Abstract

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Workshop: Re-Thinking Professional Sexual Misconduct
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In this interactive workshop participants participants will learn about the modus operandi of offender-professionals and the resulting victim-offender-institution dynamic. Participants will appreciate that this understanding is the basis of effective intervention strategies - which focuses on the slippery slope concept and provides an understanding oft he concept the path to abuse (Tschan, in print).

Furthermore participants learn that interventions must start as early as possible - preferably before serious boundary violations occur. Lastly participants are offered the opportunity to share first hand experiences and preliminary results of how to implement structures to understand, prevent and cure sexual victimization by professionals. The up-to-date knowledge on traumatic reactions of survivors are preseted in ordert o understand their reactions in the aftermath.

The modus operandi

Why do professionals commit sexual offenses in their roles? For the very same reasons as other criminals do offend. Health care professionals take advantage of their position and their role – which gives them access to vulnerable patients through their job. They misuse their position of trust and power. Through grooming they „test the waters“. Health care institutions are high risk places for sexual offenses (Tschan 2013). Professionals create the crime scenes for committing the assaults. The very similar strategy is ued by teachers, by clergy, by sport coaches – just to name a few examples.

The path to abuse illustrates the modus operandi of offenders (Tschan in print). Their manipulative action is always embedded within the institutional context. By their silence, the institution led the offenders enter on what is called „the slippery slope“, where professionals proceed from minor boundary crossings to more severe boudary violations.

We address this issue as victim-offender-institution dynamic, where the culture of institution always play a crucial role (Tschan 2013). You can see this for example in the Sandusky case as reported in the media (New York Times, 2012) or in the Jimmy Savile case, the former BBC-entertainer. Despite clear evidence in the Sandusky case no action was taken by the university’s representatives - making it clear today, that many victims could have been avoided. This is a slap in the face of survivors who trusted in the university’s statements. In the Savile case more than 450 victims are known to police nowadays; Savile was never legally accused, because no one believed in the victims.

Fantasies are the fuel for offending. Does this statement mean, that we all can become offenders, as we all have fantasies? I do not think so. Most professionals really do a great job. Only when they let their fantasies florish, and then as a consequence cross lines, they're on the slippery slope. If such a thing happens to you, then you should seek help immediately with experienced professionals (Bridges 1998): „ With inadequate preparation, trainees run the risk of engaging in destructive behavioral enactments or developing restricted practice styles that stunt the psychotherapeutic process". Case-Supervison could be a place for educaing professionals about the risks and how to cope with these challenges inherent in their job.

When offenders start targeting potential victims they have crossed the line. They now are on the path to abuse. Targeting and grooming victims means creating opportunities – the more vulerable patients are, the more they can become a victim. Some offenders use drugs and sedatives – a criminal behavior which is adressed as DFSA (drug facilitated sexual assault). Some commit their offenses during anesthesia or shortly after, when patients are still under the influence of narcotics. These substances blure the mind, they can cause amnesia – so that the memories are disturbed and do not properly work. Simon has presented one such example in his book (Simon 1996: 111ff). „ *... B. Noel wakened slowly from sleep induced by the sodium amobarbital administered by her psychiatrist, Dr. J.M., former president of the American Psychiatric Association. ... this time the awakening was shockingly different. A man was over her, and he was breathing deeply. ... To her horror, she recogized that it was Dr. Masserman*".

This does on the other hand not mean, that vulnerable patients are per se under greater risk – when their treating professional is ethically correct, he or she will not misuse this dependency; in the contrary they will help the patient sorting out their difficulties (Penfold 1998). In other words: the risk of being abused is determined by the professional only. If a professional has committed boundary violations in the past, the chance that they will do this again are considerably high – we estimated, that 80% of those professionals committing boundary violations are serial offenders (Tschan 2001). Simon underlines that abuses of professional power and authority occur across all of the helping professions. „*None are immune*" (Simon 1996: 115).

How do offenders groom their victims?

In the workshop we look at this question from the other side: what would you do when you want to sleep with someone? Offender professionals use the very same „strategies", e.g. showing interest in the other person, giving compliments and presents (for professionals: special attention, special time arrangements, special care, etc.). Offender-professionals create opportunities; some isolate or alienate their patients from friends and relatives, some commit the assault only in their offices (in order to be protected from being seen from outside), just to name a few strategies. Some health care providers address their sexual urges as „therapeutic help" for clients.

What helps in avoiding boundary violations?

Participants get to know the boundary training approach as a remedial technique which is also used for training purposes. The boundary training is a semi-structured cognitive-behavioral oriented training program used for the rehabilitation of disruptive professionals. It must be clear that it is always the professional's responsibility to maintain healthy boundaries; a duty which can never under no circumstances be deleguated to clients. Only professionals can violate their code of conduct.

How to help survivors?

The greatest challenge is the handling of the transference issues and the creation of trust and safety. Treatment interventions are based on traumasensitive dialectic-behavioral techniques combined with psychoeducation (Linehan et al. 2012). Penfold has outlined a fundamental misperception: „*On the whole, our society is not particularly sympathetic to victims, and people often assume that the victim causes her own problem in some way*" (Penfold 1998: 165). By teaching survivors about offender strategies, they realise their own position and their vulnerability. It is never their fault. Sometimes a criminal sentence helps associated survivors to really understand what has been done to their loved ones. In Switzerland a couple was attending therapeutic sessions due to their marital problems. The treating psychiatrist engaged in intimate relationship with the woman – leading to the final break of the marriage. Later the physican was sued, but the accusation was cleared. When the case went to the Supreme Court and the man was finally sentenced, only then the husbald began to understand that his former wife has become the victim of a crime, and he could now forgive her.

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