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Sexualized Violence in Health Care: Intervention and Prevention

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The health care system is affected by sexualized violence in various ways. First of all there are the victims of sexualized violence who need care and support, but who also require adequate diagnosis (Tschan, in print A). Each victim is surrounded by various relatives increasing considerably the number of associated victims. Sexual offenders are also seen in the health sector– the term „sexual offenders“ is misleading suggesting a uniform population. Disturbances in sexual behavior are embedded in a large spectrum of problems –this is not only a problem of forensic medicine or of the criminal justice system (Tschan, in print B). And finally there are professionals who violate their boundaries and health care professionals who become the victims of sexualized violence in their work (Tschan 2001).

Health care professionals are not judges; they help when help is required, no matter whether they are confronted with victims or offender. Data on the prevalence of sexualized violence in general indicates the large number of affected people; the SAVI Report (McGee et al. 2002) reveals that 42% of women and 28% of men are affected by sexualized violence during their lifetime; data from the USA indicates that 27% of woman and 16% of men are affected by sexualized violence (Finkelhor et al. 1990). The number of those affected differs in each study depending on the definitions used; for our subject the exact number is not of primary concern, rather it is the magnitude that we are faced with. It is not of question, that health care professionals see a large number of affected people as further indicated in the World Report on violence et health (Krug et al., 2002) by the WHO. Data on its prevalance is known to health professionals since the publication of the book by the French physician Tardieu in 1857 (Tschan 2001), however until recently health professionals did not pay much attention to this subject. In most medical schools the topic is still not taught in the curriculum, with the result that the majority of health care professionals do not have the essential knowledge, skills and attitudes in handling this subject properly.

Therefore it is no wonder that the topic of offenses within the instituional context is not a subject within the health care system. The professional community hesitates to openly discuss this issue which bismerches the reputation of the entire health care system. There is an urgent need for a proactive approach because this issue affects patient safety even more than the above mentioned facts (Tschan et al. 2008). We can compare this issue with the discussion once initiated by Semmelweis when he began to demonstrate the need for hygiene among medical doctors back in the 1850's. The outcry of the professional community culminated in the following statement: „Gentlemen's hands are clean. And physicians are gentlemen“ (Charles Meigs quoted in Wertz et al. 1989). It was not Semmelweis's intention to bismerch the reputation of his colleagues, on the contrary; nevertheless he was fiercly attacked.

The modus operandi of health care professionals abusing their position of trust and power when they sexually engage with their patients clearly highlights the importance of the institutional context in this type of criminal offenses (Tschan, in print B). What

we have learned over the years is that we should not only focus on the individual pathology of offender-professionals, but also take into account the systemic conditions. Institutions are high risk places for sexual offenses where offender-professionals create their crime scenes, and the institutions contribute through their silence and the support of these professionals (althought not from the health sector see for example Sandusky as an illustration of the victim-offender-institution dynamic: New York Times, 2012). Workplace violence committed by health care professionals does not fit with our professional identity and self perception and is therefore handled as a taboo (Tschan 2003).

Prevention of institutional offenses operate on three different levels: (1) reporting; note that reporting is considered the single most important step for any effective intervention (Di Martino 2002); (2) curricular integration of the topic; and (3) help for professionals with disruptive behavior (Tschan 2012). Victim support needs considerable improvements as indicated in the study by the WPA (Stewart et al. 2009); and for those professionals showing severe problems we need rehabilitation programms and monitoring: e.g. boundary training (Tschan 2001, Abel et al. 1998). The scientific data underlines the high effectiveness of these interventions, which help considerably to improve patient safety.

The rationale

„*Appropriate, good quality care should be available to all individuals who have been victims of sexual assault*“ (WHO 2003: 17).

The systematic examination of knowledge production and archives on sexualized violence can only be undertaken when one considers the historical dimension of the problem. The French author Amboise Tardieu (1818-1879) published the first book on the topic in 1857: „Etude médico-légale sur les attentats aux moeurs“ (Forensic studies on sexual crimes) (Tschan in print B). However, health care professionals did not pay any attention to the subject. In the 1960s, the book „The battered child“ by Henry Kempe was a milestone in the awareness ot the medical problems related to violent experiences (Helfer et al. 1968). Kempe’s contribution ignited both research on the subject as well as child protection measures, such as mandatory reporting and parental empowerment. A fundamental paradigm shift on children’s rights followed this development leading to the formulation of the CRC (UN Convention on the Rights of Children) in 1989. The awareness of sexual crimes has steadily increased over the last fifty years as a consequence of this paradigm shift. Sexual crimes are no longer considered a „private matter“. The term „hysteria“, used to describe „unclear“ symptoms mainly in women, disappeared literally over night when it became clear that these symptoms were caused by traumatic life circumstances (Herman 1992). In 1980 two new diagnostic entities, the PTSD (Posttraumatic Stress Disorder) and the DID (Dissociative Identity Disorder) were coined by the American Psychiatric Association – opening the discussion on trauma related experiences and their impact on health conditions (Van der Hart et al. 2006).

Despite these developments and the high number of affected patients the majority of health care professionals refused to deal with sexualized violence. Sexual crimes were regarded more as bad luck rather than a major cause of health problems. Final-

ly in 2002, the WHO published it's World Report on violence and health (Krug et al. 2002) followed by the guidelines for medico-legal care for victims of sexual violence (WHO 2003) which lead to a new perception of the resulting problems. It became clear, that the health sector was affected by sexualized violence much more than ever thought, and that the economic burden of the resulting health conditions is enormeous.

The health care system is affected by sexualized violence in various ways (Tschan 2012). Data on its prevalence clearly indicates that there is a considerable amount of affected people with severe health care problems. A total of 30 to 40% of all women are affected by sexualized violence, and 20-30% of all men (Tschan, in print A). This is not the place to discuss the magnitude in various nations and scientific findings we have on this issue – I will only emphazise the fact of the huge amount of people affected making it a global issue if not the largest pandemy we have ever seen in the health sector. Currently arround 6% of all sexualized crimes are reported to law enforcement, and approximately 15% of all reported cases lead to a criminal sentence (Tschan 2012). The current risk for a sexual offender to be prosecuted is one in a hundred. This further highlights the utilisation of the justice system – only a small proportion of victims ever use the criminal system whereas the vaste majority never see justice. This illustrates how society deals really with this issue – and it underlines the urgent need for a fundamental change in the criminal prosecution procedures including the corresponding law.

The health sector is seeing the survivors whether there is an effective prosecution or not – thus dealing with a high number of non-detected sexual crimes. The curricula needs to deal with the following aspects:

- Myths and facts
- Knowledge on modus operandi of offenders
- Diagnostic skills
- Handling of emergency situation
- Therapeutic knowledge
- Network for adequate support and handling
- Cooperation with law enforcement and justice system

Interventions are based on professional competencies. The knowledge on myths and facts helps to rectify the professional compass when dealing with such patients. Without knowledge on offender strategies any effective intervention will not be possible. However, it is not the health care professional alone who has to take action, rather this should be done in a cooperative and interdisciplinary way. Health care professionals require diagnostic skills and therapeutic knowledge to effectively help and support survivors. Mandatory reporting must become the standard in health care.

Each victim is surrounded by various relatives which considerably increases the number of associated survivors, many of whom also need therapeutic interventions. It should not be forgotten that health professionals can also suffer from secondary traumatic effects when confronted with such attrocities (see: compassion fatique).

Health care professionals are also confronted with a considerable number of sexual offenders, the vast majority of whom are non detected criminals (Tschan 2012). Health care professionals are not judges; they help when help is required, no matter

whether they are confronted with a victim or an offender. The term „offender“ suggests a uniform problem, which is misleading. In reality, we see a wide spectrum of problems associated with offensive behavior, ranging from relatively mild behavioral problems to severe forensic issues. In these cases adequate interventions differ widely. From a preventive view it is crucial that health care services are available for those who realise that they have problems related to their sexual orientation, their sexual behavior or their way of managing intimate and close relationships.

And finally, the health care institutions themselves may be confronted with sexually inappropriate behavior and/or disruptive behavior by professionals:

- PSM (Professional sexual msconduct)
- Sexual harassment between co-worker and co-worker
- Sexual harassment of co-workers by clients
- Sexual harassment of co-workers by relatives of clients, or by visitors (including contractors)
- Sexual harassment between clients within the institution
- Sexual improprieties outside the workplace which could undermine professional competency

The last point refers to examples like: if a pediatrician is accused of endulging in child pornography material then his/her professional capacity is questioned. In institutions for disabled people the banning of intimate relationships violates fundamental human rights and constitutes a form of disruptive behavior. PSM includes any form of sexualized behavior committed within a professional role: (attempted) penetration, genital touching and stimulation; sexual improprieties such as kissing, fondling, taking pictures of intimate body parts, presenting pornographic material, and any voyeuristic and exhibitionistic behavior; sexualized remarks and dating.

The decision making process within the health care sector is only possible when the cases come to the notice of the management: without reporting no action is taken. Therefore reporting is considered to be the single most important step for intervention. Workplace violence is wide ranging from sexual harassment, to sexual boundary violations, bullying, stalking and physical violence. Sexualized violence is always embedded within this wide spectrum of violence.

Intervention

The „sexual culture“ of an institution is highly dependent on the mangement strategy and its declared values. The development of the culture within an institution is the primary duty of the decision makers. Inteventions are always based on this culture. Reflecting on attitudes is therefore essential in professional training. Although not from the health sector the example of the Penn State football trainer Sandusky and the handling of this case by the university representatives illustrates the victim-offender-institution dynamic (New York Times, 2012). The individual offender pathology alone can never explain the failing of the institution.

For any effective intervention a wide range of measures have to be implemented and only their working together has the desired effect. Creating „safety“ is a proactive process based on management decicions. You might compare this process with creating safety on an aircraft carrier – it is a process which requires different measures;

and only through working together will they really help to reduce fatalities. Furthermore it is a process of constant learning where new experiences are integrated into the concept. The following steps are necessary for any effective intervention:

- Implementing reporting facilities (inside/outside)
- Implementing guidelines
- Internal competence team (gender-neutral)
- Transparent internal decision making processes
- Reporting to law enforcement
- Victim support
- Rehabilitation program for disruptive professionals
- On-going staff training on workplace violence prevention
- Effective laws
- Registry of disruptive professionals
- Monitoring of disruptive professionals

The topic must be integrated in the curricular formation of professionals. They must learn that prevention of workplace violence is possible through early interventions. However, effective prevention is only possible when society is supporting this by implementing effective law including registry of disruptive professionals. Prevention of workplace violence must be dealt with on a structural level, which means that it is considered as a sine qua non condition for any professional work. Mandatory reporting of workplace violence must be enforced through adequate laws.

The topic of sexualized violence, especially when directly affecting health professionals, is not a topic within the health sector. The professional community is still hestiating to openly discuss this issue which bismerches the reputation of the entire health care system. Traumasensitive units at psychiatric hospitals are still the exception and not the rule, as one would expect according to the high amount of affected survivors. Because all the various issues discussed here affects patient safety even more than the above mentioned facts, there is an urgent need for a proactive approach. This issue can be compared with the discussion initiated by Semmelweis, when he began to demonstrate the need for hygiene among medical doctors back in the 1850s. At the time, hygiene was considered as a waste of time by contemporary physicians. The fact, that up to a third of all women giving birth to their offspring died at these units run by physians was not examined scientifically. The outcry of the professional community culminated in the following statement: „Gentelmen's hands are clean. And physicians are gentlemen" (Charles Meigs quoted in Wertz et al. 1989). It was not Semmelweis's intention to bismerch the reputation of his colleagues, on the contrary; nevertheless he was fiercly attacked. The true nature of the problem was recognized only a decade later with the discoveries of Pasteur and Koch.

It is estimated that around half of all health care professionals are directly affected by sexualized violence at their workplace, and that a considerable number are committing sexual crimes against patients and/or co-workers (Tschan 2001). According to Canadian data on the prevalance indicate that 0.2% of the entire population annually suffers from sexualized boundary violation in the health care sector. Another 0.4% suffers from inappropriate behavior such as being watched when undressing, sexualized remarks and dating and the like. An intresting study compared the incidence of PSM between gynaecologists and ear, nose and throat specialists in the Nederlands (Wilbers et al. 1992). General practitioners were invited to collaborate in this study,

but unfortunately the National Society for GP's refused to participate giving the reason that the specific importance of the question was not evident for general practitioners „that this not of interest to GP's". The study is based on self disclosure by the participants, which is not very reliable, but anyway allowes to estimate the magnitude of the problem. Contrary to general assumption both disciplines indicated the same number of intimate contacts with their patients: 4%. The gynaecologists are then asked, why so „few" and their answer was: we learn about the importance of boundary issues in our training; and the ENT specialist are asked: why so many; their answer was: we we have never heard of this subject.

Despite clear guidelines many physicians believe that consensual intimate relationships with current or former patients are acceptable (Coverdale et al. 1995). On the other hand the medical-ethic discussion stipulates that a zero tolerance policy the only possible way to handle the issue (Cullen 1999). His contrafactual argument, that the resulting consequences would be devasting, if sexual relationships would explicitely be allowed between health care professionals and their patients demonstrates the importance of maintaing healthy boundaries.

How to understand survivor's reactions?

To really understand survivor's reactions we need to look at psychotraumatology. In order to distinguish the psychological impact from somatic wounds the term was coined by Everly 1992 in a presentation in Montreux, Switzerland (Everly 1992). The rather new area of psychotraumatology examines the impact of traumatic experiences on human life. Despite the fact that since the existence of mankind it has been affected by traumatic events, systematic research on the topic only started with Pierre Janet (1859 –1947) at the end of the 19th century (Herman 1992). He described the individual reaction on traumatic experiences in his doctoral dissertation (L'automatisme psychologique, 1889); some decades after French physicians published the first reports on sexual crimes. However, it took nearly another century, until mainstream psychiatry in 1980, labelled it's diagnosis as DID (Dissociative Identity Disorder) and PTSD (Posttraumatic Stress Disorder) in the DSM III, and through this began to consider sexualized violence and other traumatic experiences as one of the main causes of psychiatric disorders. It turned out, that nearly 50% of all people experience significant traumatic exposure during their lifetime, and that corresponding reactions are the most prominent psychiatric problems (Van der Hart et al. 2006).

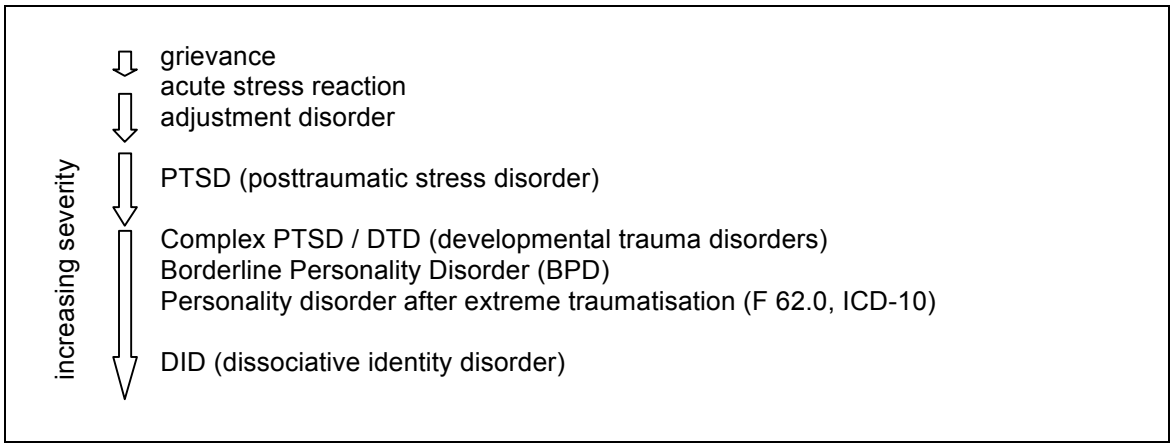

Fig. 1 The spectrum of psychotraumatology

Pychotraumatology goes far beyond the PTSD concept (Tschan, in print).
Traumatic exposure leads to a continuum of impairment ranging from grievance to severe and prolonged personality disorders, as illustrated in the above box.
Sexualized violence is one of the main causes for traumatic reactions, leading to significant developmental problems when children and juveniles are affected. Sexualized violence is always a polytraumatic experience (physical, emotional, sexual and neglect) and it is embedded within the culture of violence affecting our societies much more than we ever thought. A generation ago, professionals learned that sexual offenses are a completely rare phenomenon, and that incest cases take place with an incidence of 1-2 in a million children (Van der Kolk 2009). The impact of sexualized violence on medicine, especially psychiatric disorders, was not considered for a long time.

As sexual offenses are always embedded within a human relationship – it is a person committing the crime – it always affects bonding and social interaction, especially if offenses are committed by significant attachment figures (Tschan 2012). Therefore, sexualized violence is always a relational offense, related to the fact, that around 80-90% of all sexual crimes are committed by someone the victim knows, and that their protective figures fail. Sexually offended children may realise that their parents are not able to protect them from atrocities. Nor is society capable in effectively preventing sexual crimes despite the Declaration on the Rights of the Child. From a victim's perspective all existing conventions, laws, guidelines, etc. are not worth the paper they are written on – as prevention completely fails in their particular case. This always questions fundamental feelings of security and therefore undermines trust in those responsible to prosecute sexual crimes and to guarantee personal integrity. Due to their role, professionals must be considered as significant attachment figures.

Attachment describes primarily the affective bond between baby and mother and its impact on human development (Tschan 2001). Attachment Theory also examines human relationships and its mental and social dimensions. Proximity and autonomy are regulated by a homeostatic balance. Newborn babies begin by giving signals to their caregivers who through their responses provide feedback and therefore reciprocally enforce attachment behavior. Parents stimulate their offspring through their signals.

The inner working model serves as a metacognitive compass to anticipate the interactive behavior. Finally, attachment experience influences social interactions and personal relationships during one's lifespan.

Classification of attachment behaviors:
- secure attachment
- insecure attachment
  - insecure ambivalent
  - insecure avoidant
- disorganised

Fig. 2
Classification of attachment styles

Around 60% of the entire population can be classified as having a secure attachment pattern. During their childhood and adolescence they have experienced sensitive attachment figures. In general these people enjoy company, they have satisfying intimate relationships, and they are sensitive and flexible within their relationships. When necessary they are also able to set clear boundaries, and are capable of integrating negative relationship experiences into their self.

Those with an insecure attachment pattern have grown up differently. In the case of an insecure ambivalent attachment, their caregivers' behavior was unpredictable and confused. On occasion the child could be cherished and overwhelmed by compliments, on another it could be rejected and chastised without any clear reason. As adults these people yearn for a loving relationship and simultaneously are fearful of rejection. Those with an insecure avoidant behavior have never felt supported or accepted by their caregivers. They were constantly rejected, and did not receive attention and closeness, including bodily contact. As adults they tend to ignore social interactions and declare that they do not want to have close relationships. Their fear of being rejected is transformed into a coping mechanism, which gives them the illusion of being independent. This avoidance strategy leads to isolation, and as adults they prefer being alone.

In disorganised attachment behavior the regulation of proximity and distance is disturbed – on the one side they are completely open and intimate, on the other they are distant and unapproachable. This attachment behavior is seen after severe childhood traumatisation such as neglect or polyvictimsation, either sexual, emotional or physical.

Recovering from traumatic experiences is a fundamental human capacity, if not a universal one, seen also in the animal kingdom (Herman 1992). Traumatic experiences lead to stress-disturbances, either due to direct impact, or due to the cognitive-emotional processing of the event (Seung 2012). Any traumatic experience is processed within the limbic system and activates the amygdala, which is considered to be the central alarm co-ordinating structure. Numerous neurocircuits connecting various brain areas contribute to the "fear network". These are hard wired structures, which do not follow the rule of neuronal plasticity: synaptic structures only remain intact when used. The hippocampus serves as a cognitive map (= storage of (life-) threatening experiences). The cortex encloses the limbic system and it represents the place where cognitive processing occurs. Paul Mc Lean coined the term "limbic system" in 1952 when describing emotional processing. In connection with the brainstem the mind-body communication is orchestrated within this structure. In case of an alarm reaction the autonomous nervous system, the HPA-axis (Hypothalamus-Pituitary-Adrenal), the neurotransmitter system (catecholamins) and the immune system are the main "instruments" in this process. Trauma reactions are not solely psychological reactions due to the somatic nature of the stress cascade (Heim et al. 2001).

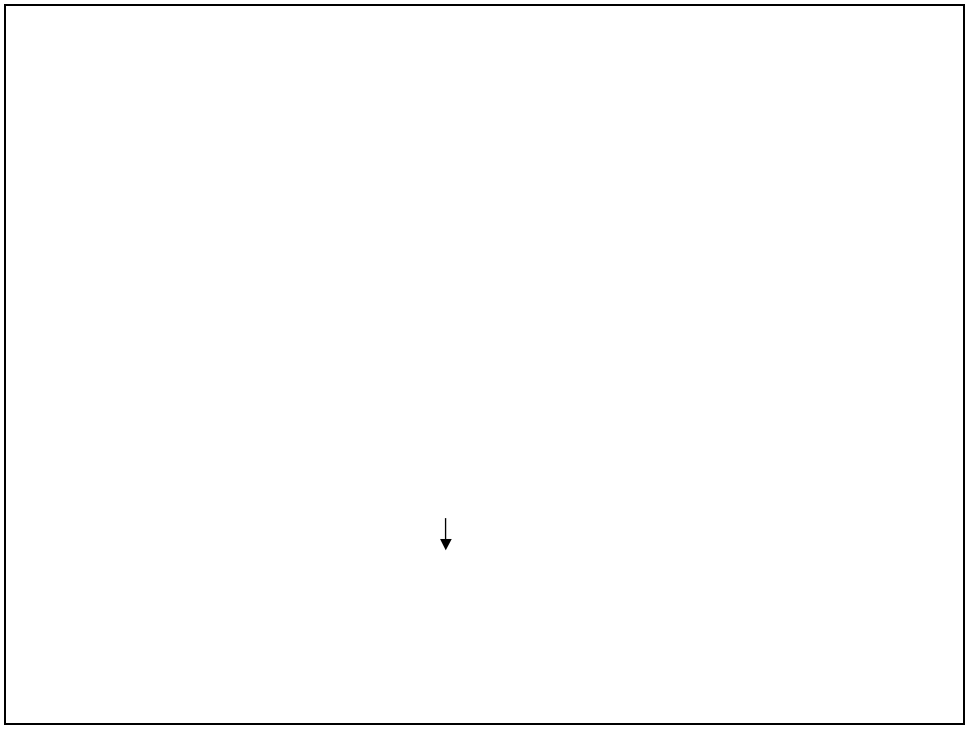

Fig. 3 Trauma response is a neurophysiological phenomenon with a complex interaction of survival mechanisms (integrated model).

Meaney and co-workers (Liu et al. 1997) demonstrated in an animal model how the number-one stress reaction in trauma – the release of cortisol – is regulated and mediated intracellular, on the level of genexpression. Postpartal traumatisation leads to a significant effect on the genetic regulation of cortisol release in the offspring. The methylisation of gene segments responsible for the mediation and the transcription of messenger-RNA for cortisol production depends on environmental factors such as mother-offspring interaction. This is significantly different in animals without traumatisation early in their life. In normal development a considerable number of DNA binding sites are blocked by methylisation, thereby reducing the gene-activity through this mechanism. This corresponds to research that non-traumatised animals show a limited response to stress later in their life compared to animals with early life trauma. Affected animals show an overreaction (long lasting, overwhelming effect) to stress. Furthermore the brain development is affected by ongoing high stress levels, as documented in humans by neuroscientific research. This has a significant impact on disorders later in life (Heim et al. 2001).

To really understand the consequences of traumatic experiences in cases of sexual offenses, collateral factors must also be considered. The polyvagal theory describes the effects on body and the inner balance mediated through the autonomeous nervous system.

Overcoming traumatic experiences is a fundamental human capacity (Herman 1992). Anxiety and intrusive thoughts are the salient symptoms after trauma. Resilience and individual vulnerability are both related to the outcome, but after 30 years of trauma research is has become clear, that the highest incidence of PTSD cases are related to human caused traumatic events (“manmade”), and this is mainly interpersonal violence. Whereas in natural disasters such as earthquakes, flooding, etc. the number of

people who are affected by PTSD symptoms is somewhere among 3-5%, the magnitude in cases of sexualized violence is over 50% of all affected people. Sexualized violence has one of the highest incidences of PTSD among all traumatic experiences with only prolonged torture and Holocaust survivors having a higher rate. Research differentiates between sexual offenses, and physical and emotional violence, but in reality they always go hand in hand. Sexual offense without physical and emotional violence does not make sense, as reality clearly indicates. Sexual offense always has a polytraumatic effect.

The physiological reactions during a traumatic event is either fight, freeze or fear, combined with the attempt to flee. These reactions are orchestrated by the limbic system and cannot be controlled by mere intent. They are considered as survival mechanisms and may therefore be influenced by genetic and evolutionary factors. Again this reinforces the fact that trauma reactions should not be considered as psychological phenomenons, but more as psycho-physiological reactions.

The longer the exposure to the traumatic experience, the younger the affected person, the closer/important the relationship with the offender, the less they are likely to overcome their traumatic experiences in the aftermath and the higher the possibility that they will suffer from complex PTSD.

Often trauma survivors develop a phobic avoidance reaction towards their own memories. Talking about their past experiences raises bodily reactions and emotions related to the offense. They are longing to forget what has happened to them, but fail to do so. They are often told: «Forget these old stories, life goes on, try to look to the future …». This is what they would like most, but the past constantly haunts them. Survivors do not invent their stories to impress others, on the contrary; they are haunted by nightmares, flash backs, sensations – once they close their eyes and try to relax, out of the blue, they are attacked by their memories. «The presence of nightmares and sleep disturbance mean that even the safety of withdrawal into unconsciousness is lost» (McFarlane et al. 1996), they no longer have a secure place to be.

Prevention

The first step for any effective prevention is the awareness of the problem. Health care institutions are high risk places for sexual offenses (Tschan 2012). The professional role and/or the institution is misused by offenders to target and groom their victims. And finally, offenders create their crime scence. A case example illustrates this: A nine year old boy tells his parents that a male nurse has played with his genitals while he stayed at the ICU of a Berlin hospital. His story was rather vague and unprecise – the reasons for this became clear only later. His parents believed their son and had the impression that something went wrong. They called law enforcement which arrested the man at the ICU and performed a search of his home. On his mobile phone the suspect had documented two cases of sexual assaults – one against the nine years old, and one against a five years old. He has used sedative to calm down his victims (in addition to the already prescribed medication); later he disclosed five incidents.

Whenever I talk about this case at workshops participants ask: „How is this possible that someone commits a sexual assault at an ICU, where always so many staff are

present?“ The answer is: offenders create their crime scene. They know when there are staff meetings and no one is present in the unit itself. When we really want to understand the problem we must look at offender strategies and not be guided by misleading assumptions.

The modus operandi of health care professionals who abuse their position of trust and power when they commit sexual crimes highlights the importance of the institutional context. We should not only focus on the offender's individual pathology but also taking into account the systemic conditions (Tschan, in print).

The following illustration offers a comprehensive model on how PSM takes place in a step by step process:

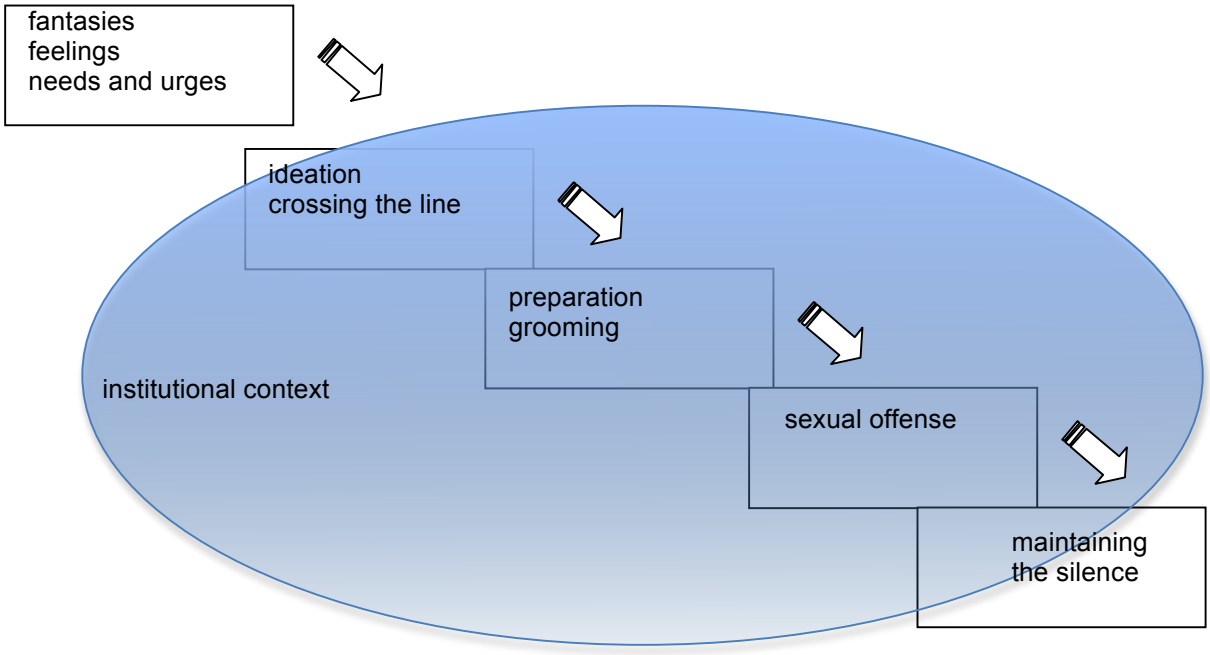

Fig. 12
Modus operandi: the path to PSM

Conclusion

There is an urgent need to integrate this topic into medical curricula (Tschan 2008). Without basic knowledge and skills, health care professionals will fail in treating victims of sexualized violence. They will not understand the resulting health problems, they will misdiagnose affected people. Consequently they do not receive the treatment they need – which is besides the human tragedy also a waste of economic resources in a time of restricted budgets in the health care sector. To reflect on attitudes related to sexualized violence as important as basic knowledge and skills. Professionals need to rectify their compass in order to be able to navigate through the many pitfalls related to the topic. The transgression of professional boundaries by health professionals should be a clear warning sign.

The health care sector is affected by sexualized violence in various ways:

- emergency situation, criminal evidence
- diagnostic procedures

- survivors with health problems
- PSM (Professional Sexual Misconduct)
- Other forms of sexualized workplace violence
- Interventions for sexual offenders (in cooperation with justice and forensic medicine)

In cases of female patients it is usually gynecologists who are responsible for diagnostic procedures and collecting evidence, but it becomes unclear in oral rape, or in rape of males. It is essential for medicine to define who is responsible for diagnostic procedures in these cases (e.g. urologists, dentists, forensic experts?). Professionals need special training for these kind of procedures as well as for therapeutic interventions.

Prevention operates on three different levels: (1) reporting, (2) curricular integration of the topic, and (3) help for professionals with disruptive behavior. Reporting is considered to be the single most important step for any effective intervention against workplace violence (Di Martino, 2002). Health care institutions in cooperation with regulating authorities should implement reporting facilites – they must be known for patients, for their relatives and for co-workers. Through adequate communication these facilities must be known by the public. Guideline need to be in place which provide a clear framework for these facilities. Reporting should become mandatory through legal means (Tschan 2012).

For victims of institutionalized sexual assaults free of charge services should be available (Stewart et al. 2009).

The curricular integration of this topic helps to prepare the professionals when they are confronted with sexualized violence. And finally help for professionals with disruptive behavior should be available. Rehabilitation programs for professionals in conection with monitoring should be implemented. Such a process should only be undertaken in combination with a registry of disruptive professionals. The scientific data we have on this kind of rehabilitation process indicates, that less than one percent of all professionals who undergo a boundary training program have relapsed (Abel et al. 1998) – with other words: these programs are highly effective and provide an significant increase in security aspects in the health sector.

Effective interventions are only possible when professionals are trained in this area (Tschan 2001). As no discipline alone can manage the consequences of sexualized violence part of the training should be done interdisciplinary. This helps one to define ones own limits and helps to create a common language – for the benefit of those patients seeking help.

The author is presenting a vision on how to handle sexualized violence in the health sector. This vision is based on practical work in this area for more than 30 years. However any effective prevention is only possible when supported by society.

Note: the term *sexual* should be used for what it is supposed to be, whereas the term „sexualized violence“ is used for all form of violence against the sexual integrity of a person. Violence is under no circumstances „sexual“.

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