Rehabilitation of Offenders after PSM (Professional Sexual Misconduct)

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

University of Zurich

Abstract

This lecture is the opening lecture for the Postgraduate Training in Psychiatry 2007. The presenter focuses on the risk inherent in our profession and discusses case examples that clearly indicate, that there is always a "path to sexual boundary violations". Avoiding entering the slippery slope process is the best way to protect oneself from facing allegations due to PSM (Professional Sexual Misconduct). The presenter provides data on its prevalence, the causes and consequences; and discusses professional strategies how to handle dilemmas and how to avoid getting into trouble.

The treatment of professionals after PSM is a challenge. The author presents results on remedial 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 becomes part of the rehabilitation process. The results are compared with the treatment experiences of sex offenders in general.

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

Introduction

The responsibility for maintaining healthy boundaries always lies with the professional. PSM must be considered as a risk inherent in our profession. How many psychotherapists admit, that they have faced sexual or erotic feelings during their work? Nearly all of us. This is a common and "natural" phenomenon – but only a few have acted this out and have violated professional boundaries. PSM is always committed in a seemingly "consensual" way, where the client accepts the sexual involvement. Otherwise this would be called rape or pedophile assault. However, PSM is still considered to be a taboo within our profession, there are few discussions in literature or conferences related to this topic, with the result that we are neither aware of the risk, nor the consequences that PSM has for professionals. Traditional curricula does not integrate this aspect in formation and training. This then

leads the professional to be unprepared for what he or she will face in their daily practice. The aim of this presentation is to discuss some case vignettes which illustrate, that there is always a “path” that leads to the sexual boundary violation – time enough for intervention and prevention. The knowledge we have gained from the rehabilitation of colleagues who have failed, is shared and used for preventive strategies, and to discuss how to handle dilemmas in our profession.

Rehabilitation of offenders

There is a tendency among regulating authorities to withdraw the licence of those who have committed PSM, without offering them an opportunity for rehabilitation. Often with the result, that they continue to offer “human relation consultation” or similar unlicensed work, where they have again access to vulnerable clients, and will re-offend. For 25 years we are treating sex offenders in general – why should we not treat our colleagues when they face problems in their professional career? The results of remedial boundary training clearly indicate, that this approach makes sense. G.G. Abel et al. have documented their treatment results of professionals since the 1990s, indicating that the relapse rate of those who have successfully finished the rehabilitation program lies below 1% [1, 2].

Rehabilitation of sex-offender-professionals only makes sense, when there is an insight into ones’ own shortcomings 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. Professionals who have committed pedophile crimes should never get permission to return to a position where they have access to children or the disabled. These professionals can only work in a field where they no longer have uncontrolled access to vulnerable people. This may be the case for paediatricians, clergies, nurses, sport trainer and teachers, just to name a few.

It is essential to integrate these aspects into the curriculum of health care professionals, as well as of other disciplines facing similar problems (e.g. teacher, sport coaches, clergy, etc.) [3]. PSM does not just happen it is done [4]. The slippery slope concept as described by Robert Simon [5] illustrates the “path” leading to the sexual offending.

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. [6]:

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 of intimate body parts, exposing oneself, etc.) [sexual transgressions]
3. All forms of verbal sexual offences (inappropriate sexualised remarks, dating) [sexual harassment]

All three forms are considered offences according to the criminal code. 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 committed 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 that is not regulated by a criminal code in relation to PSM are lawyers.

Bowlby addressed an important issue when stating: " … a patient's way of constructing his relationship with his therapist is not determined solely by the patient's history: it is determined no less by the way the therapist treats him. Thus the therapist must strive always to be aware of the nature of his own contribution to the relationship which, amongst other influences, is likely to reflect in one way or another what he experienced himself during his own childhood" [7]. However, almost no systematic research exists about professionals' variables and their influence on the therapeutic outcome. One study by North et al. [8] has examined the therapists' attachment patterns and their potential contribution to boundary disturbances among professionals. These findings clearly indicate, that the therapists' one vulnerability indeed may significantly contribute to boundary violations – which illustrates just another aspect of our own risk for failing in one's professional career.

Research on offender-professional typology clearly indicates that the majority has no diagnosable psychiatric disorder [6]; rather the crime is committed due to situational circumstances. This is in accordance with latest findings on the causes of violent behavior, as described by de Zulueta [9]: "The fact that the medical profession is seen to be particularly vulnerable to becoming the instrument of state torture and genocide is of particular interest, because it illustrates the reciprocal relationship that exists between caring and abuse, the latter being the manifestation of attachment and love gone wrong."

Psychiatry used to describe PSM as a transference issue, instead of describing the sexual involvement as a crime committed in the professional role. Even more confusing are descriptions such as "falling in love with a client", not eliciting it's true nature. Therefore, to overcome the "grey area" it is helpful to compare PSM with sexual offenders in general.

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. Professionals' 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 distortions and denial.

Main differences include:

- route to offence (= professional setting)
- knowledge of the sex-offender-professional
- denial processes/cognitive distortions
- it may be a colleague, it maybe 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 uniform mandatory reporting (none 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
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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

When there is no specific law, the justice system considers PSM when it is committed against an adult person without any violence and coercion as consensual. Cullen [10] has provided five arguments for a zero tolerance policy, 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 unacceptable consequences, this cannot be disputed.

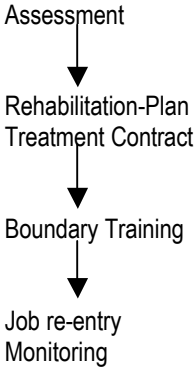
Goals of the rehabilitation program

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 [11]. We review over two decades of remedial boundary training in use, and have gained insight into the process of professional impairment and how they become disfunctional . In most cases it takes months if not years until the sexual boundary violation is committed.

Concept of the remedial Boundary Training

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



The assessment is not for fact-finding, it clarifies whether someone fits into a treatment program or not [12]. In a collaborative process a hypothesis about the underlying causes which lead to PSM will be established. If the participant is unwilling to cooperate and/or refuses the fact that he or she 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 is then negotiated and signed. The contract clarifies rights and duties, and also requires a commitment by the participant to avoid absolutely any further boundary violations. The consequences of this and of treatment dropout are also clarified. 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 [13].

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. It usually takes 25 – 30 double sessions to finish the remedial boundary training.

- introduction
- counselling 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 in English soon]

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 questionnaires, however these are not very reliable. At least, they indicate that a considerable number of professionals from various backgrounds commit PSM. For the health care system consumer reports exist, e.g. the 1999 Health Monitor from Ontario, Canada. 110'000 inhabitants from a population of 11 million indicated that they had experienced sexual intimacies with health care professionals within the last five years. Another two percent declared, that they have experienced inappropriate sexual behavior and remarks within the last five years. This data indicates, that annually 0.2 % of the population suffer from PSM (only committed by health care professionals).

The SAVI report reveals that professionals commit about one in ten of all sex crimes [14]. 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. By systematically examining what professionals do not ask (or not examine), then this bias becomes evident. 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 an 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 a transference problem. According to the existing definition PSM has to be considered as a form of a paraphilia, where the professional by the sexual offence takes advantage of the power difference and the vulnerability of clients, fails to conform to social norms and where victims suffer tremendously from the sexual boundary violation and the abuse of trust they have into professionals.

Conclusion

Rehabilitating sex-offender – professionals means that we treat colleagues and other professionals who have failed with techniques, which were developed over the last two to three decades for sex-offenders in general. The treatment approach for this specific type of offenders must be enlarged by re-establishing professional competence as part of the remedial boundary training. If people think the rehabilitation of sex-offender-professionals is not practicable, then we should question ourselves about what we are doing with sex offenders in general, when we release them from incarceration or from correction service. The knowledge we have gained from the remedial boundary training of professionals, who have failed, is used to develop preventive strategies for colleagues in training. Facing the constant

risk in our profession when dealing with intimate treatment situations is crucial. Working on this issue must be an ongoing process – as boundaries in psychiatry and psychotherapy are not static.

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