous research that the criminal justice and forensic mental health systems may exacerbate trauma and feelings of powerlessness, particularly for individuals who have serious mental health issues and/or histories of victimization and trauma (Bill, 1998; Dirks, 2004; Heney & Kristiansen, 1998; Livingston & Rossiter, 2011).

The study revealed a number of significant challenges in addressing victimization and trauma with women receiving treatment services in the forensic mental health system. The themes that emerged centered around the invisibility and fear of trauma, the ways in which the system silences and disempowers women survivors with mental health issues, and the dominance of medical and psychiatric perspectives that delegitimize trauma and devalue trauma recovery.

The findings confirm that, with respect to women receiving forensic mental health services, “the women’s pathways are not difficult to map, but to the majority of staff they remain uncharted and uncertain territory” (Williams et al., 2004, p. 31). A lack of gender-specific and trauma-informed training, along with a lack of organizational support for trauma-related work, meant that trauma was rarely addressed – despite awareness among individual staff members that it was a common experience among women clients. Some staff participants cited concerns about re-traumatizing or de-stabilizing clients as one of the primary reasons for not addressing trauma-related issues. However, it can be argued that the lack of attention to trauma-related issues serves the needs of staff, who lack the training to deal with the potential consequences, more than it serves the needs of clients who have themselves experienced victimization and trauma. According to Williams and colleagues (2004),

...it has been noted for many years that mental health services are no different from other institutions in having rules and practices that serve the interest of privilege. Hence, services are frequently responsible for compounding the past experiences of disempowerment of many service users rather than providing opportunities for acknowledgment, understanding and change. (p. 32)

Few staff participants had considered the effects of *not* asking about or acknowledging the trauma-related experiences and needs of women clients (Becker-Blease & Freyd, 2006). Avoiding trauma-related issues meant that clients' experiences of victimization and trauma were not validated, though recognition of the impact of trauma is critical for establishing safety, the first stage of the trauma recovery process (Elliott et al., 2005; Herman, 1992b).

The denial of women's experiences of victimization and trauma was even greater for women clients who had mental health issues or diagnoses that served to undermine their credibility. Staff interpreted stories of victimization and trauma reported by survivors with severe mental illnesses, such as schizophrenia, as symptoms of their mental illnesses (e.g., delusions). The recruitment process itself also revealed how some women with self-reported experiences of victimization and trauma were silenced by staff because of a perceived lack of credibility owing to serious mental health issues. These women were denied an opportunity to participate in the study by forensic treatment staff – most often their psychiatrist – and thereby denied a voice and validation, fuelled by a fear that validating their experiences might de-stabilize their mental health and impede mental health recovery, with little consideration of how acknowledging traumatic experiences could improve mental health and trauma recovery.

The mandate of forensic psychiatric services, and the dominance of the medical model in the forensic mental health system, means that the emphasis is on the treatment of major mental health and substance use disorders, and PTSD and other trauma-related disorders are not seen as particularly relevant or important. This perspective ignores evidence that integrated trauma-specific treatment has the potential to improve treatment retention and mental health recovery (Gatz et al., 2007; Morrissey et al., 2005), and that trauma plays a role in women's pathways to crime and forensic mental health services (Chesney-Lind, 1989; Daly, 1992; Gilfus, 1992; Williams et al., 2004). The dominance of the medical model in the forensic mental health system was further reflected in the professional hierarchy, with psychiatrists holding greater power over treatment decisions than other forensic treatment staff. Psychological treatment, such as counselling, was found to be particularly devalued in the forensic mental health system, despite client and staff perspectives that there is a need for psychological treatment. Yet, the role of psychologists in the forensic mental health system remains largely dictated by

psychiatric professionals, and limited to assessments and the preparation of pre-sentence reports for the courts.

The legal requirements of treatment staff in the forensic mental health system, and the power imbalance experienced by clients in this system, also contributed to the silencing of women's voices and experiences of victimization and trauma. Clients did not feel they could open up to and trust forensic staff about issues concerning victimization and trauma because of their criminal involvement and their own fears that this information could be used against them in the future. The limited confidentiality in the forensic mental health system may contribute to a "culture of mistrust" (Miller & Najavits, 2012, p. 3) similar to that observed in correctional settings.

Despite Morrow's (2008) assertion that "'trauma' is becoming a new buzzword" (p. 161), and the resurgence of this concept in the mental health and addictions field, the uptake of trauma-informed approaches in *forensic* mental health poses a number of unique challenges that reflect similar challenges in the development and delivery of trauma-informed inpatient and outpatient mental health and addiction services, and correctional services (Freeman, 2001; Harris & Fallot, 2001a, 2001c; Miller & Najavits, 2012; Poole & Urquhart, 2009).

I anticipated, at the outset of the study, that adopting the medicalized and individualized language of 'trauma' would capture the attention of forensic mental health professionals more effectively than the language of 'violence against women,' which clearly frames victimization and trauma as a gendered issue. However, the research findings suggest that this approach may not achieve its desired effect in spite of the medical model. The emphasis on risk assessment and management in the forensic system suggests that the most effective inroad for trauma-informed approaches may instead be one that emphasizes increasing safety and reducing risk for both forensic clients and staff; that is, that trauma-informed approaches may result in more effective management of client behaviours, increased safety and security (particularly in institutional settings), and increased job satisfaction (Miller & Najavits, 2012). Recognizing that traumatic experiences play a role in women's pathways to crime and forensic mental health services also suggests that addressing trauma-related issues may support women's recovery from trauma, mental illness, and substance use, thereby reducing their risk of further involvement in the criminal justice and forensic mental health systems (Salina, Lesondak, Razzano, & Weilbaeher, 2008).

Moving toward trauma-informed forensic mental health services requires a paradigm shift, or shift in organizational culture, which seems to be incompatible with the medical model (Harris & Fallot, 2001b; Richardson, Coryn, Henry, Black-Pond, & Unrau, 2012). Trauma-informed approaches, however, are compatible with patient-centered and recovery-oriented approaches to mental health care in that each views recovery as a primary goal, involves holistic approaches that focus on clients' strengths, and emphasizes collaboration and shared power with service providers (Elliott et al., 2005; Livingston et al., 2012; Mead & Bower, 2000). And while these approaches appear to be incompatible with the goals (i.e., the treatment of severe mental health and substance use disorders) and priorities (i.e., risk management) of forensic mental health services, there is emerging evidence that patient-centered models of care may be adapted to forensic mental health settings (Livingston et al., 2012).

The gendered nature of women's experiences of victimization and trauma, the nature and course of mental health and substance use problems, and women's pathways to crime suggest a need for gender-responsive, trauma-informed, and recovery-oriented approaches in forensic mental health services. Despite the differences between men and women receiving forensic mental health services, and the commonalities in women's experiences, it is also critical to recognize the diversity *among* women and to integrate a diversity perspective to individualize services and better meet the needs of women at the interface of the criminal justice and mental health systems.

Staff participants indicated that there was little organizational support for trauma-informed approaches in the forensic mental health system, and that a culture shift in the organization would be slow, but some staff were nevertheless persistent in their efforts to raise awareness and attend to trauma in their individual practice and in the system as a whole.<sup>88</sup> Indeed, perhaps the greatest challenge in the development of trauma-informed forensic mental health services is establishing the need for and value of such an approach. Given the focus in forensic mental health services on labelling and treating psychiatric symptoms and disorders, and managing behaviour and risk, one can imagine how easy it might be to ignore the underlying experiences of victimization and trauma that contributed to and shaped women's pathways to forensic services. Williams and

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<sup>88</sup> The 'Seeking Safety' model is currently being considered for use in the forensic hospital (J. Livingston, Researcher, Forensic Psychiatric Services Commission, personal communication, August 8, 2012).

colleagues (2004) argue that psychiatric labelling itself serves this purpose and hinders women's empowerment:

...diagnosis hides the connections between a woman's behaviour and distress and her lived experience. Without an understanding of these connections, behaviour is easily viewed as meaningless, out of control and dangerous. Yet we cannot hope to empower women unless we have an understanding of their disempowerment. (p. 36)

Although there is some recognition that forensic clients have extensive histories of victimization and trauma, the effects of those experiences are not always well understood by professionals who work with these clients (Richardson et al., 2012). Therefore, increasing awareness of the impact of trauma and providing training to forensic staff concerning how to effectively respond to the trauma-related needs of their clients is an important first step towards trauma-informed forensic mental health services. Training must distinguish between *trauma-specific* and *trauma-informed* approaches, so that it is clear to forensic treatment staff that trauma-informed ways of working with clients are not equated with trauma therapy. As Miller and Navajits (2012) have argued, "trauma-informed principles are helpful regardless of whether the institution chooses to make trauma-specific clinical intervention available" (p. 6).

The gendered nature of victimization and trauma provides an opportunity for staff to learn about important differences between women's and men's vulnerability to victimization and the effects of trauma (Miller & Najavits, 2012). Training should incorporate self-care strategies to ensure that staff are aware of the potential for secondary traumatic stress, and managers and supervisors can better support staff (Miller & Najavits, 2012). Trauma-informed training may also provide survivors with a voice to share their experiences of victimization and trauma, and what they perceive to be helpful for their recovery (Miller & Najavits, 2012). The involvement of survivors is fundamentally important in trauma-informed approaches and may be empowering in a system that is inherently disempowering.

The study findings that emerged with respect to the challenges faced by forensic mental health professionals in addressing issues of victimization and trauma with women clients in many ways mirrored the ethical concerns associated with conducting trauma-focused research. For example, just as staff participants were concerned about re-traumatizing and de-stabilizing their clients by asking about their experiences of victimization and trauma, or felt that they lacked the training to deal with women's

reactions, so too are researchers concerned about causing harm to participants involved in trauma-focused research and dealing with distress experienced by participants in the course of research participation. Yet, findings from the ethics component of the study suggest that women in the forensic mental health system derived benefit from sharing their stories, despite the personal nature of the questions and unanticipated emotional reactions. This evidence may inform the provision of forensic mental health services, although the confidential nature of the research may provide a sense of safety that is unlikely to be achieved in forensic settings.

The study also gave voice to women forensic clients who, by all accounts, are often silenced in the forensic mental health system where they are disempowered and their experiences of victimization and trauma are considered to be illegitimate, or worse, remain invisible. Participating in the study provided women with a confidential, and therefore, safe environment to tell their stories, an experience that most participants reported as positive and beneficial.

Findings from the ethics component of the Trauma Recovery Study suggest that, despite emotional reactions from participants, trauma-focused research is considered by female forensic inpatients and outpatients to be beneficial, with the overwhelming majority of participants indicating that they would participate in the study again if given the opportunity. The qualitative data revealed that despite physiological and psychological reactions in the course of the research interview, women in the forensic mental health system experience little distress as a result of telling their stories of victimization and trauma. These findings may be explained in part by the fact that the women have told their stories to professionals on numerous occasions or have developed an emotional 'distance' from their traumatic experiences over time. Women articulated a number of benefits associated with participation in trauma-focused research, including trauma recovery through the telling of their stories, and helping other women who have experienced victimization and trauma and are receiving services in the forensic mental health system. This suggests that participation in trauma-focused research may provide therapeutic benefits that are not readily available in the forensic mental health system.

Participation in trauma-focused research may also give voice to women survivors who have been silenced, and clients noted that the confidential nature of research was critically important to feeling safe as a research participant. It is perhaps not surprising

that participants reported positive reactions to participating in the Trauma Recovery Study given that 'telling the story of trauma' is a central aspect of the recovery process (Herman, 1992b). Not all participants described their experiences in great detail, as they were given control over the interview process, to tell their story in their own way. The qualitative interview methods employed in the study may have been a factor in participants' positive reactions, given previous research findings that interview methods are associated with greater perceived benefits in trauma-focused research than surveys, despite the fact that they may be more in-depth and emotional (DePrince & Chu, 2008). I agree that qualitative methods may be more suitable than quantitative methods for trauma-focused research with vulnerable populations, in part because qualitative approaches give participants more control over the research process, and thereby may minimize the risk of harm.

## **9.1 Strengths and Limitations**

The Trauma Recovery Study had a number of strengths, and some important limitations that should be considered when interpreting the results and applying the research in forensic mental health settings. The study shed light on the layered experiences of victimization and trauma among women in the forensic mental health system, and the challenges in responding to trauma-related issues in this system. The greatest strength of the study was that the qualitative interviews elicited rich narratives and revealed the complexities of women's lived experiences of victimization and trauma, and the barriers to trauma-informed approaches in forensic mental health services. The client interviews gave voice to a vulnerable and disenfranchised group of women whose experiences of victimization and trauma are often silenced in the forensic mental health system. The ethics component gave the women an opportunity to have their voices heard with respect to their experiences as research participants as well, and generated important evidence concerning the benefits and harms of opening up about their experiences of victimization and trauma in the context of research.

The term 'trauma' was not defined in the consent or interview process, but rather the meaning of this term was left to the women themselves to explain. This approach was both a strength and a limitation of the study. It was a strength in that women's own understandings of what 'trauma' meant to them, and all the experiences that they themselves considered to be 'traumatic,' were included in the analysis. This approach



allowed for more women's voices to be heard, as the study was not limited to women who had a PTSD diagnosis. Given that PTSD is often under-diagnosed and misdiagnosed in the criminal justice and mental health systems, more narrow inclusion criteria would likely have resulted in the exclusion of many women who had been exposed to trauma but whose experiences had not been reported or identified, or whose responses had not reached clinically significant levels. On the other hand, the broad inclusion of all self-reported trauma was also a limitation in that overly broad conceptualizations of trauma mean that many different experiences, of varying degrees of severity, were included under the same umbrella, making responses to the issue more complex and less straightforward.

Individuals invited to participate in the study had to identify themselves as fitting within the inclusion criteria. That is, they had to identify themselves as women who had 'experienced violent victimization, trauma or abuse,' had 'come into conflict with the law,' and were 'receiving forensic mental health treatment services.' Therefore, women who did not identify their experiences as 'victimization,' 'trauma,' or 'abuse' may not have considered participating in the study. Some women identify more with the language of 'survivor' than 'victim' or may not have felt that their experiences of victimization were sufficiently severe to be considered 'trauma,' a term not defined by the researcher. Some may not have been aware of their legal or treatment status, and therefore not have identified themselves as meeting the inclusion criteria. It is also possible that some trans-individuals did not identify as fitting within the limited category of 'women' and chose not to participate as a result. In fact, the sample was quite broad and inclusive, which had limitations for the analysis of the data and comparison of different sub-groups of participants at different social locations (e.g., Aboriginal women, immigrant women, older women, women living in rural areas).

The staff sample was limited to individuals who had experience working with women clients. The small proportion of female clients accessing forensic mental health services may have limited the number of staff participants eligible to participate in the study. Staff were reminded that they did not have to have extensive trauma-related knowledge or experience in order to participate. Yet, given the nature of the study, it is possible that the staff sample was biased towards forensic mental health professionals who were well versed in gender, diversity, and trauma and who felt that these were important factors to consider in treatment delivery with women clients. The potential

selection bias may have affected the findings of the study, if those staff who did participate saw themselves as different from the majority of staff concerning the issues explored in the study.

Time constraints and competing priorities may also have dissuaded some interested staff from participating in the study. For example, it was very difficult to engage psychiatrists and psychologists, despite numerous attempts to include them. The small number of participants from these disciplines in the staff sample limited my ability to draw comparisons between the perspectives of different groups of staff. It would have been very useful to have a larger sample of psychiatrists in the study, given that other staff (e.g., nurses, social workers) made so many claims about psychiatrists and their power over clients and other staff within the forensic mental health system.

Potential client participants who contacted the researcher about participating in the study were asked to give permission for the researcher to confirm with a member of their treatment team that they had the capacity to provide research consent. Any potential participants who did not want their treatment team to know that they had a history of victimization or trauma may have opted out at this point in the recruitment process. However, although this step could have deterred some clients from participating in the study, no potential participants refused to give permission to the researcher to contact a member of their treatment team. It is still possible that some individuals who did not want to risk disclosing a history of victimization or trauma may have chosen not to contact the researcher or participate in the study in the first place. As well, clients who were not willing to discuss their experiences of victimization and trauma because the memories were too emotionally distressing, may have elected not to participate. This may explain the findings from the ethics component, which suggested that participation in the study was experienced as positive and beneficial. Had the sample included women with more severe traumatic experiences or trauma-related symptoms, the ethics component may have yielded different results.

Another limitation of the study was that clients' experiences of victimization and trauma were self-reported and retrospective, and the design did not include a review of client participants' forensic files. It was therefore impossible to independently corroborate participants' self-reported trauma, criminal histories, and psychiatric diagnoses with reports from other sources, including forensic psychiatry, nursing, and social work notes, school and medical records, or interviews with family members. Information that relied

on self-reports rather than official records included current legal status, history of criminal justice involvement, including incarceration, and past and current diagnoses, including PTSD. Reviews of forensic records would also have served to triangulate staff claims about the over- or under-diagnosis of PTSD among female clients, and the purported lack of attention to trauma-related issues. Information about trauma-related histories, problems, or diagnoses (or the lack thereof) would all have been useful information to capture in the research in order to enhance the accuracy of the findings from client and staff interviews.

Obtaining information about participants' family history, mental health diagnoses, criminal convictions, and previous encounters with the criminal justice and mental health systems from charts would have assisted in mapping women's pathways to forensic mental health services, and would have allowed more time in the interview to focus on the meaning of their experiences. On the other hand, chart reviews are limited in that they reflect the official, documented version of women's experiences, and obtaining the women's consent to review their forensic charts may have damaged rapport and trust. Regardless of whether demographic and historical data were derived from interviews or charts, in the future, this information should be collected more systematically to enhance its utility in the data analysis process and interpretation of the findings.

Another possible limitation of the study is that client participants were only interviewed once. In feminist research, it may be advantageous to conduct multiple interviews to achieve greater depth through the development of trust and rapport (Oakley, 1981). On the other hand, it has been argued that interviewing about sensitive topics should be limited to a single session so that participants, knowing they will never have to face the researcher again, will not be inhibited about disclosing private or deeply personal information (Brannen, 1988). A similar limitation of the ethics component of the study was that reactions to research participation were only measured at one time point (i.e., immediately following the semi-structured face-to-face interview).

As well, clients returned the *Reactions to Research Participation Questionnaire* (RRPQ) to me directly after they had completed the survey form. Although it was completed in my absence, and returned to me in a sealed envelope, it is possible that participants reported overall positive experiences because they were aware that I would see their responses, and because they had built a relationship with me. That is, there is a possibility that their responses may have been more honest if this information had

been gathered by someone other than the researcher. However, the positive responses to the open-ended questions on the RRPQ do suggest that some participants genuinely valued the experience of participating in the study. It is possible that participants were more likely to refrain from articulating negative responses when asked in the face-to-face interview. Only a few participants noted negative reactions, and these were generally limited to observations on physiological and psychological processes that were experienced when recalling traumatic events and that would have been invisible to me as a researcher. These insights were important and would not have been captured in the questionnaire, illustrating the benefits of a triangulated approach with multiple methods.

## **9.2 Directions for Future Research**

Future research on victimization and trauma in forensic mental health settings should explore and compare the experiences of men and women clients, to advance knowledge about gender differences in their trauma-related experiences and needs. This will inform the development of gender-informed and trauma-informed approaches in forensic mental health. While victimization and trauma are gendered issues, and women receiving forensic mental health services are more likely to have histories of victimization (Nicholls et al., 2011), there are many men in the forensic mental health system who have experienced victimization and trauma, and developing gender-informed responses to their needs will require further exploration of their experiences and needs.

Trauma-focused research with women in the forensic mental health system could benefit from a deeper exploration with more homogeneous samples (e.g., Aboriginal women, immigrant women, women involved in the sex trade) to better understand their unique experiences of victimization and trauma, and their specific needs with respect to these issues so that forensic treatment staff are better able to reduce the risk of re-traumatizing these women in the delivery of services, to promote their recovery, and to improve their safety.

Research with psychiatrists (i.e., an exploration of the powerful) in the forensic mental health system would help to uncover the complexities of their work with clients in the system, and to explore the difficulties in responding to clients' trauma-related needs. This would be particularly useful with respect to those clients who are even more silenced due to specific psychiatric diagnoses (e.g., Borderline Personality Disorder) or symptoms (e.g., delusional beliefs).

Research could also be conducted with Research Ethics Board (REB) members to better understand how decisions are made with respect to trauma-focused research, in order to determine how empirical evidence on the harms and benefits of trauma-focused research informs ethical decision-making. Researchers conducting trauma-focused studies should continue to include measures of research participants' reactions to better understand the specific topics and issues that are most likely to produce an adverse reaction (e.g., sexual violence, suicide, apprehension of children), the characteristics and situational factors that render participants particularly vulnerable to adverse reactions (e.g., psychiatric symptomatology, type and recency of traumatic experience, multiple victimization), and the research methods and circumstances that are most likely to produce adverse reactions (e.g., paper-and-pencil questionnaires, face-to-face interviews, gender of interviewer).

Ideally, participants' reactions to participation in trauma-focused research should be measured at multiple time points in order to understand not only immediate adverse reactions to research participation, but also those that emerge some time after participation (e.g., six weeks or six months later). Reactions should also be measured using multiple methods, including quantitative questionnaires and qualitative interview questions, in order to gain a fuller picture of the experiences of research participants. Finally, intersectional analyses of participants' reactions to research participation may help to advance knowledge about the ethics of trauma-focused research. Researchers should aim to understand how intersecting inequalities (e.g., gender, mental illness, culture) may contribute to or exacerbate participant vulnerability to adverse reactions as a result of research participation.

A critical next step in this area is the translation of research into forensic mental health policy and practice. The development and piloting of gender- and trauma-informed training is an important first step towards services that address the trauma-related needs of women in the forensic mental health system. If forensic services are to adopt trauma-informed approaches, they will need to be adapted for forensic settings and rigorously evaluated to ensure that the services are meeting their intended goals and the needs of this vulnerable and diverse population of clients. Moving towards trauma-informed forensic mental health services involves not just the training of treatment staff, but a fundamental re-thinking of policies and practices, from policies concerning the use of seclusion to hiring practices, at the organizational level and at the

systems level. This shift towards a trauma-informed forensic mental health system should involve women forensic clients themselves at all stages in order to remain true to the principles and trauma-informed approaches and to provide women survivors with a voice.

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## **APPENDICES**

## Appendix A: Recruitment Poster – Clients



### TRAUMA RECOVERY STUDY

Are you a **woman** (19 years or older) who

- has experienced **violent victimization, trauma or abuse,**
- has come into **conflict with the law,** and
- is receiving **forensic mental health treatment services?**

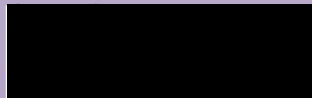
**YES?** You are invited to participate in a **research interview** about the experiences and needs of women who have experienced victimization or trauma in their lives and who are receiving forensic mental health services.

You will be **paid for participating** in the study.

Please **contact the researcher** to learn more about the project and to decide if you would like to participate.

#### **RESEARCHER:**

Katherine Rossiter



## Appendix B: Recruitment Letter – Staff

Dear [Name]:

You are invited to participate in an interview for a doctoral research project entitled ***Victimization, trauma, and mental health: Women's recovery at the interface of the criminal justice and mental health systems***. The study seeks to explore the experiences and perspectives of forensic mental health professionals and their clients concerning issues of victimization, trauma, and recovery. The research aims to inform forensic mental health policy and practice, and explores three specific research questions:

1. What are the experiences of victimization and trauma of women in contact with the forensic mental health system? What are their needs for trauma recovery?
2. What challenges do forensic mental health professionals face in addressing issues of victimization and trauma in the lives of their clients? What supports are in place to assist them in addressing these issues and reduce the risk of secondary traumatic stress?
3. What are the reactions of women forensic mental health clients to participation in trauma-focused research?

Your participation in the study would involve a 30–60 minute interview with the researcher, by telephone or in person, at your convenience. I will follow-up by telephone in the coming weeks to answer any questions you may have about the research and your potential participation in the study. If you would be interested in participating in the research, please contact me at your earliest convenience to schedule a meeting. You are welcome to forward information about the study to colleagues who may be interested in participating in a research interview.

This study is being conducted as part of a graduate program in the School of Criminology at Simon Fraser University. The research has been approved by the FPSC Research Committee and the Research Ethics Board at Simon Fraser University. Any information shared with the researcher in the interview will be maintained in confidentiality, and no identifying information will be shared in reports of the findings of the study.

If you have any questions about the study, or your involvement in the research, please do not hesitate to contact me by email [REDACTED] and I will get back to you by email or telephone to answer your questions.

Thank you for your consideration.

## **Appendix C: Consent Form – Clients**

### **TITLE OF RESEARCH PROJECT**

*Victimization, Trauma, and Mental Health: Women's Recovery at the Interface of the Criminal Justice and Mental Health Systems* (Short title: Trauma Recovery Project)

### **PRINCIPAL INVESTIGATOR**

Katherine Rossiter, M.A. (Ph.D. Student)  
School of Criminology, Simon Fraser University  
Email: [REDACTED] / Phone: [REDACTED]

### **PURPOSE OF THE STUDY**

The purpose of the study is three-fold: (1) to improve our understanding of the experiences and needs of women in contact with forensic mental health services with regard to victimization, trauma, and recovery; (2) to explore the perceived role of forensic mental health professionals in addressing these issues in the lives of their clients, and identify the existing challenges and opportunities to do so; and (3) to determine the reactions of women forensic clients to participating in trauma-focused research.

### **PARTICIPANT INVOLVEMENT**

You are invited to participate in a face-to-face interview, to be conducted by the Principal Investigator, at your convenience. The interview may last between 1 and 3 hours, and may involve two sessions, at your request or with your permission. The first part of the interview will ask about your background, your experiences in the mental health and criminal justice systems, and your experiences of victimization and trauma. The second part of the interview will ask about your experiences as a research participant in this study. You may share as much, or as little, as you feel comfortable sharing.

In order to ensure that your best interests are protected, a member of your treatment team (e.g., psychiatrist or case manager) has been asked to acknowledge that you are capable of providing informed consent to participate in this study. Your participation in this study is voluntary. Your decision to participate, or not to participate, will have no effect on clinic or legal decisions that are made about you concerning your care, treatment, or legal status. You may choose to terminate the interview and/or withdraw from the study at any time without penalty and without any consequences for your care or treatment.

## **RISKS OF THE STUDY**

Questions may be asked that you feel are personal, embarrassing, emotionally distressing, and/or difficult to answer. You may choose not to answer these, or any, questions during the interview, and can 'pass' any question that you do not feel comfortable answering. As I mentioned before, you may share as much, or as little, as you feel comfortable sharing. You may also take breaks at any time during the interview and/or request to complete the interview in two or more sessions. It is possible that you may become distressed or anxious during the interview. In the event that you do become upset or anxious, the researcher conducting the interview will talk to you about being referred to a member of your treatment team for support in dealing with these feelings. You will also be offered information about community-based services that provide specialized supports to women who have experienced violence and trauma.

There are no other known risks to you for participating in this study.

## **BENEFITS OF THE STUDY**

You will be paid \$50.00 for participating in the interview. If the interview is conducted over more than one session, you will be paid \$20.00 following the first session and the remaining \$30.00 following the second session.

Information gathered for the study may help to improve forensic mental health services for women with histories of victimization and trauma who come into conflict with the law and are referred to forensic psychiatric services. It may also help to improve the way that researchers conduct trauma-focused research with women in the future.

## **STATEMENT OF CONFIDENTIALITY**

The information gathered for this study will maintain confidentiality of your name and the contributions you have made to the full extent permitted by law. The researcher is legally required to report incidents of current or ongoing child abuse or neglect, threats of harm to yourself, or threats of harm to others, but all other information shared with the researcher will be considered confidential and will not be shared with your treatment team. Your identity will be protected and no information revealing your identity will be disclosed or published in any reports of the study. All documents will be identified only by a code number or pseudonym selected by the participant. Interviews will be digitally recorded, on a password-protected voice recorder, and the digital files will be erased immediately following transcription of the interviews. The Principal Investigator will transcribe the interviews and no one but the researcher will have access to the research data. Electronic documents will be protected with passwords known only to the researcher, and all other documents will be kept in a secure office at Simon Fraser University.

## **INFORMATION ABOUT THE STUDY**

The Principal Investigator is a doctoral student in the School of Criminology at Simon Fraser University, and the research is being conducted in partial fulfillment of the requirements of the doctoral degree. The research has been approved by the Forensic Psychiatric Services Commission (FPSC) Research Committee and the Research Ethics Board at Simon Fraser University.

If you have any questions about the study, or the results of the study, you may contact the Principal Investigator, Katherine Rossiter [REDACTED]. You may also contact the researcher's Senior Academic Supervisor, Dr. Simon Verdun-Jones [REDACTED] or the Director of the School of Criminology, Dr. Robert Gordon [REDACTED].

## **CONCERNS ABOUT THE STUDY**

If you have any questions or concerns about your rights as a research participant, you may contact Dr. Hal Weinberg, Director, Office of Research Ethics at Simon Fraser University [REDACTED].



## CONSENT TO PARTICIPATE IN THE STUDY

- I have read and understood the information about this study, and understand the risks and benefits of participating in the study.
- I understand that my participation is voluntary and that I may choose to terminate the interview and/or withdraw from the study at any time, without any implications for my care, treatment, or legal status.
- I understand that all of the information gathered for the study will remain confidential, and that the data will be secured and accessible only to the Principal Investigator.
- I have had the opportunity to ask questions about the study and have received satisfactory answers.
- I understand that, by signing below, I am not waiving any legal rights, and that I will receive a copy of the signed consent form for my records.

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Participant's name (print)

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Date

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Participant's signature

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Researcher's name (print)

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Date

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Researcher's signature

## **Appendix D: Consent Form – Staff**

### **TITLE OF RESEARCH PROJECT**

*Victimization, Trauma, and Mental Health: Women’s Recovery at the Interface of the Criminal Justice and Mental Health Systems* (Short title: Trauma Recovery Project)

### **PRINCIPAL INVESTIGATOR**

Katherine Rossiter, M.A. (Ph.D. Student)  
School of Criminology, Simon Fraser University  
Email: [REDACTED] / Phone: [REDACTED]

### **PURPOSE OF THE STUDY**

The purpose of the study is three-fold: (1) to improve our understanding of the experiences and needs of women in contact with forensic mental health services with regard to victimization, trauma, and recovery; (2) to explore the perceived role of forensic mental health professionals in addressing these issues in the lives of their clients, and identify the existing challenges and opportunities to do so; and (3) to determine the reactions of women forensic clients to participating in trauma-focused research.

### **PARTICIPANT INVOLVEMENT**

You are invited to participate in a 30–60 minute interview, to be conducted by the Principal Investigator, by telephone or in person, at your convenience. Interview questions will ask about your position and educational/employment background, your experiences in dealing with clients who have histories of victimization and trauma, your perceptions of the role of your organization in addressing these issues, and the supports and barriers that influence your capacity to do so. Your organization has been asked for approval of your participation in this study, and has approved the participation of staff. Your participation in the study is voluntary and you may choose to terminate the interview and/or withdraw from the study at any time without penalty.

### **RISKS OF THE STUDY**

There are no known risks associated with participating in the study.

## **BENEFITS OF THE STUDY**

You will be offered a small token of appreciation for participating in the study. Information gathered for the study may also help to improve forensic mental health policy and services, and the development of resources to further support forensic mental health professionals in the course of their work with clients.

## **STATEMENT OF CONFIDENTIALITY**

The information gathered for this study will maintain confidentiality of your name and the contributions you have made to the full extent permitted by law. Your identity will be protected and no information revealing your identity will be disclosed or published in any reports of the study. All documents will be identified only by a code number or pseudonym selected by the participant. Interviews will be digitally recorded, on a password-protected voice recorder, and the digital files will be erased immediately following transcription of the interviews. The Principal Investigator will transcribe the interviews and no one but the researcher will have access to the research data. Electronic documents will be protected with passwords known only to the researcher, and all other documents will be kept in a secure office at Simon Fraser University.

## **INFORMATION ABOUT THE STUDY**

The Principal Investigator is a doctoral student in the School of Criminology at Simon Fraser University, and the research is being conducted in partial fulfillment of the requirements of the doctoral degree. The research has been approved by the Forensic Psychiatric Services Commission (FPSC) Research Committee and the Research Ethics Board at Simon Fraser University.

If you have any questions about the study, or the results of the study, you may contact the Principal Investigator, Katherine Rossiter [REDACTED]. You may also contact the researcher's Senior Academic Supervisor, Dr. Simon Verdun-Jones [REDACTED] or the Director of the School of Criminology, Dr. Robert Gordon [REDACTED].

## **CONCERNS ABOUT THE STUDY**

If you have any questions or concerns about your rights as a research participant, you may contact Dr. Hal Weinberg, Director, Office of Research Ethics at Simon Fraser University [REDACTED].

## CONSENT TO PARTICIPATE IN THE STUDY

- I have read and understood the information about this study, and understand the risks and benefits of participating in the study.
- I understand that my participation is voluntary and that I may choose to terminate the interview and/or withdraw from the study at any time.
- I understand that all of the information gathered for the study will remain confidential, and that the data will be secured and accessible only to the Principal Investigator.
- I have had the opportunity to ask questions about the study and have received satisfactory answers.
- I understand that, by signing below, I am not waiving any legal rights, and that I will receive a copy of the signed consent form for my records.

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Participant's name (print)

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Date

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Participant's signature

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Researcher's name (print)

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Date

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Researcher's signature

## **Appendix E: Interview Schedule – Clients**

*The purpose of this research is three-fold: First, the research aims to better understand the needs of women at the interface of the criminal justice and mental health systems concerning issues of victimization and trauma. Second, it aims to determine the role of forensic mental health professionals in addressing these issues, as well as the supports and barriers that affect their capacity to do so. A third objective is to explore the impact of trauma-focused research on study participants, in this case women clients in the forensic mental health system. Your participation will help to advance knowledge about clients' experiences and needs with respect to issues of victimization and trauma, and will help to improve how researchers study these issues.*

### **Background and Experiences**

1. Can you tell me a bit about yourself (growing up, childhood, adulthood)?
2. How did you come to be involved with the forensic mental health system?
  - a. Have you had previous contact with community mental health services or been in a psychiatric hospital?
  - b. Have you ever been diagnosed with a mental disorder or illness?
  - c. What involvement have you had with the criminal justice system (arrests, convictions, imprisonment)?
3. How have you experienced victimization and trauma in your lifetime?
  - a. What age(s) were you when you experienced violence?
  - b. What type(s) of violence/trauma have you experienced (physical/sexual/emotional)?
  - c. What was the context of the victimization (community/institution)?
  - d. Who committed this violence (positions/roles of perpetrators)?
  - e. What was the worst experience?
  - f. How have your experiences of victimization and trauma affected you (e.g., identity, interpersonal relationships, mental health)?
  - g. How have your gender, race, ethnicity, culture, religion, income, education, sexuality, age, and/or ability have influenced your vulnerability to, experiences of, and/or recovery from victimization and trauma?

4. From your perspective, how are your experiences of victimization and trauma related to your involvement with the mental health and criminal justice systems?
  - a. How has your involvement with the mental health and criminal justice systems affected your healing and recovery from trauma?

*(Interviewees are invited to create a timeline of their experiences of victimization and trauma, as well as their involvement with the criminal justice and/or civil/forensic mental health systems, with the dual purpose of clarifying dates and improving reliability.)*

### **Treatment in the Forensic Mental Health System**

5. What do you typically talk about when you meet with your treatment team?
  - a. What specific areas does your treatment team focus on or talk about when they meet with you? What are their priorities and goals?
  - b. What specific areas would you like to talk about when you meet with your treatment team? What are your priorities and goals?
6. Has anyone in forensic psychiatric services asked you about your experiences of victimization and trauma (perhaps in your first, or subsequent, appointments)?
  - a. Is your treatment team aware of your experiences of victimization and trauma?
  - b. How much have you discussed your experiences of victimization and trauma with your treatment team?
  - c. In what ways is the forensic psychiatric system a safe place to discuss/address victimization and trauma?
  - d. In what ways is it not a safe place to discuss/address victimization and trauma?
7. Have you ever been diagnosed with Post-traumatic Stress Disorder (PTSD)? Borderline Personality Disorder (BPD)?

- a. If so, what has this diagnosis meant for you and your treatment/recovery?
8. What do you do to cope with the effects of victimization and trauma in your life?

### **Trauma-Specific and Trauma-Informed Approaches**

9. What specific services and supports have been offered to you, by your treatment team, to deal with the effects of victimization and trauma (e.g., specific treatments, emotional support, referrals to community-based organizations/agencies)?
- a. Have you accessed any of these services or supports? Why/why not?
  - b. Were these services able to offer you the kind of support you needed?
  - c. If you have been referred to community-based services that support individuals who are dealing with victimization and trauma, how appropriate did you feel these services were for you, given your gender, ethnicity, race, culture, religion, sexuality, age, income, education, mental health status, and/or criminal justice status?
10. What, in the forensic psychiatric system, has helped to reduce your trauma-related symptoms and/or support your recovery (e.g., medication, therapy, relationships)?
11. What, in the forensic psychiatric system, has made your trauma-related symptoms worse and/or had a negative effect on your recovery (e.g., restraint, seclusion)?
12. What do you think your treatment team could/should do to address your experiences of victimization and trauma?
13. If you were to imagine a forensic mental health system that was responsive to the intersections of trauma, mental health, and criminal justice issues, how would the system be different from the current system?

14. What do you feel you need to help you recover and heal from your experiences of victimization and trauma?
- What services and/or supports have been helpful so far?
  - What services and/or supports have not been helpful so far?
  - What services and/or supports do you think would be most helpful?

### **Ethics of Trauma Research**

*We've now completed the first part of the interview. The purpose of the second part of the interview is to explore your reactions to participating in the interview. In this section, I will ask you questions about your experiences as a participant in this research project. The purpose of this section is to determine the positive, negative, and neutral effects of trauma-focused research on participants, such as yourself, and to improve how future research on victimization and trauma is conducted.*

15. What it was like for you to participate in the interview today? How do you feel about having participated in the research?

*Now I would like to ask you some fixed-response questions about your reactions to participating in this research. For each question, please answer with one of the following five response options: Strongly Disagree (No), Disagree, Neutral (Maybe), Agree, or Strongly Agree (Yes). Please be as honest as possible in your responses. Hand interviewees a copy of the questionnaire to follow along, and verbally administer the Reactions to Research Participation Questionnaire (RRPQ). I would now like to ask you some further questions about your experiences as a participant in the research:*

16. What would you consider to be the positive aspects, or benefits, of participating in trauma-focused research interviews like this one?
17. What would you consider to be the negative aspects, or drawbacks, of participating in trauma-focused research?
18. Do you think your reactions to participating in the research might have been related to being a woman, your mental health status, and/or your involvement with the criminal justice system?



19. Do you have any concerns about your participation in the research? **OR**  
What could researchers do to work better with women who participate in research?

### **Concluding Questions**

20. Is there anything you feel was not addressed in the research that should have been included or discussed?
21. Is there anything else you would like to add?
22. May I contact you if I have any further questions, or wish to clarify anything you have said in the interview today?
- a. What would be the best way/time for me to reach you?
  - b. Do you have any concerns about your safety if I were to contact you? *(Develop unique protocol for contacting each client re: identifying myself, naming the study, leaving voice messages, etc.)*
23. Would you like to select a pseudonym for the study?

*Thank you for taking the time to share your thoughts and experiences with me. Before you go, I'd like to give you an opportunity to ask any further questions you might have about the study, or your involvement in it (provide time to ask/answer questions). Leave interviewees with my contact info so they can contact me if they have anything to add.*

## **Appendix F: Interview Schedule – Staff**

*The purpose of this research is three-fold: First, the research aims to better understand the needs of women at the interface of the criminal justice and mental health systems concerning issues of victimization and trauma. Second, it aims to determine the role of forensic mental health professionals in addressing these issues, as well as the supports and barriers that affect their capacity to do so. A third objective is to explore the impact of trauma-focused research on study participants, in this case women clients in the forensic mental health system. Your participation will help to understand, from a staff perspective, the opportunities and challenges with respect to addressing issues of victimization and trauma among forensic clients.*

### **Description of Position and Training**

1. What is your position and job description? How long have you been in this job?
2. What is the mandate of your organization? What are your priorities in your job?
3. What is your educational background? What is your employment background?
4. What training opportunities have been offered through your employment, concerning issues of victimization and trauma?
  - a. Have you taken advantage of any of these training opportunities? Why/why not?
  - b. What other training have you had related to issues of victimization and trauma, either before or during your employment with this organization?
5. What training opportunities have been offered through your employment, concerning issues of gender and diversity?
  - a. Have you taken advantage of any of these training opportunities? Why/why not?
  - b. What other training have you had related to issues or gender and diversity, either before or during your employment with this organization?

6. How do you personally cope with difficult issues encountered in your work with clients?
7. What supports are available to you within the organization to deal with work-related stress/distress?
8. Are you familiar with the concept of secondary traumatic stress? Have you ever experienced symptoms of secondary traumatic stress in your work? Have you experienced trauma in your own life?

### **Trauma and Victimization in the Lives of Forensic Clients**

9. How would you describe the range of clients you see?
  - a. What is the composition of your client population with respect to gender, race, ethnicity, age, income, education, physical disability, mental health status, and criminal justice status?
10. How would you describe your typical male client? How would you describe your typical female client? What are the key gender differences that affect your work?
11. How are experiences of victimization and trauma captured in routine intake, screening, and/or assessment procedures?
12. What proportion of your female clients have a known history of victimization and trauma?
  - a. What proportion of your clients have a DSM diagnosis of Post-traumatic Stress Disorder (PTSD)? Borderline Personality Disorder (BPD)?
  - b. How would a diagnosis of PTSD or BPD affect your approach or your work with a particular client?
  - c. Do you personally believe that PTSD or BPD is over-/under-/mis-diagnosed in this particular population?
  - d. Are there clients that you suspect might have a history of trauma that has not been reported or identified?
13. How would you describe the victimization and trauma experiences of your clients?

- a. What types of trauma have they typically experienced (e.g., physical, sexual, emotional)?
  - b. When in their lives was the trauma typically experienced?
  - c. What are the gender differences that you notice related to experiences of victimization and trauma in the lives of your clients?
14. How do you think experiences of victimization and trauma affect clients in the forensic mental health system?
- a. How do you think their histories of victimization and trauma relate to their current mental health and criminal justice problems?

### **Trauma-Specific and Trauma-Informed Approaches**

15. What specific programs, interventions, or supports are offered to clients to deal with the psychological and behavioural effects of victimization and trauma?
16. How do you personally see your role in addressing issues of victimization and trauma in the lives of your clients?
- a. In what ways is the forensic psychiatric system a safe place for clients to address victimization and trauma?
  - b. In what ways is it not a safe place for clients to address victimization and trauma?
17. What community-based organizations/agencies do you and your colleagues liaise with or refer clients to for trauma-specific treatment and/or support?
- a. How often do you refer clients to trauma therapy or to others who provide trauma-specific interventions?
  - b. What feedback have you received from clients about these referrals?
18. What specific policies, procedures, and practices, within the forensic mental health system, do you think help to reduce the trauma-related symptoms and behaviours of forensic clients, and promote recovery from trauma (e.g., medication, therapeutic relationships)?

- a. What specific policies or procedures are in place for working with clients who have histories of victimization and trauma?
19. What specific policies, procedures, and practices, within the forensic mental health system, do you think might exacerbate the trauma-related symptoms and behaviours of forensic clients, or impede recovery from trauma (e.g., seclusion, restraint)?
20. From your perspective, what are the specific needs of women forensic clients who have histories of victimization and trauma have?
- a. What are the main organizational/institutional and individual barriers to addressing these needs?
21. In your opinion, what do you consider to be the advantages of dealing with victimization and trauma in the lives of forensic clients?
- a. What are the implications of not addressing issues of victimization and trauma in the lives of forensic clients?
22. If you were to envision a forensic mental health system that was responsive to the intersections of trauma, mental health, and criminal justice issues, how would the system be different from the current system?
- a. Who would you identify as potential 'champions' for organizational change towards a trauma-informed forensic mental health system?

### **Concluding Questions**

23. Is there anything else you would like to add?
24. May I contact you if I have any further questions, or wish to clarify anything you have said in the interview today?
- a. What would be the best way/time for me to reach you?
25. Is there anyone in particular within the organization (in front-line and/or administrative positions) that you think I should connect with or interview for the study?

*Thank you for taking the time to share your thoughts and experiences with respect to these issues of victimization and trauma. Leave interviewees with my contact info so they can pass it on, or contact me if they have anything to add.*

## Appendix G: Questionnaire – Clients

### Reactions to Research Participation Questionnaire Revised (Newman, Willard, Sinclair, and Kaloupek, 2001)

**This questionnaire asks for your opinions about what it was like for you to participate in this study. Your responses will be used to help us understand more about what it is like to be a research participant.**

- I. From the list below, please rank the top three reasons why you decided to participate (1 = most important, 2 = second most important, 3 = third most important).

<input type="text"/> I was curious	<input type="text"/> Felt I had to
<input type="text"/> To help others	<input type="text"/> For the money
<input type="text"/> To help myself	<input type="text"/> I didn't want to say no
<input type="text"/> I don't know	
<input type="text"/> Thought it might improve my access to health care	
<input type="text"/> Other – Please explain _____	

- II. The following questions deal with your reactions to participating in this study. Please circle the number that best describes your response.

Question	Strongly Disagree (No)	Disagree	Neutral (Maybe)	Agree	Strongly Agree (Yes)
1. I gained something positive from participating.	1	2	3	4	5
2. Knowing what I know now, I would participate in this study if given the opportunity.	1	2	3	4	5
3. The research raised emotional issues for me that I had not expected.	1	2	3	4	5
4. I gained insight about my experiences through research participation.	1	2	3	4	5
5. The research made me think about things I didn't want to think about.	1	2	3	4	5
6. I found the questions too personal.	1	2	3	4	5
7. I found participating in this study personally meaningful.	1	2	3	4	5
8. I believe this study's results will be useful to others.	1	2	3	4	5

Question	Strongly Disagree (No)	Disagree	Neutral (Maybe)	Agree	Strongly Agree (Yes)
9. I trust that my replies will be kept private.	1	2	3	4	5
10. I experienced intense emotions during the research session and/or parts of the study.	1	2	3	4	5
11. I think this research is for a good cause.	1	2	3	4	5
12. I was treated with respect and dignity.	1	2	3	4	5
13. I found participating beneficial to me.	1	2	3	4	5
14. I was glad to be asked to participate.	1	2	3	4	5
15. I like the idea that I contributed to science.	1	2	3	4	5
16. I was emotional during the research session.	1	2	3	4	5
17. I felt I could stop participating at any time.	1	2	3	4	5
18. I found participating boring.	1	2	3	4	5
19. The study procedures took too long.	1	2	3	4	5
20. Participating in this study was inconvenient for me.	1	2	3	4	5
21. Participation was a choice I freely made.	1	2	3	4	5
22. Had I known in advance what participating would be like I still would have agreed to participate.	1	2	3	4	5
23. I understood the consent form.	1	2	3	4	5

**Other comments on your experience as a research participant in this study:**

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