

**Professionals as sex – offenders. Assessment and treatment.  
Differences and similarities between South Africa and Europe.**

10<sup>th</sup> IATSO Conference.

August 27-30, 2008. Cape Town, South Africa.

In cooperation with: Joan van Niekerk, National Coordinator Childline South Africa, Cape Town

Werner Tschan, M.D.

University of Zurich, Switzerland

Scheuchzerstr. 21 CH-8006 Zurich

[werner.tschan@wb.uzh.ch](mailto:werner.tschan@wb.uzh.ch)

fon +4161-331-6113



University of Zurich

---

**Abstract**

Professionals as sex – offenders. Assessment and treatment.  
Differences and similarities between South Africa and Europe.

Joan van Niekerk, Werner Tschan

Despite the clear warning provided by the historical Hippocratic Oath and codes of ethics medical and other helping professionals remain hesitant in discussing the problem of institutional abuse, committed by sex-offenders working in institutions and structures providing care to children. As professionals they are given access to vulnerable clients. It can be assumed that some of these would look for a particular profession in order to be able to act out their deviant sexual urges. There is a structural correspondence to CSA (child sexual abuse) insofar as these professionals use their professional power and position to abuse clients. The two presenters provide an overview on assessment and treatment of this special group of sex-offenders. The low relapse rate of <1% for rehabilitated professionals strongly supports this approach. The implications for medical training and rehabilitation of professionals who have become sex-offenders are discussed. Case histories and problems with case management from both the European and South African contexts illustrate the topic.

---

**Professionals as sex offenders**

Professionals engaging in intimate relationships with their clients/patients/students are considered as sex-offenders. However, there is not much discussion about this subject at conferences, nor is there much available in the literature. Also there is no existing diagnostic term in psychiatric manuals (DSM, ICD). PSM (Professional Sexual Misconduct) is often labeled as transference love, as unprofessional behavior and alike – terms which are misleading and do not address the true nature of this problem. Whether PSM is committed by a lawyer, by a teacher, or by a health care professional – in the majority of cases it has a deep impact on victims and causes psychotraumatic and attachment problems (Van der Hart et al. 2006).

Law is often negligent in dealing with this problem; and when it is regulated law usually covers only health care professionals; other professional relationships are rarely included (see for example clergy in Texas, or

in Minnesota). In Europe, Germany has the best standard for health care professionals (article 174c StGB, in effect since 2003) declaring sexual involvement in any health care professional-patient relationship as unlawful. Switzerland has created an enormous gray area with article 192 and 193 StGB; stipulating that when the dependency of a person is abused then it is unlawful. The proof lies with the victim, and the Swiss Supreme Court has set a rule which says that the abuse of the dependency has to be proven in any particular case, which makes a court proceeding highly unpredictable.

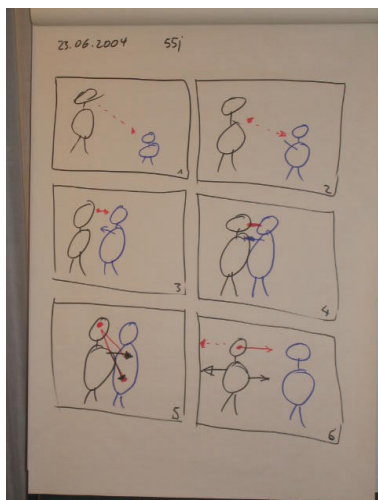
No wonder therefore that there are many controversies on what to do with professionals after PSM and how to intervene, if at all. Contrary to sexual offenders in general professionals as sex-offenders are only rarely forced into mandatory treatment; and regulating authorities have no uniform strategy on how to react towards accused professionals. The author has developed a remedial Boundary Training program which he has presented at the 2002 IATSO Conference in Vienna and which has been in use for 10 years. The therapeutic approach is based on a semi-structured, cognitive behavioral intervention program. Numerous professionals have contacted the author for advice and help, and have successfully finished the training program. The author emphasizes the need for close cooperation with regulating authorities, the justice system, employers and professional bodies.

### Case example

The following case example illustrates the many facets of sexual abuse by professionals:

A psychiatrist sexually abused a 22 year old female patient who has been diagnosed with Borderline Personality disorder. He was the doctor in charge at the inpatient facility when she was referred for treatment. He later became the treating psychiatrist after release, in an out-patient setting. The patient wanted to sit next to him; she asked him to hold her hand, later to hug her. This clearly sexually aroused him and he started to fondle her, later to kiss her, and finally engaged in sexual boundary violations. She reported this to the police and the psychiatrist was charged and received a conditional sentence; he also had to pay a fine and compensation to the victim. The court did not force him to undergo treatment, nor did they question his ability to practice.

He was fired and then voluntarily undertook a remedial Boundary Training. In his first session he presented the following story board - he was told to present what sexually aroused him, picture number 5 is the sexual abuse per se, picture number 6 how he felt after the abuse has taken place, and picture 1-4 show how the abuse was initiated.



## Story Board

In his comments she described the initial relationship as a father-daughter relationship where he recognized her as very vulnerable person, and he felt responsible to take care after her (picture number one). She then gradually improved, and after helping her to finish her training as a nurse he considered their relationship as one of equality, and he then no longer hesitated to initiate a sexual relationship (picture 4 and 5). He felt sexually attracted by her breasts and her hip – but did not draw any sexual related stuff, as one can see from his story board. He commented that this female patient had sexually aroused from the very day when he had seen her for the first time.

There was no pedophilic interest, but it clearly turned out during the Boundary Training, that he terribly suffered from attachment problems due to a prolonged separation from his parents at age 4-5, when he had to stay at a children's hospital due to poliomyelitis. He felt so terribly homesick that the nurses had to fixate in his bed; and he never could trust in a close relationship since then. He also never talked about this experience in his life until now. This female patient in her despair and need had triggered his own memories, but also his deep attachment desire; and he showed no difficulties in accepting his unprofessional behavior towards this female patient. At times he became suicidal, and went through a deep grievance process, partly because of his own life experience, partly due to the medical error and the difficulties he had caused to this female patient.

His marriage nearly broke, and his wife was about to leave. Thanks to a place where they could share their concerns they could establish a new base for their relationship. He decided to give up his psychotherapeutic work, and returned to his former job as an anesthesiologist. After finishing the Boundary Training he accepted a monitoring for the rest of his professional career, and also voluntarily participated in a training video on boundary issues.

The lack of awareness among professionals about the true nature of PSM is shocking – the World Report on violence and health (WHO 2002) does not even mention the problem. On the other hand, regulating bodies are confronted with a huge number of such cases, as a recent European conference on impaired physicians (Oslo 2008) clearly indicated – according to the Norwegian Board of Health Care Professionals 50% of all cases of license withdrawals were due to PSM, and 50% due to substance abuse. Where medicine has a considerable knowledge what to do with substance abuse, the knowledge about PSM and what can be done with affected professionals is very limited.

## Assessment

The concept of the remedial Boundary Training claims a close cooperation with regulating authorities, the justice system, employers and professional bodies. At least one of the mentioned institutions should be involved when rehabilitating a professional, mainly due to the monitoring, which is established either at the beginning of the intervention program in case an accused is given permission to continue his/her work; or when returning to practice. The monitoring is a crucial part of the rehabilitation plan and contributes to the considerable low relapse rate of <1%. Relapse is defined as any new occurrence of sexual boundary violation in the professional-client relationship. The monitoring is cooperatively developed and implemented with the accused professional and his work-place environment including employer.

The assessment has to clarify whether a professional can be rehabilitated and what are the salient treatment goals. Based on the assessment an individual intervention plan is developed. The decision can

be unfavourable for a professional, e.g. in cases of severe personality disorder; but in the majority an out-patient treatment is possible, rarely an inpatient treatment is recommended (depending on severity of the disturbance and the ongoing risk for individuals, e.g. pedophile offenders, rapists, etc.). The assessment is not a finding of facts; it has to provide a comprehensive understanding of the sexual abuse, the underlying problems, risk factors, and motivation for rehabilitation;

- biographical data, including attachment experiences, social and financial situation, employment, previous conviction(s), sexual development, sexual relationships, difficulties in the professional role
- insight into the boundary concept
- motivation for a behavior change
- underlying explanations and motivations for the boundary violation (compared with victim's version)
- risk assessment in regard to professional duties
- risk of relapse

The intervention model is based on Finkelhor's (1984) concept of the preconditions for sexual abuse – the "motivation" to abuse; and how to overcome the various hurdles. Due to their professional knowledge their cognitive distortions are even more "effective" than in traditional sex-offenders.

## **Intervention**

The offence-focused treatment is based on a semistructured cognitive-behavioral intervention approach consistent of 24 modules (see: <http://www.bsgp.ch/userdocs/Sydney%202007%20pdf.pdf> ). The specific treatment goals can be divided into offence and personality focused aspects.

offence focused:

- offence reconstruction
- cognitive distortions
- underlying causes
- impulse control (internal-external)
- offence related personality aspects
- victim empathy
- improving impulse control
- openness
- intimacy and emotionality
- responsibility
- work – life-balance
- crisis-management

personality focussed:

- anger management
- power and powerlessness
- own victimisation
- social skills
- fear-reduction
- substance abuse
- eating problems
- identity and self esteem
- nature and ecology
- ethical concerns
- personal perspectives
- spirituality

The semistructured program guarantees that all important aspects of offender strategies are covered and that effective relapse prevention is established based on individual offence pattern. During the program an individual monitoring concept is developed and then implemented in cooperation with the regulating authorities or the employer. The monitoring is performed until retirement (Abel et. Al. 1998). Usually the monitoring includes random questionnaires from patients, regular feedback from co-workers/staff and self reporting, as well as regular meetings with the therapist to discuss personal and professional issues.

The risk management includes background checks when recruiting new personnel, the signing of a code of conduct which implicitly forbids any intimate contact with a patient, and a guideline of the institution

concerning the prevention of sexual violence in the institution. The management develops a risk profile of any particular workplace and the inherent dangers and problems, e.g. vulnerable patients, night and weekend service, etc.

### **Another case vignettes**

The following case illustrates the need for therapeutic intervention:

A psychiatric nurse who was responsible for the rehabilitation of a male patient, age 19, engaged in a sexual relationship with him. In her explanation she helped him to cope with life difficulties by offering him an intimate relationship. He felt alone, having no relationship, and having no perspective. When the staff finally confronted her, she disclosed the abuse; and she was fired the same day. For the institution the problem was solved.

She voluntarily undertook (self referred) a remedial boundary training, which she successfully finished. She was never charged for the abuse, neither by the patient, nor by the psychiatric hospital. She was neither forced to undergo a treatment by her professional organization, nor the next employer, or any health care regulating authorities.

After the initial 7-8 sessions she began to disclose step by step how she felt in love with this patient and how she contributed to the abuse. In the detailed offense reconstruction she presented her own circle of abuse. During the treatment she learned to understand the concept of boundaries in medical treatment and how to cope with difficulties related to boundary issues.

To better understand contemporary situation I provide a recent case which was cleared in court.

A woman initially sought treatment for her personal problems, later the husband get involved due to marital difficulties. After three years of treatment the psychiatrist began to disclose personal issues to the female patient, gave her compliments for her attractiveness, and kissed and hugged her at the end of sessions. One day he French kissed her, and then started to fondle her, and finally they started to sexually stimulate each other. On a home visit, the therapist had penetrative sex with her, for which he billed her regularly. The intimate relationship went on for a while, until the woman stopped the "therapy", and finally sued him.

The court decided that the therapist had not misused the dependency of the female patient and cleared the case. The court of appeal also cleared the case, but sentenced him to pay a victim's compensation of 5000 CHF (3000 €). After appellation to the Swiss Supreme Court, the verdict was a clear sentence due to abuse of the dependency by this physician; but because the case run out of the status of limitation, the professional remained unsentenced, and continues to practice.

This case clearly illustrates the lack of a consequent verdict. Not only forensic experts seem to have difficulties in seeing professionals as sex-offenders, but also judges. The confusion about "love", countertransference-love and sex-offending is still present. Both from a professional perspective but also from the patient's safety perspective these approach is clearly unacceptable.

## Conclusion

The aim of this contribution is discuss sex offending by professionals in their professional role, and what kind of intervention is adequate and helpful in regard to rehabilitate them. The remedial Boundary Training in combination with a monitoring lead to a significant reduction in relapse rate; which means that rehabilitated professionals have a lower risk for committing any sexual offenses in their work than professionals in general. For the risk management of an institution it means, that they should cooperate in establishing a monitoring for their own benefit – it helps to guarantee patient's safety through adequate means.

The health care and social services system must recognize the risk inherent in the professional role, that sexual arousal may taken place in close patient-professional situations. This issue must be integrated into curricula and postgraduate training – the idea that professionals engaging in sexual boundary crossing are all psychopaths has not been proven as true, in the contrary, as Glen Gabbard (1996) hat pointed out in a article: most of them are more similar to us, than not. The idea of a us/them dichotomy is misleading. It is part of the professional duties to provide the condition where healing can take place (Bowlby 1988). Institutions including private facilities in the health care and social services sector are high risk places for sexual abuse – the opportunity is part of the professional setting.

## References

- Bowlby J.: A secure Base. London, Routledge, 1988.
- Gabbard G: Lessons to be learned from study of boundary violations. American Journal of Psychotherapy, 1996;50(3):311-321.
- Finkelhor D.: Child Sexual Abuse. New York, The Free Press, 1984.
- Krug E.G., Dahlberg L.L., Mercy J.A., Zwi A.B., Lozano R. (eds.): World report on Violence and Health. Geneva, World Health Organisation, 2002.
- Tschan W.: Sexuelle Grenzverletzungen in professionellen Beziehungen. Basel, Karger, 2005, 2nd ed.
- Van der Hart O., Nijenhuis E., Steele K.: The Haunted Self. Structural Dissociation and the Treatment of Chronic Traumatization. New York, W.W. Norton, 2006.

## Acknowledgement

I appreciate the work by native English speaking Clare Kenny who improved the style of this handout considerable.