Approved 2-21-90
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Marvin L. Littlejohn at
Chairperson

1:30 ~~a.m.~~/p.m. on February 13, 1990 in room 423-S of the Capitol.

All members were present except:

Rep. Shallenburger, absent

Committee staff present:

Emalene Correll, Research
Bill Wolff, Research
Sue Hill, Committee Secretary

Conferees appearing before the committee:

Representative Joan Wagnon
Stuart W. Twemlow, M.D. Psychiatrist, Menninger Foundation
Chip Wheelen, Kansas Psychiatric Society (and)
Kansas Medical Society
Janette Pucci, Educational specialist, Kansas Board of Nursing
Joseph Kroll, Director, Bureau of Adult/Child Care, Dept.H&E
Richard Gannon, Executive Director, State Board Healing Arts

Chairman called meeting to order, drawing attention to hearings scheduled this date. He recognized a former member of this committee, Rep. Wagnon who would introduce the first conferee.

HEARINGS BEGAN ON HCR 5046.

Chair recognized Rep. Wagnon. She noted in the past few years of study on issues involving medical mal-practice and the abuse issue in both this committee and Judiciary committee, where time after time hearings are held on issues of sexual abuse, concern grows. Dr. Twemlow had shared with the Representative a book he had written about sexual exploitation in Professional relationships. Rep. Wagnon invited the Doctor here this date as a expert in this field.

Stuart Twemlow, M. D., certified psychiatrist, who has practiced in Kansas for the past 19 years. He noted he speaks this date as a private psychologist, not associated with any particular Institution. He noted the attachment contains a biographical sketch of his credits. He appears in support of HCR 5046, based on clinical and research activities with people who have been victims of sexual exploitation by professionals. He has also on numerous occasions treated the exploiting professional. This help was sought often because of peer review because of groups and/or legal threats or by the realization that he indeed needed help. He noted the term "fiduciary relationship", used in the Resolution is a legal one, it is more widely known and understood than most psyshoanalytic ideas, thus useful because of widespread acceptance. All professional groups named in this resolution are fiduciaries within that definition by virtue of their licensure/or practice. Other fiduciary relationships, i.e., school teachers, attorneys, etc., are not addressed in this Resolution. However, he is pleased that the physician groups are addressed in the bill. He noted percentages range from 6% to 12%, however he thinks it would be more like 12-20%. Those fitting into this group of perpetrators generally are not severely distrubed. Such professionals tend to be middle-aged men who abuse women 16 years younger then they/ have unhappy marriage and family relationships/ unsatisfying professional life. He stressed specialized training in ethics and problems associated with intense emotional feelings for patients as part of the way to solve this concern. He noted the exact details of how this training should be formulated should be left to the licensing authorities. (Attachment No. 1)

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 /a.m./p.m. on February 13, 1990

HEARINGS CONTINUED ON HCR 5046.

Chip Wheelen, Kansas Psychiatric Society, commends the authors of this Resolution for their concerns. He said, sexual exploitation is unacceptable under any circumstances and measures should be continued to prevent such occurrences. We do however, oppose this Resolution. It would not be the licensing agency which affects the curricula required of those who become mental health professionals. Since the Board of Regents could not govern educational curricula of institutions throughout the United States where many health professionals receive their education, this would mean many professionals could not be licensed to practice in Kansas if such a prerequisite was imposed. HCR 5046 would represent an unprecedented change. A resolution adopted by the Legislature does not have the force and effect of statutory enactment, therefore serves little purpose other than to commemorate a special event. He requested that HCR 5046 not be recommended for adoption. (Attachment No. 2).

Mr. Wheelen, then spoke for the Kansas Medical Society, noting they concur with the Kansas Psychiatric Society.

Janette Pucci, Educational Specialist, Kansas Board of Nursing, (see Attachment No. 3) spoke to the educational process the nurses receive currently. She cited percentages of abuse cases reported, and the censure of the person who is in violation. It would be difficult to develop a specific continuing education offering to meet the educational needs of all licensees. Currently appropriate content on sexual problems, treatment and ethics is included in the basic nursing programs. She answered questions, i.e., yes, there is concern for the patient; extra training needs to focus on the clinical area, example---a nurse in the newborn nursery would have different educational needs than a nurse working in the psychiatric unit. Yes, there are more and more cases of exploitation/abuse, because of mandatory reporting. Yes, more training in certain areas could be a deterrent, but those perpetrators won't change unless they want to, and they probably would not seek out special training.

Joseph Kroll, Department of Health and Environment, (Attachment No.4) stated exploitation is not acceptable under any circumstances. Their Department does have concerns in lines 17/18/19. It is somewhat misleading to lump the subject of treating patients with sexual problems with the subject of sexual exploitation. Patients with sexual dysfunctions and sexual exploitation are not necessarily synonymous. A good time to address ethics is during initial training of health care students. Little time is spent in the classroom on how to deal with sexual contact with, or sexual attration to patients/clients. We are concerned about a laundry list being composed of continuing education subject requirements. He drew attention to ten common scenarios listed in his hand-out. He noted consumer education is just as important as educating the provider. He would recommend amending language in lines 18, and 19 to broaden it a bit more. This resolution does not go far enough. He answered questions, i.e., no they do not oppose the Resolution, do not oppose anything that would work to curtail a problem of this nature, but they would hope the Resolution could be amended before being passed.

Rep. Wagnon answered questions at this time, stating that ethical problems are hard to define, and the intent of this Resolution was to have it this set out, i.e., this is ethical, this is not, etc...

Richard Gannon, Executive Director, Kansas Board of Healing Arts gave hand-out, (Attachment No. 5). He spoke in opposition to HCR 5046. This Resolution would direct their Board to require physicians to obtain minimum training in assessing and treating sexual problems and in related ethical issues, and to implement such continuing education requirements would be practically impossible. It would also appear that the Board would be required to implement its own training program for treatment of sexual problems which would be required of all those applying for licensure. The Board would have to assess programs given by all medical schools in the United States and throughout the World, determining what, if any, training in this area had been received. We feel, he said HCR 5046 does have a noble purpose, however the problems it would create, force them to oppose its favorable passage. He answered questions, i.e., the reason he feels those perpetrators are sick, is that he looks at it from a laymans viewpoint, not as a psychiatrist; yes these exploitation concerns involve both men and women patients.

HEARINGS CLOSED ON HCR 5046.

HEARINGS BEGAN ON HCR 5041.

Chip Wheelen, Kansas Psychiatric Society (Attachment No. 6) thanked committee for their cooperation in the introduction of HCR 5041. If passed, it will help to coordinate efforts with other Agencies and other States to promote this annual event making Mental Health Awareness Week an issue we all will take notice of.

Rep. Amos made a motion to pass out of committee favorably, HCR 5041, seconded by Rep. Scott, motion carried.

Chair drew attention to committee minutes from February 7/8/12th. Rep. Cribbs moved to approve minutes of these three dates as written, seconded by Rep. Borum, motion carried.

Chair noted the revised agenda is out, and discussion will take place tomorrow on HB 2755, Chiropractor's requesting seat on Board of Blue Cross/Blue Shield, also on HB 2595, Physicians' Assistants bill. Chair noted the deadline is fast approaching and there are many many bills in need of work. There are no simple bills in committee, but he noted, health issues are not simple either.

Rep. Branson announced the booklets given to each member this date are from the Merrian/Merrell Dow Company.

Meeting adjourned 2:45 p.m.

GUEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

Date Feb. 13, 1990

Name	Organization	Address
Chap Wheelen	Ks Psychiatric Soc.	Topeka
Jodan Wagner	Lobby	
Stuart Swenson		Topeka
Barry Benoy	Bd of Healing Arts	Topeka
Richard Hanner	"	"
Janette Pucci	Bd of Nsg	Topeka
Cathy Roos	KDHE	"
Joyce Kinnee	KDHE	Topeka
Kelly Watts	KCA	Topeka
[illegible]	KAIA	Overl
Gina McDonald	SRS AS	Topeka
Sparky Kunst	Dept. of Adm	Topeka
Lou Baker	Assn Prof. Psychologists	Topeka
Alan Cobb	Ks Hosp Care Soc.	Wichita
GARY Robbins	Ks Optometric Assn	Topeka
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS	"

TO: Public Health & Welfare Committee

FROM: Stuart W. Twemlow, M.D. ← Aussie ?

RE: House Concurrent Resolution #5046

I am a board certified psychiatrist who has been in practice in Kansas for the past 19 years. A brief biographical sketch summarizing my clinical and professional background is attached. I am appearing in support of this resolution based on my clinical and research activities with people who have been victims of sexual exploitation by professionals. In addition, I have had numerous occasion to treat the exploiting professional, who has sought my help either stimulated by peer group and/or legal threats or by virtue of his own realization of the pathological nature of his relationship with the patient/client.

In the edited collection entitled Sexual Exploitation in Professsional Relationships(1), published by the American Psychiatric Association in 1989, I authored a chapter entitled "The Lovesick Therapist" together with the editor of the volume, Dr. Glen O. Gabbard, who has already presented his views to committees concerned with penalties for such exploitation. That chapter addresses the psychodynamic pathology behind the abusing therapists.

Resolution 5046 should be taken as an expression of the current increased concern with exploitation in relationships where there exists an element of emotional dependency between the client or patient and the professional individual. The legal term, "fiduciary relationship", has

PHTW
2-13-90
Attm #1

been used for this phenomenon. Although this term is a legal one, it is more widely known and understood than most psychoanalytic ideas and thus is useful because of widespread acceptance. In Black's Law Dictionary, such a relationship is defined as one; "Where there is a special confidence reposed in one who in equity and good conscience is bound to act in good faith and with due regard to interests of one reposing the confidence." (P. 753-754). All of the professional groups named in this resolution are fiduciaries within that definition by virtue of their licensure and/or practice. This resolution does not address other fiduciary relationships such as school teachers, attorneys, etc. It is apparent that such fiduciary trust occurs in these groups as well and that similar exploitation is likely as frequent as in the groups named in this resolution. I am pleased to see that the resolution addresses not only psychiatrists, but the physician group as a whole. Non-psychiatric physicians are much less aware of the problems associated with emotional dependency and more in need of such training. Our research into the nature of physician-caused (iatrogenic(2 & 3)) illness has indicated that frequently in relationships between doctors and patients, an unconscious dependency exists in which the patient relates to the doctor in a child-like way, expecting the same care, attention and consideration as they would from a parent. The vast majority of clinicians respect that unconscious trust. A small percentage of the various professions do not. At least this was the view until

PNell
2-13-90
Attn #1.
pg 2.

recently. A number of surveys have been performed by anonymous questionnaire and reported in the book, providing us with a much more worrying picture. It appears that in most groups surveyed, the prevalence of sexual contact with patients or clients exceeds the rare event one might have hoped for. A variety of estimates have been given, ranging from 6% to 12%, but one must remember that anonymous questionnaires probably only tap the tip of the iceberg. It is conceivable that perhaps even 12-20% of patients are the victims of a variety of forms of inappropriate sexual contact representing a manipulation of the fiduciary relationship with the professional concerned. From a common sense point of view, one would expect that the exploiting professional would be an extremely disturbed individual. From time to time, patients who have been the victims of perverse and bizarre sexual abuse will publish autobiographical sketches. The physicians or professionals represented in these types of books in general fall into either severely disturbed criminal elements (anti-social personality) or psychotic professionals. One recent publication in that regard is the book Therapist(4). Unfortunately, the experience of ethical committees of the American Psychiatric Association and professionals such as myself indicate that such dramatically disturbed medical professionals are only a very small percentage of the exploiting group, a majority of which never actually come to the attention of the law courts nor do the patients or physicians report the relationship. They come in the

PHbell
2-13-90
Attm #1.
Pg. 3

typical context of my practice, which is in the strictly confidential pyschoanalytic one-on-one contact. In our chapter, we summarize the pathology of this neurotic group who are not severely disturbed and who probably represent at least 90% of the abusing professionals. We have found that such professionals tend to be middle-aged men who abuse women on the average of 16 years younger than they are in the context of an unhappy marriage and family relationship and unsatisfying professional life.

With regard to the prevention of this tragic situation; I quote here from page 85 of our chapter entitled "Prevention".

> Prevention of lovesickness in therapists and the countertransference acting out that accompanies it is a formidable task. Clearly, a personal treatment experience for the therapist is not a fool-proof method of prevention. The Chapter 1 survey by Gartrell et al. found that offenders were more likely than nonoffenders to have undergone therapy or analysis. Profiles of susceptible therapists, such as those by Brodsky in Chapter 2 and by Pope and Bouhoutsos (1986), provide some guidelines for detecting which therapists might be at risk. The middle-aged male therapist, who is in the midst of a divorce or other problems in his intimate relationships should be alert to any tendencies toward overinvolvement with his patients. Does he inappropriately disclose aspects of his personal life to his patients? Does he think about a particular patient when she is not in the office with him? Does she enter his dreams? Does he begin to think that what his patient needs is love to make up for the lack of love she received in childhood? Finally, does he begin to think that he sees aspects of himself in his patients?
>
> The primary difficulty with preventing therapist-patient sexual intimacy is that all of these questions must be asked by the therapist

PHRW
2-13-90
Attm #1.
Pg. 4

himself. Many of them are simply standard questions every well-trained therapist uses to monitor his countertransference on a continual basis. However, the fact remains that no one can monitor these internal states other than the therapist himself. If the therapist does not seek out help at the first sign of these warning signals, he will rapidly descend into the chasm of lovesickness and no longer be amenable to help. Moreover, we are aware of some therapists who developed lovesickness while they were in regular supervision and simply withheld the information about the developing sexual relationship from their supervisors. These therapists felt that the relationship was so special that no supervisor could truly understand it. They concealed the information from supervision precisely because they did not want to stop the sexual relationship.

One prophylactic measure—one that therapists must enforce for themselves—is the avoidance of nonsexual dual roles with patients. A therapist-patient relationship should be a strictly professional one that is not contaminated with financial deals (other than fee arrangements) or various forms of socializing outside the therapy hour. An extensive questionnaire survey of 4,800 psychiatrists, psychologists, and social workers (Borys and Pope, in press) revealed that therapists involved in nonsexual boundary violations during psychotherapy are at an increased risk of becoming sexually involved with their patients.

While education about ethical problems in the practice of psychotherapy is important, if not essential, in training programs and continuing education workshops, the surveys reported in this book indicate that inadequate training is not the main problem. The narcissistic disturbance in the lovesick therapist is so pervasive among psychotherapists in general (see Buie 1982-83; Finell 1985; Miller 1981) that we would be hard pressed to delineate some point on the continuum at which a therapist's wish to receive certain affirming responses from his patient becomes so extreme that it places him at risk for falling in love with the patient and acting out his sexual wishes with her. Psychotherapists would do far better to assume that everyone is at risk and to engage in a continual intrapsychic monitoring process as part of their professional practice.

The data in Chapter 1 by Gartrell et al. indicate that only 41 percent of offenders sought out consultation because of their sexual involvement. Obviously, we have no data on the number of therapists who seek out consultation before getting involved as a way of preventing it. The therapist who wishes to seek help may be faced with a dilemma. As Pope (1987) points out, neither consultation nor supervision provide the extensive privilege under some state laws that the therapist-patient relationship provides. The therapist may wish to enter psychotherapy rather than pay for supervision or consultation simply to assure himself that whatever he says will be held in strict confidence. This situation may change in the near future, however, as many states are currently considering whether to allow either mandatory or discretionary reporting of therapist-patient sex even when therapist-patient privilege applies, similar to the current situation in most states regarding child abuse. For those who do seek out therapy, Pope (1987) has provided a useful model of intervention.

Finally, nothing can be more important than attention to one's private life. Far too many therapists put more energy into treatment relationships than into their marriages, where one can rightfully expect to seek personal gratification. The best prophylaxis is a satisfying personal life.

PHCW
2-13-90
Attn. # 1.
09.5.

In commentary on this excerpt; clearly for the abusing professional psychotherapist there is comprehensive supervisory and peer review, including impaired physician groups available for detection of sexually exploiting therapists and for their treatment. I am not implying that training is the only solution to the problem, but it's certainly a very important one. The other authors in this book strongly support the need for training in the ethics and problems associated with intense emotional feelings for patients. For professional counselors including sex therapists and ministers, the rules, regulations and monitoring and licensing bodies are far less formally structured and monitored, largely because of the less clearly defined nature of the professional boundaries in such groups. Such counselors are also often trained in ways which are more technique-oriented and much less attuned to subtle nuances of the relationship which can lead to unconscious emotional dependency. Whereas this resolution covers a broad range of potentially exploitative professionals, its general language enables individual licensing authorities a very broad discretion in instituting its requirements.

The resolution might well be criticized by some groups who would perhaps correctly imply that their professional licensing and monitoring authorities already contain sufficient safeguards against this type of behavior (e.g.psychiatrists), yet still in my opinion, it would be useful to specify this relationship as a unique case for

PX+W
2-13-90
Attn#1.
09.6.

this broad range of professional groups. The reasons for this include the following:

1. The problem is more widespread than had been thought.

2. The effect on patients or clients of sexually exploitative relationships is incredibly destructive. Clinical opinion of most therapists concur that at least 90% of patients are very severely damaged by such contact, including a very high suicide rate. This has also been my clinical experience. Patients who have been exploited in such a way are not dissimilar psychologically to veterans who have been severely traumatized in war. Both groups often show signs of a Post Traumatic Stress Disorder, and significant psychological disorganization, often out of proportion to any preexisting psychopathology in the patient.

3. There is a natural enough tendency in all professional groups to avoid facing issues that are distasteful to the image of the profession. No professional group is immune to this particular problem. By specifying the uniqueness of this problem, the licensing authorities and professional therapists are forced to deal directly with something that often is unconsciously swept under the carpet.

The exact details as to how this training should be instituted should be left to the licensing authorities. Most such authorities will welcome the support indicated by legislation of this type and can easily set up training

DHHW
2-13-90
Attm #1.
89.7.

within the purview of their ongoing continuing education requirements for re-licensure, including seminars, workshops and literature.

Footnotes:

1. Twemlow, S., Gabbard, G.O.: The Lovesick Therapist in Sexual Exploitation in Professional Relationships. Edited by Gabbard, G.O. Washington, DC, American Psychiatric Press, 1989; 71-87.

2. Twemlow, S., Gabbard, G.O: Iatrogenic Disease or Doctor-Patient Collusion? American Family Physician, 24:3; 129-134. September 1981.

3. Twemlow, S., Gabbard, G.O.: Iatrogenic Disease or Folie a Deux? in The Iatrogenics Handbook. Edited by Morgan, R. Toronto, Ontario, IPI Publishing, 1983; 109-119.

4. Plasil, E. Therapist. New York, St. Martins, 1985.

DHHW
2-13-90
Attm #1,
Pg. 8,

Brief Biographical Sketch Revised January, 1990

Stuart W. Twemlow, M.D., married with five children, was born in New Zealand and has traveled widely. He graduated from medical school in New Zealand and entered General Practice in New Zealand and Australia emphasizing Surgery, Obstetrics and Trauma Medicine until 1970. He then traveled to the U.S.A. to study psychiatry and became a Fellow in The Menninger School of Psychiatry, Topeka, Kansas. He is Board Certified in General Psychiatry, a Fellow of the American Psychiatric Association, and is certified in Adult Psychoanalysis by the Topeka Institute for Psychoanalysis, Menninger Foundation.

He started writing with an educational book and since has published over 75 articles and book reviews in various areas such as health care delivery systems, the doctor-patient relationship, psychotherapy, drug abuse and alcoholism, psychiatric hospital treatment, biofeedback, altered states of consciousness, guided affective imagery, intensive meditation and neuropathology. His newest book with Dr. Glen Gabbard is entitled "With the Eyes of the Mind: An Empirical Analysis of Out-of-Body States" published by Praeger Special Studies, New York, 1984.

His current professional writing includes articles on clinical aspects of Out of Body Experiences, a Psychoanalytic study of the sexually abusing psychotherapist and incest. He has a Veterans Administration funded research study of the Doctor-Patient relationships derived from his clinical research into iatrogenic disease. This questionnaire and interview study investigates unconscious factors distorting communication between doctor and patient. The study will also follow-up subsequent health and practice patterns of physicians who graduated from a medical school which placed special emphasis on doctor-patient relationships. He has begun a tentative excursion into writing on psychological topics for the general public. His first book, now under contract, is entitled "Stopping Violence: A Survival Guide for the 21st Century". This book explores the pyschology of the victim and attacker with techniques to avoid bodily harm.

Formerly he was Chief of Research Service, Topeka Veterans Administration Medical Center and a faculty member of the Menninger School of Psychiatry. Currently he is in the private practice of Psychiatry in Topeka, Kansas, and is an instructor in the Topeka Psychoanalytic Institute. He is also Associate Clinical Professor of Psychiatry in two Kansas University Medical Schools; Kansas City and Wichita, Kansas. He is a member of a number of professional and Scientific Societies including the Sigma Xi Scientific Research Society, the Shawnee County Medical Society, and the American Psychoanalytic Association.

His main (even consuming) extraprofessional interests are the Martial and Meditative Arts. With his children he studies Karate and is ranked Advanced Black Belt in three systems including the Okinawa Kobudo (weapons) system. He is a Member of the Board of Directors and Head of Certification for the United States Kempo Federation and is listed in Who's Who in American Martial Arts. He is also studying and practicing the Zen Meditative approach to Mind-Body integration and teaches these techniques to students in his Topeka School of the Mrtial & Meditative Arts.

2-13-90

Kansas Psychiatric Society

1259 Pembroke Lane
Topeka, KS 66604
Telephone: (913) 232-5985
or (913) 235-3619

Officers 1988-1990

Donald R. Brada, M.D.
President
929 N. St. Francis
Wichita, KS 67214

Samuel L. Bradshaw, M.D.
President-elect
3910 Parlington Dr.
Topeka, KS 66610

Cathy Shaffia Laue, M.D.
Secretary
P.O. Box 1634
Lawrence, KS 66044

Donna Ann Vaughan, M. D.
Treasurer
R.R. 1 , Box 197 A
Newton, KS 67114

Manuel P. Pardo, M.D.
Councillor, 1988-91
UKMC-Psychiatry
39th & Rainbow
Kansas City, KS 66103

George W. Getz, M.D.
Councilor, 1987-90
P.O. Box 89
Larned, KS 67550

Eberhard G. Burdzik, M.D.
Councillor, 1986-89
2700 West Sixth St.
Topeka, KS 66606

George Dyck, M.D.
Representative
Prairie View, Inc.
Newton, KS 67114

H. Ivor Jones, M.D.
Deputy Representative
8901 West 74th St.
Shawnee Mission, KS 66204

Jo Ann Klemmer
Executive Secretary
Telephone: (913) 232-5985

Chip Wheelen
Public Affairs Contact
Telephone: (913) 235-3619

February 13, 1990

TO: House Public Health & Welfare Committee

FROM: Kansas Psychiatric Society Chip Wheelen

SUBJECT: HCR 5046; Training in Assessing and Treating Sexual Dysfunctions

Thank you for this opportunity to express comments in regard to HCR 5046. We commend the authors of this resolution for their concerns relating to sexual exploitation of patients and clients of mental health professionals. It is indeed true that sexual exploitation is unacceptable under any circumstances and that measures should be continued to prevent such occurrence.

We must, however, oppose adoption of HCR 5046 for the following reasons:

1. It would not be the licensing agency which affects the curricula required of those who study to become mental health professionals. In fact, the curricula of those who study for such professional licensure is governed in Kansas by the Board of Regents.

2. Even if the resolution were amended to impose the requirement on the Board of Regents, the Kansas Board of Regents could not govern educational curricula at the various institutions throughout the United States where mental health professionals receive their education. This, of course, would mean that many professionals could not be licensed to practice in Kansas if such a prerequisite were imposed.

3. It is the Accrediting Council on Continuing Medical Education that governs and approves continuing education for physicians. This means that priorities for continuing education are determined by the profession. HCR 5046 would represent an unprecedented change in that policy by establishing a legislated priority for continuing education. We believe that this should remain a function of deliberation among the leadership of the various professions.

4. A resolution adopted by the Legislature does not have the force and effect of statutory enactment and, therefore, serves little purpose other than to commemorate a special occasion or event.

While prerequisite and continuing education may be important in terms of deterring sexual exploitation of patients and clients, we believe that there is a more effective way of accomplishing that same goal. This is why the Kansas Psychiatric Society and the Kansas Medical Society have ongoing professional practices review committees which consider complaints generated from consumers and other professionals. Although peer pressure may not completely eliminate the existence of unprofessional conduct, it is certainly an effective way of deterring such conduct. Furthermore, licensing agencies possess abundant authority to discipline licensees if an investigation concludes that professional misconduct has occurred. Thank you for considering our concerns. We respectfully request that you report HCR 5046 not recommended for adoption.

PHED 2-13-90 Attach 2

Kansas State Board of Nursing

Landon State Office Building
900 S.W. Jackson, Rm. 551
Topeka, Kansas 66612-1256
913-296-4929

Lois Rich Scibetta, Ph.D., R.N.
Executive Administrator

Patsy L. Johnson, R.N., M.N.
Educational Specialist

Janette Pucci, R.N., M.S.N.
Educational Specialist

Belva J. Chang, R.N., M.N., J.D.
Practice Specialist

To: The Honorable Marvin L. Littlejohn, Chairman, and Members of the House Public Health and Welfare Committee.

From: Janette Pucci
Educational specialist

Date: February 13, 1990

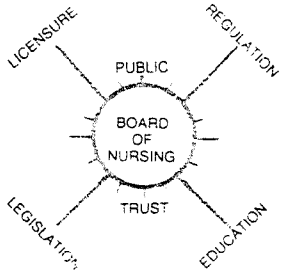
Re: House Concurrent Resolution No. 5046

Thank you for this opportunity to comment on House Concurrent Resolution No. 5046.

The Board of Nursing believes there is a spectrum of sexual problems and treatments that nurses encounter in their work settings. Because there are different types of problems and treatment modalities, basic and continuing nursing education has a difficult mission to meet all the educational needs of the nurse practitioner.

We will briefly describe the curriculum in basic nursing education for the four levels and how content on sexuality, sexual problems and ethics is presented in these programs. We will discuss the implications for mandating content for continuing education requirements for relicensure and the Board's cases against licensees who have been involved in sexual exploitation incidents.

The basic nursing programs are practical nursing, associate degree, diploma and baccalaureate degree. The practical nursing programs are required by regulation to have 550 hours of theory and 550 hours of clinical. The associate degree usually is a two year academic program. Most of the Kansas associate degree programs require 65 to 72 college credit hours for graduation. The single diploma program in Kansas is three academic years in length. The baccalaureate degree programs consist of four academic years and require on the average 124 college credit hours.



PH&W
2-13-90
attm # 3

The presentation of nursing content to the students follows the faculty's theory of nursing, conceptual framework and philosophy. Content on normal development including sexuality is needed to understand deviations from normal or sexual difficulties. Courses are developed and content is assigned based on the level of the student. Content is structured so that it flows from simple to complex and is based on a foundation of the natural and behavioral sciences, communication, social sciences and humanities.

The educational programs facilitate the learning of knowledge, skills and abilities appropriate for the level of nursing practice. The practical nursing programs provides basic content on growth and development, sexuality, sexual problems and nursing care. In professional nursing programs content on the assessment and treatment of sexual problems is included in many courses. The professional nursing programs require psychology and developmental psychology courses as prerequisites or such content incorporated within the nursing courses on the family or on the care of children and adults. (Two practical nursing programs have college psychology courses and the other programs teach such content in their nursing courses.)

The first concepts for nursing assessment are taught usually within the fundamentals course or the first nursing course. As students progress through the professional nursing program, each subsequent nursing courses builds on the concepts by providing more detailed information on assessment related to the focus of the course. Content on abnormal or alterations of sexuality can be taught in a variety of nursing courses. For instance, one program, Newman Hospital School of Nursing teaches the nursing care for alterations of sexuality in women who have undergone a hysterectomy in the Nursing and Families course. Another school, St. Mary of the Plains teaches the ethical conduct of nurses in their ethics course. Content on sexually transmitted diseases is included in their adult nursing course. One of the associate degree programs, Barton County Community College, teaches sexual problems such as rape or sexual abuse in their course on psychiatric nursing. Another program, Newman College of Kansas, includes content on sexual problems or deviations in the psychiatric nursing course. The ethical content is integrated in all the nursing courses. Wichita State University includes content on assessment and treatment of sexual problems in their psychiatric nursing course. The WSU students are assigned readings and discussions on the abuse of the professional role.

The graduates of basic programs are prepared as beginning nurse practitioners. The curriculums of the professional nursing programs provides the knowledge about sexual problems and ethics. Treatment can mean a variety of things beginning with knowledge of resources to the therapeutic interventions for an individual. The new graduate would be expected to participate in the care of an individual. The sexual component is one aspect of the total treatment plan. The beginning nurse practitioner should be able to recognize existing sexual problems, employ therapeutic communications, follow the treatment plan and/or refer the patient or client to the appropriate treatment resource.
The beginning nurse practitioner should have a sense of ethics as determined by the professional organizations including the nursing student organizations. In one psychiatric-mental health text the therapeutic nurse-patient relationship

does not include dating, intercourse, or physically acting out

PNEC
2-13-90 #3
Attm 292

affection. Rather, a therapeutic relationship means to accept, emotionally, care for, and extend affection to help another to gain a positive self-concept and confidence and skills to establish a close bond with others.(Murray & Huelskoetter)

Appropriate content on sexual problems, treatment and ethics is included in the basic nursing programs.

Following graduation, nurses are employed in agencies that treat patients with a variety of health problems including sexual ones. The nurse who works in a acute care and long term care facilities may have few clients with sexual problems. However, the nurse employed in a psychiatric setting will expect to have more patients with sexual problems and will be expected to identify and participate or initiate therapeutic interventions. Hospitals and other health care agencies have policies that determine the employee-patient relationship.

It would be difficult to develop a specific continuing education offering to meet the educational needs of all licensees. The course that is appropriate for the nurse working in a pediatrics setting may not be at the same level to increase the knowledge of the psychiatric nurse. The psychiatric nurse practitioner should have continuing education that is relevant to her practice area.

In 1989, 240 cases were reported to the Board of Nursing. Three of these cases were concerned with the sexual exploitation of patients or 1.25% of the cases. These nurses were employed in psychiatric hospitals. Their actions were violations of the patient's treatment plan. The Practice Specialist has indicated that two of these nurses were no longer employed by the agency when the infraction occurred. The third nurse was fired because of sexual exploitation of patient(s). The cases were reported to the Board of Nursing since these cases were violations of the nurse practice act.

The Board of Nursing does not support the resolution that mandates content on sexual problems, treatment and ethical actions for the basic and continuing nursing education. The Board believes that appropriate content is currently presented in the basic nursing courses for the beginning practitioner. A single continuing education offering required for relicensure would not be appropriate for all licensees. It would be appropriate for employers to identify content and ethical conduct relating to sexual problems of patients treated within that agency. The employer should provide this information during orientation and through inservices or specific continuing education offerings for employees.

Murray, R. B., & Huelskoetter, M. M. W, Psychiatric/Mental Health Nursing (2 Ed). Appleton & Lange. 1987.

PNRW
2-13-90
Attn # 3
pg. 3

State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Division of Health
Landon State Office Bldg., Topeka, KS 66612-1290

Stanley C. Grant, Ph.D., Secretary

(913) 296-1343
FAX (913) 296-6231

TESTIMONY PRESENTED TO

THE HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

HCR 5046

Background

This resolution appropriately proclaims that "sexual exploitation of patients or clients by mental health service professionals is not acceptable under any circumstances." All of the major mental health professions have declared that sexual intimacy between a patient/client and a mental health care provider is inherently unethical, unacceptable, and severely damaging. Such behavior on the part of the mental health care provider is seen as "sexual exploitation." Ethical prohibition of such activities goes back to the Hippocratic oath. Studies have shown that 90 percent of patients who are involved sexually with therapists sustain some type of damage that ranges from their personalities being negatively affected (34 percent), to hospitalization (11 percent), and to suicide (one percent).

Even though professional organizations and regulatory boards take a stand against health care providers being sexually intimate with a patient/client and discipline practitioners found guilty of the behavior, sexual exploitation is still a problem. National surveys show that approximately five to seven percent of the male psychiatrists, PhD psychologists, and physicians reported having had sexual intercourse with patients during treatment stages. Double that number have had erotic contact with patients. A recent national study discovered that children and adolescents were, unfortunately, well represented among those who have been sexually exploited by therapists. Examples of sexual exploitation that the California licensing body for psychologists has dealt with include: sexual intercourse, sexual caressing, kissing, spanking, group sexual activity, photo taking, etc.

P&H
2-13-90
Attm #4

The issues involved with sexual exploitation warrant attention. House Concurrent Resolution 5046 attempts to approach this very serious problem by preventive measures through educational requirements of health care practitioners.

Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343
James Power, P.E., Director of Environment (913) 296-1535
Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415
Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

This resolution directs the state regulatory agencies for physicians, psychologists, nurses, professional counselors, and social workers to require training in assessing and treating sexual problems and related ethical issues. One related ethical issue is the topic of sexual exploitation of patients. The training may be part of any continuing education requirements as well as prerequisite to licensure. We have some reservations about this approach. However, we applaud the authors of the bill for attempting to tackle, by a preventive means, the problem of sexual exploitation.

It is somewhat misleading to lump the subject of treating patients with sexual problems with the subject of sexual exploitation. Patients with sexual dysfunctions and sexual exploitation are not necessarily synonymous. Patients/clients being treated for a variety of problems, not just sexual dysfunctions, have been sexually exploited.

The link between the two subjects may be based on one of the common scenarios by which a mental health care provider sets the stage for or brings about sexual intimacies with his/her patients/clients. (See attachment for the 10 scenarios.) One method includes fraudulently stating that sexual intimacy is a valid treatment for sexual or other kinds of difficulties. This argument is rarely used by the mental health care provider as a defense in licensing hearings, malpractice suits, etc., because ethical codes prohibit such intimacies. The patient/client may be unaware of this prohibition or believe the care provider's declaration. A California study showed that 50 percent of the patients who were sexually intimate with their therapists did not know that such behavior on the part of the therapist was unethical. It was found that the only time the consumer is given a copy of the ethical code of a profession is after a complaint has been filed with the regulatory agency. This leads to the conclusion that educational efforts on ethical issues needs to be extended to consumers as well.

Probably the best time to address ethics is during the initial training process of health care students. Apparently little time is spent in the classroom on how to deal with sexual contact with or sexual attraction to patients/clients.

We are concerned about the tendency to create a laundry list of continuing education subject requirements. It is hard to draw the line and choose which subjects to include or exclude with only a limited number of continuing education hours required. For example, what about adding to the continuing education list the subject of treatment of sexually exploited patients. Recent developments show that patients/clients who have been sexually exploited form a distinct clinical syndrome referred to as "therapist-patient sex syndrome." This syndrome is similar to rape trauma syndrome, reactions to incest, etc.

The approach directed by the resolution in and of itself does not deal specifically with various other issues associated with sexual exploitation. For example, these educational efforts do not apply to consumers and unregulated mental health care providers (e.g., members of the clergy, rehabilitation counselors, drug and alcohol counselors, etc.). Additionally, it does not address the shortcomings of recourse options currently available to victims. Previously, the department recommended that the legislature consider steps taken in Minnesota and other states to combat the problem of sexual exploitation. These steps include: (1) require regulated and unregulated mental health care

Attm #4
P92
PAHCC
2-13-90

providers to distribute educational materials about ethics to patients prior to treatment, (2) establish a regulatory body to review complaints and discipline unethical nonregulated mental health care providers, (3) change the criminal code to make it illegal for a mental health care provider to sexually exploit a patient, and (4) create a civil cause of action for sexual exploitation victims who have been harmed.

Presented by: Joseph Kroll, Director
Bureau of Adult and Child Care
Kansas Department of Health and Environment
February 13, 1990

PHrev
2-13-90
Attm #4
p93

Extracted from JOURNAL OF COUNSELING AND DEVELOPMENT, "How Clients are Harmed by Sexual Contact with Mental Health Professionals: The Syndrome and Its Prevalence," by Kenneth S. Pope, December 1988, Vol. 67, page 31.

Ten Common Scenarios
by which a therapist sets the stage for
or brings about sexual intimacies with patients

Scenario	Criterion
1. Role Trading	Therapist becomes the "patient" and the wants and needs of the therapist become the focus of the treatment.
2. Sex Therapy	Therapist fraudulently presents therapist-client sexual intimacy as a valid treatment for sexual or other kinds of difficulties.
3. As If . . .	Therapist treats positive transference as if it were not the result of the therapeutic situation.
4. Svengali	Therapist creates and exploits an exaggerated dependence on the part of the client.
5. Drugs	Therapist uses cocaine, alcohol, or other drugs as part of the seduction.
6. Rape	Therapist uses physical force, threats, and/or intimidation.
7. "True Love"	Therapist uses rationalizations that attempt to discount that professional nature of the relationship with its attendant responsibilities and dynamics.
8. It Just Got Out of Hand	Therapist fails to treat the emotional closeness that develops in therapy with sufficient attention, care, and respect.
9. Time Out	Therapist fails to acknowledge and take account of the fact that the therapeutic relationship does not cease to exist between scheduled sessions or outside therapist's office.
10. Hold Me	Therapist exploits client's desire for nonerotic physical contact and client's possible difficulties distinguishing erotic and nonerotic contact.

Parker
2-13-90
Attm #4
294

State of Kansas

Office of
RICHARD G. GANNON, EXECUTIVE DIRECTOR
LAWRENCE T. BUENING JR. GENERAL COUNSEL
JOSEPH M. FURJANIC DISCIPLINARY COUNSEL
SUSAN LAMBRECHT LICENSING SUPERVISOR

Kansas State Board of
Healing Arts
235 S. TOPEKA BLVD.
TOPEKA, KS 66603
LICENSURE 913-296-7413
DISCIPLINARY 913-296-7442

Board of Healing Arts

MEMORANDUM

TO: House Committee on Public Health and Welfare

FROM: Richard G. Gannon, Executive Director

DATE: February 13, 1990

RE: HCR No. 5046

At its meeting February 10, 1990, the State Board of Healing Arts reviewed the language contained within House Concurrent Resolution No. 5046. The Board took a position in opposition to HCR 5046.

This resolution would direct the State Board of Healing Arts to require physicians to obtain minimum training in assessing and treating sexual problems and in related ethical issues. The training would be made a part of present continuing medical education requirements as well as a prerequisite to licensure.

It was the position of the Board that implementation of such continuing education requirements and prerequisites to licensure would be practically impossible. Individuals licensed by the Board would all be required to obtain this continuing education requirement although a majority of them would not be mental health service professionals. Therefore, continuing education in assessing and treating sexual problems would be required not only of psychiatrists but also of pathologists, orthopedic surgeons, allergists and all other medical specialists.

At present, the Board does not dictate the type of continuing education which must obtained to meet the requirements for licensure renewal. It is felt that licensees obtain the continuing education in the areas in which they practice and have a need for continual updating of information and skills. While continuing education in assessment and treatment of sexual problems is important, there are a number of other areas which are of equal importance including keeping up to date on the latest diagnostic and treatment procedures, new forms of medications and the proper method of prescribing controlled drugs. By dictating a certain portion of continuing education be obtained in one area, the Board feels this may result in other, equally important, areas being neglected.

P&HW 2-13-90 attm #5

Finally, it would appear that the Board would be required to implement its own training program for this assessment and treatment of sexual problems and in related ethical issues which would be required of all individuals applying for licensure. The reason the Board would be required to implement its own program would be the difficulty of the Board in assessing programs given by all of the medical schools in the United States and throughout the world and determining what, if any, training in this area had been received by the applicant as part of their medical school and/or residency training.

In conclusion, although HCR 5046 may have a noble purpose, the problems which would be created with its adoption have compelled the Board to oppose this resolution.

Thank you very much for the opportunity to appear before you. I would be happy to answer any questions you might have.

PH&W
2-13-90
Attm. # 5
pg. 2.

Kansas Psychiatric Society

1259 Pembroke Lane
Topeka, KS 66604
Telephone: (913) 232-5985
or (913) 235-3619

February 13, 1990

TO: House Public Health and Welfare Committee

FROM: Kansas Psychiatric Society

SUBJECT: HCR 5041; Mental Illness Awareness Week

Thank you for this opportunity to express our support of HCR 5041. As you may recall, each year the American Psychiatric Association, in conjunction with the National Alliance for the Mentally Ill, establishes a single week during the calendar year, during which we are all urged to learn more about the subject of mental illness. This allows state psychiatric societies and other organizations to focus educational efforts during a specific period of time.

In 1989, the Kansas Psychiatric Society coordinated a coalition of numerous organizations which expressed an interest in promoting Mental Illness Awareness Week among their members. In addition, thanks to the adoption of a 1989 Resolution, a gubernatorial proclamation was issued which urged Kansas citizens to become better informed about the subject of mental illness. We also organized a speaker's bureau of psychiatrists, other professionals and knowledgeable persons who made themselves available to media reporters to discuss mental illness. Furthermore, we developed and printed over 20,000 mental illness information cards which were distributed via Kansas hospitals, community mental health centers and other organizations. We developed a media information kit and issued a news release to newspapers, radio stations and TV stations.

Perhaps the most notable accomplishment of the 1989 Mental Illness Awareness effort should go to the credit of what is called the Wichita Project. A two-hour television program entitled, "Kansas Mental Illness Test" was produced and broadcast by way of the Kansas State Network. In Topeka, we convinced the local affiliate to rebroadcast the excellent Wichita program.

We urge you to recommend adoption of HCR 5041 so that we can conduct similar educational efforts during 1990. Thank you for your attention to this matter which we believe is a very important public education campaign.

CW:lg

PH+W
2-13-90
attm #6