**Rehabilitation of professionals after PSM (Professional Sexual Misconduct)**

9th Conference of the International Association for the Treatment of Sexual Offenders (IATSO)
Hamburg, September 6-9, 2006

Werner Tschan, M.D.
University of Zurich, Switzerland wtschan@wb.unizh.ch
Scheuchzerstr. 21 CH-8006 Zurich fon +4161-331-6113

University of Zurich

---

Abstract

The treatment of professionals as sex-offenders is a special challenge for an offence focused intervention technique. Due to their knowledge about their victims (based on their mutual professional relationship), their social position, and their professional knowledge in general, their cognitive distorsions tend to be a considerable obstacle in a rehabilitation process.

The author presents preliminary results about Boundary Training, which is a modular offence focused intervention program for professionals after PSM. The indications for treatment are based on an assessment and on a treatment plan derived from the individual situation. After finishing the Boundary Training monitoring is then part of the rehabilitation process. The results are compared with the treatment experiences of sex offenders when the abuse takes place in a non-professional relationship.

Within the discussion on the subject of PSM there is hope that colleagues realize the inherent danger in their professional career, and that they ask for help if necessary whenever possible before legal and administrative sanctions take place.

## Introduction

Rehabilitation of sex-offender-professionals only makes sense, when there is a insight into ones' own short-comings and problems. If this is not the case, rehabilitation doesn't make any sense at all. The decision whether a certain professional should be allowed to return to work must be based on the individual situation and a positive result in the rehabilitation process. The more vulnerable the clients or patients in the professional role-pairing are, the higher the hurdle. For those professionals working with small children or handicaped people practice re-entry is only possible if they really have overcome their underlying problems. This means for example that in cases of pedophiles where any treatment outcome is limited to control over the deviant behavior, a return is never acceptable. These professionals have to definitively change their professional role and working in a field where they no longer have an uncontrolled access to children. This may be the case for pediatricians, clergies, nurses, sport trainer and teachers, just to name a few.

**Definition of PSM**

The term PSM (Professional Sexual Misconduct) describes all forms of sexual boundary violations when committed in a professional role, e.g. in the health care system, in a spiritual service, in teaching, etc.:

1. Penetration in all forms (vaginal, oral, anal) [sexual violations]
2. All forms of hands-on and hands-off offences (fondling, erotic kissing, taking pictures from intimate parts of the body, exposing oneself, etc.) [sexual transgressions]
3. All forms of verbal sexual offences (inappropriate sexualised remarks, dating) [sexual harassement]

All three forms are considered offences in the criminal code of most nations. Only a few penal codes know a specific article against PSM. The gold standard for the health care system today is the German Criminal Code article 174c, which forbids any sexual boundary violation against a person when in medical or psychological treatment. Some nations such as Switzerland only forbid sexual acts when a person is in a inpatient treatment (Article 192 Swiss Penal Code). Some jurisdictions forbid clergy sexual involvement (Texas, Minnesota) and some forbid teacher-student sexual involvement. Paradoxically, the only profession worldwide which is not regulated by criminal code in relation to PSM are the lawyers.

**What is similar, what is different?**

When comparing professionals who commit sexual boundary violations in their professional role with sexual offenders in general we can find some differences, and some similarities. Their pro-social competence can be a considerable resource and protecting factor in the treatment process, but the same quality causes obstacles against a successful intervention program, e.g. cognitive distorsions and denial.

Main differences include:

- route to offence (= professional setting)
- knowledge of the sex-offender-professional
- denial processes/cognitive distorsions
- it may be a colleague, it may be a head of a clinic, etc.
- impact on institution and/or professional body
- media attention
- no topic in the literature / no discussions on conferences

Similarities:

- they are sex-offenders
- no specific preventive treatment for potential offenders available
- they are notoriously under-reported
- there is no mandatory reporting (at least here in Europe)
- male vs. female offender rate is 4:1
- they need treatment
- their relatives need treatment and support
- their institution need management and team consultation
- they will relapse and re-offend
- they create victims by their wrong-doing

Similarities, but … :

- lack of responsibility undermines professional competence
- almost no research about magnitude and risk prediction instruments available for this category of sex-offenders
- specifice victim treatments are not available
- confusion among justice system, regulating authorities, and professional bodies about the true nature of PSM
- sex-offender-professionals are not seen in correction service or in prison
- almost none of them get (mandatory) treatment

When there is no specific law, the justice systems considers PSM, when committed against an adult person without any violence and coercion, as consensual. Cullen (1999) has provided five arguments for a zero tolerance politic, at least for the health care system. His contrafactic statement, that if sexual boundary crossings would be accepted within the health care system, then this would lead to inacceptable consequences, this cannot be disbuted. Just recently, the Swiss Supreme Court claimed in a case of a female patient vs. a psychiatrist (BGE 131 IV 114) that PSM in the absence of violence and coercion is always carried out in a seemingly consensual way, where the dependency of the patient towards the professional undermines the capacity to make a free decision. Therefore they declared PSM as a crime and sentenced the professional. The Swiss Supreme Court stipulated in another case (BGE 124 IV 13) that the responsibility of maintaining clear professional boundaries always lies with the professional, a duty which cannot be delegated to the client or to the patient.

## Goals of the rehabilitation program

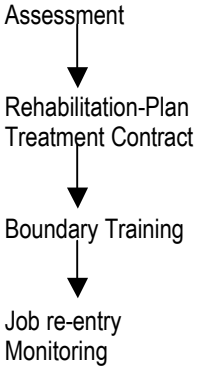
The goals of a remedial Boundary Training program are:

- re-establish professional competence
- solving the underlying problems
- relapse prevention

An important aspect of the remedial Boundary Training is the transformation of the experiences derived from individual treatment into preventive strategies, and to use the knowledge for professional training and formation.

## Concept of the remedial Boundary Training

The framework can best be described in form of an algorithm:



The assessment is not for facts finding, it clarifies whether someone fits into a treatment program or not. In a collaborative process a hypothesis about the underlying causes which lead to PSM will be established. Prior to this process the participant is instructed about available information sources, such as victim reports, findings by investigative bodies and results of medical and psychological testing. If the participant is unwilling to cooperate and/or refuses the fact that she or he has a problem the treatment cannot be undertaken. From the assessment the individual risk factors and trigger mechanisms for the offence must be identified, as well as protective factors against further relapses.

Based on the assessment an individual treatment plan is developed. A contract between the treatment provider and the participant then is negociated and signed. The contract clarifies rights and duties, and also requires a commitment by the participant to absolutely avoid any further boundary violations. The consequences of this and of treatment drop-out are clarified as well. Another important aspect to clarify is confidentiality vs. co-operation with other involved institutions, e.g. law enforcement, regulating authorities or victim support services. It is crucial for sex-offender treatment to establish a secure and transparent base right from the beginning.

**The 24 modules of the Boundary Training**

The training program is a semi-structured program which has to be adapted to individual needs. The therapeutic interventions are based on sex-offender treatment programs derived from cognitive behavioral and systemic treatment techniques, enhanced by sexual medicine interventions, psychoeducative and bibliotherapeutic techniques.

- introduction
- counseling a professional
- client-professional relationship
- boundaries
- epidemiology of PSM
- psycho-traumatology
- victims of PSM
- counseling victims
- how does it begin?
- fantasies
- masks
- cycle of abuse
- case presentation 1
- Broken Boundaries (Maryland training video)
- 20 steps
- 20 steps - interpretation
- law and justice
- sex-offender-professional (video by Michael Myers)
- institution - consequences and reactions
- burden of guilt - new beginning
- relapse prevention
- own cycle of abuse
- case presentation 2
- responsibility
- evaluation, end of program

[For more details refer to my book which will be published shortly in English]

## What do we know about the magnitude of PSM?

Sexual offences by professionals of all kinds are notoriously underreported for a variety of reasons. We have some data from professionals self report questioneers, however, they are not very reliable. They indicate that a considerable number of professionals from various backgrounds commit PSM. For the health care system there exists consumer reports, e.g. the 1999 Health Monitor from Ontario, Canada. 110'000 inhabitants from a population of 11 million indicated that they have experienced sexual intimacies with health care professionals whithin the last five years. Another two percent declared, that they have experienced inappropriate sexual behaviors and remarks whithin the last five years. This data indicate, that annually 0.2 % of the population suffer from PSM (only committed by health care professionals).

The SAVI report reveals that about one in ten of all sex crimes are committed by professionals. The fact that this reality is not sufficiently described in forensic textbooks raises the question that there is a considerable professional bias, e.g. a systematic error in the awareness and understanding of sexual crimes. The postulation of this is not to blame colleagues, rather it should help to enable the understanding of PSM and to proceed in scientific research in the topic of specific sex-offender treatment for this category of abusers. There is a urgent need to overcome the taboo and the confusion still covering this aspect of sexual offences. Sexual crimes committed by professionals, often well hidden and protected by institutions, should no longer be considered as gentlemens' problems. According to the existing definition PSM has be considered as a from of a paraphilia, where the professional by his sexual offence fails to conform to social norms and where victims suffer tremendously from the sexual boundary violation and the abuse of trust. According to DSM-IV criteria, the essential features are recurrent … behaviors … involving … children or nonconsenting persons that occur over a period of at least 6 months (criterion A); the diagnosis is made if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (criterion B).

## Conclusion

Rehabilitating sex-offender – professionals means that we treat colleagues and other professionals who have failed with techniques which have been developed over the last two to three decades. If people think the rehabilitation of sex-offender-professionals is not practicable, then we should question ourselves what we are doing with sex offenders in general, when we release them from incarceration or from correction service. If treatment for colleagues is questioned in this way, we should be honest and stop offering treatment programs for sex offenders at all. I am saying this in a provocative manner in order to make it very clear, what it is what we are talking about. If we do not believe in the positive effects of our existing treatment programs for sex-offenders, then really nothing "works". If we hesitate to help our colleagues and other professionals in difficulties, our job would not make any sense at all.

## References

Abel G.G., et al.: Professionals; in W.L. Marshall, et al. (eds.): Sourcebook of treatment programs for sexual offenders. Plenum Press, New York, 1998, 319-335.
Abel G.G. et al.: cognitive-behavioral treatment of sexual misconduct; in J.D. Bloom et al. (eds.): Physician sexual misconduct. American Psychiatric Press, Washington DC, 1999, 225-246.
Bridges N.A.: Moving beyond the comfort zone in psychotherapy. Jason Aronson, Lanham, 2005.
Celenza A.: Precursors to therapis sexual misconduct. Psychoanalytic Psychology, 1998;15:378-395.

Cullen R.M.: Arguments for zero tolerance of sexual contact between doctors and patients. J Med Ethics, 1999;25:482-486.
McGee H. et al., Royal College of Surgeons in Ireland: The SAVI report. Sexual abuse and violence in Ireland. Liffey Press, Dublin, 2002.
Marshall W.L.: Diagnosing and treating sexual offenders; in A.K. Hess, I.B. Weiner (eds.): The handbook of forensic psychology. Wiley, New York, 1999, 2nd ed., 640-670.
Maryland Department of Health and Mental Hygiene: Broken Boundaris. Sexual exploitation in the professional-client relationship (video). Maryland Department of Health and Mental Hygiene, Baltimore, 1999.
Plaut S.M.: Understanding and manging professional-client boundaries; in S.B. Levine (ed.): Handbook of clinical sexuality for mental health professionals. Brunner-Routledge, New York, 2003, 407-424.
Schoener G.R.: Assessment of Professionals who have engaged in boundary violations. Psychiatr Ann, 1995;25:95-99.
Simon Robert I.: Sexual exploitation of patients: How it begins before it happens. Psychiatric Annals, 1989;19:104-112.
Tschan W.: Missbrauchtes Vertrauen. Sexuelle Grenzverletzungen in professionellen Beziehungen. Karger, Basel, 2005, 2. Auflage.
Walzer R.S., Miltimore S.: Mandated supervison, monitoring, and therapy of disciplined health care professionals. J Legal Med, 1993;14:565-596.