

Towards a safe institution: How to prevent Sexual Abuse in the Institutional Setting?

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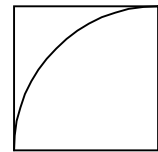
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Abstract

Sexual Abuse of Children and Juveniles takes place in institutions, not just in families. Institutions, which are dedicated to helping those in need. Sexual abuse in the institutional setting undermines trust and reputation. However, the institutional reactions to sexual abuse within the organisation itself are comparable to the incest family: complete denial of the fact, claiming that these are false accusations, or that it may happen elsewhere, but not here. In the presentation the focus will be on three main scenarios: (1) abuse by their peers in the institution, (2) abuse by professionals working in the institution (not only therapeutic professionals!), and abuse of professionals by clients, including sexual abuse and harassment by co-workers or by third parties (visitors, etc.), covered under the term workplace violence. In all the three scenarios preventive strategies are required.

To create a safe institutional environment the first step must be to raise awareness of all forms of sexual abuse. Facilitating reporting is a precondition for prevention. Furthermore the institution has to develop a policy covering this subject which must then become part of the personnel recruiting process and the employment contract. By implementing an internal task force on preventing sexual abuse in the institution all the necessary information is gathered together. This task force also provides counsel for the institution itself. The institution must develop a risk management strategy to prevent sexual abuse. Professionals must receive ongoing training on maintaining safe boundaries, wherein they can share their experiences and can also develop solution strategies. The author recommends a curricular integration of this subject into professional education.

Introduction

Sexual abuse committed by professionals in the institutional setting is still a taboo, both society and professional bodies remain in denial. This takes place despite the clear warnings provided by the Hippocratic oath, coined around 400 years before Christ, and addressing the issue for the medical field. Sexual boundary violation committed by professionals is a crime, and not a loving affair or similar expressions traditionally used to describe the fact. Furthermore, sexual engagement must also be considered a risk in the job, due to the intimacy of most professional-client situations. Pedophile offenders do not become sexually aroused by children when they work with children, rather they have that arousal-pattern and then apply for jobs where they have unsupervised access to children, due to their position. Thus, risk management must include PSM (Professional Sexual Misconduct) and preventive strategies have to address this issue as well. By making it a topic the institution overcomes

the silence and opens a space for sharing experiences; it also provides a platform for survivors, where they can come forward with their stories. By creating reporting facilities on an open-door policy affected clients feel encouraged to report their experiences. This helps to maintain the professional standards of the institution and to eliminate those who undermine professional standards and therefore bismersch the reputation of both the institution and the professional body.

PSM – abuse in the institutional setting

Most professionals think that PSM always takes places elsewhere, but not here. They forget that we are all at risk. All institutions for childcare and educating children have to be considered as high risk places, comparable to the intrafamilial situation of CSA (child sexual abuse). Most sexual child abuse takes place within the family context. Similar to the incest family, affected institutions are in denial, and attack all those who begin to talk about the issue (White 1997) .

The term PSM is used to describe all forms of sexual boundary violations, which take place within the context of a professional-client relationship, and which are committed by professionals:

- Penetrations (vaginal, anal, oral) or genital/sexual stimulation/touching
- Hands-off offences (exposing, taking pictures from intimate body parts, showing pornographic imagery, etc.)
- Verbal sexual remarks, dating, sexual harassment

In the institutional setting we have to consider four different scenarios for sexual crimes:

- Sexual crimes committed by peers in the institutional setting
- Sexual crimes by professionals working in the institution (not only therapeutic professionals!)
- Sexual crimes committed by clients (workplace violence)
- Sexual harassment (committed by co-workers within the institution)

Due to gross underreporting the magnitude of institutional abuse is not known exactly. A consumer report from Ontario indicates, that in the health care sector alone 0.2% of the population annually is affected by serious sexual crimes committed by health care providers (Health Monitoring 1999). It is estimated that 4-6% of catholic priests are pedophiles; that we have a significant number of CSA committed by youth workers, teachers and sport coaches.

The effects on the institution are devastating. It undermines trust in professionals and in the institution, and it has considerable legal and financial consequences. In most cases it also affects the motivation of co-workers within the institution, who facee difficulties in committing themselves to the institution anylonger (“do you work at thats sex-clinic?” and similar questions).

The aftermath of PSM

The effects on survivors can be described as follows:

1. psychological
2. somatic
3. social
4. financial
5. spiritual

Among the psychological aspects the isolation of survivors is one of the most salient effects. Due to the taboo victims do not feel encouraged to disclose what they have experienced. Among survivors PSM undermines trust in professionals and in society; it leads to feelings such as helplessness and all kinds of psychiatric difficulties including self harm, violent outbursts and suicidality. There is no specific “after

PSM syndrome". On the somatic level we see a similar pattern of various symptoms, predominately functional syndromes, chronic pain, and disturbances in sexuality. Many symptoms contribute to a social withdrawal and relationship breakdown, which then in addition undermines available resources. The financial consequences are dominated by a decreased working capacity, costs for legal and medical proceedings, and childcare. Finally, the spiritual consequences are based on feelings of abandonment, loss of values and beliefs.

Is prevention at all possible?

Yes, it stops with us! This clear and positive vision is based on the following aspects:

- the institution can make institutional abuse a subject: institutions are high risk places for sexual abuse
- speaking out (so that others can hear the message)
- addressing responsibilities
- challenging professional culture (overcoming the taboo)

As well as these more general conditions institutions can contribute to creating a more secure environment by establishing a few things:

- having a policy "safe institution" in place
- enforcing this "safe institution" policy
- risk management strategies
- background check should be essential when hiring new staff
- Implementing a Task Force for preventing PSM and other forms of institutional sexual abuse
- Establishing a reporting facility operating on an open door policy
- Those who report incidents must be welcomed (not blamed!) and protected (only then will this create a safe institution)

Sexual abuse within the institutional context can never be prevented on a 100% bases. However, a lot can be done, and most of the steps are quite easy to do: overcoming the silence, and breaking the taboo by just making it a subject, this is one of simplest as silence is the offender's best weapon. If nobody talks about, nobody will notice; silence leaves the victims alone, and silence certainly does not support them. Silence does not help the institution in solving the problem.

Differences and similarities in PSM cases vs. sexual offenders in general

If we compare sex-offenders in general with professionals committing PSM there are more similarities than there are differences – but often PSM is misinterpreted as "transference love", "loving affair" or as excusable behavior (we are only human ...).

Similarities:

- professionals committing PSM 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 3:1
- they need treatment
- their relatives need treatment and support
- their institutions 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
- specific 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

Differences:

- the abuse takes place in the working environment, instead of the familial context
- The institution claims to follow professional standards and guidelines
- Professionals committing PSM are trained and well aware of the consequences of their actions
- Professionals as offenders are more difficult to uncover due to their prosocial behavior, their reputation (opinion leaders, academic teachers) and their manipulative strategies

Rehabilitation

The general belief is that through firing professionals committing PSM the problem for the institution is solved. This is what is addressed as "the bad apple theory"; however the professional then applies for other jobs, and the sexual abuse continues. We need a registry for professionals who have committed PSM and a background check is essential before recruiting new personell. Some professionals go on to practice unlicensed and unregulated as "life coaches", "human relationship consultants", "religious counsellors", etc., thus creating more opportunities for further abuse. The results from the rehabilitation of offender professionals after completing a boundary training program clearly indicate that this approach significantly reduces the risk of further institutional abuse. The relapse rate of rehabilitated professionals lies below 1% which is significantly lower than the overall risk and therefore contributes to reducing the incidence of PSM (Abel G.G., et al. 1998, 2007). The rehabilitation program is based firstly on an assessment, followed by a cognitive behavioral oriented and offence focussed intervention combined with monitoring.

Conclusion

To have a vision that prevention of PSM is possible is crucial for all professionals working in the field. Furthermore they must recognize the risk inherent in their job: it happens here, it is happening now, not only by others elsewhere. The responsibility lies with all of us – it stops with us! We as professionals are responsible to make it a subject and to share our experiences. It is our job and one of the primary tasks of ISPCAN to break the silence and to overcome the taboo. It is the most important step in primary prevention, that we provide an open discussion on the subject. For secondary prevention it is crucial that the various disciplines involved are trained to deal with victims of PSM, and for tertiary prevention the awareness of the subject matter must be challenged by a curricular integration of the problem and by ongoing postgraduate training.

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