Court File No. CV-14-00000980-0000

SUPERIOR COURT OF JUSTICE

B E T W E E N:

ROBERT MCCABE

Plaintiff

- and -

THE ROMAN CATHOLIC EPISCOPAL CORPORATION
FOR THE DIOCESE OF TORONTO, IN CANADA

Defendant

P O R T I O N O F P R O C E E D I N G S A T T R I A L

BEFORE THE HONOURABLE JUSTICE G. LEMON
On May 18 and 19, 2017
at GUELPH, Ontario

APPEARANCES:

Mr. P. Ledroit	For Plaintiff
Mr. O. Sabo	
Ms. S. Metzler	For Defendant
Mr. C. Blom	

SUPERIOR COURT OF JUSTICE

T A B L E O F C O N T E N T S

W I T N E S S E S

E X H I B I T S

E X H I B I T S - *V O I R D I R E*

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Legend

[*sic*] - Indicates preceding word has been reproduced verbatim and is not a transcription error.

(ph) - Indicates preceding word has been spelled phonetically.

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THURSDAY, MAY 18, 2017

...HOUSEKEEPING DISCUSSIONS

V O I R D I R E

THE COURT: Just before we get started, good morning. You should know he did everything he could to let you stay with your patients.

DR. MCMASTER: Thank you.

THE COURT: You should know that the law required me to take you away from your patients. You can take that out on me in your own mind, but I am, and everybody here involved, is grateful to you in the sacrifice you may have made with your patients to be here and help us. That may not make you any happier, it may not make your patients any happier, but perhaps it might calm some dismay. That is the best I can offer.

DR. MCMASTER: Thank you.

THE COURT: Go ahead.

JEFF MCMASTER: AFFIRMED:

EXAMINATION IN-CHIEF BY MR. C. BLOM:

Q. Doctor McMaster, I am showing you a copy of a document, can you confirm that this is your *curriculum vitae*?

A. Yes, it is, thank you.

Q. Okay.

MR. BLOM: Your Honour, I have a copy to be marked as the lettered exhibit.

THE COURT: It will be Exhibit A on the *voir dire* with respect to Doctor McMaster.

EXHIBIT NUMBER A: Copy of Doctor McMaster's *curriculum vitae* – produced and marked.

MR. BLOM: And do you still have the copy we provided or would you like another?

THE COURT: I have mine.

MR. BLOM: Q. Doctor McMaster, I understand that you are a forensic psychiatrist.

A. Yes.

Q. Since 1999 - commencing in 1999, you have worked at the Centre of Addiction and Mental Health, known as CAM-H, in Toronto in various roles.

A. Yes.

Q. One of those roles was as a duty doctor?

A. Yes.

Q. Another role was on call at the emergency unit?

A. Yes.

Q. Another role was at the child and youth unit.

A. Well, as – as part of a duty doctor, CAM-H now has a child, youth, and adolescents unit. That's relatively new, probably over the last four years.

Q. You have also worked at the women's unit?

A. The – on call at the Clark Institute there is a designated women's unit, yes. On the ninth floor.

Q. You have also worked at the acute care unit treating men and women?

A. Yes. That's on the fifth floor.

Q. And you have worked at the major mental illness unit.

A. Yes, when I first started my residency I – I worked on a unit that primarily dealt with severe mental illness, schizophrenia or schizoaffective disorder.

Q. You have also worked in the forensic unit?

A. Yes. I have worked in the forensic out – outpatient program and on a medium secure forensic unit, yes.

Q. I understand that involves all male patients.

A. On an outpatient basis there is males and females and the medium secure unit involves all males.

Q. And one of the examples of what you do in that context is to determine if a person charged with a crime is fit to stand trial.

A. So the – the secure forensic unit is individuals who have been found not criminally responsible or they have been found unfit to stand trial. And our focus is on rehabilitating those individuals back into the community, integrating them back into the community safely, in the least restrictive and onerous way possible.

Q. Okay.

A. What you are referring to is my work at the forensic assessment unit at Whitby Psychiatric Hospital, now known as Ontario Shores.

Q. We'll come to that.

A. Okay.

Q. So let me go to your *curriculum vitae* if we may. Page 1, do you see "education and training"?

A. Yes.

Q. Starting at the bottom, you attended Brandon University from 1987 to 1990 and you completed your Bachelor of Science.

A. Yes.

Q. From 1991 to 1993 you attended the University of Manitoba and completed your Bachelor of Science in Medicine.

A. That's correct. That was during medical school.

Q. From 1990 to 1994, so encompassing a portion of those years, same university, University of Manitoba, you completed your Doctor of Medicine?

A. Correct.

Q. And from 1994 to 1999 you did your residence in psychiatry at the University of Toronto.

A. That's correct.

Q. As part of that, I understand that you worked in the – you – you did emergency medicine at hospitals in Toronto?

A. So - yes, so the – in the residency it's a five-year residency and the first year is like an internship year. So that involved emergency medicine at Sunnybrook Hospital, internal medicine working at a family physician's office, I believe it was neurology, um, consultation liaison to the medical floors.

Q. And in the course of doing that I understand that you assessed and treated patients who had experienced child sexual abuse?

A. Yes, childhood sexual abuse unfortunately is not a rare part of an individual's background, um, so you run into that all the time.

Q. As a matter of convenience, can we call that C-S-A?

A. Childhood sexual abuse? Yes.

Q. You have also assessed and treated patients with alcohol abuse or dependence?

A. Yes.

Q. You also assessed and treated patients with anxiety disorders, including P-T-S-D.

A. Yes.

Q. Known as post-traumatic stress disorder.

A. Yes.

Q. I'd like to go to page 3 of your *curriculum vitae*, so we are dealing with your employment history in – sort of in reverse order. Do you see 1999 to 2001?

A. Yes.

Q. In that period of time you were at CAM-H. I understand that you dealt primarily, uh, sorry, dealt with patients for whom the primary diagnosis was schizophrenia?

A. Yes.

Q. They experienced related diagnoses, including alcohol use and P-T-S-D?

A. So the – probably the – the three most common diagnoses in that patient population would be, other than major mental illness, would be alcohol use disorder, substance use disorder, and personality disorder. Not uncommonly they'll have another anxiety disorder which can include post-traumatic stress disorder. Individuals with schizophrenia are often victimized, unfortunately.

Q. Do people with mental illness have a high rate of substance abuse?

A. Yes.

Q. And in dealing with these patients, I understand that you would take a history, diagnose, and then treat?

A. Yes. Generally speaking, yes.

Q. Okay. And did some of these patients reveal a history of C-S-A?

A. Yes. I have also encountered individuals who have been delusional about being sexually abused.

Q. Some of these were on an inpatient basis and others were on an outpatient basis.

A. Yes.

Q. Moving on in your C-V, 2005 to 2013 you were a psychiatric consultant at the Don Jail in Toronto?

A. Correct.

Q. I understand that you were involved in the psychiatric treatment of inmates?

A. Yes.

Q. Now, is there a connection between people who are victimized, for example abuse, and people who are perpetrators, that is to say commit crimes?

A. Yes. There is often – often a perpetrator of a – of a crime, especially a violent crime, has history of – of abuse.

Q. I understand that some....

A. Or – or victimization as the crime occurred or later on in their adult years, given lifestyle factors.

Q. Now many of the patients you treated at the Don Jail had symptoms of P-T-S-D for a variety of reasons?

A. Yes.

Q. And some had a history of trauma, including C-S-A.

A. Yes.

Q. Back to your C-V. From 2000 to 2013, you were a psychiatrist at the Brief Assessment Unit at Old City Hall.

A. Yes.

Q. And in that role I understand you were doing assessments to determine if a person charged with a crime is

fit to stand trial.

A. Yes, that's correct. So it's – it's brief psychiatric assessments to assist the court in that one psycholegal issue, fitness to stand trial. I did it on a weekly basis for a period of time and then up in 2000 – up and until 2013 it was more to fill in for colleagues.

Q. I understand that some of those whom you met included patients or not patients necessarily but the people who you saw had P-T-S-D with a psychotic presentation?

A. Yes. There – there would be a psychosis presenting in a psychotic-like fashion, um, is rare but can occur.

Q. Back to your C-V. 2001 to 2003, you were a psychiatrist at the sexual behaviours clinic and the forensic outpatient program at the law and mental health program at CAM-H in Toronto.

A. That's correct.

Q. Now, in terms of the sexual behaviours clinic, I understand that you assessed people who had various issues with sexuality.

A. Yes.

Q. And that would include issues of sexuality arising from C-S-A.

A. Yes, that – that can include that issue. There is many other issues that came to that clinic.

Q. 2001 to 2007, you worked as a psychiatrist at the consultation liaison service at the workplace violence and risk program at the law and mental health program of CAM-H.

A. Yes.

Q. You saw the people with the request to determine if they posed a risk of violence at work.

A. Yes. So that was a program run by Doctor Phil Klassen it was a contract with George Weston Limited and it was to evaluate their employees for risk of workplace violence.

Q. And George Weston Limited is a company which makes, among other things, bread products?

A. Yes.

Q. I understand that these assessments included employees with an alcohol use disorder?

A. Yes.

Q. Some of whom had experienced C-S-A.

A. Yes.

Q. From the year 2001 to the present, you have worked as a psychiatrist at the medium secure forensic unit in the law and mental health program at CAM-H.

A. Yes. So I think I need to update my C-V in that one point. I stopped working on that unit as of July – or June 2016.

Q. Thank you. In that role, I understand that you were dealing with one might call the interface between psychiatry and the law?

A. Well, that would describe forensic psychiatry in general. And the – the interface in that case was reporting how an individual was doing to an Ontario Review Board, in terms of their risk, their safety, management of their illness and reintegration into the community.

Q. Okay. So would that be people who have been deemed unfit to stand trial?

A. Yes. But more commonly they would be found not criminally responsible and then under the supervision of the Ontario Review Board.

Q. And that would include patients with sexual

difficulties.

A. Yes. It can include patients with, um, paraphilias, or sexual acting out behaviours for personality reasons, or impulse control reasons and some of these patients have had histories of childhood sexual abuse and other traumatic events happened to then.

Q. What is paraphilia?

A. Paraphilia is a deviant sexual disorder, so for example, pedophilia or exhibitionism.

Q. Some of these patients had presented with a history of C-S-A?

A. Yes.

Q. Some with a history of alcohol use disorder?

A. Yes.

Q. And some with a history of P-T-S-D.

A. Yes.

Q. I understand that your role in – in part, was to provide opinions to the review board.

A. Yes. So you prepare a report on an annual basis, or at least an annual basis, present that to review board. On a day to day basis you are working with a – an inpatient team of nurses, social workers, occupational therapists, and recreational therapists.

Q. And that report would address, among other things, the status of your rehabilitation to reintegrate the person into society?

A. Yes.

Q. From – I'm sorry, turning a page back to page 2. From 2001 to 2007 and then from 2010 to 2013, you worked as a psychiatrist at the forensic assessment unit of Ontario Shores which was formerly known as the Whitby Mental Health Centre?

A. Yes.

Q. That is a psychiatric hospital?

A. Yes.

Q. And I understand it has various units of patients?

A. Yes, it does.

Q. You worked at the forensic unit.

A. The forensic assessment unit, yes. They have other forensic units that do more rehabilitation. This is an assessment unit to provide a – an opinion for the court.

Q. I understand that you led a multidisciplinary team which included psychologists, nursing staff, and social workers?

A. Yes.

Q. And what is it that you did at the forensic assessment unit?

A. So an assessment at the forensic assessment unit involves interviewing the patients, it involves reviewing the collateral information available.

Q. And what would that include?

A. The, uh, police synopsis or anything else provided by the Crown Attorney or – or defence counsel. We have a social worker whose job includes gathering collateral information so it would involve gathering prior hospital records, interviewing family and friends, and gathering any collateral information which may be useful to understand that person and assess the issue.

Q. And – and what was the purpose of the assessment?

A. The purpose of the assessment is to do a psychiatric assessment, it also involves, um, especially in more complicated cases, but in all cases, psychological

testing.

Q. Okay.

A. It also involves the observations on a 24-7 basis by the nursing and other staff so you get a good sense of – of how that person is doing on an inpatient basis. But the ultimate assessment is to do a full psychiatric assessment and understanding of that patient to provide a, um, an opinion of the matter of criminal responsibility or fitness to stand trial. And ultimately the court makes the decision in that regard. You are just there to try and assist the court.

Q. From 2010 to the present you have worked as a psychiatrist at the Northern Psychiatric Outreach Program through CAM-H?

A. Yes. It's, um, it's – yeah, it's based out of CAM-H but, um, this – this work involves flying into Kenora, Ontario. Kenora is two hours, three hours east of – of Winnipeg, Manitoba, and working with the C-M-H-A. So not CAM-H but the C-M-H-A Kenora to provide psychiatric assessments there.

Q. What is the C-M-H-A?

A. The Canadian Mental Health Association.

Q. And I understand you did general psychiatric assessments.

A. So the – there is a number of different types of assessment, um, one are, uh, you know, presentence reports, general psychiatric assessments, N-C-R assessments, fitness assessments, dangerousness assessments.

Q. And what is an N-C-R assessment?

A. So whether the person would qualify for a defence of not criminally responsible by reason of mental disorder. And again, it's just to provide an opinion. It could be for defence counsel or court order with ultimately,

of course, the decision made by the court.

Q. I understand that you have continued to make these flights to Kenora about five times a year?

A. Yes, I was last in Kenora at the end of March of this year, I believe, if I am remembering correctly.

Q. And you see about two patients each time.

A. That's correct, yes.

Q. I understand this involves the assessment of patients who have experienced various forms of trauma including C-S-A?

A. Yes. I should add too that about half of those – half the individuals I assess, roughly half, are of Aboriginal background with related psychosocial challenges.

Q. They present with various forms of addiction including alcohol?

A. The patients that I have assessed, yes. Certainly can include addiction and, uh, include alcoholism, yes.

Q. Some suffer from P-T-S-D?

A. Yes.

Q. Sources of that might be witnessing violent acts?

A. Yes.

Q. Some might be experiences such – such as being lost in the – in the woods as a child?

A. Yes.

Q. Some might be from C-S-A.

A. Yes.

Q. Since 2014, you have worked at the – sorry, as an addiction medicine and consultant psychiatrist at the Ontario Addiction Treatment Centre?

A. Yes.

Q. Where is that?

A. So, uh, that organization has a number of different clinics across Ontario, one in Manitoba now I understand. I work at Newmarket, Ontario and at Keswick, Ontario.

Q. And you do that about two half days a week?

A. Yes. I do that Thursday mornings and Friday mornings.

Q. That includes patients with an opioid addiction?

A. Yes.

Q. An example might be for – for instance someone involved in a car accident who later used oxycodone and may become addicted to it?

A. Yes.

Q. I understand once the addiction has settled down or is under control, your role then moves on to assisting and establishing their life once again.

A. Yes. It's – so it's a voluntary program but highly effective and highly rewarding to treat this patient population because they get better. But, yes, there is structure involved and we work as a team to, um, try and get their addiction under control and to assist in improved functioning in their life.

Q. Some of these patients have history of trauma, and I mentioned as an example a car accident?

A. Yes.

Q. And that may in turn to lead – lead to a diagnosis such as P-T-S-D?

A. Yes.

Q. Part of your role is to treat that.

A. Yes.

Q. I understand that one of your patients is – is a man who recently lost his family members to gang violence?

A. Yes.

Q. And when you went through the history with this gentleman, did he have a history of C-S-A?

A. Yes.

Q. I understand another is an example – as an example is a woman in counselling for C-S-A.

A. Yes.

Q. And your role, in part, is to monitor her medication?

A. Yes. We're – we're talking about her – her P-T-S-D therapy. She is with another counsellor and we're trying to monitor her medication, um, appropriately because reductions in her medication can lead to increases in anxiety which may make it more difficult for her to deal with that issue.

Q. And as I understand it one of the things that you are doing is – is delving into her past with the therapy, the past C-S-A, and you are monitoring the medication to assist her in going through that.

A. So, she is in – she's actually in separate counselling, um, where she has a – another counsellor who goes into depth with that, um, in that issue with her.

Q. Okay. But do you...

A. I – I'm....

Q. ...receive reports from that?

A. So I am monitoring with her how she's doing in that and – and adjusting our treatments accordingly.

Q. Do you receive the reports of the counsellor?

A. I don't, no.

Q. One of the addictions you treat in this role is alcohol use disorder?

A. Yes.

Q. Now, tell us about your background in terms of understanding the genetic role in alcohol use disorder.

A. The genetic role, um, well as part of the psychiatry residency we – we learned about various disorders including the disorders in the D-S-M-5 which would include substance use disorders, P-T-S-D, major mental illness, and so on and so forth. And at the end of that residency, um, if you have a patient in front of you and – and you take a history and then you do a formulation of that individual involving predisposing factors, precipitating factors, perpetuating factors, and then other factors that may influence how that individual got to you and – and your office. So throughout the entire residency it's all about trying to understand the – the perspective of that patient and that includes biogenetic background.

Q. And since your residency you have continued to see patients such as that up to the present day.

A. Yes.

Q. And can you give us an estimate of how many patients you have seen with an alcohol use disorder.

A. I don't think I could give an estimate, it's – it's certainly, you know, it's certainly a common – a very common diagnosis, obviously, right. People come into the emergency department intoxicated, they may have psychosis related to their alcohol use, alcoholic hallucinosis, um, so it's a very common diagnosis that we see all the time in psychiatry.

Q. And as a result of seeing these patients,

and doing the work you do with them, have you learned if there are various causes for alcohol use disorder?

A. Well, there is my – so there is my experience taking a history, um, and there's also a review of the literature. So my, you know, my experience would be skewed by the setting that I see the person in whereas general population surveys of alcohol use may show different findings. So you want to, you know, look at the general literature and then also incorporate your own personal experience into that understanding.

Q. So, just so I'm clear, you have read the literature on the role of genetics in alcohol use disorder?

A. Yes.

Q. And through the literature and your work with patients, have you seen some with a – a strong genetic loading leading to that diagnosis?

A. Yes.

Q. In 2015 you worked as the lead psychiatrist at the Toronto South Detention Centre?

A. Yes.

Q. I understand you did that three half days a week?

A. So – yeah, so that's – that's what I'm booked to do this afternoon and tomorrow afternoon.

Q. Oh, so you're still doing that now.

A. Yes. I am the...

Q. Okay.

A. ...I am the head psychiatrist at the Toronto South Detention Centre.

Q. I'll just put a little dash beside 2015.

A. Right.

Q. You assess and treat inmates.

A. Yes, so I have an administrative role to provide services to the Toronto South Detention Centre. I have a contract with them and I am responsible for having psychiatrists work for me to fulfil those duties.

Q. So in part you have a supervisory role?

A. Yes.

Q. And do you also have a role where you're directly in contact with the inmates?

A. Yes.

Q. Now I understand that the South Detention Centre is a remand centre where some inmates are awaiting trial.

A. Yes.

Q. And some are serving a sentence of under two years.

A. Yes.

Q. Some are suffering from mental disorders including anxiety disorders?

A. Yes.

Q. That includes P-T-S-D?

A. Yes.

Q. Some have an alcohol use disorder.

A. Yes.

Q. Some have a history of C-S-A?

A. Yes.

Q. Let me go in your C-V to page 1. So under "B. Positions", 2005 to 2014 you have worked as a psychiatrist in the psychological trauma program at CAM-H.

A. Yes.

Q. In that role I understand you do assessments for the Workplace Safety and Insurance Board.

A. Yes.

Q. And is there – in – in some sense is this program an academic program or centre?

A. It is. So, um, a patient will have a workplace incident and it can be, you know, they were attacked in the workplace, assaulted at the workplace, or it could be something – one individual was a ski instructor at Blue Mountain who rolled his ankle and then developed a chronic pain syndrome. So there is some kind of incident that leads to psychological, psychiatric difficulties and possible impairment and disability.

Q. Are - examples of those incidents, do they include sexual assault?

A. Yes.

Q. And I understand that what you did was a psychiatric assessment. Is that correct?

A. Yes. So it is an academic, um, centre so sometimes I will have – or, I am not there anymore but sometimes you will have a medical student or a resident with you. And on the other side of things there's a psychologist who does an independent assessment and they may be psychologists supervised by a P-H-D psychologist.

Q. Okay.

A. After we do our independent assessments, we have a case conference. And at the case conference we talk about our findings, reconcile any differences, and then present our findings to the W-S-I-B in a – in a more omnibus report.

Q. And that report addresses diagnosis?

A. Yes. It – it addresses what the diagnoses are and then the other issues that I stated in the C-V there.

Q. So the relationship to what happened at work?

A. Yes.

Q. Or other causes.

A. Yes. You have to look at all the various causes, again, it's another formulation. In this case the index incident is a workplace mishap or trauma. But to look at the relationship between that trauma and their current functioning, you have to assess other factors in their life.

Q. Some of these employees experienced P-T-S-D?

A. Yes.

Q. Some have a history of alcohol use disorder?

A. Yes.

Q. Some have a history of C-S-A.

A. Yes.

Q. In addition to dealing with the diagnosis and causation, I understand you also commented on the level of impairment.

A. Yes.

Q. I would like to go to page 2 of your C-V, at the top. You see consulting – "consultant for"?

A. Yes.

Q. And you have listed doing consultations for defence counsel, that would be in the criminal and civil law context?

A. Yes.

Q. Or the Attorney General which is in the criminal law context.

A. Yes.

Q. Or the Children's Aid Society which I understand deals with fitness to parent.

A. Yes.

Q. For the City of Toronto you have assessed employees.

A. Yes.

Q. For insurance companies you have assessed people making claims?

A. Yes.

Q. For the College of Physicians and Surgeons of Ontario you have assessed physicians.

A. Yes. Including a woman with severe alcohol abuse several – that was several years ago.

Q. Okay. For the Ontario College of Teachers you have assessed teachers.

A. Yes.

Q. For the Ontario Nurse's Association you have assessed nurses?

A. Yes.

Q. For the Office of the Chief Coroner you have assessed members of the staff?

A. For the Office of the Chief Coroner I reviewed a file of an individual who had committed suicide and had bipolar disorder.

Q. For the Law Society of Upper Canada you have assessed lawyers and paralegals?

A. Yes.

Q. And for the Ontario Review Board, as we have already touched on, you have done assessments in the criminal context.

A. Yes.

Q. And in the course of these assessments, do some of the patients present with symptoms of P-T-S-D?

A. Yes.

Q. Do some present with an alcohol use disorder?

A. Yes.

Q. And do some present with a history of C-S-A?

A. Yes.

Q. Now, I wanted to go – in – in the next heading you say, "With respect to matters including," we have covered much of that. But do you see "evaluation of trauma and its effects"?

A. Yes.

Q. Okay. Now I understand that is your assessment practice dealing with cases such as this in the civil context.

A. It is, yes.

Q. And that – and that's – and that includes adults who have experienced C-S-A.

A. Yes and, um, also like work – workplace harassment types of assessments as well.

Q. Okay. You have done about 40 of those?

A. It – that would be my estimation, um, I don't have an exact number...

Q. Fair enough.

A. ...but roughly...

Q. In doing...

A. ...that number.

Q. ...the assessments one of the things you do is reach a diagnosis.

A. Yes.

Q. Okay. You then consider the question of causation or the cause of what the diagnosis is?

A. Yes. I will do my formulation of the various factors to come to my understanding of – of the patient, yes.

Q. And to the extent you are dealing with C-S-A, you then comment on the impact of the C-S-A.

A. Yes. So – so if that's one of the, uh, referral questions I will address that question, yes.

Q. Let me go back to page 3. Under section "C. academic appointments". From 1999 to 2013 you were a lecturer in psychiatry at the University of Toronto?

A. Yes.

Q. From 2013 to now you have been an assistant professor of psychiatry at the University of Toronto?

A. Yes.

Q. Under "supervision", I understand that – we don't have to go through all of these, but you have played a role in supervising various students and psychiatrists in the course of your career?

A. Yes.

Q. Page 5. You have been involved in and continue to be involved in research and publication?

A. Yes, as per my C-V.

Q. Page 6 "presentations". You have been and continue to be involved in presentations from time to time?

A. Yes, the last – the last I gave with Scott Woodside and Trina Wilkie was just in April and that was on report writing for dangerous offender, long-term offender reports.

Q. Okay. Let me go to page 8, under "teaching". And let me go to – do you see "2010 residence seminar series"?

A. Yes.

Q. "Law and mental health program, University of Toronto." You taught a course on assessment in malingered P-T-S-D in the disability context?

A. Yes.

Q. And then below that from 2008 to the

present, you describe that at the residency core curriculum at the University of Toronto you teach malingered psychosis – psychosis and P-T-S-D?

A. Yes. So I last gave that in – in March of this year.

Q. Page over under "E" you have "other training". If I go down to 2005, is this a course you attended?

A. In 2000 – sorry, in 2015 or?

Q. Yes, sorry, actually I – I want to go to 2007.

A. Okay.

Q. So other training, go all the way down to 2007 "psychiatric genetics". Do you see that?

A. Yes.

Q. And is that a course you attended?

A. There is a, uh, yes, the University of Toronto has a neuroscience day and they'll bring in a - typically a prominent lecturer in an area, and – and give a – a half day of the course or a seminar on that topic.

Q. What is "psychiatric genetics"?

A. Psychiatric genetics is the – the study of genetics to understand psychiatric illness or...

Q. Okay, below....

A. ...to attempt to understand psychiatric illness.

Q. Below that 2005, "The forensic evaluation of trauma in civil cases." Another course you attended?

A. Yes.

Q. And does trauma in civil cases include C-S-A?

A. Yes.

Q. 2004 you attended, "Treating P-T-S-D and complex psychological trauma, recent advances."

A. Yes.

Q. And in that context does trauma include C-S-A?

A. Yes.

Q. And in that context would P-T-S-D be a symptom arising from C-S-A and other causes?

A. It can, yes. Yeah.

Q. Over the...

A. There's various...

Q. ...page....

A. ...causes of P-T-S-D. Yes.

Q. Over the page, item "F" your qualifications. You are a Fellow of the Royal College of Physicians and Surgeons in Canada in Psychiatry since 1999?

A. Yes.

Q. You are certified in the subspecialty of forensic psychiatry through the College and that occurred in 2013?

A. Yes.

Q. Now was there an examination that you were required to take to – to achieve that?

A. Yes, to achieve that, yes.

Q. Okay. And clearly you took it.

A. Yes. I think a couple of my colleagues haven't taken it. You're not – you're not forced to take it but I chose to take it to demonstrate, um, and to become a subspecialist in forensic psychiatry.

Q. So it was optional for you.

A. It's – it's optional for a psychiatrist, so...

Q. Okay.

A. ...um, in – in that year, the Royal College of Physicians and Surgeons of Canada designated child psychiatry, geriatric psychiatry, and forensic psychiatry subspecialties. And given – if you had enough experience in the field, you were allowed to write the examinations. Not anyone could write that examination, it was based on demonstrating experience in the area.

Q. Okay.

A. Now for someone to write that examination they have to take, after their – their five-year residency they would have to take a sixth year and that's the – it's called your P-G-Y-6, it's really like a fellowship year. And so my – my colleagues and I at CAM-H and University of Toronto, we supervise those residents.

Q. "Associations", you are member of the associations listed there as we see.

A. Yes.

Q. And then under "administrative posts", currently you are the head of forensic – of the Forensic Psycholegal Clinic at CAM-H?

A. Yes.

Q. And I understand that you have been qualified, in the past, as an expert in psychiatry?

A. Yes.

Q. In the Superior Court and the Provincial Court in Ontario?

A. Yes, the Superior Court. I assume the Provincial Court but I really don't keep track but I would assume so.

Q. That's for criminal matters.

A. For criminal matters, yes.

Q. Okay. And you have also been qualified as an expert in psychiatry before various tribunals?

A. Yes.

Q. I understand that you have been qualified as an expert somewhere in the range of 15 to 20 times?

A. Again, I am – I am not sure, uh...

Q. Okay.

A. ...I would – I would think it's at least that many times but that would be an estimation.

MR. BLOM: Your Honour, I ask that Doctor McMaster be qualified as an expert forensic psychiatrist, qualified to give evidence on the impact of...

THE COURT: Slow down, I...

MR. BLOM: ...childhood....

THE COURT: ...slow down, I left that piece of paper behind.

MR. BLOM: Okay.

THE COURT: Forensic.

MR. BLOM: An expert forensic psychiatrist.

THE COURT: Go ahead.

MR. BLOM: Qualified to give evidence.

THE COURT: Yes.

MR. BLOM: On the impact of childhood sexual abuse.

THE COURT: Questions?

CROSS-EXAMINATION BY MR. P. LEDROIT:

Q. The times that you have been qualified as an expert, they've been involved in criminal matters?

A. Yes.

Q. Never in a civil matter.

A. Well, civil matters would involve, uh, testifying at the Ontario College of Teachers, uh....

Q. Well, no, I am talking about being qualified as an expert in court.

A. Yeah, that would be at a tribunal. That's right. But in court, yes, it would be criminal matters.

Q. Criminal matters. I want to understand what a forensic psychiatrist is. Does that give you training in P-T-S-D?

A. Well, you have to understand P-T-S-D to, um, to be a forensic psychiatrist, yes.

Q. No, but is that something you have to – is that – you're – you're – it's like saying it's a subspecialty of psychiatry. Is – is it – do you go through a course to learn about P-T-S-D to become a forensic psychiatrist?

A. No. So you become a general psychiatrist first, which...

Q. Yes.

A. ....includes...

Q. I understand.

A. ...learning – learning P-T-S-D.

Q. Yes.

A. And then as a forensic psychiatrist you take your knowledge and experience of P-T-S-D to learn about forensic matters related to P-T-S-D. So...

Q. Like what?

A. ...so P-T-S-D and, um, whether someone would qualify for an N-C-R defence.

Q. N-C-R, not – can you tell me what N-C-R....

A. Not criminally responsible.

Q. Okay.

A. So it's – it's, you know, there's articles

that say yes, it could be used but it's rarely used in that context but sometimes it has been used. So....

Q. But being a forensic psychiatrist doesn't make you better qualified to either diagnose or treat P-T-S-D?

A. Well, you'd be a general psychiatrist making that diagnosis, um, and having an understanding and then as a forensic psychiatrist you would – I think you'd – yeah, you are better equipped to make a – a more fulsome diagnosis because typically you will do a full assessment involving interviews, psychological testing, gathering of collateral, and you will know about the specific psycholegal issues. But you would use your general psychiatric training.

Q. I am not with you so if – if you can, and maybe I'm thick, but, uh, what is it that becoming a forensic psychiatrist does? What training do you go through to become a forensic psychiatrist to help you better diagnose P-T-S-D?

A. Well, I am not sure – yeah, I am not sure if I – I would put it quite that way. It would give you, uh, it would give you the understanding how to do an objective assessment....

Q. How to do an assessment.

A. Well, how to do an objective assessment in a psycholegal context and...

Q. Because you're....

A. ...and – and from, you know, for any psycholegal assessment one has to assess malingering. And malingering, um, you know, psychiatrists aren't, as they say, lie detectors and the best way you can evaluate that issue, which must be evaluated in these types of assessments, is to know how an illness typically presents.

Q. So if I understand correctly, what you are saying is that in forensic psychiatry, as opposed to being a

treating psychiatrist, you are looking for malingering.

A. Well, treating psychiatrists need to look at that in certain contexts as well so, for example, at – but it wouldn't be the main focus. But that would be something you would include certainly in your forensic assessments.

Q. But – but is it the forensic psychiatry – psychiatrist does an assessment. Is – is that the differentiation?

A. Well, the – the forensic psychiatry part is having general psychiatric knowledge that you have been trained in and...

Q. Right.

A. ...and your experienced. And then knowing how it may interact in terms of someone's presentation. So if you want to know about P-T-S-D and violence, P-T-S-D and loss of control for an N-C-R context. P-T-S-D and fitness to stand trial, P-T-S-D and disability, P-T-S-D and malingering.

Q. Uh-huh.

A. You would want to know about those different areas to, you know, to assist you in your – in your determination of whether someone has a diagnosis, how that diagnosis may have affected them, how that diagnosis may impact on their presentation.

Q. Because the purpose of it is is that you want to be able to determine if somebody is either faking or not faking being criminally responsible.

A. Well, if that's – if that is the psycholegal context, that is something we'd want to consider. You would do your full assessment and that would be one part of the assessment. That's – that's not the entirety of the assessment.

Q. Okay. But your lawyer made a point or Mr.

Blom made a point of suggesting to Doctor Jaffe that – and you know Doctor Jaffe?

A. I – I know...

Q. At least you know...

A. ...of him, I – I...

Q. ...of him?

A. ...don't think I have met him but I know of him, yes.

Q. But he is not designated as a forensic psychiatrist. Does that mean you are better able – do you claim to be better able to make an assessment than Doctor Jaffe?

A. I – you know, I – I wouldn't, um, I wouldn't make any claim to that effect because I don't know Doctor Jaffe, I don't know his qualifications, I haven't heard him testify in court, um....

Q. You've read his reports.

A. I read his reports, yes.

Q. Yes. And then judging from his reports, do you claim to be better qualified than him? In making an assessment?

A. Um, I – I don't think I would want to, you know, jump to any conclusions based on reading one report and not...

Q. Well, but just....

A. ...seeing his C-V and not hearing him testify.

Q. I – I am not – I am not comparing your – your – your – what I want to understand is getting the designation of forensic psychiatrist, does that make a difference, as far as you can see, between you and Doctor Jaffe?

A. Now is Doctor Jaffe a psychiatrist?

Q. Psychologist.

A. So first of all you are comparing one discipline to another discipline so....

Q. I – yeah, yes.

A. So I am a forensic psychiatrist, I am not a psychologist. So, for example, in this area here I, um, used a psychologist, Doctor Percy Wright, to assist me in my understanding of the psychological testing.

Q. Yeah. And if you read Doctor Jaffe's report he didn't do the testing either. I am asking you a specific question, I am asking you if you can answer.

A. So I am not – I don't think I am prepared to say, um, in - to make that comparison. I don't have all the information available. I am prepared to speak on my behalf and to talk about my...

Q. Yeah, I understand....

A. ...credentials as a forensic psychiatrist and my training. I am – I – I...

Q. But....

A. ...don't have enough information to answer...

Q. But – but...

A. ...the question.

Q. ...using the word "forensic psychiatrist" what I'm really after is, in your judgment or opinion, does it matter from what you have seen of Doctor Jaffe that he is not a forensic psychiatrist.

A. Well, I, you know, I don't think that's my determination to make, I...

Q. Okay.

A. ...I think....

Q. You don't claim to be better able.

A. I – I am just saying that I have the training in this area and a part of training in this area is trying to do an objective assessment and not to be an advocate for one side or the other.

Q. We'll come to that, but....

A. Yes.

Q. But what will – really what I'm after is if you can answer my question. Because you have the designation of forensic psychiatry, do you claim that you are in a better position than Doctor Jaffe who doesn't have that designation?

A. I don't have enough information to answer that question, I'm sorry.

Q. Oh, you're not able to – you're not able to give any opinion on that. You don't claim to be better. That's all I want to know.

A. I – I am – I am – I am speaking about myself and my qualifications and I am not here to speak about someone else's qualifications. That is not my role and I don't have the information in front of me.

Q. Is the answer then no?

A. The answer is I can't answer your question.

Q. I see. When I go through what I understand your background to be and what you do is you're involved in risk assessment, correct?

A. Yes.

Q. And that would occupy the vast majority of what you do?

A. So it would be roughly three days a week is, um, the addictions and the, uh, treatment of the inmates, duty doctor on call forensic outreach assessments in Kenora. And then about two days a week I do, um, psycholegal assessments.

Q. Okay. Now, violence risk assessments, would that be a large component of what you do?

A. Actually currently I don't – I don't think I have any cases on the go with violence risk assessment, it – but it is certainly something I have done on numerous occasions, yes.

Q. Well, has – has it ever been a large component of what you do?

A. Yes, um, you know, risk assessment on a medium secure forensic unit, for example, you are assessing risk on a daily basis, whether...

Q. Well....

A. ...whether to grant someone passes, um...

Q. Okay.

A. ...reporting to the Ontario Review Board. So, yes, that's correct.

Q. Okay. Has there been a change in the last few years?

A. Yes, so I gave up my inpatient responsibilities at CAM-H in June of last year.

Q. Yeah. Well up until June of last year, was the – a large component of your practice doing violence risk assessment?

A. Well, I would do, uh, yes, dangerous offender assessments, yes.

Q. Is yes - you're answering yes to what, it was...

A. Well....

Q. ...the largest component of your practice?

A. Well, I have done probably twenty-something dangerous offender assessments in the last several years so probably one or two a year.

Q. Well up until last year when things seemed to have changed a bit, was - violence risk assessments, were they a large component of your practice?

A. It depends what you mean by "large" but it's something I feel very comfortable in doing and I have done on a regular basis, yes.

Q. Would you disagree with the word "large"?

A. Well, again, it's not, you know, if "large" means the majority of my time is doing violence risk assessments, then the answer is no.

Q. How much would you say?

A. Well one or two violence risk assessments in terms of D-Os per year, um....

Q. Yeah, a quarter, a third?

A. Yes, it's tough to estimate but it's – it's, yes it's a fairly large percentage I would say but it's certainly not the majority of my work.

Q. Okay. Would you agree with a quarter or a third?

A. You know, it's tough to – it's tough to really put a number to it.

Q. Okay. At the secure forensic unit leading to, um, well, maybe you should just explain. What's an O-R-B report?

A. So an O-R-B report is the Ontario Review Board and the report is the annual report to the O-R-B and it goes through the patient's background and history and provides diagnosis, risk assessment, and risk management.

Q. Is this what you would call a violence risk assessment?

A. It would be, yes.

Q. And that would involve what? Are you – are

you saying less than a quarter of the time?

A. So the medium secure forensic unit, and again it's – it's tough to say because it'll, you know, it's – a lot of it's treatment, meeting with the staff, meeting with the patients. So it's not really violence risk assessment *per se* but in the background, um, you have to be mindful of risk at all times with that patient population. Because your job is to reintegrate them into the community safely.

Q. Okay. I am – I am just talking about, you know, in the forensic unit. How much of the time – of that time would be occupied by you – of your time.

A. The forensic unit, um, a couple of days a week.

Q. Be about a quarter of your time?

A. Yeah, roughly about that, yes.

Q. Okay. And that's dealing with criminals.

A. They have criminal histories, they have, you know, been an N-C-R patient. I don't think, they're not technically criminals, they....

Q. Well, okay, but...

A. But – but...

Q. ...they're – they were...

A. ...but I see your point.

Q. ...involved in the criminal justice system. How's that?

A. Yes, they have been, yes.

Q. Yeah. And that's – that's why you're – you're – you're there. You are dealing with people involved in the criminal justice system.

A. Yeah. I don't want to stigmatize them by calling them criminals but, yeah, they have criminal histories to....

Q. That's why I'm using the system.

A. Yes.

Q. The criminal justice system. Okay?

A. Yes, they're in the O-R-B system.

Q. And other aspects of your work, that would involve corrections work?

A. Yes.

Q. Involving assessments to stand trial?

A. Yes.

Q. And whether somebody would qualify to be not criminally responsible?

A. Yes.

Q. Because of some type of mental problem?

A. Yes.

Q. And you deal – you do civil assessments regarding capacity to work?

A. Yes.

Q. Rehabilitation of individuals with complex medical illnesses.

A. Yes.

Q. Now, involved – you know, so and from what I gather you're a – you have an active treatment practice?

A. Yes.

Q. And you have seen people with all types of mental problems?

A. Yes.

Q. If we differentiated between psychosis and neurosis, can we use that general...

A. Sure, I – I...

Q. ...is that – is that okay?

A. ...think I understand what you mean, yes.

Q. How many of the patients or what percentage

of people would you see with, let's say, psychotic versus a neurotic problem?

A. Um....

Q. And if – and if I can...

A. Yes.

Q. ...just – just – just to be clear, I am just trying to differentiate between things like schizophrenia and bipolar disease, where people are out of touch with reality.

A. Well, they are during the active phase of their illness.

Q. Yeah.

A. And once you treat that aspect of their illness, then you – you are left with the remaining disabilities and diagnoses.

Q. Right. Can you give us some estimation between neurotic and psychotic problems?

A. So in – in the medium secure forensic unit for example, a place....

Q. I – I'm – I'm talking about the – the treating part of your practice.

A. So – so that was a treating part. So I am...

Q. Okay.

A. ...no longer doing that. So - yeah, so currently Toronto South, um, I would say about half of them have major mental illness.

Q. And the other half they're – could be in the realm of the people like in Mr. McCabe, suffering from P-T-S-D?

A. There's – yeah, there's a variety. Generalized – generalized anxiety disorder, P-T-S-D, major depression, um, substance use disorders, they may have sexual

disorders, um, so yeah...

Q. A variety...

A. ...roughly....

Q. ...of problems.

A. But it's tough to, you know, you can't really separate like that given that there is so much comorbidity so....

Q. You mean between psychotic and neurotic or?

A. Yes, so a lot of the individuals with psychosis will have comorbid depression or generalized anxiety or – or P-T-S-D, substance use, personality disorders, so....

Q. I understand but – but if – if we take those people with psychosis out of the equation, we're talking about....

A. Yes, so it would be – I – you know, I am just estimating probably half and half, I would say.

Q. And roughly speaking, and I am talking now treating, not – not just consulting but treating.

A. Yes.

Q. Because I – I think you made a differentiation when Mr. Blom was referring you to I think it was the woman who was in a car accident that became addicted to opioids.

A. So, yes....

Q. You – you weren't actually treating her, you were overseeing her treatment?

A. Yes, so – so that was in – so when he is talking about the 50-50, that's at the Toronto South Detention Centre. And then in my, um, addiction practice, I have about 95 patients, male and female, and the woman that we were referring to was one of my patients that is under my treatment....

Q. That's in the addictions program, is that what you said?

A. It's in the addictions program.

Q. Yeah.

A. And she's one of the, um, one of my patients who I am working with. She is under my direct – or I prescribe medication to her and – and we do psychiatric care. But she has separate counselling. Separate from what I am doing with her.

Q. You are not counselling her.

A. So I am – well, I – I do, you know, it's not – it's not strictly counselling. It's psychiatric management which includes talking to her and providing supportive therapy.

Q. All right. Now just so I understand it, in your active practice today, how many of those people that – not just dealing with addictions, but dealing with psychiatric non-psychotic people, how many people do you treat?

A. So in the addictions component, um, yeah, there is...

Q. Overall.

A. ...so there is 90 – I have 95 patients currently. And some patients drop out and, you know, some...

Q. Yes.

A. ...join the...

Q. Correct.

A. ...the program so there is, you know, turnover but currently about 95 patients. And none of those have active psychosis at the moment. There has been occasionally people with schizophrenia but the vast majority don't have schizophrenia.

Q. Okay.

A. There is the odd person with bipolar disorder as...

Q. Now, just so...

A. ...well but....

Q. ...I understand. I know it's 95 patients, are you involved in their day to day treatment?

A. I see them at least once a month, typically a couple of times a month.

Q. And some of those people present with C-S-A.

A. Yes.

Q. And some people present with any of – all kinds of histories, right? One of which is – one – one history could be C-S-A, another one might be the death of a close relative or, you know, they could be involved in some kind of trauma or whatever it might, but....

A. Well, yeah, when I – so when I take their history I will get their family history and do a trauma history so any history of childhood sexual abuse, physical abuse...

Q. You haven't made....

A. ...emotional abuse....

THE COURT: Mr. Ledroit, I know you are worried about the clock but you really have to let the witness finish...

MR. LEDROIT: Thank you, Your Honour.

THE COURT: ...the answer.

MR. LEDROIT: Q. You haven't made childhood sexual abuse the specific priority in your – or a specialized part or a restricted part of your practice.

A. No. No.

Q. It's just that people come, whether it's in a forensic unit or whether it's in a generalized treatment

problem that you're talking about, some people have C-S-A backgrounds and others don't.

A. Yes, so childhood sexual abuse isn't a diagnosis. So I would do a diagnosis and as part of my understanding of their diagnosis you would consider the factors that bring, you know, bringing the person to you for treatment.

Q. And is 95 – sorry, if we can just go back for a second. Being involved in treatment is – is this something different from what you were doing a few years ago?

A. Yes, so I have developed, uh, I have incorporated my addictions practice, yes.

Q. And in this treatment practice, how long has that been going?

A. It must be three years now, four years, fourth year maybe.

Q. So up until three years ago you were not involved in the treatment practice.

A. Well I was in various capacities, um, but not in this addictions program, no. Yeah.

Q. Okay. Can I ask you to be specific about what – what areas of practice your treatment was involved with.

A. Yeah, so...

Q. More than....

A. ...so, um, so it would be a medium secure forensic unit, so a duty physician consulting to the entire hospital when various issues would come up, um, on call. At the...

Q. Okay.

A. ...psychological trauma program I had several patients in treatments, treating typically anxiety and

depression and P-T-S-D.

Q. Now, you have not made it a part of your practice to investigate what the effects of C-S-A are.

A. I'm not sure I understand the question. I just – I just...

Q. Well, I mean....

A. ...I just said that I incorporate...

Q. ...you – you see....

A. ...various background information into my formulation and understanding of a patient.

Q. Talking now about the treating area, okay. If....

A. Oh, in terms of treatment.

Q. Yeah, can you....

A. Well, you have to incorporate – if someone has a history of sexual abuse that can – that can affect treatment as well.

Q. I understand, but insofar as to what the affects are of C-S-A, that's not part of being a treating doctor is it.

A. Well, I'm – I'm not sure I understand your premise because, uh, you know, typically C-S-A is a non-specific risk – risk factor for later developmental – later psychopathological issues.

Q. I think you mentioned crime being one.

A. Could be.

Q. Well, I mean, you – you mentioned it earlier to Mr. Blom.

A. I – yeah, it – it – I said it could be, it doesn't inevitably lead to crime but it could contribute to understanding of that individual, yes.

Q. But I'm just trying to understand the focus

in your in treating your 95 patients who, some of them, have C-S-A, others have other issues, they have C-S-A and other matters. I am just saying, you haven't made it a study of yours to look at what the common effects are of C-S-A.

A. I'm not sure I understand what you mean by "study", it's – certainly I try and understand every patient in terms of their background and how they may have developed various psychiatric diagnoses and incorporate that into the treatment plan.

Q. But any psychiatrist who is a treating psychiatrist with an active patient population would have the same insight, right. You said – because you have to take a history and see what happened.

A. Well, it depends on – I think it depends on the psychiatrist.

Q. Yeah.

A. Some psychiatrists are more – more knowledgeable about certain areas and others are more knowledgeable about other areas.

Q. But you claim to be knowledgeable about C-S-A?

A. Yes.

Q. And why is that? How is that?

A. How have I become knowledgeable about it?

Q. Yeah.

A. It's something that you encounter in clinical practice and I have done a lot of reading and I have encountered a lot of patients with that disorder.

Q. You have a lot of patients with that disorder.

A. Well, I have, I said I have encountered a lot of patients with that disorder and it's something you have

to evaluate.

Q. I see. But what I'm trying to say is, in comparison to a non-forensic psychiatrist, a psychiatrist in regular practice, the difference between the two of you is you say you have done some reading.

A. Yes.

Q. Okay. So that would be reading on your own?

A. Yes. It does include that, yes.

Q. You mean you haven't taken any courses on childhood sexual abuse.

A. Well, I've taken, um, courses that are outlined in there and that includes courses on P-T-S-D. But as a forensic psychiatrist one of - a common topic at the annual meetings is trauma, you know, trauma given the development of the P-T-S-D has that built-in component to trauma leads to a disorder and so it is used in the legal realm very often. So childhood sexual abuse and other traumas are something that you should know as a forensic psychiatrist.

Q. But – but specifically at those courses that you were mentioning, did they raise childhood sexual abuse?

A. Childhood sexual abuse is talked about, yes. It....

Q. Did they – did they at those courses that you mentioned?

A. Absolutely. The – the other issue that comes into play for a forensic psychiatrist especially is – is memory issues. And that comes into a matter with someone sitting in – in a criminal matter who says he can't remember the murder he committed. And in civil cases, saying they can't remember various parts of the past. So that's something that has to be evaluated by a forensic psychiatrist commonly as well.

Q. What do you mean by "evaluated"?

A. That you have to evaluate, um, that component.

Q. That they can't remember?

A. Yes.

Q. Well how do you know – how do you know they – they had it if they can't remember?

A. How do you know – pardon me?

Q. How do you know they had sexual abuse if – if – if it hadn't happened?

A. Well, you're not – you are....

Q. I'm saying if they can't remember it, rather.

A. Well, they may have not remembered it and then they say they remembered it later on. Or someone who is there because they have committed a – they have murdered their wife, for example, and they say they don't remember doing it. You have to evaluate that matter.

Q. Okay. How many of your patients have been abused by priests, these childhood sexual abuse patients?

A. I – I don't keep statistics but, um, so one gentleman I am dealing with, he is an Aboriginal man in my practice, um, he has historical sexual abuse from a priest.

Q. Is that the only one?

A. No, that's the one that comes to mind. It's prominent in my mind but I can't, you know, obviously I don't keep statistics but, um, this gentleman actually, after the, um, the death of his brother and some other recent traumatic events that childhood sexual abuse has actually come back prominently in his mind and we're dealing with that right now.

Q. Did you or do you have any memory of ever treating a patient who was – who - that had childhood sexual

abuse done by a priest, prior to being retained by this Diocese or any other Diocese of the Catholic Church?

A. Again, I don't keep statistics on that. The current patient that I am involved with, he is not involved in litigation.

Q. No.

A. As an example.

Q. But you have been doing these assessments for the Catholic Church for more than 10 years.

A. About, you know, that – that's one way to word it but, um, I am asked to evaluate a matter and I provide my opinions.

Q. Well, is – is the answer to my question yes?

A. I – I – I would rather word it the way I worded it....

Q. No, no, I am asking you to answer my question.

A. I – I don't want to be misleading to the court by saying that question "yes" or "no" but I have been asked to provide an opinion in these matters and I have done so.

Q. That is not my question, though. Are you able to answer it?

A. I – I – again, I don't think I can answer "yes" or "no". I prefer to answer it as I answered it.

THE COURT: Well, the question was have you been doing it for more than 10 years.

A. If that's the question then yes, I...

MR. LEDROIT: Q. Okay.

A. ...I would think so, roughly, I don't...

Q. And....

A. ...know the exact timeline.

Q. And I am putting to you that the first time you ever encountered someone that had childhood sexual abuse by a priest was when you were retained I don't know whether it was 10, 11, 12 years ago by one of the Catholic Diocese.

A. I don't know the answer to that question, I – I....

Q. It's more likely than not isn't it?

A. I – I don't know. I highly doubt it given that I have seen so many patients over the years.

Q. Right now you can only recollect a Native or Aboriginal person in your entire 95 practice – people practice.

A. There – there is files that come to me later on when they request information about an assessment and it's really tough to remember that person so, um, I can't remember the thousands of people I have assessed and whether that was a history or not, I would – I would assume it's more likely that I have encountered than not. But again I don't know.

Q. How many assessments have you done for the Catholic Church?

A. I have been retained by counsel in this regard, I would say, I am estimating maybe 20 to 40, maybe more.

Q. And have you ever once found that the person's problems that they were complaining about, that they were going through the lawsuit about were caused by the childhood sexual abuse? Have you ever once found that?

A. Yes, I – I think I found that in the current case before us.

Q. Oh yeah, they're minimal, uh, according to you. Minimal impact.

A. Yes.

Q. Other than a minimal impact, have you ever found more than minimal impact in any of the 20 to 40 assessments that you've done?

A. I don't recall every case I have done.

Q. I am putting to you you haven't.

A. I don't recall, um, I – I would think that in most cases, yes, there has been at least minimal, sometimes less and sometimes more.

Q. All right. You're saying that – when you remember at all, you...

A. Yes.

Q. ...you can remember a case where you have been retained by the Catholic Church and found that the person – what the person was litigating about was related to the abuse.

A. Yes. And...

Q. You....

A. ...the case in front of us would be an example of that.

Q. Yeah, minor. Okay. If – if – if – if I took out that it was causing him or – or being a major impact in – on their life. Have you ever found that in the 20 to 40 assessments that you have done for the Catholic Church?

A. I – I would have to look at all of those to – to fact check that, I don't know off the....

Q. Well, you're coming back tomorrow if you could do that tonight. I am putting it to you that you haven't.

A. Okay.

Q. What do you charge for the assessments?

A. It's an hourly rate.

Q. What did you charge for this one?

A. I don't know.

Q. You can find out tonight?

A. I could, yes.

Q. Okay. More or less than 20,000?

A. Less I would think.

Q. You wrote your report in September, right?

A. Yes.

Q. But you saw Mr. McCabe in May.

A. Yes.

Q. Four months after. Is that common what you do, is you wait four months to prepare your report?

A. Yeah, it's not uncommon that's for sure. Yes.

Q. The people that retained you, if I go to the second page of your C-V. Can you point to the civil litigation cases where you have been a consultant? I mean defence counsel, I – is – is that civil?

A. That is – well, it's – it's...

Q. Or is that criminal?

A. ...it can be both.

Q. Okay. Insurance company, that would be defence. Have you ever been retained by the plaintiff?

A. Yes.

Q. Where is that here?

A. It's – it's not on my C-V.

Q. How come?

A. I should – I should put it on, I guess. Thank you.

Q. Who was that?

A. I can find out, um, it was one of these cases. It was a sexual abuse case.

Q. You can find that out tonight?

A. I can try, yes.

Q. Okay. But generally it's been for the defence, right?

A. Yes.

Q. Okay. And the one that you were retained by plaintiff counsel, a childhood sexual abuse case?

A. Yes.

Q. Did you find that the childhood sexual abuse had a major impact on the individual?

A. No.

Q. Just a second.

THE COURT: Submissions?

MR. LEDROIT: I – I - could I just have a second?

THE COURT: Oh, yes.

MR. LEDROIT: Q. If I - can I ask you, can you tell me the common effects of childhood sexual abuse? I am just going to sit down while I write, no disrespect.

A. Yes, no, that's fine. So in terms of childhood sexual abuse it would be a risk factor for later psychopathology.

Q. What do you mean by that?

A. It increases your risk of developing, um, symptoms later on in life.

Q. And what are those symptoms?

A. It can take the place of post-traumatic....

THE COURT: Mr. Ledroit, you...

MR. LEDROIT: Yes.

THE COURT: ...you can sit down but when you sit down you have to speak up. I – I....

MR. LEDROIT: Oh, I am sorry. I will stand up, Your Honour.

THE COURT: Suit yourself, but just – I didn't hear at all your last question. The witness did but...

MR. LEDROIT: Q. I was...

THE COURT: ...I didn't.

MR. LEDROIT: Q. ...I was asking you because if you're being qualified as a – or attempting to be qualified as an expert in the effects of childhood sexual abuse and I just want you to list those effects.

A. Well, it all – I think it all depends, you have to do an individual assessment first of all to see what those effects are. I would say....

Q. Let me just ask you, common.

A. Well, the – yeah, they're – they're non – typically non-specific, there is no child sex abuse kind of syndrome *per se*. But it can increase your risk of – of later anxiety disorders, depression, post-traumatic stress symptoms or disorders, it may cause some difficulties with self-esteem, with trust. I mean the type of sexual abuse that can kind of to, you know, just call it complex trauma type of – of pictures, um....

Q. What's that mean?

A. So some of these individuals can be kind of – have affective dysregulation....

Q. Can you – can you speak in a language that I can understand?

A. Well, they – they can be kind of, um, moody, prone to misinterpreting relationships, um, have depressive reactions to things.

Q. You mentioned depression again.

A. Yeah, um....

Q. One thing you haven't mentioned is substance

abuse.

A. Yeah, um, it can lead to – it can lead to substance use, alcohol...

Q. I was...

A. ...use.

Q. ...asking if you can list the common effects.

A. Yeah. It's – again it depends on the individual you are assessing.

Q. I'm talking common.

A. Yes.

Q. What are the common effects that you see, you know, more often than not in most of the people?

A. So, anxiety, depression, substance...

Q. And depression.

A. ...use, um, and then I would say some of the complex trauma type of issues like the – the moodiness, relationship issues, self-esteem. And then as part of the post-traumatic reactions you can have various symptoms such as difficulties if - anything that reminds you of that trauma.

Q. Would you include in that list an impact on education and or career?

A. Yeah, for some individuals that's – that's possible.

Q. First of all, we're not talking about possibilities here, we're talking about what are the common effects. Because anything in our world is possible, it could snow today.

A. So – so, yeah, so the – part of the literature talks about, um, lifetime prevalence of disorders versus persistence of the disorders. And the association is more – it's more robust as a lifetime prevalence but a lot of

these disorders will come and they will go. So you have to look at lifetime trajectory, lifetime disorders versus discrete episodes.

Q. I was asking you whether an interference with employment and career was a common effect of childhood sexual abuse.

A. It would be a tough question to answer because, you know, it may cause disruption for a brief period of time but not for a whole life and trauma...

Q. If it....

A. ...isn't very specifically defined so it's....

Q. If it caused a problem for a brief period of time, that would be a – that would be an effect, would it not?

A. It'd be an effect, yes.

Q. So is that a common effect?

A. It depends on the person. It – it...

Q. Well....

A. ...it can be, um....

Q. Sir, I'm – I'm just trying to get a general, not the individual.

A. Generally you'd want to assess that...

Q. Do you...

A. ...area....

Q. ...do you see it oftentimes?

A. Again it's – I think it's – it's complicated by the fact that, you know, a – a trauma or an event can cause symptoms and then symptoms may or may not – may or may not cause, again, various distress or impairment. An impairment is something you would want to evaluate in terms of, yes, education trajectory, workplace trajectory, relationship trajectory. And there may be some distortion there at times

but to say it's common and to use a blanket term like that isn't very precise.

Q. I see, it was okay for anxiety and depression and substance abuse and P-T-S-D and trust and moody, relationship issues but not for employment and career?

A. You know, those are symptoms, those are more – they, you know, flow directly from things. But again, you are right, it is multifactorial but in the next higher level area would be leading to something else and that's impairment, and then the next level after that would be disability. And that's – those are separate assessments.

Q. Yeah. So let me just see if I can get an answer.

A. And anxiety is kind of a ubiquitous thing, right, after things happen people get anxious.

Q. Well, if you say....

A. But it doesn't mean they're impaired at their job or their school.

Q. It may or may not be.

A. That's right, that's – that's...

Q. Yeah.

A. ...what I'm trying to say.

Q. I mean it is common to see P-T-S-D and it's common to see substance abuse and it's common to see anxiety and depression in all of those matters, those common matters may well have an effect on career and education.

A. Yes. It could, yes.

Q. Yeah. Okay.

A. And you would want to evaluate that for sure.

Q. If I – if – if we talked about sexual abuse, and that's what we're talking about in this case.

A. Yes.

Q. That implies violence, does it not?

A. It depends on your definition of violence.

Q. Well, let's take a common psychiatrist's definition of it. I mean, is non-consensual sex not – not implied violence to you?

A. It depends on your definition and different studies will define it in different ways and that could certainly go into the definition of violence, absolutely. But it depends what you mean by violence.

Q. Well....

A. Some people might say violence involves, you know, hitting someone, um, but absolutely non-consensual sexual acts could be construed or coded as...

Q. How do you – how do...

A. ...violence.

Q. ...you construe it?

A. I – I think it – it depends on the circumstance you....

Q. How – how do you construe it in this case?

A. Well, there is, you know, in terms of what leads to legal charges, um, you know, sexual - acts of sexual touching would probably be – qualify for sexual violence. Exhibitionism may not qualify in – in manuals for violence.

Q. I – I couldn't hear you, say that again.

A. So exhibitionism....

THE COURT: Go ahead.

A. So again, exhibitionism, um, may not qualify for violence under certain risk assessment manuals but I think certainly sexual touching and – and without consent, would qualify in manuals...

Q. Now...

A. ...as a violence risk.

Q. ...if the D-S-M-5, that we've talked about a bit in this case, if – if I was to look at alcohol use disorder I really don't have to be a psychiatrist to determine if someone has the 11 points, right? I mean, they're pretty easy, they're not psychiatric definitions.

A. Well, you would have to use your clinical judgment in terms of those.

Q. Well whether or not someone drinks to whatever it is, I mean, you know...

A. Yes.

Q. ...they – you know, they're whatever it is. A – a layperson can answer that as well as a professional right?

A. I think the – I would have to check the D-S-M but I think it cautions against using it in a kind of a cookbook type of fashion in that regard. But I – I see your point, yes, some of the items seem pretty easy to – to ascertain.

Q. "Craving or a strong desire or urge to use alcohol." That – that's – a layman could answer that question.

A. It – it would but you have to do your overall assessment and I think the D-S-M has a caution about using it in a cookbook fashion...

Q. All right.

A. ...like that.

Q. And could I say the same thing about post-traumatic stress disorder probably the D-S-M is very specific about whether or not you qualify for it and whether or not you've got it, right?

A. Again, you – you don't want to use it in a

cookbook fashion. One of the problems of P-T-S-D is most people have an experience of some kind of trauma or stressor in their life. So if you are going to malinger P-T-S-D and not everyone malingers P-T-S-D, let's be clear about that. But I am just saying....

Q. Not everyone?

A. Not everyone malingers P-T-S-D that's claiming P-T-S-D, let's be clear about that. But as an example, in evaluating trauma, one of the confounders is the fact that, yeah, the criteria readily accessible on, you know, the internet and most people have experience stress or trauma so they – they'll know what to say. So asking university students, for example, to simulate a P-T-S-D type of picture most people can do so.

Q. You can fake it in some situations.

A. Well, that's right, because criteria are out there so...

Q. Yes.

A. ...that's why you need to assess it based on self reports, collateral interview, corroborating factors.

Q. Without applying whether or not – and let's say an individual who is looking at the D-S-M-5 and they're asking themselves whether or not they've got this symptom, anxiety, depression, whatever it is. I mean, all I'm trying to get at is that you don't have to be a genius to look at – because the D-S-M-5 is so specific. It – it – it tries to use each word – each – each word is important. I mean there is no throw away words in the D-S-M-5. Fair?

A. Well, one – one of the things with the D-S-M-5 and I think his name is Allen Frances, there is a good article on that is, the D-S-M-5 is used by researchers and for teaching and some commonality and a lot of the people who come

up with the criteria do so in that context. Outside of a forensic context. And they never – a lot of them never will kind of think of how it could be used in a courtroom, for example. So that is why the D-S-M has its caution as well about using the D-S-M in a forensic context.

Q. I'm – I'm not saying I'm about to diagnose...

A. No.

Q. ...D-S-M – or post-traumatic stress disorder, I'm just saying it's written almost so that the layman can do it.

A. I'm just – I am just – I am just adding to what you are saying, yes.

Q. One last thing, I just want to make sure I understand you on this. You talked about this woman with pain relief taking oxycodone.

A. Right.

Q. She took the oxycodone because she was in pain. Then the secondary problem comes up that she gets addicted to the relief of the pain. Is that – do I understand the way it works?

A. So – and I am sure as you know, one of the criteria for addiction is developing tolerance and – and being vulnerable to withdrawal. So in – in addiction, right, the person takes something and then it stops having the same effect so they need more and more and more of it to get the same effect. And if they don't have more and more of that substance, they'll go into a withdrawal and so a lot of these patients who, say, are in car accidents and so on, the family physician will stop feeling comfortable prescribing higher and higher doses.

Q. Okay. Thank you, doctor.

A. Okay.

THE COURT: Re-examination?

MR. BLOM: Thank you.

RE-EXAMINATION BY MR. C. BLOM:

Q. Doctor, quickly, you were asked some questions of the difference between your background and Doctor Jaffe's background. And I think we – what we have learned from you is that you are involved in assessment, diagnosis, and treatment of patients. Fair?

A. Yes.

Q. We have learned from Doctor Jaffe that he has been involved in the assessment and diagnosis of patients and we didn't hear a lot about treatment. By treating patients does that assist you in understanding the impact of C-S-A and P-T-S-D and alcohol use disorder?

A. Yes, well it adds another layer of understanding of that patient. How they are responding to treatments, whether they respond or not, and it gives you more of a longitudinal assessment of the person an assessment over time.

Q. Your reading of the literature on the impact of C-S-A, does that assist in advising you on both treatment and assessment?

A. Yes.

Q. Thank you.

THE COURT: Submissions right after the morning break.

R E C E S S

U P O N R E S U M I N G :

THE COURT: Submissions, Mr. Ledroit.
MR. LEDROIT: I was going to wait to hear from my friend.
...MR. BLOM, SUBMISSIONS
...MR. LEDROIT, SUBMISSIONS

R U L I N G O N *V O I R D I R E*

THE COURT: I think I can be equally brief. He is a forensic psychiatrist, it would be like saying I would like to have him qualified as a doctor but not a medical doctor. That is what he does, that is what he is, and he is qualified to give evidence on the impact of childhood sexual abuse. As Mr. Ledroit disclosed, there is ample ground to deal with weight issues. I need not concern myself about the adjective, or I will not concern myself and I do not think the jury needs to concern themselves or will be unduly influenced by the word "forensic". So I am satisfied with the description as requested by the defence.

THE COURT: Are we ready to go then?
MR. LEDROIT: Yes.

11:56 A.M. JURY ENTERS

THE COURT: Welcome back and thank you for your patience. Go ahead.
MR. BLOM: Thank you, Your Honour. I'd like to call the evidence of Doctor Jeff McMaster.

JEFF MCMASTER: AFFIRMED:

EXAMINATION IN-CHIEF BY MR. C. BLOM:

Q. Doctor McMaster, I am showing you a copy of a document. Can you confirm that that is your *curriculum vitae*?

A. Yes, it is.

MR. BLOM: Your Honour, I have provided a court copy to be marked as an exhibit. I wonder if we could do so now.

THE COURT: Exhibit Number 25.

EXHIBIT NUMBER 25: Copy of Doctor McMaster's *curriculum vitae* – produced and marked.

MR. BLOM: Can I provide copies for the jurors as well?

THE COURT: Please.

MR. BLOM: Q. Doctor McMaster, I understand that you are a forensic psychiatrist.

A. Yes.

Q. You have worked at the Centre of Addiction and Mental Health in Toronto also known as CAM-H in various roles?

A. Yes.

Q. You have done that since 1999?

A. Yes, I have.

Q. Part of that includes your work as a duty doctor?

A. Yes.

Q. Part of that is you work on call in the emergency department?

A. That's correct.

Q. For several years you worked in the child and youth unit.

A. The child and youth unit is a – it's a new unit at CAM-H and so I have assessed and treated people there strictly in the function as duty doctor to CAM-H.

Q. All right. You've also worked in the women's unit?

A. Yes.

Q. The acute care unit?

A. Yes.

Q. The major mental illness unit?

A. Yes.

Q. And forensic unit?

A. Yes.

Q. Now, let's go to your *curriculum vitae* if we can, to the first page under "education and training".

A. Yes.

Q. We'll move it ahead a bit. In 1994 you achieved your Doctor of Medicine at the University of Manitoba?

A. Yes.

Q. And then from 1994 to 1999 you did your residency in psychiatry at the University of Toronto.

A. Yes I did.

Q. And I understand that involved work at various hospitals in Toronto including Sunnybrook?

A. Yes.

Q. And you also worked with family physicians in their offices.

A. Yes.

Q. This included in part the assessment and treatment of patients who had experienced C-S-A or child

sexual abuse.

A. Yes.

Q. Childhood sexual abuse, pardon me.

A. Childhood sexual abuse, C-S-A, yes.

Q. Okay. It also included the assessment and treatment of patients with alcohol abuse disorders or dependence.

A. Yes.

Q. And it included those – the assessment and treatment of patients with anxiety disorders including P-T-S-D.

A. Yes.

Q. Let's go to your employment history starting at page 3 because it's in reverse order. So page 3 toward the middle from 1999 to 2001 you were a psychiatrist at the schizophrenia and continuing care program at CAM-H?

A. Yes.

Q. And I understand the primary diagnosis of the patients who presented was that of schizophrenia?

A. That would be their primary diagnosis with secondary diagnoses commonly substance use disorders and personality disorders.

Q. And some with P-T-S-D?

A. Yes.

Q. Do people with mental illness have a high rate of substance abuse?

A. Yes.

Q. Now I understand that part of your role in this position was to take a history leading to a diagnosis and then treatment?

A. Yes.

Q. Were some of these – some of these patients,

did you learn they had a history of C-S-A?

A. Yes.

Q. Moving ahead 2005 to 2013, you were a psychiatric consultant at the Don Jail in Toronto?

A. Yes.

Q. This would be the psychiatric treatment of inmates.

A. Yes. That's correct.

Q. Is there a connection between people who are victimized, that is to say people who may have been abused, and people who are involved in crime?

A. Yes. So they have high rates of victimization in various ways, yes.

Q. And some of these inmates that you assessed and treated, did they have P-T-S-D?

A. Yes.

Q. I understand that could arise for different reasons.

A. Yes. The – the traumatic stressor can be a number of different things including car accidents, being assaulted, childhood sexual abuse can be one as well.

Q, And so therefore some of these inmates had a history of C-S-A.

A. Yes.

Q. 2000 to 2013 you worked as a psychiatrist at the brief assessment unit at Old City Hall.

A. Yes.

Q. I understand that what you did was to assess people charged with a crime to determine if they were fit to stand trial.

A. Yes.

Q. Some of these had problems with P-T-S-D.

A. Yes.

Q. Now - and some, I understand, presented as psychotic.

A. Yes.

Q. And can you talk to us about the difference between people who have a psychotic problem and people who have – simply have mental health problems.

A. So if someone is psychotic they have a mental health problem but psychosis refers to someone who has lost touch with reality. And that can be typically in the form of hallucinations, so hearing things that aren't there or seeing things that aren't there or other sensory modalities. And delusions, so believing things that aren't true and that can take the form of paranoid delusions, erotomanic delusions, some individuals we have encountered have beliefs that they have been sexually assaulted which turn out not to be true.

Q. So let's compare that, a person with P-T-S-D is not necessarily a person who is psychotic.

A. No. But if the P-T-S-D takes on severe flashbacks or hallucinations, it may mimic a psychotic presentation on, kind of, superficial presentation.

Q. Moving ahead. From 2001 to 2003, you were a psychiatrist, the psychiatrist or a psychiatrist, at the sexual behaviours clinic and forensic outpatient program of the law and mental health program at CAM-H.

A. Yes.

Q. And I understand that you assessed people who had issues with sexuality.

A. Yes.

Q. That would include people with issues of sexuality arising from C-S-A.

A. Yes. More typically these individuals would

have what is called paraphilias.

Q. Okay.

A. And that can take the form of pedophilia or exhibitionism and other types of paraphilias or deviant sexual disorders. Other cases can be obsessive compulsive disorder, one of the common symptoms is getting sexual images over and over again that they don't want to have. So those types of cases that come to us and then there is also individuals who present persistence with dealing with sexual orientation questions.

Q. 2001 to 2007 you worked as a psychiatrist in consultation and liaison service in workplace violence risk program through the same program at CAM-H. Correct?

A. Yes. So we'd be consulting to other services at CAM-H to assist with their assessment in that area and sometimes at other hospitals, from CAM-H.

Q. I understand that one of the businesses that used your services is George Weston Limited?

A. Yes. So a psychiatrist, Doctor Philip Klassen had a contract with George Weston to provide violence risk assessments, um...

Q. Okay. And....

A. ...to employees at George Weston Limited.

Q. That would be in part to determine if a person poses a risk of violence at work?

A. Yes.

Q. That would include employees with an alcohol use disorder.

A. Yes.

Q. Some of whom had experienced C-S-A.

A. Yes.

Q. From 2001 it – it just has a dash there, I

understand that it should say to 2016?

A. It should say, yes, 2016, thank you.

Q. You worked as a psychiatrist at the medium secure forensic unit at the law and mental health program at CAM-H.

A. Yes.

Q. And I understand what you did was assessments for the Ontario Review Board.

A. That's correct. So these are individuals who have been found not criminally responsible by reason of mental disorder or they have been found unfit to stand trial and...

Q. What....

A. ...so I led....

Q. Sorry, go ahead.

A. So I led a multidisciplinary team including social workers, nursing staff, recreational therapists, and at times psychological consultation to try and understand these patients, treat these patients, risk manage these patients. So to try and get them back into the community as quickly as possible but only if they were safe to do so.

Q. Okay. And is it you – you do a report that goes to the Review Board and the Board makes those decisions?

A. So we present – I – I would present the findings of the team, um, at least once a year to the Ontario Review Board, provide the report and then oral testimony about the most appropriate, it's called the "disposition order" for the following year to talk about what level of security they need and the privileges and passes and so on.

Q. Okay. This would include patients with sexual difficulties?

A. Yes.

Q. Some with a history of C-S-A.

A. Yes.

Q. Some with a history of alcohol use disorder.

A. Yes.

Q. Some with a history of P-T-S-D.

A. Yes.

Q. And in doing this, is part of your role to assist in the rehabilitation of these people to reintegrate them into society.

A. Yes.

Q. 2000 – so – so if we go to page 2, so flip back. 2001 to 2007 and 2010 to 2013, you worked as a psychiatrist in the forensic assessment unit of Ontario Shores formerly known as the Whitby Mental Health Centre?

A. Yes. That's correct.

Q. That's a psychiatric hospital?

A. Yes.

Q. I understand it has various units of patients, similar to what you saw at the CAM-H?

A. That's right.

Q. And you worked in the forensic assessment unit.

A. That's the specific unit I worked at at Ontario Shores, in the forensic assessment unit, yes.

Q. Okay. Tell us what you did there.

A. So these are individuals who come to the unit for between 30 to 60 days and they are there for court-ordered psychiatric assessment of whether they qualify for the insanity defence, not criminally responsible defence. Or if they are unfit to stand trial. And then a minority would be people there for treatment to become fit to stand trial. So we are assessing, um, doing psychiatric assessments, again the

multidisciplinary team gives input and then we do the psychiatric diagnosis and then provide a specific opinion for the court. And then ultimately the court makes the – the decision.

Q. I understand that the multidisciplinary team includes psychologists?

A. Yes. So a psychologist would provide input to me and I would include that in my report, yes.

Q. Nursing staff?

A. Yes.

Q. And social workers?

A. Yes.

Q. And what you would do is you would do an interview with – of – of the – of the person?

A. Yes.

Q. And I understand you look at collateral information so for example, documentation from police?

A. Yes.

Q. Medical records?

A. Yes. And part of the job of the social worker was to gather collateral information from – if they had been hospitalized before, call family members, call, um, friends, coworkers, whoever may assist in the determination of the issue before the court.

Q. Okay. And what is done in some of these cases as well is psychological testing?

A. Yes.

Q. From 2010 – since 2010 you have been working as a psychiatrist at the Northern Psychiatric Outreach program at CAM-H in Kenora. Is that right?

A. Yes.

Q. I understand that you – you do psychiatric

assessments of – of people at that location.

A. I do, yes.

Q. Can you explain what they involve?

A. So Kenora is in Ontario, it's east of Winnipeg. It's an underserviced area especially – well, I could say all of psychiatry but especially forensic psychiatry so I, um, fly out there about five times a year and do a couple of assessments.

Q. Each time.

A. Each time I fly out, yeah, and – and the assessments are, um, it can be, you know, a variety of things, N-C-R assessments, fitness assessments, risk of dangerousness assessments, or sometimes the court just wants a general psychiatric assessment to – to see what the person's needs are.

Q. Can you describe the population from which the bulk of these people come?

A. So it's, um, male and female and I don't have the exact statistics but I would say about half are of Aboriginal background. And several have histories of trauma including abuse of various kinds as a child and as an adult.

Q. Would that include C-S-A?

A. Yes.

Q. Okay. Do some present with various addictions including alcohol?

A. Yes.

Q. Some – some are suffering from P-T-S-D?

A. Yes.

Q. And I understand that some of those have P-T-S-D because they have witnessed violent acts?

A. Yes.

Q. Some have experienced trauma such as say

being lost in the woods?

A. Yes. So they – they may develop P-T-S-D or subsyndromal like may not be the full criteria but certainly has some anxiety related to their experiences, yes.

Q. And as a child some experienced C-S-A.

A. Yes.

Q. Okay. 2014 to now you have worked as the addiction and consultant psychiatrist at the Ontario Addiction Treatment Centre. I understand that is located in Newmarket and Keswick.

A. So, yeah, that's where I work out of. There are several locations in Ontario, um, but I am based out of Newmarket and – and Keswick, yes.

Q. And you do that two half days a week?

A. Yes. Thursday mornings and Friday mornings.

Q. I understand that what you do is you focus on patients who have developed an opioid addiction.

A. Yes.

Q. And so a typical example might be a person who is injured, say, in a car accident who receives a drug, say oxycodone, for pain and they become addicted to it.

A. Yes. It's a not uncommon presentation.

Q. Part of your role is to assist in settling down the addiction.

A. Yes.

Q. And once in control your role then becomes assisting them in re-establishing their life?

A. Yes. So after the addiction portion is over the person, now that they are not tormented, so to speak, by the addiction they will need several months, if not years, to develop new patterns and habits and so on outside of that addiction to become stable and – and functional.

Q. Some of these may have a history – or sorry, history of trauma leading to a diagnosis of P-T-S-D.

A. Yes.

Q. And so your role to that extent is to treat the P-T-S-D?

A. Yes. There is a shortage of psychiatrists in that area so my role is to treat them psychiatrically when the need arises.

Q. Okay. I understand you are treating one gentleman who recently lost his family to members of gang violence?

A. Yes.

Q. And in doing so did you learn if he had a history of C-S-A?

A. Yes. So after the – and he had some other family, uh, unfortunate events happen. But after that happened, actually his history of childhood sexual abuse became much more prominent and on his mind. He hadn't been thinking about it very much and it hadn't really been affecting him but after he experienced these other traumas, it started to really bother him and be on his mind quite often.

Q. I understand that you are also treating a woman who is in counselling for C-S-A?

A. Yes.

Q. So....

A. So I'm not counselling her for childhood sexual abuse and...

Q. What....

A. ...childhood sexual abuse isn't a diagnosis but it can lead to symptoms and – and diagnoses or can contribute to that. She is in counselling for that and I speak to her about her counselling and try and work with her

treatment to being in, you know, to not impact on her other treatments.

Q. Part of that is the use of medication?

A. Yes.

Q. In your role here at the Ontario Addiction Treatment Centre, I understand one of the addictions you treat is alcohol use disorder.

A. Yes.

Q. And can you tell us about your background in terms of understanding the genetic role in alcohol use disorder.

A. Well as – as part of becoming a psychiatrist you, um, you spend a lot of time with what's called formulation. And that's looking at, um, predisposing factors to someone's presentation of why they are in front of you with the symptoms they have and their life trajectory. So you look at predisposing factors, you look at precipitating factors, so more recent precipitating factors, and then perpetuating factors, things that may keep things going on. And you can also look at protective factors and you look at that in a variety of different ways: biological, psychological, sociological. And one of the factors that you learn about is biogenetic factors. And so in terms of your formulation you would want to consider family background and – and genetics in understanding that person.

Q. Can you give us a sense of how common it is for you, in dealing with patients with alcohol use disorder, to learn that there is a genetic background or a role.

A. So it's – it's – I wouldn't say every person with alcoholism has a – a family history of – of alcoholism. But it certainly is a strong risk factor for development of alcoholism. But it's not like a one to one type of

correlation.

Q. Okay.

A. But it's a strong risk factor.

Q. I understand that you keep abreast of the literature of the role of genetics in alcohol use disorder.

A. Yes.

Q. Going back to your *curriculum vitae*, you are a lead psychiatrist at the Toronto South Detention Centre?

A. Yes.

Q. Are you the lead psychiatrist?

A. Yes, I am. So I am responsible for providing psychiatric services to Toronto South and I have, um, four psychiatrists now working for me or with me in that capacity.

Q. So I understand what you do is you supervise what they do but you also have direct contact with the inmates?

A. I do. And I wouldn't – I wouldn't say I directly supervise their day to day function but I provide a supervisory role if they want to ask me questions and so on. Especially with the some of the newer psychiatrists.

Q. You do this three half days a week?

A. About three half days a week, yes.

Q. And this involves the assessment and treatment of inmates?

A. Yes.

Q. Some are remanded to the centre awaiting trial.

A. Yes.

Q. Others are serving a sentence of under two years?

A. Yes.

Q. Some of the mental disorders you come across include anxiety disorders such as P-T-S-D.

A. Yes. And – and adjustment disorder, so for some of them it's their first time in jail and they get quite anxious. There is lockdowns in jail where they are confined for long periods of time and they get quite anxious. And yes, there is histories of trauma and other disorders.

Q. Okay. This can include an alcohol use disorder.

A. Yes.

Q. And some have a history of C-S-A.

A. Yes.

Q. Now let's go back to page 1 of your C-V, if you go to the bottom. 2005 to 2014 you worked as a psychiatrist in the psychological trauma program at CAM-H.

A. Yes.

Q. I understand what you did was assessments for the Workplace Safety and Insurance Board.

A. That's correct. Yes.

Q. This is something of an academic centre?

A. Yes.

Q. I understand what you – what you did was to assess people with a history of workplace trauma. Examples might include assault at work?

A. Yes.

Q. Injury in the workplace?

A. Yes.

Q. Sexual assault in the workplace?

A. Yes.

Q. And I understand that your role in part was to do psychiatric assessments, you also had a psychologist doing psychological assessment?

A. So, yeah, the way it's structured is I would do my psychiatric assessment and then independently with the same information a psychologist would do an independent assessment. And then we would case conference it together, work out any areas of disagreement, and then provide a summary report to the Workplace Safety Insurance Board.

Q. So this leads to, in part, the diagnosis?

A. Yes, so there, uh, several questions had to be answered, including psychiatric diagnosis, an opinion about impairment, any barriers for return to work, an opinion about other causes of why they're there like are there any other traumas or incidents or – or contributors to their psychiatric presentation.

Q. Some of these employees experience P-T-S-D?

A. Yes.

Q. Some have a history of alcohol use disorder.

A. Yes.

Q. Some have a history of C-S-A.

A. Yes.

Q. And – and part of your role was to diagnose, determine the cause, and the level of impairment?

A. Yes.

Q. Now let's got to, um....

A. And – and also engage in treatment of – of those individuals.

Q. Second page, again if we can, toward the top. It says "consultant for", do you see that?

A. Yes.

Q. You were a consultant for defence counsel and I understand that is in both criminal and civil context.

A. Yes.

Q. So in the civil context, an example of that

would be me.

A. Yes.

Q. Okay. Consultant for the Attorney General. That would be in the criminal context.

A. Yes.

Q. Children's Aid Society would be things like assessing fitness to parent?

A. Yes.

Q. The City of Toronto, you did consultations for – for – of employees?

A. In the past psychiatric assessment, violence risk assessment.

Q. Okay. For insurance companies you do assessments of claimants?

A. Yes.

Q. For the College of Physicians and Surgeons of Ontario you assess physicians.

A. Yes.

Q. For the Ontario College of Teachers you assess teachers.

A. I – I have assessed teachers, yes.

Q. And just so – I will stop for a moment. These are assessments of people who may have psychiatric disorders.

A. Yes.

Q. Okay. For the Ontario Nurses' Association you assessed nurses?

A. Yes.

Q. For the Office of the Chief Coroner you have assessed a staff member, I understand?

A. I – I assessed one case of an individual who committed suicide.

Q. For the Law Society of Upper Canada you have assessed lawyers and paralegals?

A. Yes.

Q. And I gather none of them had any psychiatric disorders. No need to answer. Through the Ontario Review Board, as we have heard, that's in the criminal context.

A. That's correct.

Q. Okay. And that's with respect to matters including, and there is a list and I want to take you to – do you see the evaluation of trauma and it's effects?

A. Yes.

Q. Now I understand that includes adults who have experienced C-S-A.

A. Yes.

Q. So some of these people, lawyers, doctors, so on, some you will find in the history had experienced C-S-A.

A. Yes.

Q. And some of the evaluation of the trauma and effects is in the civil context. So for example, litigation such as this or through the various tribunals or associations we just reviewed?

A. Yes. So a recent paralegal I had assessed for the Law Society had a history of – of some trauma growing up.

Q. And I understand in that civil context, litigation and tribunals, you have done about 40 of those.

A. Yeah, in terms of – it's tough, I am estimating. I don't know the exact number but I would estimate 40 or so.

Q. What you do is you – you – you diagnose,

consider the cause and then the impact.

A. Yes.

Q. And you have been doing this in the – in these – for these various organizations for over 10 years.

A. Yes.

Q. Let me turn over to page 3 "academic appointments", item "C". From July 1999 to 2013 you lectured in psychiatry at the University of Toronto?

A. Yes.

Q. And since 2013 to now you have been an assistant professor in psychiatry at the University.

A. Yes I have.

Q. And then below that "supervision". I don't want to go through them all but I understand that what you do is you supervise students and other psychiatrists in terms of the work they do?

A. Yes. And I need to update that because I am currently supervising residents so that needs to be updated slightly.

Q. Fair enough. Page 5 "research and publications", you have been involved in that to the extent listed?

A. Yes.

Q. "Presentations" you have been involved in those to the extent listed?

A. Yes.

Q. "Teaching" page 8, you have been involved in teaching the various courses described there.

A. That's right.

Q. And in particular let me – let me take you to 2010. So you taught a course called "Assessment of Malingered P-T-S-D in the Disability Context".

A. Yes.

Q. What is "malingering"?

A. So malingering is, um, it's – so it's not a diagnosis but it's where an individual, um, exaggerates, grossly exaggerates psychiatric or medical symptoms consciously. So some individuals will exaggerate it but are not conscious of exaggerations, so that would be somatoform disorders. These are individuals who are consciously doing it and doing it for secondary gain.

Q. Okay. And then the next one, 2008 to the present you have been teaching a course called "Malingered Psychosis and P-T-S-D".

A. Yes.

Q. The next page over "other training". If you go down about a – to the last third of the page, 2007 "psychiatric genetics". Do you see that?

A. Yes.

Q. What is that?

A. So psychiatric genetics is – it refers to the understanding of – of genetics or the use of genetics to understand something complex, like psychiatric illness, which is multidetermined; many things lead to psychiatric diagnosis. And complicating matters further is that psychiatric diagnosis is polygenic, so many different, you know, combinations of genetics can lead to a certain outcome. So it's just the study of – of – of that area.

Q. Next page over "qualifications", item "F". You are a Fellow of the Royal College of Physicians and Surgeons in Canada in the area of psychiatry and have been since 1999?

A. Yes.

Q. I understand that psychologists do not

receive this designation. Is that correct?

A. That's correct.

Q. Okay. You were certified as a subspecialist in forensic psychiatry by the College in September 2013?

A. Yes.

Q. And that was after completing an examination?

A. That's right.

Q. In terms of administrative posts at the bottom, since 2014 you have been the head of the Forensic Psycholegal Clinic at CAM-H?

A. Yes. So – so that's a clinic at CAM-H where a third party will request an independent assessment, whether a criminal matter or a civil matter like the current one. And one of the psychiatrists if available will perform that assessment.

Q. And you have been qualified in the past as an expert in psychiatry?

A. Yes.

Q. In Superior Court, such as this?

A. Yes.

Q. And in the Provincial Court where some criminal matters are held?

A. Yes.

Q. You have been qualified, as well, before some of the tribunals we have talked about?

A. Yes.

Q. I understand you have been qualified as an expert somewhere in the range of 15 to 20 times?

A. It's tough to estimate. I would think – I would think about that many times if not more.

MR. BLOM: Your Honour, subject to any questions

Mr. Ledroit may have, I ask that Doctor McMaster be qualified as an expert forensic psychiatrist, qualified to give evidence on the impact of childhood sexual abuse.

THE COURT: Well, he has invited you, if you want to ask questions at this point, Mr. Ledroit. But do you wish to at this point?

MR. LEDROIT: I do.

THE COURT: Go ahead.

MR. LEDROIT: Thank you, Your Honour.

CROSS-EXAMINATION BY MR. P. LEDROIT:

Q. I just want to make some notes on the easel if I may. Make sure I understand what you are saying. The times that you have been qualified as an expert – is it M-C?

A. Yes.

Q. Does that indicate that you're a Catholic?

A. No.

Q. Usually the Macs come from Scotland, and the Mcs come from Ireland. Are you Catholic?

A. Uh, no.

Q. Okay. You hesitated there for a second.

A. Well I'm not really sure if I should be answering personal questions about...

Q. Well...

A. ...my background....

Q. ...if – if – if your lawyer has an objection, he'll make it, okay?

A. Thank you.

Q. So, you're not.

A. That's right.

Q. Okay. Were you brought up in the Catholic

Church?

A. No.

Q. Okay. Now, we talked about the times you've been qualified. You said 20 to 40 times?

A. Well, I don't have an exact number but that's an estimation, yes.

Q. Okay. They've all been matters relating to whether or not a person is insane. They're in the criminal justice system or whether or not they can be let out, whether they're safe now. That kind of thing. Whether they're fit to stand trial? That kind of thing?

A. Yes, dangerous offender, long term offender.

Q. They've all been – they haven't been dealing with sexual abuse.

A. That's right.

Q. Right. And certainly the bulk of your practice over the course of your lifetime has been dealing with these matters in the criminal justice system, like I've just mentioned, like you – I know you have a lot of acronyms for them but fitness to stand trial was one.

A. Yes.

Q. And – and, uh, N-C-R, what's that?

A. So, N-C-R is not criminally responsible by...

Q. That means...

A. ...reason of mental disorder.

Q. ...I plead guilty by reason of insanity? Is that – is that what – is that what you mean?

A. Yeah. So insanity – insanity is no longer used in the *Criminal Code* but it's...

Q. I know, but....

A. ...but that's – yeah, that's the gist of it,

yes.

Q. Okay. And what – what's the other one? Oh, yes, if somebody is confined up in Penatanguishene because they did something because they were not criminally responsible, you make a report once a year or something like that, as to whether or not they should be let out. Is that what I understand?

A. So, we – not in Penatang, so it's at CAM-H.

Q. Okay.

A. And, uh, I've done that on a – yeah, on a – an outpatient basis and on a medium secure unit, so that's – we're working with a multidisciplinary team to rehabilitate that person, um, in terms of improving their diagnoses and risk factors so that they can be reintegrated into the community safely, yes.

Q. Nothing to do with sexual abuse except some of those people may have, at one point in their life, been sexually abused.

A. There are sexual abuse histories, and...

Q. Yeah.

A. ...you know...

Q. But the focus...

A. ...that - that....

Q. ...wasn't that they're insane because of sexual abuse, or is it?

A. Typically they wouldn't be insane, no, from sexual abuse.

Q. Okay.

A. No.

Q. Now....

A. But that – but after the finding of not criminally responsible, you are left with the individual in

front of you and you treat that individual accordingly.

Q. If I can just take you a little out of your area. You know how our court system works. Like, there's lower courts and higher courts?

A. I'm not an expert on that, but I – I have some understanding, yes.

Q. I'm not asking for your expert opinion on it, just aware – are you aware. For example, there's the Ontario Court of Appeal.

A. Yes.

Q. Do you know what that is?

A. The ONCA? Yes.

Q. Sorry?

A. The – the acronym is I think, yeah.

Q. Ontario Court of Appeal.

A. Yes, O-N-C-A. I see that in the literature as O-N-C-A.

Q. Okay.

A. So, I'm just saying that yes, I've heard of it.

Q. Well, let me – let's just call it the Court of Appeal. You understand that that's the highest court in Ontario?

A. I wasn't sure if that was the highest court, no.

Q. Let me put it to you the – the only one superior to that is the Supreme Court of Canada.

A. Okay.

Q. Okay? There is a justice that we heard about in this case. His name was Robins. And he headed a Royal Commission for two years to investigate childhood sexual abuse by teachers up in Sault Ste. Marie. Did you hear

anything about that case?

A. No.

Q. No. All right. And who do you think they hired as the expert to be involved in that commission?

A. I don't know.

Q. It wasn't you, was it?

A. No.

Q. Did they even ask you?

A. No.

Q. They hired Doctor Jaffe. And I am going to suggest to you because he knows more than anybody else in Ontario about childhood sexual abuse.

A. I – I don't know Doctor Jaffe's credentials.

Q. No, I'm just saying to you, do you think the fact that a judge of the highest Court of Ontario, heading a commission that lasted for two years, wants to find, presumably, he wants to use the best expert on childhood sexual abuse in Ontario. He goes to Jaffe and not you.

A. Well, he didn't – yeah, he didn't go to me.

Q. Okay.

A. That's correct.

Q. I'm asking you this because assuming you are qualified, this jury has to decide if they're going to be influenced at all by either you or Doctor Jaffe, whether they're going to be influenced by you or by Doctor Jaffe. Just – you understand what I'm going to.

A. Yeah, no, I understand what you're saying.

Q. Okay.

A. Yeah.

Q. Now, have you ever heard of the Cornwall Public – or, the Cornwall Inquiry?

A. Yes.

Q. What was that about?

A. I – the – I don't have the details at my fingertips so to speak, but I have heard of that.

Q. Yeah. That was an inquiry with a commission. The commissioner was Justice Normand [*sic*], not the Court of Appeal, but a pretty high court in Ontario. I mean it was held in Superior Court.

A. Yes.

Q. Like – just as here, uh, and it was looking into childhood sexual abuse in Cornwall by priests and by other people. And who do you think they used as their expert on that inquiry?

A. I'm not here to guess, but – I – I don't know.

Q. You probably think I'm going to tell you the answer, right?

A. I'm expecting you will, yes.

Q. Well, it was Doctor Jaffe.

A. Okay.

Q. It wasn't you.

A. It wasn't me, no.

Q. Did they even ask you?

A. They didn't ask me, no.

Q. Would you think that an inquiry like that might want to have the best expert in Ontario?

A. I....

Q. On sexual abuse?

A. I would think they would want someone qualified on sexual abuse, yes.

Q. Well they'd want the best possible one, wouldn't they?

A. I – I'm not sure. I think they would want

someone qualified, but I am not sure how they determine who the best – the best would be. But I would think the better, you know, the better qualified the happier they would be, sure.

Q. Have you ever heard of the Sylvester case in Chatham?

A. Yes.

Q. Is that one of the – the victims in that case, did you provide a – an opinion to the Church in that case?

A. I provided an opinion in that case.

Q. To the Church?

A. Well, to the lawyer that retained me.

Q. Yeah, well that was on behalf of the Diocese of London, was it not?

A. I can't think of the specifics but I – I think you're – you're right, um....

Q. Yeah.

A. Yeah.

Q. The Crown Attorney - because there was so many women abused, 50 women abused by Father Sylvester. The Crown Attorney wanted to investigate how this could possibly have happened. Who do you think he retained as the child sexual abuse expert for that inquiry?

A. I don't know.

Q. Who do you think they did?

A. I'm not here to guess. I'm – I'm sure you know and you're....

Q. Would it surprise you that in all three matters, public matters, not where somebody wants to hire somebody for their case to make it better, okay? Where there could possibly be no bias, Jaffe was hired in each one.

A. I take your word for it that Jaffe was hired in each one.

Q. Well, that is what he has testified to today and so far in this case.

A. I'm not – I'm not doubting that. I believe you.

Q. Do you think that might have some influence for the jury as to whether or not they should pay more attention to what he said than what you say?

MR. BLOM: Well, Your Honour, that's for the jury to decide. It's not...

MR. LEDROIT: Thank you, Your Honour.

MR. BLOM: ...it's not for a witness to comment...

MR. LEDROIT: All right.

MR. BLOM: ...on.

MR. LEDROIT: Q. Let me just talk about bias, if I may. You know that financial reward may colour someone's opinion.

A. It could, yes.

Q. Well you mention it in your report, do you not?

A. Yes.

Q. That if somebody like Mr. McCabe is here for financial reward, that might influence what he said.

A. It could, yes. It'd be one of the secondary gains in that context, absolutely.

Q. Now the Catholic Church has retained you in what, 40 matters?

A. I have been retained in sexual abuse matters. Again, I don't know the exact number, but it could be up to 40, yes.

Q. They're like a repeat customer for you?

A. Various lawyers have contacted me to give an opinion in these matters.

Q. For the Catholic Church.

A. For childhood sexual abuse matters involving...

Q. From the Catholic Church.

A. ...involving the Catholic Church and...

Q. Forty times.

A. ...and the Anglican Church as well.

Q. Okay.

A. It's – yeah, no, it's been – it's been several times, yes.

Q. All right. About 40 times for the Roman Catholic Church?

A. Again, I don't have the exact...

Q. It could be...

A. ...times.

Q. ...that much?

A. Yeah, it could be, yes.

Q. And as I said, sort of like a repeat customer?

A. I have been retained several times.

Q. Well they're a good client, right?

A. I – I – I – I hear where you're going with that and, uh, they've retained me several times, yes.

Q. The – the financial gain that you get from being retained by the Catholic Church over and over and over again, might that influence your opinion?

A. Is that – you mean - is that your question that....

Q. Yes.

A. You would have to consider that as a possibility, absolutely.

Q. All right.

A. You'd have to – every evaluator has to guard against bias.

Q. So we should at least consider it.

A. It's – well, it's something I would – yeah, I would consider, yes.

Q. Can I assume that one of the reasons why the Church would retain you is because they like what you say?

A. Well, I – yeah, I mean, if you want to word it in that way, I would think they're happy with my evaluation and....

Q. And they know you're going to say the same thing case after case after case?

A. Well, it's not the same thing case after case because every individual is different, and every individual has their own life story to tell.

Q. And I – I understand that maybe in 1 of those 40 cases you found that the sexual abuse had a major impact on the life of the victim? Is that what I understand you to say?

A. Well, when you are....

Q. One out of forty?

A. Well, when you are evaluating – evaluating these matters, um, you have to look at the entirety of the person. You don't just look at sexual abuse you look at other potential factors that can lead someone to end up where they are. Childhood sexual abuse, again, it is not a diagnosis. It's an event that has happened to someone and it – and it may or may not lead to various symptoms and outcomes.

Q. Can I ask you to answer the question?

A. Can you repeat the question? I think I've forgotten the question.

Q. See if you can focus on what I – I am asking rather than what you want to say.

A. Well, I am – I'm trying to answer it as best I can, um...

Q. Okay, but...

A. ...so I don't mislead anyone.

Q. ...it's a simple question.

A. Okay, what's – what's the question please?

Q. I asked you if there was any case in which you found that the childhood sexual abuse had a major impact on the life of the individual. That's either a yes or a no.

A. So I would say yes, but it...

Q. Yes?

A. ...but it's complicated by the fact that the abuse may have a major effect at certain periods of time, not so much of an effect at other periods of time, and then it may come back and have an effect on someone.

Q. Okay, then let me change the question. Sure, sexual abuse can have a major impact for half an hour, right?

A. And – and it also, I think, depends on you know, what you mean by major impact. How are you, you know, are we talking about the symptoms or impairment in various...

Q. Wait - look...

A. ...areas?

Q. ...sir, you used the word "minor" in your report. You know what I mean by major. Come on.

A. I don't, actually, because it all depends on....

Q. You're the – you're the one who proffered

the word....

MR. BLOM: Sorry, Your Honour, I am wondering if we could let the witness finish?

THE COURT: I agree.

MR. LEDROIT: Thank you.

THE COURT: Why don't you...

MR. LEDROIT: Q. Can I ask....

THE COURT: ...why don't you repeat the question now, please.

MR. LEDROIT: Q. You were having trouble with the word "major" and I was putting it to you, look, those are your terms. You used "minor" in your report. I am just using your kind of terminology.

A. So, you can use that terminology in terms of describing sexual abuse itself. It's more complicated when you look at the effects of sexual abuse. So, sexual abuse would be severe, for example, if it involves intercourse, violence, the person is physically beat up. It may be minor if someone flashes, there's a flash to someone, like an exhibitionist that - and that might be...

Q. Uh-huh.

A. ...minor. The other would be, um, more severe, and then there is different areas in between. We can also look at sexual abuse based on, like, frequency and major findings are the more severe the sexual abuse is and or the more often it happens can lead to greater risk of adverse outcomes.

Q. Are you done?

A. Yes.

Q. Okay. Let's go back to my question. I am going to see if you can answer my question. I am talking about impact, not the abuse itself. I am talking about

impact. Has there been a case where you have found that the impact of the sexual abuse had a major impact on the life of the individual? When you – when you were acting for the Church.

A. So – again, so it's all – it all depends on what your outcome variables are, um...

Q. Okay.

A. ...so it's....

THE COURT: No, I – here, I am going to try.

A. Okay.

THE COURT: Because as Mr. Ledroit has asked you, it does sound like a yes or a no.

A. Okay.

THE COURT: Have you, in your work with the Catholic Church, found a case that had a major effect on the individual you were assessing?

A. For a period of time, yes.

MR. LEDROIT: Q. Well, what's the period of time, like a week, a day, a month?

A. Well, they could have developed a post-traumatic stress disorder, uh, yeah, for several months or a year.

Q. That would be the maximum? It had a major impact for a year and then they settled right back down?

A. No, I'm not...

Q. Is that....

A. ...I'm not saying they settled right back down but I'm saying that would be a major impact. But it may not have affected their life trajectory in any significant way, absent the abuse.

Q. Let me, then, redefine the question.

A. Sure.

Q. Is there a case, when you have been acting for the Roman Catholic Church, where you have found that it had a major impact on, to use your words, "their life trajectory"?

A. I would say not. Like, would I say their whole life was – had a major impact and destroyed their whole life, I would say not. Having said that, I haven't seen major forms of abuse including forced intercourse and so on. I – I have done other cases where that has been the case, but I haven't been retained in those types of cases.

Q. So, if I have – do I have it right here, in the 40 cases that you have reviewed for the Church, you have never found that in all those 40 cases, it's never had a major impact on their life trajectory? I'm just asking if you have – if I have put down the words that you have used, or if you want me to add different words.

A. It's – I'd say it's, you know, it's better to expand and each individual case is different but, yes, overall, if you are looking to put it in those terms, it may have had a major effect for a period of time, but not in their overall – overall life, no.

Q. I am just trying to pin you down to some wording, that's all.

A. I know you're trying to pin me down and it's – it's tough. You know, I don't want to be misleading by being pinned down. But I think – yeah, that's fair to say.

Q. I have got the gist of it.

A. Yeah.

Q. All right. Now, in your report I don't once see the word "priest". I see things like "stealing milk bottles", I see things like "being too short". But I don't see anything related to the fact that this abuse was caused by a

priest. Is that in your report at all?

A. Well, I think it's – he is abused by – in the summary of the abuse, he was abused by a priest.

Q. Okay.

A. That's...

Q. But – but....

A. ...quite obvious.

Q. The fact that he was abused by a priest, you do not take that into consideration in assessing the impact of the abuse. You were talking about the number of times and whether or not there was penetration, or whether or not it was flashing. Things like that, that influenced the significance of the abuse, but I don't see anything in there that this abuse being caused by a priest was significant.

MR. BLOM: Your Honour, I wonder if I can just stand at this point. This sounds like cross-examination on the issues in the case, not cross-examination on the qualification of...

MR. LEDROIT: Goes to bias...

MR. BLOM: ...the expert.

MR. LEDROIT: ...Your Honour.

THE COURT: Well, but you – that is where I thought you were going, but let's get closer to the point.

MR. LEDROIT: All right. I am going to leave it. I want to move on.

Q. You see people – you see people in your practice of whether or not they should be put on trial for – because they're – have psychiatric issues or whether or not they should have a defence of not – they're not criminally responsible, or insanity as I call it, or whether or not what's - that they should be let out, and in the course of

that practice, some of them had been sexually abused.

A. Yes.

Q. Okay. And you're there, not to assess the impact of the sexual abuse, simply that – you're there – are they a risk to the overall population.

A. Yeah, that's – that's – that's fair. So, when I assess any person, I – I do my formulation and I look at various factors that bring the person to a certain state or a certain diagnosis.

Q. You're not...

A. And then....

Q. ...you're not a therapist – sorry. You finish.

A. So, someone with, uh, someone with childhood sexual abuse may have emotional dysregulations. In other words, they can be moody or prone to paranoid issues and that can impact on their – call it kind of complex trauma, they have been traumatized over a long period of time and they can develop that. They're a little at times...

Q. And some....

A. ...moody and so on, so....

Q. Some of them have alcohol issues?

A. Yeah. So, in – in those cases, um, we can refer them to D-V-T training, so dialectical behavioural therapy training, to help them with interpersonal issues that may have been impacted by various abuses, including childhood sexual abuse. So in that case that would be very important in terms of their reintegration into society. It may contribute to anger management difficulties. It may contribute to ability to hold down a job because they're, um, dysregulated emotionally.

Q. But it's in those assessments that you're

doing for the court, you're not there assessing the impact of the sexual abuse. You're just indicating that look, they've had all these problems in their life. One was sexual abuse, one was stealing milk bottles, or one was – whatever it is that – that led them here, but you're not there to...

A. No.

Q. ...to help the court understand why...

A. No, no, that's....

Q. ...they became a criminal.

A. No, no, that's – that's correct. So, the court is requesting a specific psycholegal question. So it could be N-C-R or it could be fitness, dangerous offender, and so on. And that ultimately is the opinion that the court is, you know, relies upon to make their own independent determination. Now...

Q. And....

A. ...in terms of...

Q. And....

A. ...looking at factors, I think the work in the psychological trauma program has really assisted my development, in terms of looking at the impact of various incidents or traumas on someone.

Q. What have you published about that?

A. I haven't published on that.

Q. You haven't published on sexual abuse.

A. I haven't published on sexual abuse.

Q. Would it be surprising for you to learn that Doctor Jaffe has?

A. No, not based on what you are telling me, um...

Q. So....

A. ...so – do you want me to – I was going to

say that in the psychological trauma program one doesn't focus just on one area. One focuses on various areas. So the way psychiatric diagnosis works is, various things can impact on someone. And if you focus just solely in one area, you may – you may get kind of tunnel vision about that area without seeing all the various factors that can come into play.

Q. You've written of, not published. Do I have that – I know you were talking about something else, but I....

A. That – no, that's correct.

Q. That's not what my question was.

A. I haven't – I haven't published on childhood sexual abuse. I am...

Q. Okay.

A. ...I am actually putting something together, it is currently in draft form, but I haven't published yet.

MR. LEDROIT: Thank you, Your Honour.

THE COURT: Re-examination?

RE-EXAMINATION BY MR. C. BLOM:

Q. Doctor, what is it you are putting together in draft form?

A. I have got it with me, actually, and I am happy to share that with you if you like. But it's, um, it's – it's going to be an article on the evaluation, forensic evaluation of childhood sexual abuse.

Q. Such as in this case?

A. Such as in this case, yes.

Q. How many days a week in your current practice do you dedicate to doing the civil side, such as this, as compared to the other work you do, that we have heard you speak of?

MR. LEDROIT: Your Honour, that didn't come out

of cross-examination.

THE COURT: I'm sorry?

MR. LEDROIT: That didn't come out of cross.

THE COURT: I think Mr. Ledroit is right on that.

MR. BLOM: Fair enough.

Q. Mr. Ledroit talked about bias. You told us that that should be considered as a possibility.

A. Yes.

Q. Did the fact that you were paid to do the assessment of Mr. McCabe, in this case, influence the conclusions that you drew?

A. No.

Q. Does the fact that you might be retained in the future by a Diocese in a similar type of case, influence the conclusions you draw in your opinions?

A. No. So, one of – one of the things you learn in forensic psychiatry training is kind of the ratio of not giving the retaining lawyer an opinion that – that they, you know, that they want. So in an N-C-R assessment, for example, a lawyer may really want the person to be found N-C-R and you may not give that opinion. It may not be helpful. Or a defence counsel may want you to say the person is not a dangerous offender but you say the person is a dangerous offender, for example.

Q. Now this business about the need to consider the possibility of bias because of the fees, would that apply equally to someone like Doctor Jaffe if Mr. Ledroit is a repeat customer?

A. Yeah, I don't know about Doctor Jaffe, but um, I think yeah, I think bias is important to look at.

Q. Have you been retained on the plaintiff side

of civil cases such as this?

A. Uh, not – certainly not 40 times but – but one or – one time in a historical sexual abuse case and other times in terms of sexual harassment at work.

Q. Now, Mr. Ledroit put some emphasis on Mr. Jaffe's work for Justice Robins and in the Cornwall Inquiry, and in respect of Father Sylvester in London. What does it mean to take a longitudinal approach to the understanding of the impact of child sexual abuse?

MR. LEDROIT: Your Honour, I – I – I don't think that came out in cross.

THE COURT: I am not quite sure where you are going, so I am not quite sure if it did or did not. I take it it has some context to do with Robins and Cornwall and Sylvester.

MR. BLOM: Well, it – the context is trying to show the difference between Doctor Jaffe's credentials and ability to comment, and Doctor McMaster's credentials and ability to comment.

THE COURT: I will let you go ahead but one question at a time.

MR. BLOM: Q. In these cases, I understand you do an assessment?

A. Yes.

Q. That leads to a diagnosis?

A. Yes.

Q. And in your treating practice you treat?

A. Yes.

Q. Do you treat once or does it continue for a period of time?

A. Um, so at the psychological trauma program it would go on for several months, some cases over a year, or

be – it would be typically years, a year or two, before they'd go onto the next level of security. The addictions patients, it's a matter of, yeah, typically months to years as well. So, yeah, we – you know, we see people improve. We can see them relapse, we can see remission and then, um, relapse into a major depression, and treat it. Disorders can come and disorders can – can go.

Q. And in these – these patients that you treat, you have told us that some have a history of C-S-A.

A. Yes.

Q. Some have a diagnosis of P-T-S-D?

MR. LEDROIT: Your Honour.

A. Yes.

MR. LEDROIT: We're just repeating the chief.

THE COURT: Seems to me.

A. That's correct.

MR. BLOM: Q. Okay.

MR. BLOM: I'll just wrap it up then, Your Honour, if I can, in this area.

Q. We've heard that Doctor Jaffe, what he does in these cases, is he does assessments and diagnosis. We didn't hear so much about treatment.

THE COURT: Oh, now you've covered that in your examination.

MR. BLOM: Fair enough. Thank you. Those are my questions, Your Honour.

THE COURT: Thank you. It's a little early for the lunch break for you folks who came a little later, it's a little late for some of us. I think we'll take an early lunch and be back at 2:15.

12:54 P.M. JURY RETIRES

THE COURT: You have surprised me a little bit there, which is fine. The process we have been doing so far is that I have ruled on the *voir dire* out of the presence of the jury. Nobody has asked to cross-examine. I take nobody wanted to cross-examine. Now we have cross-examination, which is the right way to do it. Were you contemplating arguing at this point or – I just didn't want to get into that in front of the jury. And so lunch came – for my purposes, just about the time I wanted. What did you think was going to happen next?

MR. BLOM: From my perspective, Your Honour, we have your ruling and my friend had the right to cross-examine before the jury, just as I had the right to do the examination in-chief on qualifications.

THE COURT: Oh, I – I quite agree that he had the right to. I am – I am sort of concerned going both ways. One, nobody cross-examined in front of the jury before. I take it that that was everybody's preference.

MR. BLOM: Agreed.

MR. LEDROIT: I'm sorry, I'm not – I'm – I'm – I'm not with you.

THE COURT: There is no doubt that you have the right to cross-examine in front of the jury.

MR. LEDROIT: Yes.

THE COURT: I got that, and that is what you did.

MR. LEDROIT: Yes.
THE COURT: The experts, up to this point, nobody has asked to cross-examine in front of the jury.
MR. LEDROIT: Oh.
THE COURT: I take it that everybody – that was what they intended.
MR. LEDROIT: I – I had thought – I thought Doctor Jaffe had been cross-examined in front of the jury.
THE COURT: Not in front of the jury.
MR. LEDROIT: Okay, I'm sorry.
THE COURT: But I take it that you didn't wish to cross-examine any of the other defendant's experts...
MR. LEDROIT: No.
THE COURT: ...in front of the jury. Okay.
MR. LEDROIT: No.
THE COURT: That solves...
MR. LEDROIT: Thank you, Your Honour.
THE COURT: ...that problem. Now since we have done the process a little differently, which is the appropriate way to do things, I just wanted to know what you thought was going to happen next. Mr. Blom says the ruling has already been made and I should simply say he is qualified and carry on.
MR. LEDROIT: Yes.
THE COURT: Is that what you think as well?
MR. LEDROIT: Yes, that is – thank you.
THE COURT: Okay. That's fine.
MR. LEDROIT: Fine.

THE COURT: Two-fifteen. Oh, just before we leave. Have a seat. Mr. Ledroit kept cutting you off in your answers and I chastised him for cutting you off. It would seem to me, and it will be up to jury, but I think you need to focus on his questions because it did seem that he was awfully patient with you answering questions that he didn't ask. And – and one of the ways to know that is when you said, "I don't remember the question," and you were still in mid-answer. I am not going to stop you, although counsel might, but I think if we are planning to be out of here before next Friday, let alone tomorrow, you might want to focus on everybody's question, answer it. You don't – if you don't understand the question you can ask for it to be repeated. But focus a bit, would you, doctor?

A. Thank you, Your Honour.

THE COURT: Two-fifteen.

L U N C H R E C E S S

U P O N R E S U M I N G :

2:15 P.M. JURY ENTERS

THE COURT: Thank you. With all of that information I am satisfied that Doctor McMaster is qualified to give opinion evidence as a forensic psychiatrist in the area of the impact of child sexual abuse.

V O I R D I R E C O N C L U D E D

MR. BLOM: Thank you, Your Honour.

THE COURT: Go ahead.

JEFF MCMASTER: PREVIOUSLY AFFIRMED:

EXAMINATION IN-CHIEF BY MR. C. BLOM:

Q. Doctor McMaster, you were retained by our office to conduct an assessment of Mr. McCabe to consider the impact of the abuse that he experienced.

A. Yes.

Q. I understand you conducted the assessment in May of 2016?

A. That sounds about right, yes.

Q. And you delivered your report dated in September 2016?

A. Yes.

Q. Can you tell us the format that you followed in doing the assessment?

A. Um, so an assessment involves interview, review of collateral information, and I administered psychological testing and I had a psychologist work with me to interpret that testing.

Q. Okay.

A. So those are the three basic areas.

Q. Okay. And just so we're clear, collateral information would be things like medical records, academic records and so on?

A. Yes.

Q. Okay.

A. And your office provided me with collateral information and as is my practice, I ask the person I am evaluating for permission to contact other sources of information to...

Q. Uh-huh.

A. ...assist with filling in any blanks that may arise and to get a different perspective.

Q. Did you do that here?

A. Yes.

Q. And what – did you receive authority to do that?

A. No, I did not.

Q. And then having reached that stage in the assessment, what do you do?

A. Well, um, one has to look at all of the available information and summarize that information, and come up with a formulation, as I have stated earlier, come up with a psychiatric diagnosis, and then look at the referral questions and try to answer those referral questions based on the available information.

Q. Now....

MR. BLOM: And if it assists, Your Honour, I am at page 48 of Doctor McMaster's report.

Q. By way of introduction, doctor, what are some of the factors that you considered to assess the impact?

A. Well, one looks at family background, family history of – of psychiatric disorders, substance use disorders, suicides, criminality. We look at an individual's childhood. We look at various traumatic events that could have occurred in childhood, including sexual abuse, so you'd want to look at, um, various adverse childhood experiences: physical abuse, neglect, other traumas. You want to look at

their school performance and adjustments. You want to look at family background not only in terms of, um, psychiatric disorders and alcohol use disorders and so on, but what is the nature of the family, the structure of the family, the support in the family, the achievement in the family? A family is a natural control group in which to compare the person you are evaluating.

Q. And why are you looking at all of these things when we just asked you to assess the impact of the abuse?

A. To assess the impact of the abuse you have to look at other causes of the person's symptoms and impairment. You can't just automatically assume childhood sexual abuse lead – you know, "X" leads to "Y". You have to do a full assessment, a full – a full formulation.

Q. You mentioned alcohol use. So did you get any information from Mr. McCabe about the alcohol use of his father?

A. Yes, I believe I did.

Q. What were you told?

A. I am just mindful, I have been asked to exclude the – some of the records. I want to make sure I get the source of the information correct.

Q. Fair enough.

A. But I understand that his father did use alcohol.

Q. Uh-huh. If it helps, I am at page 49 of your report.

A. Thank you. I'm just trying to look at the main body of the report just to be absolutely sure who said what, just to – but I'll look at page 49, thank you. Yeah, I am sorry, I just want to make sure I am clear of what came

from Guelph and, uh, Homewood and I think that my report refers to some of that information, in terms of his father suffering from alcoholism, or having used alcohol excessively.

Q. Okay. We – we learned from Mr. McCabe that his – there was a period of time from the early 1960s until about 1967 when his father drank heavily. Did you get that information?

A. Yes.

Q. And we learned from Mr. McCabe that his father drove impaired from time to time. Did you get that?

A. Yes. He told me that as well.

Q. Okay. He gave examples, for – for instance, when he – he was caddying for his father at the...

MR. LEDROIT: Your Honour?

MR. LEDROIT: Q. ...golf course.

MR. LEDROIT: ...can the witness be not led through this?

THE COURT: If it is an issue, that is fine.

MR. BLOM: Thank you.

Q. Um, does that sort of evidence, with respect to his father, raise a - a question with respect to a genetic influence in the use of alcohol by Mr. McCabe?

A. Yes. It's a – it supports – that's evidence supporting that there is a genetic component...

Q. Okay.

A. ...to Mr. McCabe's alcohol use.

Q. Did you learn anything about the alcohol use of his brother James, known as Jim?

A. Yes.

Q. What did you learn?

A. Mr. McCabe told me that Jim was at least a hard drinker and borderline alcoholic.

Q. All right.

A. And he was arrested for impaired charges.

Q. Okay. And again, does that sort of evidence raise, um, the genetic influence in the alcohol use by Mr. McCabe?

A. Yes. It provides another piece of information suggesting a genetic component to Mr. McCabe's alcohol use, yes.

Q. Were you told anything about the alcohol use by his brother Tom?

A. So - yes, he – he took – he spoke of speaking of Jim and Tom, meeting both his brothers for drinks.

Q. And did you get any more information about the alcohol use by Tom?

A. And this is not first hand information to me, this is from...

MR. LEDROIT: No.

A. ...his examination for discovery and Mr. McCabe had absolutely no idea how much he drank when he was not with him. When they got together, Mr. McCabe would drink to excess and Tom would have "several".

MR. BLOM: Q. We've received some additional information in the trial. We were told that he drank heavily for a period of time and we were also told that he quit because of a diagnosis of diabetes.

MR. LEDROIT: Your Honour, that's not...

MR. BLOM: Q. Now if we...

MR. LEDROIT: ...in evidence.

MR. BLOM: Q. ...put all that....

THE COURT: It will be up to the jury to recollect the evidence and it - to the extent that the evidence is different than what the

expert places his opinion on, that will be up to the jury. I gather that that is the recollection of Mr. Blom and will leave it at that. Go ahead. Perhaps you could repeat the question.

MR. BLOM: Yes.

Q. We were told, sir, that Tom drank heavily for a period of time and we were told by Mr. McCabe that his brother Tom quit because of a diagnosis of diabetes. Again, is that the kind of evidence that raises a genetic influence in consideration of the alcohol use by Mr. McCabe?

A. It does. Not to the same extent as a full diagnosis of alcoholism, or say, Tom couldn't stop drinking despite having diabetes. That would be more impactful, but it does increase risk, yes.

Q. Did you receive any information about the alcohol use of his paternal uncles?

A. Yeah, he spoke of having an uncle who may have struggled with alcohol.

Q. Okay. Did you receive the name of that uncle?

A. I don't believe I did.

Q. Okay. We learned in the course of the evidence that he had two uncles named Vic and Ralph, both of whom drank a lot. Is that the kind of evidence that raises the genetic influence?

A. Yes, it could, um, it would be I think more powerful if the evidence was that the person had a diagnosis of alcoholism or some sense that drinking a lot led to problems in the person's life.

Q. Okay. Did you receive any information about the extent of the alcohol use by Mr. McCabe's son Nick?

A. Yes, oh, and I also found the reference – the reference that he said that his paternal uncle – he said that to me – drank a lot and there was also information in the file about his son having some issues with drinking as well.

Q. Okay. And we learned in the evidence that Nick struggled with alcohol at – at – at some level. Is that the kind of evidence that, again, raises a genetic influence?

A. Yes, it's a first degree family member of Mr. McCabe and that would, um, supports that there is a genetic – genetic influence.

Q. Now, I understand that one of the things that we're going to talk about in time is something called an alcohol use disorder.

A. Yes.

Q. And that is a diagnosis under the D-S-M-5?

A. Yes.

Q. Does the D-S-M-5 require you, when considering family members, to diagnose those family members with alcohol use disorder in order to draw the connection between genetics and the disorder in Mr. McCabe?

A. Um, there doesn't have to be a formal diagnosis, no.

Q. Okay.

A. I don't have to formally diagnose his family members.

Q. If his father, brothers, and son were not sexually abused, does - does that help us to understand the role of the genetic influence?

A. Yes. It, um, in terms of there is various pathways to a psychiatric diagnosis or where someone is in their life. There can be various pathways: biogenetic, environmental, and people can arrive at the same place through

different pathways. It suggests that in Mr. McCabe's case, the pathway involved a significant genetic contribution.

Q. Thank you. Can alcoholism in a family expose a child to adverse childhood experiences?

A. Yes.

Q. Can you give us examples in this case of any such experiences?

A. Well, emotionally, if someone has a father who is drinking a lot, they – they won't be as available to their children. They may be intoxicated. They may be loud. They may have arguments with their spouse. Not in this case but may be unavailable in some ways, not just emotionally, but I mean, to take them to school or to take them to various places may account for some of Mr. McCabe's school absences.

Q. Would that include things like sporting events that the child is participating in?

A. It could, yes.

Q. Okay. Now I think you mentioned you looked at family background. What – what's the significance of doing that?

A. Um, there's a couple of things. One is, again, the biogenetic vulnerability and the other thing is, what's the person's upbringing. There is also, um, not only just, again, a family background of disorders but there is personality styles, the level of - of occupational attainment tend to be similar; may not be in the exact same field but maybe at a similar level. It gives you a sense of potential and also in terms of upbringing there is modelling. Children model after their parents in their behaviours.

Q. Okay. So did you consider Mr. McCabe's education, um, consider it against other members of the family?

A. Yes. So I think overall, his overall educational achievement is similar. The – the one difference would be that Mr. McCabe failed a grade where his - whereas his siblings did not.

Q. And did you also take into account the, um, the vocational accomplishments or the work history of his siblings?

A. Yes, so there's a similar – you know, there is a similarity there as well. A lot of his brothers were in sales, his father was in sales. So, there is a similar achievement of family members compared to Mr. McCabe.

Q. Did you also consider his relationship history against that of his siblings?

A. Yes, so there is a history of divorce in his siblings. His parents stayed together, with his father passing away at a fairly young age.

Q. And did you look at all to the, um, the way in which he was parented? His father, his mother?

A. Yes.

Q. What did you learn?

A. So, his father was described as a taskmaster – a taskmaster, um, demanding, authoritarian, don't get him upset. He spanked Mr. McCabe hard enough not to do it again. Mr. McCabe did describe that as non-abusive. His father could be loud and the angrier he got the louder the – the decibels. And he – although he denied that his father was violent, his father was a screamer and did scare him. So that's one aspect of the parenting that Mr. McCabe received until his...

Q. I'll stop you...

A. ...father passed away.

Q. ...there for a moment. We talked earlier about adverse childhood experiences. You talked about his

father's drinking and how that might lead to certain behaviours. What impact can these adverse experiences have on a child?

A. So, various childhood adverse experiences can increase risk of later difficulties, later disorders, risk for suicide, risk of poor occupational, educational achievements. It's a non-specific risk – risk factor and these difficulties are additive, so the more you have, the – the worse the potential outcome can be.

Q. Okay. Now, did you learn about his mother's, uh, the way she treated him?

A. Um, I believe – yeah, I don't believe there is anything significant there. She gave him swats on the behind and time-outs.

Q. Okay.

A. So nothing, I don't think, out of the ordinary.

Q. Did you learn about whether she was a smoker?

A. She was a smoker, yes.

Q. What's the significance of that?

A. There – well, there's a couple of things. One, it is a risk factor for addiction, so the genetic risk for addiction, it can be specific to substance, but it can be a general risk factor as well. So if you're addicted to one thing you have higher risk in terms of becoming addicted to another thing. His father was a smoker, I believe, as well and worked at a tobacco plant.

Q. So are you telling us that if his mother was a smoker, she has a risk of being addicted to other things?

A. She does, and she has a risk of – of passing on that vulnerability to general addiction to – to her

children.

Q. Okay. What did you learn in respect of the practice of the Catholic faith in the household?

A. So, his, um, mother was Catholic. His father joined the Catholic Church to marry his mother, but then didn't really practice the Catholic faith.

Q. Now we know that there were six siblings in the family, including Mr. McCabe. Where did he fit in terms of the – the line of siblings?

A. So he was one of the younger siblings, and he was the second youngest.

Q. And what's the significance, if any, of being the second youngest of six?

A. Well, larger family sizes in general you're – you're splitting parental attention into six kind of pieces, as opposed to say, two children or an only child where it's only – you get more attention as a child. So I think that may have impacted on that for – for Mr. McCabe. There's – there's studies that suggest larger family size can increase the risk of conduct problems in youth.

Q. What is a conduct problem?

A. So, just basically not following the rules and being more rebellious than others.

Q. Okay. Did you inquire into any emotional – sorry, educational difficulties that Mr. McCabe may have had?

A. So, as we were – as we were talking about it - he did fail grade four, um, and that occurred – his first grade four year was 1961 to 1962.

Q. And can you – can you tell us was that before or after the abuse, that concerns us, took place?

A. So that was before the abuse. So it's – it's unclear, you know, why he failed, exactly, but the usual

reasons are the person has difficulty academically or the person has difficulty behaviourally. Or there may be, if the person is of normal intelligence, they may have a specific learning problem that gets in the way or an attention problem that gets in the way. But in any event, there is some kind of issue going on that leads to his grade failure that predates the sexual abuse and that wasn't experienced by the rest of his family members.

Q. Now did you talk with Mr. McCabe about he felt – the way he felt at the time of your assessment about failing grade four?

A. Yes, he felt quite embarrassed about it. He was shamed by it. And these days, there is – there is more split classes because they realize it is a big impact on a child's – for them to fail a grade, on self-esteem and peer development and so on. So, that's in keeping, I think, with Mr. McCabe's experience at that time.

Q. And this failure of grade four, is that something that can affect a child in the long term, years after?

A. It – it could. Um, again, there's the – the fact that he did fail and what – what, you know, the influence that is, in terms of later achievement and then there is also the – you know, it's an adverse childhood experience. It's another stressor that the person goes through and that it's kind of lasting over a long period of time because the person knows that they have been....

Q. Did you make any observations from – from his grades in terms of whether he was weak in any particular subjects?

A. He – yeah, he seemed to be weak at, um, I think it was spelling and reading.

Q. And did he – did he tell you the way he would describe himself as a student?

A. Um, he – well he – he spoke about missing a large number of classes throughout the years but not knowing why. And again, I am trying to be mindful of the fact that I can't include some of the collateral information and the school records, so I don't want to....

THE COURT: Perhaps we might just take a moment, members of the jury, just take a short break, I will have you back shortly.

2:36 P.M. JURY RETIRES

THE COURT: I take it you haven't given evidence very often. I think...

A. Not in civil court.

THE COURT: ...since somebody told you not to refer to something...

A. Yes.

THE COURT: ...saying, "I'm not going to refer to the thing you told me not to refer to," doesn't really help the exercise. "My lawyer told me not to refer to the Homewood records, so I am not referring to the Homewood records," will only underline to the jury, "What the heck are in the Homewood records?" Does that make my point clear enough?

A. Yes, Your Honour.

THE COURT: Mr. Ledroit you've twitched a couple of times. Does that cover your objection?

MR. LEDROIT: I don't know where he's now going to go with the school records. I just want it

clear that only the marks are to be referred to. Not the comments.

THE COURT: Have you...

MR. BLOM: And I advised....

THE COURT: ...have you reviewed that?

MR. BLOM: I advised that – Doctor McMaster of that too. So just – just to be perfectly clear, I sent an email to the doctor saying, we're not referring to Homewood, just reference to Guelph too, we didn't deal with that, but we're not referring to Guelph and we're not referring to the comments in the report cards. What I did is I drew lines through all those things, and my recommendation to him was draw lines through those things or obliterate them in some fashion. So, that should be crystal clear.

THE COURT: Any doubts about that, sir?

A. No. That's my understanding and I am sorry, I am just trying to be cautious and I am sorry if it came out that way, Your Honour.

MR. LEDROIT: And there will be no reference, I understand then, that the – the witness will not say, "Well I can't look at the school comments." I think....

THE COURT: I would hope that that's clear.

A. It's clear, Your Honour, and I apologize for that. I'm just trying to be abundantly cautious to ensure that I don't say anything that the jury shouldn't hear, but I – I...

THE COURT: Well...

A. ...hear your point.

THE COURT: ...your cautiousness has – has not

worked out so far, so I am not too sure about your cautiousness, so let me do this. If you have any thoughts in your mind that either lawyers' questions take you to those records that we have now discussed, you are going to have to say, "I don't understand the question." Or, "Can you make your question clearer," because sometimes lawyers do that and the witness is now in a real bind having been yelled at by the judge, and now it sounds like the lawyer is asking a question to take you directly there. So if it sounds like that, you need to say, "Can you make your question clearer," or "I'm not understanding the question."

A. Thank you, Your Honour.

THE COURT: Okay.

A. I think I will just go to the body of the report, where it's clear the source...

THE COURT: Yes.

A. ...as opposed to the later part of the report. I think that should help things.

THE COURT: My experience has taught me that when I raise my voice like that, 10 minutes would benefit us all. I will be back.

R E C E S S

U P O N R E S U M I N G :

2:51 P.M. JURY ENTERS

THE COURT: Go ahead.

MR. BLOM: Thank you, Your Honour.

Q. When you had an opportunity to review Mr. McCabe's grades in school, did you observe if there was a change after the abuse took place?

A. No, there was no significant change.

Q. And does that assist us in understanding the impact of the abuse at that time?

A. Yes, it argues against a significant impact of the abuse at that time.

Q. You have assessed other claimants in similar circumstances, where they have experienced C-S-A?

A. Yes.

Q. And have you had other cases where you have observed a change in grades after the incident of abuse?

A. Yes.

Q. Now did you – did you learn from Mr. McCabe, if in elementary school, he had the opportunity to do – to do things outside of the classroom?

A. Yes. He said to me that he loved getting out of class in order to do things outside of the classroom, yes.

Q. What's the significance of that?

A. Well, it's consistent with someone who has failed grade four. They may not be as focused on academic work, school work, and want to do other things.

Q. And is that something that can be of influence later in academic years?

A. And then later on, you may see individuals like that who maybe drop out of school because they want to start working and making money. It's a common – a common explanation for that.

Q. Now did you look into the questions of

personality style that I think you have talked about?

A. Yes.

Q. And what is that?

A. What is personality style?

Q. Right.

A. So, the D-S-M talks about, you know, various personality disorders, but personality style just talks about the way someone is. Their characteristic traits, ways of interacting with people, ways of thinking about the world and themselves, how well they can kind of modulate their mood and so on, so we all know what our – our personality is, and we all have our own personality style.

Q. Where does that come from?

A. There is a strong genetic component to that as well.

Q. What did you learn about Mr. McCabe?

A. So, Mr. McCabe, um, McCabe, he described himself as quiet and shy. And he was different from the other family members. He grew up in a family that was quite loud and boisterous and funny. He described himself as coming from an Irish family. He – he felt different within that family group.

Q. Did he talk to about whether he felt different, from say his brother Jim?

A. Yes. So, he also had some insecurities in comparison to his brothers. So, for example, he noted Jim was mechanically inclined.

Q. Uh-huh.

A. Paul was musically inclined and Tom was very involved in playing sports. And what he said was in contrast, he had nothing. He didn't get the attention. So, I think he didn't get the attention there and he also didn't get the

attention maybe because he was the fifth sibling and as he put it, maybe his parents had kind of burned out at that point in time.

Q. So, did you talk to him about the extent to which he had friends, and – and so on, when he was young?

A. So he said that he kept to himself, kept in the shadows, um, I – I - Mr. McCabe also felt he was more quiet than – than shy. He always had one or two people he associated with, but he never hung on to friends for very long.

Q. What's the significance of all of this, when we consider his, um, his subsequent years?

A. Well, it's – it's a factor when looking at, you know, again, the pathway of how someone ends up the way they are, it's – it's Mr. McCabe's life in terms of feeling insecure for a variety of different reasons growing up. One, within the family unit itself, another one is failing grade four, and some of the other adverse childhood – you know, childhood experiences, such as his father's drinking, and – and heart attack, and so on. It – it gives a sense of Mr. McCabe's experience growing up and how he may deal with that going forward.

Q. Now you had an opportunity to review the records of Ms. Elizabeth Schramm, therapist.

A. Yes.

Q. And did you note anything in particular in there, dealing with personality style?

A. There was a note in July 2015 and his sisters spoke of him as a gentle soul as a child, and there's note of unable to defend himself with bullies. So, it's unclear if he was bullied, but to the extent that there were bullies, he was unable to defend himself.

Q. And how does that fit within what you've just described earlier?

A. Well, you know, there's more and more studies these days on the effects of bullying on childhood adjustment and so on. So, it'd be another adverse childhood experience, to the extent that that did happen.

Q. All right. Did you talk with Mr. McCabe about his experience in – in relating to women when he was young?

A. Yes, so he said he's always lacked the confidence to approach , uh, women. He was afraid of rejection. And at the time I saw him, he said it continued to the present day. So again, suggesting a life-long personality trait in Mr. McCabe.

Q. And all of these things you've told us about, you know, a quiet and shy kid, um, talking about friendships, the therapy note, um, his, um, way in which he – he approached women, is any of that significant in considering the disorders he may have held later in life?

A. Yes. So, it speaks to his personality. Again, his personality style, which is consistent throughout life and his way of dealing with things. Procrastination was another way he described himself. That can carry - that personality trait for example, can carry forward to work, procrastinating at work and decreased work performance.

Q. Does any of this inform us in terms of – the questions of P-T-S-D, alcohol use disorder, that sort of thing?

A. Well, in – in terms of P-T-S-D, um, you'd want to look at did the, uh, did the trauma, in this case, the index sexual abuse is the one trauma we're looking at, did that lead to any P-T-S-D symptoms and any change in his

behaviour.

Q. Okay. We'll get to that in a moment.

A. Okay.

Q. But in terms of his personality style, this history you've given us, is – is that, um, in part, uh, before the abuse took place?

A. Oh, yes. That's right.

Q. Okay. And so to the extent it - it was, does that inform us in any way in terms of the risk of an alcohol use disorder, for example?

A. Yes. So, um, we can also look at how he started using alcohol. He started using alcohol to fit in through peer influence and he also felt more confident using it, so yes, these personality traits, um, can inform one's understanding of how someone would use alcohol.

Q. Okay.

A. So, when he's shy asking a woman out, he may have a drink or two to get the courage up to do so.

Q. Now, let's talk about the – the sexual abuse that brings us here. What information did you receive about it?

A. I received information, um, that there was two types of abuse. One was the fondling and long embraces, and then there was a trip to – to Montreal in the summer of 1963 which constitutes the most severe abuse in Mr. McCabe's case.

Q. How old was he at that time?

A. He was 11 years of age.

Q. And just to sort of summarize, what is your understanding of what took place?

A. My understanding is, um, there was kissing, fondling, stroking Mr. McCabe's body, and there was oral sex

involved.

Q. Now, um, what is your understanding of what happens after that abuse and for the rest of the weekend?

A. So there is – he – he had this, um, terrible night in this motel and then the next day he participated in Mass and then eventually they made their way back, away from Montreal, back to his house and he was dropped off.

Q. And did you learn of any discussion between Father Robert and Mr. McCabe through the course of the ride from Montreal back home?

A. So, he indicated that in the morning, it wasn't really talked about. Um, when they continued on to Montreal, um, he was enthralled by the Notre Dame Cathedral. On the way back, um – sorry, with - Father Robert wanted to make a few stops but Mr. McCabe took a position of defiance, at that point, and said to stop asking him to do stuff and that he wanted to go home. And then....

Q. Then what....

A. Sorry.

Q. Go ahead.

A. And then they went home and it sounds like he just, you know, kept to himself. There wasn't much said and he passed the time as quickly as possible.

Q. Okay. So you said a position of defiance, and, um, what we heard Mr. McCabe tell us in his evidence was, Father McCabe [sic] wanted to stop somewhere and he said no, and he didn't stop. Is that what you're talking about?

A. Yes – or did...

Q. And what does he....

A. ...well, to do things and he said no.

Q. What's the significance of that?

A. Well, when looking at, um, the - the sexual

abuse itself, you'd want to look at how much force is used, how much coercion, physical force, was the person physically assaulted, and it sounds like Mr. McCabe was able to say no to further requests and eventually got home. Quite uncomfortable experience in the car ride home, but was able to get home. After that, uh, night as well, he indicated that he lost the fear. He was enthralled by that – the Notre Dame Cathedral.

Q. Okay, but again, I'm going to go back to this saying no. What's the significance of saying no?

A. Well the significance of saying no is in keeping with, you know, lack of – of physical coercion or lack of physical abuse occurring concurrently, and at the same time as the sexual abuse.

Q. Now, let's talk about Mr. McCabe's – a bit of his, uh, history that you took after that. Did you – did you talk with him about, um, his alcohol use?

A. Yes.

Q. And what did you learn?

A. So after the abuse, um, he stayed on as an alter boy and his first use of alcohol was when he and another alter boy were caught drinking the sacramental wine. And he indicated that he was just trying it and that he wanted to be friends and he was a follower and - and that led to him using that first drink of alcohol.

Q. Now did you get any information about whether Father Robert was still in the parish at that time?

A. No, I don't believe so.

Q. Okay.

A. Um...

Q. Did mister - or....

A. ...but Father – but he – he did leave, um, and then it was six – sorry, and then it was six months later

that he had his first drink of alcohol.

Q. Got it. Did anything happen as a consequence of that?

A. They got in trouble and...

Q. Did he continue to....

A. ...he was suspended.

Q. Right. Did he continue to serve as an alter boy?

A. No, he quit.

Q. All right.

A. Along with the other boy, he quit as well.

Q. Okay. Did – did you receive any explanation about why he, um, drank the sacramental wine?

A. He said he was just trying it and he was a follower.

Q. Following whom?

A. He was following the other boy, the other alter boy. So....

Q. Okay. And so let's move it into high school. Did you get any more information or any information about his use of alcohol in his high school years?

A. Yes, well, he started, um, high school and although he was this, you know, quiet in his younger years, he became quite social in high school and actually achieved in high school, um, on the student council. And he indicated that part of that was alcohol gave him a confidence and eased his anxiety.

Q. And, um, can you share with us your opinion with respect to that conclusion he gave you?

A. So, there's a number of influences in terms of development of alcohol use and that certainly is a commonly given reason for using alcohol. It makes them feel more

confident and reduces anxiety.

Q. So do you mean becoming a social person?

A. Yeah, and – and becoming a social person.

Q. Okay.

A. And, you know, there's the peer pressure, wanting to fit in, and then there was influence. So, he indicated when asked who introduced him to alcohol, he said, you know, the high school guys. So it's not like Mr. McCabe was the only one doing it. It was a group of individuals doing it.

Q. And did he tell you in his later high school years the extent to which he was drinking?

A. Yes. He said by grade 12 he was drinking to impairment three to four times a week. But...

Q. Now....

A. ...he kept – but he kept that amount hidden from others.

Q. Okay. Now we'll get to this later, but did you consider a diagnosis of alcohol use disorder?

A. Yes.

Q. And did you conclude that Mr. McCabe had an alcohol use disorder?

A. I think he did, um, it sounds like he's got that under control...

Q. Okay.

A. ...these days.

Q. Now going back to these – this high school period of time, you said grade 10, he wanted to be a social person, alcohol helped. If a person has a genetic predisposition toward alcohol use disorder, what is the significance of drinking in these early years?

A. Well, if someone has a - an alcohol use

disorder based on genetic facts – significant genetic factors, they tend to drink at an earlier age. They may drink, um, higher amounts. They may have more severe alcoholism. And then the – you know, and then they may drink regardless of the – of the environmental factors or lack of environmental triggers so depending how strong the genetic influence is.

Q. So we – we touched a bit on grade 12. Did you ask him about his drinking in grade 13?

A. Yes, he – he said he was drinking at that point, probably three to five beers a day and he talked about how he – he enjoyed it. He liked it. So it was self reinforcing, which is another factor that leads to alcohol problems. So, some people, um, Asian people, some Asian people don't have the – the enzyme, for example, to metabolize alcohol and they get a really bad reaction from drinking, so their alcohol use tends to be less than individuals who have that enzyme. Mister – in Mr. McCabe's case, he liked the alcohol. He didn't have that bad reaction.

Q. When you say self reinforcing, what does that mean?

A. It means doing something and it reinforces, uh, the person to do the behaviour again.

Q. Okay. Did you learn anything more about his social behaviour in high school?

A. He indicated that he became more confident, more – he was more talkative and social. And as I was stating before, he became, um, more social to the extent of going on the student council, being the class president and then the vice-president of the student council for the school.

Q. Now is....

A. And he got – and he got confidence from those positions.

Q. Right. So what does this tell us about, you know, the shy boy that we talked about earlier?

A. You know, it talks about how Mr. McCabe is overcoming, um, these – these insecurities that he had through this type of achievement. It's something that he found himself good at. His brothers were good at other things. He found that he was good in – in this area.

Q. Okay. Now did you, um, talk about in high school years, his, um, dating girls, that sort of thing?

A. Yes. He, um....

Q. What did you learn about that?

A. So, he, um, he was – he was weak in terms of dating the opposite sex. He was shy, so although he had compensated in terms of his school council, he was – he was still afraid when it came to specifically approaching women in that regard.

Q. So if a person is able to compensate in one area, does that mean they're able to compensate in all areas of their life and interaction with others?

A. No. So, individuals who have a – who have severe social phobia, they may have what's called a specific phobia, just one area, or they may have a generalized social phobia where it encompasses a number of different areas in their life. So, um, in Mr. McCabe's case he seemed to do better outside of kind of that girlfriend, romantic context.

Q. Okay. What's his height?

A. He said that he is five foot four inches.

Q. And did he talk about whether that was an issue at any point in time?

A. Yes. He said he was conscious of it and he was also conscious in grade 13 of losing his hair more than his classmates, which could also impact on his self-esteem and

his – his reluctance to approach the opposite sex out of fear of rejection.

Q. Did you talk with Mr. McCabe about where his siblings went to high school?

A. Yes. So, Mr. McCabe said he didn't attend the same high school as his siblings.

Q. Did you learn why?

A. Well, I think in keeping with how he said that his – his brothers had special talents and so on and he – he was lacking, he didn't want to go to the same high school as his brothers. He wanted to, I think, show, um, show himself that he could do better and not be in the shadow of his siblings, so he chose to go to a different high school. He didn't want to go – as he put it, he didn't want to go through high school as Tom's younger brother.

Q. Okay. Did he talk to you about jobs he held during his high school years?

A. Yes, he – so, he had a number of part-time jobs in high school: a grocery store for four or five years, he did pizza delivery, and selling pots and pans, and he also had a paper route, and – and also, I think worked for his father in the last six months of high school as well.

Q. If he had these sorts of jobs, what does that – what does that tell us about his ability to get along with people?

A. In general, I think it's – it's indicative of someone who is functioning quite well. They have the energy to go out and do that. They're interacting with the public. But the energy he is putting into work, is obviously energy he's not putting into his studies. Having said that, he – he did fairly average at school.

Q. So, I'm sorry, I want to just ask another

question along the lines of what you just said. Does this help us to understand whether – whether he had a preference for school, a preference for – for work or both?

A. Well, in – in keeping with all of the information, uh, it looks like he – he again, is interested in – in working from a young age. There's other reasons for that, you know, financial reasons at the – at the household. Going back, he wanted to get out of the class. He wanted to be doing things as opposed to stuck in a classroom and this may be similar to that. I didn't ask him that specifically, though.

Q. Now you had an opportunity to review his high school grades?

A. Yes.

Q. And can you comment on – from a lay perspective, about how he appeared to do?

A. They appeared average to below average.

Q. Did you talk with him about whether he considered going to university?

A. He indicated that he did consider it. And he, um, decided not to attend due to financial limitations.

Q. What do you mean by that?

A. He couldn't afford to go to university.

Q. Okay.

A. His father's heart problems had returned and unable to do the bus run, so Mr. McCabe actually helped out his father at that point in time. So, there's some instability in the family unit and some financial difficulties that the family was experiencing.

Q. And did he tell you whether any of his money from his work went to the family or whether he kept it all?

A. Yes, some of the money he – I mean, he's a

hard worker, and some of the money he earned went back to the family. He didn't think, because of that, he could afford to attend university.

Q. Did you talk to him about whether the part time work he was doing had an impact on his grades in high school?

A. Um, when asked, yes, he – his opinion was it didn't. It didn't have an impact on his grades at that time.

Q. Did you talk about his – his behaviour in high school?

A. We did talk about, um, again, the – the social aspect of things. He became more social, he had several girlfriends, and he also received detentions for being disrespectful to certain teachers in the class, kidding around, joking around, being disruptive, and not having assignments done on time. The latter I think, was – which is in keeping with how he described himself as having the long-term personality trait of procrastination.

Q. Did you further consider his behaviour in his early years?

A. Yes. Um, and I should add as well, that I think that those behavioural issues in high school are indicative of someone who, you know, is – is giving less priority to academics and more priority to social issues.

Q. What did you learn about his behaviour in his early years?

A. So, um, from the age of seven or eight, and that – and that continued until his early teens, so that's about five years or so, he would steal items – small items from the neighbours. So, empty milk bottles, for example, to cash them in.

Q. Let me stop you there for a moment. And did

he say to you, when you were talking about this, did he say something like, "At the time I did it, I felt guilty"?

A. I – I think he did. I don't recall specifically, but I think he might have said something like that.

Q. Okay.

A. But I don't recall.

Q. Anything further along these lines, through his later years?

A. So, in terms of looking at the rule breaking, it's indicative of, you know, minor rule violations from a young age, and those have continued throughout his life.

Q. And what....

A. So, in high school again, the kidding, joking around and the detentions, being disruptive, is another form of – of – of that type of behaviour. And then in his adult years, um, he would steal items to pawn off or to sell, to have money to buy alcohol. He would put the pinch on someone for money.

Q. What do you mean by that?

A. So he – he would borrow money with no intent to pay them back.

Q. Anything further along those lines?

A. And then, um, he would find things left around apartment buildings and sell them. And he also would, um, during the current assessment he also described himself as having no financial integrity when he was supervising others. So he would decrease others' hours of pay to make the bottom line look better. And he cut their pay unfairly, as he put it, as he wanted to look good. And he described guilt about that, feeling bad about that.

Q. Now I understand that one of the things you considered, in terms of the diagnoses, is post-traumatic stress disorder.

A. Yes.

Q. Maybe at this point, we'll talk a little bit about what that is and how you formulate such a diagnosis.

A. So post-traumatic stress disorder, um, first of all it consists of having a – a very traumatic stressor happen to someone. And then after that stressor happens, they develop post-traumatic symptoms. Typically, they – if they – if the event is traumatic they remember it all too well, so it – it haunts them afterwards. They can't get it out of their mind, um, they'll have nightmares about it. They may feel like they're reexperiencing it while they're awake, kind of like a nightmare while you're awake. Those are – those are the reexperiencing or the intrusion symptoms of P-T-S-D. The flipside of that is, because it was a – such a bothersome thing, you'll avoid anything that reminds you of that. So, if you were in a severe car accident you may not get in the car for quite a while. So, reexperiencing and avoidance are two symptoms of P-T-S-D.

Q. Let me stop you there for a moment. We'll go into more later. Did you talk with Mr. McCabe about the first job he had after he left high school?

A. Yes. So the first job after high school, um, involved working with the archdiocese, priests and nuns. And, um, so again, that – that to me, is inconsistent with a diagnosis of P-T-S-D at that time. He would want to avoid reminders of the sexual abuse at that time.

Q. Okay, so let's just back up for a moment. When he went to Senator O'Connor High School, did he tell you if that was a Catholic school or a public school?

A. Um, I think it was a – a Christian Brothers' school. I'm not sure if that's....

Q. That's what you learned?

A. Is it Catholic or....

Q. And – Catholic, yes.

A. Yeah.

Q. Did he tell you about the type of garb or clothing worn by the teachers in the school?

A. No.

Q. Okay. So, um, we learned in the evidence that Christian Brothers wore their, um, religious clothing, at least in the early years he was there. Did he tell you if he was taught by others, such as nuns, for example?

A. I don't believe so, no.

Q. Okay. We learned in the evidence that he was and they wore their – their habit, for – for I think, all of the years he was there, if not most of the years. So, tell us what this, um, tell us the significance of this. Choosing to go to Senator O'Connor where he is taught by the Christian Brothers and nuns, wearing the clothing that they are wearing.

A. Well, it – it could be indicative of – of not having P-T-S-D. But having said that, people who are exposed to traumatic stressors, the vast majority may have some P-T-S-D symptoms but then they dissipate with time. And a treatment of P-T-S-D is exposure to – to something that bothers you. Kind of like a phobia. If you have a phobia of dogs, gradually exposing yourself to a picture of a dog and then to a dog, and so on, um, can get – help you get over that phobia. So the fact that he went to high school and had all – had all those reminders, they – that may have helped him to the extent that if he did have any P-T-S-D symptoms, they'd help those symptoms dissipate.

Q. Did – did you talk about his dating relationships after high school?

A. Um, so he, uh, he had his first serious relationship with a woman named Elaine, that he met at a Youth Corps. And also of significance, the diagnosis of P-T-S-D, was he had no problems sexually with her.

Q. Let – let's stop there for a moment. You said significant. What – what do you mean?

A. So if someone has been, uh, experienced a trauma that's sexual in nature, they may avoid sex or sex may precipitate, you know, a lot of distress and discomfort and difficulties in that area. He – he did not experience that.

Q. Let me cover something right now. Did you learn, um, whether Mr. McCabe had other relationships after Elaine with other women?

A. Yes, he did.

Q. And were you told of any avoidance, on his part, in terms of having sex, in the course of those relationships?

A. I don't recall him saying that there was any sexual difficulties in any of those relationships. No.

Q. Okay. And so, would that include the question of – or the issue of sex precipitating distress?

A. Yes.

Q. All right, what – what more did you learn about that relationship?

A. So, I think it was a, um, a relationship that he – he valued and after she broke up with him he felt totally rejected by it. So I think probably reinforcing his sense of being unattractive or reinforcing his fear of being able to approach women. So it certainly heightened that – that issue for him. And as he put it, he turned to alcohol to

ease the pain in that regard.

Q. Now if at that time, Mr. McCabe had an alcohol use disorder and he is rejected in the fashion you described, um, can you help us in understanding why he turned to alcohol?

A. Well, I think he was drinking before that as well, but it may have exacerbated his drinking. Um, he may have had more time to drink because he wasn't with her and she wasn't asking him not to drink. And - and also, people may drink to ease anxiety.

Q. Now you – you assess and treat patients who have alcohol use disorder?

A. Yes.

Q. And do you ever receive in the histories, um, information similar to what you have just told us about, with respect to Mr. McCabe and his relationship with Elaine?

A. Yes, so the ending of a relationship can be a significant stressor for people. It can actually lead to P-T-S-D symptom-like picture in some people, it can lead to major depression for some people. It can be one of those precipitating factors that we look at in terms of why someone may develop a certain disorder. It doesn't look like Mr. McCabe developed any of those serious disorders at that time, but he did talk about his drinking and being totally rejected.

Q. Okay. Now can the manner in which that relationship ended affect his ability to have relationships with women in the future?

A. It – it could, yes.

Q. In what way?

A. Well, it could heighten his pre-existing vulnerability, to being anxious socially around women and that fear of rejection. It could also impact his self-esteem.

MR. BLOM: Your Honour, I wonder if this is a good point for the afternoon break?
THE COURT: That will be fine. I was sort of flirting with going right through until 4:30 but it is a little warm and at least two jurors are saying yes, a break would be just fine. Thank you very much. So, quarter to.

3:24 P.M. JURY RETIRES

THE COURT: Or was that a signal you wanted to talk about something?
MR. BLOM: No.
THE COURT: Mr. Ledroit has something. Have a seat.
MR. LEDROIT: Your Honour, I like to think in a courtroom we deal with probability not possibility and I hear so many "coulds" coming out of the - this witness. "Could this affect this, could this affect that?" Anything is possible, but could it? I mean, is it probable that it did is a more useful exercise. Because I don't under – I am not sure whether the jury understands, I mean, did it or could it have? You know, I mean it's – we – we raise possibilities and it's difficult to deal with them.
THE COURT: Mr. Blom, any response?
MR. BLOM: My – my first response was going to be a bit flippant. I can conduct the examination any way I choose, but to help my friend, I am going to get to what he is talking

about.

THE COURT: I don't think you have broken any rules in the evidence that we have been dealing with, and I am sure that the jury is not missing the point. The opposite would be to say more probable than not every time you ask a question. They will have it clear, the issue...

MR. LEDROIT: Thank you.

THE COURT: ...is more probable than not. Quarter to.

R E C E S S

U P O N R E S U M I N G :

3:43 P.M. JURY ENTERS

THE COURT: Go ahead.

MR. BLOM: Q. Doctor McMaster, did you learn if Mr. McCabe married?

A. Yes, he did.

Q. And who did he marry?

A. He married, uh, Nancy.

Q. When was that?

A. In 1978.

Q. And where did they live in the first few years?

A. They bought a home together in St. Catharines in 1980.

Q. Now, where did they marry?

A. They married in the Catholic Church.

Q. And do you know if Nancy was Catholic by

upbringing?

A. No. She converted to Catholicism.

Q. What does this tell us in terms of this issue of avoidance in the criteria of P-T-S-D, if any?

A. It would be a factor that's inconsistent with P-T-S-D or non-indicative of P-T-S-D. So, instead of avoiding the Catholic Church he's actually bringing people towards the Catholic Church.

Q. Did you learn about the quality of the relationship?

A. It seemed to be good, he said, initially. The relationship was fine from a sexual perspective initially, but then finances and his drinking became a – a point of contention for the two of them.

Q. Did you learn anything about the financial issues in the family?

A. Well, he – as he put it, he had a complete inability to be honest with her about anything that would make him look bad, and certainly the financial aspects of things made him look bad and he was afraid that if she found out about those that she would leave him. And he described, in terms of finances, being irresponsible with money. Spending things on alcohol – spending money on alcohol. He also mentioned playing golf and buying a new drill at Canadian Tire as examples.

Q. Where was he working at this period of time?

A. He had a job in Woodstock at that time, it looks like. I have to...

Q. Is that....

A. ...cross-reference things. He – at one point he was working at the Workplace Safety Insurance Board, the W-C-B [sic] and at that point he was making, as he put it,

good money, $37,000 a year.

Q. Okay. Did you learn anything about the financial issues surrounding his income at the W-C-B [sic]?

A. He, um, he indicated that he never saved money, and in fact he dipped into his pension, um, being irresponsible with money. And Nancy, unfortunately, never knew anything about it until, um, she caught him intercepting the mail.

Q. And were there any consequences of – of – that led from that?

A. That seemed to lead to the ending of the relationship as she couldn't trust him any longer.

Q. Now in the course of your treatment of the patients you have talked about, do you ever hear stories similar to that?

A. Yes, it's one of the criteria for alcohol use, is you continue to do it despite having negative consequences. You lose control of your drinking.

Q. And in – in the patient population you treat, do you hear of consequences such as this in patients who have alcohol problems but have not been abused?

A. Yes.

Q. So the marriage ended, as we have learned. We understand that Mr. McCabe has some children. Did you learn of the number?

A. Yes, he had three children who are now all in their 30s.

Q. Okay. And did Mr. McCabe tell you the extent to which he had contact with them after the separation?

A. So after the marriage ended in about 1986 he had custody of his children every second weekend and then maintained that for about a year or two.

Q. What is the significance of that, if – if at all?

A. Well even after the marriage ended, which was I'm – I'm sure a significant stressor for him, he still maintained contact with his children. He still had that connection with them and he was responsible in terms of – of seeing them every second weekend.

Q. Did you learn if Mr. McCabe's use of alcohol led to any criminal involvement?

A. Yes, it did.

Q. Okay.

A. So about a year after the marriage ended, he incurred an impaired driving conviction.

Q. And based on the information you received, to what do you attribute the impaired driving conviction?

A. It would be the alcoholism that Mr. McCabe was suffering from.

MR. BLOM: Your Honour, what I would like to do with the witness, if I may, is to review the summary of income that we marked as an exhibit.

THE COURT: Six, I think.

MR. BLOM: May I provide a copy to the witness?

THE COURT: Well, we will give him the exhibit. It...

MR. BLOM: Oh, the exhibit.

THE COURT: ...would be better.

MR. BLOM: Perfect, yes. And may I provide copies to the jury?

A. Thank you.

THE COURT: Go ahead.

MR. BLOM: Q. Doctor McMaster, can – can a diagnosis of P-T-S-D affect someone's income earning history?

A. Yes, it can.

Q. Can a diagnosis of alcohol use disorder affect someone's income earning history?

A. Yes.

Q. So if we could review this summary of income, it starts in 1972, and I'd like to start by reviewing the years from 1972 to 1985. Do you see those years?

A. Yes.

Q. And what we've heard from Mr. McCabe is that we can describe these years as years of steady growth in income, years in which he was regularly employed and received some raises. You'll just accept that?

A. Yes. He would have been at 20 years of age in 1972 and his income steadily increased up until 1985.

Q. Now, what does that tell us in terms of the impact of P-T-S-D or alcohol use disorder on his – his earnings?

A. Well, despite any symptoms of those disorders that were present, they didn't impair him in his work and his ability to earn an income at that time. He steadily increased his income throughout that period.

Q. We learned that the separation took place in 1986 and I think we can all plainly see a significant drop in earnings. Do you see that?

A. Yes.

Q. And can you assist us in understanding the reason or reasons for the drop in earnings?

A. Well he had a significant stressor happen to him and he – I believe he moved and he got an impaired driving conviction shortly thereafter.

Q. This, um, this drop in earnings, after a – a steady period of regular employment, can you comment on

whether this is something you see in any of the other patients you – well, I shouldn't say it that way – in some of the patients you treat?

A. Yes. So, um, the ending of a – of a marriage is a – is a significant stressor and it can lead to not only symptoms but disruption in someone's lifestyle. They may have to move. They may change jobs for various reasons. So it's a significant stressor, and certainly his decrease in income correlates with that stressor, yes.

Q. And is that something you see in patients who have not been exposed to C-S-A?

A. Yes.

Q. Now in years after that, from 1987 to 1994, we see a fluctuation in earnings. Do you see that?

A. Yes.

Q. Okay. Starting in 1994 Mr. McCabe started at a company called M-P-W. Did he tell you about that job?

A. He did, yes.

Q. And if we turn the page over, uh, to 2010 he was – he was employed at that company until 2010 and if you just sort of skim those years in terms of earnings, um, we see what Mr. McCabe agreed was steady growth consistent with regular employment and raises, certainly to 2010, and then some slight drops after that, attributed to changes in the auto industry.

A. Yes.

Q. Do you see all that?

A. Yes.

Q. Okay. So, again, what does that tell us about the impact of P-T-S-D or alcohol use disorder in those years?

A. It – again, it means that despite symptoms,

it did not lead to impairment in the ability to earn that amount of money during those years.

Q. Now did you learn from Mr. McCabe any information about the people he worked with at M-P-W?

A. Yes, he did speak about that job. He mentioned a number of things about it.

Q. Did he tell you about the man that he worked for?

A. So, yeah, so the man he worked for was also a drinker and they would actually drink together, so that was a contributor to his substance use at that time.

Q. So, if someone has an alcohol use disorder and they're in an environment such as this where the person they work for also drinks, how does that, um, have an effect, if at all?

A. Well, it increases the – the chance of someone drinking. Um, it's a, you know, it's a perpetuating factor of his – of his drinking alcohol at that time.

Q. So let me move ahead a bit. Did you learn the circumstances leading to the termination of this job?

A. I – I – I learned that there was some mistake made by Mr. McCabe in terms of making a mistake on an invoice of $15,000 which lead the company to terminate his employment...

Q. Okay.

A. ...due to that mistake.

Q. We obtained a little bit more information from Mr. McCabe. He told us that he ordered, um, I think it was safety equipment for employees. There was a certain budget for that equipment and he felt he needed to spend more to ensure that they were safe. Having exceeded the budget he was terminated. Now, um, does that sound like a termination

somehow related to the impact of C-S-A?

A. It doesn't, no, I don't see any correlation there or connection there.

Q. Or P-T-S-D?

A. No, I don't see any connection there either.

Q. Or alcohol use disorder?

A. No. With alcohol use disorder someone would – they would more often be irresponsible as opposed to making that type of mistake.

Q. You had an opportunity, I think we touched on earlier, to review the notes of Elizabeth Schramm, the therapist.

A. Yes.

Q. And did you review in those notes any significant entries with respect to the person for whom Mr. McCabe worked at – worked with at M-P-W?

A. Yeah, he – well, the note describes, um, that he had an abusive relationship with the person he worked with, the director of his work from 1993 to 2010. And he noted that this person quote, "scared the hell" end quote, out of him.

Q. Now what - if – if he was able to continue to work in that job, for someone who was abusive and scared the hell out of him, what does that tell us about his ability to function in those years?

A. Well, despite having that concern about his boss, and – and drinking with his boss, he still was able to hold down a job and – and earn increasing amounts of – of money, of earnings. Part of his job was supervising, being responsible for 20 people and he also indicated that he was happy that, you know, he got out of the job, to be relieved of the job, given that it was a pressure cooker, no one was ever

happy. And then there is the automotive downturn as well, which contributed.

Q. Now if he was not terminated, did Mr. McCabe give you – give you any indication if he was planning to leave that job?

A. He spoke about – let's put it – just to be relieved to be out of it.

Q. No, but before the termination, did he say to you, "I was planning to leave anyway"?

A. I – I can't recall off-hand. I'd have to take a look further, to the reports.

Q. Okay. If he was not terminated from this job, did you receive any evidence from him to suggest that he could not continue in the job?

A. No.

Q. Or in a similar job?

A. No. He in fact had plans to start a new company, his own consulting company, but he reported, um, that he would procrastinate, tell himself he'd do things tomorrow, and instead he turned to drinking.

Q. And....

A. And again, I note that procrastination is a – a – a personality trait he's described himself as having.

Q. Now, that was the summer of 2010. Did you talk with him about what happened in the next half year or so?

A. So, after that job ended it looks like he felt quite bad about himself, felt like a failure, and he started to really increase his use of alcohol.

Q. So, how do we understand the termination of his employment in this context?

A. Well, losing someone's job, especially a job of - of over a decade, um, that would be a significant

stressor for Mr. McCabe. And significant stressors can lead to various outcomes, including an exacerbation or an increase in drinking and distress and despair and so on.

Q. And is this also something you see in your patients?

A. Yes.

Q. Um, and does that mean they were necessarily abused as children?

A. No. I've seen this in my patients, um, without a history of childhood sexual abuse. The drinking can take a life – on a life of its own for some people.

Q. Did Mr. McCabe tell you about his ultimate decision to stop drinking?

A. Yeah, he – he spoke of having made this decision in December of 2010.

Q. And were there any ways in which he received support in doing that?

A. Um, he – yeah, he had his – after his decision, he had started attending Alcoholics Anonymous about two days later, on December the 6th. And he has been involved with it since. He now – now sponsors other individuals.

Q. You had an opportunity to review the chart of Doctor John Laird, the family physician?

A. Yes.

MR. BLOM: Your Honour, I wonder if we could pass the exhibit copy to the doctor?

MR. LEDROIT: What's the number? Eighteen?

A. Thank you.

Q. Doctor, could you go to an entry of July 16, 2013?

A. I found it, yes.

Q. I'll wait until Mr. Ledroit finds it.

MR. LEDROIT: What date?

MR. BLOM: July 16, 2013.

MR. LEDROIT: Okay.

MR. BLOM: Q. So, let me read, doctor, and there's some short forms and so on, um, I might need some of your assistance. "Trouble in dealing with issues, E-S-P – [especially] last six months, in context of his alcoholism. Sponsor had suggested he see a doctor. (He hasn't seen him this place before times years). [Example] – E-G, [example], a lot anger related to self from things in the past and business relationship. Also, anxiety to finances and security. Not able to help his kids, fear of the unknown future. Feelings of failure, I don't see a positive future. Although he has insights to see the positives in his life, he is working as a supervisor in a building but he got screwed in work orders, and...," then there is two question marks, "Excessive anger. Also, some resentments being held I-E in the program. Feels sad quite a bit, tired a lot, sleep is off 5-7-H." Which I take to mean hours, "Exhausted all the time. Cried a couple times in the last two months, triggered from his regrets, (I-E about not helping). He is also doing meditation and prays daily. But he hasn't felt the serenity that he expects. Hard to say if he has been depressed in the past. Never," looks like, "Never saw a [doc] D-O-C [doctor] for it." And there's a blood pressure reading and then it says, um, "A: recovering alcoholism, mild depression, P [*sic*]: discussed lifestyle, trial meds, [or medications] see in six weeks." Now, could you just turn the page? So, it's the same day, "Start escitalopram, 5-M-G." Do you see that?

A. Yes.

Q. What is escitalopram?

A. It's a – it's called an S-S-R-I antidepressant. It's like a cousin of Prozac. The other name for it is Cipralex.

Q. So he appears to have been placed on an antidepressant by the family physician after this consultation?

A. Yes.

Q. Okay. Is there any indication in this consultation that he disclosed that he was subjected to C-S-A, child sexual abuse?

A. Not in that conversation, no.

Q. Now did Mr. McCabe tell you how he came to the decision to pursue this litigation or this court action?

A. Yes, to some degree.

Q. What did he tell you?

A. He indicated that he had, um, previously talked about it. He'd started law proceedings in 2010 but then he – he became sober and didn't pursue it. And then on Christmas day 2013 he indicated that he relived the experience of the abuse while thinking about why he is a drunk and then shortly thereafter, the lawyers, he said, called him up and suggested that he pursue a lawsuit along with another person.

Q. Now we've talked earlier about the counselling with Elizabeth Schramm and your opportunity to review the file.

A. Yes.

Q. When you reviewed the file – sorry, let me back up. I want to preface these questions with the following. I'm going to ask you some questions about memory. How does memory work when someone like Mr. McCabe is recounting events over a lifetime?

A. So, um, a couple of things about memory is

that – that, first of all, memory is not like a video recorder, so you don't remember everything perfectly. Memory is reconstructive. So you may have a memory of it, then it – it changes based on subsequent experience.

Q. So, can we rely on his memory without question?

A. No, and that wouldn't be the case with anyone. Mr. McCabe....

Q. And then to be fair, without suggesting he's misleading.

A. Yeah, no, so memory – you have to take memory, um, the nature of memory and the reconstructive nature of memory into account when looking at someone's self-report.

Q. Does memory play a role in one's perception of their life in the past?

A. Um, so yeah, that's – the way I would put it is some people will look back at their life and try and reflect on it and make meaning, and this – this is a developmental stage, typically in the – in the – someone's 60s when they look back at their life and try and make sense of it, and it's called integrity versus, you know, despair. So Mr. McCabe at this point in time has, um, he has sobered up and he's looking back at his life, and his regrets and so on, and he's going to A-A and he's giving these, um, A-A steps. It's in that context that he's looking back at – at his life, trying to make sense of it, and that's when the – the sexual abuse pops into his mind.

Q. Okay. Now we talked about the counselling he's received. Can participation in therapy of this sort impact on Mr. McCabe's memory or perception of the past?

A. Yes, it can.

Q. Having reviewed Ms. Schramm's file did you

see any indication of this?

A. Yes.

Q. In what way?

A. Well, he's – he was referred to Ms. Schramm, to deal with childhood sexual abuse, by his lawyer and like any therapy relationship there is going to be suggestive elements and guiding of viewing things through the lens of your therapist. And I – and I think there is elements of that in – in the therapy that Mr. McCabe had with her, yes.

Q. And did you – did you flag any specific entries or passages on her chart that fit within what you were just suggesting?

A. Well, they – they talked about the abuse a lot. Um, there's mention of another piece of memory arising with regards to Father Robert.

Q. Okay. So, what's the date of that entry?

A. That's June 17, 2014.

Q. And did you quote that entry in your report?

A. Yes.

Q. So give us the quote?

A. So the session of June 17, 2014 included that, "Another piece of memory arose, in the past week, of contact with Father Robert lying behind him in bed."

Q. Okay. Any other entries of significance?

A. There is noted him, um, beginning to understand the relationship between past abuse and the incapability to have intimate relationships in the past.

Q. When is that entry?

A. And that was August 2014.

Q. Any others of significance?

A. And then they reflected on the gap between walking up the driveway after the abuse to the present and the

past four or so years, when he woke up to the reality of what has happened.

Q. So did you draw any conclusions about what these types of entries might tell us?

A. Yeah, um, you know, it's – I think it's – it's – it's complicated, but I think the way he's talking about the abuse is consistent with the literature in terms of childhood sexual abuse. And then later, um, you know, realizing what has happened is – you know, what's happened to himself, and then becoming traumatized at that point in time or quite upset about it at that point in time. And it's also – it speaks to the influence of the type of therapist you have, in terms of your appraisal of the past.

Q. Now if – if we read these passages that you just talked about, um, so for example, in October 2014 there was reflecting on the gap between the time he walked up the driveway, coming back from...

A. Yes.

Q. ...the church in Montreal up to the past four years or so, when he woke up to the reality of what has happened.

A. Yes.

Q. Does that necessarily mean that's an accurate perception or understanding of his life?

A. Well, there's a couple of things there. There is the gap and then there is waking up to the reality of what has happened. So, in terms of the gap, she has mentioned dissociative amnesia, like, not being able – not having a memory of something as meaning that something bad happened.

Q. Well, let me try a different entry.

A. Okay, all right.

Q. I'll go back – maybe August 2014 is a more

concrete example.

A. Okay.

Q. He was beginning to understand the relationship between the past abuse and the incapability to have intimate relationships in the past.

A. Uh-huh.

Q. Okay. So, if he's come to this realization in 2014, does that mean the realization is correct?

A. So, there – yeah, so there is – there is memory of – of past and then there is your perception of past, and – and – and putting down a sense of kind of cause and effect. And again, memory can be distorted in those circumstances.

Q. So if I come back to my question, if he was beginning to understand the relationship between past abuse and the inability to have intimate relationships in the past, if that's his perception in the summer of 2014 does that mean it's true?

A. So, he may have issues, so, you know, I'm – another example is, the roots of these issues as they may relate to past abuse were discussed in therapy. The roots of these issues. So, he may have had issues but now in therapy he's assigning causation to those issues. That is, he's assigning those issues were due to abuse and that doesn't mean it's true that those issues were due to abuse. You would want to assess the file and look at what happened over the years, too, before making that conclusion.

Q. Did you talk with Mr. McCabe about any financial difficulties he had at the time of your assessment?

A. Yes, I did.

Q. What did you learn?

A. He indicated that he still has significant

money owing to the Family Responsibility Office to the extent of 120 to $150,000.

Q. Now do you see patients with alcohol use disorder who have significant debt?

A. Yes, um, it – it varies. This – this is a – it's a larger number than I have - typically run across, but financial difficulties are part and parcel of – of addiction, because they can't, um, meet their responsibilities...

Q. And does that....

A. ...and then they spend their money on substances.

Q. And does that include patients who do not have a history of C-S-A?

A. Yes.

Q. Let's talk about, um, talk about the litigation. Did you discuss with him the way in which he felt about it?

A. Yes.

Q. What did you learn?

A. He indicated that it's been stressful for him, over the last three years, to deal with the stress of the litigation. To deal with the stress of the civil case.

Q. Now we've heard, for example, that, um, some of the things that increased stress in this context included the issuing of the claim, the discovery process, assessments with Doctor Jaffe and yourself, and – and trial preparations.

A. Yes.

Q. Can you – can you assist us in understanding whether that's common in this type of situation?

A. It – it is, um, and it's not just litigation involving childhood sexual abuse. Any litigation can be stressful. Thomas Butel (ph) coined lithogenic harm and the

harm of litigation to an individual because it is – it is stressful and it can be adversarial. And then there is the added stressor, and that is the, um, litigation of the trauma forces someone to essentially relive it and to talk about it and reexperience it, and they may not be fully ready to do that, or to do it to the extent required in the litigation. So there can be, um, kind of a worsening of their symptoms during the time of – of the litigation.

Q. Okay. Now, um, we learned through, uh, the evidence of Ms. Schramm that he was told by his lawyers that the archdiocese was aware of Father Robert's abusive conduct before he was abused. Is that something that could increase the stress of the litigation?

A. It – it - well, it – hearing about that may be a stressful thing at that time, yes, and if that occurred around the time of the litigation it would make it – or could make it more stressful, yes.

Q. And if it turns out that there is no basis whatsoever to say that, could that add to the stress of the litigation?

A. Well, I think it – thinking that, regardless of whether it's true or not, can add to the stress of the litigation, yes.

Q. Can you assist us with this? I will leave it at that. Did you talk with Mr. McCabe about any symptoms he was experiencing at the time you met with him?

A. Yes.

Q. What did you learn?

A. So, when I met with him he did not report any sexual difficulties.

Q. Was he in a relationship at that time?

A. Not in a romantic relationship but he had a

number of female friends.

Q. What did he tell you about his ability to be in those relationships?

A. Um, he indicated that, um, well, he's got these female friends. He's also on good terms with both Nancy and Judy, his – his past wives, um, and he also indicated that he doesn't – you know, he's hesitant to approach these three female friends out of concern that it may ruin the actual friendship he has with them.

Q. Okay. Now we've learned at trial that since your assessment, he met Elaine. Not the first Elaine.

A. Okay.

Q. A new, um, a lady by the name of Elaine. And it appears, from what we've heard, they're engaged. What can we draw from that?

A. It – it speaks to Mr. McCabe doing well at this period in time. He's able to have a – an intimate relationship and a – a relationship absent of any sexual difficulties, according to when I saw him.

Q. Did you talk with Mr. McCabe about his view on the effects of the abuse he experienced?

A. Yes.

Q. What did he tell you?

A. He indicated that, um, how the abuse affected him never came to his conscious mind until that Christmas day in 2013.

Q. Now how do we – how do we understand that? Never came to his conscious mind?

A. Well, I – I don't think he really, um, like, he certainly didn't report having reexperiencing symptoms to me throughout his life. And then when he started the litigation I think, um, it became – you know, obviously came

to him more and more, given the nature of the litigation.

Q. All right. And what else did he tell you about, um, his thoughts about the abuse?

A. Um, he – yeah, so I should say he had no recollection of thinking about the abuse on a regular basis, always knew he was abused, just didn't think about it. Never attributed his life difficulties to the abuse.

Q. Sorry, I'm going to stop you there. He never attributed his life difficulties due to the abuse.

A. That's correct. Until that time.

Q. Okay. Sorry, until what time?

A. Until, uh, 2013, and he indicated that after filing – filing the lawsuit, he came to see that the index abuse impacted every aspect of his life that he could think of.

Q. Now you talked earlier about intrusive thoughts in the context of P-T-S-D. Did you talk with him about, um, about whether he had intrusive thoughts before initiating the lawsuit?

A. Well that – that's just it. He didn't have that – those intrusion symptoms prior to initiating the lawsuit, as reported by Mr. McCabe to myself.

Q. What are examples of these intrusive type thoughts?

A. So, examples would be, um, constantly thinking about it, um, things reminding you of it. Driving by a church, for example, and then the abuse coming to mind. Seeing a priest and the abuse coming to mind. Nightmares, flashbacks.

Q. What – what's a flashback?

A. A flashback is where the person, uh, not just thinks about something that happened, but it feels almost

real to them.

Q. So is this while they're awake or while they're asleep?

A. While they're awake.

Q. Now let me just go through this. If this never came to his conscious mind until Christmas 2013, if he has no recollection of thinking about this before then on a regular basis, if he's never attributed his life difficulties to the abuse, and if – if he was not having these intrusive thoughts, how do we understand the potential impact of the abuse on his life before 2013?

A. Yeah, there's – so there's, you know, a few things – there's a few things there. Um, so the impact of his – on his life before 2013, well I think that the abuse was a terrible thing that happened to him, and very stressful – a very stressful thing that happened to him, and I think it did increase, you know, later risk of developing difficulties, um, but it's – it's a risk. It's not a – not a certainty in terms of outcome. In terms of P-T-S-D, um, the literature talks about many individuals who are abused and because they're so young and sexually naive at the time it happens, it's actually a protective thing for them, although it can be quite stressful for them, it's protective. And then later on, they go on, they always knew they were abused, don't really think about it that much, kind of in the background, and then later on they, um, they start thinking about it more, and it gets more meaning to them at that time, they fully understand what happened, and how terrible it was and then at that point in time, they can actually develop a P-T-S-D, um, kind of clinical picture and the evidence I have before me with Mr. McCabe is that that's what happened. He didn't have those typical P-T-S-D symptoms, um, again, he was – he was without

any sexual difficulties, not avoiding trauma that reminded him – or not – not avoiding things that reminded him of the abuse, again, working at the Catholic job and so on. And then when he files the lawsuit, starts thinking about it and really, the impact of it I think really hit him at that point in time.

Q. Now you – you talked about sexual naivety.

A. Yes.

Q. There's a note in Ms. Schramm's records and I – I think it reads something like this, "After the abuse he didn't understand, he didn't have a sense of whether it was right or wrong, but he felt bad."

A. Yes.

Q. Does this assist us in understanding anything about his sexual naivety?

A. Yes, I think her notes as well speak to him being sexually – sexually naive at that time.

Q. Now moving ahead, um, did you talk with Mr. McCabe about whether he himself felt that the abuse he experienced caused him to be an alcoholic?

A. Yeah, he – I don't think he was – when I – when I met with him, he wasn't convinced of that, but he – he did, um, speak of that, yes.

Q. Now after, um, taking the history, doing the interview you told us about, reviewing the records you told us about, there was some testing, which we'll come back to tomorrow. Did you reach a diagnosis or diagnoses in your assessment?

A. Well, um, so when I – when I saw him, he seemed to be doing relatively well. And so, when we look at historical, you know, historical issues. So again, as I was saying earlier, disorders can come, disorders can go, and things can wax and wane. When I saw him he was doing fairly –

I think, fairly well but yes, I think in the past he has suffered from alcoholism. And to add to your previous question, I found a reference here, and Mr. McCabe himself said, the ultimate question in all of this, is did the abuse cause him to become an alcoholic.

Q. What was his answer?

A. And he said to himself that he wasn't sure, but at minimum it added gas to a fire.

Q. So in terms of diagnoses, you – you just – I think you used the word "alcoholism". We have also talked about alcohol use disorder, so what is the diagnoses – diagnosis, in this area?

A. Sorry, pardon me? Do you mean what's the diagnosis for Mr. McCabe?

Q. Relating to alcohol.

A. So he has an alcohol use disorder.

Q. All right. Yeah, and was it active at the time you met him?

A. It was in remission.

Q. Okay. Did you, um, raise the possibility of any other diagnoses?

A. Yes.

Q. What were they?

A. So in terms of an understanding of someone, you want to look at - at the background, how did the person function, kind of from their personality, in the background, and then there's major disorders that come up, that can be like alcoholism, that come and go, or major depression can come and go. But the constant behind all of that is a personality disorder, personality style, so that's something I considered for – for Mr. McCabe.

Q. Okay.

A. And I noted some problematic personality traits over his lifetime.

Q. Any other diagnoses?

A. Um....

Q. I – I just want to list them now, and then we'll – we'll come to details in a moment.

A. Yeah, it's – it seems like he has – what also, in the background, you want to look at someone's overall level of intelligence, and someone may be of average intelligence but have small areas of - of difficulty, like a learning disorder, which can impact on school performance. I just try and consider what may have contributed to him failing grade four. And he may have, you know, special difficulties in mathematics and there was also a special difficulty – difficulty in English and spelling at one point. So, learning disorder is a possibility.

Q. Uh-huh.

A. Um, and then there's also symptoms based on stressors. And the D-S-M talks about stressors leading to symptoms in various ways. One can be an adjustment disorder, they call it, and another can be post-traumatic stress disorder.

Q. So, is that – is that an anxiety disorder?

A. Yes. Although they're now reclassified in D-S-M-5 in their own separate area now.

Q. Happily, we don't have to go there.

A. Okay.

MR. BLOM: Your Honour, as I go through in more detail the various diagnoses, it's going to take me more than three minutes to do the first one.

THE COURT: That's what I thought too. Ten o'clock tomorrow.

4:27 P.M. JURY RETIRES

THE COURT: Have a seat. My guess is that you have been as busy as I have and haven't been able to think about what we are likely to accomplish tomorrow or the following day or the following day, and we should just get through tomorrow and see where we are?

MR. BLOM: I think so. I do need to raise with the doctor, his coverage for tomorrow. But I'll chat with him about that, make sure it's taken care of.

THE COURT: Sadly, whether it is or not, he will be – well, if we are not going to finish him anyway, I may rethink that for Friday afternoon. We will see where we are. Does that raise any concerns?

MR. LEDROIT: About?

THE COURT: Well, it – I mean if we....

MR. LEDROIT: Let's just deal with it then.

THE COURT: That's fine. That's good.

MR. LEDROIT: My – my mate here has some more law for you, just in case you had some time.

THE COURT: Sure. Yeah.

MR. LEDROIT: You've got nothing else to do.

MR. SABO: This is concerning the issue that arose yesterday, not the argument, but this...

THE COURT: Okay.

MR. SABO: ...may be of some assistance.

THE COURT: And do you have a copy as well? You do now.

M A T T E R A D J O U R N E D

FRIDAY, MAY 19, 2017

9:58 A.M. JURY ENTERS

THE COURT: Go ahead.

MR. BLOM: Thank you, Your Honour.

JEFF MCMASTER: PREVIOUSLY AFFIRMED:

EXAMINATION IN-CHIEF BY MR. C. BLOM: (Cont'd)

Q. Doctor McMaster, yesterday we left off after you reviewed the various diagnoses for Mr. McCabe. And what I wanted to do this morning was to start with, um, substance abuse disorder. Can you assist us in understanding that in relation to Mr. McCabe?

A. Yes. So Mr. McCabe currently does not have any substance use difficulties. So that diagnosis is in remission.

Q. Okay.

A. And he hasn't had difficulties now, I believe, since 2013. So....

Q. In order to....

A. I'm sorry.

Q. In order to better understand it, can you tell us what the characteristics are, generally speaking, of a substance abuse disorder.

A. So a substance use disorder has various symptoms. They include loss of control of drinking, so drinking, um, more often than you would like to, unsuccessful

attempts to cut down and to – to stop drinking. It could lead to adverse consequences and yet the individual keeps drinking. Failure to meet obligations, so not showing up for work for example, or not picking up the kids at school would be another example of that. Continuing to drink despite it being risky for the person or causing medical problems. Drunk driving, um, to continue to drink under those circumstances. When alcohol becomes quite problematic, the individual will drink more and more to get the same result. And when that happens if they don't continue drinking at that same amount, they can develop withdrawal symptoms.

Q. Now what are the causes, generally speaking, of a substance use disorder such as this?

A. In – in general or in Mr. McCabe's case?

Q. In general. Just - just talk generally first.

A. So genetic factors would account for 40 to 60 percent of the risk of someone developing an alcohol use disorder.

Q. What are some of the other factors?

A. And then environmental factors would also play a role.

Q. And what is an environmental factor?

A. It's a factor that the individual is exposed to in the course of their life, as opposed to what they are born into.

Q. And can you give us, you know, more examples of that.

A. So on a societal level if alcohol is readily available, if it's – if it's permissible to use alcohol, that would increase someone's risk. Peer influence is another one, um, dealing with symptoms such as anxiety or depression.

Q. Uh-huh.

A. Conversely alcohol can lead to those symptoms as well.

Q. Okay.

A. So there is a variety of different factors that can – besides genetics that can contribute to someone's risk of alcohol use disorder.

Q. Now I want to talk a little bit more about genetics. You just mentioned that, um, it accounts for 40 to 60 percent of – of something and I didn't quite catch that. Can you explain?

A. So it's a statistical term of – of the variance. So if you are talking a look at one group versus another group...

Q. Uh-huh.

A. ...and why one group would have an outcome and the other one wouldn't, to account for the differences.

Q. Uh-huh.

A. The variance is what percentage is accounted for by the genetic factors and that number is 40 to 60 percent in the alcohol use disorder.

Q. Now I asked Doctor Jaffe about this, I hope I get it right, I think he explained it this way. If we looked at 100 people in a room say at the treatment centre for alcohol, 40 to 60 of them would have an alcohol use disorder related to genetics. Is that the correct understanding of – of the variance?

A. No – no, that's not correct. So – so I think he is speaking more of prevalence. So if you have 100 people you would want to look at the differences between the people and what accounts for that difference between the – the groups. And 40 to 60 percent of what accounts for that

difference would be genetic factors.

Q. Okay. Now just so we are clear, we have marked as Exhibit 11 in – in these proceedings, a page from the D-S-M-5 that talks about risk and prognostic factors. And I understand that what you are talking about now comes from that page.

A. That is – yeah, that would be one source of that, yes.

Q. Okay. So let's talk a little bit more about it.

A. Uh-huh.

Q. So you said it accounts – genetics accounts for 40 to 60 percent of the variance of risk.

A. Yes.

Q. What is the rate of this condition, that is to say an alcohol use disorder, in families where relatives make use of alcohol?

A. Sorry, can you repeat the question for me?

Q. Yes.

A. Thank you.

Q. If we have a family such as Mr. McCabe's, and – and I – previously I – I illustrated it, and I will point you to this – this easel here.

A. Yes.

Q. We have Mr. McCabe in the middle.

A. Uh-huh.

Q. We have the information about the alcohol use of his father above. We have the information about his – the alcohol use of his uncles, his paternal uncles, branching out from the father. We have the information about the alcohol use of Tom and Jim, his brothers, we even had the information about the alcohol use of his son, Nick. How does

this help us understand, um, the influence of genetics in the use of alcohol by Mr. McCabe?

A. It – it, uh, strongly indicates that there is a genetic component in Mr. McCabe's historical alcohol abuse problem.

Q. Okay. And – and looking at this illustration, so to speak, can you tell us whether the D-S-M provides information about the rate of the condition in these sorts of circumstances.

A. Yes, it does.

Q. And what is the information in the D-S-M on that?

A. Essentially, and it is included in my report as well, but the rate of alcohol use disorder is three times higher in close relatives of individuals with alcohol use disorder. So the value is highest for individuals with a greater number of affected relatives.

Q. Okay. So just so I understand that, you said higher in close relatives. So if we are looking at this chart, I assume it doesn't get any closer than, say, father and son or continuing on Mr. McCabe is father and Nick is his son.

A. Yes. So first degree relatives would give the highest risk to the individual of developing the disorder.

Q. Okay. And that would apply to Tom and Jim as well?

A. Yes.

Q. Okay. Whereas the paternal uncles, who I have illustrated here, would be say one generation removed, so to speak?

A. Yes.

Q. Okay. And you also talked about, uh, values

highest for individuals with a greater number of affected relatives. So here, in this chart, we appear to have one, two, three, four, five, six relatives surrounding Mr. McCabe.

A. Yes.

Q. And so does that mean if there is a fewer number then the genetic risk is lower?

A. Yes.

Q. Okay. Does sexual abuse contribute to the risk of alcohol use?

A. Yes.

Q. Can you tell us a little bit more about that.

A. Studies have shown that individuals with a history of childhood sexual abuse have higher rates of alcohol use disorder.

Q. And so how do we reconcile the genetic influence that you have talked about and the studies which show that sexual abuse can lead to a higher use of alcohol? In Mr. McCabe's situation.

A. Well, you have to evaluate the factors specific to the individual you are assessing. There is relative risk of alcohol use disorder due to childhood sexual abuse but you would want to look at all the factors in the case in front of you. And in Mr. McCabe's case there are – the factors including his strong genetic component, his father modelling the drinking and drinking in front of him. There is, in Mr. McCabe's case, a strong peer influence, he also has social anxiety which he has self-medicated, so to speak, with alcohol. And in Mr. McCabe's case, unlike other people, he – he found that the use of alcohol made him feel good. It was self-reinforcing. So those are factors also that, you know, one would look at besides childhood sexual abuse to account

for the onset and continuation of his disorder.

Q. Okay. Now yesterday when you talked about reinforcement, I think you gave us an example, I want to get it right, in the Asian community they do not have the enzyme to digest alcohol?

A. Yeah. That would be one example. So if they don't have an alcohol dehydrogenase they can get a bad reaction to it. Essentially an adverse reaction which prevents them from wanting to drink again.

Q. Okay. So how do we understand that in the – in the situation of Mr. McCabe? What's the significance of that?

A. Well, the significance of that is Mr. McCabe's genetic component is such that he didn't experience that reaction. He experienced a reaction where he felt better upon using. So it's a positive reinforcer, um, and it encourages subsequent use.

Q. But does that tell us about whether Mr. McCabe has that enzyme that you talk about?

A. In all likelihood he does, yes.

Q. Okay. Now are there other things that we can look at in order to understand whether it's the genetic influence or the C-S-A? So, this abuse occurred in the summer of 1963 between grade four and five, um, and you looked at his grades. Is that something that we can consider in this context?

A. Well, yes, you would want to look at, uh, the impact of the childhood sexual abuse and what happens after that. And from the review of the file, his grades did not deteriorate after the childhood sexual abuse.

Q. Uh-huh. You told us earlier in your evidence that you asked him the extent to which he thought

about the abuse up until around 2013. Is that something that helps us, inform us in understanding what we are talking about now?

A. Yes. He indicated he didn't really think about it that much. He really started thinking about it more in 2013. And he also advised me he didn't – not only did he not think about it, he didn't have those intrusive symptoms that you may see in P-T-S-D like the – the nightmares and flashbacks.

Q. Okay.

A. Avoidance of anything that reminds him of the abuse. He didn't have any of that throughout his life.

Q. You also told us that there was no evidence of any sexual problems. Does that assist us in understanding this debate between genetics and C-S-A?

A. Yes. So if someone has a post-traumatic reaction to – to sexual abuse, they may have difficulties, same as post-traumatic reaction, they may have difficulties sexually. It would be expected that, um, that sex would bring up bad memories and anxiety and perhaps lack of performance because it's such a strong reminder of what happened. In Mr. McCabe's case we don't see that – any evidence of that. He had no sexual difficulties.

Q. So in your expert opinion, what was the cause of the alcohol use disorder in Mr. McCabe?

A. Well, I – I think the – the strongest component, um, would be the genetic component for him and then the other factors that we just discussed. I think he, uh, the sexual abuse was a – a – a stressor for him, it may have provided some contribution to risk. But again, it's – it's risk, it's not an absolute.

Q. Okay. Just so I understand that. What we

are looking at here are the different risks in terms of whether it's genetics and the other factors, or whether it's the – the – the C-S-A that led to the alcohol use disorder.

A. Yes.

Q. Okay. Now one of the things you had mentioned when we reviewed the various diagnoses was the question of personality style.

A. Yes.

Q. And what can you tell us further in relation to that about Mr. McCabe?

A. So Mr. McCabe has a number of personality traits which may have impacted on his life over the years. He described himself as being somewhat quiet, certainly compared to the rest of his family. And that may have led to difficulties with self-esteem and that drive to – to become social in his – in his school years. Which, again, may have also contributed to alcohol use but led to him, um, achieving on the student council and so on.

Q. Okay. Now you also mentioned a possible learning disorder.

A. Yes. So in terms of, you know, again looking at why someone may have failed grade four. There may be academic difficulties and the other reason would be behavioural difficulties. Testing has shown that Mr. McCabe is of average intelligence so there is no academic reason that would account for his grade failure so the most likely reason would be behavioural problems at that time. Having said that, it would be helpful to look if there – at, you know, a possible learning disorder. A learning disorder is where someone has a specific difficulty in a subject despite average intelligence. And if that learning problem, say, is reading it can impact on someone's grades. But in Mr. McCabe's case

that is a consideration but I am not – I don't have any evidence in that regard.

Q. Thank you. I think you mentioned adjustment disorder yesterday.

A. Yes.

Q. And tell us how that fits here.

A. An adjustment disorder refers to when a – a stressor causes a change in the person. So it – they can develop, um, symptoms typically anxiety, depression, or it can cause – what's caused – I mean what is described as disturbance in conduct. So their behaviour changes based on the stressor.

Q. And are there examples in Mr. McCabe's life that led to an adjustment disorder?

A. Yes, so common stressors in an adjustment disorder would be, um, the end of a relationship, um, moves can cause adjustment disorders, a job loss can cause adjustment disorders. We see those types of issues in Mr. McCabe's case throughout his life.

Q. Okay. And so in your opinion, when the relationship ended with Nancy, did that lead to the symptoms of an adjustment disorder?

A. Well I think it led to – yes, a – a low, uh, mood and – and change in his behaviour. I think it led to more drinking at that time.

Q. And can you comment on whether Mr. McCabe experienced the symptoms of an adjustment disorder after he was terminated by M-P-W in the summer of 2010.

A. In all likelihood I think he did experience some adjustment issues. It was certainly a big stressor for him. I don't think I canvassed with him specifically exactly whether he met criteria for adjustment disorder, but that

certainly appears to be the case given, uh, his history of low mood following a – following stressors.

Q. And I'm sorry, you said that, um, in each case that led to an increase in alcohol use?

A. It – it – it seemed to correlate with increased use of alcohol, yes.

Q. Okay. Now let's talk a bit about P-T-S-D. What are your conclusions with respect to that diagnosis?

A. Well, first of all P-T-S-D is a, uh, it is a controversial diagnosis overall. I think Mr. McCabe had P-T-S-D symptoms in 2013 probably up until 2015 or so, given that he reported anxiety about talking about the abuse, I – I believe some nightmares. It was pretty bothersome to him at that time. So these would be symptoms of P-T-S-D at that time.

Q. Okay. And what was the cause of the symptoms of P-T-S-D in that period of time?

A. The cause of, uh, would be re-evaluating his life. So Mr. McCabe, in 2013, he has been sober now for about two or three years and as part of the tenets of A-A, he is looking back at his life and making amends and so on. He is meditating, he is in a state of reflection. He is getting older in his life as well, looking back at, I think, his life and how he ended up in this place with, uh, with some regrets. It's in that context that he does pursue a – a lawsuit and does get into therapy with Ms. Schramm and he starts talking about the abuse. And he starts thinking about the abuse and he is in a – in therapy with a – a counsellor who is framing his past difficulties, which are non-specific, the – the – the counsellor is framing that as a result of – of childhood sexual abuse. So in that context he starts thinking about it more and it's quite bothersome to him.

Q. Okay. So can you comment on whether there is some connection between the – the C-S-A, that he is thinking about starting in 2013, and the P-T-S-D.

A. Yes, um, and I think that's when the C-S-A had a large – the largest affect on him is at that time when he starts thinking about it constantly and he has the stress of – of the lawsuit as well, related to that. So I think that's when it was the most bothersome to him, following the abuse.

Q. Okay. Now I would like to take you to another area and talk with you about the effects of – of sexual abuse in general. Can you – can you assist us with that?

A. Yes.

Q. First, are there – are there specific risk factors or things that arise from P-T-S-D?

A. Risk – sorry, risk factors for P-T-S-D?

Q. Right. I'm sorry, C-S-A.

A. So childhood sexual abuse can cause a number of different adverse outcomes. So it's a – it's a general risk factor for later psychopathology, later psychiatric problems including depression, anxiety, substance abuse and, um, difficulties with trust, self-esteem issues, and – and so on. So in general it can cause a number of different issues.

Q. So let me try it in reverse. If someone has those issues or symptoms or problems, does that necessarily mean they experienced C-S-A?

A. No. So that would – that would be the outcome and individuals can get to that outcome by way of various pathways depending on their own individual background, genetic background and their experiences in life.

Q. Now, do all people who have experienced C-S-

A suffer long-term effects from it?

A. No.

Q. Are some people capable of recovering?

A. Yes, and – and when I – when I say long-term effects I would say, you know, we are talking about adverse effects. Anyone who has been sexually abused that becomes, you know, part of them, right. Something that, um, obviously they probably don't want to think about and rather not have happened but – so, that's not to say it doesn't affect them. But in terms of having long-term adverse outcomes, it's not an inevitable outcome.

Q. Okay. Could we say that an individual's response to something like that may vary?

A. Yes.

Q. And does it vary depending upon certain factors?

A. It – it can, yes.

Q. Okay. Can we talk about those factors?

A. Yes.

Q. What are they?

A. I think the – the two strongest factors would be the severity of the abuse. So for example, abuse involving intercourse, force, physical harm, um, physical coercion, that would be, um, one factor. So on a continuum from, um, being exposed to someone – so let's say of an exhibitionist exposing themselves to someone, that would be on the – that'd be the far end and then on the more severe end would be forced, you know, anal penetration...

Q. Okay, and...

A. ...for example.

Q. ...and so in the circumstances of the abuse here, as we know them, do they lie somewhere in between that?

A. Yes.

Q. Okay. Now was there, um, sorry, does – does the period of time over which the abuse occurred play a role?

A. So I think there is two parts to that question. So there is the age of the abuse and how long the abuse goes on for.

Q. Okay. Sorry, what was the first thing?

A. The – well, the age of the – of the victim when....

Q. And what is the significance of that?

A. Studies, you know, studies – studies are – are mixed, um, some would say the earlier the abuse the – the worse the person is. Other studies talk about the abuse isn't – is more damaging say from the age of 13 to 16, when the person is in adolescence and knows exactly what is happening to them. And then it becomes more bothersome.

Q. Okay. And so let's take that study for a moment. If the – if the person is younger than the age of 13, then how does that study approach the implication of age or the factor of age?

A. Well, it – depending on the nature of the abuse, um, if the abuse isn't fully understood as abuse, if it's more confusing and – and bothersome than, you know, like say forced anal rape or something severe of that nature, the abuse is more of the, um, the milder side. It may not be fully understood and it may not be fully synthesized as a trauma. And it may not come back to cause damage until the person understands it, um, looking back at their life as, "Oh my – oh my goodness, that's – that's what happened at that time."

Q. So on that point, Ms. Schramm's note that he wasn't sure if it was right or wrong, does that assist us in

understanding – in helping us understand Mr. McCabe's perception of it at the time?

A. It – it – it does, that's – that's one piece. And then the lack – again, the lack of any sexual problems and not thinking about it for a number of years, um, Ms. Schramm's comments and so on, the fact that he was quite young and sexually naive, um, found it confusing and so on. All of those goes – go into that analysis, yes.

Q. Okay. Now does the frequency of the abuse play a role?

A. That – that would be the other – I think the other main factor in terms of the abuse. Abuse that occurs over a long period of time can have more lasting effects than say what's described as a bolus, like a one-time type of abuse.

Q. Sorry, you said a bolus?

A. Like a – yeah, they call it bolus trauma...

Q. Yes.

A. ...for example. So the classic P-T-S-D is you get a severe trauma, and then you get a P-T-S-D picture but when the abuse takes place over and over again, um, it can have more wide-ranging effects.

Q. Okay. Now you said, uh, you mentioned something about coercion, was there any coercion here that you are aware of?

A. Well, there was no – there was no physical coercion, there was certain, I think, an emotional component to what happened to Mr. McCabe. You know, being alone in a – in a motel room away from supports and – and, yeah, I think there was some emotional coercion there, yes.

Q. Okay.

A. I think it was, you know, especially

confusing for him given that it was a, you know, a priest doing this to him as well.

Q. If there is a – a use of force, does that play a role in the factors you are considering?

A. If – if there is, uh, force I think there is more of a chance for the person to view it as – as traumatic at the time it occurs. And it's – it's more bothersome at that time.

Q. Was there any evidence of force in this case?

A. There was – there was no holding down or hitting or anything of that nature.

Q. Okay. Now after the abuse has concluded, it – it takes place and – and in this case we heard Mr. McCabe remained with Father Robert until he was driven home.

A. Yes.

Q. Can you assist us with, um, whether support is a factor to be considered at that stage?

A. Yes, so I think, um, if – if someone has something bad happen to them and they have a lot of support around them, that can be a protective factor, yes.

Q. Now we heard that, um, Mr. McCabe did not receive support directly because he did not disclose the – the abuse.

A. Yes.

Q. Let's talk a little bit more about that. We heard evidence that he – he walked up to the driveway, and I think it was from Ms. Schramm, that he walked to the house which was considered a place of safety.

A. Yes.

Q. Does that assist us in this area of the question of support?

A. Yes. So in Mr. McCabe's case the, uh, the most, um, kind of severe – severe abuse, the Montreal abuse if we're call it – or the Cornwall abuse I guess we'll call it, um, was a one time event. And it took place outside of the home so he had a place to escape to, the safety of his own home. As opposed to say, if he was abused by his – sexually abused by his father where there would be – have no escape so to speak. He was also, um, favourable that, uh, that priest moved thereafter. And so that abuse didn't take place again.

Q. Okay. We have also heard that generally speaking Mr. McCabe's family was supportive. And so – not supportive in the sense that they knew there was abuse and they immediately provided assistance in that regard. But it was a supportive family. Does that help us to understand this factor we're talking about?

A. It – so – so I think there – there was support for Mr. McCabe from his family. I think there was dysfunctional components to his family, for example his father's drinking. Financial limitations and stressors there. But, yeah, the – the family wasn't, um, severely physically abusing him, the family wasn't sexually abusing him but there was some dysfunctional – certainly some dysfunctional components to his family.

Q. Now this abuse took place at the hands of a priest. What is the significance of that?

A. The – well, it's a trust, uh, it's a trusted individual so I think it can lead to a lack of trust going on – or going, you know, further on. It's also a component that makes the abuse confusing to the individual. And I think it, yes, it may make it more difficult for the person to understand what's going on, how is this happening. And – and he spoke about that, I think. At the church the next day,

trying to make sense of it all and being disgusted by how a priest could – how could a priest do that.

Q. Okay. Now we have heard evidence from Mr. McCabe that before he went on the trip he felt somewhat uncomfortable about Father Robert. Does that assist us in – in understanding this area of trust?

A. Well, I would have to hear more about that but I think he – he was uncomfortable given all the – the long embraces that he experienced.

Q. And how does that assist us in understanding the level of trust he had in Father Robert?

A. Well again, I think it made him uncomfortable. It made – it may have made him question things but it was confusing for him at the time.

Q. Okay. We learned that his father did not attend church, his mother took Mr. McCabe and his siblings to church but his father did not go. Does that assist us in – in understanding this issue of trust at all?

A. Well, I think the one aspect of that is that it decreases the importance of – of church in that family. Mr. McCabe saw that his father didn't attend, um, so it decreases the – the importance – the relative importance to him in that family and therefore lessens, I think, that impact.

Q. Okay. Now when we take into account all of these factors that we have talked about, in your expert opinion how do you assess the nature of the abuse?

A. Well, overall this is a, um, it's – it's - the most severe abuse for Mr. McCabe happened one time. It was kind of a bolus trauma, the – the lower level of abuse so to speak, it took place on a more extended basis with the extended hugs. The abuse wasn't, you know, severe in the

extent of there is no physical damage, there is no anal penetration, again it only took place in a – on a one time basis. So in terms of looking at the overall abuse, in – in those types of terms, it would kind of be in the middle as – as you said earlier.

Q. What I'd like to do, sir, is – is go to some testing was – that was done at your request in the course of the assessment of Mr. McCabe. And to assist it is at page 45 of your report. Now I understand that from time to time what you do is to arrange psychological testing in the course of these sorts of assessments.

A. Yes.

Q. Do you do the testing or does someone else?

A. I usually administer the testing and so it's a pencil and paper test, uh, the person reads questions and then fills in the answer.

Q. And what test did you administer?

A. The M-M-P-I...

Q. What is...

A. ...two.

Q. ...that?

A. It's – it's a test somewhat similar to the P-A-I, um....

Q. Okay. Let's get the full name, is it called the Minnesota Multiphasic inventory?

A. Yes, personality inventory, yes.

Q. Okay. And what – what does it do?

A. It, um, it helps, uh, first of all it looks at, um, whether the person may be trying to present themselves in an overly favourable light. Or it may look at the person trying to exaggerate problems, psychopathology or – or disability. So there is validity scales involved in that.

And then it looks at personality functioning and if there is any psychopathology.

Q. Okay. And what is psychopathology?

A. So problems with depression, anxiety...

Q. Okay. So, let's talk first...

A. ...and psychosis.

Q. ...about these validity scales or indicators. What did they reveal?

A. So all the validity scales for Mr. McCabe were well within normal limits.

Q. And what does that tell us?

A. He approached the testing in an honest fashion.

Q. And what about the measures of personality and psychopathology that you talked about?

A. So I – I had – yeah, I had the testing, um, scored by an interpreted by Doctor Wright, a psychologist, and he indicated that the clinical profile that Mr. McCabe filled out was well within normal limits as well.

Q. Okay. So let me just stop you there for a moment. You had it scored or interpreted by a Mr. Wright so...

A. Yes.

Q. ...Mister...

A. Doctor Wright.

Q. ...McCabe – Doctor Wright. Mr. McCabe fills out the – I guess it was answers to questions?

A. Yes. On the – on the M-M-P-I-2 I believe it's, yeah, 3 to 400 questions.

Q. And as I understand it he is just filling in circles to endorse the particular answer?

A. Yes.

Q. Okay. That then goes to Doctor Wright, and what does he do with it?

A. Doctor Wright looks at it, I believe I gave him Doctor Jaffe's report as context, um, and then he scored the items.

Q. What does that mean to score the items?

A. There is a computer readout, the computer can give you a – a computer readout of the interpretation and then he will look at it individually and do his own assessment...

Q. So...

A. ...of....

Q. ...the – the pieces of paper with the marks on it, then do they go into a computer?

A. So they go into a computer and the computer can score it and give different sub-scales. So one sub-scale how much above the kind of norm would it be, or below, and there are various sub-scales and the validity items. The computer needs to do that, there is 3 to 400 questions. And then Doctor Wright can say what does this mean for this person.

Q. Okay. So what were the results arising from that scoring?

A. So Doctor Wright indicated that the clinic profile was well within normal limits.

Q. What does that mean?

A. It means there is not much psychopathology there.

Q. What are examples of the type of psychopathology that could arise in the circumstances of, say, Mr. McCabe?

A. Well, it would be items that he present what

he did endorse in terms of critical items, you'd have to ask Doctor Wright exactly, you know, to explain that in more detail. He is the psychologist. But for example, historical alcohol abuse, anxiety, sadness, sleep difficulties.

Q. And this test was administrated in the spring of 2016. So does it tell us about Mr. McCabe in the spring of 2016?

A. I – I think it's consistent with Mr. McCabe to be fairly well at that time. He is no longer drinking, he has friendships, he is reconciling with family members, he is working at the apartment buildings. Overall he is doing okay at that – at that point in time.

Q. Now you said you gave the doctor, uh, Wright, the information about the P-A-I administered by Doctor Jaffe?

A. Yes.

Q. And I think we have heard that's the personality assessment inventory?

A. Yes.

Q. What does that assess?

A. It's a similar test to the M-M-P-I, Doctor Wright has advised that it focuses more on self-concept, interpersonal functioning, and substance abuse.

Q. What did it reveal?

A. And it's revealed, um, that Mr. McCabe actually presented himself in a positive or virtuous light.

Q. And what does that mean?

A. He may have overplayed his positive features.

Q. Any other results from that test?

A. And despite that, he did endorse a number of difficulties that Doctor Wright said were in keeping with his

history and interpersonal adjustment style.

Q. And can you remind us, where does the interpersonal adjustment style come from?

A. So it would be in keeping with the personality factors that would be found in his history.

Q. What do you mean "his history"?

A. So history in – difficulties in relationships and his perhaps work and so on and so forth. I would have to ask Doctor Wright to be more specific but that would – that is my understanding of that....

Q. Okay. And is this the normal way you conduct the assessments, you have, um, you – you would administer the test and you give it to Doctor Wright to score?

A. Yes.

Q. Okay.

A. Or – or it would assist me in understanding the results of that psychological test.

Q. Is his background in psychiatry, psychology, or something else?

A. He is a psychologist.

Q. Okay. Now in the P-A-I administered by Doctor Jaffe, does it have items that relate to historical trauma?

A. So, yeah, Doctor Wright indicates that it is important to note that the P-A-I does have a range of items related to historical trauma and, uh, no such statements were generated by the automated report as provided by Doctor Jaffe.

Q. Okay so – let's back up. How does this test have items related to historical trauma? So – so that we understand, you know, what you're talking about.

A. Well it would have items related to previous traumatic events happening to the person. Doctor Wright would

be able to indicate what those items are. But historical trauma items can be a wide range of different things: car accidents, something bad happening, interpersonal assault, natural disasters, those are...

Q. C-S-A?

A. ...typical – C-S-A, yes.

Q. Okay. So, just so I properly understand it. You said with the M-M-P-I he is answering questions and – and marking an answer in a circle.

A. Yes.

Q. Is that the same sort of – sort of thing that is being done on the P-A-I?

A. Yes.

Q. And there would be a section of the P-A-I dealing with historical trauma, trauma in Mr. McCabe's life.

A. Yes.

Q. And if he scores that there was trauma in his life, then the computer interpretation comments on that?

A. Yes. So the computer gives an automated report and then – and of course Doctor Wright can look at the individual sub-scales and – and provide more meaning as it applies to the individual assessment.

Q. And so in the automated report, were there any statements generated about trauma in the past life of Mr. McCabe?

A. No such statements were generated, no.

Q. Okay. And what's the significance of that?

A. Doctor Wright indicated that it suggested subclinical endorsement to such symptoms at the most.

Q. So what, um, in order to tackle what subclinical means, is there such a thing as clinical endorsement?

A. Well, it would be – you know, if it happened maybe it caused some distress but not to the point of leading to major depression or a full-blown anxiety disorder, anything leading to a full diagnosis. That would be my understanding of that. Again Doctor wright would – he is the psychologist, he'd be able to answer that more specifically.

Q. Okay. Fair enough. So let's – let's go back to where we were.

MR. BLOM: And just to assist His Honour, I am going now to page 65 of your report.

Q. Now, as part of your assessment, we asked you to consider certain questions. And in – in doing so I understand you considered the index sexual abuse in further detail. Can you provide us with your overall assessment of it?

A. Yes. And we have already talked about the two aspects of the abuse, the – the long embraces and then the incident in the motel room.

Q. And how did you, you know, in sort of summary terms, what's your interpretation of that?

A. My interpretation of that was that it was a – certainly a stressor for Mr. McCabe but I don't see any evidence that it caused any P-T-S-D reaction after – after it occurred.

Q. Now moving on, sir, I want to take you to the summary portion of your report, page 67.

A. Yes.

Q. How did, in your expert opinion, how did the C-S-A play a role in Mr. McCabe's life?

A. Well, I – I – I think my assessment of that would be it was one adverse event that happened to him, it was one of the many type of adverse childhood experiences he had.

He has also had that genetic loading to the substance use. I think it would contribute to a risk of difficulties later on in his life. It would cause some increase risk to use of alcohol, difficulties with mood and self-image. And those, in turn, could cause some difficulties with relationships and workplace adjustment.

Q. Now, in your practice do you see patients once? That is to say, when you treat patients, um, only for the purpose of assessment or do you follow them for some period of time?

A. So in my – in my practice, I will see them on more than one occasion. And my addiction patients I – I – the best results are the people that stay in the treatment for usually years actually. Those are the best outcomes for those patients so my – my patients have been with me, most of them, for quite some time, yes.

Q. How does that assist in your ability to offer an opinion on the cause of the difficulties in the life of someone such as Mr. McCabe?

A. Well in – in my experience with my addiction patients, I can see that sometimes they do well and then sometimes they are at increased risk for relapse. I can see the impact of various stressors on their life and the risk for relapse and how things are going for them.

Q. So....

A. So – so – so things are not a – a constant, it all depends on how the treatment is working, various stressors in their life, and the course of their disorder.

Q. Thank you. Now with that in mind, can you comment on the extent to which the C-S-A affected Mr. McCabe's educational trajectory, we will call it.

A. Well, in terms of looking at his educational

trajectory, I think the most important thing to keep in mind is that before the – before the childhood sexual abuse ever occurred to Mr. McCabe, he failed grade four. And that's a significant thing, that's different from any of his siblings. He failed grade four despite apparently having average intelligence. So there is something going on with Mr. McCabe that led to that grade failure. We also know that he was more focused on being out of class and doing things as opposed to academics. That wasn't his focus. And I think within the school, given his insecurities, probably for a number of different reasons, including feeling that he doesn't – doesn't measure up, so to speak, in his family and I guess and to the siblings, there is a drive to be popular and for the – the school council, again as opposed to academics. So I – I would say those are major contributors, um, to his school adjustment.

Q. And we touched on evidence about the availability of, you know, if we look at the high school for example. We touched on evidence about the availability of money to go to school. Is that something to be considered in this area?

A. Well, if we're looking at university, there is the financial aspect and he was working and giving money back to the family.

Q. Okay.

A. He was also working during his school years because of the financial problems the family was having which may have impacted on his ability to focus on his studies in some way. It may have been a contributor in some way. And now the sexual abuse, you would certainly want to consider that, I think it was a stressor, I think is, uh, contributed in some ways to difficulties focusing on his studies for a

period of time. But in looking at his grades, there is no major change following the childhood sexual abuse.

Q. Now can you comment on whether the abuse affected his occupational trajectory, and that's to say his – his work.

A. It – well again, it may have led to some difficulty with supervisors, emotional resilience, maybe too reactive at times. But overall when looking at Mr. McCabe's history, he has done I would say fairly well in – in – in his work over the years. He has had brief periods where his income has fallen off but he has gotten another job and that income has continued to go up.

Q. And one of the things you told us about yesterday was a comparison of his employment history with that of his siblings. Is that something to be considered on this point?

A. Yes, um, in terms of looking at someone's education potential, occupational potential. Siblings are like a natural control group and educationally Mr. McCabe has done as well as his siblings. He has done as well as his siblings despite failing grade four before the abuse, and despite the fact that his siblings didn't fail. So I think that's one factor to consider. And then occupationally it seems like his level of achievement has been similar to his siblings.

Q. Okay. So let's move to interpersonal and social trajectory or history. Can you comment on the extent to which the abuse affected that area of his life?

A. Well the – the one thing we know is, in terms of intimate relationships, he did not have any sexual problems related to the – to the sexual abuse. So to me that is one – one factor that suggests that the sexual abuse wasn't

a major contributor to his difficulties. Sexual difficulties came up after there was a loss of trust from Mr. McCabe's partners due to financial problems and hiding financial difficulties. Mr. McCabe has shown himself capable of establishing intimate relationships with others. He has, over the years, had a fear of rejection and that's, I – I think, led to some use of alcohol. Despite all of that, again, he has been able to form relationships and maintain long-term relationships. Now could the abuse have contributed in some way? I – I think it could have contributed on a day to day basis to some of – some of his difficulties in relationships. But there is certainly other factors there that I think are stronger contributors.

Q. And so, doctor, can you give us your comments on the overall impact of the C-S-A in Mr. McCabe's life.

A. So overall, looking at the entirely of Mr. McCabe's life, I think it's had a minor impact for the reasons we have discussed. I think the most, um, or the biggest impact, the largest impact for Mr. McCabe would have been from 2013 probably to 2015 when it was on his mind continually and – and quite bothersome for him.

Q. I wanted to touch on this area. You have prepared a report, as we have heard?

A. Yes.

Q. And how long – so your report included the review of the interview, I gather?

A. It included my interview, yes.

Q. Right. Your review of the documents you received?

A. Yes.

Q. Your analysis?

A. Yes.

Q. And your conclusions?

A. Yes. And – and looking at Doctor Wright's report and just having conversations with Doctor Wright...

Q. Okay.

A. ...about the results and then....

Q. What – what's the length of your report?

A. About 70 pages.

Q. You had an opportunity to review the report of Doctor Jaffe?

A. Yes.

Q. What's the length of his report?

A. I think it was about 15 to – 14 or 15 pages.

Q. Okay. The last area I wanted to ask you about, doctor, was the need for treatment. Do you see the need for treatment for Mr. McCabe?

A. Well, there is the time, of course, we are talking about it so currently Mr. McCabe seems to be doing fairly well. At least when I saw him. His M-M-P-I results were within normal limits. He does have some longstanding interpersonal issues, he has some, I think, longstanding anxiety issues and he certainly has risk of alcoholism. So although he hasn't been drinking now for maybe seven or six or seven years, that's, I think, something that he should continue to monitor and address and doing so in Alcoholics Anonymous.

Q. Do you see the need for any treatment beyond that?

A. So to the extent that these proceedings are stressful for him, I think some supportive psychotherapy and monitoring of his mood to see if he needs any further treatment, would be helpful.

Q. And would that be akin to what he is receiving from Ms. Schramm?

A. Well – well Ms. Schramm is, I think, providing counselling but the nature of the counselling appears to be to – to review the abuse in the meaning of his life which may cause, in the short-term anyway, some distress for him.

Q. And so what sort of treatment do you have in mind in talking – in dealing with the extent to which the proceedings may be increasing the distress?

A. One thing that may be helpful for Mr. McCabe is treatment to increase his coping mechanisms to deal with stress, to deal with his emotional resilience, and in turn to decrease his risk of alcohol use.

Q. Thank you, sir. Those are my questions.

CROSS-EXAMINATION BY MR. P. LEDROIT:

Q. Do you – do you suggest that if you write a longer report your opinion is better?

A. I didn't – I didn't say that.

Q. Well, you brought it up.

A. I didn't bring it up either, no.

Q. I'm sorry?

A. I – I was asked a question about that.

Q. Well you and your lawyer must have talked about it. You must have pointed out to him, "Well, Jaffe's report is only whatever number of pages. My report must be much better, it's three or four times as long."

A. I....

Q. Did – did you talk to Mr. Blom about that?

A. I – I didn't point that out to him.

Q. Did you talk to Mr. Blom about that?

A. Before we came in he, um, asked me about the length of my report and then did I know the length of Doctor Jaffe's report.

Q. That was the extent of it?

A. Pretty much, yes.

Q. Well, what do you mean "pretty much"?

A. Well that – that was the extent of it, yes.

Q. You didn't talk about anything else, "My report is more significant." Or there was no implication of that?

A. It was very, uh, it was a very brief conversation about that but my – my opinion of – of length and quality of the report would depend on the actual report. So I have colleagues who, in my opinion, do a very concise report and they can do a very concise and good report in...

Q. All right.

A. ...you know, 10, 20, 30 pages.

Q. Is that because perhaps they are more focused?

A. No, um...

Q. Yeah.

A. ...so we just did a – a report writing exercise for the Fellows in forensic psychiatry. And it was interesting, we all assessed three related – two related victims and the perpetrator and interestingly enough all of our reports came out to 69 pages. If – if you don't want to review the entire file again before testifying, it's good to have a thorough report and to be thorough in terms of the factors you are considering. So one of the criticisms I would have for Doctor Jaffe's report would relate to the length of his report and we wanted some psychological testing.

Q. Oh, so now you change your answer. You are

saying the length of the report does matter to be – because before you told me it didn't.

A. Well, it depends. Sometimes it....

Q. No, no. No. Just stay...

MR. BLOM: Your Honour, the question....

MR. LEDROIT: Q. ...with the question.

MR. BLOM: No. Your Honour, the witness is entitled to answer the question. My friend is doing what he did yesterday which is not fair.

THE COURT: You are going to have to wait for the answer, Mr. Ledroit. Or focus your questions.

MR. LEDROIT: Okay. Because the witness is sometimes unresponsive to the questions, do you mind if I sit down while he....

THE COURT: No, frankly now that you have raised it, I find that rude. I – I...

MR. LEDROIT: Thank you.

THE COURT: ...I wouldn't...

MR. LEDROIT: All right.

THE COURT: ...have raised it but given...

MR. LEDROIT: Okay.

THE COURT: ...that you ask, I will...

MR. LEDROIT: All right.

THE COURT: ...answer your question.

MR. LEDROIT: Thank you.

Q. You are changing your answer.

A. Well it all depends on the quality of the report and how the report is written.

Q. Do you say that the report of Doctor Jaffe's is lacking in quality?

A. You know what, I haven't looked at Doctor

Jaffe's report for some time in terms of reading it detail to detail. But any report that relies on a computerized readout of psychological testing, as one example, I wouldn't hold as much weight to that report as to someone who has thoroughly looked at all of the various factors and – and synthesized those factors.

Q. Are you saying Doctor Jaffe's report is based upon a computer's analysis?

A. I would have to look at Doctor Jaffe's report.

Q. Are you suggesting that in your evidence right now?

A. I am suggesting that I have seen that in other reports of that nature, yes, but I....

Q. We're not – we're not talking about other reports.

A. Well, if I can see Doctor Jaffe's report I could provide an accurate answer.

Q. You have had it for more than a year.

A. Like I said I haven't reviewed it...

Q. Are you...

A. ...recently.

Q. ...suggesting that Doctor Jaffe's report is based upon a computer analysis?

A. I would have to look at Doctor Jaffe's report.

Q. You're the one that raised it, sir.

A. And what I said was I have seen those types of reports before, that are...

Q. Are you...

A. ...based...

Q. ...suggesting....

A. ...on that.

Q. Are you suggesting Doctor Jaffe's report is such a report?

A. I'd like to take a look at that before I...

Q. You have...

A. ...answer your question.

Q. ...had a year to look at it. Are you suggesting that in your evidence now?

A. It's – I would have to look at it to answer the question.

Q. So without looking at it are you casting aspersions on it?

A. I wouldn't say that, I would – I would say my experience is that that would be a criticism of reports that are short and that overly rely on – on the readouts of psychological testing.

Q. So if I can summarize the last five minutes. I asked you if you discussed it with your lawyer, or with Mr. Blom, and you said we only discussed the fact that it was like - nothing else and you're a little bit – at least the answer was a definite maybe you were – I forget the words you used, but you discussed the length of it and I seemed to get the impression that was all you discussed. And I asked you why you brought it up and you said that was because Mr. Blom brought it up, not you.

A. That's correct.

Q. Okay.

A. He asked me if I knew the length of the report, I said I didn't...

Q. I'm....

A. ...and so I didn't read the – you know, all 15 pages of the report....

Q. I don't want to spend anymore time on it. Let me just say this, if you start out with a conclusion, would it be correct in saying that it takes more time and more pages in a report to justify your conclusion?

A. No.

Q. All right.

A. You – you – you wouldn't – first of all you don't – you don't want to start out with a conclusion. You want to look at all the evidence and then form your opinion.

Q. I mean, one of the things Doctor Jaffe did not look at was stealing milk bottles at the age of seven. And you thought that was important.

A. It – it adds information to the assessment, yes.

Q. And you put that in your report.

A. Yes.

Q. Because you thought it was important.

A. It – it adds to my assessment of the individual, yes.

Q. Well it justifies that he had some other – or reasons in his life for the causes the – or the way his life turned out. Stealing milk bottles is one of your justification for the way Mr. McCabe's life turned out.

A. Yes.

Q. Okay.

A. Definitely.

Q. All right. All right. And the fact that his mother smoked, that led to his alcoholism. I mean, mister – or Doctor Jaffe doesn't speak about that but you do.

MR. BLOM: Well, now, I have to stand. If he is going to put evidence to the witness it – it – it should not be mischaracterized. The witness

did not say "smoking led to alcoholism". The witness said smoking is an addiction and can influence other addictions.

MR. LEDROIT: Q. It's in your report.

A. Yes.

Q. And you must have thought it important if you put it in your report.

A. Yes. There is, um, maternal smoking is correlated with conduct disorder and smoking – maternal smoking is another factor that leads to genetic loading for addiction in Mr. McCabe.

Q. Okay. Genetic loading, in other words, it's part of his genes...

A. It's – it's – well it's...

Q. ...that his...

A. ...part of his genes and....

Q. ...that his mother smokes....

THE COURT: Okay. Wait until he answers, asks the question. I am not going to let him interrupt you, I have got to fair both ways.

A. Thank you.

THE COURT: Go ahead.

MR. LEDROIT: Q. The fact that his mother smoked increased his risk for alcoholism. Is that what you are saying?

A. Yes.

Q. All right. Did you – did you ever watch the T-V series *Madmen*?

A. Yes.

Q. Back in the 50s and 60s everybody smoked, in every room of the house, in offices, on trains, in planes, in buses. Everybody smoked then, right?

A. Agreed. Well, I wouldn't say everyone smoked but it was certainly more socially permissible at that time.

Q. Well, it was very common for everybody to smoke.

A. It was certainly much more prevalent than it is today, yes.

Q. What's the answer to my question?

A. It was more common at...

Q. Yes.

A. ...that time, yes.

Q. Thank you. And are you saying that all of those people like my parents and perhaps yours, made us more susceptible to alcoholism because they smoke?

A. Yes.

Q. All right.

A. Yes the – and that's a factor so....

Q. And it also increased the risk – what, you mentioned personality disorder that I might steal milk bottles?

A. It's – again, it's not a one to one correlation, so just because you have that it doesn't mean that's going to happen. It's not inevitable but it's one of many risk factors for development conduct disorder. And, you know, the mechanism probably isn't that – it's not clear, it can be a number of different reasons. It can be a shared genetic component between antisocial personality disorder and conduct disorder. It could be when Mr. McCabe's mother was pregnant with him there was nicotine on board to the developing fetus. And then there is the shared, you know, component. One addiction can lead to increased risk of another addiction.

Q. And what I am – what I am suggesting is because you wrote upwards of 40 reports for the Church all supporting the same conclusion. You were looking for other factors in those reports as you are looking for other factors in this report, to justify your opinion.

A. Well, I look at all the factors and then I form my opinion as – of that...

Q. Yeah.

A. ...individual's life.

Q. I'm going to suggest you start out with an opinion and you go about looking for factors as to whether or not mother smoked or whether or not he stole milk bottles at the age of seven to try to justify your opinion.

A. No, um, I write the conclusions at the end. So I look at all the factors, I do that quite thoroughly, and then I try and put them all together to formulate my understanding of that patient.

Q. Would – would you find it unusual that in each and every case you come to the same opinion?

A. Every individual is different and I – I – I am not responsible for the cases referred to me and the type of abuse referred to me. But every case is a different story and a different set of factors contributing to someone's life.

Q. One of the other factors that you might look for, because you – you want to find some justification for your opinion is, for example, how – the fact that Mr. McCabe was a shrimp. I think he's what, five six or – well, I forget the number. But he wasn't tall.

A. Five foot four.

Q. And that – did that lead to his alcoholism?

A. Again I wouldn't say it's a one to one correlation but as Mr. McCabe put it, he was insecure. He was

insecure about that and – and felt socially awkward about that. So it was one contributor to his social anxiety, I would say one contributor to his fear of rejection from the opposite sex, and that may have led to increased use of alcohol to try and fit in and to deal with that anxiety.

Q. You mentioned, as well in your report, that he was shy around girls when he got to high school. And you found that sufficient or important enough to put in your report and mentioned in your testimony.

A. Yes.

Q. You find – you find that – that leads to alcoholism?

A. I have had many patients where social anxiety contributes to abuse of alcohol, yes.

Q. Well, when you were in high school were you not shy around girls?

A. I am not here to talk about my own personal life, but many people are shy around the opposite sex, yes.

Q. That they don't become alcoholics.

A. That's right.

Q. I'm going to suggest to you that it's universal. Have you ever – have you – do you know anyone? I don't. Do you know anyone in your life who wasn't shy around girls in high school?

A. Yeah, there is some people who aren't, yes. But I – I agree, it's common, yes.

Q. It would be very uncommon for you not to be shy.

A. Well, you know we are talking about that in a vacuum and he has mentioned specifically – Mr. McCabe has mentioned specifically fear of rejection, not – not approaching his first wife, she approached him.

Q. All right. I – I want to just see if I can understand some of the things you have said. I am going to go back to what I was on – but some of the things you have said about alcoholism. Do you claim to know the cause of alcoholism?

A. I would say no one knows the cause of alcoholism.

Q. Exactly...

A. And – and there...

Q. ...because your lawyer has....

A. ...is – and there is no one cause of alcoholism.

Q. No one knows the cause of alcoholism. Right?

A. That's right.

Q. And because Mr. Blom was saying, what was the cause of Mr. McCabe's alcoholism, and if I understood correctly in your response, genetics was mentioned.

A. Yes.

Q. Yeah. But genetics is not the cause.

A. Well, it – no one knows for sure exactly what the cause is. We know that there is an association between genetics and later, um, in a population developing alcohol abuse.

Q. Would you go so far as to say, and I think you can agree with this, that it is a risk?

A. Yes.

Q. Okay. So genetics is not a cause, it's a risk.

A. It's – well, I would say it's – it's – there is – there is no one cause so it's a contributing factor. And it's a risk factor, yes.

Q. There is no one cause. Let me go back to the difference between this wording because it's important to understand, I agree. That no one knows the cause, all we can do is look at a risk factor. Is that fair?

A. Well, when we would speak about etiology we would speak about various factors that contribute to risk so, you would say – etiology being cause, you would think of genetics as one contributor and one etiology towards alcohol use. So I think we are talking about semantics here but it certainly is a – it certainly is a strong risk factor, yes.

Q. Okay. If – if I had put risk – is that....

A. That – that – no that's fine.

Q. Okay. And would I be correct in understanding that the strength of the risk depends upon to what extent alcohol use disorder was a factor in your close relatives.

A. That's – that demonstrates that genetic – genetic component, yes, in...

Q. Now....

A. ...an individual.

Q. You have mentioned something in the D-S-M-5 about this. And you mentioned close relatives?

A. Yes.

Q. Can you – do you have your D-S-M-5?

A. I do in my briefcase, I don't have it up here with me.

Q. Maybe Mr. Blom can give you his copy.

THE COURT: Would the exhibit work?

MR. LEDROIT: No.

A. I have got it, thank you.

Q. Can you just state it slowly because I want to write it down, what you were saying to Mr. Blom about this

fivefold increase.

A. So....

Q. About close relatives whatever it was.

A. So it says, yes, "Alcohol use disorder runs in families."

Q. Yes.

A. "With 40 to 60 percent of the variance of risk explained by genetic influences."

Q. Carry on.

A. "The rate of this condition is three to four times higher in close relatives of individuals with alcohol use disorder."

Q. Okay. That means if you have got close relatives with alcohol use disorder the risk is high.

A. The relative risk would be higher than say, you know, a second cousin has alcohol use.

Q. Yeah.

A. It would be higher if, say, your father or a brother or your son.

Q. So, if I – parents with alcohol use disorder would that be....

A. Yeah, that would be a first degree relative, that would be a close relative, yes.

Q. A parent. I will just put one...

A. Yes.

Q. ...A-U-D. Okay.

A. Yes.

Q. Have I got that right? Or other – other close relatives.

A. Well, yeah, you know, the other close relatives would be, um...

Q. Mom.

A. ...other than parent would be sibling or – or a child of the person. Those would be the closest relatives.

Q. So that would increase the risk?

A. Yes.

Q. And if you didn't have a parent or a sibling with alcohol use disorder, the risk is lower.

A. The risk would be lower, yes.

Q. Okay. So depending upon whether or not they have alcohol use disorder is what we look at in considering the risk, to what extent are they abusing alcohol.

A. Yes, so it also goes on to, say, higher severity of the alcohol related problems in which relatives.

MR. LEDROIT: I want to setup, with Your Honour's approval, is a projector. I don't mind setting it up now but it will just take about 30 seconds or so.

THE COURT: Now that you have broken the line of questioning, I think it is probably a good time for the break.

MR. LEDROIT: Thank you.

THE COURT: 11:35.

11:12 A.M. JURY RETIRES

THE COURT: Just as I came in, doctor, you were sitting in the body of court and through no fault of yours, somebody didn't tell you to be up here. I knew the jury was coming in quickly so I think I was a bit blunt where I simply pointed at you and – all I am explaining to you is, that is why I was a bit blunt about that.

Relax, you hadn't done anything wrong. I was just worried that my reaction might have been a little offensive to you and I was just explaining it.

A. Thank you, Your Honour.

THE COURT: 11:35.

R E C E S S

U P O N R E S U M I N G :

11:36 A.M. JURY ENTERS

MR. LEDROIT: Q. I am just going to put up the alcohol use disorder, that is out of the D-S-M-5 and you are familiar with this, are you not?

A. Yes.

Q. And because you were talking about the parents – or the parent and the sibling of Mr. McCabe, we just want to go through as to whether or not in your opinion that either any close relative of Mr. McCabe had alcohol use disorder. Question – or number one, right at the bottom of the page, do you see that? Are you having trouble reading it from there?

A. No, I can see it, yes.

Q. What does that say?

A. "Alcohol is often taken in larger amounts or over a longer period than was intended."

Q. Now did you come to understand that either Mr. McCabe's parent or siblings were in, um, close proximity to number one?

A. Well, I didn't have the opportunity to speak

to collateral sources about that, so I – I – I don't know the answers specifically for all of the family members, in terms of the criteria.

Q. Well when you say you didn't have the opportunity. Would you have liked to talk to the siblings of Mr. McCabe?

A. Yes.

Q. Did you ask Mr. Blom to do that for you?

A. No, I asked Mr. McCabe for his permission.

Q. Okay. And you asked for a blanket permission to talk to any source, anywhere, about any factors of this case.

A. No. I – I – what I will do is I will talk to the person and say let's, you know, can you sign a consent for this person or this person and we'll give you the contact information to sign.

Q. I see.

A. But...

Q. Well, when you....

A. ...I think the response was a blanket response that that wouldn't be provided.

Q. I see. I am just saying when wasn't provided and you wanted more information, did you ever make that request to Mr. Blom saying, "Look, I need this information"?

A. I don't believe so, no.

Q. You don't believe so. You didn't do it, did you?

A. No, I don't think I did so, no.

Q. You don't think you did. I am suggesting to you you did not.

A. I – I did not make that specific request.

It's in my report that that consent wasn't provided.

Q. You did not make the request of Mr. Blom to get that information for you.

A. That's correct.

Q. Not, "I didn't think so." You didn't.

A. I don't think so, no.

Q. Not, "I don't think so." You did not.

A. I – I can't remember a hundred and....

Q. Okay, let's see your file. Is it in your file? There would be an email or a – a letter from you to Mr. Blom making that request.

A. I am just trying to answer honestly. I am willing to concede that, I don't think it's a big deal. I don't recall asking Mr. Blom for that.

Q. You see, sir, I think it is a big deal. All right. You mentioned in your testimony yesterday you sought that consent and you didn't get it.

A. That's right.

Q. You thought it was a big deal then. Otherwise you wouldn't have mentioned it.

A. Well, it is important to state what source of information you have to base your opinion on. And, as I said yesterday, having that collateral information can help fill in the blanks.

Q. Then why didn't you get it?

A. I wasn't provided with that opportunity.

Q. Sir, you could have said, "Mr. Blom, I want this information. Go get it." Right?

A. That's true.

Q. We have a saying in our rules here, there is no property of the witness. Mr. Blom could have talked to any of the siblings, anybody who knew anybody about this. He

could have done that, I am putting that to you.

A. I – I didn't know that.

Q. All right. But you could have tried a little bit harder.

A. I could have asked Mr. Blom to attempt to get a permission to speak to other people.

Q. Let me ask you this, did you ever ask Mr. McCabe about number one?

A. No.

Q. Even though that information was important.

A. I generally asked about alcohol use in the family. I didn't go over all the criteria in the – in the family.

Q. Well, in being able to understand what the strength of the risk was for Mr. McCabe developing his A-U-D, alcohol use disorder, or alcoholism, you would want to know what that is because you're giving an opinion here.

A. You don't need to diagnose all the family members with alcohol use disorder. The strong family history that we have in here is sufficient in my opinion to say there is genetic loading.

Q. Well, the strong family history is based upon a broad statement, "My father was a heavy drinker."

A. Yeah. And – and Mr. McCabe didn't have a lot of the details so there is no point of even going over every specific question. Time – well, time wouldn't permit and he wouldn't have had the answers anyway, but....

Q. Time – time permitted you to ask about whether or not he stole milk bottles at age five or six.

A. That came out in my – yeah, when I asked about conduct disorder.

Q. How long does it take to say, "Well, to what

extent did alcohol in your father, his use of alcohol..."

A. Yes.

Q. "...to what extent did it interfere with his job, his marriage, his raising of the kids, anything else"?

A. And – and, you know, we canvassed that generally and he didn't have a good understanding or a good sense of that.

Q. Oh, now you are saying you did ask questions like that?

A. No, I wouldn't have asked every specific question given his previous answers.

Q. You didn't ask any specific question. I want to know what you asked. It will be in your notes, let's see it.

A. I – I don't have my notes with me.

Q. Yeah.

A. But I would definitely not have gone through every family member the complete list.

Q. No, I am putting it to you, look, you got the information from Mr. McCabe that my dad was a heavy drinker and you struck gold. That was going to support your opinion that he would have been an alcoholic in any event.

A. Well, it – it is a significant factor in the development of substance use disorder so it would be something that I would consider in my opinion.

Q. What does "heavy drinker" mean to you versus me versus our Registrar versus the judge or any of the jury? A heavy drinker to one person is – that's an opinion, right?

A. Yes.

Q. And opinions to some people are different to others, right?

A. Yes.

Q. What – what – what I may consider to be a heavy drinker may not be the same as a member of the jury, right?

A. Yes.

Q. It's virtually no information.

A. I disagree with that.

Q. But you don't have any particulars of what it means.

A. Well, for example, if someone's father is driving – driving the person home intoxicated, I think that's a pretty good indicator of alcohol use on the more severe side.

Q. How old was Mr. McCabe when he made that observation of his father?

A. I am not sure, I would have to doublecheck that. So he told me that for a period of time from the early 60s....

Q. No, I have asked you how old he was.

A. Of when he made that observation? Oh, it doesn't say.

Q. Fine. Now, when someone gives you an opinion of a person being intoxicated, might it make a difference as to how old they are, whether or not they were 6 or 7 or 12 or 25 or 50?

A. It could.

Q. Right. And we – so we don't know how old Mr. McCabe was when he made that observation that he related to you. Did you ask him how old he was?

A. I don't think I did, no.

Q. Did you ask him how do you – or how did you determine that your father was intoxicated? Was he weaving on the road, was he unsteady on his feet, was he – his speech

slurred? Mine is now. Was – were his eyes red? Whatever. Could he touch his nose, whatever the police do for you when you pick – when they pick you up for drunk driving. Did you make any questions like that? How – how did you make that determination?

A. No, I didn't ask all those specific questions.

Q. Well, you're – you mentioned as a forensic psychiatrist it's your duty not to accept things at face value. But – but when you got something helpful in supporting the Church, you don't investigate it.

A. Investigate it?

Q. Yeah. You don't ask any questions about it. "My father was intoxicated." Okay.

A. Well he – he indicated that it was - made him nervous to be driven home by his father. He turned to alcohol to cope and that his....

Q. And that's an opinion again, isn't it?

A. And that his physician told him to pick alcohol or a casket, um....

Q. Again, all that stuff helpful to you, right? But...

A. Yes, I...

Q. ...no....

A. ...think it is helpful.

Q. No investigation at all, how to cope, he used alcohol to cope. What do you mean by that? I mean, I – I mean maybe it's because I'm a lawyer but I'd want to know if I was an investigative psychiatrist. I'd want to know how you determine – I mean, what do you mean by "coping"? Was he having problems coping? I mean in what way, how did alcohol help him and that kind of thing? You never asked those

questions.

A. Well, we talked about his – yeah, we talked about it generally, I didn't go through all the criteria and – and, no, I – I think you can always ask more questions and I could have asked more questions about his father in this case. But I – I am – the collateral information I had at the time I put my report together, um, I thought was helpful in – in making that determination.

Q. It was helpful to supporting your opinion.

A. It was helpful in helping me come to my opinion, yes.

Q. Now when Mr. Blom was asking you questions yesterday about the father's use of alcohol, he didn't put to you the evidence of Tom McCabe, his brother.

A. Yes, I don't recall that.

Q. I'm sorry?

A. I don't recall that now....

Q. No, I know.

A. Yes.

Q. It was selective. Right? Are you aware of the evidence before this court of Thomas McCabe, Mr. McCabe's older brother?

A. I don't believe I am, no.

Q. And did you understand that he testified here?

A. No, I haven't heard about that. No.

Q. Okay.

A. Other than what was put to me yesterday.

Q. Well, no mention of Tom came up.

A. Not that I can recall, no.

Q. Okay.

A. No.

Q. Tom McCabe testified here, father's alcohol consumption was that he drank when friends came over, I saw him have a beer but never saw him falling down drunk, never saw what he would – or what – "he" meaning Tom, would consider to be a drunk. Guessed that he was an average drinker for that time growing up. Alcohol did not cause any issues in the home that he was aware of. He never beat anyone up, no sign of the common alcoholic at the home. Now, is that a little bit different information than what you were working with to support your opinion?

A. Yes. I think that – that information, um, lowers the severity of his father's drinking problems.

Q. Now....

A. According to Tom, yes.

Q. Well if the jury accepts what Tom had to say rather than the history that you took, because Tom did go on to testify that alcohol never interfered with father's work. It didn't interfere with the marriage, it didn't interfere with his career, it didn't interfere with anything. I mean, that's – that's what we look for, is it not? Those kind of factors that we look for in the severity of someone's alcohol use?

A. Those can be markers, definitely.

Q. Well, they're objective factors and they're listed if – if we go on. Just go on to the next page if you would.

A. And again, to....

Q. Just let's deal with this. Here, a failure to fulfil major role obligations. A persistent or recurrent social interpersonal problems, occupational recreational activities. That's we have and we see here what the D-S-M is trying to do is, if I can use the term, objectify the use of

words such as "in my opinion he drank" or "he was a heavy drinker". We objectify the use of alcohol, do we not?

A. Yeah. And to – to meet the criteria for – for mild use you only need two of those.

Q. Yeah.

A. And in his father's case he likely had....

Q. No. I don't mean likely. On the information that you had.

A. Well, if his...

Q. There is no...

A. ...physician....

Q. ...guessing.

A. Well if his – if - if his physician is telling him to pick to stop drinking or a casket, um, I would think that, yeah, yeah, it's indicative of the alcohol causing problems in his life. And if he is driving home his son drunk repeatedly, I would – I would think it results in risky behaviour. So it's – it's not hard to meet that criteria of an alcohol use disorder.

Q. All right. Now, you talk about a doctor saying pick alcohol or pick the casket. That's the right – have I got that term right?

A. Yes.

Q. That would depend upon one's heart condition?

A. Yes.

Q. All right. And did you understand that Mr. McCabe – or father McCabe, old man McCabe.

A. Yes.

Q. Had a heart attack that took him off work and he lived another, what, 10 or 12 years whatever it was.

A. Yes.

Q. And it was at the end of those 10 or 12 years that the doctor told him this?

A. It – it – probably, yeah, was after the heart attack I would imagine, yes.

Q. Okay. Well, as I understand it, maybe I am wrong, but it was several years later.

A. Yes.

Q. And – and – and – and if one has a heart condition, might that influence, I mean, you're a doctor. You have got some general knowledge other than psychiatry of medicine. Might that influence what a doctor tells you about your habits, your habits of drinking?

A. Yes. Alcohol can certainly cause cardiac problems, high blood pressure, other issues.

Q. No, but if you have already got that.

A. Yeah, you'd...

Q. If you have...

A. ...want to....

Q. ...had a severe heart attack, severe enough that you have to go off work, you can't stay in that stressful job, six or seven years later whose doctor says to you, "Hey, look, you better stop drinking. You know, otherwise you're gonna end up in the – in the casket." That's not unusual. Right?

A. It would be good advice by his physician, yes, in...

Q. Yes.

A. ...those circumstances.

Q. That's not an indication that he had alcohol use disorder or that he was an alcoholic.

A. It – well, it could be.

Q. It could be.

A. Yes.

Q. And we are not basing this case on what may be.

A. Well, I don't want to draw any conclusions. I don't have his father's medical file in front of me.

Q. We have got Mr. McCabe's life in our hands here, sir, and I don't want to understand what could be.

A. Well that's – well that's the most accurate way to look at it. Although we don't have his father's file in front of us, we have the fact that his father drove home intoxicated, we have information that his physician told him to stop drinking, and we had information that his father drank very – very heavily from the early 60s until 1967.

Q. And we have Tom's evidence.

A. And we have Tom's evidence that you have made – that you have informed me of, yes.

Q. Yeah. And without conjector of what could be or may be, if the jury were to accept Tom's version of what he saw, would that eliminate any alcohol use disorder in the old man?

A. I – I'd want to look at Tom's evidence in its entirety but I think what you are telling me is that there was no, um, if he – if he didn't meet any of those criteria or there was no indication of that, one would lower the – the genetic loading from his father. If Tom's evidence was that his alcohol use was non-problematic.

Q. No. And that would lower the risk that we have here. The strength of the risk.

A. Yeah, when you look at the genetic studies, they look at – they would look at alcohol – it used be called alcohol abuse, alcohol dependence, and obsessive drinking and all of those are correlated, you know, genetically as well.

So even in those genetic studies there doesn't have to be a diagnosis *per se* about heavy drinking. But I agree with you, if – if Tom's evidence is that the father's alcohol use was lower, I would give lower weight to the genetic...

Q. Right.

A. ...risk.

Q. And because your opinion is based upon the foundation of facts that you have. If – if we take away part of the foundation for that then your opinion has to change, correct?

A. Yes.

Q. Right.

A. I – I would have – I would re-evaluate the factors and change my opinion accordingly if...

Q. Now...

A. ...required.

Q. ...were you greatly influenced by brother Jim's drinking?

A. Was I greatly influenced by it? What Mr. McCabe told me was that Jim was at least a hard drinker and quote "borderline alcoholic" and that he was arrested and had impaired charges and so on.

Q. What does "and so on" mean?

A. I – that was his words. "Impaired..."

Q. Now did you....

A. "...charges and so on. Nothing that he ever did time for."

Q. When someone says "and so on" when you are a forensic psychiatrist, do you not ask them what you – what they mean by "and so on"?

A. I may have but I didn't make note of it. It may have not – may have not been noteworthy in my opinion. I

don't know what he would have said. The – the quote was dot, dot, dot, "nothing that he ever did time for".

Q. Now based on what you had from Jim, brother Jim, that would put him maybe three factors or so or maybe even four factors in our A-U-D, right?

A. You know, it's tough to say. I don't have all the information for Jim but I – I think he is certainly above that threshold that he would – he would be called a problematic drinker. And remember the criteria is only for a 12 month period having that and then you can meet that. It's not like you have to be an alcoholic for years and years and years to meet that criteria. But, yeah, Jim – Jim's alcohol use looks problematic.

Q. Now did you ask when Jim had his impaired driving conviction? What age?

A. I don't think so. He said he had impaired charges.

Q. Well, did you even ask when – what stage in his life?

A. I didn't, no, his – his father....

Q. No. Just about Jim.

A. Right. So to – to answer that question I would say that Mr. McCabe said that his father went and talked to the police.

Q. Oh, I'm sorry.

A. So – so it must have been that Jim was – it suggested that Jim was probably in his teenage years or early 20s if his father is talking to the police. But that's...

Q. Now the....

A. ...an inference.

Q. And that would have been, knowing that Jim was that much older, that would have been sometime in the

1960s that event?

A. Yeah, it sounds...

Q. Around then.

A. ...yeah, it sounds about right, yeah.

Q. The only reason I raise that, sir, is that – sir?

A. I am listening, yes.

Q. No, are you – I'll...

A. No.

Q. ...I'll wait until you're finished reading.

A. Oh, sorry. Okay. Sorry, I'll give you my....

Q. Are you....

A. I was just looking up the Jim....

Q. I – I just wanted to raise the issue of when it happened, that is to say the 60s or the early 70s. Drinking while intoxicated [*sic*], I don't want to say that it was condoned, but it wasn't the same as it is today. Is that fair?

A. I agree. I know – I think I know what you mean by that, yes.

Q. I mean, in fairness, or it would be hard to get through university or college without having – I'm not suggesting you did it, but, you know, it wouldn't be as frowned upon. It would be much more common than it is today where people are much more responsible about alcohol.

A. I agree.

Q. Yeah. Now would you agree with me that the best person to talk about Jim's use of alcohol would be his life spouse?

A. To the extent?

Q. She would know her husband better than

anyone else.

A. To the extent that she would know, she probably would know. She may know while she is with him, um, to the extent that he has shared his – his life before he met her, I would have to know about that.

Q. Well I understand that they were married in either their late teens or very early twenties.

A. Uh-huh.

Q. Okay. So – and – and I think her testimony was that the – his impaired conviction, everybody calls it a D-U-I so I will call it that. His D-U-I was before they knew each other or before they got married, whatever. Something like that.

A. Right. Okay.

Q. Now during the course of their marriage between, I mean, she is 71 now so let's say it's 50 years ago, there was no impaired charges. Right. And I'll try to be as specific as I can, she met him she said in 1963 or 1964, so it goes back a long time.

A. And he was born in 42 so she – she would have been – he would have been 21, yes.

Q. Yes. In the early days of the marriage he drank most days, just liquor, C-C and 7-Up on the side. It was one or two drinks while at home. He may have a drink once a week after work. Is that information something different than what you took from Mr. McCabe?

A. About Jim?

Q. Yeah. That's what we're talking about.

A. Yeah, Mr. McCabe said he was at least a hard drinker, as he put it, and borderline alcohol. And no question that Jim drank more than other drinkers. He wasn't aware of alcohol leading to any job loss but it was possible.

The drinking never cost him his marriage. And then Jim was arrested for an impaired charge.

Q. And – and one other thing she said, alcohol did not rule his life, he might pour a glass at noon and it would still be there that evening. That was her testimony.

A. Yeah. So, I don't know the – the – the timeline that she is...

Q. During the...

A. ...talking about...

Q. ...course of their...

A. ...exactly....

Q. ...marriage.

A. Right. So at some point during the course of the marriage, it doesn't – that doesn't sound like a problematic alcohol use to me. Um....

Q. Not "at some point", I am – I – I asked her over the course of your marriage, what was his alcohol use.

A. Yes. So that doesn't sound like problematic alcohol use to me.

Q. You would rule out A-U-D altogether for him.

A. No. You only need it, again, it – he – he may have had that diagnosis, again I don't know I don't have his medical file in front of me. But if he had a 12 month period where he had heavy drinking, he would get that diagnosis. But that's the, I think, the important thing to note with psychiatric diagnosis. You can have the diagnosis and then it can go away.

Q. Well he – he never did have that period of heavy drinking. He had one impaired charge when he was a – a teenager.

A. I....

MR. BLOM: I have to stand, Your Honour. My

friend is incomplete. Part of her evidence – her – of her evidence was, "He was a hard drinker."

THE COURT: I think there was also some evidence about his decision not to keep drinking because that was...

MR. LEDROIT: I – I would have...

THE COURT: ...part of him or...

MR. LEDROIT: ...come to...

THE COURT: ...something to that....

MR. LEDROIT: ...that.

THE COURT: Well, but you can't just put some of the evidence...

MR. LEDROIT: Oh, I'm not.

THE COURT: ...and – you have to sort of review it all with the doctor if – in going to that point.

MR. LEDROIT: Yeah, sorry. I'll just do that right now.

Q. He was told by his doctor to stop drinking. Did you understand that?

A. I am just hearing it from you now but...

Q. Okay.

A. ...and I understand...

Q. But...

A. ...it, yes.

Q. ...but he was told that when he just had a few months to live because he was dying of cancer.

A. Okay.

Q. And he said, you know, listen, what's the point? I mean, you know, I – it – it wasn't the doctor told him to stop drinking because it was going to – it was going to

affect his health or whatever. I don't – I mean, I don't know why but.

A. Right.

Q. I mean you – can you understand why somebody who has only got a few months to live would say well, why should I give up that?

A. Yeah, I can...

Q. I mean....

A. ...understand that. Again, I think it – it speaks to his proclivity for alcohol use. Again, other people might feel very uncomfortable drinking, it might make them feel terrible. It doesn't seem like that was the case for Jim.

Q. Right.

A. And it does sound like, at least not in his marriage, but maybe a – a period prior to his marriage it was problematic. He had impaired charge, for example, and his....

Q. And I - I believe the – the word "hard drinking" was referring to those years before they were married.

A. Right.

Q. Yes.

A. So he may have had an alcohol use disorder and it sounds like he got it under control which is good.

Q. All right. Going from your life experience, and I – I didn't put this to you before but I just want to make sure. I mean, going through university – just because, you know, those – not that Jim was in university, I don't mean to suggest that. But in your teen years, is it that uncommon for people to drink heavily at times and maybe get an impaired charge?

A. I think it's uncommon – uncommon to get an

impaired charge....

Q. Today.

A. Well even, I think even back then, I don't think everyone is getting arrested. That could be because police were more tolerant but I – I think that's a – a significant marker even back then but in terms of alcohol use and age, there is a curve where, um, when people are younger they drink more and then it – it varies according to age. It tapers – it tends to taper off as people get older.

Q. But knowing now what I have told you about Jim's drinking pattern and how it may or may not have affected his life, their marriage. Maybe because she does go on to say that there marriage was good and their family was good.

A. Uh-huh.

Q. Work was good. It didn't interfere with any of those things. Would – would you – would you say that that has to lower the strength of the risk?

A. It – yeah, it could. My sense of – of Jim was – from Mr. McCabe was that he was at least a hard drinker and borderline alcoholic so Mr. McCabe himself didn't describe the alcohol use as severe.

Q. Sorry, I know that's the history you took and your opinion was based upon that history.

A. Yes.

Q. I am just saying if one were to take the spouse of Jim's evidence into account. A person who would know presumably much more.

A. Well, the information I had before you told me that was the drinking never cost him his marriage – sorry...

Q. Yeah.

A. ...I didn't mean to...

Q. No, no, no.

A. ...interrupt but I'm just trying to answer the question.

Q. But all I'm – I am – I am not talking about the costing his marriage, I am just saying if – if you were to assess the strength of the risk here. I mean, you said look at close relatives and we were looking at the father and we were looking at Jim. I am saying if you were take Jim's wife's evidence into account, the risk has got to be reduced.

A. Yeah, it could – it could be but what I am saying about Jim's drinking never costing his marriage is I – I factored in that when he got married it didn't seem like it was problematic enough to cost him his marriage, unlike say Mr. McCabe, where the drinking got in the way. So it was less severe than Mr. McCabe.

Q. But the opinion that you wrote and – and you were basing that opinion on the information that you had from Mr. McCabe.

A. Yes.

Q. All I'm asking you is having given you new information and perhaps better information because it came from Mr. McCabe's wife – or Jim McCabe's wife. Would that not decrease the strength of the risk that you were assessing?

A. It's tough to say because I was already factoring in, like I said, it never cost him his marriage. So it didn't seem like a severe, like you know, a severe disorder like Mr. McCabe to begin with. I hope that answers your question.

Q. Well, could you agree with me that from the description I have from Tom McCabe and from Helen McCabe about the use of either father's drinking or Jim's drinking, I am putting it to you. It's not very substantial insofar as

making a genetic link.

A. Yeah, I think it lowers that, uh, the severity of the drinking and – and the close degree family relatives.

Q. Okay. But I'm going a little bit further than that and suggesting to you that there is not much of a genetic link.

A. Well, the genetic link can be, again, based on even a year of problematic drinking. And I – I – I understand what you are saying about kind of the – you know, the age and – and use curve, um, but even with that history, that would contribute to genetic risk.

Q. Right. Absolutely.

A. But it would be tempered by the fact that the drinking was less severe and didn't cost him his marriage and – and didn't continue on to the same extent.

Q. The only point I am trying to make, sir, is that the genetic risk is low. It may still be there but it's low.

A. Well, when there – when there is an alcohol use problem in even one family member, that's genetic risk, right? And the genetic risk is 40 to 60 percent in terms of the variance.

Q. Even – even if it's low. Is that what you are saying the stats show?

A. I don't think the stats have exact stats on someone of Mr. McCabe's exact family composition. But in – in large samples when there is history of alcohol abuse or excessive drinking or severe alcohol problems, there is genetic risk.

Q. All right. So let's just say that there is – well, not just "let's just say", there is that genetic risk.

There is some risk.

A. Yes.

Q. But what I am trying to suggest is that it's minimal and you think it might be a little bit more than that.

A. Well, I think the – you know, that there is genetic risk there and to the extent that what you are telling me that there is less family history, um, that would, you know, temper I think the contribution of that – of that factor, yes.

Q. Now we know from the evidence that we have had here in this courtroom that you – you had mentioned divorces in the family. I mean, we know that, um, Tom McCabe after six months or so was divorced. His – maybe it was a year, but it was a short period of time and it happened early on. And he is about to celebrate, I think, his 40th wedding anniversary in a few days or weeks.

A. Uh-huh. Okay.

Q. Do you see that divorce that Tom had in his early life as suggestive that Mr. McCabe was following in the same pattern as his siblings?

A. Well I – I think the similarity is that there is divorce in family members. Obviously Mr. McCabe is a unique individual, his life has taken a different course, if not for that alcohol abuse, his marriage may have continued for 40 years and he may never have been divorced. So I am not saying it's exactly the same, but it's a – it's a marker that in his family there has been relationship problems.

Q. It's not much of one.

A. No, I – I think it's great that he has been married for so long. That's, uh...

Q. No, but that's...

A. ...that's indicative...

Q. ...not the...

A. ...of a...

Q. ...question, though.

A. ...long-term relationship.

Q. Yeah. Mr. McCabe's never had a long-term relationship.

A. He's had a relationship for several years.

Q. Well, I think the longest one was Nancy, right? His wife?

A. I believe it was, yeah, it was several years with – with her, yes.

Q. Eight years.

A. Yes.

Q. That's not – do you consider that a long-term?

A. Yes.

Q. Okay.

A. Some individuals, um, have the inability to go on in a relationship even longer than three months or six months or a year.

Q. Oh, I see. Okay.

A. So relative, you know, like relative to that it is – it is quite a long time.

Q. But Mr. McCabe's life appears to have been entirely different from that of his – of all of his siblings. Would you agree with that?

A. I'd say he – his life has taken a different course than his siblings although there are similar areas there, yes.

Q. Well, do we know any other sibling that has lost a job due to alcohol use?

A. No, I don't think so.

Q. Do we know any other sibling that has lost their marriage because of alcohol use?

A. I don't think so, no.

Q. Do we know of any other sibling that has abandoned their children in their very formative years, like Mr. McCabe did?

A. No, he mentioned his one brother was upset that he couldn't see his kids because of the dissolution of his marriage.

Q. Okay.

A. So that would be a similarity but, no, not to the extent of Mr. McCabe, no.

Q. Do we know any other siblings where alcohol was a problem during their marriage years?

A. I don't – I don't think so, no.

Q. I'm just qualifying it that way...

A. Yeah.

Q. ...because I – I wanted to go out beyond Jim – brother Jim's D-U-I at 19 or whatever year it was, when he was a teenager.

A. That's right. And then Jim, uh, the alcoholism didn't get in the way of his marriage, that's right.

Q. And what we know is that Bob McCabe had a severe alcohol use disorder.

A. Yes.

Q. Much different than any of his siblings.

A. Yes.

Q. And the siblings had the same parents?

A. Yes.

Q. Same genes?

A. So if you had identical – an identical....

Q. Well, not identical genes, but you know what I mean. They...

A. Yeah. They're...

Q. ...they are....

A. ...they share – they share the same parents so there is definitely, you know, sharing of genetic components, yes.

Q. The one difference that I am going to suggest to you, the major difference between Bob and his siblings, is that he was abused by a priest at the age of 11.

A. Well that – that is a – that is a difference. Yeah, none of his siblings were abused.

Q. It is a major difference.

A. Well, it's – it's black and white. Some were abused, some weren't – one was abused and the rest weren't abused.

Q. I am saying that difference is a major difference.

A. Well, it is a major difference, yes.

Q. Yeah. Now I want to talk about that abuse for a couple of minutes. My friend – I – I didn't mean to offend you yesterday by asking you about your religion. And I don't want to inquire into that but I think you have agreed in your testimony to Mr. Blom that a priest, or who does the abuse to you is a factor to consider in the severity.

A. Yes, it can be in terms of – of the meaning for the person. It's – there is not a lot of good evidence on – on that exact relationship.

Q. But it just makes sense, doesn't it.

A. It's something you would evaluate I think in terms of the person's subjective response to what happened to them, um...

Q. Now...

A. ...absolutely.

Q. ...would – would you agree with me that most childhood sexual abuse is done by a person known to the victim?

A. Yes.

Q. The horrible story we hear of the stranger picking up one of our children and doing something horrible to them, that's the uncommon part of childhood sexual abuse isn't it?

A. Yes.

Q. What we are dealing here was with, whether it's an uncle, a parent, the milkman or the you know, whom, whatever, is some – the person next door or down the street, right?

A. Usually, yeah, usually a family member, um, or someone known to them, yes.

Q. Now I spent a lot of time in the early part of this case and I hope I didn't bore the jury and I hope I won't bore you but I certainly am not going to repeat it. But to try to educate them as to what it's like to be a Catholic boy growing up in a Catholic home going to a Catholic school next door to a Catholic church. Okay. And it is difficult for anyone who has not gone through that experience to appreciate, right, I mean I – I – I don't expect that you could possibly appreciate what that's like because you didn't live it.

A. That's right, I didn't live it, yes.

Q. Yeah. But – but let me try, if I can, and I – and like – by saying this I don't mean to be demeaning of what you may or may not know. I mean, you tell me but, you know, if – if it is but, um, a Catholic boy growing up in a

Catholic home has a crucifix in every room and usually some type of semi shrine in some area of the house. Like - like the picture of the blessed virgin or a statue or something like that. Can - can you understand that?

A. Yeah, I hear what you're saying.

Q. Okay. And - and they say the rosary at night. You have heard of what the rosary is?

A. I have heard of that, yes.

Q. Yeah. They need to get down on their knees and pray and stuff like that.

A. Yes.

Q. And then when - and they go to church together on Sunday.

A. Yes.

Q. Okay. And then when he reaches of six or so he goes to a Catholic school where, among other things, he is instructed in the Catholic religion. And he at least once a month, as a class, is taken over to the church where he is required to go to confession and then the next day take Holy Communion. They go as a class, the whole school. And - and he believes and is taught that a priest, and only a priest, has the power to forgive sins. And if one were to die with a sin on their souls they go to something called hell, a place of eternal eternity, forever. Damnation. And in order to get to heaven one has to lead a holy life. And they receive something called the Holy Communion or the Eucharist which is so precious you can't touch it. You can't even chew it when it's put in your mouth, it's a piece of bread. And they are taught and Mr. McCabe, Bob, believed that when the priest consecrates and says - says prayers over this piece of bread and some wine, he actually transforms that piece of bread into the body of Christ. In fact, Father Clough who was testifying

a couple days ago said he – that that's his belief. He believes that that piece of bread is the body of Christ. But only a priest has the power to change that bread. So the priest has these super powers. Now, rightly or wrongly, Tom [*sic*] believed that the priest was somewhere between being an ordinary human being and God. But he was superhuman in a way.

MR. BLOM: Your Honour, is there a question in the near future?

MR. LEDROIT: Yes, there is.

MR. BLOM: Good.

THE COURT: It is a bit wordy but I see where you are going. Go ahead.

MR. LEDROIT: Well, I have asked a couple of questions. I have asked if he can understand that.

Q. But now that we have had the interruption, can you imagine the importance that a priest would have in the life of an 11-year-old boy?

A. Yes.

Q. Of him to have superhuman powers?

A. Yes.

Q. To – to be maybe if not God, sort of somewhere in between.

A. Yes.

Q. Okay. Then – and the priest comes to the Diocese and starts coming over for supper and in the afternoons has – has tea with mom. And he becomes important to the family. And I forget whether it comes directly from the priest or from mom, but mom says, "Father Robert is going to take you to Montreal to see the Notre Dame Cathedral." Do you – have you ever been there?

A. I don't think so, no.

Q. It's one of the landmarks in Montreal.

A. I have been to Montreal so I – I....

Q. Yes. In any event, the boy having had some experience with the priest, some unusual hugging and whatnot. You know, he's got a little bit of mixed emotion but he's excited, he wants to go to Montreal. And he gets in the car with the priest and the priest starts talking about sex. "Do you ever touch yourself?" An 11-year-old boy. "Do you masturbate?" "I do." "I cum in a milk bottle." Telling this to an 11-year-old boy. Can you imagine the terror that that 11-year-old boy would have?

A. It would be uncomfortable to say the least.

Q. Fear, right?

A. It would be, I think, confusing and uncomfortable for that person.

Q. Would you not think he'd be frightened?

A. He – well, he'd be confused as to what's going on and to this – to the extent that he is so sexually naive.

Q. Okay.

A. It could be – yeah, fear could enter into that, like, what's going on here, sure.

Q. And the sex in religion is always sort of a no, no, or it's, you know, don't touch yourself and things like that. I mean, he knows that, well, touching yourself you're not supposed to do. Right? An 11-year-old boy knows that, he was taught by his mom. And the priest is talking about that. He knows it's wrong but it's the priest, that's what you are talking about the confusion, right?

A. Yes.

Q. One person says it's right and here we have a man of God saying, "Hey, I do it."

A. Yeah, it's confusing because it's the priest and it's confusing because he doesn't know, you know, about sex.

Q. But it's not just confusing, it's – it – it's – it's very frightening. You're in a car. Somebody can, you know, walk out of room. You're on a highway, you can't go anywhere. You are confined and you have got this man of God saying these things to you. It's got to be frightening.

A. Yeah, I mean, it – it could be. It – I would use the word more uncomfortable and confusing and creepy. All of those types of words as opposed to....

Q. And then you – you come to a motel and the priest takes you in the room and there is only one bed in there. I mean, these are memories that never leave you, right.

A. If, well, if they were traumatic it would – it would stay with a person, yes.

Q. Well....

A. More so than something that's non-traumatic.

Q. Leaving the trauma aside, just – just to have someone talk like that to you. A priest talk like that to you. You are likely, now really what I am looking at is more likely than not. You're – that's indelibly, in – in....

A. Indelibly.

Q. Etched.

A. Yes.

Q. Etched on your mind, isn't it?

A. I think...

Q. From what....

A. ...it would be something to stand out for – for – yeah. I think...

Q. For life.

A. ..it would – it would be something that'd stand out for the kid, yeah.

Q. And then you get into the motel room and there is only one bed and you're an 11-year-old boy. He falls asleep, he's obviously got a little bit of worry. And then he feels the priest touching his penis and his scrotum. That's got to be terrifying, isn't it?

A. It – again, I don't think it – it inevitably leads to terror.

Q. Not inevitably. More likely than not, sir.

A. I would – I would say it would be, again, for someone sexually naive who doesn't know about sex, has that person at a an assaultive kind of position, it would be certainly uncomfortable, um, it would, uh, lead to anxiety, no doubt about it. And it would be very confusing. Terror is a bit of a, um...

Q. Okay. Wrong word.

A. ...it's a....

Q. But – but the 11-year-old little boy, his hair has to be standing up on his neck.

A. You – yeah, it would be very – I would say very anxiety producing for the person.

Q. He's got to have goosebumps all over his body.

A. It would be very anxiety provoking I would think, yes.

Q. And he pretends to be asleep because what's he going to do?

A. Yes.

Q. It's not like he can run out of the room and go anywhere.

A. Agreed. Yes.

Q. He is in Cornwall, Ontario. A place he's never been before. He has got no escape.

A. Yes.

Q. And then a few moments later the priest comes around to the other side of the bed and pulls off his pajamas and puts his mouth on his penis.

A. Yes.

Q. Absolute terror.

A. Again, terror is a subjective emotion. Again, I think it'd be – anyone would think of that in a, yes, extremely confusing, uncomfortable, and anxiety provoking.

Q. Just uncomfortable?

A. No, I didn't say that. I said anxiety provoking, obviously very uncomfortable, to say, you know, to say the least, I said, and very confusing. Terror to me means fear that you are going to die or to be shot at or something like that. That's the – that's the use of the word for me when I think of...

Q. That's fine.

A. ...terror.

Q. You know what, I'm going to ask my good associate here to put up P-T-S-D on the screen. To meet the criteria, the criteria are very, very narrow, are they not?

A. So there is the, um, the so-called gatekeeper criterion, that's criterion "A".

Q. No, I want to go back down to where we were.

THE COURT: Mr. Sabo, Mr. Ledroit wants P-T-S-D not – oh, there you are.

MR. LEDROIT: Q. All right. "The following criteria apply to adults, adolescents and children older than six years. Exposure to actual or threatened death, serious injury, or sexual violence." Pretty narrow definition, right?

A. So yeah, that's the gatekeeper criteria and what is the stressor that leads to the diagnosis. And that's criterion "A", yes.

Q. You have to meet this criteria to have that diagnosis.

A. No, yeah, that would be your starting point.

Q. Yes.

A. You don't kind of get in the door so to speak to the diagnosis unless you have criterion "A".

Q. Yes. Unless you meet this.

A. Unless you have that, yes.

Q. And what was happening to this 11-year-old boy was sexual violence.

A. Depending on your definition of "violence", yes, you know, it was a sexual assault on him.

Q. It was sexual violence as described in the P-T – or in the D-S-M-5.

A. Yes, it is. So one of the – one of the concerns about the D-S-M-5 is that, yeah, that opened the – it opens up the door to actually even exhibitionism...

Q. We went through that.

A. ...non – non-touching and so on.

Q. We're talking about a priest, I don't know whether he was on his knees or not, but he's got his mouth on this little boy's penis. It's sexual violence, right?

A. It's a sexual assault, yes.

Q. It's sexual violence as we see in the D-S-M-5.

A. Yes. It would qualify for the D-S-M-5, yes.

Q. Now, that little boy can't go anywhere.

A. No.

Q. He can't run home. He can't run to a

neighbour, he can't run to the school, he can't get any – he is a prisoner in this motel room.

A. He went – yeah, he – he went away from the priest in – within the – the room itself.

Q. And he sat in a chair and spent the rest of the night in the chair.

A. Yes.

Q. Because he was terrified. Right?

A. Well, I – I think, uh, again, we have gone through that before. Terror to me is something that is more serious than – than what is described there but it's a subjective feeling. And – and I wasn't there and I'm not Mr. McCabe.

Q. No, I know. I am – I am just asking you to think of what is reasonable in the circumstances of this Catholic boy having this man of God doing this to him and not knowing what to do and no place to go, you think...

A. Yes.

Q. ...the use of the word "terror" is too strong?

A. I – I do. You know, the original – the original use of the word "terror" in – in D-S-M has changed over the years. And they have actually eliminated the word terror in the criteria from D-S-M-4.

Q. How about in the way that the jury might understand the word, sir? They're not looking at the definition, in a medical textbook, of "terror". I am talking about terror as we understand it.

A. Yeah, so, you know, you could use that descriptor, um, you know, Mr. McCabe himself during the assessment with – with me said that he was in absolute terror of his wife finding out about their financial difficulties.

So, you know, so...

Q. Yeah.

A. ...so that's – that's what I'm trying to say.

Q. Yeah, okay.

A. It's the subjective use of the term, um...

Q. Okay. But...

A. ...but to....

Q. ...I'm talking about a reasonable sort of objective – I – I am just saying, any – any child in this situation, not just Mr. McCabe. But any child with a priest doing this to him with no means of escape would find that terrifying.

A. So....

Q. Not in the medical sense of the word, but in the everyday sense of the word.

A. In terms of, you know, the use of the word, I – I think Mr. McCabe has used that.

Q. Okay. I'm not asking whether he has, I'm asking would you agree that that would be what the response....

A. I – I think a – a layperson could describe it in those – in those terms, I....

Q. You would expect to have that response.

A. Well – well, for someone who doesn't understand sex and is sexually naive and holds someone at that exalted position, um, again I – I don't know if I'd describe it as terrifying in the original sense of the way it was used in P-T-S-D. But Mr. McCabe has used that term. I think a layperson could use that term and Mr. McCabe has also used that term to describe fear of his wife finding out about his finances.

Q. Yeah.

A. So I – I just want to give it some context.

Q. I'm – I'm – those aren't, you know, what is what he said to his wife or whatever. And it's – it's not where I am at. I am – I am just saying to you, sir, any reasonable person would think that an 11-year-old boy in those circumstances would be terrified.

A. Again, I think I have – I have said it could – that could be a word used, um, but I...

Q. Right.

A. ...I think it's important to have that in context of the use of the word. It's certainly a very unpleasant experience for – for – it would be an unpleasant – a very unpleasant, anxiety provoking, very stressful situation.

Q. That's the word you used, right, "unpleasant"?

A. Well, to say – I said, you know, to say the least. So it's a very anxiety, um, inducing experience.

Q. But the use of the word unpleasant really diminishes it, doesn't it?

A. Let's – let's eliminate that word so as not to diminish it and just say it's very anxiety producing.

Q. It was a word that you used in your report.

A. It's true, it is unpleasant for him. But if – if that, I don't want to diminish the fact that it was very – it would be very anxiety producing for a child in that circumstance.

Q. But it was your choice of words, "unpleasant".

A. Well....

Q. I know it says "extremely unpleasant"

but....

A. Well, it is unpleasant to say the least.

Q. But doesn't that diminish what happened?

A. I – I – well, I am trying to clarify that I don't want to diminish it by using that word and that's why I said let's just talk about how it would be very anxiety producing for a child.

Q. You – you say you know about the effects of the childhood sexual abuse. Are you aware of the term "revictimization"?

A. Yes.

Q. That the pain someone would have if someone in a respected position would diminish what happened to them?

A. I'm sorry, could you repeat the question? I don't think I got the gist of it.

Q. We're talking about revictimization. A victim of sexual abuse, that went through what we just described, having his Church, that he grew up in, his Church's doctor describe this as "unpleasant" would cause him a lot of pain. In later life, I am talking about, when he – when he reads that report. This is the Church's doctor describing what happened to me as "unpleasant", "extremely unpleasant". That choice of words. Can you see the pain that that would cause a boy - or a man?

A. Well, I – you know, I think before I – I undertake an assessment, I meet with the individual and make sure he gives informed consent to have the assessment. So the assessment can be stressful just being interviewed and the assessment can be stressful reading the report afterwards.

Q. I am just – that's not the question I asked you. I am just saying, is it a responsible word. I am not denying that the Church has a right to defend itself in a

lawsuit. I am just asking if it's not proper to play fair.

A. I – I don't think – think I understand the question if you...

Q. Well, I am...

A. ...don't mind repeating it.

Q. ...I am – I am saying – I am saying to you, as a – and I am going to put it to you, sir, you are an advocate for the Church. Not an unbiased witness. You are an advocate. And to use the word "unpleasant" in trying to diminish what happened to Mr. McCabe can hurt him. Hurt him bad. Can you understand that? It's called revictimization.

A. Oh, that's what you meant. Okay.

Q. Yeah.

A. Oh, okay. I understand. So, with – with people – my understanding of revictimization and I – what I thought you were referring to is the fact that people who have been victimized, and these are typically ones that have complex trauma abuse affecting their personality development can be at increased risk of a later victimization. I – I thought you were talking about that. I am – I apologize.

Q. I was talking about the pain that I think a reasonable person could foresee when a doctor – the Church's doctor, using that term, "unpleasant". Can you see the pain that that would cause?

A. Well, I am – I am looking at his description of – of what happened at that time. And there is other descriptions that he has used. So I would disagree with that because he has described it as disgust the next day, he spoke about how when he first came to the realization in 2013 he then kind of chuckled. So these are his descriptions of what happened, so I would disagree with that.

Q. He chuckled about what, that it happened?

He was happy it happened? He was laughing about it?

A. Yes, that's what he said. He then kind of chuckled after he said the sick man's prayer. So, um, the – that's his wording. So I am just – I am, uh, I don't think he would feel that. I think it's stressful for – it would be stressful for him to read the report. It – it talks about what happened to him. And I think this whole litigation is very stressful for...

Q. Sure it is.

A. ...an individual.

Q. Would it surprise you to learn that this bothered him?

A. No, I think – I think this whole litigation would be bothersome for him. I wouldn't be surprised by that.

Q. I mean, I....

A. And – I'm sorry. Go ahead.

Q. You have a Hippocratic oath to do no harm.

A. Yes.

Q. And I know you have a duty to your client, the Church. But could you see the two may be conflicting with each other, your Hippocratic oath and your duty to your client?

A. I see your point so that's why there is full consent before undertaking an assessment. So the person is advised that it's not a treating relationship, there is no treatment here. And acknowledging that the interview can be stressful and then the process of reading the report can be stressful. That's explicitly outlined in my consent form. And that the person may agree, disagree, or be neutral to my opinions and that he may be stressed by that.

Q. Okay.

A. And – and the person will either consent to

have that assessment or not. But we do – I do make it quite clear this is not a treatment assessment, I....

Q. Yeah, that's not quite my question. I'm wondering if you could answer my question.

A. So I – I – this is part of psychiatric practice and – and that's standard practice in terms of doing these types of assessments.

Q. I know, sir, but I was talking about playing fair, not playing dirty. That's what I was talking about.

A. Maybe you could repeat the question because I am not sure what you mean by "playing fair" versus...

Q. I am saying...

A. ..."playing dirty".

Q. ...I was asking you whether it's possible to do your duty to your client and maintain the Hippocratic oath.

MR. BLOM: Your Honour, before he answers, maybe this is the point for me to stand. He said it twice "duty to your client". He doesn't have a duty to his client, he has a duty to this court to be impartial.

THE COURT: He has answered your...

MR. LEDROIT: Thank you, Your Honour.

THE COURT: ...question, Mr. Ledroit. He says...

MR. LEDROIT: I will move on.

THE COURT: ...there wasn't a conflict based on the consent.

MR. LEDROIT: And that's not my question.

THE COURT: Well, it sounded like your question to me and I thought he answered it but...

MR. LEDROIT: Can – can you....

THE COURT: ...so maybe both of us are confused.

Give us the question again.

MR. LEDROIT: All right.

Q. I am asking you about the use of the word "unpleasant" as being diminished and as to whether or not you could foresee that causing pain. And I am asking you as to whether or not you could write a report without so diminishing what happened to Mr. McCabe.

A. First of all, it's not meant to be diminishing of him it's meant to give my opinion of what happened. And I can't control his subjective opinion in terms of what I have said, after the fact. That is why there is a consent form and he can either choose to go ahead with things or not go ahead with things, and that is standard practice. And – I'll just leave it at that.

Q. I just want to make sure we get the wording right because I was exposed to some criticism for leaving some words out. Now I trust that I have written it correctly. Do you have it in front of you, sir?

A. Yes, thank you.

Q. "While the experience was extremely unpleasant, fear-inducing, and disgusting to him, given his naivety it appears unlikely that it was overwhelmingly terrifying [for example] E-G, that he could be physically harmed."

A. Yes.

Q. "The next day his fear went away and he was able to take a position of defiance." Have I written it correctly?

A. I believe you have, yes.

Q. Okay. Now, we know that after the – what happened in bed, at some later time, maybe it was in the morning, I think Mr. McCabe was in the washroom and the priest

came and he had an erection and said something about, "This is a really big one." Or something like that.

A. Yes.

Q. Do you remember that, it's part of the history?

A. Yes.

Q. And then the next day they set off for Montreal. And you say his fear went away. Did Mr. McCabe tell you his fear went away or is that conjector on your part?

A. No, that's what he said.

Q. But you don't have your notes here because I am going to suggest he didn't say that.

A. I understand he said that at the examination for discovery.

Q. It's not something he said to you?

A. No.

Q. All right. All right. Now, Mr. McCabe says and he certainly wasn't challenged on this, at this trial, that he was in fear when he went to Montreal. He was in fear the entire weekend until he got home. You know, you say it was defiance because he told Robert, "I don't want to stop, I want to go home." Isn't that an indication that he was in fear of Robert?

A. It – it could be, it's, uh, I think – I'd say the best way to put it is that it's an extremely – it's an anxiety provoking experience for him. Now there is – now there – now if – because there is fear of, fear of what? There is fear of, um, you know fear is such a general term. I think it's clear and there is no – no dispute that he'll have a lot of anxiety about that. He described it as a fear and he said the fear went away the next day, when he was at the cathedral. And then he recalled being disgusted at the time

in – in the presence of the priest.

Q. You can understand, he didn't want to spend one moment with this horrible person.

A. No, he didn't. I think he wanted to get home as soon as possible, yes.

Q. Now, just – just before we – just one question before we go to lunch. One of – in fact, I am going to suggest to you it is universal, effects of sexual abuse – childhood sexual abuse is guilt and shame. I am going to suggest that to you.

A. Okay.

Q. Is that true? It's in – universal. I have never seen a case without it. That is what I am putting to you. You have never seen a case without it.

A. I would – yes, to – at least to some extent, yeah, I think that would be very common, yes.

Q. And even more so when it is in Bob's belief, God is doing this to me.

A. Yes.

Q. I am not saying that's a reasonable belief, I am saying it's an 11-year-old Catholic boy's belief.

A. I think it brings up – yeah, that...

Q. And – and...

A. ...those emotions, sure. Yes.

Q. ...the difference between guilt and shame, I think as Mr. McCabe explained it and he understands it to be, is that guilt is for something that you do, something bad that you do. And shame is that you are a bad person. Is that a good brief description of the difference between the two?

A. Yeah, I think that – yeah, they are open to subjective interpretation but I think that, yeah, that's a fair way to put it.

Q. Okay.

MR. LEDROIT: Is this convenient, Your Honour? I think maybe half an hour. I – I think.

THE COURT: Two things. One, I think it is early. The second proposition...

MR. LEDROIT: Okay, I'll carry on.

THE COURT: ...hang on. Hang on. The second proposition I leave it entirely to the examiner. If this is the appropriate time for the evidence and the jury to break and you think this is appropriate, I am all in favour.

MR. LEDROIT: Thank you, Your Honour.

THE COURT: 2:15.

12:53 P.M. JURY RETIRES

...SCHEDULING DISCUSSIONS

L U N C H R E C E S S

U P O N R E S U M I N G :

...WITNESS SCHEDULING DISCUSSIONS

2:18 P.M. JURY ENTERS

MR. LEDROIT: Q. We were just talking before lunch about guilt and shame being universal. But that it happens in all childhood sexual abuse cases.

A. I – I think there would be some degree of that in all of them, yes.

Q. And guilt because the child thinks that they have done something wrong?

A. That can be a common reaction, yes.

Q. Even though they didn't but they are looking at it as child, right?

A. Yes.

Q. And that – that guilt is something they have. Without therapy it's not uncommon that they carry with them throughout life.

A. They could to some degree, yes.

Q. And help me with this, when something like this happens to a child, and I don't mean not sexual abuse but any kind of trauma. Some – some more than unpleasant event. Is it true that they tend to look at it throughout their life through the eyes of an 11-year-old or a 7-year-old or whatever they were at the time? That is, as opposed to an adult.

A. No, not necessarily, no.

Q. Not necessarily, but is it – is it a common thing? I am telling you without therapy....

A. Yeah, no, I – it's – I can't say that because they do develop and their understanding of the world develops, um, so no, it – that's not necessarily the case. And a lot of the times if they don't think about the abuse, they're not thinking about it all on a regular basis until sometime and then they may reconceptualise it through the eyes of an adult and find it very traumatic or bothersome at that time.

Q. But say people that come to you in therapy, they would be having unpleasant feelings of some kind, whether it's guilt or anxiety or depression or whatever it might be, that's bothering them, takes them to a therapist. Oftentimes they don't know what it is that is making them depressed or making them anxious or making them feel guilty. Is that fair?

A. That's fair, yes.

Q. But they still have the feeling even though they don't know why it's there.

A. Yeah, that's – that's fair, yes.

Q. Common?

A. You know, for the so-called neurotic disorders there is going to be that tendency the worriers and high-anxiety individuals, yeah, that can....

Q. Generalized anxiety, they're – they're afraid not because a train is coming down the track to run over them, they don't know why they're afraid.

A. Well, in generalized anxiety disorder they worry excessively. So they may worry about family members just driving to work, are they going to get into an accident and they spend a lot of time worrying about something like that. So their worrying is excessive and – and inappropriate to most people who hear about their worries, so call them worry warts.

Q. But as opposed to worry, I am talking about generalized anxiety. You're uptight, you're anxious, you don't know why you're anxious. You're not anxious because you're worried about getting to work or something like that, but anxious. Anxious about being on time or anxious about not having enough, your anxious about doing too much, whatever it might be.

A. Well, that – that would be an anxiety disorder N-O-S if it was causing, you know, severe distress or impairment so it doesn't fall into one of the common anxiety disorders. So – which are generalized anxiety disorder, panic disorder, phobias.

Q. And we'll come to panic in a little while, but guilt. I am just trying to understand that – that – that people come to a therapist saying, "I feel guilty and I don't

know why."

A. Yeah, I'm not sure about, you know, guilt and shame are emotions that people feel, they...

Q. Yeah.

A. ...are not diagnoses.

Q. No, I know that.

A. And – and you may explore those emotions in....

Q. But I'm – I'm just saying, if somebody has the feeling of feeling guilty and they – they don't know why and that's why they go to a therapist, "Can you help me?"

A. Well, they – again, these are emotions and the therapist isn't to find out why, it's to provide support and better coping mechanisms as opposed to trying to unearth some reason.

Q. But isn't that what a psychotherapist does? I mean, you – you go to the psychiatrist and you lay on the couch or sit in the chair, whatever it is, and assuming he doesn't have a German accent and a bust of Freud on his desk and whatnot. But – but, you know, he – he goes back into your childhood.

A. So – yeah, so there is psychoanalysis...

Q. Analysis, yes.

A. ...and then there is psychodynamic psychotherapy and, you know, psychoanalysis certainly is a little outdated and the theory on it is outdated and – and so on. People still do it, um, and there are pschodynamically informed psychotherapy where you can make connections to their past and to the present and deal with what's called transference. So the way someone has experienced someone from the past is now inappropriately projected to how they deal with someone in the present. So that would be psychodynamic

psychotherapy.

Q. I don't – I don't want to....

A. And then – no, but that there...

Q. I don't want to go....

A. ...is a whole range of different therapies. And then now more commonly we use cognitive behavioural therapy.

Q. Sure. What I am trying to get at, the person has the unpleasant sensation and they don't know why.

A. Well, and they – that – that could be talked about in therapy but that's – that wouldn't be a common reason, I don't think, for coming in. But guilt and shame are universal emotions that people can experience that they would probably discuss at some point.

Q. Okay. Shame as opposed to guilt, we were talking about this before lunch. As opposed to guilt, I did something bad and I feel badly about that, like I stole a candy bar or whatever it is and now feel badly about something I did. And that – that – that's different than shame, shame being I'm a bad person.

A. Again, these are – and they are non-specific concepts which people experience them, you know, inappropriate guilt is one of the criteria for major depression, feeling bad about oneself, poor self-esteem is a criteria of major depression. So people can come in with that but it's – it doesn't mean it's due to any one thing, it can just be a symptom of...

Q. I'm not...

A. ...being depressed.

Q. ...sorry, I'm not saying that. I'm just trying to distinguish between the two.

A. Yeah. Uh-huh.

Q. Right?

A. Yeah, they are....

Q. And – and I am saying I did something bad, I am bad.

A. Right.

Q. Yes. Now, rightly or wrongly Mr. McCabe as he was at a 11 years old, thought that God was doing this to him. That's what he us.

A. Yes.

Q. And therefore I must be a bad person. That's the shame that he was telling us about.

A. That could be an – yeah, it could be an emotion or a thought he had in that experience.

Q. And – well in the history that you took from him you understood that he had this feeling of being a bad person throughout his lifetime.

A. Yes, he had – he had self-esteem issues for sure.

Q. Self-esteem.

A. Yes.

Q. There is something the matter with me and...

A. Yes.

Q. ...I am not as good as other people.

A. That's right. Yes.

Q. Now, believing that it was God that did this to you, would that make the shame worse?

A. I think, it's tough to say. I think at that moment in time it would be quite confusing for the person. It – it – so the answer is it could, yes, but it would depend on the person and how they dealt with it at the time.

Q. In particular with a young Catholic boy whose belief is, you know, God is going to send you to hell

and things like that, you know, if I – if I am a bad person. I am just saying to you the threat of hell for being a bad person would be accentuated in somebody like Mr. McCabe.

A. It would certainly be – be something that could be experienced under those circumstances, yes.

Q. Now, you talked about – and you were saying this to, I think, maybe it was under P-T-S-D, but as a common effect of – of a childhood sexual abuse, anxiety and disorder – or, anxiety and depression?

A. Yeah, those – those – you are at increased risk of those based on childhood sexual abuse, yes.

Q. And another one, an effect on education, you mentioned that?

A. It could to the extent that it led to impairment or a stress reaction at the time.

Q. It could lead to but simply because you don't see an effect on his marks here doesn't mean that he wasn't suffering from the effects of childhood sexual abuse. It didn't show up in his marks is what you're saying.

A. It didn't show up in his marks. No, he could have still had symptoms related to the abuse.

Q. Now....

A. Despite no change in his marks.

Q. Self-esteem you mentioned.

A. Yes.

Q. And there was several others, I mean we can go through them. Substance abuse? Right?

A. Yes. Those – so when looking at studies of people who report childhood sexual abuse, um, higher rates are found of anxiety disorders, depression, substance use disorders including alcohol use disorders.

Q. And is it fair to say that the substance

abuse arises because the – the childhood sexual abuse that the child suffers creates whatever feelings of anxiety, guilt, shame, depression, and the person is looking for a way to deal with uncomfortable feelings.

A. Well, no one knows for sure because these are correlations found. So....

Q. Does that seem the reasonable explanation?

A. So, one would look at various possibilities. For – one thing you have to look at for childhood sexual abuse is taking into account that childhood sexual abuse is often associated with other adverse experiences as a child. So the research needs to control for that, and when it does that the – the differences found between the two groups is narrowed.

Q. Okay.

A. So you have to look at the entire clinical picture of....

Q. I understand. We're looking here at the common effects of childhood sexual abuse.

A. Right, so, um, and again common, it's an increase – it's a relatively increased risk. So one of the papers that I refer to in my report talks about if someone reports a history of childhood sexual abuse, a male reports a history of childhood sexual abuse, the risk of alcohol use as an adult is 30 percent in terms of their lifetime risk. And if they don't report a history of childhood sexual abuse the risk is about 19 percent. So there is a relatively increased risk.

Q. That was the one study that you looked at but other studies indicate substantial differences in that, right?

A. I am just saying the studies show that there is that difference, that gap narrows when you control

appropriate family experiences but – so what I am saying, it's not a universal cause and effect thing, but when looking at that outcome over someone's lifetime you see – you do see a difference. Now, in terms of what is the mechanism or the causal mechanism, you would be looking at theories...

Q. For example....

A. ...about that.

Q. I mean, there is a lot of – there is a lot of writing on the issue of childhood sexual abuse and substance abuse. So I – to give you an example, if you look at Google you will get four and a half million hits.

A. Yes.

Q. If you look at Google Scholar it's a little narrower, you might get only 40,000. But there has been a lot written about the relationship between childhood sexual abuse and substance abuse, right?

A. Yes. And then you would look at the quality of the evidence in terms of the evidence.

Q. Right. And what – what the published articles, and if we looked at Google Scholar, whatever, what we see is that there was a correlation. I mean, you try to say it's – it's only 10 or 20 percent. I mean Doctor Jaffe testified otherwise but....

A. I – I am – I - there is various rates, there is no absolute rate. So each study will show a different rate but there is an increased relative risk depending on the absolute rates.

Q. Right.

A. It depends also on what group you are looking at or if you are looking at a community sample or if you're looking at a clinical sample, they are going to have higher rates of psychopathology.

Q. The other one was sexual dysfunction. You mentioned that earlier, right?

A. Yes.

Q. And you didn't – you didn't see any evidence of this with Mr. McCabe's case. But isn't it true that it's women who suffer this – women abused child – in child – in children – women abused in childhood can suffer more from sexual dysfunction than males.

A. Women versus – well, women are more vulnerable to the effects, I think, in general than males. But males can also experience sexual dysfunction, yes.

Q. I know they can also experience, I am just saying it is more common in females.

A. It depends on the type of abuse. So if someone has a history of repeated abuse, they may be prone to later dysfunctional relationships, promiscuity, and so on. The P-T-S-D picture doesn't really explain that very well. For – for males the same thing can apply but it would, yeah, be less so than the females.

Q. Are you able to comment that it's more prevalent in women than men?

A. Well, when you mean sexual dysfunction, um....

Q. Yes, not enjoying sex, um...

A. Yeah, you know, so....

Q. ...not engaging in sex that kind of thing.

A. So, yeah, so there is different, like, disorders like, um, they are even in the D-S-M like anorgasmia and so on and so forth.

Q. Yeah, women tend to experience sexual dysfunction more than men.

A. They have – yeah, they have those

difficulties, yes.

Q. All right. Now, we know in this case that Mr. McCabe went home and had these feelings of confusion and fear and whatnot. But he had no one to talk to?

A. Well, I – he had – he had a father who had his own problems, his – his mother was there but he didn't disclose the abuse to anyone. So if you mean if he had had anyone to talk to about the abuse, he didn't disclose it at that time.

Q. Sir, I know that you are anxious to tell us about the father's problems, I mean, have you – have you – did – I sent the video to Mr. Blom some time ago, did he ever show you the video of the family functions?

A. No.

Q. You didn't see him smile, being happy, having picnics, wedding anniversaries?

A. No, I don't believe I saw it.

Q. Weddings, 25th anniversaries?

A. No.

Q. Picnics, Christmas with mom bringing a turkey to the table?

A. No. I didn't see that.

Q. Did – did you ever ask Mr. McCabe about – I mean, you – you found out about mother's smoking but did you review with her what a good provider she was, what a happy home she made? Things like that?

A. It didn't – I don't think I heard about that but as I said yesterday, I didn't see any difficulties with his mother in terms of her support.

Q. Well you – you told us this was a dysfunctional family. That's what your evidence was to Mr. Blom.

A. Yes.

Q. And you based that on, I think you said father was authoritarian?

A. Yes, um....

Q. You say that in one breath and then you say in another that being the fifth of six children, discipline was probably lax in the home. So which do we have?

A. Well, when you look at other – other factors that you want to control for, it would be financial problems in the family, alcoholism in the family, other mental illness in the family, family size and discipline in the family. Those are some of the things you would look at. And he also the – the adverse experience of a grade failure and his father's heart attack at the age of eight. So there were dysfunctional components and adverse experiences, you know, in his childhood years.

Q. How many – how many children failed in the grade four? How many other kids failed that year?

A. I am not sure.

Q. We don't know. What was his relationship like with the teacher?

A. I – I can't comment on that I don't think.

Q. Yeah, well we – we don't know why it could be. It could be all kinds of reasons, right?

A. It could be, usually it's academic or behavioural.

Q. I mean you – you keep going back to the fact that that separated him from his other siblings which made him really different. Right?

A. Yes.

Q. You look at the negative thing but I don't hear much about the fact that he's the only one in the family

that got grade 13. Sir, it goes back to what I was saying this morning. You pick and choose, you're selective about what you – what – what you – what you – what you focus on in order to support your theory.

A. I disagree, maybe I am not distinguishing well enough between grade 12 and grade 13. But I think all of his siblings have high school.

Q. Yeah, they – they have grade 12. Did you know that? He was the only one in his family to reach grade 13. Did you know that before I just mentioned that?

A. It – it wasn't a – a – no, it wasn't – I might have known it but it didn't stick out to me as a...

Q. Well, what does...

A. ...significant factor.

Q. ...mean, that – that he had more intention to go to post-secondary education than his siblings?

A. I am not sure, I didn't ask him. He – he discussed going to university which is a positive for him for sure.

Q. Yes. So you didn't – I mean, you knew that he went to grade 13.

A. Yes.

Q. It's in your report.

A. Yes.

Q. You – are you saying that you knew his other siblings went to grade 13?

A. No. I'm not saying that, I'm – I'm saying that I would have to look exactly at my report in terms of what their grade levels were. I – I don't, at this stage, make much of a distinction between going to grade 12 and grade 13.

Q. Oh, okay.

A. In terms of them having...

Q. What's the reason....

A. ...high school.

Q. Well, let's just explore that. Did you go to grade 13?

A. No.

Q. You weren't living in Ontario then?

A. That's correct.

Q. If I suggested to you the reason why people go to grade 13 was because they planned on going to either university or college. Would that surprise you?

A. No.

Q. I mean, the fact that Mr. McCabe went to grade 13 and his siblings don't, does that not make a difference between him and his siblings as to what he wanted to do, what he though he could do, what his intentions were?

A. Well, I think it is in keeping with someone who, again, just didn't have any deterioration in grades and was focused on student council in school and so on, I know his grades, as far as I am recalling, went up into grade 13. He may have had intentions of going to university but he didn't have the financial means to do so.

Q. He didn't, well – well, did you know in Ontario that we have a program called "student loans"?

A. Yes.

Q. Someone whose father is sick and can't work, his mother doesn't have a great occupation because she was a homemaker all of her life. Did you discuss the – the availability of that with Mr. McCabe?

A. No, I didn't, no.

Q. Did you just dismiss it if – because he – he didn't have the money. I mean, didn't he tell you he was

using the lack of money as an excuse why he didn't go?

A. Yes. That's what he told me.

Q. And did you tell us that yesterday?

A. What is that?

Q. That he was using the lack of funds as an excuse not to go.

A. Yes, I think he said something like he was going to – he told people he was going to take a year off and go back but he never intended to.

Q. Did he mention to you that he didn't feel adequate that he would pass?

A. I can't recall. I would have to look at my notes.

Q. Have a look at your notes.

A. Thanks.

Q. If it saves you any time I'm going to suggest to you it's in your report.

A. Yeah, I know, I found the educational section, thank you. It's about page 10. So – so he ended – he said that he completed grade 13, planned on going to university but did not end up doing so, didn't think that he was smart enough, feared that he would fail. And his out was to say to others and himself that he would just work for a year and then – and then go to university after that but he never did.

Q. Why didn't you tell us that yesterday? Why do I have to bring that out of you?

A. I'm not – I'm not sure in the line of questioning yesterday that....

Q. Well, the evidence I heard from you yesterday, and perhaps it was this morning, was he didn't go to university because he didn't have the money. That's what I

remember your testimony to be.

A. Yes. That....

Q. But you – you didn't – you didn't tell us this, what you just read.

A. Yeah, well I think one of the reasons was he didn't have the money.

Q. No, no, that's not what I'm asking you. I'm saying why did you give us the full answer yesterday? Why do I have to drag it out of you? If you are an unbiased expert.

A. It – it – it may not have come to mind at that time, just like...

Q. I see.

A. ...it didn't come...

Q. It's not that....

A. ...to mind now.

Q. It's not that you just want to focus on the negative things.

A. I am certainly not saying there was any negative part there. I am saying that his grades didn't decline in those years.

Q. Okay.

A. And that's what I said yesterday, is the grades didn't decline.

Q. If somebody feels inadequate in themselves.

A. Yes.

Q. If they fell that there is something the matter with them, would you agree with me that they'd try to be a perfect person? That they're the people that get into perfectionism?

A. Well, that can be one way to compensate.

Q. Sure.

A. Yeah.

Q. And because they're – they're trying to show themselves and show everybody else that they're okay, when they feel that they're not.

A. Yeah, and now that you mention it, um, going to university when his other siblings didn't would be a way to – to show that, yes.

Q. Sure. And – and the other problem we've got here is the self-confidence issue, right? Because you said Mr. McCabe tells you that he lacked self-confidence, you just read that.

A. Yes.

Q. Didn't have the confidence. And one of the problems of going to university is – is that you're sort of putting things on the line. If you fail, you're sort of cementing to you the idea that you are not good enough.

A. That can – yeah, that can – that can be a concern for people, um, I think the transition from, you know, like to high school is one transition that can be a stressor for people. And then the transition after high school can be another stressor for – for students.

Q. But we know that lacking in self-confidence is a common effect of childhood sexual abuse. You have mentioned that?

A. It can be an outcome, yes.

Q. Now, it's common isn't it.

A. Lacking – well, it depends on the type of sexual abuse and person and family and – but it can be a contributor, yes.

Q. And you mentioned trust is another issue.

A. Yes. It can – it can contribute to difficulties with trust, yes.

Q. And this perfectionism Mr. McCabe had. You

know that he has been a hard worker all his life.

A. Yes.

Q. And you're saying that shows that he didn't have the effects of childhood sexual abuse but if you looked at it another way, the perfectionism as showing – trying to make up for the inadequacy of his feelings that he is struggling all of his life to show that he is good enough. Even though he is failing all the time.

A. Well, you know, these – these – these concepts that we're speaking about, they're not due to any one thing, they are multidetermined. There is lots – there's lots of different factors that go into someone's self-esteem.

Q. Right. I'm saying here.

A. Including, you know, we have talked about some of the other ones. And, yeah, including the sexual abuse experience.

Q. And I – yeah, I'm saying what I am trying to establish with you is that the only thing we can look at – well, not the only thing. Because there are other factors, there is other factors. But the major reason Mr. McCabe has these problems of trust and self-confidence and perfectionism and all that kind of stuff; it's because of the abuse. Not because of it, but the abuse is a major factor.

A. Well, it would be a contributing factor, I wouldn't...

Q. It's not just....

A. ...I wouldn't say it's all because of the abuse. This is a – this is a – this is a man who, again, failed grade four, felt insecure for a number of different reasons including insecure around his siblings, who didn't have any difficulties after the abuse academically and he had no decline. So you have to look at the information in this

particular case before making those types of conclusions.

Q. And we are looking at them. But if I put it on a scale and if I say short stature, sexual abuse. Where are we? Is the short stature more important in lacking in self-confidence than the sexual abuse? Is that what you are telling the jury?

A. Well, it wouldn't just be short stature but that's something that person lives with all the time and it can lead to insecurities. The sexual abuse, you know, could obviously have significant affects as well. So I am not just looking at one aspect like the short stature, I am looking at all of the factors and putting them together.

Q. I know, I – I am just asking you to weigh things. I mean, do you honestly tell us that short stature in comparison to childhood sexual abuse, what happened here, should even be considered?

A. Well, it should be considered because he mentioned it as a cause of his insecurities.

Q. Of course it's a cause of – we could have a million causes for insecurity. Some people could be fat, some people could be too thin, some people could be too tall, too short, I mean, none of us is ever born perfect. Right?

A. Correct.

Q. I mean, there is always something the matter with us but it's – it's how big of a deal it is and isn't – I mean, you have got to give some weight to these things, don't you? I mean, do you just throw them all – all – all – all in the pot and – and – and say, well, they're all a bunch of contributing factors so therefore you can't point to any one.

A. Well, you – you have to do your formulation and look at all the different factors. So we have some with genetic loading – loading for alcoholism, some adverse

childhood experiences, a grade failure, insecurity next to his – his brothers, and then you go so on and so forth. And then you'd look at the factors specific to the case to see if there was any change after a specific factor. So it's not any one thing versus any other thing when it's something of that nature. I considered the entirety of the information.

Q. Is it true that the psychological effects that we were discussing on the previous page, the – those effects of P-T-S-D and anxiety, depression, guilt, shame, self-esteem, substance abuse. They get worse if they're not treated, things like anxiety and depression. Fair?

A. Well, no, there is spontaneous remission of depression.

Q. Well, there can be but what – but, sir, is it not true, and you have testified to this before, that depression gets worse left untreated?

A. Well, if you leave something untreated it can spontaneously remit but it is a disorder that can come and go depending on stressors in the person's life.

Q. Of course, but if somebody has stress to the point that they want to use drugs or alcohol to relieve the stress, they abuse it because of that, it's a little bit more than just regular everyday anxiety. Right?

A. Well, if someone has a stressor and then the effects of that stressor remit, the mood will go up, the anxiety will go up [*sic*], and the disturbance in conduct will – will improve as the stressor remits. Now if it's a chronic stressor, yeah, it would continue in all likelihood unless the person developed a better way to cope.

Q. Well, all right. But – but what I am getting at is untreated depression gets worse as time goes on. In fact, it's what you would call progressive.

A. No, a lot of people who have only had one major episode of depression in their lives. So if we're talking about major depression it can come and – and go. Even manic depression of a bipolar episode can come and go.

Q. I am just going to put this to you. "Post-traumatic stress inadequately treated or not treated at all, if it goes untreated it either stays at the same level or it can get worse. There can be waxing and waning in severity of the illness, but overall it's a progressive course of the illness."

A. Yes.

Q. Did you ever testify to that?

A. I – I can't recall, um....

Q. Shall I show you the transcript?

A. Sure. That would be great, thank you.

Q. You were testifying in a criminal case there. You can look at the front page it will give you the reference of the case.

A. Yes, and then I go on to say, "Having said that, some individuals can remit without treatment."

Q. Anything is possible.

A. Yeah.

Q. But you – did you say that it was a progressive matter if untreated?

A. I said there - yeah, there is a waxing and waning in severity but it can be a progressive – it – overall it's a progressive course of the illness, yes.

Q. So, you said that two years ago. Are you prepared to say it today or do you want to change your opinion on that?

A. Well, it – it – again, um, if someone has post-traumatic stress disorder it can spontaneously remit. It

is waxing and waning. And as I mentioned with Mr. McCabe yesterday, if he has exposures, naturally in the course of his illness, it can improve.

Q. Let's talk about alcohol. I think you were mentioning yesterday that you had a patient with an opioid problem, in other words, having taken oxycodone or OxyContin whichever it was, because of pain suffered from a car accident and the person became addicted to that.

A. That's a common scenario, yes.

Q. And it – it's not uncommon if you are in pain, whether it's emotional or physical, to take something to relieve it.

A. Not uncommon, no.

Q. And in particular – well let's just look at Mr. McCabe's drinking habits. You – you were mentioning that when he was an alter boy, which would be when he was in grade school, he and another boy got into some sacramental wine.

A. Yes.

Q. And you saw that as an indication early on that he was an alcoholic, or he was on his road to becoming an alcoholic?

A. No, I think it demonstrates a peer influence and his personality of being a following and wanting to fit in. And I – I – I don't think it means he is an alcoholic but it – I think it means that non-sexual abuse components led to his first drink.

Q. You – I know you weren't brought up Catholic, but did you – I'm sure you have Catholics that you work with and may have been alter boys. But did you ever go around to see what the prevalence was of alter boys getting into the sacramental wine?

A. No.

Q. So you don't know whether this was a common or uncommon experience for alter boys to do?

A. No, I don't know how common it is, no.

Q. What we have is in high school and I said....

A. Although – sorry, although I think he might have got into trouble for it but I – I don't know common it is.

Q. Well, it's – it's not something that would be condoned by the priest, right.

A. That's right. So it's probably not that common.

Q. Why do you say that? Why do you say it's uncommon because it wasn't condoned by the priest?

A. I – I said it's probably not – or probably not common.

Q. Why do you say that?

A. If it's not condoned then why would it be common?

Q. Because alter boys will be alter boys. I mean, just because a priest doesn't condone it doesn't mean to say that it was uncommon. I mean, the – the two don't follow logically, do they?

A. I – I would think so if there is rules not to do something, um, I wouldn't think that they automatically all would not follow the rules unless they don't follow rules.

Q. But you just don't know, right?

A. I – I don't know, I haven't done a study of that.

Q. And so you want to – you want to emphasize that it wasn't that common even though you don't know.

A. Well, that's just – I would think it's not

that common but I said I don't know. If there is a rule against it I would think it's not that common. And if he had any – and if he had – if he was asked to – to leave or he had gotten in trouble for it, I don't think it would be that common. But I don't know.

Q. You don't know. Now, but you mention it in your report and you mention it here. Drinking as an alter boy. That was certainly something worth mentioning.

A. Yes.

Q. Yeah, okay. Now what we do know is he started to get into alcohol when he was in high school and I think you had testified the extent to which he was drinking by the time he got to grade 12.

A. Yes.

Q. And I forget, did you mention how much it was?

A. I can take a look. I found it on page 25.

Q. Okay.

A. So he was drinking daily by grade 13, probably 3 to 5 beers per day.

Q. That would be uncommon in your experience?

A. Yeah, I would think that grade 13, that – that much would be uncommon.

Q. And what does that indicate to you?

A. Well, as he was saying he was drinking more, his – his use was escalating with time.

Q. Now, if we go to – to the little boy of 11 years old that went home and he's got no way of dealing with whatever his feelings are. He can't talk to anybody and you wanted to mention to us well, his father had his alcohol problems, and his mother had whatever. I mean, the fact is he couldn't talk to them, not because they were not people he

could confide with but no one would believe him. And he was filled with shame.

A. Yes, I think that's possible.

Q. Not possible, I mean....

A. I didn't ask him so I – I – yeah. I would agree.

Q. If you have dealt with people that are treated for – or people that are sexually abused, whether as adults, teenagers, I mean, they're ashamed of that, aren't they?

A. Yeah, one of the challenges in assessing it is that a lot of people don't mention the abuse until later on in their lives, yes.

Q. They're ashamed of it. They don't want to talk about it, they're names are taken out of the newspaper when they're in courts because they're ashamed of it. They don't want it to be made public that they were abused. Right?

A. Yes.

Q. Even though they did nothing wrong, they're ashamed of it.

A. Yes. That's correct.

Q. And they don't – they don't want to talk about it.

A. Yes.

Q. So as an 11-year-old being Catholic and, you know, the priest, well, you know, mother wouldn't believe me if I told her, I mean, this was such an heinous act, no one would believe it. He had no one to talk to.

A. Well....

Q. And – and I am – I am saying to you that he had – he had no ability to deal with whatever feelings were going on inside of him. Right?

A. Well, yeah, I agree with you he didn't feel comfortable in disclosing that abuse to anyone.

Q. And – and he had to deal with it on his own.

A. Yes. That's right.

Q. And the common way for all of us to deal with uncomfortable feelings, is distraction. Right?

A. That would be one way, yes.

Q. Well, it – it's what you would call a defence mechanism, isn't it?

A. Yeah, that can be a way to – to improve things, distract yourself. Yeah.

Q, But not to improve things, just to make things less painful the way they are.

A. Which improves things, yes.

Q. All right. And I mean, that – that would be the only thing the child would have, right? If he can't talk to anybody, the only thing he can do is distract himself. I am not going to think about it. I am – I am going to put it out of my mind as much as I can and bury it.

A. That's one way to deal with it, yes.

Q. Well, what – how else could the boy deal with it?

A. Well, with – with trauma it would be – you know, the symptoms tend to peak right, you know, right after it happens and then they tend to go away naturally, with time.

Q. Because we don't want to think about it.

A. Well the body just naturally deals with it, trauma is a – a part of being human and a part of life, stressful events happen. Most people have been exposed to a stressful event in their life. Most don't go on to P-T-S-D and then most do experience P-T-S-D symptoms, and then they'll go away with time.

Q. But most people aren't abused by a priest at the age of 11.

A. Correct.

Q. And – I mean, Doctor Jaffe said that it was severe in his opinion. You don't agree with that, do you.

A. No, I don't.

Q. He says it was....

A. That's not to say that the abuse was not – the abuse is, you know, certainly wrong and it's terrible. There is no doubt about that, but in terms of the severity of the – of the abuse, on that spectrum I have talked about, I would say it's in the – you know, more in the middle.

Q. He was – he was adding, too, the fact that it was a priest and he was confined, you know, he didn't – he had no place to go to escape. You know, the impact of – of that act was magnified because of who did it and where he was.

A. There's not a lot of good evidence on clergy abuse in terms of randomized control trials, good methodological rigor. In the hotel room itself he was able to get away, it's not like the priest grabbed him and pulled him back in and forced him and did some of those awful things that can happen. So I have unfortunately encountered victims where the abuse has been much more severe, to Mr. McCabe, and it has happened over a longer period of time. So in my experience it would be more moderate than severe.

Q. But your experience is based mostly on the readings that you have done, right? On the research.

A. No, in terms of violence risk assessments. So you can look at what the – what happens to the victims.

Q. But you don't go into the detail that we do here, do you, in these kinds of cases?

A. Well, you get the synopsis and exactly what

happened, you – so you get a wide range of – of what happens to people and – and the victimization.

Q. Having regard to Doctor Jaffe's experience in sexual abuse matters, would you say that his opinion might be more valid than yours?

A. No. But that's not my determination.

Q. No. Now the little boy who has these feelings and tried the only way he can deal with them is distraction, right? There is no other method, he can't take a pill, he can't go and talk to somebody, he can't talk to a therapist. The only thing he can do is distract himself and bury the feelings as best he can. Right?

A. That's – yeah, that's one way he can do it. He can keep himself busy, yes.

Q. But there is no other way he has.

A. I'm sure he can involve himself in school activities and...

Q. That's what I'm talking about.

A. ...and bolster his...

Q. Distraction.

A. ...self-esteem and do various things like that.

Q. And he tried to do that, becoming president of the class and...

A. Yeah.

Q. ...stuff like that. Right?

A. Yeah.

Q. But it is common in psychotherapy to understand, is it not, that you can only pull the wool over – or the covers over your head for so long. These things boil up inside and they – they – they come up in life. Right?

A. Well, that's, again, that's kind of I think

more, you know, the kind of Freudian view of things. You push things down and they bubble up to the surface and so on. But, no, that's not necessarily the case. People can deal with things and get on with things.

Q. It's not necessarily the case but it happens, right?

A. Yeah, it – when someone is traumatized, again, most people don't go on to develop P-T-S-D. The studies are clear about that. Most people have severe, you know, the more severe symptoms at the beginning and then they naturally dissipate with time. And....

Q. And drinking alcohol is one way to deal with these uncomfortable feelings that keep bubbling up.

A. Yes. Someone can deal with their anxiety through alcohol use.

Q. And Mr. McCabe's drinking, as you have described it in grade 12, was radically different than any of his siblings.

A. Yeah. He had a higher – it looks to me like he had a higher – certainly in the course of his life, a higher degree of drinking. More severe alcoholism than his siblings, yes.

Q. It looks like it?

A. Well we were talking earlier about how – you were talking about that one area in high school. And I think it was Jim who had the difficulties before marriage, before age 21.

Q. Difficulties because he got stopped by the police.

A. Yes.

Q. Yes.

A. But certainly as Mr. McCabe's life continued

on his alcohol abuse was more severe.

Q. It was more severe when he was in grade 12.

A. It could have been, I don't have the information to – to say when Jim's impaired was and so on.

Q. Well, drinking to the extent that Mr. McCabe was in grade 12 is a lot more than an impaired charge, isn't it?

A. It could be, um....

Q. He's – he's – he's impaired three times a week did you say?

A. Well, it depends how much he is drinking. If he is drinking....

Q. Well, what is the history that you told us?

A. Well, it's three to five beers per day.

Q. Wow. Five beers in grade 12, for a little short guy like Mr. McCabe?

A. Yeah, it's – it's quite – it's quite high use, yes.

Q. Impaired?

A. That could lead to impairment, yes.

Q. Moderate – well, not legal impairment. He is impaired drinking five beers in grade 12. Right?

A. Well, people metabolize about one beer per hour so it depends on how quickly he drank the beer. Certainly if he drank them all in the first hour or in a very short period of time, yes, absolutely, that would lead to impairment.

Q. And he's got at least moderate to severe A-U-D in grade 12.

A. He very well could. I haven't looked at the criteria for him but he very well could have had that, yes.

Q. And that has lasted throughout his lifetime.

A. He's had severe drinking issues in his lifetime, yes.

Q. All right. He has had – they have continued throughout his lifetime. There never was a period....

A. Well, he's been sober since 2010.

Q. All right. Yeah, yeah. But up until he was – is he 59 or 60 at the time when he got sober. Up until the age of 60 he was a drunk.

A. He was, yes.

Q. His brothers and sisters weren't bad. We have heard – we have heard their life histories, they weren't.

A. I agree.

Q. And what I am suggesting to you and I gather you are not going to agree with it. But the reason he was so radically different is he turned to alcohol to deal with these feelings that he couldn't control, and alcohol grabbed – grabbed him.

A. Well, I think that would be one contributor to alcohol use. My assessment of what happened with Mr. McCabe was it was confusing, the abuse was confusing at the time. And he didn't really think about it for years and years until he became sober and started reflecting back on his life, tried to make sense of it. He re-experienced it again during meditation, because as I said he – he said kind of chuckled about it and then went on cleaned the place. And then he entered therapy where he started talking about the abuse repeatedly.

Q. Mr. McCabe, did you understand that the chuckling was about trying to get over the resentment for Father Robert?

A. Yes. He has also been described as, you know, we were all talking about drinking to, you know, quell

negative emotions and so on, he has also been described by – that he was a happy drunk, over the years, not a sad drunk over the years.

Q. Well, drinking made him happy, that's why he turned to it.

A. You may – yeah, I mean you can still be a – a – a sad drunk or an unhappy drunk if you are dealing with negative emotions. So...

Q. You drink...

A. ...so – so...

Q. ...you drink – you drink....

A. ...so my read of – of Mr. McCabe and what happened with him is, yeah, it's a terrible thing what happened to him. But – and this is in keeping with the literature and people who are, you know, 12 or – or younger when they are sexually naive and they don't understand fully what's going on to them. They may be able to get on with things even though it is a discrete stressor at that time. And then – and just as Mr. McCabe did as he starts to reflect on the past, it takes on more meaning. And I agree, he is not drinking so he is – he is able to think about it more clearly and it had a lot of distress for him at that – at that point in time with P-T-S-D symptoms.

Q. One of the things that you mentioned about the P-T-S-D symptoms, did – did he develop P-T-S-D when he was 60? Is that what you're saying? When he started to think about this?

A. Well, he – he had – he certainly started thinking about the abuse a lot so he had those....

Q. That's not what I asked.

A. So I don't know if he developed P-T-S-D, but he certainly had P-T-S-D symptoms. So he had – he had the

symptoms, he had a trauma, and he had I think distress. So to get a diagnosis of P-T-S-D we need distress or impairment. He certainly had distress about it and he had re-experienced these symptoms about it.

Q. But he didn't have that until he was 60.

A. Yes. That's what he told me.

Q. That's because he dealt with his symptoms by using alcohol. Right?

A. That – that wasn't my understanding of that. You're not completely intoxicated 24-7 and alcohol doesn't stop people from thinking about things. It may quell their emotional reaction to things, but it doesn't stop them from thinking about things.

Q. It depends how much you drink, doesn't it?

A. And – well, and a lot of people with alcohol in – start to ruminate more about – about things. And become, you know, an unhappy drunk. That wasn't the case for him but....

Q. Are you seriously telling the jury that Mr. McCabe's use of alcohol, to the extent that it was, from grade 12 to the age of 60, was not because of the P-T-S-D symptoms caused by the abuse? Is that what you are telling us?

A. Yes, it is.

Q. He just drank like this for other reasons that these other factors that you set out in your report. The short...

A. Yes, and...

Q. ...stature and the....

A. ...and – well, you know, you keep mentioning that but it's never just one thing. There is a number of different risk factors that he had. And if people have – if a – if a clinician has experience with people that don't suffer

from sexual abuse, you can see that alcohol use disorder is a severe disorder, it can take on a life of its own, it can be self-perpetuating, and you certainly don't need a history of childhood sexual abuse to develop alcoholism. And my read of this situation is, he was drinking because he was an alcoholic.

Q. And he was doomed to become an alcoholic. Is that what you are saying?

A. I didn't say he was doomed. I am saying he had a number of risk factors that led to his development of alcohol abuse.

Q. Well, we know that Tom was short.

A. Yes.

Q. That was his risk factor too, but he didn't become an alcoholic.

A. We're – well, we're talking about Mr. McCabe. And I agree, he didn't become an alcoholic.

Q. So how come Tom being short didn't become an alcoholic and Bob did?

A. Because these things are multifactorial, many different factors contribute to risk and risk is manifested in some people and not in others. So, for example, that study I mentioned to you, 30 percent of people with a history of childhood sexual abuse developed a substance use disorder at some time in their life, not their entire life; 19 percent developed it who didn't. So again, it's not cause and effect, it's not like one thing automatically leads to another, it's increased risk.

Q. Would it be surprising that Doctor Jaffe testified otherwise in that 30 percent? I think his evidence was it was like 70 percent or greater.

A. It would depend on the study but there is

higher relative risk.

Q. Yeah, I mean....

A. So I'd have to look – I'd have to look at the study and then – and then comment on that.

Q. I – I....

A. And this – and this is a population study in Ontario that I am quoting from.

Q. What I am trying to indicate is that your use of the 30 percent is maybe picking one study. I mean, Doctor Jaffe, who I am going to suggest to you is much more experienced in this area than other – judging – or – or than you are. Taking from his personal experience as well as what he knows about this, 70 percent of people with childhood sexual abuse develop...

A. Did – did....

Q. ...alcohol use – or substance use problems.

A. Yeah, I – I would disagree with that, um....

Q. Well – well I'm just saying, you – you don't agree with what his...

A. I – I don't....

Q. ...experience was.

A. I don't agree with that, so if someone only deals with childhood sexual abuse victims that have alcohol problems or – or psychiatric problems or agency involvement, that's a selected sample. You are going to have higher risks of these disorders than if you take a general population survey.

MR. LEDROIT: That's all I've got. Thank you, Your Honour.

THE COURT: Thank you. Re-examination.

MR. BLOM: Could we have one moment, Your Honour.

RE-EXAMINATION BY MR. C. BLOM:

Q. Doctor, in the early questions of the cross-examination you were asked if you had looked at Doctor Jaffe's report and you pointed out that he relied on I think it was the – the reading out of the psychological testing making his conclusions less reliable. Do you remember that?

A. Yes. So I – I said I – I have....

THE COURT: All he asked you was did you remember. And the question is coming after that.

A. Thank you, Your Honour.

MR. BLOM: Q. Okay. You didn't have the report – you don't have the report with you at the desk where you are sitting now.

A. I – I – I found...

Q. At the witness stand.

A. ...it actually. Yes.

Q. Oh, okay.

A. Yes.

Q. So, having now found it can you....

A. It's somewhere in this pile.

Q. Sorry?

A. I know it's in this pile somewhere.

Q. Okay. Can you assist us in telling us whether the report is reliant on the reading out of the psychological testing.

A. The – yeah, that is provided on page 11, 12, and part of 13.

Q. Now, what do you mean by the reading out of psychological testing?

A. So the – the psychological testing when you

put it in the computer it prints a computer readout. It – it interprets it for you and so one thing working with Doctor Wright, in these types of cases, to insure – is to insure that the entirety of the readout is provided. So in some cases it's not. And – and also to be mindful that the computer readout can't tell you what trauma may have caused certain things or what trauma may have caused certain disability. And it can't tell you that a trauma happened. So ultimately the psychological testing can assist in answering the question or providing a diagnosis, but it can't replace looking at all of the factors in a certain case.

Q. Thank you. Those are my questions.

THE COURT: Thank you. You are free to go.

A. Thank you.

THE COURT: Thank you very much.

A. Thanks.

THE COURT: We will take that afternoon break. We - I want to talk with the lawyers about scheduling issues that may have changed since the last time I have talked to you about scheduling. We are all going to take a 20 minute break and then we will come back and discuss those issues. So I should have you back shortly but it will be longer than 20 minutes. Thank you.

3:18 P.M. JURY RETIRES

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M A T T E R A D J O U R N E D

FORM 2

CERTIFICATE OF TRANSCRIPT (SUBSECTION 5 (2))

Evidence Act

I, **Dolores Daly**,
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