Preventing Sexual Abuse in Institutional Settings

XVI[th] ISPCAN International Congress on Child Abuse and Neglect.
York, UK, September 3-6, 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

Awareness of the magnitude and the impact on victims of PSM (Professional Sexual Abuse) has increased considerably in recent years. The is still a lack of training programs focussing on this subject, nevertheless. The author will outline the major components of a two-day comprehensive training program for helping professionals including executive staff (program development supported by German government). He will also discuss boundary training programs in order to provide the audience with an overview of current concepts in teaching boundary issues.

Introduction

The prevention of Sexual Abuse in institutional setting is the ultimate aim of this presentation. To overcome todays silence about the subject of institutional sexual abuse there are a number of hurdles to take:

- PSM is not considered to be a problem of our disciplines
- PSM will never happen here (in our institution)
- There is nothing which can be done to prevent this, it's human nature

The result is a silence among the various disciplines and involved institutions, as well of among regulating authorities. The most tragic situation is seen within the health care system, especially the psychotherapeutic field, which sees the victims of CSA (child sexual abuse) and other traumatic events, and yet has no open policy of how to combat PSM.

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, but only a few penal codes have 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 receiving 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.

Why do professionals need specific training?

There is a urgent need to integrate PSM in the curricula of various disciplines:
- Their daily work leads to dilemmas in relation to proximity and distance
- Impaired coping mechanisms leads to PSM
- When confronted with clients / patients in the aftermath of PSM specific knowledge is essential
- Prevention is possible (there is a route to PSM)

Professionals do not share their experiences about cases of PSM. The subject is not a topic at conferences, neither is there much literature available on this subject. PSM is almost never covered by textbooks about sexual violence. Professionals looking for help and support often feel isolated. In many cases those who start discussing the subject are often blamed, quite similar to situation in CSA cases. This situation is completely unacceptable. There is an urgent need for ISPCAN and related organisations to discuss the current situation. Without specific training professionals are not able to fullfill their professional roles. It is important therefore, to share the pioneering work by the German national ISPCAN partner DGGKV which has undertaken measures to combat the issues of PSM, a concept supported by German government. The author has been involved in the conceptualisation and the training of professionals.

What do we know about the magnitude of the problem?

Over the last three to four decades the main knowledge about causes and magnitudes are achieved through four avenues:
- Self reporting questioneers
- Reports from therapist treating victims of PSM
- Victim reports (classified ads in newspapers or magazines)
- Consumer reports

The first three approaches are considered highly unreliable, because it remains unclear who participated, and whether the answers were given correctly. But at the very least the results enables an estimation about the amount of professionals involved in PSM in various disciplines. This research has been undertaken among physicians, psychotherapists, nurses, clergy, lawyers, law enforcement professionals, socialworkers, physiotherapists, etc. The most reliable data we have is from the health care system. The 1999 Health Monitor taken of the 11 million inhabitants of Ontario, Canada, revealed that 110'000 people (1%) indicated, that they had suffered sexual abuse by health care professionals within the last five years. Another 2% indicated that they experienced inappropriate sexual behavior by health care professionals within the same time period. When estimating the number of affected people in a country such as Switzerland, with a population of 7.5 million, this would mean that we should expect 15'000 cases of PSM annually within the health care system alone.

This data shows two things: (1) there is a considerable number of people affected by this, (2) and that this is a public health problem which can be neglected no longer.

The slippery slope concept

This concept was first described by Robert Simon when he was attempting to understand the processes which leads to sexual boundary violations. Opportunities always play a major role – but some offender-professionals seem to create this opportunity by misusing their fiduciary and trusted role. They are 'testing the waters' in order to target potential victims. In the conference presentation three examples of the precursors to sexual boundary violations using the «story board» were discussed.

The «story board» is a technique which is used in boundary training programs. On a flip chart, the offender-professional has to make six drawings. Number 5 illustrates the circumstances of the sexual boundary violation, number 6 shows how the offender felt in the aftermath, and number 1 to 4 illustrate the time before it happens. It is always astonishing to realize, that the time of preparation of the abuse often lasts for years – clearly time enough to intervene! Offender-professionals are not stupid, they try to avoid being caught. They manipulate their clients by their prosocial behavior (which is related to their professional skill) pretending that they are taking special care of them and similar excuses. Without a clear understanding of the offender-professional-strategies any effective intervention will fail.

Consequences for victims

The framework for understanding victims' consequences is provided by the (1) Attachment Theory and (2) Psychotraumatology. The establishment of a secure therapeutic alliance depends on the interaction between the help-seeker and the help-giver. It was Bowbly, when publishing his oeuvre "The secure Base", who stated: *The psychotherapist's job, like that of the orthopedic surgeon's, is to provide the conditions in which self healing can best take place. The therapeutic alliance appears as a secure base, an internal object, as a working … model of an attachment figure …* The wrong perception that psychological caused disorders always have a good prognosis by Jaspers 1913 lead to a considerable bias: *this blind acceptance of psychiatric dogma meant that a poor outcome must be the result of premorbid vulnerabilities.*This led to a wrong understanding and interpretation of victims' responses in the aftermath of PSM.

The phobic reaction of a patient after PSM towards his physician is not the result of premorbid vulnerabilities, but is directly linked to the sexual abuse and the breach of trust. The patients' dependency of his or her physician explains the vulnerability. It was Pierre Janet (1859-1947), who laid down the fundation for the understanding of these effects when writing his doctoral dissertation "L' automatisme psychologique" (psychological automatism) in 1889. He was the first to describe how trigger mechanisms produce bodily and emotional reactions and how they are linked to past traumatic experiences. Most symptoms can simply be understood today as stress responses. The results from modern Affective Neuroscience clearly support this understanding.

Help or punishment?

Despite ongoing controversies it has become widely accepted, that the best way to handle sex-offenders is to refer them for mandatory treatment. The same is true for sex-offender-professionals. Gene Abel and Richard Irons were among the first to develop specific treatment approaches for sex-offender-professionals. Their results are convincing. Abel reported that less than one 1% of physicians undergoing treatment due to PSM relapsed. He also pointed out, that in their sample the number of patients victimized, the sex of victims, and the extent of sexual involvement are not factors determing

the acceptability of a physician returning to practice. *Instead, assuming compliance with treatment, it is primarily the ability to establish a practice plan that protects the public that determines the viability of the physician returning to practice* (Abel et al., 1999, p.245). The author has developed a modular based Boundary Training Program consisted of 24 modules. This semistructured program was presented for the first time at IATSO conference in Vienna 2002. The higher the level of dependency in the client-professional pairing, especially when children and adolescents are involved, the higher the professional quality standard must be for a safe return into work – in cases of pedophile deviance this will never be possible.

An important aspect of the remedial Boundary Training Program is the transformation of the knowledge and experience into preventive strategies and the design of training programs. The author has chaired several task forces on these subject. He also developed course programs and participated in management training. The aim of these programs is to raise awareness about PSM and how it can be prevented. The three pillars of an effective prevention are: training of professionals, having clear consequences in effect, and help available for impaired professionals – with the hope, that they will look for support before boundary violations happen.

Conclusion

"*Prevention is having professional abuse never happen at all*". This quotation from John Gonsiorek (1995) underlines the zero tolerance standard for sexual boundary violations in professional roles. As one sex-offender-professional in treatment once stated: "*you cannot be an offender just a little bit. Either you're one or not*." Preventing PSM within the institutional setting means firstly, there must be an awareness of the phenomenon per se, and secondly an acceptance of about the responsibilities of institutions as stipulated in the CRC (Convention on the Rights of the Child, 1989) art. 3.3, and art. 19. Prevention includes specific training of professionals in relation to PSM, a clear policy of the institution including the selection process of personnel, its reporting and investigation facilities, victim support and last but not least help for affected professionals. The understanding is that, that the impairment of professional competence is based on the slippery slope concept, in which there is often time enough to intervene. Prevention of PSM is possible, and it is effective. In case of PSM offender-professionals have to undergo a remedial boundary training in order to overcome their sexual problems. If they successfully complete the rehabilitation program job-re-entry under an accompanying monitoring is possible.

References

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 therapist sexual misconduct. Psychoanalytic Psychology, 1998;15:378-395.
Child Rights Convention. United Nations, 1989.
Cullen R.M.: Arguments for zero tolerance of sexual contact between doctors and patients. J Med Ethics, 1999;25:482-486.
Gonsiorek: Breach of trust. Sage, Thousand Oaks, 1995.
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.: Boundary Training: A teaching program for impaired physicians and other health care professionals. Paper presented to the 7th IATSO Conference (International Association for the Treatment of Sexual Offenders), Vienna 2002.
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.