“HURT PEOPLE” IN THE COURTROOM: AN EXAMINATION OF OFFENDER PTSD IN CANADIAN CRIMINAL CASES

by

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ABSTRACT

A rapidly growing body of interdisciplinary literature is helping to elucidate the complex biopsychosocial effects of post-traumatic stress disorder (PTSD). While PTSD is relatively common among incarcerated individuals, there is a dearth of research examining the disorder's impact in Canadian courtrooms. Accordingly, this research examines judgments in 122 criminal cases in which PTSD was raised with respect to the accused. An examination of the legal defences employed uncovers inconsistencies in the evaluation of criminal liability of individuals with PTSD. Patterns in expert testimony are also explored. An analysis of sentencing reveals that PTSD is often treated as a mitigating factor; however, sentencing disparities exist for offenders with the disorder, which appear to be related to judges' differing interpretations of a key sentencing concept. Optimal approaches to treating PTSD are contrasted with what is currently available in the criminal justice system, and recommendations for addressing PTSD in this context are offered.

Keywords: Post-traumatic stress disorder; PTSD; mentally disordered offenders; sentencing; expert testimony; trauma therapy

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1. INTRODUCTION

In her 1997 book, *Creating Sanctuary: toward the Evolution of Sane Societies*, psychiatrist Sandra Bloom called for a recognition that individuals who victimize others often have had experiences of victimization of their own, which may have contributed to their offending behaviour. She argued further that this type of repetition or cycle of violence needed to be acknowledged, because "'hurt people hurt people' with a regularity and predictability that is frightening" (p. 222).

To date, there has been a fair amount of research which supports Bloom's assertion, and finds a link between victimization and offending, and especially violent offending. Lewis et al. (1985), for example, examined the neuropsychiatric records of juveniles who were later charged with murder and compared these records with those of juveniles who were later charged with non-serious to serious, but non-fatal, crimes: they found that "severe" physical abuse was present in the histories of 87.5% of those who had murdered and in 58% of those who committed other types of crime.

In order to examine differences in violent offending behaviour, a widely cited study by Rivera and Widom (1990) used a prospective-cohorts design with a group of 908 participants who had experienced substantiated incidents of physical abuse, sexual abuse, or neglect, compared to a matched control group of individuals who had no substantiated or self-reported incidents of abuse or neglect. These authors found that early childhood victimization significantly increased the risk of violent offending later in life, and that this was especially true for males.

By studying 449 youths aged 14 to 17, drawn from two Florida high schools, Scudder, Blount, Heide, and Silverman (1993) were also able to demonstrate that levels of victimization are higher among young-offender versus control samples. Their research revealed that individuals with delinquency referrals had significantly higher rates of abuse compared to individuals not reported to have been involved in any delinquent behaviour. Conversely, those who had been abused were more likely to have been referred for offending behaviour than those who had no reported history of abuse.

A now-famous study by Caspi et al. (2002) established a role for genetics in the so-called "cycle of violence." These authors made note of the fact that there are differences in response to childhood maltreatment – in other words, it does not consistently lead to criminality, but only heightens the risk of it – and accordingly investigated a possible genetic susceptibility factor. Spurred on by previous research showing that genetic deficiencies in monoamine oxidase A (MAOA) activity were linked to aggressive behaviour, Caspi et al. focussed on the MAOA gene. Using data from a longitudinal study of 442 males, the authors found a gene-environment interaction, such that childhood maltreatment was a significant predictor of four indicators of antisocial behaviour (meeting the criteria for conduct disorder, being convicted of a violent crime, and scores on the Disposition Toward Violence and Antisocial Personality Disorder scales) at age 26 among males with a genotype conferring low MAOA activity, but not among those with a high MAOA activity genotype.

Therefore, research has established that at least some of those who are being processed by the criminal justice system as offenders will have had experiences of victimization of their own. It would thus seem advisable for those working in criminal justice, as well as researchers, to direct attention towards the consequences of

victimization within offending populations. One such relevant category of consequences involves trauma-related psychiatric disorders.

This thesis addresses the most well-known trauma disorder, post-traumatic stress disorder (PTSD), and examines how it is handled by the Canadian courts in criminal cases. In so doing, the thesis attempts to close a gap in the literature, considering that, to date, the interface between this disorder and the criminal justice system has not been studied in any depth.

Chapter 2 provides an overview of the effects of trauma. Many researchers in the area of traumatic stress do not restrict themselves to diagnosable disorders, but instead refer to “trauma,” a term that both encompasses and extends beyond the diagnostic category of PTSD. Therefore, the “trauma” literature is examined in this chapter, with a special focus on PTSD. The psychological and biological impact of traumatic stress on the individual is reviewed, along with the wider social ramifications of trauma.

Chapter 3 sets out the rationale and methodology underpinning this research. First, in order to provide a background for the study of this topic from a trial/sentencing perspective, the chapter reviews research establishing the presence of PTSD in offending populations. Subsequently, the chapter discusses the extant literature relating to PTSD in the courts. A rationale for the present study is provided, and the method used to gather and analyze case law is detailed.

Chapter 4 is divided into a description of the cases examined, and a discussion of the defences raised in the cases examined (a legal analysis). The results of this research are continued in Chapter 5, which contains a discussion of patterns in expert testimony and sentencing (a discourse analysis).

Chapter 6 discusses treatment, comparing and contrasting the “ideal” treatment for PTSD with some of the options currently available to offenders in the criminal justice system. Thereafter, suggestions for preventing PTSD – where applicable – and improving its handling in correctional institutions are offered. This chapter also outlines a “criminal justice framing” of PTSD, which consists of the PTSD-related issues likely to be of greatest interest to criminal justice policymakers.

Chapter 7 draws together the study’s findings and the recommendations made in Chapter 6, and makes some final comments on the nature of PTSD in the courts and in the criminal justice system more generally. Limitations of this work are considered, and avenues for future research in this area are briefly explored.

2. TRAUMA THEORY: UNDERSTANDING CAUSES AND EFFECTS

Trauma theory is a growing body of interdisciplinary knowledge, which is being fed by psychiatrists, clinical psychologists, neuroscientists, physicians, and sociologists, among others. This is a relatively new area of inquiry, developed in response to the effects of combat stress in the aftermath of the Vietnam War: the term “post-traumatic stress disorder” (PTSD) was only incorporated into the psychiatric nomenclature in 1980 (Briere & Scott, 2006). However, the earlier roots of PTSD can be traced to the 19th century Freudian concept of “hysteria,” and to the concepts of “combat neurosis” and “shell shock,” which emerged in the first half of the 20th century, out of World Wars I and II (Kolb, 1993; van der Kolk, Weisaeth, & van der Hart, 2007). Psychiatrist Judith Herman’s *Trauma and Recovery*, published in 1992, is recognized as a seminal text in the trauma area. Along with Bloom’s (1997) *Creating Sanctuary*, Herman’s work helped to elucidate the deleterious impact of severe or chronic stress and to articulate principles relating to treatment and recovery. Today, these psychiatrists, both based in the United States, have been joined by others from many different disciplines and countries in the study of traumatic stress.

Many researchers have chosen to study “trauma” instead of restricting themselves to the diagnostic category of PTSD, which is viewed as one manifestation of trauma. Most researchers are in agreement that trauma (which includes PTSD) is the result of events that either involve “threats to lives or bodies”; feelings of terror or helplessness; an individual’s ability to cope or respond to threat being overwhelmed; a sense of loss of control; or a challenge to a person’s belief that life is “meaningful and

orderly" (Yoder, 2005, p. 10). A more concise definition of trauma, which captures the way that trauma is conceptualized in many books and studies, is offered by Briere and Scott (2006), who propose that "an event is traumatic if it is extremely upsetting and at least temporarily overwhelms the individual's internal resources" (p. 4). This means that trauma-causing events can range from natural disasters to interpersonal violence; from military service to child abuse; from rape to motor vehicle accidents. In addition, according to this definition, an individual does not have to experience an event personally in order for it to be traumatic: seeing a loved one harmed may be equally as overwhelming as having it happen to oneself.

The definitions of trauma set out above are not at odds with the criteria for post-traumatic stress disorder provided in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2000; hereinafter referred to as the DSM-IV TR), which is the authority for psychiatric diagnoses. However, the DSM-IV TR criteria for PTSD have been criticized for being too narrow by some researchers – because of the strict criteria and timeframe applicable in diagnosing PTSD (as outlined shortly), some individuals who are still greatly affected by their traumatic experiences are considered not to have the disorder, and for these individuals the label of "trauma" is used instead (Yoder, 2005).

There are four criteria which have to be met in order for a DSM-IV diagnosis of PTSD to be made. PTSD is set apart from most other psychiatric disorders in the sense that it requires an external traumatic stressor triggering the illness. Specifically, Criterion A in the DSM-IV TR provides that the individual must have been exposed to a traumatic event in which two features were present: 1) actual or threatened death or serious injury, or a threat to the physical integrity of self or others was experienced or witnessed, and 2) the individual's response must have involved "intense fear, helplessness, or horror"

(APA, 2000). Criterion B is that the event is “persistently re-experienced” through intrusive memories, dreams, flashbacks, or distress at stimuli which is reminiscent of the trauma. Criterion C notes that an individual must show numbing or avoidance of stimuli associated with the trauma, and Criterion D outlines “persistent symptoms of increased arousal.” Criteria B, C, and D must persist for more than one month in order for PTSD to be diagnosed (Criterion E), and Criterion F states that there must also be “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2000). The DSM-IV TR provides for two PTSD subtypes: acute, for durations of less than three months, and chronic, for cases lasting more than three months. When PTSD does develop, it is often chronic, persisting for at least one year in an estimated 50 percent of cases (Firestone & Marshall, 2003). PTSD with “delayed onset” is also recognized, and is diagnosed if symptoms do not begin until six months or more after the traumatic event. The full DSM-IV TR diagnostic criteria for PTSD are provided in the Appendix.

Interestingly, Herman (1992) notes that, when PTSD was initially brought into the DSM, then in its third edition (DSM-III; APA, 1980), it was thought that traumatic events were uncommon, and thus the diagnostic criteria for the disorder described traumatic events as “outside of the range of usual human experience.” With time and recognition of the pervasiveness of traumatic events, this description was removed. However, it should be made clear at this point that most individuals exposed to potentially traumatizing events adapt and do not experience long-term psychopathology – Quirk, Milad, Santini and Lebrón (2007) note that only 12% of adults who have had experiences fitting the DSM criteria for PTSD have the corresponding symptoms; similarly, in their discussion of prevalence studies, Ozer, Best, Lipsey, and Weiss (2003) report that prevalence estimates for traumatic events fitting DSM criteria in the general

population range from 50-60%, but the prevalence of lifetime PTSD is generally found to be 5-10%. Many individuals – perhaps 90% – experience PTSD-like symptoms following a traumatic event, but these usually do not persist long enough for the disorder to be diagnosed (Firestone & Marshall, 2003).

The fact that only some individuals develop PTSD has led to a search for factors which may contribute to vulnerability when an individual is faced with a traumatic event. The risk factors which have been discussed in the literature can be divided into several broad categories. The first involves factors relating to characteristics of the traumatic event or stressor itself. It has been found that the intensity and duration of a traumatic event aid in predicting whether one will develop a pathological response: there is evidence of a 'dose-response' relationship where war and natural disasters are concerned, with those receiving more intense exposure being more likely to develop psychopathology (Herman, 1992; Yehuda, 1999). In addition, certain types of traumatic events, especially those involving interpersonal violence, such as combat, torture and sexual abuse, have been found to be more highly associated with the development of PTSD than events such as natural disasters (APA, 2000; Breslau, Kessler, Chilcoat, Schulz, Davis & Andreski, 1998).

Factors relating to the environment or situation in which the event is experienced have also been implicated. Situational variables, including whether the individual was prepared for the event and whether adequate social support was available during and after the event, are also somewhat predictive of the likelihood of developing PTSD (Shalev, 2007a). A recent meta-analysis of seven predictors of PTSD found the peri-traumatic response, and specifically whether an individual dissociates during the traumatic event, to be the most robust predictor of PTSD (Ozer et al., 2003).

Characteristics of those experiencing traumatic events appear to be important as well (Yehuda, 1999). For example, women have been consistently found to have higher rates of PTSD compared to men (Breslau, 2002). Furthermore, individuals of low socioeconomic status and those with pre-existing psychological dysfunction (Briere & Scott, 2006), poor coping skills, or lower intelligence (Bowman & Yehuda, 2004) have been shown to be more likely to display more intense and complicated responses to trauma. Prior victimization also appears to be important: for example, one study found that soldiers who developed combat-related PTSD were more likely to have experienced physical abuse in childhood compared to those who did not develop the disorder (Bremner, Southwick, Johnson, Yehuda & Charney, 1993).

There is also increasing evidence of a role for genetic susceptibility in the development of PTSD, which is leading to discussions of a diathesis-stress framework for PTSD, which proposes that an underlying predisposition to the disorder (diathesis) is expressed following exposure to the requisite traumatic event (stressor) (Flouri, 2005). Twin studies conducted with male combat veterans (Goldberg, True, Eisen & Henderson, 1990; Koenen et al., 2003) and with male and female non-veterans (Stein, Jang, Taylor, Vernon, & Livesley, 2002) have found that genetic factors help to explain exposure to traumatic events, as well as the development of PTSD symptoms in response to them. Moreover, in support of the diathesis-stress framework, Binder et al. (2008) reported finding a gene-environment interaction, such that polymorphisms in the FKBP5 gene, which is related to the production of stress hormones, are associated with increased severity of PTSD symptoms in adulthood among individuals who experienced abuse in childhood (the PTSD in question was thought to be either a result of the childhood abuse itself, or of exposure to subsequent trauma).

PTSD is thus perhaps best described as a "multicausal system" (Young and Yehuda, 2006) – there are a number of factors which appear to contribute to this outcome, and these are still being studied in earnest. Below, the effects of trauma, with a focus on PTSD, are reviewed in terms of three categories: the impact on psychological functioning, the biological changes that have been shown to occur, and the social ramifications of trauma.

2.1 Psychological Impact of Trauma

As noted previously, the symptoms which comprise post-traumatic stress disorder can generally be divided into three categories. The first is "re-experiencing." Herman (1992) explains: "Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present. They cannot resume the normal course of their lives, for trauma repeatedly interrupts" (p. 37). Interestingly, these memories are not like normal memories, which are encoded "in a verbal, linear narrative." Instead, they are "frozen and wordless," and encoded in the form of sensations and images (Herman, 1992, p. 37). Neuroimaging research, reviewed in the next section, offers clues as to why this may be the case. In PTSD, re-experiencing may take the form of distressing memories, including thoughts, images, or perceptions; distressing dreams about the traumatic event; having "flashbacks" that lead to the feeling that the traumatic event is recurring in the present (this can include auditory, olfactory, or visual hallucinations); intense distress at internal or external stimuli symbolizing or resembling the traumatic event; or physiological reactivity to internal or external trauma-related stimuli (APA, 2000). Kolb (1993) has nicely captured the re-experiencing aspect of PTSD in the following:

> Not only are [PTSD] sufferers continually prisoners to arousal through the frequently recurrent external stimuli reminiscent of the traumatic experiences coming through their sensory channels, but they are also the

> constant prey of their own imagery recollections during both daytime and at night in dreams (p. 300).

The second symptom category of trauma in PTSD form is variously referred to as constriction of emotions, numbing, or avoidance (the latter being the term employed by the DSM-IV TR). This is a mechanism designed to release the trauma victim from rage, pain and terror, and to invoke a state of detached calm in which unbearable experiences or memories can be denied. Herman (1992) explains that many aspects of existence are constricted: relationships, activities, thoughts, memories, and importantly, emotions. The individual often loses interest in previously pleasurable activities and just “goes through the motions” of everyday life (van der Kolk, McFarlane & van der Hart, 2007). This shutting down of feelings, thoughts, and judgment has been referred to as “robotization” (Herman, 1992, p. 84). The DSM-IV lists diverse behaviours associated with avoidance, including efforts to avoid certain thoughts, feelings, activities or places; a restricted range of affect; inability to recall certain aspects of one’s trauma; and a sense of a “foreshortened future” (i.e., not expecting to have a career, marriage, children, or normal life span) (APA, 2000). In essence, individuals who have experienced trauma restrict their lives in an attempt to avoid re-experiencing the trauma in any way possible (Herman, 1992). Significantly, when individuals have difficulty achieving numbness through dissociation or by avoiding thoughts of the trauma, they may turn to substance use in order to artificially induce it (Herman, 1992; Bloom, 1997).

The final symptom category, that of hyperarousal, denotes, from a psychological point of view, a feeling of being on edge, startling easily, sleeping poorly, and feeling generally anxious. The individual remains on high alert for danger at all times, even when there is no objective reason to believe that they are currently at risk in any way. Therefore, individuals with PTSD become unable to trust their bodily sensations to warn them of potential danger (van der Kolk, McFarlane, & van der Hart, 2007). Moreover, as

a result of their hyperarousal, they may feel irritable and unable to concentrate, leading to learning difficulties and memory disturbances. The exaggerated startle response is particularly pronounced in some cases. Studies have shown that some individuals suffering from PTSD do not habituate to repeated loud, startling noises the way that individuals normally do: instead, they show a startle response and distress in response to each new repetition of the noise (Kolb, 1993).

It is important to note that there are other presentations resulting from trauma, which extend beyond the single diagnostic category of PTSD. Leading researchers have noted that “trauma covers a much larger and more ambiguous terrain than the concept of PTSD would suggest” (Kirmayer, Lemelson, & Barad, 2007, p. 1). Herman (1992) has argued that a new diagnostic category should be formed to reflect the fact that “people exposed to prolonged, repeated trauma develop an insidious, progressive form of post-traumatic stress disorder” (86). She suggests labelling this type of trauma, associated with such experiences as child sexual or physical abuse, domestic abuse, or being a prisoner of war or concentration camp survivor, “complex post-traumatic stress disorder” (p. 121). Moreover, van der Kolk (2007a) argues that the PTSD label is not developmentally sensitive and does not adequately capture the effects of trauma on a child. He accordingly suggests a new category, “developmental trauma disorder,” which would recognize the profound effects of trauma in childhood, where it is associated with severe personality problems in the sense that “every aspect of the self will be distorted and bent in the direction of traumatic exposure” (Bloom, 1997, p. 72). However, neither of these disorders has been recognized in the DSM to date.

It is also understood, although perhaps not widely recognized, that traumatic experiences can give rise to two major stress disorders apart from PTSD, one being Acute Stress Disorder (which involves symptoms similar to those outlined with respect to

PTSD, but in a shorter timeframe of less than one month), and the other being Brief Psychotic Disorder with Marked Stressor (which involves psychotic symptoms known to be precipitated by a stressful event) (Briere & Scott, 2006). These disorders are common differential diagnoses considered in the formulation of a PTSD diagnosis (APA, 2000). A number of other psychiatric disorders also have a connection to traumatic experiences: Borderline Personality Disorder, for example, is a psychiatric illness which is associated with severe and extended childhood trauma (Briere & Scott, 2006). In addition, depression, anxiety, schizophrenia, and dissociative disorders, as well as self-destructive behaviour, such as self-mutilation and substance abuse, also appear frequently as comorbidities or outcomes of traumatic stress (Bloom, 1997). Therefore, responses to trauma are protean and “best understood as a spectrum of conditions rather than as a single disorder” (Herman, 1992, p. 119). In addition, individuals who are diagnosed with PTSD usually are diagnosed with least one other psychiatric disorder (comorbidity), such as depression or substance abuse, which makes the picture even more complex (Breslau, 2002; Foa, Keane, & Friedman, 2000). The DSM-IV TR (APS, 2000) lists major depressive disorder, substance-related disorders, panic disorder, obsessive-compulsive disorder, and bipolar disorder as some of the common disorders that are seen along with PTSD.

In terms of psychological symptoms, then, the basic experience of PTSD, a trauma disorder, is the continued occurrence of physiological hyperarousal and intrusive memories, dreams, or flashbacks of the traumatic experience, with intermittent periods of numbness and detachment. The alternation between reliving an experience and repressing it creates the tension which Herman refers to as the most characteristic feature of PTSD and “the central dialectic of psychological trauma” (1992, p. 1).

2.2 Biological Impact of Trauma

It is now recognized that "psychological" trauma is not, as it were, all in one's head: there are documented physical changes associated with trauma and with PTSD. The emerging research on the biological effects of trauma is quite complex; however, a consideration of the psychophysiological, neurohormonal, neuroanatomical and immunological abnormalities which have been discovered with respect to trauma disorders are instructive, as they provide a physiological understanding of some of the behaviours and psychological experiences described in the previous section. Patterns of trauma-related illness vary, based on the person and the type of trauma (e.g., rape versus combat stress), but some common biological effects can be identified across categories (Mayer, 2007).

The key biological correlate of trauma, and PTSD, is physiological hyperarousal. Thus, the traumatized person reacts strongly to many types of stimuli, including sounds, temperature, pain, and tactile stimuli, and displays significant increases in heart rate, skin conductance, and blood pressure when presented with such stimuli in laboratory studies (van der Kolk, 2007b). Hyperarousal is found to persist even when individuals are not exposed to reminiscent stimuli: men with chronic, combat-induced PTSD have been shown to have elevated baseline blood pressure measurements, compared to individuals of the same age without PTSD (Kolb, 1993).

Changes in neurohormonal systems have also been documented. Since trauma is inherently stressful, stress hormones play a significant role in the trauma response. The adrenergic (or sympathetic nervous) system is important, since it affects, among other areas, the hippocampus and amygdala, which are found to be altered by trauma, as will be discussed shortly. The adrenergic system releases norepinephrine, which is associated with focusing attention and increasing fear, and helps to modulate the "fight

or flight” response, which stimulates the heart. Normally, the brain increases the release of norepinephrine when an individual is stressed or under threat and, when the threat or stressor is removed, the adrenergic system returns to its baseline state (Briere & Scott, 2006). This system has been found to be chronically dysregulated in individuals with PTSD, who are found to have increased levels of norepinephrine compared to individuals without PTSD (Bremner, 2007) and compared to individuals with other psychiatric disorders (Kolb, 1993), suggesting that the adrenergic system has not returned to a baseline state of arousal. Sustained activation of the adrenergic system has been associated with PTSD symptoms such as hyperarousal, re-experiencing, and irritability (Briere & Scott, 2006).

The hypothalamic-pituitary-adrenal (HPA) axis, which modulates other stress hormones, such as cortisol, is also dysregulated in the trauma response (Rau & Fanselow, 2007). The finding is that PTSD is associated with decreased cortisol at baseline, and with a marked increase of cortisol with exposure to stress (Bremner, 2007). Normally, the release of cortisol helps to down-regulate adrenergic arousal; low levels of cortisol in individuals with PTSD thus allow the sympathetic nervous system to be chronically overactive, as discussed above (Briere & Scott, 2006). Lastly, decreased serotonin levels, which are related to hyperirritability, hyperexcitability, and hypersensitivity, are also thought to play a role in the trauma response (van der Kolk, 2007b).

Neuroimaging studies show that the areas of the brain which seem to be most affected by traumatic stress, are the hippocampus, amygdala, cingulate, and prefrontal cortex (Bremner, 2007). Specifically, the hippocampus, which is involved in learning, memory storage and categorization of experience, is found to have a decreased volume in traumatized individuals (McEwen, 2000), and this shrinkage is manifested in poor

performance on tests of verbal memory relative to one's age group (Bremner, Krystal, Southwick, & Charney, 1995). The amygdala, which is involved in conditioning of fear responses, attachment of affect to neutral stimuli, and associations between sensory modalities, is found to be very active during recollection of traumatic events. Significantly, van der Kolk (2007b) reports that Broca's area (which governs language) was found to be "turned off" while the amygdala was highly active during a laboratory exposure to traumatic memory. He notes, "We believe that this reflects the tendency in PTSD to experience emotions as physical states rather than as verbally encoded experiences" (p. 233). Another finding from this study was that of "marked asymmetry in lateralization in the direction of the right hemisphere while the traumatic memories were activated" (p. 234), and this relates, again, to the language difficulties of PTSD, since the left hemisphere of the brain is responsible for language production, and to the failure to integrate experience, due to the fact that cognitive analysis is also handled by the left hemisphere (van der Kolk, 2007b). This lack of integration may contribute to the persistent intrusion of the memories, which have not been properly "worked through." Finally, with respect to the prefrontal cortex, decreased activation among individuals with PTSD exposed to memories of their trauma, or related stimuli has been documented in several different studies (Bremner, 2007).

Mayer (2006) discusses the fact that trauma is also associated with a broad range of somatic complaints, including cardiovascular, gastrointestinal, dermatological, ophthalmological and gynaecological symptoms. It appears that immune functioning may be compromised as well. McFarlane and van der Kolk (2007) note that the relationship between the brain and the immune system is mediated by the HPA axis, which, as noted previously, is dysregulated in PTSD. Furthermore, van der Kolk, Wilson, Burbridge and Kradin (1996, as cited in McFarlane and van der Kolk, 2007) found that women with

histories of chronic sexual abuse had significant immunological abnormalities. Thus, trauma, once considered a purely psychological or even imaginary disorder (Bloom, 1997; Herman, 1992) has been found to affect the body in a myriad of ways, most of them long term (Bremner, 2007), and detrimental to well-being.

2.3 Social Impact of Trauma

Trauma is not contained solely within a person; it spills over to affect families, communities, and entire societies. Owing to the manner in which it can destroy a victim's fundamental assumptions about safety and meaning, induce paranoia, and lead to uncontrolled bursts of anger, trauma – and PTSD in particular -- has profound effects on interpersonal functioning and can thus lead to marital conflict or breakdown, and to loss of friends or a job (APA, 2000).

Bloom (1997) contends that those who have been traumatized since childhood come to see the world as consisting only of victims or abusers, and find it difficult to relate to others outside of these roles. An individual's capacity for empathy towards others may also be affected as a result of having been abused or having experienced a lack of empathy or emotional resonance from caretakers. Trust in others is obliterated in many cases as well – individuals who have been victimized, especially in a chronic fashion, may be suspicious of the motives behind kind behaviour. Thus, alienation can be a core element of the response to traumatic stress: as Herman (1992) explains, a sense of disconnection "pervades every relationship, from the most intimate familial bonds to the most abstract affiliations of community and religion" (p. 52). The individual who has experienced trauma may be alienated from other people both because he or she distrusts them and because his or her behaviour drives them away, which is somewhat understandable given that addictions, unmodulated affect, anger, and avoidance of feelings are all common features of trauma disorders (Bloom, 1997).

PTSD also has an impact on society through its relationship with crime. The concept of *re-enactment* helps to explain how and why an individual with a trauma disorder, such as PTSD, might come into contact with the law. This aspect of trauma is not mentioned explicitly in the DSM-IV TR criteria for PTSD, but is acknowledged by many researchers, who refer to it by such alternate terms as "compulsion to repeat" (van der Kolk, 2007c) or "compulsive re-exposure" (van der Kolk & McFarlane, 2007). Yoder (2005) explains that "paradoxically, re-enactments represent attempts to resolve the trauma" (p. 32). Researchers have noted that these re-enactments may take the form of "acting in" – self-harmful behaviours such as substance abuse, self-mutilation, depression and anxiety, even suicide; the DSM-IV mentions "self-destructive behaviour" – or "acting out" – harm to others and criminal activity (Yoder, 2005). Through "acting out," individuals who have been hurt often come to hurt others in similar ways, such as the sexually abused becoming sexual abusers in turn (Bloom, 1997).

Another issue to consider within this category is the intergenerational transmission of trauma, which has been well researched with respect to Holocaust survivors. Bloom (1997) quotes Herzog (1982), who states simply that "The children of survivors show symptoms which would be expected if they had actually lived through the Holocaust" (as cited in Bloom 1997, p. 63). Yehuda, Halligan and Bierer (2002) demonstrated that the cortisol levels of adult offspring of Holocaust survivors with PTSD were also abnormal. Traumatic stress syndromes in a parent have been hypothesized to affect children through a number of routes: a mother's health during pregnancy, attachment problems, and modelling of fear behaviour by parents, to name a few (Yehuda, Halligan & Bierer, 2002).

2.4 Assessment of Trauma

The assessment of trauma is not an uncomplicated affair. Briere and Scott (2006) acknowledge that this is often done on an informal basis during a clinical interview, in the course of which the clinician seeks to determine whether there was a past event that overwhelmed the individual's resources and considers whether the current symptoms resemble the PTSD diagnostic criteria, as provided by the DSM-IV TR. For the clinician or researcher seeking a more structured approach, however, a number of self-report measures have been developed, with the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995) being considered the "gold standard" for assessment of PTSD (Briere & Scott, 2006). However, measures such as the Trauma Symptom Inventory (Briere, 1995) and the Posttraumatic Stress Diagnostic Scale (PDS; Foa, 1995) are also used. More generic measures, such as the Minnesota Multiphasic Personality Inventory (MMPA-2; Butcher, Dahlstrom, Graham, Tellegen & Kaemmer, 1989) or the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, Davis & Millon, 1997), also collect some information on posttraumatic outcomes, and have the added advantage of validity scales to help detect exaggeration or malingering (Briere & Scott, 2006). However, there have been some reports of these scales having failed to detect fabricated PTSD (e.g., Perconte & Goreczny, 1990). There are also a number of measures, which have been developed in order to assess specific PTSD subtypes, such as the Mississippi Scale for combat-related PTSD (Keane, Caddell, & Taylor, 1988).

Because there are concerns about PTSD being malingered or faked in a legal context (as will be discussed in more detail), certain assessment-related protocols have been developed in order to ensure that the clinician or individual performing an assessment of trauma or PTSD as part of a forensic psychiatric examination does not ask leading questions or accept responses too readily. One potentially useful technique

is to begin with a non-directive interview, during which an individual can be encouraged to describe any difficulties that he or she has been experiencing. If no symptoms of PTSD are mentioned by an individual during this initial description, but they then endorse every item on a PTSD scale, their responses to the latter should be viewed with caution (Pitman, Sparr, Saunders, & McFarlane, 2007). A second technique, to be used in conjunction with the administration of a structured interview or self-report instrument, is an "insistence on detailed illustration" (Pitman et al., 2007, p. 389). The rationale for this is that, if an individual endorses all of the symptoms of PTSD, he or she should be able to recount instances when these symptoms actually occurred. Finally, the use of collateral sources is encouraged in order to see if other reports collaborate or contradict those of the individual being assessed (Pitman et al., 2007).

In some cases, psychophysiological methods may be relied upon to help diagnose PTSD. With these methods, an individual's heart rate, blood pressure, skin conductance, or muscular tension can be assessed before and after he or she is exposed to visual and/or auditory stimuli related to the traumatic experience. Psychophysiological methods are viewed by some as a more "objective" and valid measure of PTSD (Firestone & Marshall, 2003). It was even proposed that psychophysiological measurement "has the potential to redeem the PTSD diagnosis from its current subjectivity and to help separate the wheat from the chaff in forensic evaluations of PTSD claims" (Pitman & Orr, 1993, p. 40). However, this optimistic claim has not yet been borne out, and this type of measurement is not currently commonplace in the assessment of PTSD.

2.5 Conclusion

Trauma theory is a relatively new, but quickly growing, area of inquiry. Post-traumatic stress disorder, the most common type of psychopathology resulting from

traumatic experience, can be diagnosed where an individual has a certain set of symptoms within a certain timeframe. This chapter has examined the disorder from a biopsychosocial perspective, reviewing research which indicates that it can greatly alter an individual's biology, psyche, and social functioning. It has been suggested that these disruptions can prompt individuals to come into contact with the law, in some cases. A range of options exist for the clinician wishing to assess the presence of PTSD; however, special precautions have been advocated for assessments made in the context of legal issues.

3. TRAUMA IN THE CRIMINAL JUSTICE SYSTEM

3.1 Relevant Literature

Considering that the study of trauma and its effects is still very much in development, it is not surprising that PTSD has not yet acquired a strong presence in criminological research. In the following sections, the existing research relating to the presence of PTSD among individuals in correctional settings, and its use in legal contexts, is reviewed.

3.1.1 PTSD in offending populations

A search for literature that considers the impact of trauma on offending populations reveals that much of the research which does mention PTSD in connection with offenders, has been conducted only with juvenile offenders. For example, Cauffman, Feldman, Waterman and Steiner (1998) conducted interviews with 96 girls in a California youth detention facility, and discovered that 50% of them met the diagnostic criteria for PTSD, meaning that they were six times more likely to have the disorder compared to the general adolescent female population. Other researchers (Dixon, Howie, & Starling, 2000) found that the rate of PTSD in their sample of 100 incarcerated female juvenile offenders was 37%. Sexual abuse was identified as the precipitant of PTSD in 70% of these cases. Additionally, this study reported that youth with PTSD had significantly more comorbidities than those who did not (a mean of 5.1 for those with PTSD compared to 3.1 for those without).

Using a version of the CAPS adapted for children and adolescents, Erwin, Newman, McMackin, Morrissey, and Kaloupek (2000) found a current PTSD rate of 18%

among 51 incarcerated male youth, and noted that studies of community-dwelling male youth have found prevalence rates as low as 1%. Abram, Teplin, Charles, Longworth, McClelland, and Dulcan (2004) studied a large sample of 898 male and female youth in a detention centre using the Diagnostic Interview Schedule (DIS-IV, which is based on DSM-IV criteria) and found the rate of current PTSD to be 11.2%, which is again higher than community rates of youth with current PTSD, found to be 3.5% in one study (Abram et al., 2004).

Some researchers have examined adult populations, although in some cases it is only exposure to trauma that is being assessed – Neller, Denny, Pietz and Thomlinson (2006), for example, used self-reports of "experiencing a traumatic event" as an indicator of trauma in a sample of male inmates in a maximum security prison, and found that 96% of the 93 inmates interviewed had experienced a traumatic event such as physical or sexual abuse, a serious accident, witnessing death or serious injury. Similarly, Battle, Zlotnick, Najavits, Guttiemez and Winsor (2003) suggest that as many as 90% of incarcerated women in one sample had been exposed to similar traumatic events. While these studies are useful in describing the prevalence of exposure to potentially traumatizing events, they say little about the impact of those events.

A number of studies have examined the presence of actual trauma disorder. Powell, Holt, and Fondacaro (1997), using the Diagnostic Interview Schedule for DSM-III (DIS-III-R), found that 21.1% of 213 male inmates drawn from jails and prisons in a U.S. state met the DSM-III criteria for posttraumatic stress disorder, making it one of the most common psychiatric disorders among the inmates studied (only alcohol and drug dependence and antisocial personality disorder were found to be more prevalent). Kubiak (2004), using DSM-IV criteria and the Trauma subscale of the Composite International Diagnostic Interview (CIDI), found that 55% of her sample, which was

comprised of 199 male and female prisoners undergoing substance abuse treatment in a minimum-security facility in the United States, met the criteria for lifetime (current or past) PTSD. Gibson, Holt, Fondacaro, Tang, Powell, & Turbitt (1999) reported PTSD rates of 33% (lifetime criteria) and 21% (current criteria) in a sample of 213 male inmates in a rural New England state. Gibson et al.'s study also revealed that, consistent with the literature on victimization in offending populations, self-reported causes of PTSD among inmates differed from those in the general population in terms of their proportions, with sexual and physical abuse being more common antecedents to PTSD among inmates, while witnessed violence or injury is more common as a precipitant to PTSD in the general population. This research also confirmed that the comorbidities which were described with respect to PTSD in the general population, were also relevant for incarcerated males with PTSD: those who had PTSD were more likely than inmates who did not meet the criteria for PTSD to also have major depressive disorder, obsessive-compulsive disorder, generalized anxiety disorder, as well as alcohol and drug abuse and dependency (Gibson et al., 1999). Finally, Teplin, Abram, and McClelland (1996) found a rate of 21% for current PTSD among a U.S. female prison population. Thus, even the *current* prevalence rates outlined in the (exclusively U.S.-based) studies reviewed in this section are quite high compared to the *lifetime* prevalence of PTSD in the adult population of the United States, which is approximately 8% (APA, 2000; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), or lower, depending on the study consulted (e.g., Davidson, Hughes, Blazer, & George, 1991).

However, offender prevalence rates are not found to be uniformly high across all studies: Brink, Doherty, and Boer (2001) found a current PTSD prevalence of only 4.0% among 202 Canadian adult male offenders sentenced to a term of federal incarceration, using the Structured Clinical Interview for DSM-IV (SCID). Goff, Rose, Rose, and Purves

(2007) note that the prevalence rate found by Brink et al. is lower than those found in other studies of PTSD in sentenced prison populations (prevalence rates from other studies in their review ranged from 10% to 21%). Goff et al. pointed out several features of the Brink et al. study which may have led to the lower prevalence rate: PTSD was only measured for symptoms having occurred within the past month, where other researchers define "current" as within a six to 12 month period; an exclusively male sample was used, when prevalence rates are known to be higher for females; and the assessment tool, the SCID, which was administered by forensic psychologists and psychiatrists in Brink et al.'s study, "explicitly allows the assessor to use clinical judgment" (p. 156).

It is unfortunate that other Canadian studies of PTSD prevalence among offenders/inmates are lacking – a number of researchers have investigated the prevalence of mental disorder in these populations, but have not looked specifically at PTSD (e.g., Bland, Newman, Thompson, & Dyck, 1998; Motiuk & Porporino, 1991). It is worth noting, however, that the rate of 4.0% for current PTSD found by Brink, Doherty, and Boer is still higher than that resulting from a survey conducted in the Canadian city of Winnipeg, Manitoba, which found that the 1-month prevalence of DSM-IV PTSD among this community sample of 1,002 individuals was 2.7% for women, and 1.2% for men (Stein, Walker, Hazen, & Forde, 1997).

The issue of PTSD has also been investigated with respect to forensic settings. Spitzer, Dudeck, Liss, Orlob, Gillner, and Freyberger (2001) conducted the first systematic investigation of trauma disorders in this population, conjecturing that the high prevalence of traumatic stress among criminal offenders and psychiatric patients should mean that individuals who are both mentally ill and offenders also have relatively high rates of PTSD. Among the 53 (male and female) German forensic patients studied using the CAPS, 36% were found to meet the lifetime criteria for PTSD, while 17% were

judged as having the disorder currently. Sexual and physical abuse in childhood were the most common type of trauma experienced in this sample, with the second most common precipitant of PTSD being the offender's own criminal offence. Papanastassiou, Waldron, Boyle, and Chesterman (2004) studied mentally ill perpetrators of homicide in a United Kingdom forensic hospital, also using the CAPS, and reported prevalence rates of 58% for lifetime and 26% for current PTSD in their sample of 29 inpatients.

In an interesting study, Sarkar, Mezey, Cohen, Singh and Olumoroti (2006) compared 28 psychiatric patients and 27 forensic patients in the United Kingdom, all of whom had a primary diagnosis of schizophrenia, and found that PTSD was more prevalent among the forensic patients, 33% of whom met current criteria for PTSD, compared to 21% of the psychiatric patients (the rates for lifetime criteria were 52% and 29%, respectively). The authors noted of their forensic sample, "no patient had received a diagnosis of PTSD, suggesting under-recognition of the extent of trauma and trauma related illness" (p. 668).

In sum, traumatic stress disorders do exist in incarcerated populations, and in rates proportionately higher than those seen in the general population (Gibson et al., 1999). When the consequences of PTSD and other trauma-related disorders (as outlined previously) are considered, it would seem prudent to attend to their presence in offending populations, for reasons that will be discussed throughout this research. At a basic level, it will be argued that to the extent that a goal of the criminal justice system is rehabilitation, an offender's needs have to be met in order for any measure of rehabilitation to be achieved.

Having established that PTSD is prominent in offending populations, with large numbers of offenders apparently suffering from the disorder, a question to consider is how often the issue is raised in courts, where offenders are judged and sentenced. How

often is PTSD discussed as a factor in Canadian criminal cases? This issue is addressed below.

3.1.2 PTSD in the legal context

There are few review papers that discuss PTSD in a Canadian legal context: those which do exist have generally been produced in the United States, but are nonetheless instructive. In 1996, Sparr noted that, "although PTSD has received a generally enthusiastic reception in the legal community, it has achieved mixed success as a criminal defence" (p. 405). Pitman et al. (2007) point out that PTSD presents some difficulties where reduced criminal intent is concerned, given that its sufferers are usually not out of contact with reality or unable to appreciate wrongfulness. For this reason, they wrote, "the dissociative state [which is sometimes associated with cases of PTSD] seems to have become almost the *sine qua non* for the PTSD criminal defence" (p. 384).

Over twenty years ago, Sparr and Atkinson made note of the rising concern that PTSD and its legal defences would acquit too many individuals, effectively providing "a blank check to commit crime" (1986, p. 612). So far, it should be noted that, in the United States, those fears have not materialized: the disorder is rarely used to abrogate criminal responsibility. As far as the insanity defence is concerned, Sparr reports that, with respect to PTSD, it "is raised infrequently, and, like other insanity pleas, is often not successful when it is raised" (1996, p. 407). Kormos (2008) also acknowledges this fact, but argues that "the current legal temperament in Canada is ripe for [the not criminally responsible on account of mental disorder, or NCRMD] defence to be pleaded" (p. 29). Kormos makes special reference to members of the Canadian Forces, among whom a surge of the disorder – and a failure to respond appropriately to it – has been identified (the CBC has run a series of articles on this issue in 2008 – see Canadian Broadcasting Corporation, 2008a, 2008b).

Drawing upon criminal decisions made in the early 1990s in the United States, Sparr pointed out that evidence relating to the accused suffering from PTSD is used to mount other criminal defences such as diminished capacity or responsibility, unconsciousness/automatism, and self-defence (which includes claims based on battered woman syndrome). With respect to automatism, PTSD "is on a short list of disorders, mostly organic," that can be used to argue that an individual was not conscious of the act performed (Pitman et al., 2007, p. 385).

Although not all of the defences discussed above exist in the same forms in Canada, the American jurisprudence provides an idea of the relatively broad scope of defences to which the disorder might be applied. Correlates of PTSD, such as sensation seeking, guilt and self-punishment, mood lability, sleep disturbance, substance abuse, and dissociation, are often discussed in the context of such defences in order to establish a link between the stressor which preceded the PTSD symptoms, the symptoms themselves, and the criminal behaviour. PTSD "syndromes," or typical symptom profiles associated with victims of rape, incest, or combat veterans, may also be taken into account as mitigating factors in sentencing (Sparr, 1996). For example, Slovenko (2004) reports on a study which found that "from 1980 to 1988, the defence of PTSD resulted in outright acquittals, shorter jail sentences, and treatment in lieu of jail for over 250 Vietnam veterans" (p. 414). Research has found that PTSD-based defences are more likely to succeed when certain factors are present in the circumstances of the offence, such as the behaviour being uncharacteristic of the individual, lack of dialogue showing that the offender was oriented to time and place, lack of rational explanation or motivation for the act, and complete amnesia for the episode (Pitman et al., 2007).

Although PTSD, as a disorder, is seemingly easy to understand and theoretically has a clear cause, it ultimately rests upon an analysis of the sufferer's self-report, which

is difficult to verify. For this reason, Lacoursiere refers to "fictitious," or faked, post-traumatic stress disorder as "one of psychiatry's difficult diagnostic problems" (1993, p. 141). He lists a number of reasons why an individual would fake PTSD in a court proceeding, including the wish to gain attention; to explain and cover up a dysfunctional life; to benefit financially; or to avoid criminal responsibility. The threat of malingering should, therefore, be considered carefully in the context of criminal proceedings (Friel, White, & Hull, 2008).

3.2 Rationale

Aside from Kormos' (2008) examination of PTSD and the NCRMD defence in Canada, which focused on members of the Canadian Forces, no systematic studies PTSD in Canadian court cases appear to have been conducted. This research addresses this gap, in considering all Canadian criminal cases of PTSD available through three electronic case law databases which mention PTSD with respect to the accused.

As mentioned in Chapter 2, "trauma" consists of more than the strictly-defined symptoms falling under the diagnostic rubric of posttraumatic stress disorder. However, since other trauma-related disorders are lesser-known and less frequently diagnosed, this research was restricted to the examination of PTSD, a psychiatric concept which has a clear reference in the DSM-IV.

The purpose of this research was to undertake an exploratory examination of the impact of PTSD in Canadian criminal cases, the circumstances under which the issue of PTSD is raised, and how it tends to be handled by the courts. Specifically, the central questions guiding the research were as follows:

1. Under what conditions is offender PTSD mentioned in Canadian criminal cases? Does it tend to be raised more for certain genders, offences or subgroups (e.g., veterans)?
2. What defences are raised in the context of offenders with PTSD?
3. What role do experts play in cases involving offenders with PTSD?
4. How does knowledge of an offender's PTSD affect judges' sentencing decisions?

3.3 Method

Judgments in which PTSD was mentioned with respect to the accused were located using three Canadian electronic legal databases: QuickLaw, Criminal Source and Criminal Spectrum. In each of the databases, a search of criminal law cases in all jurisdictions in Canada was conducted with the search terms "posttraumatic stress disorder OR post-traumatic stress disorder OR PTSD." All resulting cases were then reviewed to determine whether the references to PTSD within each case applied to the offender (it was often the case that PTSD was mentioned only in the context of the impact of the offence on the victim; such cases were not of interest to this analysis and were excluded). Cases which met the criteria of mentioning one of the PTSD keywords at least once - and with respect to the offender - were retained for analysis. Docket and judgment numbers were recorded in a spreadsheet to ensure no duplication of cases from the three databases. In total, 127 judgments which fit the criteria were found and included in the research. These judgments belonged to 122 different offenders.

3.3.1 Coding of variables

A coding sheet was developed by the author, and this was used to consistently record (where available) variables of interest to the study. These offender and case variables are listed in Table 1.

Table 1. Variables coded in the research.

GENERAL/DEMOGRAPHIC VARIABLES • Jurisdiction and court • Offence • Age of offender and age category (young offender or adult) • Gender of offender • Whether the accused had legal counsel • Document Type (e.g., trial, appeal, sentencing, dangerous offender hearing) • Number of PTSD keyword “hits” • Etiology of PTSD • Status of PTSD (When was it diagnosed? By whom? On what basis?) • Number and type of comorbidities • Whether alcohol and/or drugs were involved in commission of the offence • PTSD-related defence raised, if any, and success or outcome of the defence • Offender subgroup (e.g., battered woman, combat veteran) • Age of offender and age category (young offender or adult)
EXPERT EVIDENCE VARIABLES • Which side experts are called by (Crown, defence, or both) • Qualifications of experts • Any measures used by experts in making or refuting PTSD diagnosis
SENTENCING VARIABLES • Criminal record of offender • Aggravating and mitigating factors mentioned • Sentencing objectives mentioned • Sentence handed down • Any special conditions, especially related to counselling

The information captured on the coding sheet was entered into SPSS as each case was coded.

3.3.2 Legal analysis

The first part of the analysis consisted of a consideration of the PTSD-specific defences raised in the trial decisions examined. In this analysis, the legal arguments and expert testimony supporting successful and unsuccessful attempts to raise different defences are examined. Several important questions or dilemmas in the application of law and legal defences to individuals with PTSD are raised and discussed.

3.3.3 Discourse analysis

In addition to the more quantitative task of variable coding, this research also employed a qualitative, discursive approach to exploring the judicial reasons for sentencing which formed part of the data for this study.

Discourse analysis is intertwined with social constructionism, in that it views truth as “a matter of taking, negotiating and contesting perspectives created in and through language” (Gee, 2005, p. 5). This research, therefore, also adopts a constructivist framework, acknowledging that judicial discourse serves a number of different functions with respect to truth making. Guided by some key questions and considerations offered by Gee (2005), it is apparent that the discourse of judges performs several functions, including: deciding what is significant and what is not in the life of an offender and the commission of an offence; enacting activities outside of the discourse (e.g., orders, sentences); communicating what is acceptable, right, or moral; deciding when things are - or should be - connected in a case; and privileging or disprivileging different types of knowledge and belief, such as the opinion of experts.

These particular discursive functions, viewed through a Foucauldian lens, are all expressions of power vested in judges by virtue of the position they hold and the knowledge they are assumed to have. For Foucault, knowledge and power are strongly interrelated; power depends on knowledge, and it creates and reproduces knowledge (Hall, 2001). As Hook (2001) notes of Foucault's method of discursive analysis, "one should approach discourse not so much as a language, or as textuality, but as an active 'occurring', as something that implements power and action, and that also *is* power and action" (p. 20).

In analyzing the judicial reasons which form the data for this thesis, I have attempted to, as is commonly done in qualitative research, allow common themes within and across cases to emerge. I have also, however, tried to use Foucault's (1972) principles for acting as an "archaeologist of discourse". According to Foucault, instead of permanent, meaningful themes, "[w]hat one finds are rather various strategic possibilities that permit the activation of incompatible themes, or, again, the establishment of the same theme in different groups of statement" (p. 37). In discussing Foucauldian discourse analysis, Hook (2001) also emphasizes the importance of discontinuity:

> The analyst of discourse is predominantly then concerned with exploiting the gaps or shortcomings of a given discourse, with systematically demonstrating its contradictions and discontinuities; these are the seams to be pulled, the joints and weaknesses to be relentlessly stressed (p. 26).

I have thus tried to be aware of divergences and conflicts within the discourse examined. Following Foucault's method, I have also endeavoured to be aware of the constraints on discourse and the "power-knowledge complex" (Hook, 2001) which juridical discourse both exists inside of and continues to reinforce.

3.4 Conclusion

Research has established that incarcerated individuals suffer from post-traumatic stress disorder at rates greater than those seen in the general population. Working backwards from this knowledge, one can ask whether the courts are aware of this psychopathology, and if so, how it applies in terms of legal defences, expert evidence, and sentencing decisions. These questions led the author to construct a method involving data coding, legal analysis and discourse analysis, using case law as data. The results of this research are presented in the following two chapters.

4. DATASET AND DEFENCES

4.1 Description of Dataset

For the purposes of this discussion, the offender is the unit of analysis, and a "case" refers to the judgment or judgments that were available for a single offender. The 122 cases included in this study span more than 17 years, with the earliest judgment examined dated December 19, 1991, and the most recent February 11, 2009. Judgments covered all Canadian provinces and territories except Quebec (which was omitted because the search was conducted in English only). As would be expected based on population size, the greatest number of cases came from Ontario (34.7%), followed by British Columbia (20.5%), and Alberta (20.2%).

The types of documents examined are illustrated in Figure 1. Most (57.5%) of the 127 documents examined related to sentencing.

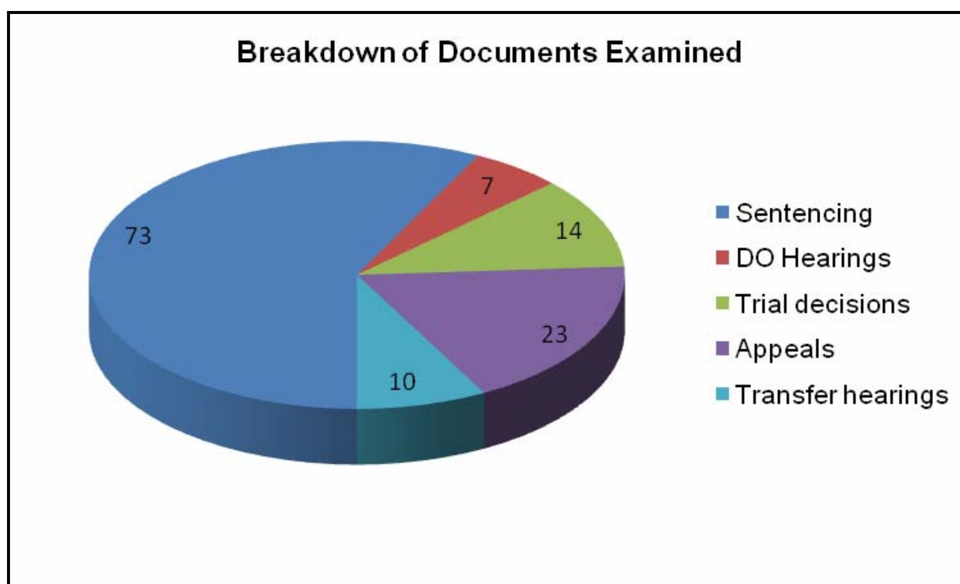

Figure 1. Breakdown of 127 documents examined by type.

The offenders involved in the judgments examined ranged in age from 12 to 62 years of age at the time of trial or sentencing, with the average age being 32.5 years. Of the 122 offenders, 19 (15.5%) were young offenders, and the remaining 103, or 84.5%, were adults. The offenders were also more frequently male -- 94 offenders, or 77% -- than female -- 28 offenders, or 23%.

The most serious offences committed in each of the cases studied are summarized in Table 2 below.

Table 2. Breakdown of cases by most serious offence.

Offence	Number of Cases	Percent of Cases
Assault Causing Bodily Harm	5	4.10%
Aggravated Assault	11	9.02%
Assault with a Weapon	5	4.10%
Assault Total	*21*	*17.21%*
Criminal Negligence Causing Bodily Harm	1	0.81%
Criminal Negligence Causing Death	3	2.46%
Criminal negligence Total	*4*	*3.28%*
Impaired Driving	6	4.92%
Impaired Driving Causing Death	1	0.81%
Unlawfully Operating a Motor Vehicle	1	0.81%
Dangerous Driving Causing Death	3	2.46%
Criminal Negligence in Operation of Motor Vehicle Causing Death	2	1.64%
Failing to Stop at Scene of an Accident	2	1.64%
Total Driving Offences	*15*	*12.30%*
Trafficking Heroin	4	3.28%
Possession of Cocaine	2	1.64%
Conspiracy to Import Narcotics	1	0.81%
Total Drug Offences	*7*	*5.74%*
Total Fraud	*5*	*4.10%*
Total Kidnapping and Abduction	*1*	*0.81%*
First-degree Murder	10	8.20%
Second-degree Murder	8	6.56%
Manslaughter	11	9.02%
Attempted Murder	5	4.10%
Conspiracy to Commit Murder	1	0.81%
Total Murder and Manslaughter	*35*	*28.69%*
Total Robbery	*5*	*4.10%*
Total Public Mischief	*3*	*2.46%*
Sexual Assault	12	9.84%
Sexual Assault with a Weapon	4	3.28%
Total Sexual Offences	*16*	*13.11%*
Theft Under	1	0.81%
Theft Over	3	2.46%
Total Theft	*4*	*3.28%*
Unauthorized Possession of Firearms	1	0.81%
Careless Storage of Firearms	1	0.81%
Total Weapons Offences	*2*	*1.64%*
Uttering Threats	1	0.81%
Cruelty to Animals	1	0.81%
Money Laundering	1	0.81%
Resisting or Obstructing Police Officer	1	0.81%
Total Other	*4*	*3.28%*

As this table shows, the offences committed by offenders with PTSD were quite diverse, with many different offence categories covered. The offences were also, for the most part, quite serious: nearly one-third of the sample had committed murder, manslaughter, or attempted murder, and an additional 30% of the offenders were charged with, or convicted of, assault or sexual offences.

All of the cases in the study were selected on the basis of mentioning post-traumatic stress disorder at least once. In approximately half (51.6%) of the judgments, PTSD was mentioned only once. The highest number of "hits" was 40, which occurred only in one judgment. The average across all judgments was 2.88 mentions.

The etiology, or identified cause of the offender's PTSD, was mentioned in 79.5% of the cases. Categories were developed by the author to reflect the different themes in the stated causes of the offender's PTSD. The 101 cases which provided an etiological explanation of PTSD led to the creation of ten etiological categories. PTSD was variously attributed to:

- Sexual, physical and/or emotional abuse in childhood;
- Spousal/partner abuse;
- Accident or assault in adulthood (including motor vehicle accident);
- Witnessed violence or harm (e.g., seeing one's mother killed);
- Occupational experiences as police officer or correctional officer;
- Being a survivor of a Residential School;
- Experiences of refugees (torture, war-torn environments);
- The effects of incarceration;
- Tours of duty as a combat veteran; and,
- The commission of the offence (in most cases, a car accident which occurred when the offender was driving impaired).

The percentage of offenders falling into each of these categories is shown in Table 3. It should be noted that offenders can belong to more than one category (e.g., if they were both a Residential School survivor and a victim of spousal abuse).

Table 3. Breakdown of cases by PTSD etiology.

Etiology	Number of Cases	% of Cases with Etiological Explanation
Abuse in childhood (physical, emotional, sexual)	45	44.5%
From commission of offence	13	12.74%
Combat exposure	11	10.89%
Spousal/partner abuse	9	8.91%
Refugee	7	6.93%
Residential school survivor	6	5.94%
Accident or assault in adulthood	5	4.95%
Occupational (police or correctional officer)	5	4.95%
Witnessed violence or harm	4	3.96%
From imprisonment	2	1.98%

Childhood abuse was by far the most common cause of PTSD among the offenders studied: indeed, 44.5% of the sample for whom an etiological explanation was offered had their disorder attributed to this cause – a finding that is consistent with previous studies of offenders with PTSD (Gibson et al., 1999). The commission of the offence was the second most common etiological factor, and this is consistent with the findings Spitzer et al. (2001), who also found, in their forensic sample, that this type of trauma was second to childhood victimization.

In terms of comorbid disorders, 44 of the 122 offenders (36%) had no noted comorbidities, while the other 64% had between one and six (mean = 1.3) comorbid diagnoses. The different types and frequencies of the most common comorbidites raised are presented in Table 4.

Table 4. Comorbidities mentioned in the cases examined.

Comorbid Disorder	Number of Offenders Diagnosed	Percentage of Sample
Substance Abuse	33	27.05%
Depression	30	24.60%
Attention Deficit Hyperactivity Disorder (ADHD)	12	9.83%
Antisocial Personality Disorder	10	8.20%
Borderline Personality Disorder	8	6.56%
Conduct Disorder (young offenders only)	6	4.92%
Fetal Alcohol Spectrum Disorder (FASD)	4	3.28%

As this table shows, substance abuse and depression were both very prevalent in this sample, with approximately one-quarter of the sample afflicted with each of these disorders. Again, this fits with previous findings (Gibson et al., 1999).

4.2 Defences Raised

The trial judgments collected in this study demonstrated that four categories of legal defences were raised by individuals with PTSD, these being self-defence, duress and necessity, automatism, and not criminally responsible on account of mental disorder (NCRMD). Each of these is discussed in turn.

4.2.1 Self-defence

Canadian law recognizes two types of situations in which citizens may use force to defend themselves or their property against unlawful attack (Verdun-Jones, 2007). The first situation involves defence of an unprovoked assault. As stated in section 34(1) of the *Criminal Code*:

> Every one who is unlawfully assaulted without having provoked the assault is justified in repelling force by force if the force he uses is not intended to cause death or grievous bodily harm and is no more than is necessary to enable him to defend himself.

The provocation referred to in this section can include blows, words and gestures. In addition to not having provoked the assault, the defendant must not have intended to cause death or grievous bodily harm. There is also a requirement, under section 34(1), that the force used to deflect or repel the assault is proportionate to the degree of force employed in the initial attack. Section 34(1) is thus quite restrictive (Verdun-Jones, 2007), and it was not raised in relation to any of the cases examined in this research.

Section 34(2) of the *Code* provides for the second type of self-defence scenario:

> Every one who is unlawfully assaulted and who causes death or grievous bodily harm in repelling the assault is justified if
>
> he causes it under reasonable apprehension of death or grievous bodily harm from the violence with which the assault was originally made or with which the assailant pursues his purposes; and
>
> he believes, on reasonable grounds, that he cannot otherwise preserve himself from death or grievous bodily harm.

This subsection differs from Section 34(1) in that it may be relied upon by an accused person who performed the first aggressive act in a series of acts that eventually required them to use force as self-defence (*R. v. McIntosh,* 1995). Unlike s. 34(1), it applies to a defendant who intended to cause death or grievous bodily harm. It also does not require that the degree of force applied by the accused be proportionate to the degree of threat, as does s. 34(1). The issue of proportionality was discussed in *R. v. Baxter* (1975), wherein it was stated that “an accused’s belief that he was in immediate danger from an attack may be reasonable, although he may be mistaken in this belief.” What if the mistaken belief results from a mental disorder, however?

It has been held, in previous cases, that the trier of fact should take into account an accused’s mental illness when evaluating the reasonableness of his or her belief that

he or she was in reasonably likely to be harmed or killed, and could not otherwise prevent death or grievous bodily harm. In the case of *R. v. Kagan* (2004), Justice Roscoe, writing for a unanimous Nova Scotia Court of Appeal, noted that expert evidence that the accused was suffering from Asperger's syndrome should be taken into account when the jury assessed the issue of reasonableness. Justice Roscoe noted that the jury "should consider whether the perception of the accused was reasonable, given his specific situation and experience," and that "expert evidence of the accused's mental disorder is helpful, and necessary to appreciate why the accused's fear might have been reasonable in his situation." This could be very applicable to PTSD, given that it is a disorder that may result in an individual having an extreme reaction to seemingly benign or nonthreatening stimuli because they are reminiscent of the original trauma.

All of the cases which raised the self-defence defence in this research did so with reference to Section 34(2) of the *Criminal Code*, and to "battered woman syndrome," which was mentioned in addition to the fact that the accused suffered from PTSD.

Battered woman syndrome refers to a pattern of response by women who have experienced ongoing physical abuse at the hands of their partners (Schuller & Vidmar, 1992). The concept emerged out of a theory advanced by Lenore Walker (1984, 2000), on the basis of a study, conducted in the late 1970s and early 1980s, of more than 400 women who related their experiences as individuals who either currently or formerly lived in situations of domestic abuse. Walker's theory attempted to explain several aspects of the behaviour of these "battered women," including the puzzling question of why they did not simply leave the relationship. Dismissing the notion that these women were masochistic or suffering from personality disorders, Walker drew upon the work of Seligman (1975) and theorized that battered women develop a form of learned helplessness. Battered woman syndrome thus paints a portrait of a woman who, with

continued abuse, becomes passive rather than active, depressed rather than angry, and accepting rather than indignant.

Walker also posited the existence of a recurring cycle of violence, having three distinct phases. The first is *tension-building*, during which the batterer shows hostility and anger, while his partner attempts to placate him; when she is somewhat successful in this, it is proposed, she has an illusion of having some control over her partner and the relationship. However, the second phase involves *the acute battering incident*, which is said to be an inevitable result of the mounting tension from the first stage, which can never be truly suppressed. The battered spouse may actually precipitate the incident in order to break the unbearable tension and exercise some control over when, and where, the battering occurs (Walker, 2000). Finally, during the *loving-contrition* stage, there is calm and remorse on the part of the abuser, which leads the battered spouse to believe that there will be change and that she should stay in the relationship. As the cycle repeats over time, the stages are said to shorten, and the violence thus becomes more frequent, and also more severe. The batterer threatens to harm the spouse if he or she leaves the relationship, making them feel as if they have no choice but to remain in it, until at some point, they may try to break out of it with lethal violence (Walker, 2000).

Common law relating to battered woman syndrome was established in *R. v. Lavallee* (1990), a Supreme Court of Canada decision which resulted in a woman being acquitted on a charge of murdering her abusive partner. In this case, it was established that evidence relating to battered woman syndrome may be admitted to assist the trier of fact in determining whether the accused believed that killing the victim was necessary to avoid death or grievous bodily harm, under the provisions of s. 34(2) (Verdun-Jones, 2007). *Lavallee* established that in cases of battered woman syndrome, the standard to be applied is not that of the “reasonable man,” but that of the “reasonable woman” -- one

who has experienced the same abuse as the accused (Verdun-Jones, 2007). As the court observed in *Lavallee* (at para 50):

> Using the case at bar as an example the "reasonable man" might have thought, as the majority of the Court of Appeal seemed to, that it was unlikely that [the victim] would make good on his threat to kill the appellant...The issue is not, however, what an outsider would have reasonably perceived but what the accused reasonably perceived, given her situation and experience.

The court, in *Lavallee*, determined that expert evidence could be useful on several fronts: assisting the fact-finder in drawing inferences in areas where the expert has more knowledge than the lay person, which is the usual role of an expert; and additionally, and more specific to battered woman syndrome, helping to dissipate some of the common beliefs or stereotypes associated with the syndrome, such as the belief that women would leave the relationship if they were beaten as badly as they claimed, unless they were masochistic and enjoyed the abuse. Expert testimony, it was opined in *Lavallee*, can also be useful in addressing the issue of why an accused did not in fact flee in times of abuse and danger.

The case of *Bear* (1999) appears to be a textbook illustration of the principles of battered woman syndrome. Bear was charged with aggravated assault for stabbing her live-in boyfriend with a knife, resulting in several serious injuries to the victim, including the loss of sight in one of his eyes. Justice Whelan of the Saskatchewan Provincial Court affirmed at the beginning of his judgment that "the question to be considered is whether, having regard to s. 34(2) of the Code, she acted in self-defence."

At trial, it was established that the accused had been assaulted by the victim on numerous occasions, with the incidents being as severe as stabbings. There were also frequent references to a former partner of the victim, who went into a coma for unknown reasons; the victim taunted the accused that he would make the same thing happen to

her. On the evening of the offence, he made this threat, and swung at her with a knife, whereupon she was stabbed in the hand and leg before gaining control of the knife and stabbing the victim to death.

A psychologist and self-professed expert on the abuse of women was admitted to provide expert opinion evidence relating to battered woman syndrome, for which the accused was said to fit the criteria. The expert's overall opinion was that Bear believed that she would be killed or seriously injured if she did not take action in self-defence, and that this fear was not unreasonable given the history of violence in the relationship. The judge found that this evidence fit with the circumstances of the offence and helped to put the offence in context, and accordingly, attached a great deal of weight to it. Bear was found to have acted in self-defence, according to the two stages set out in s. 34(2) of the *Code*, and was acquitted. What is notable about this case is that the expert presented battered woman syndrome as a sub-category of PTSD, which is problematic, as will be discussed in more detail. It is unclear how – or whether – this information affected the judge's ruling.

In another case (*R. v. Bird,* 2004), a question was raised as to whether the accused, who was said to suffer from post-traumatic stress disorder and battered woman syndrome, could fairly invoke the battered woman syndrome and its altered standard of reasonableness in relation to a victim whom she did not know well. The circumstances of the offence were that the accused, who had a history of being sexually assaulted and battered by strangers and partners, and had worked as a prostitute some years earlier, decided to "turn one trick" at age 45 in order to make money to buy food for her family. She was picked up by the victim, and taken to his residence. At the time that she expressed a desire to leave, the victim restrained her and would not allow her to go. The accused stabbed the victim after he restrained her several times and asked her

to perform further sexual acts. In court, her explanation for this behaviour was that “she had had enough, and could not take it anymore.”

The same psychologist and expert in partner abuse who testified in *Bear* appeared before the court and testified that the accused’s post-traumatic stress disorder and battered woman syndrome could help to explain the accused’s actions. Indeed, it was argued that the accused’s history of being battered, sexually assaulted and restrained during assaults “played a role in her appraisal that there was a real risk of her being raped, assaulted, or losing her life.”

In evaluating the viability of the s. 34(2) defence, the trial judge’s focus was on battered woman syndrome in the context of near-strangers. Justice Kolenick thus reviewed the principles outlined in *Lavallee* as well as the theory of battered woman syndrome and concluded that the focus of the syndrome “appears to be on relationships in which the specific parties thereto have a history of abuse.” It was thus established that battered woman syndrome was not applicable to the accused, and she was, therefore, considered to have failed to meet the standard of the “reasonable [battered] woman.” Justice Kolenick determined that the accused had not stabbed the complainant under reasonable apprehension of death or grievous bodily harm, and that she did not believe on “reasonable grounds” that she could not otherwise preserve herself from death or grievous bodily harm.

This case has the effect, therefore, of possibly closing the door to other individuals with battered woman syndrome and PTSD who perceive that they are in danger with current partners based on similar precursors to abuse experienced with past partners. However, Bird’s actions, while they may not fit into the mould of battered woman syndrome, could be explained in the context of PTSD. One of the diagnostic criteria for PTSD involves “intense psychological distress at exposure to internal or

external cues that symbolize or resemble an aspect of the traumatic event" (APA, 2000). The important thing to emphasize is that an individual with PTSD becomes triggered by things that *symbolize* or *resemble* the initial trauma: in this sense, PTSD is a disorder where generalization is an important feature. Combat veterans, for example, can become very afraid, or even dissociate, in response to loud noises which remind them of gunfire, despite not being gunfire (Kolb, 1993). A woman feeling threatened in the context of a man behaving in ways that indicated danger with other partners is, therefore, understandable in the context of this disorder.

The argument being made is that perhaps *Bird* would have been decided differently if evidence relating to the features of post-traumatic stress disorder had been proffered in addition to that explicating battered woman syndrome, which has not yet addressed the transferring of fear triggers and the fight-or-flight response to them from one intimate partner to another. However, in *Bird*, as in *Bear*, the claim that the accused was suffering from battered woman syndrome became a much more central issue at trial than the accused's post-traumatic stress disorder, which would be useful in assessing reasonableness in the context of self-defence.

The above is interesting given the somewhat shaky status of battered woman syndrome itself. Walker's theory has been criticized in terms of its method – for example, Faigman (1986), an early critic, pointed out several issues: Walker failed to include a control group of nonbattered women in her study; the interviews conducted with battered women contained leading questions; the cycle theory was not placed in a meaningful time frame; and conclusions were drawn that were not substantiated in the data. Commentators have also averred that there are flaws in the theory: a frequently noted one is that battered woman syndrome focuses on helplessness, a notion which is

inconsistent with an abused woman taking the action needed to kill her abuser (Downs, 1996; Faigman, 1986; Schuller & Vidmar, 1992).

Another criticism of battered woman syndrome, often raised by feminists, should be considered in this context. It has been argued that the medicalization or pathologizing of the response to battering through the use of the word "syndrome" implies that the battered woman is psychologically impaired. This, in turn, does two things: shifts the focus from the victim's environment to her psyche (Rothenberg, 2003), and casts doubt upon the assertion that the woman's perception of danger was, in fact, reasonable (Downs, 1996). In addition, the term "battered woman syndrome" suggests that there is a single pattern of response to battering, when research in fact suggests otherwise (Campbell, 1996). The courts may then fixate on and evaluate this expected response very rigidly, as in the case of *Bird* above, while neglecting other important considerations relating to the woman and her environment which may have an impact on the reasonableness of her response, including mental disorders such as PTSD. Recognition of this fact has led Downs (1996) and others to assert that "it is far better to ask whether a battered woman's actions were justified under the circumstances than to seek to explain them as the result of BWS...the focus should be on battered women's situation, not battered woman's syndrome" (p. 227).

4.2.2 Duress and necessity

In one of the cases examined, the accused, who was diagnosed with PTSD, raised the defences of duress and necessity based on battered woman syndrome. These defences are related in that both form excuse-based defences and "concessions to human frailties," as they were described in *R. v. Perka* (1984). The defence of necessity has been established in common law as one which recognizes that an accused acted involuntarily from a "moral or normative" point of view, as outlined in *R. v.*

Perka (Verdun-Jones, 2007). The defence recognizes that individuals may perform actions which contravene the law out of necessity – that is, to prevent a greater harm or disaster. In *Perka*, Justice Dickson noted that the defence functions to provide an excuse – an acknowledgement that the action was wrong, but an explanation as to why it needed to be performed – as opposed to a justification, which would seek to diminish or challenge the wrongfulness of the act. The *Perka* case also established that an accused should not be entitled to the defence of necessity if they had any reasonable alternative to breaking the law.

The defence of duress is raised when criminal behaviour is attributed to a threat from another person. Again, the conduct of an individual acting under threat would be considered involuntary, and this defence thus presents an excuse for his or her actions (Verdun-Jones, 2007). Section 17 of the *Criminal Code* contains the law relating to the defence of duress, and specifies that the individual must have performed the offence under threat of "immediate death or bodily harm," the individual must believe the threats will be carried out, and that the individual doing the threatening must be present during the commission of the offence. The s.17 defence does not apply to several categories of offences, including sexual assault, hostage taking, or murder in any form. However, in *R. v. Ruzic* (2001), a case which involved a woman who imported heroin into Canada under threats that her mother would be harmed if she did not, the Supreme Court declared some parts of Section 17 unconstitutional. Specifically, the requirements that the threat be immediate, and that the issuer of the threat be present during the commission of the offence (i.e., the "temporal and spatial limitations"), were found to breach the Charter because they "allow individuals who acted involuntarily to be criminally liable," where the court had previously established that it was a principle of fundamental justice that only voluntary conduct should be criminally liable.

Having struck down part of the *Code*, Justice LeBel turned to the common law established with regard to duress, which "has freed itself from the constraints of immediacy and presence and thus appears more consonant with the values of the Charter". The four requirements of a defence of duress according to common law, as summarized in *Ruzic*, are as follows: the accused person acted only because of threats of death or bodily harm to themself or someone close to them; the accused believed that the threats would be carried out; the threats were of such gravity that any "reasonable person" would have reacted to them in the same manner as the accused, and the accused must not have had "an obvious safe avenue of escape" to pursue, which considers whether there was a course of action that the accused could reasonably have pursued in lieu of the criminal activity.

The case of duress and necessity examined in this research, that of *R. v. Stephen*, involved a woman accused of laundering money resulting from her husband's drug trafficking activities. The judge in this case proceeded by first examining the evidence presented by the accused in support of the defence, in order to determine whether there was an "air of reality" to the defence. It was decided that there was an air of reality to Stephen's claims of duress and necessity, which were then considered after it was established beyond a reasonable doubt that she had knowingly engaged in the activities with which she was charged.

The judge accepted the accused's testimony that she had experienced abuse at the hands of her husband for some years, and that she had sometimes retaliated against such abuse. The accused's psychotherapist was admitted as an expert on "anger and aggression, trauma impact and recovery and domestic violence." This expert, whose training consisted of a Master of Divinity degree and some experience in counselling, diagnosed the accused with battered woman syndrome and PTSD. However, the judge

attached little weight to her evidence, believing that she "simply accepted at face value everything that Stephen told her." Another expert called for the defence, a forensic psychologist, endeavoured to explain why the accused may not have felt she could leave her husband, even while he was incarcerated, according to principles of battered woman syndrome. Another forensic psychiatrist appeared in rebuttal for the Crown, asserting that the accused may have had some features of battered woman syndrome, but that she would not actually qualify for it. He argued that it was not common for women with battered woman syndrome to retaliate against their partner's abuse, as Stephen had. The judge seized upon this information and, recounting one such incident in which the accused was alleged to have stabbed her husband with a pair of scissors, said (at para 148):

> This incident, coupled with other examples of Stephen being verbally confrontational with Patriquen, is highly relevant to her claim that she was a battered spouse and in particular that she was suffering from battered woman syndrome. It is relevant as well to her defence of duress. These incidents speak against her claim that she lived in fear of Patriquen.

Being unconvinced that Stephen suffered from either post-traumatic stress disorder or battered woman syndrome, and believing - based on the evidence - that Stephen remained in her relationship by choice and did not take advantage of "numerous opportunities to leave," the judge rejected the defences of necessity and duress, and the accused was convicted.

What is interesting about this case is that, again, the issue of whether the accused suffered from battered syndrome again overshadowed any interest in her putative post-traumatic stress disorder. Another feature of battered woman syndrome which has been discussed by Downs (1996) is apparent here: the learned helplessness aspect of battered woman syndrome "creates a kind of character expectation, which serves more passive women at the expense of women who do not exhibit the qualities of

victimhood" (p. 166). Women who do not fit the mould of a completely passive victim are thus seen as not meeting the helplessness aspect of battered woman syndrome, which, as discussed previously, does not itself fit with the (often serious or lethal) violence engaged in by the battered women who appear in court claiming self-defence. Again, it is worth asking what PTSD and other features of Stephen's situation may have contributed to the defence.

Furthermore, it appears that duress and necessity are not defences which accommodate an individual with mental disorder, or a condition such as battered woman syndrome. In particular, the intersection of battered woman syndrome and the defences of necessity and duress provide a conflict in terms of the standard of reasonableness to be applied, insofar as the *Lavallee* case established that the standard for battered woman syndrome is the "reasonable woman" who has experienced similar abuse, while the common law relating to duress applies the standard of the "ordinary reasonable person," although this is a modified objective test taking into account certain characteristics of the accused. It was noted, in the case of *R. v. Ahmad* (2000), that with respect to the defence of duress and the requirement that there not be a safe avenue of escape:

> ...when you are considering the perceptions of a reasonable person, an ordinary reasonable person, the personal circumstances of the accused should be taken into account. The defence would fail if an ordinary reasonable person of his or her age, sex, background and other relevant personal characteristics and circumstances, would have realized there was an obvious safe avenue of escape...(para 8).

The accused was found not to suffer from battered woman syndrome in *Stephen*, but if that diagnosis had been accepted, it would have been interesting to see how aspects of the defence of duress would have been analyzed. Would the requirement of no "safe avenue of escape", for example, be considered from the

circumstance and perspective of the battered woman, who, in the very definition of her syndrome, feels that she cannot leave? It is also unclear how individuals with mental disorders such as PTSD are to be handled in the context of this defence. Future instances of battered woman syndrome and PTSD discussed in the context of duress and/or necessity may force Canadian courts to confront these questions.

4.2.3 Automatism

While the defences of duress and necessity are used to claim that the accused did not have the necessary *mens rea* (guilty mind) to be found criminally liable, automatism is a defence that is relevant to the *actus reus* element of a criminal offence. Like duress and necessity, automatism relates to the idea that only voluntary actions should result in criminal liability. However, it is physical, rather than moral, involuntariness that is at issue in automatism.

The currently accepted definition of automatism, set out in the pivotal case of *R. v. Stone* (1999), is “a state of impaired consciousness, rather than unconsciousness, in which an individual, though capable of action, has no voluntary control over that action.” Prior to *Stone*, automatism was often referred to as “unconscious” behaviour – however, as Justice Bastarache noted in delivering his judgment for the majority of the Supreme Court in *Stone*, “medically speaking, unconscious means ‘flat on the floor’, that is, in a comatose-type state.” Therefore, it was suggested that “impaired” or “altered” consciousness were more appropriate terms to apply to individuals making claims of automatistic conduct.

Two broad types of automatism are recognized. The first is automatism determined not to have been caused by a mental disorder, or “disease of the mind,” in legal parlance. A successful defence of *non-mental-disorder automatism* leads to an

acquittal (except if the automatism is the result of voluntarily ingested drugs or alcohol). In the second type, a "disease of the mind" is determined to be the cause of automatism. For such *mental disorder automatism*, the proper defence to be applied is that of not criminally responsible on account of mental disorder (NCRMD), as outlined in section 16 of the *Criminal Code*. As noted in *Stone*, "the inclusion of mental disorder automatism within the ambit of s. 16 provides courts with an appropriate framework for protecting the public from offenders whose involuntarily criminal acts are rooted in diseases of the mind."

The defence of automatism is not contained in the *Criminal Code*, but has been established and maintained through common law. In *Stone*, Justice Bastarache argued that there should be a general evaluative test for cases in which automatism is raised. Accordingly, he outlined a two-step framework to be used for evaluating all claims of automatism, which can be attributed to various triggers, such as somnambulism (sleepwalking), hypnosis, a blow to the head, or a so-called "psychological blow". Drawing upon the Supreme Court decision in *R. v. Parks* (1992), Justice Bastarache stated that the two steps to be undertaken by the trial judge where a claim of automatism is made are (1) assessing whether a proper foundation for a defence of automatism has been established, and (2) if a proper foundation has been established, determining whether the condition is mental disorder or non-mental disorder automatism.

Justice Bastarache noted that the first step, which is equivalent to satisfying the evidentiary burden for this defence, should require the defence to prove involuntariness to the trier of fact on a balance of probabilities. In order to do so, the defence must make a claim that the accused acted involuntarily at the time of the offence, and "present expert psychiatric evidence confirming its claim." It was noted that more weight should be given to psychiatric evidence establishing a history of "automatistic-like dissociative

states." Where it is psychological blow automatism being claimed, the defence must additionally adduce evidence of a "shocking" trigger. Finally, for all cases of automatism, Justice Bastarache noted that "a motiveless act will generally lend plausibility to an accused's claim of involuntariness," and, correspondingly, the claim will be less plausible where there is a clear motive to perform the criminal act. It was also noted that a trial judge faced with a defence of automatism should ask whether the crime is explicable "without reference to the alleged automatism," and if the answer is negative, then this raises the plausibility of the claim. Once the accused has asserted that his or her conduct was involuntary and called expert evidence to support this claim, the trial judge determines whether there is "evidence upon which a properly instructed jury could find that the accused acted involuntarily on a balance of probabilities."

The second step of the *Stone* test, undertaken if it is determined that a proper foundation for a defence of automatism exists, addresses the issue of how mental disorder and non-mental disorder automatism should be distinguished. The distinction is, of course, an important one, since a successful defence of non-mental disorder automatism leads to an acquittal, while an accused judged NCRMD may be committed to a psychiatric facility, with strict conditions relating to future release (Verdun-Jones, 2007).

The difference between the two types of automatism, as stated earlier, depends on whether or not the automatism was caused by a "disease of the mind." Justice Bastarache drew upon two different approaches to determining whether a condition is a disease of the mind, the "continuing danger theory" and the "internal cause theory," both of which were discussed by Justice La Forest of the Supreme Court in *R. v. Parks* (1992). In essence, the internal cause theory states that if the condition that the automatism is attributed to stems from "the psychological or emotional make-up of the

accused, rather than from some external factor," it should be found a disease of the mind. The "continuing danger theory" holds that in deciding whether a particular mental condition should be considered a disease of the mind, considerations of public safety need to be made in addition to medical ones. In particular, this theory posits that a condition should be considered a disease of the mind if it is likely that the automatistic condition will recur. Two issues that are relevant to determining whether there is continuing danger relate to whether there is a history of automatistic states, especially if they have resulted in violence, and whether the accused is likely to encounter the trigger of the automatism again. As noted by Justice La Forest, both of the theories share an emphasis on recurrence, as the internal cause theory includes the reasoning that "an internal weakness is more likely to lead to recurrent violence than automatism brought on by some intervening external cause."

Justice Bastarache suggested that overall, "the question of what mental conditions are included in the term 'disease of the mind' is a question of law" (in other words, a question to be decided by the judge, not medical experts, though the opinions of the latter are taken into account) for which a "unified holistic approach" is needed. This holistic approach would involve considering the internal cause "factor," as he preferred to call it, along with the "continuing danger factor," each where appropriate, meaning that a trial judge may employ either, or both, of the approaches in a given case. However, Justice Bastarache's decision also noted that most cases of automatism will be found to be caused by mental disorder – hence, he suggested that judges should start with this assumption. Justice Bastarache also mentioned that policy concerns should be considered in determining whether mental or non-mental automatism should apply. Policy concerns include the question of whether the automatism could have been

easily feigned, and whether the acquittal of a particular accused may “open the floodgates to a wave of similar defences in the future” (Verdun-Jones, 2007, p. 202).

The framework outlined in *Stone* also applies to so-called “psychological-blow automatism”, which is relevant to PTSD, and refers to a state of dissociation being triggered by a profound psychological shock. In addition to the holistic approach outlined above, another consideration is introduced with respect to this particular defence: the reasonable or ordinary person test, first discussed with respect to psychological-blow automatism in the case of *R. v. Rabey* (1980), where it was noted that an accused could raise the defence “if a reasonable person might have become dissociated in the same circumstances.” The Supreme Court in *Stone* (1999) affirmed this approach, with Justice Bastarache declaring that in order to be acquitted on the basis of psychological-blow automatism, it must be shown that the blow suffered by the accused was “extremely shocking” and would have caused any so-called “normal person” to enter a state of automatism.

Trial decisions for three cases in which automatism was raised were examined as part of this research. In each case, the automatism was referred to by the defence as “non-mental disorder automatism,” despite the fact that it was linked to the individual’s post-traumatic stress disorder in each case. The DSM-IV TR description of PTSD provides that

> In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment.

It was this type of rare occurrence that the defence tried to prove on the balance of probabilities in each of the three cases available for study, by making reference to a

psychological blow suffered by the accused. In only one of the three cases was the defence of non-mental disorder automatism accepted, and the accused acquitted.

The case in which the non-mental-disorder automatism defence was successful was that of *R. v. MacInnis,* heard in 2002. The accused in this case was a 31 year-old member of the Canadian Armed Forces charged with impaired driving and driving with excessive alcohol level. The defence submitted that MacInnis suffered from post-traumatic stress disorder, which developed as a result of two tours of duty in Yugoslavia during the early 1990s. The accused's psychiatrist, who had been treating him for PTSD for some time prior to the offence, was qualified by the court as an expert witness in post-traumatic stress disorder (and particularly military PTSD), and testified for the defence at trial.

The recounting of the offence by the accused revealed that MacInnis' PTSD symptoms had been very bothersome in the days leading up to his act and, after trying to calm them through vigorous exercise and various diversions, such as computer games, the accused drove to a bar where he used to work and consumed some beer. While at the bar, he noticed a fight about to break out between a "little guy" who was being "picked on" by three much larger patrons, and he immediately took the man described as the target of the aggression into his car, and drove away with him at a high rate of speed. MacInnis claimed not to remember anything between the time he registered that "this fellow...was going to get beat up" and the time that he saw the police car's lights reflected in his rear-view mirror, as he was pulled over by the arresting officer.

The judge accepted MacInnis' testimony, finding that it provided "a symptomological thread that connects the day's events, making them a coherent whole." He also accepted the evidence of Dr. Passey, the accused's psychiatrist and an expert

in military PTSD, who explained that the conflict in the bar had provided a "trigger" for the accused's seemingly bizarre fight-or-flight reaction, which was understandable in the context of his post-traumatic stress disorder. The expert further testified that it was the accused's PTSD that had driven him to drink, given his general avoidance of alcohol and drugs prior to the development of the disorder, and that the accused entered a dissociative state after he began drinking. The Crown chose not to call any *viva voce* evidence in rebuttal. Justice Wenden thus determined that the facts of the case were consistent with automatism and that, indeed, the offence would not be explicable without reference to it.

The next question was thus whether the accused's automatism should be classified as mental disorder automatism or non-mental disorder automatism. Justice Wenden argued that post-traumatic stress disorder "is a disorder not amenable to analysis using the internal cause factor." This conclusion he owed to the fact that by definition, PTSD is caused by an external factor (e.g., abuse, disaster, combat stress), and it may result in a dissociative state, triggered by occurrences which "symbolize or resemble," according to the DSM-IV, the initial traumatic event (or events, as PTSD can also be developed through chronic exposure to stressors like abuse). Taking into account the expert's opinion that "under the right circumstances anyone can develop this disorder," Justice Wenden concluded that PTSD, and the ensuing possibility of dissociation, is not due to a pathology or abnormality within the individual. (This, of course, ignores the issue of genetic susceptibility, as discussed in Chapter 2). He then turned his attention to the continuing danger factor. Here, he found that while the accused had some history of previous episodes of dissociation, as corroborated by his psychiatrist, he had never acted violently, and when his fight-or-flight reaction was provoked, "the accused invariably chooses to flee." Additionally, he accepted Dr.

Passey's testimony that the accused was improving through treatment, and that "extreme reactions" of the type characterizing the offence were unlikely to recur. Thus, finding that there was no significant basis to either the internal cause factor or the continuing danger factor, Justice Wenden found the accused not guilty on both counts, due to non-mental-disorder automatism.

The trial of *McEachern*, held in 2003, came to a different conclusion about the relationship of PTSD and automatism. In this case, the accused was also an off-duty member of the Canadian Forces, charged with impaired operation of a motor vehicle, operating a motor vehicle with a blood alcohol concentration in excess of the legal limit, dangerous operation of a motor vehicle, assault of a peace officer, and mischief, by wilfully damaging property after he consumed alcohol, drove to an army base and plowed his vehicle into a headquarters building. Once again, the defence of non-mental-disorder automatism was raised by the accused, but in this instance, it was not successful.

The facts as presented at McEachern's trial bear some resemblance to those presented in *MacInnis*. McEachern's PTSD was also attributed to combat experiences, these having occurred in Uganda in the mid-1990s. The disorder was said to have resulted in McEachern becoming ostracised by, and separated from, his unit and eventually to his release from the Canadian Forces. Like MacInnis, McEachern was diagnosed with PTSD and treated by Dr. Passey, as well as another military psychiatrist, for a number of years prior to his offence. On the morning of his offence, McEachern, who had not had any contact with his unit in some time, received a medal associated with his deployment in Africa. While ruminating about his service, the medal and his impending release from the CAF, McEachern consumed a quantity of beer. After also taking his anxiety medications, he lost his "time-line" and his subsequent recollection

consisted of only the taste of scotch, which he did not normally like to drink, followed by a woman tapping on the hood of his truck, after it had entered the headquarters building.

As in *MacInnis*, Dr. Passey testified for the defence, offering his opinion that the accused performed his actions in a dissociative state brought on by a "rush of traumatic memories" that occurred as McEachern looked at his medals. He established a history of dissociation during therapy, as he had done with MacInnis, and discussed other events which appeared to suggest dissociation which had been reported by McEachern's girlfriend and her father, with whom he lived. Based on these past incidents, and the description of his behaviour during the offence, Dr. Passey speculated that McEachern's behaviour would not have been voluntary, because he would not have been "aware of thoughts, emotions, morals, ethics, or even laws" at the time of the offence.

In this case, however, Dr. Passey's evidence was rebutted by a Crown expert. Dr. Boddam, the Chief Psychiatrist of the Canadian Forces, testified that there were two types of dissociation found in PTSD – flashback dissociation, in which the individual feels as though he or she is re-experiencing the initial trauma, and dissociative amnesia, in which the individual cannot recall the trauma or an important part of it. He testified that in the "flashback dissociation" caused by PTSD, an individual "would still be conscious of his actions and capable of voluntary action." Dr. Boddam differentiated the dissociative states in PTSD from automatism, which he defined as a state wherein an individual behaves like a robot and does not act consciously or voluntarily. It is significant that this contradicts the definition of automatism set out by Justice Bastarache in *Stone*. In essence, then, Dr. Boddam stated his opinion that PTSD would not be capable of inducing automatism under any circumstances. He reframed the offence as the actions of an intoxicated, emotionally distraught, suicidal man responding to a perceived insult

from the Canadian Forces. He did admit in cross-examination, however, that he had not had an opportunity to review McEachern's medical or CF personnel file.

In determining whether non-mental-disorder automatism had been proven on a balance of probabilities, Justice Sulyma stated that she preferred the evidence of Dr. Boddam. She acknowledged that Dr. Passey may have had better knowledge of the accused, but noted that Dr. Passey made a number of assumptions in his testimony, such as his statement that looking at his medal had caused McEachern to experience "a rush of traumatic memories." She, therefore, did not accept Dr. Passey's conclusion that the accused went in and out of a dissociative state during the commission of the offence: instead, she accepted Dr. Boddam's opinion that the accused's actions were significantly influenced by intoxication and that, had McEachern been in an automatistic state, he would have had no memory of it and would not have responded to questions from people at the scene of the accident in the way that he did. She found that there was a motive for the offence and that it could be explained without reference to automatism.

In rendering her judgment, Justice Sulyma made reference to *MacInnis*, calling the judicial analysis in that case "flawed." In particular, Justice Sulyma criticized Justice Wenden's consideration of the initial (external) trigger of PTSD as the test for whether any other similarly-situated individual would have acted the same way. Justice Sulyma opined that this was an error, for "the stressor or stressors to be considered are those the accused faced prior to entering into the dissociative state ... the trigger or shocking event must occur independently of the events which caused the original diagnosis." She argued that, in *MacInnis*, the fact that the development of PTSD does not depend on an internal cause was given improper weight. Ultimately, Justice Sulyma stated that, if she had found the facts supporting a defence of automatism to be borne out in McEachern's case, she would have determined it to be mental disorder automatism.

In turn, Kormos (2008) has argued that the *McEachern* case contains several errors, with the first being the judge's decision to side with an expert who had "barely a scintilla of foundation for his opinion" (p. 23). As noted previously, the judge also chose to accept evidence which contradicted the definition of automatism set out in *Stone*. Secondly, Kormos argues that the judgment contains an error in law, in that Justice Sulyma did not follow *Stone*, as she proceeded to consider whether the issue of non-mental disorder automatism had been made out, without first properly considering whether the accused had a "disease of the mind" – an important consideration given that the accused had PTSD.

Putting the above issues aside, the two cases of *MacInnis* and *McEachern* raise an interesting question that, to this author's knowledge, has not yet been answered in a definitive way: should an accused's PTSD be considered an internal flaw, given that its development depends, at least to some extent, on an external trigger? Judge Sulyma's conclusion that it does qualify as an internal factor makes sense when one considers that although PTSD does not necessarily stem from an internal cause, it becomes an internal cause which can lead to an individual with the disorder responding in an extreme fashion when faced with a stressor reminiscent of the trigger of PTSD. Indeed, in both *MacInnis* and *McEachern*, individuals without PTSD likely would have responded to the triggers for the alleged automatism in a way quite different from the accused, suggesting that the "ordinary" or "normal person" test used in cases of psychological-blow automatism has not been met. Additionally, in attributing the etiology of PTSD to external factors only, the courts have yet to take into account the suspected role of genetic vulnerability in the development of PTSD.

The third case of alleged non-mental disorder automatism examined did not have to grapple with the above question, for the judge did not accept the evidence of a

defence expert who opined that the accused, who suffered from PTSD related to abuse, repeatedly abused her infant child, each time in a state of flashback dissociation. The judge instead accepted the rebuttal of a Crown expert, who testified that it was highly unlikely that the accused would have repeatedly entered the "rare" state of dissociation in order to harm only her child. The decision in this case fits with another factor outlined in *Stone*, where it was suggested that courts should regard cases in which the victim of the automatistic act also triggered the act with suspicion, since this implies motive.

Thus, the defence of (psychological-blow) automatism, which was successful in only one case, is not well-established with respect to PTSD; nor is it likely to become so in the future, given that the Supreme Court in *Stone* has imposed severe restrictions on the defence (Livingston & Verdun-Jones, 2002). Even when the issue of internal-external cause is put aside, the continuing danger factor prescribed by *Stone* will no doubt hinder many claims of non-mental disorder automatism with respect to offenders with PTSD, if, as in the cases examined, their offences and histories betray a recurrent lack of control over their actions. As noted by Livingston and Verdun-Jones, a history of similar dissociative/automatistic states strengthens a defence of automatism; however, evidence of such also tends to work against a defence of automatism to the extent that it suggests continuing danger, which should lead to a verdict of NCRMD. However, judges may continue to acquit individuals with PTSD whose offences are not violent and whose "continuing danger" appears to be increasingly dampened by treatment, as was the case in *MacInnis*.

4.2.4 Not Criminally Responsible on Account of Mental Disorder

The defence of not criminally responsible on account of mental disorder (NCRMD) recognizes the fact that individuals suffering from mental disorder may not perform offences voluntarily or with real understanding of their consequences, and

directs that such individuals should be exculpated. Very strict criteria are used to apply the defence, and it is not often successfully raised (Verdun-Jones, 2007).

In Canada, the defence of NCRMD is a derivative of the *M'Naghten Rules*. These rules were articulated as the result of an English case, heard in 1843, in which the eponymous M'Naghten, spurred on by persecutory delusions, shot and killed the British Prime Minister's Secretary, while believing that it was the Prime Minister himself that he was shooting. The British House of Lords formulated the *M'Naghten Rules* in response to the case. The most important of these rules stated (as cited in Verdun-Jones, 2007):

> ...to establish a defence on the ground of insanity it must be clearly proved that, at the time of the committing of the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.

The current rule for establishing that an individual is NCRMD, contained in Section 16 of the *Criminal Code*, is noticeably similar to the passage above. Section 16 currently notes that a person is not criminally responsible for any act or omission made while a person was "suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong." A difference between the original *M'Naghten Rules* and the current *Criminal Code* incarnation is that in the currently used version, the capacity to appreciate has been added to the rule. Thus, in addition to an individual being judged NCRMD if he or she lacks *knowledge* that an act is wrong, whether an accused has the capacity to *appreciate* the "consequences, impact, and results" that his or her act is likely to have, as noted in *Cooper*, is also relevant to a finding of NCRMD. The effect of adding the "leg" of appreciation to the *Criminal Code* rule is to broaden the applicability of the NCRMD defence, compared to the original M'Naghten Rule (Verdun-Jones, 2007).

As in mental-disorder automatism, the "mental disorder" referred to in Section 16 of the *Criminal Code* has been established as a legal concept rather than a medical one, following the Supreme Court judgments in *Cooper* (1980) and *Stone* (1999) (Verdun-Jones, 2007). The steps to be undertaken were also outlined in *Stone*: the trial judge first determines whether the accused's condition meets the "legal test" for a disease of the mind – the "holistic approach" advocated in *Stone* and discussed in the context of automatism is applicable again here. If this criterion is met, the question of whether the accused actually suffered from a disease of the mind at the time of the offence is a question of fact, to be decided by the trier of fact (jury or trial judge). In *Cooper*, the Supreme Court offered a definition of "disease of the mind," saying that this term

> [E]mbraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion.

Such a broad definition means that many DSM disorders could in theory be used to raise an NCRMD defence, including personality disorders (Kormos, 2008). In reality, however, only disorders involving psychotic symptoms typically result in successful section 16 defences. The burden of showing that the accused suffered from a disease of mind at the time of the offence "is on the party that raises it," according to Section 16 of the *Code.*

Three trial decisions, in which the NCRMD defence was raised with respect to an accused diagnosed with PTSD, were available for study. As in the cases of automatism reviewed above, the criminal activity was said to have been committed in a dissociative state. The defence was successful in only one of these cases. The two cases discussed below are those in which PTSD was a central factor in raising the Section 16 defence. In the other NCRMD trial judgment that was reviewed for the

purposes of this study (*R. v. Fell*, 2003*)*, the accused had been diagnosed with PTSD; however, the accused suffered from this disorder along with several other disorders which were more likely to have contributed to the commission of the offence, making the impact of PTSD on the NCRMD defence difficult to analyze.

In the case of *R. v. Moraru*, heard in 2006, Justice March stated at the outset of his reasons that "the defendant was suffering from post-traumatic stress disorder, which is a mental disorder as described in Section 16 of the *Criminal Code*." The NCRMD defence was not successful in this case, as the Court found that there was not enough evidence supporting the accused's claim that he was in a dissociative state when committing the offences of theft and uttering threats. Moreover, the expert retained by the defence failed to provide useful information about the accused's disorder, merely stating that he believed the accused met the criteria for the NCRMD defence. Nonetheless, the case does serve as an instance in which a court immediately considered PTSD to qualify as a "disease of the mind": Justice March offered no justifications for this statement, but issued it seemingly as a matter of fact. This provides an interesting contrast to the case of *MacInnis* reviewed previously, in which the disorder was found not to fit the criteria for mental-disorder automatism outlined in *Stone*.

R. v. Borsch is the only case examined in which the defence of NCRMD was successful for an individual with PTSD, with a decision rendered in 2006. Borsch's circumstances by now sound familiar: he was a Canadian Armed Forces member who developed PTSD following a tour of duty in Yugoslavia in 1994, during which time he was witness to a number of horrific events, including the slaughtering of men and the rape of a child by a Serbian soldier. Ten years later, Borsch was alleged to have committed three crimes: unlawful break and enter, sexual assault with a weapon, and uttering threats to cause death. The victim of the sexual assault was a young girl who

lived several houses away from the accused. The accused claimed to have no memory of committing the acts – he recounted that he did not recall anything on the night of the offence after the time that he consumed some beer and smoked some marijuana at a baseball game, and that he woke up in a canoe on a river the following morning, with no knowledge of how he got there.

The defence called four experts to testify at trial: two psychiatrists and two psychologists. One of the psychiatrists was said to have "extensive experience in combat-related post-traumatic stress disorder," and he reported that higher rates of dissociative reports exist in combat-related PTSD. Each of the other experts had at least some experience with PTSD in clients from the military, and one of the psychologists had been treating Borsch for his PTSD symptoms since 2003. Together, the four experts agreed that Borsch did appear to have PTSD, and that there was evidence of dissociation within his history, and surmised that it must have been a dissociative state that he was in at the time of the offence, which in some sense replicated an event that had traumatized him.

The Crown strongly opposed the accused's plea of NCRMD, and two experts appeared to challenge the assertion that Borsch was dissociated due to PTSD at the time of his offence. In fact, the judge's account states that not only did they contest the defence of NCRMD, but both were specialists in malingering, and they "were rather adamant in their view that Mr. Borsch was not credible and accordingly did not suffer the trauma that he alleges took place in Bosnia." They also questioned the lack of a trigger to set off the alleged automatism, and opined that it was likely Borsch's consumption of alcohol and marijuana that led to the offence. However, the judge noted that neither of these experts had experience with military PTSD, and he expressed concern that one of them was brought onto the case merely as an expert in malingering. Ultimately, Justice

Nurgitz stated that he preferred the evidence of the defence's experts over that of the Crown's, and concluded (at para 31),

> In all of these circumstances I find what is required by Section 16(1) of the *Criminal Code* of Canada, Mr. Borsch is not criminally responsible for the act committed, the subject matter of this case, by reason of suffering from a mental disorder that rendered him incapable of appreciating the nature and quality of the act or of knowing that it was wrong.

The oral reasons for this decision are somewhat scanty, and do not furnish any details as to how it was decided that PTSD met the mental disorder or "disease of the mind" criteria provided by common law. Similarly, it is not clearly established in what sense the s.16(1) test is being met, in terms of how Borsch was found incapable of "appreciating" or "knowing," or both.

The finding of NCRMD was appealed by the Crown on the grounds that the trial judge did not make the necessary findings of fact to justify his acceptance of and reliance on the evidence offered by the accused's experts. In particular, the Crown argued that the trial judge failed to "find that the incidents in Bosnia about which the accused testified did actually occur, so that the accused's claim to be in a dissociative state had some factual underpinning." It was also noted that the trial judge did not adhere to the *Stone* test in evaluating the accused's claim of automatism.

The accused refuted the argument that using *Stone* as an authority was necessary, for it was argued that the defence of automatism had not been raised. Instead, it was submitted, Borsch was merely in a dissociative state (which is an altered state of consciousness, as described in *Stone*) that rendered him incapable of appreciating the nature and quality of his acts, or knowing that they were wrong. The claim of dissociation was said to be supported by the out-of-character nature of the offence, the choice of victim, a neighbour who recognized him easily, and the fact that the girl was able to fight him off after his initial sexual touching of her. The defence

argued that the judge made several things implicit in his acceptance of the defence experts' testimony – namely, that he believed the accused's account of his combat experience, and did not believe that the accused was malingering PTSD.

The Manitoba Court of Appeal considered several definitions of automatism, including that offered in *R. v. K* (1970): "automatism is a term used to describe unconscious, involuntary behaviour, the state of a person who, though capable of action is not conscious of what he is doing." This definition, which was once authoritative, was considered despite its rejection in *Stone* (1999), where Justice Bastarache supplanted "unconsciousness" with "impaired consciousness" in his definition of automatistic behaviour.

If one does refer to *Stone*, it is clear that the definition of automatism provided therein is a good fit with what was being argued in Borsch's case: essentially, that he was in an altered state of consciousness, acting involuntarily, without awareness of his actions, at the time of the offence. However, Justice Freedman, speaking for the Court, noted that the issue of automatism was not raised by any of the experts, and thus concluded the discussion of the issue:

> Perhaps the evidence could have established that automatism and dissociation were alternative terms for the same condition, or that a person with automatism is in a dissociative state. But none of that was established since, as noted above, there was no mention of automatism in the evidence. It is, simply, not an issue here.

This statement is interesting, and rather surprising: in essence, the accused was able to exempt himself from the common law governing the defence of automatism, simply by insisting that he was not pleading that defence, despite all indications that the dissociation upon which the NCRMD defence was founded would qualify as automatism (although whether it was mental-disorder or non-mental disorder automatism remained to be seen). Indeed, in *Stone*, the terms "dissociation" and "automatism" are used

interchangeably, and it was expert evidence on the topic of dissociation that was applied by the court to the issue of automatism.

Livingston and Verdun-Jones (2003) have pointed out that, as a result of the legal tests devised to evaluate claims of automatism, judges have come to rely heavily on expert witnesses where this issue is concerned. In this case, the judge was not willing to address the issue of automatism simply because the word had not been uttered by the experts. However, since automatism is a legal concept, rather than a psychiatric or psychological one (for example, it is not included in the DSM-IV), the experts could not be faulted for not making reference to it. Indeed, experts are urged to stay within the province of their expertise and not delve into legal issues, as will be discussed in Chapter 5. Williams (1978) addresses this very issue, noting that "a psychiatrist should be asked to testify to the mental condition as psychiatrically recognized, not to 'automatism.' It is for the judge to make the translation" (as cited in *R. v. Rabey*, 1980). Had the appeal court in *Borsch* referred to the proper authority of *Stone* on the issue of automatism, perhaps it would have been clear that the discussion of dissociation by the defence experts was relevant to the legal issue of automatism.

Although the issue of automatism was set aside, the Court of Appeal in *Borsch* decided that the trial judge did not focus enough on all the relevant questions, such as whether the accused was in a dissociative state at the time of the offence, and whether that fact, if established, qualified him for the Section 16 defence. The Court of Appeal was concerned that the trial judge "regarded the applicability of s. 16(1) as capable of being determined by choosing which set of experts' views he preferred" and in so doing, failed to establish whether the expert opinions were based on fact. The Court of Appeal stated that the trial judge should have made three things clear: "that he decided, and why he decided, that the accused suffered from PTSD," including why he was

persuaded that the accused was not malingering; "that he decided, and why he decided, that PTSD induced a dissociative state in the accused at the time of the offence"; and finally, "that he decided, and why he decided, that the PTSD-induced state constituted a mental disorder that prevented the accused from appreciating the nature and quality of the acts he was committing, or of knowing that they were wrong." A new trial was ordered for Borsch on the basis of the appeal.

Taken together, the cases of *MacInnis*, *McEachern*, and *Borsch* illustrate a lack of consistency in the defences and the legal analysis applied to individuals with PTSD. The three cases involve strikingly similar circumstances: all of the accused were combat veterans, diagnosed with and treated for PTSD before the commission of their respective offences, and all were said to show evidence of dissociation (or automatism) and lack of awareness or voluntary action during the offence, which was preceded by the consumption of alcohol in each case. These similar cases resulted in three very different outcomes: an acquittal, a conviction, and a finding of NCRMD (although it is possible that this last will be overturned). There clearly remain questions about how the disorder should be treated where non-mental-disorder automatism and the s. 16 defence are concerned. It is clear that different judges have used different reasoning, and have relied on the authority of *Stone* to varying extents and with varying results when considering offenders with PTSD. It is hoped that the judgments issued in future cases involving PTSD and criminal liability will help to clarify some of these issues.

4.3 Conclusion

Post-traumatic stress disorder is not a rarity in Canadian criminal courts. This analysis uncovered 122 cases in which the disorder was mentioned in connection with offenders during a period of less than twenty years. In addition, a variety of different legal defences were mounted in the context of offenders with PTSD. However, the

defences of self-defence and duress resulted in a rigid fixation on whether the accused fit the criteria for battered woman syndrome, while their concurrent diagnosis of PTSD did not, in the end, receive much focus. Cases involving non-mental-disorder automatism and NCRMD centred on the dissociative state, referred to earlier as the "*sine qua non*" of the PTSD-based criminal defence (Pitman et al., 2007). There appears to be a lack of consistency in the application of these defences, however, with different understandings of the internal cause issue and different applications of *Stone* leading to different outcomes in seemingly similar cases. Overall, an examination of the four defences employed suggests that the courts are still grappling with questions about how to handle this disorder.

5. EXPERT EVIDENCE AND SENTENCING

5.1 Expert Evidence

5.1.1 General rules

The *Criminal Code* does not outline stringent criteria with regards to expert evidence. It merely provides, in section 657.3(1), that

> In any proceedings, the evidence of a person as an expert may be given by means of a report accompanied by the affidavit or solemn declaration of the person, setting out, in particular, the qualifications of the person as an expert if
>
> (a) the court recognizes that person as an expert; and
>
> (b) the party intending to produce the report in evidence has, before the proceeding, given to the other party a copy of the affidavit or solemn declaration and the report and reasonable notice of the intention to produce it in evidence.

The *Code* further states that such experts may be called upon to testify in court, or to issue proof of their statements. However, the *Code* does not address the issue of who should properly be considered to qualify as an expert. With the description of experts in the *Criminal Code* thus being rather vague, more stringent criteria have been set out in case law, and especially in the case of *R. v. Mohan* (1994). In *Mohan*, Justice Sopinka of the Supreme Court set out four criteria to be examined when the admissibility of expert evidence is being considered. The first is relevance, which means that the evidence tends to make a fact of consequence to the case more probable or less probable, and is a threshold requirement to be decided by the judge as a question of law. The second criterion is “necessity in assisting the trier of fact” – the proffered

evidence should be outside of the normal experience or common sense or knowledge of the judge or jury.

The third criterion requires the absence of any exclusionary rule. In general, expert opinion evidence is admitted into criminal trials as an exception to the exclusionary rule pertaining to opinion evidence. The exception allowing experts to provide opinions is based on necessity: it is assumed that they possess a skill or body of knowledge not shared by the judge or jury (McWilliams & Hill, 2003). They are thus admitted to use their skills or knowledge to analyze the facts of a case and express their opinion as a "ready-made inference" based on the facts. While the opinions of experts can be very useful in helping to interpret the facts of a case, caution is needed to ensure that their evidence does not infringe upon or "usurp" the role of the trier of fact, confuse or mislead the trier of fact, or create a diversion or distraction or undue consumption of time (McWilliams & Hill, 2003). The fourth and final *Mohan* criterion states that "evidence must be given by a properly qualified expert with accepted expertise." A properly qualified expert was defined in this context as someone who "is shown to have acquired special or peculiar knowledge through study or experience in respect of the matters on which he or she undertakes to testify."

The *Mohan* test also includes elements of the Frye and Daubert standards established in the United States. *Frye* (1923) stated that expert evidence should be admitted only if it has gained general acceptance in the expert's scientific community; Daubert (1993) extended this rule, articulating factors such as peer review and publication, which can be considered relevant to acceptance. Thus, "novel science" is unlikely to be accepted under the *Mohan* test (Paciocco, 1999).

If a favourable ruling is obtained after applying the *Mohan* test, expert evidence is still only provisionally admissible, as there is a residual basis to exclude such

testimony based on a cost/benefit analysis. This entails a consideration by the judge of whether the costs of admitting the evidence (i.e., its potential prejudicial effect) outweigh the benefits of the court receiving such evidence (McWilliams & Hill, 2003).

Once an expert's evidence/opinion is admitted and heard in court, it may be accepted or rejected by the trier of fact. The decision to accept or reject such evidence should be made based on the "totality of the evidence," which includes the expert's qualifications, as well as the nature of the evidence itself and the facts upon which it is based (McWilliams & Hill, 2003).

5.1.2 Expert evidence and PTSD

In this research, *viva voce* evidence pertaining to PTSD was provided in 39 cases (which is 31.9% of those studied), with up to four experts testifying about the subject per case. This included all of the cases where a defence (such as automatism or NCRMD) was raised. It was less common for experts to testify in the sentencing hearings.

Experts testifying about PTSD were more commonly called by the defence. Overall, in the cases examined, the accused and their counsel called 37 experts who made or supported a PTSD diagnosis, 2 who refuted the diagnosis, and 2 who were equivocal about the offender's PTSD, while the Crown called 5 experts supporting a diagnosis of PTSD and 4 experts refuting evidence that the offender had PTSD. The nine Crown experts included four psychologists and five psychiatrists; the 41 defence-retained experts consisted of 20 psychiatrists, 17 psychologists, two general practitioners (physicians), and two individuals identified as "therapists," who were not registered psychologists (or who did not possess a doctorate degree in psychology). The same experts were called in a number of different cases: for example, one psychologist

testified in four cases, always for the defence. There were no instances in which an expert testified for different sides in different cases, or expressed a different opinion (e.g., supporting vs. refuting a diagnosis of PTSD) in different cases.

Experts called by the defence were more likely to be specialized in the treatment of trauma; in fact, none of the experts called by the Crown were noted to be experts in the area of PTSD in particular -- instead, they were noted to be forensic psychiatrists or psychologists. However, a number of the defence experts were referred to by titles such as “psychiatrist with expertise in military PTSD” or “forensic psychologist who has treated many individuals with PTSD.” The fact that the defence experts were, on the whole, more specialized in PTSD may be due to the fact that in a number of cases, they were providing therapy to the accused for this particular condition, as will be discussed in more detail below.

An analysis of the discussions of these experts and their testimony shows that the experts often did not rely on published measures or tests in order to establish the presence or absence of PTSD – only one mention was made of diagnosis using the “Posttraumatic Stress Disorder Scale”. In one case, an expert stated that psychological tests would not have been of any assistance in evaluating whether the accused suffered from PTSD. Instead, diagnoses seemed to have been made by clinical judgment and presumably through comparison of the individual’s symptoms with those specified for PTSD in the DSM, although the diagnostic criteria were seldom mentioned.

Overall, descriptions of how the experts arrived at their diagnoses were scarce, but it bears repeating that it is the discourse of *judges* that was the subject of analysis – trial transcripts containing the actual statements of experts were not reviewed. Accordingly, descriptions of the experts and their testimony were filtered through the judges’ views of them, and it could be that judges found details about diagnosis

cumbersome or irrelevant and, therefore, did not include them in their recounting of the evidence in their reasons. However, when mention was made of how PTSD was diagnosed or ruled out, it typically resembled a comment such as that made in *R. v. Ayach*, where the judge noted that “Dr. Ley’s assessment [that the accused had PTSD] was based on information provided to him by Mr. Ayach during seven hours of interviews.” As noted in the above discussion of the *McEachern* case, however, experts may not have ever met the accused, nor examined their files or anything other than media coverage relating to their offence. In *McEachern*, this “tremendously limited foundation upon which to base any evidence” (Kormos, 2008, p. 22), was not a hindrance to the Crown expert, whose testimony the judge accepted over that of the defence expert, who was the accused’s treating psychiatrist.

It is questionable whether the “properly qualified expert” standard established in *Mohan* was met in some of the cases reviewed in this research, as there appeared some experts with questionable credentials. For example, in the case of *Stephen*, the accused’s therapist was admitted to provide evidence on domestic abuse. Her training consisted of a Master of Divinity degree – there was no mention of her having received psychological or psychiatric training of any kind. Nevertheless, the expert claimed to have extensive experience in treating individuals who had been abused and felt comfortable making a diagnosis of post-traumatic stress disorder. This is concerning for at least two reasons: first, the use of the DSM IV TR to apply a potentially life-altering label to an individual is no small matter, and one would hope that it would be undertaken by a suitably qualified individual. In addition, the integrity of expert opinion is said to be partially maintained through scientific and professional associations or organizations that are “self-policing” (McWilliams & Hill, 2003). In other words, professionals such as

psychologists and psychologists are bound by rules or codes of ethics and conduct, while non-professional “experts” are not.

There also was some indication, in the cases examined, that some experts were willing to overstep their boundaries and go beyond the assumed limits of their expertise. In their 2006 book *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals*, attorneys Hy Bloom and Richard Schneider outline the role of the expert in forensic psychiatry as follows:

> The primary task of the expert is to serve as a consultant; that is, to diagnose a mental disorder; to define psychological variables that may be at play in a case; and, above all, to educate the court (and lawyers and retaining agencies) about matters the court knows little about (p. 35).

Pitman et al. (2007) concur with this advice, noting that experts who render testimony about PTSD “can avoid problems if they stick to describing the evaluee’s history, signs and symptoms, diagnostic conditions and mental disabilities, and leave the judge and jury to weigh these in the context of legal standards” (p. 392). Bloom and Schneider underscore the importance of experts remembering their roles as consultants/educators, and not acting as part of the defence or prosecution team, lest they be viewed as biased experts or “hired guns” who will give any opinion for the right price. The term “forensic identification” has been used to refer to clinician experts who come to adopt the opinion of the lawyers who retain them (Bloom & Schneider, 2006).

Expert alignment with the defence strategy was apparent in some of the cases examined. For example, in *R. v. Moraru* (2006), the judge’s reasons note that the defence expert repeatedly asserted his opinion that the accused was “not criminally responsible” or “qualifies for a Section 16 defence.” In cases such as this, it is clear that the expert has gone beyond providing information on “matters the court knows little about,” and has crossed over into providing inappropriate opinions on matters that are

for the court (or, more properly, the trier of fact) to decide. Pitman et al. state unequivocally that “the expert should not attempt to resolve questions of damages, competence, or criminal responsibility” (2007, p. 392). The issue of experts overstepping their boundaries is a worrying one. In some instances, judges criticized the experts for doing so, but in other cases a psychologist or psychiatrist addressing legal issues seemed to be accepted. This relates to a trend identified in *R. v. McIntosh* (1997) – the courts are, in some cases, “overly eager to abdicate their fact-finding responsibilities to ‘experts’ in the field of the behavioural sciences.” It may be appropriate to refer, again, to the appeal court’s reluctance, in *Borsch* (2007), to consider the issue of automatism, simply because the connection between dissociation and automatism had not been made by the experts.

Furthermore, some of the evidence proffered by experts was not correct, or misleading. For example, the psychologist who provided opinion evidence relating to battered woman syndrome in the trials of *Bear* (1999) and *Bird* (2004) told the court that “battered woman syndrome is a sub category of post-traumatic stress disorder.” There is a possibility that the judge misinterpreted her evidence as making this claim when it did not. However, if the expert did make this claim, it should be considered misleading, and a cause for concern. While post-traumatic stress disorder is contained in the *Diagnostic and Statistical Manual of Mental Disorders*, battered woman syndrome is not a disorder that is recognized by this system; it is, instead, a theory or syndrome that has been proposed and not yet recognized by medical or psychiatric authorities. Although Walker (1991) and some other researchers have worked to have it recognized as a subcategory of PTSD in the DSM, this has yet to occur. Schuller and Vidmar (1992) clarify the issue by saying that, “despite the label *syndrome*, battered woman syndrome is not a diagnosable mental disorder, but rather a descriptive term that refers to the *effects* of

abuse on a woman" (p. 281, emphasis in original). To suggest that battered woman syndrome is a sub category of PTSD thus lends the syndrome a medical/psychiatric status that it does not actually hold, and could certainly influence the way that it is viewed by the trier of fact. Another expert (in *Stephen*) was reported to have explained that "if post-traumatic stress is not dealt with over time, it accumulates to become the battered woman syndrome." In this case, battered woman syndrome is misrepresented as a severe form of PTSD, which again paints a false portrait of the syndrome and its status.

Erroneous evidence relating to PTSD itself was also offered in the cases reviewed. In *Stephen* (2008), a forensic psychiatrist disputed another expert's opinion that the accused suffered from PTSD from ongoing spousal abuse, stating that the trauma required as a precursor to PTSD needed to be a very severe or intense episode. In fact, it is well-recognized that PTSD can result from ongoing abuse such as that experienced by the accused – the DSM-IV TR criteria, which were available at the time of Stephen's trial, include the following two requirements in terms of the Criterion A, relating to the stressor leading to PTSD:

> (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
>
> (2) the person's response involved intense fear, helplessness, or horror.

These criteria would not in any way preclude spousal abuse from being a stressor leading to PTSD, for physical or sexual (or even psychological) abuse perpetrated by one's partner certainly has the potential to cause serious injury, threaten physical integrity, and lead to feelings of helplessness and/or horror. Furthermore, as noted in Chapter 1, "Criterion A" for PTSD has a subjective quality in the DSM-IV, such that the individual's own response is more important than whether others would have

found the stressor to be overwhelming (Breslau, 2002). Pitman et al. (2007) have noted that "idiopathic thresholds for diagnosis" do exist among experts which lead to underdiagnosis of PTSD in forensic contexts (p. 393). However, this trend may be balanced by a bias towards overdiagnosis on the part of some experts, who are inclined to view virtually any type of emotional distress as PTSD, and fail to consider the diagnostic criteria or to consider differential diagnoses. In both cases, the remedy would seem to be for experts to be thoroughly educated about, and adherent to, the diagnostic criteria for PTSD.

Judicial reaction to expert testimony ranged from judges dismissing experts and their views entirely to attaching great weight to their opinions. Some themes emerged in the acceptance or rejection of expert evidence. First, there were instances in which judges were willing to take very seriously the pronunciations of experts because they were well-acquainted with the issue being discussed. For example, in *R. v. MacInnis*, Justice Wenden was prepared to accept the views of the testifying psychiatrist because "the importance of Dr. Passey's testimony...lies in the fact that the expertise has direct application to the facts before the Court. That is, Dr. Passey's expertise is in the area of PTSD as it has developed among UN peacekeepers."

However, experts propounding PTSD were frequently thought by judges not to be credible, and their evidence was variously described as "too speculative," "insufficiently based on factual information," "anecdotal," "theoretical," and "soft science." These conclusions were presumably drawn because, in making a diagnosis of PTSD, the psychiatrist or psychologist would have to rely heavily on the individual's self-report. Indeed, McWilliams and Hill (2003) have noted of behavioural science testimony in general: "retrospective inquiry into past mental state defies objective measurement" (p. 12-46). "Factual information" concerning PTSD is hard to acquire, given that, even if it

can be established that an individual was exposed to a situation that was potentially traumatizing, whether he or she develops PTSD as a result may depend on a number of factors, as mentioned in Chapter Two. None of the symptoms which result if PTSD does develop is necessarily outwardly observable.

A related reason that experts testifying about an offender's PTSD were sometimes doubted is that they were viewed by the judges as advocates, rather than as impartial, dispassionate clinicians. As the judge in *P.T.* (2005) remarked of an expert, "As can happen often in a doctor-patient relationship developed over a number of years, the doctor seems to have taken on the role of an advocate." In the case of *Stephen* (2008), the expert providing an opinion about battered woman syndrome emphasized that "I'm not only the objective assessor, I'm also the woman's therapist." This was a cause of concern for the judge, who stated that "an assessor's role is to be critical and provide an independent opinion." In general, Bloom and Schneider (2006) advise that "Treating clinicians (that is, the accused's own physicians) should generally avoid being conscripted into the expert role" due to the fact that treating clinicians "are by definition supposed to advocate for the interests of their patients" (p. 37). However, this advice was not heeded in a number of cases examined in this research. It is possible, of course, that, since trauma and its treatment is still an emerging area of inquiry, it would have proven too difficult to locate an expert other than the accused's treating clinician. This seems especially likely where PTSD subtypes (e.g., military PTSD) are concerned. In some of the cases examined, having the treating doctor testify was seen as an advantage by the judge in terms of the in-depth knowledge that he or she was assumed to possess, even if he or she did advocate for the offender to be seen as a victim.

Of interest is the circumstance that different characterizations of the same experts were made by different judges – for example, a psychologist who testified in four

cases, was portrayed as a highly respected and credible expert by one judge, and as not objective and "more of an advocate" by another. Likewise, Dr. Passey, the military psychiatrist who testified in the trials of *MacInnis* and *McEachern*, was described by the judge in *McEachern* as "an expert in psychiatry" with "considerable expertise regarding the diagnosis and treatment of PTSD." In *MacInnis*, however, where more importance was attached to his testimony, Dr. Passey's status was inflated to "expert in psychiatry and post-traumatic stress disorder. His expertise in the latter field is impressive, and he is undoubtedly the leader in this field in Canada, if not worldwide."

Discussions of the offender's PTSD were frequently overshadowed by dialogues about risk, particularly when certain comorbidities were involved. PTSD is not a disorder whose diagnosis leads to clear prognoses in terms of future risk: as Young and Yehuda (2006) note, "the diagnosis of PTSD is limited in allowing us to make decisions about issues crucial to the court, related to long-term trajectory and outcome" (p. 63). Notwithstanding the fact that "expert opinions about recidivism and risk are often wrong" (Ruby, 2008, p. 304), judges frequently deferred to experts who confidently proffered such predictions. This was especially true when PTSD was raised in dangerous offender hearings. In *R. v. Ominayak* (2007), when faced with one expert who diagnosed an offender with PTSD and another who diagnosed him with antisocial personality disorder, Justice Topolinksi dismissed the evidence pertaining to PTSD and declared, "I am satisfied that Mr. Ominayak's chances of treatability are but a slim hope."

The patterns of expert evidence also reveal a concern about malingered PTSD, and perhaps a reluctance to have offenders portrayed as victims, that existed on the part of the Crown attorneys. In several cases, it was suggested by experts called by the Crown that the offender was not truly suffering from PTSD, but wished to convey that image of him or herself for some gain. For example, in "strenuous opposition" to a

defence expert who diagnosed the accused in *Borsch* (2006) (who raised an NCRMD defence) with PTSD, the Crown called two experts, one being a psychiatrist who attempted to refute the diagnosis, and the second a psychologist whose "specialty is malingering." However, the judge attached little weight to this expert, whom he viewed as brought onto the case simply to support a suspicion of malingering. Further questioning of her status and intentions was warranted when it was revealed that she left parts of what the accused said to her out of her report because she decided these utterances lacked credibility. Finally, it was noted that she had no experience with military PTSD, which cast doubt on her assertion that Borsch was faking his illness. Judges also frequently questioned experts about how they knew that the accused was not "faking" the disorder – a question that did not seem to arise when experts testified about other conditions, such as antisocial personality disorder. The concern about PTSD being faked seems to imply a general understanding that PTSD can be an advantage in sentencing – one that should not be granted to an undeserving offender.

5.2 Sentencing

In *R. v. Mohamed* (2008), Justice Bellamy noted that sentencing is

> a very human process that has been called a delicate art. It is a delicate art because the judge has to try to carefully balance the societal goals of sentencing versus the moral blameworthiness of the accused person and the circumstances of the offence. At the same time the judge must take into account the needs of the current conditions of the community.
>
> In the final analysis, though, the paramount question is always this, and it remains so in this case: what should this offender receive for this offence committed in the circumstances under which it is committed?

Attempting to isolate the impact of one factor, such as PTSD, on sentencing in cases such as the ones examined, in which an offender often had a number of psychiatric problems and a variety of different aggravating and mitigating factors to be

balanced by the judge, is thus no simple feat. Through examination of some of the key variables coded in this study, however, a number of patterns and conflicts or discontinuities emerged.

5.2.1 Sentencing objectives

One area examined in this analysis was sentencing objectives emphasized by the judges. Since the passing of Bill C-41 in 1996, section 718 of the *Criminal Code* has delineated the purpose and objectives of sentencing as follows:

> The fundamental purpose of sentencing is to contribute, along with crime prevention initiatives, to respect for the law and the maintenance of a just, peaceful and safe society by imposing just sanctions that have *one or more of the following objectives*:
>
> to denounce unlawful conduct;
> to deter the offender and other persons from committing offences;
> to separate offenders from society, where necessary;
> to assist in rehabilitating offenders;
> to provide reparations for harm done to victims or to the community; and
> to promote a sense of responsibility in offenders, in acknowledgement of the harm done to victims and the community.

Therefore, judges, in handing down sentences, have the liberty to decide which of the six objectives outlined above (it may be more proper to say seven, given that specific and general deterrence are treated as separate aims) to select and emphasize given the circumstances of the offence and the offender. These objectives are applied in the context of the "fundamental principle" outlined in s. 718.1, which states that "A sentence must be proportionate to the gravity of the offence and the degree of the responsibility of the offender." The *Criminal Code* does note, however, in s. 718.01, that "when a court imposes a sentence for an offence that involved the abuse of a person under the age of eighteen years, it shall give primary consideration to the objectives of denunciation and deterrence of such conduct." In these cases, then, the freedom of the judges to choose is removed. It is also important to point out that judges do not choose

among the above sentencing objectives where young offenders are concerned: section 38(2) of the *Youth Criminal Justice Act* (YCJA) sets out separate principles to be considered when sentencing young persons.

Sentencing objectives were, therefore, examined only for adults, excluding those who committed crimes against minors or who were undergoing dangerous offender hearings from analysis. Sentencing objectives were thus available for 56 offenders. Figure 2 displays the frequency with which various objectives were emphasized. In addition, the chart shows the proportion of cases in which a given objective was specifically noted to be either a primary or secondary consideration in sentencing. Denunciation and both types of deterrence were the most commonly-cited objectives of sentencing. It is also worthy of note that rehabilitation was most often said to be of secondary importance – this particular objective is examined in more detail below.

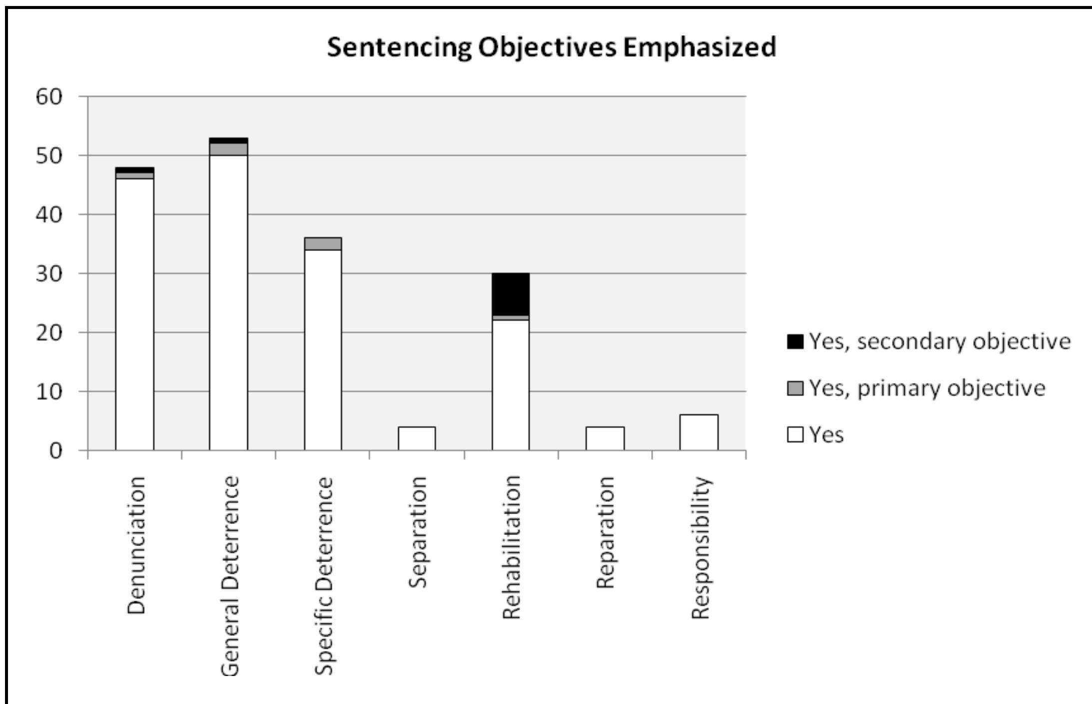

Figure 2. Sentencing objectives emphasized by judges.

5.2.1.1 Rehabilitation

All of the offenders involved in the cases under analysis suffered from post-traumatic stress disorder. As mentioned previously, 64% of the offenders in the sample also had one or more comorbid psychiatric conditions. A question of interest to this research was thus how often the objective of rehabilitation was invoked, given that these are mentally-disordered offenders.

Examining the discourse of the judges provides insight into why rehabilitation was deemed possible or important or not possible or important in each case. In *R. v. J.S.* (1998), for example, Justice Diehl took into account the offender's history of abuse, and in choosing to make rehabilitation a focus of sentencing, opined that "being tough in the sentencing of this accused is not the solution, because leniency is not the cause of her problem." In other cases, rehabilitation was seen as a way to ultimately emphasize public safety, in that if the offender's mental health problems could be addressed, their offending behaviour would cease. An example of this is found in *R. v. Perrault* (2007), in which the judge determined that Perrault's offence must have been linked to his mental disorder, "as his conduct is otherwise completely inexplicable." He further stated that "the probable role of Mr. Perrault's mental health issues suggests there is a critical need to address his rehabilitation." This sentiment was echoed in a number of other cases in which the offender's trauma was seen as a precursor to their offence.

Other judges, however, refused to give a central role – or, indeed, any role – to rehabilitation in the sentencing of offenders with PTSD. In *R. v. Andrejczak* (2001), a case of criminal negligence in operation of a motor vehicle causing death, Justice Blacklock recognized that incarceration would not be the best option when considering the accused's rehabilitation, but said that it would be imposed nevertheless because sentencing in this case had to be "more than just a sole consideration of the accused's

rehabilitation." A similar judgment was made in *R. v. Gholamrezazdehshirazi* (2008), wherein the judge considered the devastating impact of the crime on the victim and declared:

> ...the ultimate rehabilitation of the offender would serve to protect the community. There is logic to that position. However, I am unable to accede to it because it does not adequately respond to the paramount sentencing principles that are needed in this situation: deterrence and denunciation.

Where PTSD co-existed with psychopathy, and experts formulated poor prognoses in terms of risk, the view that such individuals are untreatable precluded judges from sentencing with regard to rehabilitation:

> Given G.L.'s anti-social personality disorder, his very high scores on the PCL-R and on the VRAG, the principles of deterrence and rehabilitation are not applicable in this case... As an intelligent pathological liar and psychopath, I am persuaded ... that he will not meaningfully commit to treatment.

Another instance of this theme was found in *R. v. I.J.W.C.* (2006), when the judge felt that given the offender's history, "I cannot 'take a chance' and craft a rehabilitative sentence."

A further reason that offender PTSD did not lead to rehabilitation being considered in sentencing is that some judges were reluctant to factor rehabilitation into sentencing if the disorder did not seem to be connected to the crime (a situation that will be discussed further below).

Finally, in several cases, there appeared to be a belief on the part of the judge that PTSD was not a serious enough disorder to warrant consideration. In *Andrejczak* (2001), the judge remarked that the offender's case should not be sentenced in accordance with those of offenders with "much more serious psychiatric disorders than the accused has." It was also common, in the cases examined, for a judge to remark that

the accused did not suffer from “severe mental disorder,” even when it was clear that PTSD symptoms caused considerable distress to the individual.

An examination of the sentencing objective of rehabilitation raises an interesting discontinuity: specifically, it appears that judges do not always seem to agree on the definition of rehabilitation, in terms of what it is, and what it is supposed to accomplish in the criminal justice context. The term was interpreted as follows by Justice Kukurin in *R. v. M.L.R*. (2002):

> [R]ehabilitation in M.L.R.’s case is not limited to the confines of criminal conduct. Rehabilitation has a connotation of restoring to a state of mental health through therapy or treatment.

However, a quite different interpretation was expressed by Justice Charron of the Ontario Court of Appeal (with whom one of her two fellow judges concurred) in *R. v. Shahnawaz* (2000):

> Rehabilitation as a goal of sentencing is not the restoration of an offender’s physical and mental health but his reinstatement as a functioning and law-abiding member of the community.

The latter view has been accepted and directly quoted in a number of different cases, such as *R. v. C.F* (2000), wherein the sentencing judge acknowledged the accused’s “multiple difficulties,” including PTSD, but determined that they were not relevant to sentencing. Rehabilitation as a restoration to a law-abiding, functioning community-member state is also implied in other cases: for example, in *R. v. Getkate* (1998), the accused was diagnosed with PTSD by two psychiatrists. In considering what sort of sentence to impose, the sentencing judge opined that “Lillian Getkate does not require rehabilitation.” In making this statement, the accused’s mental disorder was not mentioned and, instead, the following issues were emphasized: “she has tremendous remorse and guilt...she has also been involved in fundraising events and other

community events." In other cases, the definition of rehabilitation being adopted by the judge is unclear. In the case of *C.N.B.R.* (1995), the court stated that "if her treatment needs are met, I am satisfied that her rehabilitation can be successful." It is unclear whether the "treatment" being considered relates to the accused's mental health problems, or to treatments specifically designed to curb offending.

In their 1999 book, *Making Sense of Sentencing*, editors Julian Roberts and David Cole provide a definition of rehabilitation that does not clearly endorse either of the contradictory views espoused above: they note that, as an aim of sentencing, rehabilitation is supposed to "restore the offender to the community by changing him or her from an 'offender' into a law-abiding citizen," and that "this goal can be accomplished in a number of ways and the means include treatment programs of all kinds" (p. 9). Similarly, Ruby (2008) notes that the rehabilitation principle "is premised on the idea that offenders can be 'treated' and cured of criminal tendencies" (p. 15). He also points out that "There is serious doubt that the criminal law ought to be in the healing business at all" (p. 17).

The limits of the criminal justice system with respect to rehabilitation are mentioned, or alluded to, in other cases reviewed in this study. In attempting to craft a sentence that would address the needs of a traumatized young offender, one judge stated, "We can only attempt to assist in this young man's recovery. One sentence for one offence cannot begin to undo years of abuse." In *R. v. M.B.W.* (2007), the judge commented, "The criminal justice system has a limited narrow role. It cannot avenge a mother's loss, nor mend a mother's damaged child."

The question of whether "rehabilitation," in a criminal justice context, needs to address an offender's mental health issues thus seems to be both a practical one and an ethical one. If it is correct that rehabilitation is "not the restoration of an offender's

physical and mental health but his reinstatement as a functioning and law-abiding member of the community," then it seems logical that, in some cases, mental or physical health issues will need to be addressed *in order for* offenders to cease offending and become functioning, contributing members of their communities. This logic applies to cases in which the offence is connected to, and apparently driven by, the accused person's mental disorder. Although it may not seem intuitive that PTSD, an anxiety disorder, can lead to the commission of crimes, several mechanisms help to explain why offences are sometimes attributed, or directly linked, to the disorder by judges. The first is the intergenerational cycle of abuse. The literature reviewed in Chapters 1 and 2 establishes a link between being abused and abusing others in similar ways. This link has been recognized by judges who have noticed similarities between the victimization experienced by the accused and that which they have in turn inflicted on others. For example, in *R. v. J.W.D.* (2001), the judge remarked during the sentencing of a First Nations residential school survivor:

> At the residential schools, the hands that reached out in violence shaped generations of First Nations people and created a painful legacy. Years later, those same hands reached out through D. to assault the complainant. The cycle of abuse from generation to generation continues.

PTSD is also known to lead to anger-management problems, which can be quite dangerous for those in the vicinity of an individual who finds him or herself unable to control aggressive impulses. The case of *Malley* (2008), an off-duty combat soldier who, while suffering from PTSD, became intoxicated, "lost control" and assaulted another patron at the bar, is a suitable example. Reviewing the facts of the case, the judge felt he had to ask whether the incident would ever have occurred had Malley not gone to war and returned with post-traumatic stress disorder.

A further complication of PTSD, which has great potential for leading to criminal behaviour, is substance abuse. The link between trauma and substance abuse has is well-established – Chilcoat and Breslau (1998), for instance, found a significant relationship between drug abuse and PTSD, such that, in a community sample, the incidence of drug abuse was four times higher in individuals with a history of PTSD compared to those without. Similarly, Davidson and van der Kolk (2007) report that a high percentage of individuals (between 60 and 80 percent) who enter treatment for PTSD also present with alcohol or drug abuse or dependence. Among traumatized people, substance use is theorized to be a form of self-medication (Chilcoat & Breslau, 1998; Davidson & van der Kolk, 2007) or an attempt to produce alterations in affective state and control the distressing intrusion symptoms associated with PTSD. A study of individuals with PTSD and substance use disorder confirmed that when their PTSD symptoms worsened, their substance use also worsened (Brown, Stout, & Gannon-Rowlely, 1998). Researchers have suggested that individuals dually diagnosed with PTSD and substance use consistently show poorer substance use treatment outcomes (compared to individuals without PTSD) if treatment for PTSD is not provided concurrently (Amaro, Chernoff, Brown, Arevalo, & Gatz, 2007; Kubiak, 2004; Ouimette, Brown, & Najavits, 1998). As mentioned previously, more than a quarter of the offenders in this study were diagnosed with substance use or dependence in addition to PTSD.

Finally, a sad reality of PTSD is that, in some cases, it affects the ability to connect with, and have empathy for, other people, as touched upon in Chapter 2. Terms such as “numbing” and “robotization” (Bloom, 1997) have been used to explain the behaviour of traumatized persons who, in a desperate attempt to curtail the suffering of PTSD, shut down their emotions entirely. They also apply to individuals who were abused in childhood and did not experience emotional resonance with caregivers, and

subsequently became unable to relate to others, or feel badly about causing them the same type of pain that they have been caused. A sentencing judge recognized an instance of this phenomenon in *R. v I.J.W.C.* (2006), noting that, "Mr. C. Is an offender whose early childhood neglect has doubtless contributed to his addiction and inability to overcome it, as well as his inability to empathize with or appreciate the impact his actions have had on others."

In criminal cases resulting from the four types of problems described above – a sexual assault on a child, an assault motivated by uncontrolled rage, an alcohol-fuelled offence by a known abuser, and a crime that demonstrates a clear lack of regard for the suffering of the victim(s) – the sentencing options may appear to be straightforward to a judge who considers rehabilitation to be merely a matter of stopping the offender from engaging in criminal behaviours and restoring the offender to the ranks of law-abiding citizens. The sexual offender requires a program directed at his inappropriate urges; anger management will be suitable for the second; the offender with the alcohol addiction will need an addiction-oriented program. The behaviour of the fourth may be deemed callous – it is possible that he will be branded a psychopath, and viewed as untreatable, beyond reach of any type of rehabilitation.

A judge who considers rehabilitation a tool to address an offender's mental health, however, might consider the offender's PTSD in each of the cases described, and may recognize that it could underlie the offending behaviours as well as their immediate precipitants (e.g., substance abuse). An offender who continues to abuse alcohol to dampen the symptoms of PTSD may not be able to benefit from rehabilitation and overcome his or her substance abuse problem without having treatment specific to PTSD. Similarly, an offender who suffers from uncontrollable bursts of rage might not be able to benefit, or benefit fully, from anger management treatment until he is treated for

PTSD. In such cases, a nexus between criminal justice programs and more specialized psychological or psychiatric ones seems warranted -- one might argue that the criminal justice system does after all need to venture into the "healing business" (Ruby, 2008), or at least partner with it, in order to achieve its aim of curtailing criminal activity.

The foregoing is not meant to suggest, however, that just because an offender has post-traumatic stress disorder, it automatically plays a role in the commission of any offence perpetrated by him or her. Among the cases examined, there were a number of instances in which it would be very difficult indeed to forge a connection between this mental disorder and the crime committed. Indeed, this was the stance taken by the judge in *Shahnawaz* (2000), the case from which one of the conflicting views of rehabilitation originated. Shahnawaz, before immigrating to Canada as a refugee, was imprisoned for three years in Afghanistan because it was believed that he had connections to rebel fighters. While a political prisoner, Shahnawaz was subjected to "horrific and repeated torture" which led to the development of PTSD. While in Canada, Shahnawaz became involved in the drug trade, trafficking heroin. Justice Charron opined that

> [T]here is no connection between Mr. Shahnawaz's post-traumatic stress disorder and his illegal drug activities. The situation would be otherwise, of course, if, for example, Mr. Shahnawaz's involvement in the offence was due to an addiction of heroin. In such a case, the treatment of the addiction would have a direct bearing on his rehabilitation and its availability could indeed become the focal point of sentencing.

For offenders who suffer from mental illness which has no apparent link to the offence committed, Ruby's (2008) doubt about the appropriateness of healing in a criminal justice context is understandable, as such a practice is clearly beyond its scope. In cases such as *Shahnawaz*, courts have affirmed that they do not exist to attenuate general suffering, and that they need to keep their focus on reducing criminal activity.

5.2.2 PTSD as a mitigating factor

Mental disorders can act as aggravating or mitigating factors in sentencing (Ruby, 2008). Antisocial personality disorder and substance abuse are examples of disorders which may be considered aggravating. Other mental disorders generally are included under the mitigating category (Schneider, 1999). In this study, mitigating factors were specifically mentioned in 56 of the 73 reasons for sentencing. In eight instances, PTSD was included among these factors; in eight additional cases, the judge mentioned the offender's "mental illness" or "psychiatric problems," which, in most cases, could refer to PTSD as well as comorbid disorders. Furthermore, in three cases, an offender's "unfortunate personal history" or "tragic background," which often led to the development of post-traumatic stress disorder, was seen as a mitigating circumstance. PTSD was never listed among the aggravating factors. In certain cases, however, an accused's anger management and substance abuse problems, which may be connected to PTSD, were considered to be aggravating features in sentencing.

Some judges acknowledged the offender's PTSD but deemed it not to be a mitigating circumstance. These were generally cases in which the disorder was not clearly connected to the offence, as discussed previously. One example is found in the case of *R. v. Ward* (2007), an individual whose post-traumatic stress disorder was attributed to his tours of duty with the Canadian military in Bosnia. Justice Glass found the offences of which Ward had been convicted – including sexual assault with a weapon and unlawful confinement – were not the result of his suffering PTSD, and stated that he was therefore "not prepared to give weight to this factor in the sentencing process as a mitigating factor."

Even when there is no connection between an offender's PTSD and his or her offence, some sentencing courts have found it important to consider the disorder's effect on the accused should he or she be incarcerated. This issue is discussed below.

5.2.3 Effect of imprisonment

In a number of the cases reviewed, judges noted that sentencing the individual to a term of incarceration might be "counterproductive" (*R. v. Andrejczak,* 2001) or "a step backwards" (*R. v. J.W.D.*, 2001) if offenders were removed from support networks and treatment programs which they rely on in the community. In other cases, a term of incarceration was viewed as potentially very detrimental, even "crushing" (*R. v. Ahier,* 2006), in light of the offender's mental disorder.

In *R. v. Ferguson* (2006), a sentencing judge deemed the mandatory minimum sentence of four years imprisonment for manslaughter carried out with a firearm to be "cruel and unusual punishment." This conclusion was drawn because Ferguson, as a former police officer who had killed a prisoner using his firearm, would need to be in protective custody in order to protect him from other inmates. It was recognized that spending 23 hours a day confined to a cell would likely have a quite detrimental impact on an individual suffering from PTSD (Ferguson's PTSD was in fact a consequence of the incident in which he shot the prisoner, who had tried to disarm him). Ferguson was granted a constitutional exemption from the minimum sentence, and a conditional sentence of two years less one day was imposed.

When the sentence was appealed by the Crown, however, the Alberta Court of Appeal varied the sentence to match the mandatory minimum (this decision was later appealed, and was upheld by the Supreme Court of Canada in 2008). Justice Paperny, speaking for the majority of the Alberta Court of Appeal (two concurring judges versus

one dissenter), voiced concern about the future integrity of mandatory minimum sentences if it could be argued that individual offenders should be exempted from them based on the plea that it is cruel and unusual punishment in their particular circumstances. He acknowledged the fact that PTSD made the sentence more “harsh,” but argued that

> ...such a sentence is not "cruel and unusual punishment" because s. 121 of the *Corrections and Conditional Release Act*, S.C. 1992, c. 20, gives parole authorities discretion to grant parole any time the offender's physical or mental health would be seriously damaged by continued confinement.

Here, we can again look to the case of *Shahnawaz* (1999, 2000), which casts doubt upon this assertion. Like Ferguson, Shahnawaz was initially granted a sentence which took into account the fact that imprisonment would be extremely nocuous given his circumstances. As mentioned previously, Shahnawaz, who was convicted of trafficking heroin, came to Canada as a refugee from Afghanistan, where he was imprisoned and tortured as a political prisoner during his early adulthood. His posttraumatic stress disorder was diagnosed shortly after arriving in Canada, and he was also receiving treatment under the care of a psychiatrist since that time. At trial and at the sentencing hearing, his psychiatrist testified as to his PTSD, and the evidence was uncontested by the Crown and accepted by the judge. Justice Molloy determined that the most fitting sentence for Shahnawaz was a conditional sentence of two years less one day, followed by two years of probation. This, she acknowledged at the beginning of her Reasons, “will be seen by some as a substantial departure from the type of sentence traditionally imposed for an offence such as this.” She then proceeded to carefully outline the reasons why a conditional sentence order was appropriate under the circumstances.

Chiefly, it was noted that, after his conviction, which occurred on June 2, 1999, Shahnawaz was not released on bail but held in custody pending his sentencing. Sentencing did not occur until September 30, 1999, meaning that Shahnawaz was in jail for nearly four months before he returned to court for sentencing. At this time, his psychiatrist testified as to the impact that detention had upon him – it was said to have "reactivated and intensified" his PTSD. A second psychiatrist called by the defence supported this assessment, finding that imprisonment was exacerbating Shahnawaz's symptoms of PTSD and depression. Justice Molloy herself recognized changes in the accused, noting that Shahnawaz looked "very fearful, submissive in the extreme (almost cowering), unable to make eye contact, withdrawn and visibly trembling." Agreeing that a penitentiary term would likely render Shahnawaz "even more dysfunctional and unable to cope with the stresses of everyday life," she determined that "prolonged incarceration would make eventual rehabilitation upon release more unlikely, and perhaps impossible." She thus considered that this was a case where it was appropriate to exercise judicial clemency, and invoked s.718.2(e) of the *Criminal Code* (which states that "all available sanctions other than imprisonment that are reasonable in the circumstances should be considered") in partial justification of her decision to impose a conditional sentence, which, she felt, could satisfy the principles of denunciation, deterrence, and rehabilitation. She concluded that "I have chosen to place more weight on the devastating consequences of imprisonment on this particular individual and to relieve his suffering which I consider to be out of proportion to his degree of culpability."

Shahnawaz's sentence was subsequently appealed by the Crown, and his case brought before the Ontario Court of Appeal. There, it divided the three judges. The two judges who formed the majority opted to allow the appeal, and varied the sentence to six years' imprisonment. In providing the reasons for this decision, Justice Charron declared

the sentence imposed “manifestly unfit” and argued that, “while Mr. Shahnawaz’s personal circumstances could properly be taken into account in reducing the sentence, the trial judge placed too much emphasis on this factor.” Here the definition of rehabilitation as “not the restoration of an offender’s mental and physical health but his reinstatement as a functioning and law-abiding member of the community” was proffered. Justice Charron conceded that the accused’s disorder warranted a reduction in the term of incarceration normally imposed for Shahnawaz’s offence (which ranges from 9 to 12 years), but pronounced that a disorder not connected to the offence should not have been as strong a determinant of sentencing as Justice Molloy allowed it to be.

Hence, even though the evidence that had been introduced strongly suggested that Shahnawaz had been - and would continue to be - significantly damaged by incarceration, the needs of the criminal justice system – specifically, the need to denounce unlawful conduct, deter other would-be offenders and minimize disparity in sentencing – outweighed the needs of the offender, dire as they were. The decisions of Justices Molloy and Charron illustrate diverging perspectives on the role of the criminal justice system. In the former case, the justice system exercises care and compassion towards those caught in its gears, while in the latter, the machinery is efficient and expedient, not to mention relatively unforgiving: the view expressed is that the offender must be processed in a certain way for the good of the system, no matter how mutilated he becomes in the process.

5.2.4 Sentencing young offenders with PTSD

As mentioned previously, the philosophy underlying sentencing individuals under 18 is noticeably different from that underpinning the sentencing of adults. This is especially true since the passing of Bill C-7, the *Youth Criminal Justice Act* (YCJA), which came into force on April 1, 2003. Previously, under the *Young Offenders Act* (in

force between 1984 and 2003), individuals who were sixteen-years-of-age or older and who committed the crimes of murder, attempted murder, manslaughter, or aggravated sexual assault were automatically tried in adult court, although a transfer hearing could be held at the request of the defence, in appeal of the automatic transfer. Transfer hearings were also held in cases where an automatic transfer was not imposed, but the Crown wished to see the young offender tried in adult court.

Since the introduction of the YCJA, transfer hearings are no longer needed because all cases involving youth are now heard in youth justice courts, although adult sentences can still be imposed after a finding of guilt in youth court (Ruby, 2008). The YCJA was also designed to address the fact that, under the YOA, Canada had one of the highest rates of youth incarceration in the Western world, and the perception that courts were being relied on to process non-serious offences which could be dealt with more appropriately outside of the courts (Endres, 2004). Doob and Sprott (2006), in their analysis of the YCJA, approvingly label it a “sheep in wolf’s clothing,” for although it was presented (through a clever communications strategy) as a “tough” measure to a public demanding a crackdown on youth crime, in actuality, it aims to reduce the use of the formal youth justice system, with principles guiding the use of extrajudicial measures and emphasizing the avoidance of custody. Under the YCJA, judges are encouraged to craft sentences which focus on rehabilitation, rather than incapacitation (Bala, Carrington, & Roberts, 2009).

Ruby (2008) argues that the current sentencing model for adults blends a moral/retributive approach to punishment, which focuses on denunciation and repudiation of an offender and his conduct, with a utilitarian approach, which regards deterrence and treatment interventions as the chief aims of sentencing. The tension between the different approaches to sentencing adults can be seen, for example, in the

case of *Shahnawaz* discussed above. The *Young Offenders Act* was accused of a lack of clarity where sentencing principles were concerned, meaning that the same types of ideological conflicts and disparities could arise during sentencing. Ruby notes that the approach taken to sentencing young offenders under the YCJA is coherent, and more consistent with a primarily utilitarian approach to sentencing, with the main objectives emphasized being rehabilitation (although again, there is no clear discussion of what this entails), reintegration, and promotion of a sense of responsibility. The difference in sentencing objectives in young offender cases after 2003 examined in this research is apparent: for example, in *K.D.* (2003), the sentencing judge stated:

> The reports talk about her diminished responsibility and in the same breath the person seems to talk about the need for deterrence and when I look at the *Youth Criminal Justice Act*, deterrence is not something that is given high or any profile.

In another case (*R. v. M.B.W.*, 2007), the judge underscored that "Parliament has directed that youth courts not consider punishment, denunciation or general deterrence as principles of youth sentencing."

However, of the 19 of cases involving young offenders examined in this research, the majority (78.9%, or 15 cases) were processed under the *Young Offenders Act* (only four cases examined were processed after the introduction of the YCJA in 2003). The sentencing of young offenders with PTSD under the YOA does betray more of a punishment orientation. In *B.W.* (1995), the judge expressed his hope that a term in custody would serve as a wake-up call:

> A short sharp sentence to be followed by a long term of probation ought to be imposed in this case. It is important that B.W. appreciate that his violent actions are wrong and that they carry consequences.

The 19 cases involving young offenders examined involved serious offences, for the most part: five youths were charged with first-degree murder; seven with second-

degree murder; one with manslaughter; and the remainder with assault (aggravated assault in one case) or sexual assault, except for one youth who was charged with mischief (relating to a false accusation of sexual assault by a teacher). Furthermore, in approximately two-thirds of the cases, comorbidities were mentioned, with FASD, ADHD and conduct disorder being commonly diagnosed in addition to PTSD.

In cases spanning both sets of youth justice legislation, a theme running through the judicial discourse is that youths with PTSD (and often, a number of comorbid disorders) must be treated as soon as possible. Several references were made to young offenders being at a "crossroads," or a "critical stage" of their lives. In one case (*R. v. D.C.*, 1993), a judge cited an expert's opinion that there was a "window of opportunity with respect to treatment of D.C. which must not be lost." A window of opportunity connotes a period of time in which action must be taken, or else the chance to act will be lost. The suggestion being made is that young offenders are somehow more capable of reform, and that these offenders may be beyond reach of rehabilitation in (in whichever sense this term is interpreted) if the "golden opportunity" (*R. v. D.C.)* to help them is not seized. This is interesting for what it suggests about how the mentally-disordered adults in this study may have been viewed by the courts.

An unfortunate finding of this research is that the determination of the judges in the cases examined to place young offenders in the appropriate programs before it is "too late" was often stymied by the lack of availability of appropriate programs. Of the 19 cases involving young offenders, eight were transfer hearings conducted under the YOA. Five of these resulted in young offenders being transferred to adult court, and a factor in this decision was often the availability of treatment resources. In *R. v. P.J.J.* (1996), for example, Justice Lilles noted that "indications are that the treatment resources in the adult system are superior."

A related problem is that youth sentences were sometimes seen as being too short to achieve anything meaningful in terms of treatment, and this was used as a justification for transferring young offenders to adult court. As Justice Franklin noted in *R. v. M.B.W.*, “The *Youth Criminal Justice Act* provides that after balancing the criteria this Court must be satisfied that a youth sentence would be of sufficient length to hold M.B.W. accountable. This Court is not.”

Therefore, it seems that, in order to achieve the aims of the youth justice system, which does seem to have a clear focus on rehabilitation, young persons with PTSD may be transferred back into the adult system, where notions of rehabilitation, treatment and the necessity to address mental disorder become muddled by conflicting interpretations and belief systems. In addition, the adult sentences that they receive mean that they can be subject to stagnation during incarceration, in some cases, and greater harm caused by incarceration, in others.

It should be noted that there are some rehabilitative options designed for, and applied to, young offenders, such as the Intensive Rehabilitative Custody and Conditional Supervision sentence (IRCS). However, eligibility for such programs can be very strict, as will be discussed in further detail in Chapter 6.

5.2.5 Keywords in sentencing

In an effort to quantify some of the themes which emerged across the sentencing documents examined, a keyword search was carried out in order to examine the frequency with which various terms were used by judges in sentencing individuals with PTSD. This is an – admittedly crude – method of measuring the salience of different issues. It is important to remember that, when a keyword, such as “rehabilitation” is mentioned by a judge, it could be mentioned in the context of a statement such as “this

individual requires rehabilitation" or, conversely, "rehabilitation is not appropriate for this individual." Nevertheless, whether a term is being applied to an offender in a positive or negative way, an examination of its frequency of use still provides some insight into how central the particular issue was to the case.

Searches were carried out separately for adults and young offenders in order to reflect differences in sentencing for young offenders, which are mandated by the *Youth Criminal Justice Act*. Dangerous offender hearings were also examined separately, given that these sentencing hearings are governed by a separate section of the *Code*, which dictates the primary considerations in these hearings. The "average per case" column in each table allows for comparisons of the frequency of a keyword across the different demographics, controlling for the number of cases.

Table 5. Keyword search conducted for adult sentencing decisions (n = 82).

Keyword	Number of Mentions	Average per Case
"Post-traumatic stress disorder"/ "PTSD"	227	2.77
"Treatment"	434	5.29
"Rehabilitation"	275	3.35
"Danger"*	322	3.93
"Risk"	242	2.95
"Punishment"	162	1.98
"Substance" (abuse, dependence)	172	2.09

***The keyword search captures partial words, so that searching for the word "danger" also returns words like "dangerous."**

The keywords for adult offenders show that PTSD was mentioned 227 times across 82 cases. "Rehabilitation" was mentioned with about the same frequency, and "treatment" was the most frequent keyword of those examined, mentioned 434 times. However, this search also shows that competing with the themes of "treatment" and "rehabilitation" for salience were the themes of "danger," "risk," and "punishment." This

does not come as a great surprise given the relative seriousness of most of the offences examined, but it does illustrate an interesting dialectic, and suggests that the courts may be torn between helping offenders with PTSD and restraining them. The keyword "substance," which returned instances where substance use/abuse/dependence was discussed, shows that this was a significant issue in the cases examined.

Table 6. Keyword search conducted for young offender sentencing decisions and transfer hearings (n = 19).

Keyword	Number of Mentions	Average per Case
"Post-traumatic stress disorder"/ "PTSD"	45	2.36
"Conduct disorder"	97	5.10
"Treatment"	333	17.53
"Rehabilitation"	177	9.32
"Danger"	63	3.32
"Risk"	170	8.95
"Punishment"	18	0.95
"Substance" (abuse, dependence)	52	2.74

Where young offenders are concerned, approximately the same number of mentions of PTSD are made relative to the number of cases, compared to the adult offenders. One disorder that overshadows PTSD is, as the keyword search demonstrates, conduct disorder, which was mentioned by judges 97 times. The issue of treatment was highly salient for courts dealing with young offenders – far more so than any other issue. Rehabilitation was also a concern, but it again competed with "risk" for salience in these decisions. Substance use/abuse/dependence was also just as salient as in the adult cases.

Table 7. Keyword search conducted for dangerous offender hearings (n = 7).

Keyword	Number of Mentions	Average per case
“Post-traumatic stress disorder”/ “PTSD”	25	3.57
“Treatment”	469	67
“Rehabilitation”	40	5.71
“Danger”	850	121.42
“Risk”	574	82
“Punishment”	13	1.86
“Substance” (abuse, dependence)	170	24.28

The third keyword search revealed that, for the small sample of dangerous offender hearings, which resulted in long-term offender designations in three of the seven cases, and in dangerous offender designations in the remaining four, PTSD was mentioned an average of 3.57 times per case. The risk posed by the offender, and whether it can be managed in the community, is a central consideration in dangerous offender hearings, and this is reflected in the frequency with which the term “risk” appeared in these hearings. The salience of treatment, mentioned 469 times in 7 cases, is also understandable given that the issue of treatability is germane to whether an individual may be found a long-term offender (in order for this designation to be made, there must be “a reasonable possibility of eventual control of the risk in the community,” as outlined in s. 753.1(1)(c) of the *Criminal Code*) or a dangerous offender (a label that is applied when, among other things, “the offender’s behaviour in the future is unlikely to be inhibited by normal standards of behavioural restraint”, as outlined in s. 753(1)(a)(iii)).

For these offenders, the “danger” keyword appeared most often. However, a judge would be forced to utter “dangerous offender” a certain number of times in a dangerous offender hearing, so this estimate of salience is inflated. Substance abuse was also a very significant issue in these hearings.

5.3 Conclusion

It is not surprising, given the complicated legal arguments made regarding PTSD (as reviewed in Chapter 4), and given the complex nature of PTSD itself, that experts were called to testify in a number of cases examined. The testimony of experts played a significant role in some of the cases, although the degree of influence they were able to exert depended on a number of factors, including the judge presiding over the courtroom. Experts were sometimes found to be questionably qualified, or to proffer evidence containing misleading or erroneous statements.

Overall, based on a discursive analysis, there appears to be significant disparity in terms of how PTSD is treated in sentencing. In some cases, differences arose as a consequence of disagreements about central issues, such as the role and purpose of rehabilitation in the criminal justice system. Sentencing for young offenders has become more harmonized under the *Youth Criminal Justice Act*, but when young offenders are transferred to the adult system because of lack of treatment options or insufficient sentence lengths in the youth court system, they will face the uncertainties and conflicting ideologies that prevent consistent decisions about how to manage mentally-disordered offenders from being made.

6. RESPONDING TO PTSD IN THE CRIMINAL JUSTICE SYSTEM

6.1 The Ideal Treatment of Trauma

The treatment of trauma is a subject that has received a lot of attention from researchers. Below, a three-stage psychotherapy technique advocated by numerous writers is reviewed, as well as the current evidence regarding pharmacotherapy as a complement to talk therapy. Some alternative techniques are also briefly reviewed.

6.1.1 Three stages of psychotherapy

Herman (1992) outlined three broad phases of recovery from trauma, and delineated the tasks of therapy to be undertaken at each stage. These broad stages are cited and mirrored in the writings of many other individuals studying trauma therapy (e.g., Bloom, 1997; Briere & Scott, 2006; van der Kolk, McFarlane, & van der Hart, 2007). Throughout Herman's stages, the focus is on empowering the individual, reconnecting him or her with others, and transforming him or her from a "victim" into a "survivor".

The first stage involves restoration of safety to the survivor of trauma. In order to recover, a traumatized individual needs to feel as though he or she is in a safe, predictable environment. The establishment of such a safe environment gives those who are traumatized and continually on alert for danger a chance to let down their guard and begin the process of introspection (Briere & Scott, 2006). However, establishing safety can be more of a challenge than it sounds; as a consequence of the hypervigilance associated with PTSD, individuals may not be able to perceive safety where it exists,

and it may take some time before the individual in treatment is able to recognize that the therapeutic environment is indeed safe. Bloom (1997) differentiates between physical safety in an environment (i.e., being in a place that is free from threat of harm) and psychological safety, which refers to the ability to be safe with oneself and self-protect from harmful impulses. In order to create psychological safety, a traumatized individual needs to address and challenge feelings of helplessness and worthlessness, and self-destructive impulses. This phase of treatment is sometimes referred to as "stabilization," and can involve tasks such as acquiring a framework for understanding symptoms; learning relaxation or stress inoculation techniques; "scheduling, planning, and anticipating daily activities"; and identifying and labeling emotions, as many individuals with PTSD develop alexithymia, or an inability to relate one's somatic sensations to basic emotions such as anger or sadness (van der Kolk, McFarlane & van der Hart, 2007, p. 426).

Remembrance and mourning of the traumatic experience forms the second stage of psychotherapy. Here, the survivor is encouraged to revisit the trauma and transform it into language – in other words, he or she tells the story of their trauma, so that it can be integrated into their personal history as a coherent narrative and a part of their life experience and not remain an alien, incomprehensible, unspeakable horror (Herman, 1992; van der Kolk, McFarlane, & van der Hart, 2007). This phase of treatment can also be time-consuming, given that the need to tell the story must be balanced with the need to remain safe; telling the story should be done carefully so that intrusive images or self-destructive tendencies do not overwhelm the individual. Briere and Scott (2006) caution that exposure to the traumatic memory must be "carefully titrated" so that the individual's already compromised biological and psychological capacity for stress is not overwhelmed; techniques such as systematic desensitization, in which individuals are

exposed to their feared memory in a state of relaxation, are relevant to this (p. 191). Additionally, this phase can be very challenging for therapists, whose normal instinct is to help their client avoid pain; however, "learning to tolerate the memories of intense emotional experiences is a critical part of recovery" (van der Kolk, McFarlane, & van der Hart, 2007). In addition to storytelling, techniques such as prolonged imaginal exposure and "flooding" may be used in this stage. Ultimately, according to Herman, telling one's story of trauma amounts to giving testimony about one's experience, which is recognized as a universal ritual of healing. It is also believed that the action of telling a story and of transforming the experience into words helps to correct the abnormal processing of the traumatic memory (Herman, 1992).

Telling the story of trauma often leads to an individual experiencing feelings of grief, and the "mourning" part of this stage acknowledges that the individual has experienced a loss or injustice which has altered him or her in a fundamental way. In therapy, an individual is encouraged to feel sadness, which, although it may be viewed by some victims as a victory for or concession to the perpetrator, needs to be reframed as a reclaiming of one's full range of emotions after the numbing of trauma. At this point in therapy, an individual may also design revenge fantasies and then have to come to terms with the unrealistic nature of "getting even" (Herman, 1992).

Finally, the third stage is that of reconnection, in which a therapist may seek to help the trauma survivor recreate a self that is not centered around trauma, and to reinstate trust and closeness with other people, which may involve working on relational schemas, or assumptions about others and their intentions (Briere & Scott, 2006). As Herman (1992) puts it, "Having come to terms with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed, now she must develop a new self" (p. 196). In this stage, "survivors" may wish to seek

out ways to expose themselves to the danger that their trauma represented – in other words, reenact it – but in a healthy, active way, such as by taking a self-defense course or a trip to a location that they previously avoided due to fear. This stage may also involve revealing abuse to others, challenging the indifference of bystanders or accusing those who have done the abusing, but only if the individual feels this is necessary to his or her healing process (Herman, 1992).

According to Herman, the first stage of treatment – the establishment of safety – is usually best accomplished in one-on-one therapy, while group therapy can be ideal for the remembrance and mourning stage, as group members can encourage the individual to tell his or her story and provide a support network for him or her as they do so. A group also "bears witness to the survivor's testimony" (p. 221), which gives it a larger meaning. However, in order for a group to function well, it needs to have a consistent set of members who have established safety with one another, as well as active, engaged leadership (Herman, 1992). In the third stage, reconnection, the individual may have moved beyond needing the trauma therapy group, and may find it more appropriate to join a psychotherapy group focused on interpersonal relationships, as he or she begins to connect with others in different social networks and activities.

Briere and Scott's guide to trauma therapy (2006) echoes the three stages outlined above, but places a somewhat greater focus on what they term "psychoeducation," or providing information relating to trauma and its effects (p. 87). This process includes a cognitive reframing of symptoms, such as hyperarousal and numbing, as adaptive responses or attempts to "metabolize" the trauma that have simply gone into overdrive and continued beyond the length of time that they were necessary (p. 67). Adopting such an approach conceptualizes PTSD (and other trauma disorders) as a "disorder of recovery" (Shalev, 2007b) and, hence, as an opportunity for growth.

Briere and Scott (2006) report that “some of the best interventions for posttraumatic psychological injury are implicitly existential and hopeful” (p. 69).

Although these general guidelines have been established for trauma therapy, a willingness to tailor the process to the needs of the individual is always important. Herman (1992) notes that her three stages of trauma recovery are a “convenient fiction, not to be taken too literally. They are an attempt to impose order upon a process that is inherently turbulent and complex” (p. 155). Cloitre, Koenen, Cohen, and Han (2002) point out that needs will vary according to an individual’s comorbidities and his or her willingness to talk about the traumatic experiences – therefore, attention to their individual characteristics and concerns is of great importance to successful therapy. Others have suggested that because gender-specific reactions to trauma and trauma therapy have been observed, sensitivity to gender issues is critical in trauma therapy, as is sensitivity to cultural differences (Briere & Scott, 2006).

The literature on trauma therapy suggests that it may also be unrealistic to expect that one course of psychotherapy will provide permanent relief from symptoms. A recent meta-analysis (Bradley, Greene, Russ, Dutra, & Westen, 2005) found that “the majority of patients treated with psychotherapy for PTSD recover or improve” (p. 214), but could not draw strong conclusions about how long treatment gains would be maintained. Some writers suggest that relapse is common in the face of new stressors (Kolb, 1993) and when enduring the stress of major life transitions (Herman, 1992). Individuals receiving trauma therapy should, therefore, be made aware that they may have to return for further assistance when they face symptom recurrences in the future. Kolb suggests that “after initial therapeutic goals are achieved, most PTSD patients are best placed on a self-demand regimen of therapeutic contact” (1993, p. 298).

6.1.2 Pharmacotherapy

Psychotherapy remains the most common treatment for trauma (van der Kolk, McFarlane, & van der Hart, 2007), but psychotropic medication is often used as an adjunct to this approach. Medication may be used throughout an individual's course of recovery, but is especially useful in the early or stabilization stage of therapy, during which the individual's symptoms may be very overwhelming, and some improvement through medication can help to establish trust, hope and therapeutic alliance (Briere & Scott, 2006). Prescription medications help to address the tendency for individuals with PTSD to self-medicate with alcohol or non-prescription drugs such as opioids (Davidson & van der Kolk, 2007). They can also be useful in treating comorbid conditions, such as depression, which may interfere with psychotherapy, and in addressing the "debilitating" sleep problems associated with PTSD (Briere & Scott, 2006, p. 193).

Several different avenues of drug therapy have been explored. There is no single, ideal medication for the treatment of PTSD, but rather "a range of pharmacological agents that may be of assistance in treating different symptom clusters" (Briere & Scott, 2006, p. 187). Davidson and van der Kolk (2007) explain that medications for PTSD have been prescribed in an attempt to accomplish many diverse goals, such as the reduction of intrusive symptoms, reduction of hyperarousal, improvement of depressed mood and numbing, and reduction of impulsive aggression against self and others. Typically, the classes of drugs prescribed for PTSD target the noradrenergic and serotonergic systems known to be implicated in the disorder, and include monoamine oxidase inhibitors (MAOIs), tricyclic antidepressants, mood stabilizers such as lithium, beta blockers such as propranolol, antipsychotics, and selective serotonin reuptake inhibitors (SSRIs), among others (Briere & Scott, 2006). SSRIs, traditionally prescribed for relief from depression, anxiety and panic, have been

found to be efficacious in the treatment of all three symptom clusters (re-experiencing, hyperarousal, and avoidance) of PTSD (Briere & Scott, 2006). It has, therefore, been suggested that SSRIs should be the first course of psychopharmacologic treatment attempted, with other classes of drugs being subsequently prescribed if there is little or no response (Friedman, Davidson, Mellman, & Southwick, 2000).

It must be emphasized that psychoactive medication on its own is not expected to be sufficient to provide recovery from PTSD (Briere & Scott, 2006); Davidson and van der Kolk (2007) note that, while pharmacotherapy is not expected to result in a “cure” for an individual’s PTSD, “the symptom relief that results from effective drug therapy enables patients to move ahead towards more productive lives and to participate more effectively in other forms of therapy” (p. 521).

6.1.3 Alternative techniques

In contrast to the stages of psychotherapy outlined previously, some therapists prefer to use alternate approaches such as solution-focused brief therapy, which is future-oriented and strengths-focused, and does not assume that individuals need to work through the traumatic memories in order for treatment to be successful (Bannink, 2008). Other clinicians eschew gradual exposure to traumatic memories in favour of immersion techniques such as prolonged exposure (PE), which has empirical support for certain types of trauma (Rothbaum & Foa, 2007).

Another alternative technique is Eye Movement Desensitization and Reprocessing (EMDR). In this approach, individuals attempt to “work through” their traumatic experience while their therapist engages them in “rapid rhythmic eye movements” (van der Kolk, McFarlane, & van der Hart, 2007). Evidence relating to the efficacy of this procedure remains mixed: meta-analyses have shown that the process

may work as well as other therapy techniques (Van Etten & Taylor, 1998), but the technique remains controversial, and there have been suggestions that the eye movements themselves add nothing to the process (Davidson & Parker, 2001), making it essentially just another form of psychotherapy.

6.2 The Criminal Justice System Response

Many have decried the lack of appropriate, accessible treatment for offenders with mental disorders in the criminal justice system, and PTSD appears to be no exception to this rule. In *R. v. M.C.* (1999), Justice Jordan noted, when considering a young offender's need for treatment for his trauma, "treatment resources are severely limited in both the young offender and adult correctional systems in this province [Alberta] and elsewhere in the country."

Does the offender with PTSD typically receive any help with his or her disorder as a result of his or her entanglement with the criminal justice system? A discussion of the suitability of the dispositions offered to offenders with PTSD should begin with a discussion of what the actual dispositions were in the cases studied. Figures 3 and 4 provide these separately for adult and young offenders.

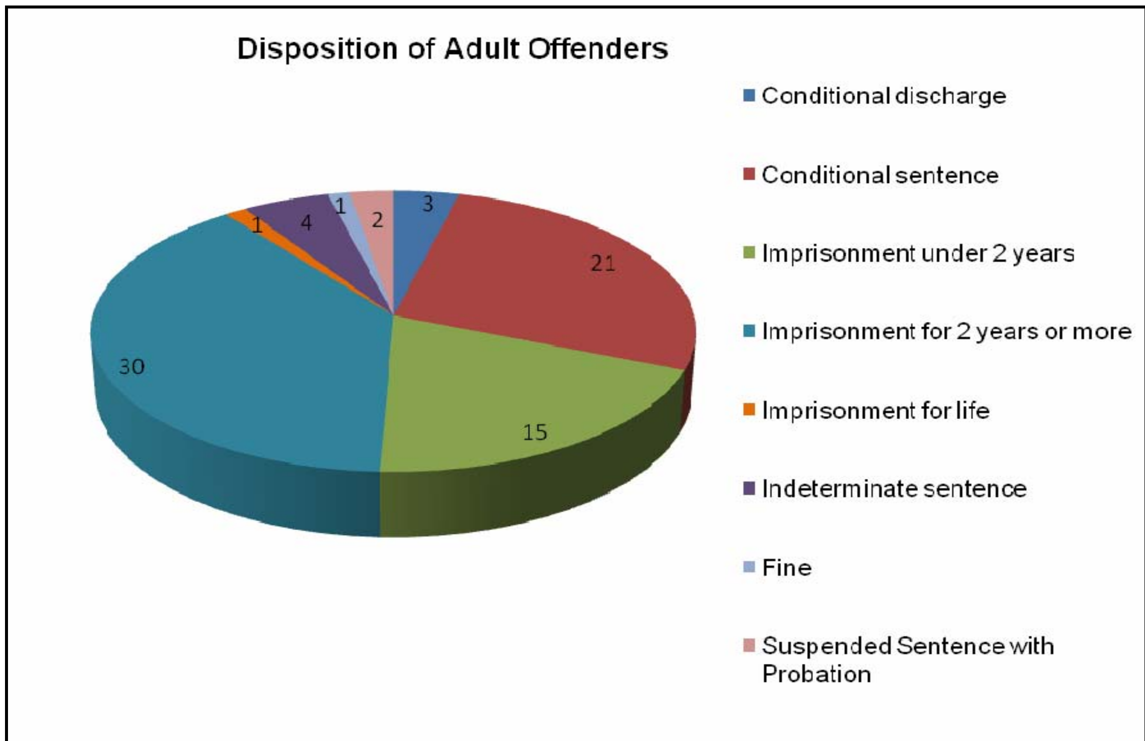

Figure 3. Disposition of adult offenders (n = 77).

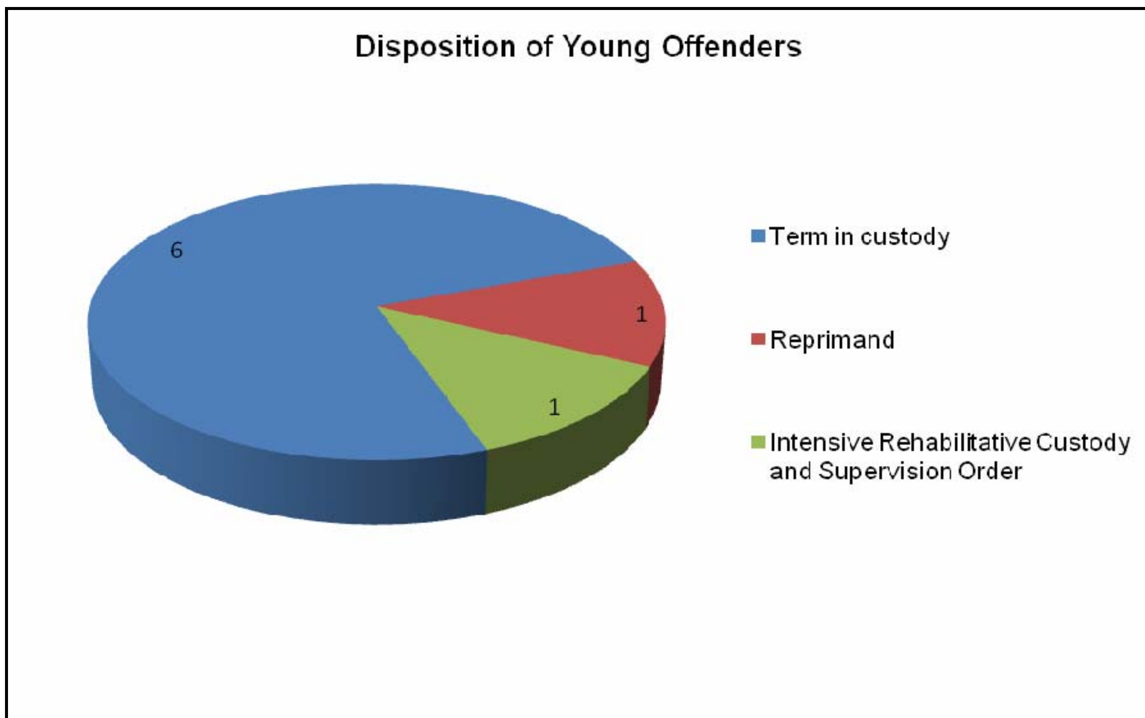

Figure 4. Disposition of young offenders (n = 8).

6.2.1 Incarceration

In examining these two charts, it is clear that most offenders with PTSD processed by Canadian courts are ending up incarcerated, in either a provincial or a federal institution. In addition to the anecdotal arguments made in the judgments examined about the detrimental effect of imprisonment on individuals with PTSD, as discussed in Chapter 5, researchers have also examined this issue more systematically.

First of all, there is cause for concern about whether an individual's diagnosis of PTSD will even receive any notice once he or she enters a correctional institution. An analysis of U.S. prisons by Kupers (1996) suggests that, given the stresses on prisons (in terms of being underfunded, relative to the number of current inmates, and understaffed), mental disorders tend to go untreated, especially if they are not "major mental disorders," such as schizophrenia and depression, whose symptoms may be more visible than those associated with PTSD or other stress disorders.

Kupers notes that there was no mention of PTSD in the hundreds of medical/psychiatric charts of prisoners that he reviewed throughout his career. It appears that the issue may have been largely overlooked in Canada as well: in a report commissioned by Correctional Services Canada, entitled *The Prevalence, Nature and Severity of Mental Health Problems Among Federal Male Inmates in Canadian Penitentiaries* (Motiuk & Porporino, 1992), there is no mention of PTSD or any other trauma disorder, despite the fact that the measure employed, the Diagnostic Interview Schedule (DIS), has the ability to detect it. That PTSD is overlooked in correctional settings is not entirely surprising in light of research suggesting that there is low recognition of the disorder's prevalence in primary care (Liebschutz et al., 2007) and even in general psychiatry practice (Zimmerman & Mattia, 1999).

A subsequent issue is that even if PTSD is recognized in a correctional facility, appropriate treatment resources may be lacking. From their survey of 1,027 U.S. facilities with capacities ranging from less than 250 inmates to more than 1,000 inmates, Morris, Steadman, & Veysey (1997) discerned “a clear pattern of screening and evaluation, followed by a marked decline in services to respond to the needs identified” (p. 9). This study noted that crisis intervention and psychotropic medication were the most common responses to mental illness among inmates, while the use of psychotherapy and special housing units for inmates with mental illness, which would be appropriate for individuals with PTSD, were less common. Thus, an individual with PTSD might be stabilized after exhibiting self-injurious or suicidal behaviour, and offered medication, but not receive any more in-depth attention to their condition. Kinsler and Saxman (2007) point out that the medication offered itself may be substandard, as “to cut costs, inmates are prescribed ‘last generation’ medications such as trycyclics for depression, rather than the more current SSRIs” (p. 85).

Ogloff, Roesch and Hart (1994) have offered the view that deficiencies in mental health treatment in prison may undermine rehabilitation not only because individuals are unable to move beyond their symptoms, but also because the inmate becomes frustrated and resentful towards a system that denies him or her treatment, especially if the ongoing illness is used as a rationale for denial of release. Kinsler and Saxman (2007) discuss how untreated PTSD may interfere with progress:

> Trauma-based symptoms such as dissociation, numbing and flashbacks are often seen as lack of cooperation and lead to prisoners being ‘failed’ at their treatment. Discussing past trauma is often seen as engaging in a prohibited self pity or taking a victim role. Having a flashback to a trauma during anger management treatment, for example, can result in a prisoner being judged as disruptive, dismissed from the program, and reported as non-cooperative to the judge (p. 86).

The situation with respect to treatment for PTSD – or lack thereof – appears to be similar for young offenders. Commenting on the situation in the United States, Ford, Chapman, Hawke, and Albert (2007) identified a variety of screening instruments and treatment interventions which have been developed for youth with PTSD. However, they reported that "very few juvenile justice agencies, facilities or programs are routinely screening for trauma or offering trauma-specific interventions to the youth in their care"(p. 2).

Another issue worthy of consideration is sentence length. It is recognized that many offenders, especially if they are afflicted by mental illness, tend to be "entangled in a cyclical pattern of recurrent and brief encounters" with the criminal justice system (Porporino & Motiuk, 1995), leading to references to a "revolving door" for mentally ill offenders (Schaefer & Stefancic, 2003). Many of the offenders in this study were sentenced to relatively short prison terms of six months or less. It is worth asking whether the short time that many individuals are detained leads to the issue of assessing and treating mental disorders being deemed otiose? Bland et al. (1998) concluded, based on a study of 180 Canadian male inmates sentenced to prison terms of two years or less, that brief sentences, combined with "a population that is socially and psychiatrically disadvantaged...and to which little or no treatment or rehabilitation is given, appears to serve no one very well" (p. 278).

Even when individuals are sentenced to longer terms of incarceration, Schneider (1999) notes that treatment is often left until the end of the period of incarceration, with an expectation that it can be completed quickly in anticipation of an offender's return to the community. The literature on treatment of trauma therapy consistently indicates, however, that treatment of trauma and PTSD is anything but quick, and it is also not "one-shot." Furthermore, it is rare, in the United States, for offenders to be linked to

community mental health services for follow-up upon their release from a correctional facility (Morris, Steadman, & Veysey, 1997; Watson, Hanrahan, Luchins, & Lurigio, 2001). Thus, medications may be abruptly discontinued and therapies left unfinished.

Another possibility to consider is that institutional practices may impinge in a negative way upon a traumatized individual. Author Jerome Miller (1996) has argued that "criminal justice processing, in and of itself (arrest, jailing, conviction, imprisonment) is an alienating and destabilizing exercise that usually creates more problems than it solves" (p. xiii). Taking this perspective into account might lead us to examine how criminal justice activities may be especially deleterious to an individual who is experiencing trauma-related symptoms, such as intrusion and hyperarousal. Kupers (1996) has argued that individuals with traumatic pasts are "especially prone to stress response syndromes, decompensation, suicide, and other forms of psychiatric morbidity while incarcerated" (p. 189). In some cases, life in prison is reminiscent of certain characteristics of the trauma. Certain correctional practices, such as excess use of solitary confinement, are known to lead to a range of negative psychiatric outcomes (e.g., Grassian, 1983) and, given that isolation and disconnection from others is a symptom of trauma, it seems likely that this practice would not lead to any improvement in a traumatized individual's condition, and might worsen it. Abram et al. (2004) point out that a common response to psychiatric crises in youth detention centres is isolation and use of restraint, which can trigger or escalate PTSD symptoms. Simkins and Katz (2002) also note that, for women who have been sexually abused, being restrained and placed in isolation may force them to relive their trauma. Although isolation is sometimes needed for safety reasons (even though Kupers claims that it is often used superfluously), ultimately it could well exacerbate the trauma victim's sense of alienation and his or her current symptoms. Finally, being confined and controlled in prison may

reactivate a person's memory of being confined and controlled by an abusive spouse. Moreover, Sigafoos (1994), in a study of Vietnam veterans in U.S. prisons, noted the similarities between prison and combat which may trigger PTSD symptoms:

> As in Vietnam, [in prison] you never know where or who your enemy is. You are always in a state of possible danger. There is no front line. You are told what to do. Your life is not totally in your control, and you have a set amount of time you must serve. There is no such thing as "total relaxation" (p. 121).

Thus, to the extent that Canadian prisons are environments that resemble those in which trauma occurred, and to the extent that they suffer from some of the litany of problems outlined by Kupers – including rampant violence; rape; suicide; overcrowding; underfunded rehabilitation problems – there is cause for serious concern about the welfare of all inmates, but especially those suffering from PTSD. Violence in prison can also generate new cases of PTSD, as it did for some of the offenders in this study. In the case of *R. v. McConnell* (1996), the Supreme Court of Canada allowed a defence of self-defence under s. 34(2) involving "prison environment syndrome." The syndrome, said to be analogous to battered woman syndrome, recognized that offenders sometimes adapt to a "kill or be killed" environment, or at least come to develop a perception of such. Clearly, a "kill or be killed" environment is not an ideal one in which to attempt to recover from the impact of traumatic stress.

It should be noted that there have been reports of treatment for PTSD in prisons. For example, Sigafoos (1994) reported on a PTSD treatment program for Vietnam veterans in a U.S. prison. This program, offered to 13 inmates, involved elements of safety (establishing rapport with the fellow participants and the therapist), remembrance and mourning (in this context, recalling and discussing the traumatic memories was referred to as "the second tour") and reconnection (individual and group therapy focusing on interpersonal relationships, especially those with family members). Attempts were

made to concurrently address the substance use that many of the participants were involved in. However, Sigafoos (1994) commented on the difficulty of offering such a program in a prison environment, noting that

> To effect change, the therapist may feel that he has to break the veteran out of the survivor mode. But by breaking the veteran out of this mode, the therapist takes away the only defences they have to survive prison. A precarious dilemma is created.

In addition, PTSD-specific prison programs appear to be rare. Based on the bulk of the literature reviewed, it appears that prisons, here and abroad, may be not the only places where trauma disorders go unrecognized, but also places where the requisite conditions to overcome trauma – safety, working through the trauma, and reconnection with others – are largely denied.

6.2.2 Disposition of offenders judged NCRMD

Section 672 of the *Criminal Code* provides that where an accused has been given a verdict of not criminally responsible on account of mental disorder, a disposition hearing is held, either by the court or a provincial Review Board. The particular dispositions available to an accused judged NCRMD are noted in s. 672.54: he or she must be discharged absolutely if not found to be "a significant threat to the safety of the public"; alternatively, the court or Review Board may discharge the individual under conditions that they deem appropriate; finally, the accused may be detained in a hospital - again subject to any conditions that are deemed appropriate.

When individuals are detained in a forensic hospital, one might assume that the situation with respect to recognition and treatment of trauma disorders would be much better than within purely correctional institutions, given the greater focus on mental health in forensic hospitals and the likelihood that patients will be housed for longer periods than in correctional institutions. However, Sarkar et al. (2005) have noted a

phenomenon which they term the "hierarchical approach" to diagnosing mental illness in forensic settings: once it is determined that a patient has a disorder such as schizophrenia, major depression, or antisocial personality disorder, this may lead to "diagnostic closure," meaning that a co-occurring disorder such as PTSD is either overlooked or its symptoms are assumed to be a part of the primary disorder (p. 668). It has been noted that 84% of individuals with PTSD fit the criteria for at least one other psychiatric disorder (Brunet, Akerib, & Birmes, 2007).

Another potential issue for users of forensic systems is that they may be viewed warily by the mental health system in light of their criminal histories, especially if these involve violence (Lamb, Weinberger & Gross, 1999). Therefore, if trauma-related services were not available within a forensic hospital, it might be difficult to arrange for a patient to receive them elsewhere, such as within the community. Finally, given that forensic mental health facilities are like prisons in at least some respects, concerns relating to seclusion and restraint of individuals, as outlined above, are also relevant here.

6.2.3 Conditional sentences

The conditional sentence disposition has existed since 1996, but has become more commonplace in response to the Supreme Court of Canada's assertion, in *R. v. Proulx* (2000), that the number of individuals being sent to prison needed to be reduced, especially in view of evidence suggesting that incarceration was failing to properly rehabilitate and/or reintegrate offenders. The conditional sentence may be seen as a hybrid sentence, which "lies between probation and prison on a continuum of severity" and blends the principles of rehabilitation, denunciation and deterrence (Roberts & Verdun-Jones, 2002, para 60). The conditional sentence also contains elements of

restorative justice, and fits with the *Gladue* decision[1] (Ruby, 2008). An offender may be given a conditional sentence – in other words, be ordered to serve their sentence in the community – if they meet several criteria outlined in Section 742.1 of the *Criminal Code*, such as not having committed a serious personal injury offence, receiving a sentence of less than two years, and not being perceived as a danger to the community (Ruby, 2008). In addition, Roberts and Verdun-Jones (2002) have noted that the conditional sentence can serve as a mechanism allowing a court to order that a mentally disordered offender will serve his or her sentence in a psychiatric facility rather than in a prison, an option endorsed by the majority of the Supreme Court of Canada in *R. v. Knoblauch* (2000). According to the reasoning employed by Roberts and Verdun-Jones, confinement in a psychiatric institution does qualify, under the conditional sentencing paradigm, as a viable alternative to imprisonment, for the sequestration occurring in the former case is therapeutic and protective, while punishment is the primary motive of the latter.

No offenders in this study received conditional sentence orders directing them to treatment facilities, but a number of cases examined in this study resulted in the accused being given a conditional sentence involving house arrest. In such cases, a judge can order that the accused must undergo treatment while serving the sentence. Ruby (2008) has argued that a conditional sentence is better positioned than a custodial one to achieve the aim of rehabilitating the offender. However, in the cases examined, judges often made a vague order that the accused "attend counselling" – given that many accused were also diagnosed with alcohol abuse, it was not clear which condition

[1] In *R. v. Gladue* (1999), a Supreme Court decision, Justices Cory and Iacobucci considered the problem of overincarceration in Canada, as well as the overrepresentation of Aboriginal Canadians in penal institutions, and urged judges to consistently consider s. 718.2(e) of the *Criminal Code* in sentencing. This section of the *Code* states, "all available sanctions other than imprisonment that are reasonable in the circumstances should be considered for all offenders, with particular attention to the circumstances of aboriginal offenders."

counselling was being ordered for. If left to the discretion of the probation officer, there is no guarantee that treatment for PTSD would be sought due to the fact that, as mentioned previously, substance abuse and other disorders which are comorbid with PTSD are often seen as more serious and/or more relevant to offending behaviour. In only one case examined did the judge order counselling specifically for PTSD.

6.2.4 Deferred Custody and Supervision Orders and Intensive Rehabilitative Custody and Supervision Orders for young offenders

Under the *Youth Criminal Justice Act*, there are only four circumstances in which a young offender can be sentenced to a term in custody: they have to have committed a violent offence; failed to comply with a non-custodial sentence; committed an offence for which an adult would be liable to imprisonment for more than two years and have a history of prior offences; or have committed an indictable offence with significant aggravating features. Youth meeting one of these four criteria are still not automatically sentenced to a term in custody, given that “all alternatives to custody raised in the sentencing hearing that are reasonable in the circumstances” must be considered before a custodial sentence is made, according to section 39(2) of the YCJA.

With the power to grant custodial sentences thus restricted, community-based sentences were created as alternatives under the YCJA. The Deferred Custody and Supervision Order (DSCO), mirrors the conditional sentence offered to adults, with the youth being on a “much shorter leash” than if they were on probation only (Bala, Carrington, & Roberts, 2009, p. 149). A DSCO, not granted to any young offender examined in this study, would have similar benefits to the adult conditional sentence: it may be easier for a youth to receive appropriate treatment for PTSD from a specialist in the community than would be the case if they were housed in an institution. However, the hurdle still remains that the PTSD has to be recognized as a disorder worth treating.

An intensive rehabilitative custody and supervision order (IRCS), as set out in Section 42(2)(r) of the *Youth Criminal Justice Act*, is a custodial-type sentence available where a young offender has been convicted of murder, attempted murder, aggravated sexual assault, or a third violent offence. Other requirements are that the young person suffers from "a psychological disorder, emotional disturbance or mental illness"; that there is a treatment plan which outlines how the treatment will lessen the chance of reoffending; and that "the provincial director has determined that an IRCS programme is available, and the young person's participation in the programme is appropriate" (Ruby, 2008, p. 740).

Under an IRCS, a young person can be confined to a mental health facility if that is deemed appropriate, or he or she can be given special treatment options (for example, intensive one-on-one sessions, or treatment providers contracted from the community) while being housed in a correctional setting. However, the IRCS cannot order that a young person submit to involuntary medical treatment, such as drug therapy (Bala, Carrington, & Roberts, 2009). Very few IRCS orders are made each year (Doob & Sprott, 2005; Bala, Carrington, & Roberts, 2009). One reason that such orders are applied seldomly is that they are very resource-intensive: as reported in *R. v. L.A.B.* (2007), up to one hundred thousand dollars per year may be allocated to a youth receiving such a disposition.

One youth in this study, who was convicted of second-degree murder and diagnosed with PTSD as well as ADHD, FASD and conduct disorder, did receive such a sentence, involving the maximum of four years of custody followed by three years of community supervision. A youth facility willing and able to accommodate the accused in *L.A.B.* was located, and the feasibility of the order was considered by an interdisciplinary team consisting of a psychiatrist, probation officer, social worker, and the facility's

program manager. A plan for treatment was devised, and it was noted that the youth would receive "victim empathy, peer interaction, social skills, problem solving, decision making, trauma, and attachment counselling."

Another young person, who had an equally – if not more – complex case of PTSD combined with ADHD, alcohol abuse, depression and conduct disorder, and who met the criteria set out in s. 42(2)(r) of the YCJA, was determined not to be a suitable candidate for such a sentence because of low motivation, as assessed by a psychiatrist at the facility where it was hoped he would serve the sentence. The psychiatrist whose report was quoted in *R. v. M.B.* (2007) opined that "hope for progress would require evidence of his consistent endorsement of pro-social plans and behaviour, willingness to deal with his past, along with *tangible indicators of life changes, as shown by new behaviours*" (emphasis added). In other words, there was an expectation that the youth had to demonstrate some degree of recovery before he could be admitted to a program dedicated to his recovery, which is a difficult standard to meet. The judge in this case expressed his opinion that "I frankly doubt that anyone with the young person's symptoms...could possibly, humanly, demonstrate the sort of motivation which the psychiatrist appears to have believed necessary for participation in an IRCS order." Nonetheless, an IRCS order could not be granted without a facility willing to participate in it.

Given the rarity with which IRCS orders are made, there have not been any systematic studies of their success. In theory, they seem well-positioned to consider the needs of young offenders with mental health issues. However, as the case of *M.B.* illustrates, the difficult part may be gaining access to them. Given the resources invested, courts (or mental health facilities) may guard this option carefully in cases where a positive treatment outcome cannot be easily foreseen.

6.2.5 Diversion

Individuals who are diverted from the court system were not included as a part of this study because the data examined consisted of judgments rendered in court. However, it is still worth examining the diversionary options which exist and how these might allow for the treatment of PTSD. Diversion involves not only "diversion from" the criminal justice system, but also "diversion to" other needed services, so that a complete view of diversion involves "a multi-systems collaboration between criminal justice and community-based agencies", including those devoted to mental health (Landsberg, Rock, & Berg, 2002, p. 87).

Whether a formal diversion program is available depends on one's location in Canada, as some provinces have such programs and others do not. In Ontario, for example, a formal diversion program for adult and young offenders with mental disorders who have committed non-serious offences has existed since 1994. However, whether an offender will be diverted is at the discretion of the prosecution, and thus depends on their agreement with the assertion that "the most efficacious and appropriate course is to divert mentally disordered accused back into the civil mental health system from which they have become disconnected or insufficiently well-connected" (Bloom & Schneider, 2006, p.102).

There are, of course, a number of criteria which must be met before deciding on diversion. To name a few: there must be a reasonable prospect of conviction; no serious threat to public safety; and a mental disorder will be presumed to underlie the offence committed. In addition, the Ontario Ministry of Health has outlined some practical considerations, such as whether a mental health facility is willing to accept the individual as a patient, and whether the individual is likely to respond to treatment (Bloom &

Schneider, 2006). In some respects, this option resembles the IRCS protocol for young offenders.

In response to the growing numbers of mentally ill offenders in correctional facilities, and the difficulties that courts face in addressing these offenders, specialized mental health courts have begun appearing in recent years to adjudicate cases involving mentally disordered individuals. Mental health courts, which are a type of "problem-solving court" (Redlich, Steadman, Monahan, Robbins, & Petrila, 2006), have emerged following the success of drug courts for individuals with noted substance abuse problems (Kuehn, 2007; Steadman, Davidson, & Brown, 2001). They also draw upon the principles of therapeutic jurisprudence, an approach which advocates for various criminal justice processes and interventions to be viewed through the lens of mental health treatment, and evaluated in terms of the extent to which they are therapeutic or anti-therapeutic (Watson, Hanrahan, Luchins, & Lurigio, 2001). In Canada, mental health courts exist in Toronto and London, Ontario and in Saint John, New Brunswick, and additional courts are being piloted and developed in Newfoundland and Nova Scotia, respectively. In addition, Vancouver has developed a community court, which resembles a mental health court in the sense that it does divert individuals from the standard court system, and focuses on linking individuals with treatment resources.

Redlich et al. (2006) outline six characteristics of mental health courts in the United States: first, they are criminal courts with separate dockets for individuals with mental illness. Their goal is diversion away from the criminal justice system and toward community mental health treatment, and they typically mandate such treatment – individuals being processed by the courts must agree to engage in treatment, take medication, and adhere to other conditions as part of their diversion. These courts engage in judicial status review hearings, during which an offender's compliance with

treatment is assessed, and they coordinate supervision by community treatment providers and/or criminal justice personnel such as probation officers. Another key aspect of these courts is that they offer praise and encouragement to the offender who complies with treatment, and sanctions for offenders who do not (including return to regular court). Individuals are typically declared “graduated” after a certain period of success in treatment and stability, and their charges may be dropped at this point. Finally, mental health courts must be entered into voluntarily, with defendants choosing to be adjudicated in such a court (Redlich et al., 2006). Other noted features of mental health courts is that they are nonadversarial, with legal and mental health professionals working jointly on recommendations for the accused (Moore & Hiday, 2006); in addition, mental health courts may choose to accept only offenders with misdemeanour crimes, or only felonies, or both (Redlich et al., 2006). Finally, such courts house specialized staff: typically, the dedicated judges who preside over mental health courts have received special training in mental illness and community treatment options (Kuehn, 2007). In addition to dedicated judges, the mental health court in Toronto is staffed by two permanent dedicated Crown attorneys, two dedicated duty counsel, nine Mental Health workers (social workers), and has a psychiatrist from the Centre for Addictions and Mental Health in attendance each day to perform assessments (Toronto Mental Heath Court, 2008).

There have been no systematic evaluations of the mental health court system in Canada, but evidence emerging from the United States, where a number of such courts exist, is positive. One evaluation (McNeil & Binder, 2007) examined a San Francisco mental health court which processed both violent and non-violent offenders, with a mission to provide mentally disordered offenders with dispositions that take their mental illness into account, connect them to appropriate treatment services, and decrease their

rates of recidivism. To study the success of the court in reducing recidivism, the authors compared 139 individuals processed by the mental health court with a “treatment as usual” group adjudicated in regular court. Results showed that participation in a mental health court predicted a significantly longer interval to any new criminal charge, and any new violent criminal charge, compared to participation in a regular court. The researchers concluded that “these results support the effectiveness of a mental health court in reducing the involvement of persons with mental disorders in the criminal justice system” (McNeil & Binder, 2007, p. 1401).

A study by Moore and Hiday (2006) of a mental health court in the Southeastern United States which hears cases of individuals with mental illness and/or substance abuse who committed misdemeanours or felony offences, found a similar trend. Offenders who were referred to the court and “graduated” – that is, demonstrated six months of compliance with treatment and court appearances – showed significant reductions in average numbers of rearrests and severity of recidivism versus the comparison group who had similar mental illness but whose cases were heard in regular court. However, those who did not complete the “full dose” of treatment and follow-up prescribed by the mental health court did not fare significantly better than the comparison group. This study thus underscored the point that such courts will not be effective if offenders cannot be persuaded to remain in the program (Moore & Hiday, 2006). In addition, no long-term studies (i.e., beyond a few years after treatment) of individuals adjudicated in mental health courts have been conducted. This leaves open the question of how long a mental health court’s effect on recidivism will last, especially if individuals do not continue to receive needed supports in the community (Moore & Hiday, 2006). The issue of service gaps must also be considered – the courts cannot be effective where appropriate treatment resources do not exist (Watson et al., 2001).

Overall, mental health courts, which exist "at the interface of the criminal justice and mental health systems" (Redlich et al., 2006, p. 347) and provide avoidance of incarceration, community treatment options, and offender supervision, would seem to be appropriate for addressing the behaviour of at least some individuals with PTSD who become involved in criminal activity. Currently, as noted, mental health courts do not exist in many Canadian jurisdictions, but it appears that they are becoming more widespread. They may therefore be a viable option for the offender with PTSD in the future.

6.3 A Way Forward

Given that the current situation for PTSD-disordered offenders in Canada does not appear to be particularly promising, especially if they are sentenced to terms of incarceration, there is ample room for suggestions as to how this state of affairs can be improved. Below, both preventative and tertiary approaches are discussed.

6.3.1 Prevention of PTSD

Some commentators on the subject of offences committed by individuals with PTSD have focussed on the need for prevention. One area in which this appears to be especially relevant, and somewhat feasible, concerns combat veterans, who formed ten percent of the offenders in this study. In recent years, it has been recognized that the response by the Canadian Forces to significant numbers of CF members returning from combat missions with "mental injuries" has been inadequate – a recent report by the National Defence and Canadian Forces Ombudsman to the Minister of National Defence has strongly underscored this point (McFadyen, 2008). A key question posed by this report was whether CF members with PTSD were being diagnosed and receiving the care and treatment that they needed. The question had to be answered in the negative,

as the Ombudsman recognized that at least some “injured soldiers, sailors, airmen and airwomen who have served their country with courage and dedication are slipping through the cracks of an *ad hoc* system” (McFadyen, 2008, p. 5).

It has been suggested that the CF should be providing better treatment to soldiers with PTSD, and also taking steps to prevent it from developing – where possible – in the first place. Kormos (2008), in his examination of members of the Canadian Forces who committed violent crimes and raised the NCRMD defence, offered a number of potential avenues for preventing PTSD and its associated offending behaviour. Chief among his suggestions is that Canadian Forces soldiers should receive “stress inoculation training” before being sent into combat missions. This type of training involves giving soldiers very detailed, realistic information about the dangers they are likely to face, and then allowing them to rehearse coping strategies relating to these stressors (Kormos, 2008). In the present research, the CF members who developed PTSD claimed that they were wholly unprepared for the extent of the violence and carnage that awaited them on their missions, indicating that they received no such training.

A second prong to a CF prevention strategy would involve providing support and treatment during and after the missions. Usually, the symptoms of PTSD are not recognized or responded to until a soldier returns home – and even then, it is claimed that the response is not adequate, with afflicted individuals being “stigmatized as being fakers, malingerers or as being weak and incapable,” instead of being offered appropriate care and support (McFadyen, 2008, p. 16). A culture change is clearly required, and it has been proposed that education and training relating to PTSD for CF members, which would be led partially by members or former members who suffer from the disorder, would be helpful in this regard (McFadyen, 2008).

Kormos (2008) suggests that frequent mandatory appointments with field psychiatrists be required for everyone during combat missions, so that PTSD might be detected in its early stages, where it can manifest as exhaustion, emotional detachment, or shock. Individual and group counselling could then be made available for afflicted individuals. CF members could also be required to meet with a mental health practitioner specializing in military PTSD upon their return to Canada. In all of these mandatory sessions with mental health professionals, the stigma and effort associated with seeking treatment would be eliminated (Kormos, 2008). However, each of the above suggestions hinge upon adequate monetary and human resources being devoted to the problem: the 2008 Ombudsman report indicated that “an insufficient number of caregivers” and “caregiver burnout” were hindrances in the provision of mental health services to CF members. However, this report also mentioned that the CF was expecting to hire an additional 218 mental health professionals in 2009. The Ombudsman report discussed a number of additional recommendations, such as appointing a “PTSD coordinator” whose sole responsibility would be to handle issues related to PTSD among CF members, coordinate the provision of education, training, assessment and treatment, and ensure that the treatment of this disorder remains an ongoing high priority for the Canadian Forces (McFadyen, 2008).

Another prevention-oriented approach is intervention designed to help metabolize or digest experience in the aftermath of a traumatic event, when individuals may display acute stress reactions (Briere & Scott, 2006). The two major extant types of intervention for acute stress are psychological debriefing, and brief cognitive-behavioural therapies (Cahill & Foa, 2004). Psychological debriefing typically occurs in one or several group sessions, closely following a traumatic event such as a terrorist attack or natural disaster. Specific protocols, such as Critical Incident Stress Debriefing (CISD;

Mitchell, 1983) have been outlined. Broadly, the focus of debriefing is on discussing the facts of the event, the beliefs that survivors have concerning what happened, and their feelings and reactions to the event. Coping strategies and psychoeducation regarding trauma are typically reviewed, and additional plans may be made to further deal with survivors' traumatic responses. In general, the aim is to promote emotional processing of trauma through "the ventilation and normalization of reactions and preparation for possible future experiences" (Bisson, MacFarlane, & Rose, 2000, p. 555). Psychological debriefing can be undertaken with individuals or groups. However, while this approach is widely advocated, a number of studies suggest that this approach may have a detrimental iatrogenic effect, interfering with natural recovery processes rather than aiding them (Bisson, MacFarlane, & Rose, 2000; Briere & Scott, 2006; Mayou, Ehlers, & Hobbs, 2000).

The second approach, brief cognitive-behavioural therapy, is recommended when individuals begin to display symptoms of acute stress disorder (ASD) (Cahill & Foa, 2004). This usually consists of several sessions begun 2 to 4 weeks after the traumatic event, which involve the same sort of relaxation, psychoeducation and stress inoculation training procedures which may also be found in the treatment of PTSD. Studies have suggested that individuals with acute stress disorder who receive this type of intervention within a month after the traumatic event are less likely to develop PTSD compared to control groups with ASD who do not receive such an intervention (e.g., Bryant, Moulds, & Nixon, 2003). Therefore, if made available to individuals known to be experiencing acute stress symptoms within the right timeframe, some cases of PTSD might be prevented. In the context of the criminal justice system, brief cognitive-behavioural therapies might be considered by victim services agencies as a way of

alleviating the distress attending experiences of victimization, and averting the individual and social problems resulting from the development of post-traumatic stress disorder.

In many cases, however, it would seem that PTSD is not easily prevented: it often emerges out of covert child and spousal abuse, and the lifestyles led by individuals who are marginalized and, all too often, victimized. In many cases before the courts, therefore, prevention does not seem to be a viable option: the damage to the individual, and to the individual's victims, has already been done. In these cases, a discussion of the most effective correctional treatment options is warranted.

6.3.2 Trauma awareness in criminal justice institutions

If an offender is receiving specialized treatment for trauma in the community, as a result of diversion or a conditional sentence, it may resemble that described in Section 5.1, and may accordingly be effective. Of course, access to such treatment depends on the recognition of the court or probation officer or psychiatrist that the individual is suffering from PTSD. However, what can be done when an offender is incarcerated, and some of the features of his or her environment work against the requirements for recovery from trauma, such as the establishment of a feeling of safety, or worse, exacerbate his or her symptoms and actively prevent recovery?

The answer to this question may lie in the concept of becoming "trauma-informed" before attempting to offer trauma-specific services (i.e., diagnosis and treatment). In the context of mental health services, Harris and Fallot (2001a) note that "to be trauma informed means to understand the role that violence and victimization play in the lives of most consumers" (p. 4). They offer, as an analogy, that being "trauma-informed" is roughly equivalent to a facility providing wheelchair access for disabled persons: it does not equate to providing services specific to their condition, but is about

accommodating them in a safe manner. These authors acknowledge that adopting trauma-informed practices in the mental health arena demands a significant shift in thinking and, indeed, comprises a new paradigm. One can only surmise that such a shift would be even more difficult for the criminal justice system to make. Nonetheless, the feasibility of some of the recommendations made by Harris and Fallot, as well as other authors, is considered below.

One way to become trauma-informed is to implement universal screening for trauma disorders, including PTSD. This helps to identify the scope of the problem: how many individuals are affected, and how severely? Screening can typically be done by self-report or clinical interview, in a relatively fast manner, and would seem to be a fairly simple practice for correctional institutions to adopt (if they were motivated to do so – this is a separate issue, to be discussed shortly). Inmates who are flagged as having potential psychopathology can then be assessed further, in a “multitiered screening” process which is cost-effective, because it does not require the most expensive professionals to be involved at all levels. It has been suggested, for example, that initial stages of screening may be carried out by correctional staff (with appropriate training), followed by mental health workers examining those who appear to need further assessment, and clinical psychologists, at the top tier, being asked to see those who appear to require attention based on the first two levels of screening (Morris, Steadman, & Veysey, 1997).

Screening is seen as an important activity in trauma-informed care insofar as it communicates “institutional awareness of and responsiveness to the role of violence in the lives of consumers” to the consumers or clients themselves (Harris & Fallot, 2001b, p. 25). It is also important in light of research reviewed earlier suggesting that PTSD tends to be overlooked in psychiatric, medical, and correctional settings, if it is not

systematically searched for. McMakin, Morrissey, Newman, Erwin and Daly (1998) expressed their belief that assessment of PTSD “needs to become part of each juvenile corrections agency’s standard intake protocol” (p. 39). However, if screening is not feasible, it should be noted that it is also effective to assume that all individuals in the system are trauma survivors, and to proceed on that basis (Harris & Fallot, 2001a).

A second recommendation for trauma-informed systems is to focus on training and education. In this author’s opinion, this is the most important component of becoming trauma-informed where the criminal justice system is concerned. Recall that the Appeal Court judge in *R. v. Ferguson* declined to reduce Ferguson’s term in prison, arguing that parole authorities could grant parole if it was determined that his mental health would be damaged by continuing imprisonment. A similar statement was made in *R. v. Shahnawaz*, when his sentence was varied to match the mandatory minimum. In both cases, it is assumed that correctional staff have the ability to recognize when a PTSD is causing distress that may imperil an individual or those around him. Given that PTSD is generally a disorder of quiet suffering (compared to, for example, psychotic disorders), this may be a dangerous assumption, and a correctional officer or parole board not familiar with the disorder may not recognize signs of its worsening before the consequences are borne out. McMackin et al. (1998) have suggested that trauma training for all staff who have interactions with young offenders is “critical.”

Harris and Fallot note that training does not have to be intensive; in fact, they advocate for a more general introduction for all staff, instead of in-depth training for a few, if only one of these options can be chosen. A general training session might simply cover the causes of trauma and its effects, but it could also address “strategies of safe de-escalation” for distressed individuals (Harris & Fallot, 2001c), which, in all likelihood, could also be usefully applied to individuals without PTSD. The time investment required

for such a session is small, but the effects may be far-reaching (Harris & Fallot, 2001a). Furthermore, in addition to offering training to staff, McMackin et al. propose that PTSD awareness can become a part of educational and counselling activities for young offenders. Learning about the disorder could allow them to put a name to their chaotic and distressing feelings, may provide relief that they are not "crazy," to the extent that PTSD is framed as a coping mechanism, or may encourage them to discuss the issue with a therapist.

In addition to an institution's staff having a basic knowledge about trauma and its effects, Harris and Fallot (2001a) recommend having one or two "trauma champions" who are highly knowledgeable about trauma and who can help to hold a focus on this issue (similar to the dedicated PTSD coordinator position being proposed for the Canadian Forces). Within the correctional system, a trauma champion could be of assistance in carrying out another of the best practices for trauma-informed service systems, which is a review of policies and procedures to determine to what extent they may exacerbate trauma disorders such as PTSD.

As discussed previously, some criminal justice procedures may involve "traumatic re-enactments masquerading as benign practice" (Harris & Fallot, 2001a, p. 9). It does not require a stretch of the imagination to understand how certain criminal justice practices, such as being forcibly stripped of one's clothing, having one's bodily cavities searched, or being segregated, confined in small spaces or restrained, may be reminiscent of trauma, especially for those who have experienced sexual abuse or assault. Furthermore, practices exist which appear unnecessarily degrading: in the case of *R. v. Munoz* (2006) examined in this study, the offender, who was diagnosed with PTSD, was forced to wear a "baby doll, a short sheath type of covering to distinguish him from other prisoners," for two 14-day periods while in segregation. The judge noted

that he was satisfied "the sole objective of the baby dolls was to humiliate and further isolate segregated prisoners and had no other valid purpose." It is clear that practices like these could be easily eliminated and replaced with more humane options in a trauma-informed system, which by definition is compassionate and caring, and avoids inflicting pain on individuals, especially that which is gratuitous, as in the case of *Munoz*. In a trauma-informed system, close attention might also be paid to housing (Bebout, 2001), so correctional institutions might address this issue by, for example, involving trauma champions or other mental health professionals in considering safety and other mental health needs while assigning inmates to housing based on custody level (Morris, Steadman, & Veysey, 1997). In general, a review of policies and procedures with a trauma lens would aim to establish perceived and actual safety for inmates.

If criminal justice institutions become trauma-informed, this will set the stage for them offer trauma-specific care – that is, to provide treatment for trauma as outlined at the beginning of this chapter. A question to be considered, however, is why policy makers would make the administrative commitment to focus on PTSD as a priority. This question is addressed below.

6.3.3 Criminal justice framing of PTSD

When making recommendations concerning the handling of PTSD by the criminal justice system, it must be recognized that - from the perspective of criminal justice policy-makers - this disorder is currently either not a top priority for the allocation of programming dollars, or it is viewed as not worth dealing with at all. However, this thesis has contended that PTSD has the potential to cause great harm, and that it is highly relevant to offending behaviour in some cases. PTSD can cause great suffering for the individual afflicted with this disorder. However, if the criminal justice system is not concerned with alleviating the suffering of individuals who are caught up in it, PTSD can

still be framed as an important issue for policy-makers, by emphasizing the following points:

1. *Providing treatment for PTSD fits with the goal of protecting society*. If criminal justice policy-makers are not willing to treat PTSD just for the sake of easing an individual's suffering, then they can take the attitude that, even if it did not cause this offence, it could well cause another one. As we have seen, PTSD has the potential to cause dissociation and lead to violent and dangerous outcomes while an individual is in such a state.

2. *Lack of treatment for PTSD may make other types of treatment less effective or ineffective*. As noted throughout this research, there is a strong relationship between PTSD and several other disorders which frequently appear as comorbidities in cases of PTSD. Substance abuse is one of these disorders and it is posited that individuals with PTSD may turn to substance use as a means of dulling the very distressing symptoms of the disorder. Therefore, it is not surprising that individuals who are treated for substance abuse but not PTSD (although they have the disorder) fare less well than those who receive trauma therapy as well, as has been established in many studies (e.g., Amaro et al., 2007; Kubiak, 2004). Therefore, if treating substance abuse is a priority for the criminal justice system, treating trauma (PTSD) should be as well. The same point can be argued in relation to depression and a number of other disorders.

3. *Treatment for PTSD would help to maintain a safe environment for correctional officers and inmates*. It must be underscored that PTSD, in addition to causing anguish for the individual suffering from it, also expresses itself in terms of violence towards others. A study of 1140 inmates in North

Carolina prisons by Collins and Bailey (1990) revealed that those with PTSD had a significantly increased likelihood of six indicators of violence, including multiple incidents of fighting in adulthood and arrest for a violence offence, compared to inmates without PTSD. This was found when controlling for the presence of antisocial personality disorder, which, as in this study, appears as a comorbidity with PTSD. Therefore, policy makers should also be aware that the individual with PTSD may also contribute to the violent nature of the prison environment. PTSD can also lead to prison safety incidents insofar as it is related to self-harming behaviours such as self-mutilation (van der Kolk, 2007) and to suicide attempts (Foa, Keane, & Friedman, 2000; Kessler, 2000).

4. *Failure to treat PTSD may result in longer, and repeated, terms of imprisonment*. It is recognized, in British Columbia and beyond, that offenders with mental disorders are often cycling repeatedly through the correctional system because their needs are not being met (B.C. Corrections, no date; Bland et al., 2004). A related problem is that offenders are denied release and kept in facilities for long terms because they fail to show improvement (Ogloff, Roesch, & Hart, 1994). PTSD is a disorder that responds fairly well to treatment. Its treatment could realistically reduce recidivism.

6.4 Conclusion

In an ideal world, we could, recognizing the causes and symptoms of PTSD, prevent it from occurring in the first place. It has been argued that preventative strategies can make a difference, especially for individuals, such as combat soldiers, whose exposure to traumatic events can be predicted in advance with some certainty. However, traumatic events which seem outside of the reach of preventative efforts do occur

regularly, which has led to the articulation of treatment principles, mainly involving psychotherapy and pharmacotherapy. An examination of sentences and dispositions offered to offenders with PTSD in Canada, however, suggests that they will often not have access to these treatment options. Given that large numbers of PTSD-disordered offenders are being sentenced to terms of incarceration, it seems important to urge correctional facilities to focus on creating a safe environment for affected individuals, and perhaps eventually integrating treatment for trauma into their programming. Suggestions of this type are more likely to be successful if they are framed in terms of benefits to the criminal justice system.

In the end, it should be noted that treatment for trauma, while technically a tertiary or after-the-fact response, is still preventative in view of the evidence which suggests that there is a fairly predictable repetition or cycling of violence through successive generations of individuals who have experienced certain types of abuse. Thus, treating one offender prevents future victims from becoming offenders themselves. In order to halt the cycle, there also needs to be effective treatment offered to individuals exposed to and traumatized by violence and abuse, who have not yet begun offending but who research shows may well do so. Victim services agencies should thus take note of PTSD and its effects, and should make appropriate referrals for treatment. It does not behoove the criminal justice system – or any member of society, for that matter – to wait for a victim to become an offender before offering treatment for this disorder.

7. CONCLUSION

Post-traumatic stress disorder, the result of exposure to one or more traumatic experiences which overwhelms an individual and leads to feelings of fear, helplessness or horror, has the potential to profoundly affect an individual's psychological, biological, and social functioning, and is associated with criminal activity in some cases. This research has shown that, despite a dearth of literature examining the interface between post-traumatic stress disorder and the law in Canada, the issue of PTSD is not infrequently raised in Canadian courtrooms, with 122 cases of offenders with PTSD being available for study. An examination of the characteristics of these individuals tends to support previous research on offenders in PTSD, which has found that the most common etiological factor for PTSD was abuse in childhood, and that depression and substance use were common comorbidities.

PTSD-based legal defences, which fell into the categories of self-defence, duress and necessity, automatism, and NCRMD, appear to be still in their infancy. None are well-established or common. PTSD was found to be overshadowed by a rigid fixation on whether the defendant met the criteria for battered woman syndrome in cases of spousal abuse leading to the defences of self-defence and duress and necessity. This is unfortunate, as PTSD (in addition to other features of the woman's situation) may have helped to interpret the reasonableness of the woman's behaviour in these cases.

It is also unclear whether the defence of non-mental-disorder automatism – based on an alleged psychological blow – is truly a viable one for offenders with PTSD. It seems much more likely that courts will continue to find that PTSD constitutes a "disease of the mind," leading to a determination of whether the accused should be

found NCRMD. The interesting debate surrounding the issue of whether PTSD is an "internal cause" should mature and evolve in coming years, as more cases of offenders with PTSD are heard, and perhaps successfully appealed all the way to the Supreme Court of Canada (this was attempted in the case of *Borsch*, but leave to appeal was dismissed). It also remains for the courts to recognize the role of genetic susceptibility in the development of PTSD, which will certainly add another dimension to the debate.

As much as this study has uncovered patterns in the way PTSD is dealt with by the courts – for example, it is often considered to be a mitigating factor, and it is more likely to be taken into account in sentencing if its relevance to the criminal activity is apparent – it has also found a great deal of disparity in terms of how defences are applied and how offenders are sentenced. An analysis of this disorder's use in sentencing has illuminated some fundamental conflicts, and competing discourses: the examination of judges' sentencing decisions revealed that judges hold different views about the meaning of "rehabilitation" and goals of the criminal justice system where mentally disordered offenders are concerned. These differing perspectives seem to be consistent with Ruby's (2008) observation that the current sentencing model is a somewhat haphazard blend of retributive and utilitarian (treatment-oriented) ideologies. In the context of this research, I have argued that it is nonsensical to insist that rehabilitation applies to an offender's criminal activity and not to his or her mental health, for it is often difficult to assess the impact of a mental disorder such as PTSD on offending.

What is clear is that judges, by virtue of their learned status, possess great power to determine what will become of an offender with PTSD. There are certainly constraints on a judge's discourse, insofar as there is a need to refer to the *Criminal Code* and case law in making sentencing decisions. However, the discourse of judges is still significantly

imbued with choice: in sentencing, the judge has the ability to make PTSD a central issue or to declare it completely irrelevant. The fact that greatly diverging positions are sometimes taken with respect to the same offender (viz., *Shahnawaz*), underscores the fact that the relevance of PTSD appears to be in the eye of the judge beholding it.

Experts are also endowed with significant powers of influence where PTSD is concerned: the disorder and its symptoms being somewhat complex and esoteric, they were often relied upon to produce knowledge/truth about offenders with PTSD in the cases examined. In fact, expert evidence was necessary, or essential, in some of the cases examined, given that the Supreme Court of Canada, in *Stone,* made expert testimony a requirement in cases where the defence of non-mental-disorder automatism is raised. Thus, the courts have granted significant power to experts insofar as certain legal tests cannot be applied in their absence. In *Rabey* (1980), Justice Dickson of the Supreme Court acknowledged that with respect to automatism, "The argument is made that the success of the defence depends on the semantic ability of psychiatrists, tracing a narrow path between the twin shoals of criminal responsibility and an insanity verdict." Indeed, the testimony of experts appears to have greatly influenced the cases examined in which defences to a criminal charge were raised. It is significant that *MacInnis* and *Bear*, the two cases examined in which individuals with PTSD were granted an absolute acquittal, both involved unrebutted expert testimony.

Brunet et al. (2007) have argued that owing to the fact that the diagnostic criteria for PTSD have become increasingly restrictive in the DSM-IV, the disorder is unlikely to be overdiagnosed or misused. However, this statement assumes that experts are applying the criteria correctly. There are two broad opportunities for experts to err where PTSD is concerned: their diagnoses may or may not be based on correct application of diagnostic criteria, and subsequently, their application of the diagnoses to the facts of

the case may or may not be appropriate. In this research, expert testimony was found to be misleading or inappropriate in some cases, or provided by experts with questionable credentials. This is a cause for concern insofar as judges were sometimes found to attach great weight to the evidence of said experts.

However, owing to the fact that PTSD is frequently considered a mitigating factor, and that there are frequently concerns about malingering, evidence by Crown experts rebutting defence experts is common, as is cross-examination of defence experts, with the result that errors in testimony are more likely to be discussed and resolved. As Slovenko (1987) put it, the cross-examination is “a built-in antiabuse device...a time-honored technique for testing competency or credibility” (p. 147). However, as noted, cases of unrebutted and unquestioned evidence about PTSD do occur. Overall, then, this research comes to the conclusion that it will be very difficult to predict what will become of any given offender with PTSD, as which judges he or she appears before and which experts testify in his or her case may lead to significantly different outcomes.

This research should be viewed in light of its limitations. Firstly, it must be noted that databases such as QuickLaw, Criminal Source and Criminal Spectrum do not contain every judgment made in every Canadian criminal case, but rather a selection of these. It is likely, therefore, that some cases involving offenders with PTSD in Canada have been missed, although highly-publicized or highly-cited cases are unlikely to have been left out of the analysis, as these are more likely to be included within one of the three databases. The literature review conducted for the area of PTSD and the law did not reveal any mentions of Canadian cases that had not already been captured by the search strategy, thus increasing this author’s confidence that relevant cases had been captured.

Another limitation relates to the fact, as alluded to previously, that this research did not address trauma disorders other than PTSD. Therefore, cases in which an individual experienced a trauma and was subsequently diagnosed with acute stress disorder, for example, have not been included. Similarly, cases in which an offender was traumatized but had not been diagnosed with PTSD, were also not included. For example, those cases in which the accused was known to have experienced a traumatic event and some psychological sequelae suggestive of PTSD would not have been included in this research if the PTSD label had not actually been applied.

This research is also limited to what happened to offenders with PTSD within the court system – it does not capture instances of diversion, where offenders with PTSD may have been dealt with outside of the courts. This is especially relevant to young offenders – a stated aim of the YCJA is to reduce the use of the courts and minimize the interactions of youth who have committed less severe crimes and the criminal justice system. Accordingly, the youth crimes which were examined as a part of this study tended to be serious ones, with less serious ones dealt with via diversionary, extra-judicial measures or sanctions not being captured.

Finally, some may view the fact that the research is based on judges' accounts of the facts/evidence to be a weakness. It is acknowledged here that certainly different judges will choose different aspects of cases to discuss and emphasize in their reasons, making it difficult to know what was truly said, presented, argued, and so on during a trial or sentencing hearing, compared to what was simply seized on, understood, or interpreted by the judge. However, every effort was made to capitalize on the fact that the research examined discourse. The discourse examined was understood by the author to be far from objective but instead, filtered through the lens of a certain individual who listens, understands, decides and speaks from a particular vantage point, as much

as this author does in attempting to interpret the discourse of judges on a second-hand basis.

Building on the limitations of this work, it would be very interesting, from a discourse analysis perspective, to examine trial transcripts in conjunction with judgments for offenders with PTSD, in order to discern differences between the information actually presented and that understood or emphasized by judges. Other future avenues for research relating to PTSD and the law might include a study of outcomes for offenders with PTSD who were diverted from the criminal justice system, compared to those who were not, or a comparison of those who were sentenced to periods of incarceration and those who received conditional sentences. There is also a need to establish more definitively the prevalence of PTSD among incarcerated individuals in Canada. Overall, it is freely noted that, as an exploratory study, this research has achieved more breadth than depth. Many of the issues examined represent merely a "scratch on the surface," and can be examined more thoroughly in future work.

In the end, with respect to the use of PTSD in sentencing, this author is in agreement with Schneider (1999), who, on the topic of mentally disordered offenders, argued, "Considering the flexibility the court has in sentencing, one is drawn to the tremendous importance of knowing the accused and the specifics of the mental disorder with which he or she has been affected" (p. 171). This exhortation was directed at an accused's counsel, who, although not possessing the same power that judges have in terms of deciding whether an offender's mental disorder is relevant to sentencing, may impact how it is presented and discussed in court proceedings. Counsel who are aware that their client suffers from post-traumatic stress disorder might therefore seek to elucidate the ways in which the disorder could have contributed to the offence, as well as the ways in which treatment directed at the disorder may ultimately impact on

recidivism. Counsel who are informed about the disorder could also conduct more effective more cross-examination of experts.

This research also leads to recommendations for judges, particularly where expert evidence is concerned. Given the errors and biases which appear to be inherent in some expert testimony relating to PTSD, it is important that judges do not accept such evidence too readily, and attempt to carefully evaluate the evidence and those supplying it. Judges do not have to become "amateur scientists" (McWilliams & Hill, 2003, p. 12-33), attempting to understand all of the evidence themselves, but they can be wary of experts who do not appear to have the necessary education or practical skills or training, and those who provide inappropriate advice concerning the legal issues at hand. They can also, in acting as gatekeepers, question the extent to which proffered evidence is currently in favour in the scientific community. Where there is a jury, a trial judge can help to review the basis for an expert's testimony, direct attention to its shortcomings, and remind jurors that their job is not to choose the expert whom they prefer, but to carefully scrutinize the evidence offered by all experts (McWilliams & Hill, 2003).

Finally, this thesis has offered recommendations for prisons. As in the courtroom, an emphasis on the crime-related effects of PTSD may be used to help convince criminal justice policy-makers of the utility of treating the disorder. In their review of mental health services in jails and prisons, Ogloff, Roesch, and Hart (1994) wrote:

> One would hope that concern for the physical and mental well-being of others would serve as ample justification for providing mental health services to all people -- including those people who are incarcerated (p. 2).

However, it appears that incarcerated individuals with PTSD are not likely to currently be treated for their disorder, and decisions such that made by the Ontario Court of Appeal in *R. v. Shahnawaz* (2000) demonstrate that the type of "fundamental

humanistic concern" (Ogloff, Roesch, & Hart, 1994, p. 2) alluded to above does not always exist: some courts and judges are not willing to take into account evidence that an individual is suffering from a mental disorder and that incarceration would worsen this condition, if the condition is judged not relevant to the offence committed. Therefore, to direct attention to the need to treat PTSD, it must be emphasized that it may hinder recovery from other conditions (such as alcohol abuse), that it may lead to instances of aggression within prisons, and that ultimately, a failure to treat it may work against the criminal justice system's twin goals of reducing offending and thereby protecting the public.

Some cases of PTSD appearing before the courts may be preventable: there seems to be cause for optimism that the Canadian Forces could prevent the rampant development of PTSD in its ranks by focussing on providing stress-inoculation training, education and intensive support to members who begin to show signs of the disorder. A concerted effort to prevent PTSD could also prove worthwhile among other professionals reliably exposed to stress, such as police officers, and in cases where victims of crime show signs of traumatic stress. In order to provide effective treatment solutions for offenders with PTSD for whom prevention is a moot issue, however, a stronger nexus between criminal justice and mental health would be required, as well as a shift in perception.

The *Youth Criminal Justice Act* states, in section 39(5), that "a youth justice court shall not use custody as a substitute for appropriate child protection, mental health or other social measures." In other words, troubled adolescents should not be imprisoned due to the fact that the judge, knowing that the issue is more about mental health than criminality, sees no other way of providing intervention (Bala, Carrington, & Roberts, 2009). In this author's opinion, such a principle needs to be adopted for offenders of all

ages, and the criminal justice system should partner more closely with mental health services so that meaningful alternatives to incarceration can be available to and recognized by judges. Conditional sentences, as well as mental health courts, in cases and jurisdictions where they are available, may offer a good solution for offenders with PTSD who require treatment more than they require a sanction for their conduct. Where incarceration is unavoidable, the criminal justice system can deal with PTSD in a positive manner by first becoming trauma-informed, and then (eventually) offering trauma-specific treatment. However, adopting trauma awareness in criminal justice institutions would require a significant commitment both in terms of a willingness to critically examine policies and procedures with a trauma lens, and also in terms of the resources that would be required.

An interesting challenge for the criminal justice system would be to adopt the physician's credo where individuals with PTSD are concerned. The credo, which fits with a trauma-informed philosophy (Harris & Fallot, 2001a) states, *Primum non nocere*: above all else, do no harm. This research has established that there are a fair number of "hurt people" being processed by Canada's criminal courts, and that their dispositions may be harming them further, which means that unfortunately the cycle of "hurt people hurt[ing] people" is only perpetuated. In the interest of many different objectives – including public safety, rehabilitation, reducing risk and reoffending, promoting mental health, and of course, compassion – there is a need for those involved in criminal justice to be aware of PTSD and its consequences.

APPENDIX

DSM-IV Criteria for Posttraumatic Stress Disorder (APA, 2000)

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

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