Approved 2-26-92
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Rep. John Solbach at
Chairperson

3:30 ~~a~~m./p.m. on February 19, 1992 in room 313-S of the Capitol.

All members were present except:

Representatives Douville and Parkinson who were excused.

Committee staff present:

Jerry Donaldson, Legislative Research
Jill Wolters, Revisor of Statutes
Judy Goeden, Committee Secretary

Conferees appearing before the committee:

State Representative David Heinemann
State Representative Kathleen Sebelius
State Representative Joan Wagnon
Wendy Roach, Intern, Representative Joan Wagnon's office
Sarah Jane Russell, Director, Douglas County Rape Victim Support Service
Cathy Rooney, Director, Health Occupations Credentialing
Gigi Felix, Executive Director, Kansas Chapter of National Assn of Social Workers
Dr. William Albott, Kansas Psychological Association
Amy Bixler, National Organization of Women
Diane Glynn, Kansas State Board of Nursing
Joseph Kroll, Director, Bureau of Adult & Child Care
Chip Wheelen, Kansas Medical Society & Kansas Psychiatric Society
Lawrence Buening, Exec. Director, Kansas State Board of Healing Arts
Jim Clark, Kansas County & District Attorneys Association
State Representative Alex Scott

The Chairman called the meeting to order.

Hearing was opened on HB 2426, sexual exploitation by a mental health service provider.

Representative David Heineman gave background information on HB 2426. He gave committee members copies of Proposal No. 18. (Attachment #1) He said SB 425 received no action in the Senate, therefore this bill was introduced.

State Representative Kathleen Sebelius endorsed HB 2426 and HB 2253. She served as a member of the interim committee which recommended the proposals. She thought civil and regulatory remedies at the same time would be appropriate.

State Representative Joan Wagnon testified in favor of HB ~~2624~~ 2253. (Attachment #2) She said there was support from Menninger Foundation staff, however they were unable to attend today's committee meeting. She introduced her intern Wendy Roach to the committee.

Wendy Roach, intern, testified in support of HB 2426 and HB 2253. (Attachment #3) She answered committee members questions.

Sara Jane Russell, Director of Douglas County Rape Victims Support Service, testified in favor of HB 2426. (Attachment 4)

Cathy Rooney, Director of Health Occupations Credentialing, Kansas Department of Health & Environment, testified in favor of HB 2426. (Attachment #5) She suggested several technical amendments.

Gigi Felix, Executive Director of Kansas Chapter of National Association of Social Workers, testified in support of HB 2426. (Attachment #6)

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY,

room 313-S Statehouse, at 3:30 ~~a~~p.m./p.m. on February 19, 1992.

Dr. William Albott, Kansas Psychological Association, testified in favor of HB 2426 and HB 2253. (Attachment #7) He felt that the bill should not be limited to mental health providers only. He had several suggested amendments and answered committee members questions and concerns. He also submitted written testimony on HB 2253 in support of that bill. (Attachment #8)

Amy Bixler, National Organization of Women, testified in support of HB 2253 and HB 2426. (Attachment #9)

Hearing on HB 2253, reporting of sexual exploitation of patient by mental health professional, was opened.

Diane Glynn, R.N., J.D., presented testimony in favor of HB 2253 from Patsy Johnson, Executive Administrator of Kansas Board of Nursing. (Attachment #10)

Joseph Kroll, Director of Bureau of Adult & Child Care, Kansas Department of Health & Environment, testified in favor of HB 2253. (Attachment #11) He suggested a more comprehensive approach to sexual exploitation.

Chip Wheelen, Kansas Medical Society and Kansas Psychiatric Society, testified that he thought HB 2253 and HB 2426 were both too narrowly focused. (Attachment #12) He submitted several suggested amendments.

Lawrence Buening, Executive Director of Kansas State Board of Healing Arts, testified in favor of HB 2253. (Attachment #13)

Jim Clark, Kansas County & District Attorneys Association, said he had a technical question about HB 2253, and he offered to work with the committee on the language in the bill.

State Representative Alex Scott, M.D., gave the committee insight from a physician's standpoint. He said medical doctors are different from mental health providers since they generally see their patients without clothing. They see their patients as problems, not sex objects. He said suggestive patients are certainly a hazard to physicians.

Hearings on HB 2426 and HB 2253 were closed.

The meeting adjourned at 5:20 P.M.

GUEST LIST

COMMITTEE: House Judiciary DATE: 2-19-92

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATIO
Carol Scott	Topeka	Washburn Univ.
William Abbott PhD	Topeka	Ks. Psy. Assoc.
Lisa Seip	Twp	KS Nat'l Assoc of Social Work
Mary Ann Gabel	"	BSRB
Joseph Moore	KDHE	
Marvin Stottlemire	KDHE	
Cathy Rooney	KDHE - Topeka	KDHE - Lawrence
Sarah Jane Russell	DG. Co. Rape Victim Support Service	
Wendy L. Koch	Topeka	Intern - Wagnon
Diana Duncan	Winfield, Ks.	Nursing Student
Cindy Bailey	Topeka	NOW

RE: PROPOSAL NO. 18 – MENTAL HEALTH PROFESSIONALS*

Proposal No. 18 directed the Special Committee on Corrections/Mental Health to examine alternatives for recourse and redress available to consumers who are victims of sexual exploitation by mental health and counseling professionals.

Background

this interim topic was requested by the House and Senate Committees on Public Health and Welfare and by the Secretary of Health and Environment. During a 1985 review of a credentialing application for professional counselors and a 1988 review of a credentialing request for marriage and family therapists, the issue of sexual exploitation of mental health consumers by mental health and counseling professionals was brought to the attention of the Department of Health and Environment.

A principal question which arose during the reviews was whether the creation and verification of standards of training for mental health professionals would address the issue of sexual exploitation or whether other means of addressing the issue of sexual exploitation are more appropriate.

Committee Activity

The Committee reviewed a staff memorandum which discussed recent literature on the subject of sexual exploitation by mental health professionals, including the incidence and prevalence of sexual exploitation, remedies currently available to victims of sexual exploitation by mental health professionals, and problems which have been noted with the available remedies. The Committee reviewed laws which have been enacted in Minnesota and other states which have addressed the issue.

The Committee held hearings and provided interested parties with the opportunity to appear before the Committee. The following is a summary of the principal testimony and recommendations of the conferees.

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* S.B. 425 accompanies this report.

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Kansas Psychiatric Society

A representative of the Kansas Psychiatric Society presented oral and written testimony stating that the Society is not opposed to the concept of imposing additional or more severe penalties if a mental health professional were to sexually exploit a patient or client, so long as the due process rights of the licensee are preserved. However, the Society questions whether there is a need for any change in current law in light of prohibitions against such conduct found in codes of professional conduct and in light of current sex offense provisions in the criminal code.

The Director of C. F. Menninger Memorial Hospital presented oral and written testimony in which he discussed the scope of the problem and stated the reasons why sexual exploitation of patients is unacceptable under any circumstances. He discussed civil, criminal, administrative, and professional sanctions for therapists who sexually exploit their patients. In his opinion, existing remedies and sanctions are adequate for the vast majority of health care professionals. In addition to civil, criminal, and professional sanctions, he stated that Kansas has stringent risk-management laws which require the reporting of sexual misconduct by health care professionals. Risk-management laws apply to both hospital and nonhospital settings.

Kansas Department of Health and Environment

Representatives of the Kansas Department of Health and Environment discussed the scope of the problem of sexual exploitation, its effect on clients, and recourse options for victims. The Department recommended four bills modeled after the Minnesota Client Protection System, which the Department provided to the Committee in draft form.

The first bill recommended by the Department would amend current criminal law to make sexual exploitation and aggravated sexual exploitation crimes.

The recommended civil law would give a patient or former patient a cause of action for sexual exploitation for injury caused by sexual contact with the mental health services provider, if the sexual contact occurred during the period the patient was receiving mental health services from the mental health services provider; or after the period the patient received mental health services if the former patient was emotionally dependent on the mental health services provider at the

time of sexual contact; or if the sexual contact occurred by means of therapeutic deception.

The third piece of legislation recommended by the Department of Health and Environment would require all mental health service providers to provide to each client prior to treatment a written copy of a disclosure of information statement and to post a statement in a prominent location in the office of the mental health services provider. Among other provisions, the statement informs clients that, in a professional relationship, sexual intimacy is never appropriate, is against the law, and should be reported to the state regulatory board. Clients also are informed that they may expect to be free from verbal, physical, or sexual abuse by the provider.

The final bill recommended by the Department of Health and Environment would require all unlicensed and unregulated mental health service providers to file certain specified information with the state on a form provided by the Behavioral Sciences Regulatory Board. Providing mental health services without filing with the Board constitutes a class A misdemeanor.

Rape Victims Support Service

A representative of the Rape Victim Support Service (RVSS), Lawrence, spoke about the work RVSS does in the Lawrence community and read a letter written by a victim of sexual exploitation. She also introduced a victim of sexual exploitation, who spoke about her experiences.

Behavioral Sciences Regulatory Board

A member of the Behavioral Sciences Regulatory Board offered testimony which included a discussion of the problem of sexual exploitation and stated the number of complaints on the basis of sexual misconduct filed against professionals licensed and registered by the Board. He stated that the Board generally endorses the draft bills proposed by the Department of Health and Environment, but offered suggestions for amendments to the bills.

Marriage and Family Therapists

Representatives from the Kansas Association for Marriage and Family Therapy, the American Association for Marriage and Family Therapy, professors of Human Development and Family Studies at

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Kansas State University, and a practicing therapist testified in support of full licensure of all therapists, including marriage and family therapists.

Psychologists

Representatives of the Kansas Association of Professional Psychologists and the Kansas Psychological Association spoke in support of the legislation recommended by the Kansas Department of Health and Environment.

Kansas Mental Health Counselors Association

A representative of the Kansas Mental Health Counselors Association testified that the Association is opposed to criminal statutes as a means to combat the sexual exploitation of clients by therapists and believes instead that the problem of sexual exploitation should be handled through impaired provider statutes. If criminal statutes are used, he stated, the statutes should apply to all health care providers licensed, certified, or registered to practice in Kansas.

Conclusions and Recommendations

The Committee expresses its concern that the current criminal law does not always adequately address the issues present in the case of sexual exploitation of clients by mental health professionals. The Committee recommends the introduction of S.B. 425 to address these issues.

S.B. 425 incorporates the amendments to current criminal law recommended by the Department of Health and Environment, which would define sexual exploitation and aggravated sexual exploitation as sex offenses. Sexual exploitation, which would be made a class E felony, is defined as sexual contact with a patient when the offender is a mental health services provider who is not married to the patient and the sexual contact occurred during the psychotherapy session; when the offender is a mental health services provider who is not married to the patient and the patient or former patient is emotionally dependent upon the mental health services provider; or when the offender is a mental health services provider who is not married to the patient and the victim is a patient or former patient and the sexual contact occurred by means of therapeutic deception. Aggravated sexual

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exploitation, a class D felony, is defined as sexual intercourse or sodomy under the circumstances stated above. Consent by the victim is not a defense to either crime. The statute defines several terms, including "mental health services provider," "emotionally dependent," "sexual contact," and "therapeutic deception." There is a rebuttable presumption that a patient is not emotionally dependent after a period of one year during which there is no personal contact between the patient and the therapist.

The Committee notes that the Judicial Council is now studying whether amendments to current sexual offense statutes are advisable. The Committee recommends that the Judicial Council consider this recommendation in its deliberations.

Respectfully submitted,

November 20, 1989

Rep. David Heinemann,
Chairperson
Special Committee on Corrections/
Mental Health

Sen. Paul Burke, Vice-Chairperson
Sen. Roy Ehrlich
Sen. Frank Gaines
Sen. Joseph Harder
Sen. Michael Johnston
Sen. Nancy Parrish*
Sen. Alicia Salisbury

Rep. Gary Blumenthal
Rep. Arthur Douville
Rep. Duane Goossen
Rep. Henry Helgerson
Rep. Anthony Hensley
Rep. Kenneth King
Rep. Phil Kline
Rep. Jo Ann Pottorff
Rep. Kathleen Sebelius

* Ranking minority member.

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STATE OF KANSAS

JOAN WAGNON
REPRESENTATIVE, FIFTY-FIFTH DISTRICT
1606 BOSWELL
TOPEKA, KANSAS 66604
(913) 235-5881
OFFICE:
STATE CAPITOL, 272-W
TOPEKA, KANSAS 66612
(913) 296-7647

TOPEKA

HOUSE OF
REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIR: TAXATION
MEMBER: ECONOMIC DEVELOPMENT
FEDERAL & STATE AFFAIRS
LEGISLATIVE POST AUDIT

February 19, 1992

To: Judiciary Committee
Re: HB 2253

This proposal adds language to the various practice acts of mental health service providers that allows for disciplinary action for sexual exploitation of patients or former patients.

A similar bill was introduced in the 1990 session which was also heard by the Judiciary Committee rather late in the session. Their recommendations were incorporated into the language used this session.

The idea for the bill came from Dr. Stuart Twemlow from his practice and a book, Sexual Exploitation in Professional Relationships. Since he is not able to be present today, I have attached his testimony which describes in detail the problems professionals experience and remedies which have been in use in other states.

Since originally introducing the bill, I have been contacted by a number of women who have been exploited by providers. In conversations with them, I have come to understand that the problem is much more prevalent than I initially believed (a point also made by Dr. Twemlow in this book); and that this kind of exploitation is best dealt with by drawing clear lines about acceptable behavior for providers as well as informing victims of what constitutes acceptable professional behavior.

I would urge your favorable consideration.

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STUART W. TWEMLOW, M.D.
PSYCHIATRY AND PSYCHOANALYSIS

TO: Judiciary Committee

FROM: Stuart W. Twemlow, M.D.

RE: House Bill #2253 and 2426

I am a board certified psychiatrist who has been in practice in Kansas for the past 22 years. A brief biographical sketch summarizing my clinical and professional background is attached. I support these bills 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.

Bills 2253 & 2426 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

5040 SOUTHWEST 28TH STREET
TOPEKA, KANSAS 66614-2320 TELEPHONE (913) 272-5222

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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 bill are fiduciaries within that definition by virtue of their licensure and/or practice. This bill 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 bill. I am pleased to see that the bill 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 recently. A number of surveys

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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 typical context of my practice, which is in the strictly

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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

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himself. Many of them are simply standard questions that 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.

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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 medical psychotherapists 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.

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

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

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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 psychologically dissimilar 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. To imply that such abuse occurs only rarely and in very disturbed professionals is not supported by the facts.

In summary these bills provide a specific category for sexual exploitation, and a specific protection for those who report such offences.

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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.

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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 Martial & Meditative Arts.

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TO: Representative Solbach, Chairman, and Members of the Judiciary Committee

FROM: Wendy J. Roach

DATE: February 19, 1992

SUBJECT: **HB 2253 AND HB 2426**

I am here today to testify in support of House Bills 2253 and 2426 in the capacity of one who has experienced the trauma of having been sexually exploited by a licensed psychologist in the State of Kansas. These two bills deal with an issue that is adequately addressed in no current Kansas statute: what it means to be sexually exploited by a professional to whom you turn when you are physically and/or emotionally distressed.

House Bill 2253 is meant to facilitate a more accurate picture of the frequency of sexual exploitation among mental health professionals by allowing non-offending professionals to file reports to appropriate licensing boards without fear of recrimination. This will also permit us all to gain a better understanding of the offenders, the victims, and how we can work to prevent sexual exploitation.

House Bill 2426 is intended to restructure our criminal code to include penalties that reflect society's views of sexual exploitation: stronger penalties place a stronger emphasis on the crime. But the most important feature of the bill is the New Section 1(4) which states that, in short, consent by the victim to the sexual contact by a mental health provider is not a defense. The majority of lay persons, like myself at one time, are not educated enough about the field of mental health to understand the

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potential dangers and long-term consequences of becoming involved in a physical relationship with a mental health provider, especially in an on-going relationship that is supposed to be therapeutic. Most people do not even know it is against the law for a professional to do so.

The State of Kansas has a rational basis for holding health care providers to a much higher standard of care than other professionals in that the nature of the relationship between the professional (whether he or she is a physician, a psychologist, or other type of health care provider) and a client creates within itself an emotional dependency on the part of the client. This can and does happen to anyone: it happened to me, it can happen to you, your spouse, your child. We are all vulnerable when it comes to a relationship with a health care provider, particularly a mental health provider.

I am placing emphasis on the area of mental health providers not only because of my own experiences, but also because of the length of time sexual exploitation normally occurs in these types of relationships. Like rape, sex is a secondary issue to the perpetrator. The primary focus in on control. Unlike rape, however, sexual exploitation is not a one-time incident. The exploitation occurs over a period of years, as in my case, which began in August of 1980 and continued until June of 1984.

When reviewing House Bills 2253 and 2426, I ask that the committee consider these objectives:

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1. To enact legislation that will require health providers, particularly mental health professionals, to disclose information to his or her client **prior to** the commencement of any treatment about the laws regarding sexual contact between the professional and the client as well as what legal remedies are available should such an incident occur.
2. To set a public policy regarding the education of health care providers to improve the awareness and treatment of both victims and offenders of sexual exploitation.
3. To provide criminal legislation that accurately reflects the severity of the damage that can be done by a sexually abusive professional.
4. To give professional licensing boards the tools necessary to thoroughly investigate sexual misconduct claims by consumers.

The Behavioral Sciences Regulatory Board is currently regulating over 5,400 professionals in the State of Kansas. That Board consists of volunteer members, all of whom work in full-time positions outside of the Board. None of them are qualified to investigate consumer complaints for the purpose of any legal prosecution. While $5,000 was included the 1992 fiscal budget for the Behavioral Sciences Regulatory Board to hire a private investigator, one legitimate claim of professional misconduct could easily consume the entire allocated amount of funds.

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As members of the Judiciary Committee, you have each been given a copy of the written testimony of Dr. Stewart Twemlow, whom I have worked with regarding my own case. I urge you to read his testimony in its entirety: it explains sexual exploitation in a manner which I fully support and can attest to its accuracy.

HJC
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DOUGLAS COUNTY
RAPE VICTIM
SUPPORT SERVICE

1419 Massachusetts
Lawrence, Kansas 66044
843-8985

Testimony Presented

to

House Judiciary Committee

by

Sarah Jane Russell, Director

Douglas County Rape Victim Support Service

House Bill #2426

Let us remember: what hurts the victim most is not the cruelty of the oppressor, but the silence of the bystander.
-Elie Wiesel

I. Douglas County Rape Victim Victim Support Service

- Since 1972, Douglas County Rape Victim Support Service has provided 24/hour comprehensive crisis services to rape/sexual assault victim-survivors, their families and friends. Educational programming, curriculum development, service-provider training/consultation and bi-weekly peer support groups complete the menu of services offered by Douglas County Rape Victim Support Service.

Funded by United Way of Douglas County
and KU Student Senate

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Testimony - Douglas County Rape Victim Support Service
House Bill # 2426

II. The Damage of Sexual Betrayal/Exploitation: Similiarities to Rape and Incest

- What is Rape? Rape is the commission of sexual intercourse forcibly and without consent. Fifty to seventy-five percent of all rapes occur in the context of an on-going relationship with varying degress of trust existing.
- Sexual Betrayal/Exploitation: lack of psychological freedom of consent.
- Sexual Betrayal/Exploitation: parent-child quality in "counseling" relationship. If the ethical responsibilities/boundaries of the "parenting" role are violated, psychologically speaking, not only rape but incest has occurred.

III. Rape Trauma Syndrome

- Rape Trauma Syndrome (pg. 9 in Surviving Rape and Sexual Assault in Douglas County)- cluster of emotional/physical responses characterized by overwhelming feelings of depression, fear, anxiety, guilt, shame, and self-blame.
- Rape Trauma Syndrome will occur in every instance of unwanted sexual violation.
- THERE IS NO TIMELINE FOR RECOVERY

IV. The Cycle Continues

- Victim-survivors of rape/sexual assault tend not to report violations because of their own guilt and fear.
- Victim-survivors who do report are often futher victimized by the "system". (The Second Rape, L. Madigan and N. Gamble, 1991)
- The Cycle Continues

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State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

TESTIMONY PRESENTED TO

HOUSE JUDICIARY COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2426

The Kansas Department of Health and Environment was alerted to the problem of sexual exploitation of patients by mental health care providers through the reviews of the professional counselors' and the marriage and family therapists' licensure application requests. Under the credentialing review program (KSA 65-5001, et seq), the Secretary of Health and Environment examines an application from a health care occupation that desires state licensure requirements of its members to be made into law. The final product of the review is a report that is generated by the Secretary and submitted to the legislative House and Senate Public Health and Welfare committees. The report addresses whether a particular health occupation should be licensed in order to protect the public from a specified harm.

The Secretary concluded that the problem of sexual exploitation was indeed serious and warranted attention. However, the problem is not confined to professional counselors or marriage and family therapists. It involves all types of mental health care providers, both licensed and those not licensed. The Secretary reported to the legislature that there are initiatives that provide a comprehensive approach that are needed to protect the public from sexual exploitation. The initiatives are: (1) changing the criminal code to make it illegal for a mental health care provider to sexually exploit a patient, (2) require mental health care providers to distribute educational materials about ethics to patients prior to treatment, (3) create a civil cause of action for sexual exploitation victims who have been harmed, and (4) establish a regulatory board to review complaints and discipline unlicensed mental health care providers. These initiatives are from legislation enacted in Minnesota. Several other states have similar laws comparable to one or more of these initiatives.

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During the 1989 session, House and Senate Public Health and Welfare committees and the Secretary of Health and Environment requested that an interim study be conducted on the issue of sexual exploitation. The Special Committee on Corrections and Mental Health conducted an interim study on the issue of, recourse for, and redress of victims of sexual exploitation. The committee recommended that a bill be drafted to make it illegal for a mental health care provider to sexually exploit a patient. House Bill 2426 is that bill and is modeled after legislation enacted in Minnesota.

Effects on Patients

All of the major mental health professions have declared that sexual intimacy between a patient and a mental health care provider is inherently unethical, unacceptable, and severely damaging. Such behavior on the part of the therapist is seen as "sexual exploitation." 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). Negative personality affects include increased depression, impaired social adjustment, exacerbated drug and alcohol use, etc.

Glen O. Gabbard, MD, Director of the C.F. Menninger Memorial Hospital and editor of the book Sexual Exploitation in Professional Relationships, described in his testimony during the interim study several reasons why such behavior on the part of the therapist is unethical and unacceptable. Dr. Gabbard stated that "in every therapeutic relationship the patient begins to experience the therapist as though the therapist is a parent." Therefore, "the effects of patient-therapist sex on the patient is similar to the effects of incest on children." In addition, the therapist in these types of situations takes unfair advantage of a position of power and trust. The therapist has privileged information about the patient that he/she can use to manipulate the patient. Dr. Gabbard noted that therapist-patient sex is wrong due to the fact that the original psychological problems of the patient for which he/she sought treatment have gone unaddressed and even further damage has been caused by the sexual relationship. "

The American Psychiatric Association has taken the stand that at no time after the termination of the patient-therapist relationship is it ethical to be sexually intimate with a former patient. Dr. Gabbard testified at the interim study that there are several reasons why sexual intimacies with former patients do not confer acceptability of patient-therapist sex. He stated:

> Numerous studies have demonstrated the tendency to experience the therapist as a parent for many, many years after treatment is over. Also, formal ethical standards, legislation, and case law have established that the therapist's obligation to respond appropriately to the

patient's rights to privacy, confidentiality, and privilege is unaffected by termination or passage of time after termination.

In addition, many patients return for follow-up consultations.

Scope of the Problem

Studies have attempted to determine the magnitude of the problem of sexual exploitation by mental health care providers. Surveys show that approximately five to seven percent of 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. Eighty percent of the mental health care providers who reportedly had intercourse with a client also reported doing so with more than one patient. Examples of sexual exploitation that the California licensing body for psychologists has dealt with include such acts as: sexual intercourse, sexual caressing, kissing, spanking, group sexual activity, masturbation, photo taking, etc.

It is likely that the prevalence of sexual exploitation of clients would be the same in the unlicensed mental health care occupations, such as biofeedback therapists, drug and alcohol counselors, etc. For example, the Kansas Attorney General's office concluded there were from 25 to 35 complaints filed against unlicensed therapists in 1985. The most common complaint made against persons who call themselves "counselors" or "therapists" who are not regulated was that the practitioner made sexual advances or actually engaged in sexual conduct with the patient.

Studies have shown that 92 percent of the patients involved with a therapist are women. Other studies have shown that the male therapists involved have a mean age of 43 with five to 30 years of private practice experience. Some 90 percent of the therapists reported feeling vulnerable, unwanted, or lonely when the sexual contact occurred. Most of these therapists were separated, divorced, or unhappily married at the time.

The patients are generally women who are 12 to 16 years younger than the therapist, vulnerable, with low self-esteem, and also trust the therapist. Often they were not sexually attracted to the therapist but desired acceptance. A task force of the American Psychological Association concluded that erotic contact with patients is based on the mental health care provider's need for power or sexual gratification. Patients who have been sexually exploited come from all age groups. A recent national study discovered that children and adolescents were unfortunately well represented among those who have been sexually exploited by therapists.

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Recourse Options for Victims

Presently in Kansas, patients who are sexually exploited have three basic avenues for recourse: (1) attempt to have rape charges filed (criminal law), (2) attempt civil action for injuries suffered, or (3) complain to the state regulatory agency or the therapist's employers, if any. These recourse options are not currently effective. In the case of criminal sanctions, by classifying the incident as rape, the mental health care provider is afforded the consent plea (e.g., the patient consented to the sexual act). There is currently no existing course of action which addresses this harm. A civil plaintiff seeking redress would be required to convince the Kansas courts that a new cause of action should be created. Victims can and do complain to state regulatory agencies and employers, but not all mental health providers are regulated or have an employer. In the case of the unlicensed or unregistered professions, even if there is a government agency to which a complaint can be filed, there are no legal avenues to pursue the matter further. For example, no action could be taken by the Kansas Attorney General's office on the complaints received about nonlicensed or nonregistered therapists who allegedly sexually exploited patients unless the therapist misrepresented him\herself as a licensed or registered professional.

House Bill 2426

House Bill 2426 provides the victim of sexual exploitation a more viable criminal recourse alternative than the present law provides. This measure protects the public by sending a clear message that such behavior on the part of the mental health care provider is against the law.

The bill amends the criminal code (KSA 21-3501, et seq) and makes it unlawful for health care providers rendering mental health care services for pay to be sexually intimate with a patient or a former patient under certain circumstances.

For the purposes of clarity, the department recommends some technical changes to the bill. (Please refer to the attached bill balloon.) These changes do not alter the intent or policies of the bill.

The following is a summary of the contents of the bill.

Under the new Section 1, a health care service provider is defined as a physician, psychologist, nurse, professional counselor, social worker, marriage or family therapist, alcohol or drug counselor, member of the clergy, or any other persons, whether or not licensed or registered by the state, who provides or purports to provide mental health services for remuneration. Mental health services is also defined in this new section.

Under the new Section 1, subsection (2), page two, the circumstance in which sexual contact between therapist-patient is sexual exploitation is defined as: (1) when sexual contact occurred during the psychotherapy session, (2) when the patient or former patient is emotionally dependent upon the mental health service provider, or (3) when sexual contact occurred by therapeutic deception. Sexual exploitation is defined as a Class E felony.[1]

"Sexual contact" is defined under subsection (f) on page one and refers to any lewd fondling or touching of the victim or the offender for the intent to arouse or satisfy sexual desires of either party or both.

"Aggravated sexual exploitation" is defined under the new Section, subsection (3), page two, as sexual intercourse or sodomy under the same circumstances as described pertaining to sexual exploitation. Aggravated sexual exploitation is defined as a Class D felony.[2]

Subsection 4, page two, removes consent by the victim as a defense to the crime of sexual exploitation and aggravated sexual exploitation.

Amendments to KSA 21-3501, Section 2, subsection (4) on page three, add sexual exploitation and aggravated sexual exploitation to the list of unlawful sexual acts. KSA 21-3525, the rape shield statute, is amended under Section 3(n) and (o) to afford victims of sexual exploitation and aggravated sexual exploitation the same protection during prosecution that other sexual assault victims are provided regarding previous sexual histories.

Other State Laws

At least four states (California, Colorado, Minnesota, and Wisconsin) have specific criminal penalties for this type of activity. In Minnesota, the Attorney General's office is aware of 14 cases that have been charged alleging therapist-patient criminal sexual conduct since the law went into effect in 1985. These cases involved a chemical dependency counselor, eight psychologists, a spiritual guide, an alcohol abuse counselor, a psychiatric aide, and two ministers. In nine cases, the therapist was convicted or pled guilty. In two cases, the therapist was acquitted after a jury trial and two cases were dismissed by the judge. One case is still in process. Attached to the testimony are the responses received from a Minnesota county attorney's office and the

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[1]Class E felony - a minimum of one to two years and a maximum of one to five years (state prison); up to $10,000 fine.

[2]Class D felony - a minimum of two to five years and a maximum of three to 10 years (state prison); up to $10,000 fine.

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Minnesota Attorney General's office which includes a summary of nine of the fourteen cases.

The Minnesota Special Assistant to the Attorney General had several suggestions that this committee may want to consider. Based on Minnesota's experience, she suggested that: (1) the statute include protecting victims from having their entire psychological histories presented to the jury; and (2) instead of requiring proof of emotional dependency by the victim where there is an ongoing counseling relationship, sexual exploitation, whether or not a formal session, be deemed criminal.

Recommendations

The department supports this bill and recommends that technical revisions provided in the bill balloon for clarification purposes be made. Thank you for the opportunity to testify.

Presented by: Cathy Rooney, Director
Health Occupations Credentialing
Kansas Department of Health and Environment
February 19, 1992

KANSAS NASW

National Association of Social Workers, Inc.
Chapter Office
817 Southwest Sixth Avenue
Topeka, Kansas 66603-3130

Telephone: 913-354-4804

Gigi Felix, LMSW
Executive Director

TESTIMONY IN SUPPORT OF HB2426

Good Afternoon Chairman Solbach, and members of the House Judiciary Committee, and thank you for giving me the opportunity to speak to you today on HB2426. It is my understanding that this committee may send HB2426's companion bill HB2253 to the House floor. From K-NASW's perspective, our choice would be the enactment of HB2426, but I would like to address both pieces of legislation.

Our choice for 2426 over 2253 is that 2426 includes language on pg.2, lines 24 - 30 which disallows the victim's consent as a defense to charges of sexual exploitation. This is a very important concept as the victim's will probably have consented to some degree in response to the power issues addressed by the legislation. Often the patient receiving mental health services is unduly influenced by the practitioner - this is a violation of ethics for professionals and is addressed specifically in the KARs regulating them. If 2253 is the bill which is sent to the floor, please consider amending this section of 2426 into it.

Another strong point for 2426 is that it clearly defines terms of what a "former patient" is, and gives a definite time frame for the definition of one year. This makes the possible infraction of the statute, and the prosecution of the offense easier. HB2426 also has a more usable definition of "mental health provider" which lists certain professions, but does not exclude other persons. We feel that is extremely important since more and more professions are seeking governmental regulation and recognition. HB2253 lists certain professions currently regulated by the state, but this list is not complete. It would be necessary to amend that bill on pg. 1, line 38 to include the registered marriage and family therapists who gained recognition last session.

HB2253 does include important language which holds harmless any professional from reporting a violation of this act if the report is done in good faith. If HB2426 is passed from committee, we suggest this language be incorporated into it.

Our biggest question on HB2253 is why the statutes for the named professions is being amended to reflect what is already a part of the KARs. If the legislation was making the offense a criminally prosecutable action, then we could understand the need for the change. However, the KARs for social work, psychology, and professional counselors, (already licensed or registered) include the right to revoke, suspend, or deny renewal for a professional who is found guilty of these acts. I am sure nursing, physicians,

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KANSAS NASW
National Association of Social Workers, Inc.
Chapter Office
817 Southwest Sixth Avenue
Topeka, Kansas 66603-3130

Telephone: 913-354-4804

etc. do also. According to the Attorney General's office, the KARs have the full "force and effect" of statute. This bill gives them the right to do what they already have the right to do under the KARs. If it is the intent however, to have statute changed for the symbolic impact, fine. However, the RMFT statute would also need to be changed in this legislation, and SB458 (the bill giving regulation to the alcohol and other substance abuse counselors, now in Senate Public Health and Welfare) needs to be amended to have this language added for consistency of all the regulated professions.

Our bottom line is that we strongly support HB2426 in its language, and intent of making the sexual exploitation of clients, and former clients a criminal offense. It is our hope that this committee will agree, and pass that bill out favorably. If you choose to pass HB2253 out favorably, we urge you to incorporate the suggested amendments, and rethink the need to amend the current statutes of the professions when the regulatory boards already have the ability to do what this legislation proposes.

Thank you for the opportunity to address these bills with you, and will be glad to stand for questions.

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KANSAS PSYCHOLOGICAL ASSOCIATION

TESTIMONY ON HB 2426
February 19, 1992

I am Dr. William Albott and I am presenting to you today on behalf of the Kansas Psychological Association in reference to **HB 2426.** I am a licensed psychologist in private practice here in Topeka, KS. In part I was asked to present testimony because I have been in the past a member of the Behavioral Sciences Regulatory Board and because I have been an outspoken advocate of regulations and statutes such as **HB 2426** and **HB 2253**.

The Kansas Psychological Association is fully supportive of the intent of **HB 2426**. There are, however, a number of areas in the current bill which leave sufficiently vague or are not addressed, as to preclude what we believe is effective and efficient enforcement. Some of our concerns can be addressed with rather specific technical changes and these are included in the attached balloon of **HB 2426**.

Our association and our national affiliate, the American Psychological Association, take strong stands against any type of sexual contact between the psychologist and his/her client/patient. We believe that **HB 2426** is a necessary and helpful step in the direction of dealing with this issue. We believe that criminal sanctions against this behavior are a most appropriate step. Statutes that facilitate the reporting of such behavior on the part of providers or that facilitate civil litigation against the provider are inadequate to deal with the issue. The fact is that providers who are not regulated by the state or who are not part of an association such as ours are in effect immune to accusations and effective redress.

One central question which we believe should be asked is "Why restrict the legislation to just "**mental**" health providers?" Would it not be in the best interest of all health care consumers to expand this legislation to include **all health care providers**? Granted the issue of emotional dependency may not seem so apparent in the case of non-mental health care, but it is our believe it none-the-less exists and as a result the vulnerability of the patient can be exploited by the health care provider.

On page 1, line 18, following the word "**clergy**" insert the words "**registered masters level psychologist**". We believe that since this group is already a regulated group inclusion here makes the listing more complete.

On page 1, line 40, insert the words "**and who had terminated services within a two year period**" following the word "time". In our testimony on **HB 2253** we suggested that this two year period be included in the specific prohibition of sexual contact. This specific time frame make it very concrete that any sexual contact between the provider and the client/patient in a two year period following termination of services is prohibited.

On page 2, line 6, following the word "**any**" insert the words "**regular and ongoing**". On page 2, line 34, following the word "**no**" insert the words "**professional or regular and ongoing**". On page 2, line 33, delete the word "**one**" and insert the word "**two**".

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Official Affiliate of the American Psychological Association

On page 2, line 14, strike the words "~~during the psychotherapy session~~" and insert the language "**when the patient was under the care of the mental health provider**". While the HB 2426 intent seems clear, experience has shown that literal interpretations that stick to the letter of the statute require that this change be made.

In our reading of **HB 2426** we could find no provision for false reporting and the penalties for such conduct. While it is unusual for a person to report such conduct if it is not true, such had and does occur. While it is our belief that sexual contact between provider and client/patient has far reaching detrimental consequences for the client/patient, we also recognize that accusation of such conduct has far reaching and detrimental consequence for the provider. In this regard, we would also like to ask that the committee give serious consideration to adding a provision that proceedings be allowed to occur "in camera". One major reason for not reporting sexual misconduct is that the client/patient rightfully feels that the proceeding serves to re-victimize them. They feel humiliated by the original experience, their self-esteem is lowered and by reporting the act they are often subjected to examination that further attacks their self-esteem, erodes their self-worth, etc. Much of this could be averted by having the proceedings held in camera. Should the finding be that the provider is found guilty then public announcements of the findings should also protect the identity of the client/patient by prohibiting public disclosure.

Thank you for your time. I would be happy to answer any questions now or at a later date.

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Session of 1991

HOUSE BILL No. 2426

By Committee on Public Health and Welfare

2-21

AN ACT defining certain crimes relating to sexual exploitation by mental health service providers and prescribing punishments therefor; amending K.S.A. 21-3525 and K.S.A. 1990 Supp. 21-3501 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (1) As used in this section, the following words and phrases have the meanings respectively ascribed thereto:

(a) "Mental health service provider" means a physician, psychologist, nurse, professional counselor, social worker, marriage or family therapist, alcohol or drug counselor, member of the clergy, or any other person, whether or not licensed or registered by the state, who provides or purports to provide mental health services;

(b) "mental health service" means the treatment, assessment, or counseling of another person for a cognitive, behavioral, emotional, mental, or social dysfunction, including any intrapersonal or interpersonal dysfunction;

(c) "emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the mental health service provider are such that the mental health service provider knows or has reason to know that the patient or former patient is significantly impaired in the ability to withhold consent to sexual contact or sexual intercourse by the mental health service provider;

(d) "patient" means a person who seeks or obtains mental health services from a mental health services provider and who is not married to the mental health services provider;

(e) "former patient" means a person who obtained mental health services from a mental health service provider prior to sexual contact with that mental health service provider, who was not obtaining mental health services from such mental health service provider at the time of such sexual contact, and who is not married to such mental health service provider at the time;

(f) "sexual contact" includes any lewd fondling or touching of the person of either the victim or the offender, done or submitted to with the intent to arouse or to satisfy the sexual desires of either

----------"registered masters level psychologist"

----------"and who had terminated services within a two year period"

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the victim or the offender, or both;

(g) "therapeutic deception" means a representation by a mental health service provider that sexual contact with the mental health service provider is consistent with or part of the patient's or former patient's treatment; and

(h) "personal contact" means any direct contact in person and does not mean any indirect contact or communication, whether or not written or oral or by means of the mail or telephone or any other telecommunications device.

(2) Sexual exploitation is sexual contact with a person under any of the following circumstances:

(a) The offender is a mental health service provider and the victim is a patient of the mental health service provider and the sexual contact occurred ~~during the psychotherapy session~~;

(b) the offender is a mental health service provider and the patient or former patient is emotionally dependent upon the mental health service provider; or

(c) the offender is a mental health service provider and the victim is a patient or former patient and the sexual contact occurred by means of therapeutic deception.

Sexual exploitation is a class E felony.

(3) Aggravated sexual exploitation is sexual intercourse or sodomy under any of the circumstances described in subsection (2).

Aggravated sexual exploitation is a class D felony.

(4) Consent by the victim to sexual contact under any of the circumstances described in subsection (2) is not a defense to the crime of sexual exploitation. Consent by the victim to sexual intercourse or sodomy under any of the circumstances described in subsection (2) is not a defense to the crime of aggravated sexual exploitation.

(5) It is a rebuttable presumption that a former patient is not emotionally dependent upon a mental health service provider if there is a period of ~~one~~ year or more, prior to the sexual contact, sexual intercourse or sodomy, during which period there is no ~~personal~~ contact between a former patient and a mental health service provider.

(6) This section shall be part of and supplemental to the Kansas criminal code.

Sec. 2. K.S.A. 1990 Supp. 21-3501 is hereby amended to read as follows: 21-3501. The following definitions apply in this article unless a different meaning is plainly required:

(1) "Sexual intercourse" means any penetration of the female sex organ by a finger, the male sex organ or any object. Any penetration,

"regular and ongoing"

"when the patient was under the care of the mental health provider."

"two"

"professional or regular and ongoing"

KANSAS PSYCHOLOGICAL ASSOCIATION

TESTIMONY ON HB 2253
February 11, 1992

I am Dr. William Albott and I am presenting to you today on behalf of the Kansas Psychological Association and to provide testimony in reference to HB 2253.

KPA is fully supportive of the intent of HB 2253. There are, however, a number of problems which the current bill does not address or leaves sufficiently vague, as to preclude effective and efficient enforcement. Some of our concerns can be addressed with specific technical changes. These are included in the attached balloon of House Bill #2253.

On page 1, line 16, insert the words or "patient" and on line 18 through 21, beginning with the word "for" delete. On line 17, delete the words "for remuneration".

On page 1, between lines 21 and 22 insert:

> **"(2) (a) all sexual contact between a provider and a "client/patient" shall be prohibited during which time the person is receiving mental health services; and (b) all sexual contact between a provider and a client/patient within 2 years after termination of services; or (c) during such period of time where the provider would have reason to believe the client/patient remains emotionally dependent upon the provider.**

On page 1 line 40, delete the words, "for remuneration".

On page 2, between lines 23 and 24 insert the following language:

> **(7) An action for sexual misconduct shall be filed with the provider's board or regulation within 5 years after the alleged misconduct.**
> **(8) All providers of mental health services shall provide all patients at the point of initiation of services with a Patient Rights statement. Such a statement shall include:**
> **(a) The name, address and telephone number of the provider's regulatory board;**
> **(b) A statement indicating that sexual contact between a provider and a client/patient is grounds for disciplinary action should the contact occur during therapy or within 2 years following termination;**
> **(c) The 5 year reporting period limitation.**

A major, and very serious problem with HB 2253 is found on page 1, section (5). Note that provider includes individuals neither registered or licensed. This raises a number of questions that if HB 2253 is enacted must be answered:

1. To whom will the complaint be made?
2. What is the penalty?
3. Who will bear the expense of investigation and litigation?

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Testimony on HB 2253
February 11, 1992
Kansas Psychological Association

4. Who will serve as the hearing officer or panel?

My experience on the BSRB taught me that investigation and litigation of cases involving sexual misconduct are time consuming and very expensive. This also taught me that there are a number of issues that often preclude filing of complaints. These are not addressed in HB 2253. For example, there is no penalty for false reporting. There is no provision for hearings to be held in camera -- both to protect the client/patient from exposure in the media and to protect the practitioner if falsely accused.

It is our hope that Representatives Wagnon and Sebelius will take this opportunity to see appointment of a Special Committee made up of representatives of the Board of Healing Arts, the BSRB, the State Board of Nursing, members of the state professional associations for Psychiatrists, Psychologists and Clinical Social Workers, members of the legislature and at least representatives from Kansas Mental Health Association and that this committee be charged with drafting a bill that would address this area in a manner that would allow for effective and efficient enforcement.

I thank you for your attention. If I may answer any questions, I would be pleased to do so.

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Session of 1991

HOUSE BILL No. 2253

By Representatives Wagnon and Sebelius

2-13

AN ACT concerning mental health service providers; relating to certain acts of sexual abuse, misconduct or exploitation by such providers; amending K.S.A. 1990 Supp. 65-1120, 65-2837, 65-4209, 65-5809, 65-6311, 74-5324 and 74-5369 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) As used in this section:

(1) "Client" means a person who seeks or obtains mental health services ~~for remuneration~~ from a mental health services provider and who is not married to the mental health services provider. ~~For purposes of this section, a patient of a physician or nurse shall be considered a client if the patient seeks or obtains mental health services from the physician or nurse.~~

or "patient"

(3) ~~(2)~~ "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the mental health service provider are such that the mental health service provider knows or has reason to know that the patient or former patient is significantly impaired in the ability to withhold consent to sexual contact or sexual intercourse by the mental health service provider.

"((a) all sexual contact between a provider and a "client/patient" shall be prohibited during which time the person is receiving mental health services; and
(b) all sexual contact between a provider and a client/patient within 2 years after termination of services; or
(c) during such period of time where the provider would have reason to believe the client/patient remains emotionally dependent upon the provider.

(4) ~~(3)~~ "Knowledge" means acquired information which is clearly not the product of delusional thinking or the imagination of a client.

(5) ~~(4)~~ "Mental health service" means the treatment, assessment or counseling of another person for a cognitive, behavioral, emotional, mental or social dysfunction, including any intrapersonal or interpersonal dysfunction.

(6) ~~(5)~~ "Mental health service provider" means a physician, psychologist, masters level psychologist, nurse, mental health technician, professional counselor, social worker, alcohol or drug counselor, member of the clergy or any other person, whether or not licensed or registered by the state, who provides or purports to provide mental health services ~~for remuneration.~~

(7) ~~(6)~~ "Sexual abuse, misconduct or exploitation" means sexual intercourse or sodomy, as defined by K.S.A. 21-3501 and amendments thereto, or any lewd fondling or touching of the person of either

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t[illegible]ent or the mental health service provider, done or submitted to with the intent to arouse or to satisfy the sexual desires of either the client or the mental health service provider, or both.

(b) A mental health service provider who possesses knowledge that a second mental health service provider has committed an act of sexual abuse, misconduct or exploitation against a patient or former patient of such second mental health service provider shall lawfully report such knowledge to the state agency, if any, which licenses, registers or certifies such second mental health service provider after acquiring written permission from the patient or former patient of such second mental health service provider.

Any mental health service provider who makes a report to a state agency as required by this section must appear in person at any subsequent investigative proceeding involving the alleged sexual abuse, misconduct or exploitation in order to corroborate such report and submit to questioning by members of the board or staff of the agency.

(d) Any person who, in good faith, makes a report as authorized by this section shall not be liable in a civil action for damages or other relief arising from the reporting except upon clear and convincing evidence that the report was completely false and that the falsity was actually known to the person making the report at the time thereof.

Sec. 2. K.S.A. 1990 Supp. 65-1120 is hereby amended to read as follows: 65-1120. (a) *Grounds for disciplinary actions.* The board shall have the power to deny, revoke, limit or suspend any license or certificate of qualification to practice nursing as a registered professi[illegible]l nurse, as a licensed practical nurse or as an advanced registered nurse practitioner that is issued by the board or applied for in accordance with the provisions of this act in the event that the applicant or licensee is found after hearing:

(1) To be guilty of fraud or deceit in practicing nursing or in procuring or attempting to procure a license to practice nursing;

(2) to have been guilty of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust;

(3) to have committed an act of professional incompetency;

(4) to be habitually intemperate in the use of alcohol or addicted to the use of habit-forming drugs;

to be mentally incompetent;

to be guilty of unprofessional conduct;

(7) to have willfully or repeatedly violated any of the provisions of the Kansas nurse practice act or any rule and regulation adopted

(8) An action for sexual misconduct shall be filed with the provider's board or regulation within 5 years after the alleged misconduct.

(9) All providers of mental health services shall provide [illegible] patients at the point of initiation of services with a Patient Rights statement. Such a statement shall include:

(a) The name, address and telephone number of the provider's regulatory board;

(b) A statement indicating that sexual contact between a provider and a client/patient is grounds for disciplinary action should the contact occur during therapy or within 2 years following formal termination;

(c) The 5 year reporting period limitation.

KANSAS

NATIONAL ORGANIZATION FOR WOMEN

To: House Judiciary Committee

From: Amy C. Bixler
National Organization
for Women

Re: In Support of House Bills
Nos. 2253 and 2426

Date: February 19, 1992

The National Organization for Women (N.O.W.), as a supporter and spokesperson for all exploited women, supports House Bills Nos. 2253 and 2426.

The methods and avenues used by one class of persons to exploit another, usually weaker and defenseless, class of persons vary greatly. Many statutes currently address those forms of exploitation which occur openly and conspicuously. Yet, it is the quiet and insidious forms of exploitation which, going unnoticed and untreated, can traumatize victims for life. House Bills Nos. 2253 and 2426 finally raise consciousness to one type of such unspoken exploitation and seek to address the egregious wrongs committed against the victims.

The relationship between a therapist and a patient is delicate, mentally intimate, and one of trust. It can also be one of power, dominance, control, and co-dependence. The patient, in order to achieve success, must expose oneself emotionally, vulnerable to the therapist in many ways. The unscrupulous breach of this trust is as violating as a physical assault, but is conveniently without the bodily bruises and incriminating evidence.

When any individual is found, through the appropriate due process, to have exploited for his own purposes a patient's weaknesses or insecurities, action should be taken to ensure that the individual <u>never</u> be allowed in such a formal position of trust or authority thereafter.

Therefore, for the reasons set forth above and those as may be further delineated in hearings on this matter, the National Organization for Women encourages and supports the passage of House Bills Nos. 2253 and 2426.

HJC
2-19-92
Attach. #9

Kansas State Board of Nursing

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

Patsy L. Johnson, R.N., M.N.
Executive Administrator
913-296-3068

TO: The Honorable Represenative John M. Solbach, III,
Chair, House Judiciary Committee

FM: Patsy L. Johnson, R.N., M.N.
Executive Administrator

DT: February 18, 1992

RE: HB 2253

Thank you Chairman Solbach for allowing me to testify to HB 2253. The Kansas State Board of Nursing supports the protection of patients or former patients from acts of sexual abuse, misconduct or exploitation from all mental health service providers. This would include nurses and mental health technicians.

In the past, the Board has investigated sexual abuse, misconduct, or exploitation under regulation on unprofessional conduct; K.A.R. 60-3-110 for R.N.'s and L.P.N.'s, and K.A.R. 60-7-106 for L.M.H.T.'s. In the last three years, we have had four cases investigated involving sexual misconduct or exploitation. Three cases involve registered nurses and one involved a licensed mental health technician. In three of the four cases, we were unable to proceed due to gray areas of the regulation.

HJC
2-19-92
Attach #10
1-2

Janette Pucci, R.N., M.S.N.
Education Specialist
296-3782

Diane Glynn, R.N., J.D.
Practice Specialist
296-3783

Patricia McKillip, R.N., M.N.
Education Specialist
296-3782

In the fourth case, a stipulation agreement was reached and the nurse is in another type of nursing.

The Board of Nursing agrees there is a need to strengthen the ability to take action against a nurse's license for sexual abuse, misconduct or exploitation of patients or former patients. We also support such action with regard to other disciplines who deal with patients who become emotionally dependent. The Board of Nursing hopes HB 2253 is passed.

Thank you. I would be glad to answer any questions.

PLJ:msb

HJC
2-19-92
Att #10
2-2

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Azzie Young, Ph.D., *Secretary*

Reply to:

TESTIMONY PRESENTED TO THE

HOUSE JUDICIARY COMMITTEE

BY

THE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

House Bill 2253

House Bill 2253 requires any mental health services provider to report to the state licensure/registration board another mental health services provider who has sexually abused or exploited a patient or former patient. "Mental health services provider" means a physician, psychologist, nurse, professional counselor, social worker, alcohol or drug counselor, member of the clergy, or any other person, whether or not licensed or registered by the state, who provides mental health services for remuneration.

It is indeed appropriate to require such reporting upon consent of the patient. Compared to the projected number of incidents of sexual exploitation, very few victims choose to file complaints on their own to regulatory boards. However, mandatory reporting upon consent of the patient should assist in stimulating additional complaints, particularly since the therapist who made the report is to appear in person at the investigation/hearing to provide information.

In addition, this bill amends the licensing/registration acts for nurses, mental health technicians, professional counselors, social workers, and master's level psychologists. The amendments allow disciplinary action to be taken if the practitioner has committed an act of sexual abuse, misconduct, or exploitation of a patient or former patient who is emotionally dependent on the practitioner.

The bill's provisions concerning disciplinary action that may be taken against nurses, social workers, psychologists, and professional counselors who sexually abuse or sexually exploit patients is appropriate. However, physicians and psychiatrists already can be disciplined for sexual abuse or exploitation of a patient and the threat of revoking one's license has not been an effective system of control. As you are aware, national surveys show that approximately five to seven percent of licensed male psychiatrists, PhD psychologists, and physicians reported having had sexual intercourse with patients during treatment stages.

Once a therapist becomes sexually involved with one patient, there is repetition of the behavior in 75 to 80 percent of the cases. In addition, the bill allows for disciplinary actions to be taken against mental health services providers who sexually abuse or exploit former patients who are emotionally dependent on the mental health services provider. The issue of determining emotional dependence will be complicated and difficult even with the statutory definition of "emotional dependency."

HJC
2-19-92
Attach #11
1-4

This proposal is also limited in that it only applies to disciplinary actions that can be taken against professionals who are regulated by the state. The bill does not allow for the reporting of an act by a nonregulated practitioner. There is a problem with nonregulated practitioners. For example, the Kansas Attorney General's office concluded that there were 25 to 35 complaints filed in 1985 against nonregulated mental health services providers. The most common complaint made against these individuals was that the practitioners made sexual advances or actually engaged in sexual conduct with clients. In addition, no action could be taken on the complaints received about the nonregulated therapists unless the therapists misrepresented themselves as licensed or registered professionals.

The Department endorses the bill as a welcome effort in attempting to address a serious problem that has not received proper attention. However, as noted above, this measure alone is not adequate to address the issue of sexual exploitation of patients by mental health service providers. Several states have taken a comprehensive approach to the problem of sexual exploitation. A summary of four initiatives that Minnesota and other states have initiated is attached.

The Department recommends House Bill 2253 be reported favorably.

Presented by: Joseph Kroll, Director
Bureau of Adult and Child Care
Kansas Department of Health and Environment
February 19, 1992

HJC
2-19-92
Att #11
2-4

COMPREHENSIVE APPROACH TO SEXUAL EXPLOITATION

There are four approaches that can be taken to combat the problem of clients being sexually exploited by health care personnel. Combining the these approaches creates a comprehensive set of initiatives to protect the public from sexual exploitation. These initiatives are: (1) change the criminal law, (2) change the civil law, (3) require mental health providers to distribute educational materials to clients prior to treatment, and (4) establish a regulatory body to oversee unlicensed and unregistered mental health providers.

Criminal Law Changes

One of the initiatives is to make it against the law for a physician, psychologist, nurse, professional counselor, social worker, marriage and/or family therapist, alcohol and/or drug counselor, the clergy, hypnotist, rehabilitation counselor, or any other person who provides mental health services for remuneration,[1] whether or not licensed or registered by the state, to sexually exploit a client. Sexual exploitation is defined as intercourse, sodomy, or lewd fondling or touching with a client during certain circumstances. The circumstances being: during the therapy session, or if the client or former client is emotionally dependent upon the therapist, or if the actions occurred by means of therapeutic deception. Conviction of aggravated sexual exploitation (intercourse or sodomy) is a Class D felony and sexual exploitation (fondling or touching) is a Class E felony. In either case, consent by the client is not a defense for the health care provider.

Civil Law Changes

Another initiative is to create a statutory cause of action (change to civil law) for clients who have been sexually exploited by a physician, psychologist, nurse, professional counselor, social worker, marriage and/or family therapist, alcohol and/or drug counselor, the clergy, hypnotist, rehabilitation counselor, or any other person who provides mental health services for remuneration, whether or not licensed or registered by the state. This approach allows the victim of sexual exploitation to sue, for damages, the abusing health care provider and the provider's employer. (Sexual exploitation refers to intercourse, sodomy, or lewd fondling and touching.) No longer will each injured client have to prove that sexual contact between the health care provider and client is unacceptable professional behavior that warrants legal attention. The employer or the health care provider may be sued if the employer failed to take action when he/she knew that the health care provider was engaging in sexual activity with any client, the employee failed to ask previous employers of the health care provider about his/her sexual conduct with clients, or the employer failed to pass on such information to subsequent employers who asked for it. Employers who comply in good faith with the law cannot be sued.

Educating the Client

This initiative creates a new statutory requirement that all mental health services providers distribute to clients prior to treatment a disclosure of information. Mental health services provider is defined as a psychiatrist, psychologist, social worker, professional counselor, marriage and/or family therapist, alcohol and/or drug counselor, the clergy, hypnotist, rehabilitation counselor, or any other person, whether licensed or registered by the state, who provides mental health services for remuneration. The disclosure includes such information as:

---

[1]Mental health services is defined as the treatment, assessment, or counseling of another person for a cognitive, behavioral, emotional, mental, or social dysfunction, including intrapersonal or interpersonal dysfunctions.

HJC
2-19-92
Att #11
3-4

(1) a statement that in a professional relationship sexual intimacy is never appropriate and against the law (assuming the proposal to change the criminal law is enacted) and should be reported to the state regulatory body; (2) procedures for filing a complaint with a supervisor, if any, and the appropriate state regulatory body; (3) education, training, and other qualifications; (4) fees per unit of service and billing method, (5) a statement that the client has a right to reasonable notice of changes in services or charges; (6) summary of the theoretical approach of the provider; and (7) various statements about confidentiality of records, ability of client to choose freely among providers within limits of health insurance, etc., the client's right to coordinate transfer when there is a change in the provider of services, and the client's ability to refuse services unless otherwise provided by law.

Regulating Unlicensed and Unregistered Mental Health Providers

This initiative allows the public access to information about unlicensed and unregistered mental health providers, allows clients to register a complaint against such a provider, and provides for a regulatory body to take practice-related actions against such a provider for unethical/immoral actions. This approach requires mental health providers that are not required to be licensed or registered to file certain information with the regulatory body in order to practice. Violation of the requirement is a Class A misdemeanor. Mental health provider is a marriage and/or family therapist, alcohol and/or drug counselor, the clergy, hypnotist, rehabilitation counselor, and any other person who provides mental health services for remuneration. Mental health services is defined as the treatment, assessment, or counseling of another person for cognitive, behavioral, emotional, mental, or social dysfunction. The regulatory body can approve, deny, or reject the filing, or revoke, or suspend, or limit the right to practice should the provider violate provisions of the act. The provisions deal mainly with unethical/immoral actions, such as engaging in sexual intimacy with a client, convictions of a crime related to providing mental health services, violation of client's confidentiality, or abusive or fraudulent billing practices. The initiative sets procedures for filing of information, a permit to practice, a consumer complaint procedures/process, and disciplinary actions which include the ability to stop the mental health provider from practicing. This action does not establish educational requirements for practice of the various occupations, nor does it imply or certify in any way that a particular mental health provider has met any standards or criteria of education or training, nor does it protect or define a scope of practice for the various occupational groups not required to be licensed or registered by the state.

HJC
2-19-92
Att # 11
4-4

Joint Statement
to the
House Judiciary Committee
from the
Kansas Medical Society and the Kansas Psychiatric Society
February 19, 1992
House Bills 2253 and 2426

Although psychiatrists specialize in diagnosis and treatment of mental illness, many other physicians also provide mental health services, and both HB 2253 and HB 2426 define "mental health service provider" in a manner that includes all physicians. Therefore, this neutral testimony regarding HB 2253 and HB 2426 is a joint statement on behalf of both the Kansas Medical Society and the Kansas Psychiatric Society.

We generally support the provisions of House Bill 2253. You will note that the amendatory language contained at lines 26-28 on page 5 constitutes very little change in the Healing Arts Act regarding the prohibition against sexual misconduct. We do, of course, have reservations about the reporting requirements spelled out in the bill, but would emphasize the importance of the wording at lines 10-11 of page 2 which requires informed consent by a patient prior to the reporting of misconduct or exploitation. So long as the patient is required to consent to the disclosure of information that was communicated during a confidential information exchange, and the due process rights of the accused are upheld, we have no objection to the concepts embodied in HB 2253.

Our only reason for not supporting HB 2253 is that it is too narrowly focused. It implies that the only category of professional who ever manipulated and exploited a client or patient is a provider of mental health services. The scientific research on this subject indicates otherwise. Although the client or patient of a mental health professional might be more vulnerable than the client or customer of some other type professional, the psychological and emotional injuries of exploitation can be equally damaging. Therefore, we have attached to this statement balloon-style amendments to HB 2253 that we believe would improve upon its content.

The amendments on page 1 would broaden the definition of client to include any person who obtains services from a professional. Professional would be defined as a person who receives a license, registration, or certification under Kansas law. Also, we would define the student of a teacher to be a client for purposes of this section of the statutes. On page 2 we would broaden the reporting requirement to include any client who has been sexually abused or exploited by any professional.

We are also reluctant to endorse HB 2426 because it creates a new crime reserved for mental health service providers only. This seems terribly unfair when there are others (whether professionals or not) who on occasion manipulate and exploit vulnerable victims. Unfortunately, such perpetrators can oftentimes show evidence of consent by the victims which serves as defense in a criminal prosecution.

We have provided amendments to K.S.A. 21-3501 which would define therapeutic relationship and counseling relationship for purposes of sex crimes. In addition, we would amend the definitions of sexual battery and aggravated sexual battery such that consent would not be a defense when there existed a therapeutic or counseling relationship, and thus there would be genuine criminal penalties for sexual exploitation when the perpetrator purports to provide any form of therapy or counsel to the victim.

We respectfully request that you adopt our amendments to HB 2253 and substitute our amendments for HB 2426 prior to taking action on the bills. Thank you for considering our recommendations.

H JC
2-19-92
attach #12
1-5

HJC 2-19-92 Att# 12 2-5

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612
(913) 235-2383 FAX # (913) 235-5114

Chip Wheelen
Director of Public Affairs

Session of 1991

HOUSE BILL No. 2253

By Representatives Wagnon and Sebelius

2-13

AN ACT concerning ~~mental health service providers~~; relating to certain acts of sexual abuse, misconduct or exploitation by such ~~providers~~; amending K.S.A. 1990 Supp. 65-1120, 65-2837, 65-4209, 65-5809, 65-6311, 74-5324 and 74-5369 and repealing the existing sections.

professionals

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) As used in this section:

(1) "Client" means a person who seeks or obtains ~~mental health~~ services ~~for remuneration~~ from a ~~mental health services provider~~ and who is not married to the ~~mental health services provider~~. For purposes of this section, a patient of a physician or nurse shall be considered a client if the patient seeks or obtains mental health services from the physician or nurse.

professional

For purposes of this section, a student shall be considered a client of a teacher if the student is or was enrolled within a one year period at a school where the teacher is or was employed.

(2) "Emotionally dependent" means that the nature of the patient's or former patient's emotional condition and the nature of the treatment provided by the mental health service provider are such that the mental health service provider knows or has reason to know that the patient or former patient is significantly impaired in the ability to withhold consent to sexual contact or sexual intercourse by the mental health service provider.

(3) "Knowledge" means acquired information which is clearly not the product of delusional thinking or the imagination of a client.

(4) "Mental health service" means the treatment, assessment or counseling of another person for a cognitive, behavioral, emotional, mental or social dysfunction, including any intrapersonal or interpersonal dysfunction.

(5) "Mental health service provider" means a physician, psychologist, masters level psychologist, nurse, mental health technician, professional counselor, social worker, alcohol or drug counselor, member of the clergy or any other person, whether or not licensed or registered by the state, who provides or purports to provide mental health services for remuneration.

"Professional" means any person who receives a license or other credential from the state of Kansas which allows that person to engage in an occupation or to use a title that is registered pursuant to Kansas statutes.
¶ (7)

(6) "Sexual abuse, misconduct or exploitation" means sexual intercourse or sodomy, as defined by K.S.A. 21-3501 and amendments thereto, or any lewd fondling or touching of the person of either

2/15/92

the client or the mental health service provider, done or submitted to with the intent to arouse or to satisfy the sexual desires of either the client or the mental health service provider, or both.

(b) A mental health service provider who possesses knowledge that a ~~second mental health service provider~~ has committed an act of sexual abuse, misconduct or exploitation against a ~~patient~~ or former ~~patient~~ of such ~~second mental health service provider~~ shall lawfully report such knowledge to the state agency~~, if any,~~ which licenses, registers or certifies such ~~second mental health service provider~~ after acquiring written permission from the ~~patient~~ or former ~~patient~~ of such ~~second mental health service provider~~.

professional
client
client
professional
professional
client
professional

(c) Any mental health service provider who makes a report to a state agency as required by this section must appear in person at any subsequent investigative proceeding involving the alleged sexual abuse, misconduct or exploitation in order to corroborate such report and submit to questioning by members of the board or staff of the agency.

(d) Any person who, in good faith, makes a report as authorized by this section shall not be liable in a civil action for damages or other relief arising from the reporting except upon clear and convincing evidence that the report was completely false and that the falsity was actually known to the person making the report at the time thereof.

Sec. 2. K.S.A. 1990 Supp. 65-1120 is hereby amended to read as follows: 65-1120. (a) *Grounds for disciplinary actions.* The board shall have the power to deny, revoke, limit or suspend any license or certificate of qualification to practice nursing as a registered professional nurse, as a licensed practical nurse or as an advanced registered nurse practitioner that is issued by the board or applied for in accordance with the provisions of this act in the event that the applicant or licensee is found after hearing:

(1) To be guilty of fraud or deceit in practicing nursing or in procuring or attempting to procure a license to practice nursing;

(2) to have been guilty of a felony if the board determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust;

(3) to have committed an act of professional incompetency;

(4) to be habitually intemperate in the use of alcohol or addicted to the use of habit-forming drugs;

(5) to be mentally incompetent;

(6) to be guilty of unprofessional conduct;

(7) to have willfully or repeatedly violated any of the provisions of the Kansas nurse practice act or any rule and regulation adopted

2/9/94
HJC
2-16-94
Att #12
3-5

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612
(913) 235-2383 FAX # (913) 235-5114

Chip Wheelen
Director of Public Affairs

K.S.A. 1990 Supp. 21-3501 is hereby amended to read as follows:

2/9/92
HJC
2-19-92
Att #12
4-5

21-3501. Definitions. The following definitions apply in this article unless a different meaning is plainly required:

(1) "Sexual intercourse" means any penetration of the female sex organ by a finger, the male sex organ or any object. Any penetration, however slight, is sufficient to constitute sexual intercourse. "Sexual intercourse" does not include penetration of the female sex organ by a finger or object in the course of the performance of:

(a) Generally recognized health care practices; or

(b) a body cavity search conducted in accordance with K.S.A. 22-2520 through 22-2524, and amendments thereto.

(2) "Sodomy" means oral or anal copulation, including oral-genital stimulation between the tongue of a male and the genital area of a female; oral or anal copulation or sexual intercourse between a person and an animal; or any penetration of the anal opening by any body part or object. Any penetration, however slight, is sufficient to constitute sodomy. "Sodomy" does not include penetration of the anal opening by a finger or object in the course of the performance of:

(a) Generally recognized health care practices; or

(b) a body cavity search conducted in accordance with K.S.A. 22-2520 through 22-2524, and amendments thereto.

(3) "Spouse" means a lawful husband or wife, unless the couple is living apart in separate residences or either spouse has filed an action for annulment, separate maintenance or divorce or for relief under the protection from abuse act.

(4) "Unlawful sexual act" means any rape, indecent liberties with a child, aggravated indecent liberties with a child, criminal sodomy, aggravated criminal sodomy, lewd and lascivious behavior, sexual battery or aggravated sexual battery, as defined in this code.

"Therapeutic relationship" means a contract or understanding between two persons which is in effect or was in effect within a one year period, wherein one of the persons receives a diagnosis, evaluation, or assessment of that person's physical or mental condition or receives any form of treatment, therapy, cure or relief.

(5) "Counseling relationship" means a contract or understanding between two persons which is in effect or was in effect within a one year period, wherein one of the persons receives an evaluation, assessment, consultation, or recommendation.

¶ (6)

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612
(913) 235-2383 FAX # (913) 235-5114

Chip Wheelen
Director of Public Affairs

K.S.A. 21-3517 is hereby amended to read as follows:

21-3517. Sexual battery. (1) Sexual battery is ~~the~~ unlawful, intentional touching of the person of another who is not the spouse of the offender and who does not consent thereto, with the intent to arouse or satisfy the sexual desires of the offender or another.

: ¶ (a) The

; or ¶ (b) the unlawful, intentional touching of the person of another with the intent to arouse or satisfy the sexual desires of the offender or another, regardless of whether the person consents thereto when there exists a therapeutic or counseling relationship between the offender and the person.

(2) Sexual battery is a class A misdemeanor.

(3) This section shall be part of and supplemental to the Kansas criminal code.

2/9/92
HJC
2-19-92
Att #12
5-5

K.S.A. 21-3518 is hereby amended to read as follows:

21-3518. Aggravated sexual battery. (1) Aggravated sexual battery is:

(a) The unlawful, intentional application of force to the person of another who is not the spouse of the offender and who does not consent thereto, with the intent to arouse or satisfy the sexual desires of the offender or another;

(b) sexual battery, as defined in K.S.A. 1983 Supp. 21-3517 and amendments thereto, against a person under 16 years of age;

(c) sexual battery, as defined in K.S.A. 1983 Supp. 21-3517 and amendments thereto, committed in another's dwelling by one who entered into or remained in the dwelling without authority;

(d) sexual battery, as defined in K.S.A. 1983 Supp. 21-3517 and amendments thereto, of a person who is unconscious or physically powerless; or

(e) sexual battery, as defined in K.S.A. 1983 Supp. 21-3517 and amendments thereto, of a person who is incapable of giving consent because of mental deficiency or disease, which condition was known by, or was reasonably apparent to, the offender.

; or ¶ (f) sexual battery, as defined in K.S.A. 21-3517(b) and amendments thereto when sexual intercourse or sodomy results from the sexual battery.

(2) Aggravated sexual battery is a class D felony.

(3) This section shall be part of and supplemental to the Kansas criminal code.

KMS
KANSAS MEDICAL SOCIETY
1300 Topeka Avenue • Topeka, Kansas 66612
(913) 235-2383 FAX # (913) 235-5114

Chip Wheelen
Director of Public Affairs

State of Kansas

235 S. Topeka Blvd.
Topeka, KS 66603

913-296-7413
FAX: 913-296-0852

Board of Healing Arts

MEMORANDUM

TO: House Judiciary Committee

FROM: Lawrence T. Buening, Jr.
Executive Director
Kansas State Board of Healing Arts

RE: House Bill 2253

DATE: February 19, 1992

Thank you for the opportunity to appear before you and present testimony on behalf of the State Board of Healing Arts expressing its support for House Bill 2253. As it relates to the State Board of Healing Arts, Section 3 of the bill would amend the definition of unprofessional conduct to also include sexual abuse, misconduct or exploitation committed against a former patient who is emotionally dependent on a licensee of the State Board of Healing Arts (Page five, lines 25-28).

At present, the commission of an act of sexual abuse, misconduct or exploitation constitutes unprofessional conduct only if that act is related to the licensee's professional practice. The Board's concern is that sexual contact after termination of a physician-patient relationship can, in many instances, still be harmful to the former patient.

HJC 2-19-92 Attach #13 1-14

Attached to this testimony is an article which appeared in the January 1992 Federation Bulletin as well as an article which appeared in the November 20, 1991 Journal of American Medical Association.

There are two concerns as to the present language of House Bill 2253. The first is that, as the attached articles reflect, sexual contact by a health care provider with a former patient can be harmful to the patient even if the professional has not provided mental health services. While I am uncertain as to how the Revisor would deal with New Section 1, the use of the terms "sexual abuse, misconduct or exploitation" and "emotionally dependent" seem to be limited only to such conduct by mental health service providers. Therefore, a question arises as to whether the change made to the definition of unprofessional conduct in the Healing Arts Act as set forth in Section 3 of the Bill would actually serve to be a more restrictive definition than that which presently exists.

The second concern is that the definition of "sexual abuse, misconduct or exploitation" requires the licensing agency to prove that such conduct was done or submitted to with the intent to arouse or to satisfy the sexual desires of either the client or the mental health service provider, or both. This is an extremely difficult burden of proof. As the attached articles would seem to indicate, perhaps a more proper definition of inappropriate conduct would be when such occurred in a manner in which there was no legitimate medical or therapeutic purpose for the contact.

HJC
2-19-92
Att # 13
2-14

In conclusion, the Board acknowledges that it is extremely difficult for this Legislature to adopt a statute that on the one hand would prohibit sexual abuse, misconduct or exploitation but on the other hand not preclude contacts which should not constitute criminal conduct or grounds for discipline by the regulating agency. Therefore, the Board generally supports House Bill 2253 and believes that it is a step in further protecting the public from this type of activity.

I would be happy to respond to any questions.

HJC
2-19-92
Att #13
3-14

Sexual Misconduct in the Practice of Medicine

Council on Ethical and Judicial Affairs, American Medical Association

The American Medical Association's Council on Ethical and Judicial Affairs recently reviewed the ethical implications of sexual or romantic relationships between physicians and patients. The Council has concluded that (1) sexual contact or a romantic relationship concurrent with the physician-patient relationship is unethical; (2) sexual contact or a romantic relationship with a former patient may be unethical under certain circumstances; (3) education on the ethical issues involved in sexual misconduct should be included throughout all levels of medical training; and (4) in the case of sexual misconduct, reporting offending colleagues is especially important.

(*JAMA*. 1991;266:2741-2745)

THERE is a long-standing consensus within the medical profession that sexual contact or sexual relations between physicians and patients are unethical. The prohibition against sexual relations with patients was incorporated into the Hippocratic oath: ". . . I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons. . . ."[1]

Current ethical thought uniformly condemns sexual relations between patients and physicians.[2-4] In addition, the laws of many states prohibit sexual contact between psychiatrists or other physicians and their patients.[5-9] The ban on physician-patient sexual contact is based on the recognition that such contact jeopardizes patients' medical care.

PHYSICIAN-PATIENT SEXUAL CONTACT

Incidence

A number of studies have tried to establish the incidence of physician-patient sexual contact. Much of the research done on the prevalence of physician-patient sexual contact is based on studies that survey physicians about their own behavior.[10-13] The general stigma attached to sexual contact with patients and the professional repercussions that may result from admitting to such contact have led many researchers to believe that the occurrence of patient-physician sexual contact is underreported.[10,14,15]

Studies indicate that there is a small minority of physicians who have reported having sexual contact with patients.[10,11,16,17] Psychiatrists have been particularly diligent in examining the phenomenon of sexual contact with patients. Consequently, the majority of existing studies on physician-patient sexual contact examine sexual contact between psychiatrists and their patients. Studies of psychiatrists indicate that between 5% and 10% reported having sexual contact with patients.[10,11,16,18] Data for all specialties are not available, but a 1976 study suggested that the percentages may be comparable for other specialties.[11] While much of the discussion in this report centers on sexual misconduct by psychiatrists, it is clear that sexual misconduct is a problem not confined to any particular specialty.

Sexual contact between physician and patient can occur in a variety of ways: (1) physicians may become involved in personal relationships with patients that are concurrent with but independent of treatment[10]; (2) some physicians may use their position to gain sexual access to their patients by representing sexual contact as part of care or treatment[19]; and (3) others may assault patients by engaging in sexual contact with incompetent or unconscious patients. There seems to be little or no data indicating the prevalence of each type of sexual misconduct.

Physicians Who Engage in Sexual Contact With Patients

Failure to Handle the Emotional Content of the Therapeutic Relationship.—For some physicians, sexual contact with a patient is a result of a

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temporary failure to con[illegible]ctively manage the emotions arising [illegible]om the physician-patient relationship. The professional physician-patient relationship frequently evokes strong and complicated emotions in both the physician and the patient.[20-22] It is not unusual for sexual attraction to be one of these emotions. Many commentators agree that sexual or romantic attraction to patients is not uncommon or abnormal.[2,23]

However, sexual attraction to a patient, while not necessarily detrimental to the physician-patient relationship, can also lead to sexual contact or a sexual relationship between the patient and physician. The emotions of admiration, affection, and caring that are a part of the physician-patient relationship can become particularly powerful when either party is experiencing intense pressures or traumatic or major life events. The usual professional restraint exhibited by physicians may falter under such profound emotional influences, resulting in the transformation of sexual attraction into sexual contact.

Currently, the research on sexual misconduct is insufficient to determine how many sexual interactions between physicians and patients occur under these circumstances. Although figures vary widely, one nationwide study of psychiatrists showed that 67% of psychiatrists who reported sexual contact with a patient indicated that the contact occurred with only one patient.[10] This study showed that approximately 50% of psychiatrists who reported sexual contact with only one patient sought help or consultation for the matter.[10] However, engaging in sexual contact with a patient because of temporary impairment of proper judgment or perspective is not ethically excusable or condonable.

Sexual Contact Under Exploitative Conditions.—For some physicians, sexual misconduct is the conscious (and usually repeated) use of their professional positions in order to manipulate or exploit their patients' vulnerabilities for their own gratification. Presumably, most physicians who represent sexual contact to patients as part of treatment would belong to this category. Certainly, self-gratification is the only basis for the behavior of physicians who engage in sexual contact with incompetent or unconscious patients.

Several researchers have compared the occurrence of sexual misconduct with sexual assault and incest.[15,19,24,25] It is clear that, for at least some offenders, sexual misconduct with patients results from an impulse to assert power over or to humiliate another person.[26(pp60-61)] Masters and Johnson[27] advocated that therapists who exploit their power in ord[illegible] have sexual intercourse with their patients should be charged with rape.[28] Four states classify sexual exploitation by a psychotherapist as sex offenses under criminal statutes.[4-6,7]

The comparison with sexual assault is most easily understood when a physician represents sexual contact to the patient as being an appropriate medical or therapeutic procedure or an appropriate part of the therapeutic relationship. For health professionals engaged in a therapeutic relationship with patients, sexual misconduct is also often a manifestation of the health professional's own need to control or subjugate the patient or the sexual relationship.[26(pp60-61),29] In such situations, a physician uses his or her status as a physician to influence or coerce the patient into accepting sexual contact. For instance, one researcher examined the responses of 16 women who had been sexually molested during routine gynecological examinations by the same physician.[19] The majority of the women did not stop the physician even after becoming uncomfortable with the length and nature of his examination since they trusted that their physician would not conduct an unethical examination.[19]

Several elements of the physician-patient relationship can combine to give the physician disproportionate influence over the patient. Within the physician-patient relationship, the physician possesses considerable knowledge, expertise, and status. A person is often most vulnerable, both physically and emotionally, when seeking medical care.[1,25] When a physician acts in a way that is not to the patient's benefit, the relative position of the patient within the professional relationship is such that it is difficult for the patient to give meaningful consent to such behavior, including sexual contact or sexual relations.[15,25] It is the lack of reliable or true consent on the part of the patient that has led researchers to compare physician-patient sexual contact with other sexually exploitative situations such as sexual assault and incest.[15,24,26(p47)] It is noteworthy that several states specify that consent of the patient or client cannot be used as a defense to charges of sexual misconduct.[5,7]

In fact, instances of sexual contact with patients do seem to occur most commonly where there is considerable disparity in power, status, and emotional vulnerability between physician and patient. Physicians who engage in sexual contact with patients are typically older and male, while patients are typically younger and female. Studies among psychiatrists indicate that approximately 85% to 90% [illegible]tact involves a male psyc[illegible] female patient.[10] In one study [illegible] atrists, a majority admitted [illegible] contact with a patient was for [illegible] emotional or sexual gratifica[illegible] er studies of patient-psychiatrist sexual contact showed that the patients who were involved in sexual contact with their psychiatrists were also the ones most likely to be particularly vulnerable emotionally.[15] Patients who had sexual contact with psychiatrists were more likely than other patients to consider exploitative relations with an authority figure to be normal.[15]

A significant amount of sexual contact with patients does not seem to be an isolated instance of mismanaging the emotions of the professional relationship.[10,19] In one study, 33% of psychiatrists who reported sexual contact with patients also reported repeated instances of sexual contact with patients.[10] Despite considerable evidence to the contrary, repeat offenders were the most likely of all psychiatrists to claim that their conduct was beneficial to patients. These repeat offenders were also the least likely to seek help or consultation regarding the sexual contact.[10]

Effects of Sexual Contact Between Patients and Physicians

Some early attempts were made to show that sexual contact between patient and physician is or could be beneficial to the patient.[28,29] However, most researchers agree that the effects of physician-patient contact are almost universally negative or damaging to the patient.[15,19,24,26(pp24,39-45),30,31] (and *Boston Globe*. June 18, 1990:29, health science section). Studies show that 85% to 90% of patients experience such sexual contact as damaging.[32] Similar to the reactions of women who have been sexually assaulted, female patients tended to feel angry, abandoned, humiliated, mistreated, or exploited by their physicians.[14,26(p205),30,31] Victims have been reported to experience guilt, severe distrust of their own judgment, and mistrust of both men and physicians.[15,26(pp41,43,205),33] Patients who have been involved in therapist-patient sexual relationships can suffer from depression, anxiety, sexual disorders, sleeping disorders, and cognitive dysfunctions and are at risk for substance abuse.[15,26(pp43,45,205),34] While most researchers agree that sexual contact between patient and physician is potentially deleterious, it is important to note that most research has been based on patients who have initiated

disciplinary action against physicians or on patients whom subsequent psychiatrists or therapists have identified as being harmed by the sexual contact with a physician. Patients not harmed by sexual contact with a physician may have escaped the attention of researchers. Also, assessing damage to patients may be complicated by the existence of preexisting conditions that are exacerbated by sexual involvement with the physician.[2-4,6,7,9]

Most studies that have examined the effects of physician-patient sexual contact have focused on psychiatrists or therapists and their patients. However, one study found that the psychological impact of physician-patient sexual contact was negative for the patient regardless of the type of practitioner involved.[7] The study suggests that it is at least in part the betrayal of the patient's trust in the physician that produces negative psychological consequences for the patient. In addition, the risks posed to patient well-being due to loss of professional objectivity are equal regardless of the physician's specialty.

ETHICAL CONSIDERATIONS

Serving the Needs of the Patient

The satisfaction or gratification that a physician derives from treating patients is a fortunate benefit of the physician-patient alliance. However, the physician's professional obligation to serve the needs of the patient means that the physician's own needs or gratification cannot become a consideration in decisions about the patient's medical care. Regard for the physician's needs or gratifications may interfere with efforts to address the needs of the patient. At the very least, the emotional factors that accompany sexual involvement may affect or obscure the physician's medical judgment, thus jeopardizing the patient's diagnosis or treatment. Sexual contact or relationships between patient and physician are unethical because the physician's gratification inappropriately becomes part of the professional relationship.[10,11,15]

Trust Integral to the Physician-Patient Relationship

From ancient times, members of the medical profession have accepted the special responsibility that is accorded them by virtue of their unique skills of healing. The degree of knowledge, training, and expertise required to practice the art of medicine is highly sophisticated and complex. Physicians recognize that the health of individuals and society depends on their willingness to employ their knowledge, expertise, and influence solely for the welfare of patients. Patients who seek medical care must, in turn, be able to trust in the physician's dedication to the patient's welfare in order for the physician-patient alliance to succeed.[2]

A physician who engages in sexual contact with a patient seriously compromises the patient's welfare. The patient's trust that the physician will work only for the patient's welfare is violated. Consequently, sexual contact and sexual relationships between physicians and their patients are unethical.

Ethical Implications of Nonsexual Physical Contact With Patients

The ethical prohibition against romantic relationships or sexual contact with patients is not meant to bar nonsexual touching of patients by physicians. In addition to its role in physical examination, nonsexual touching may be therapeutic or comforting to patients. However, even nonsexual contact with patients should be approached with caution. It may be difficult to identify a strict boundary between nonsexual and sexual touching. Either the patient or the physician may misinterpret the touching behavior of the other.[2] There is also some concern that what may begin as benign, nonsexual contact may eventually lead to sexual contact.[11,12]

If a physician feels that a patient may misinterpret the nature of physical contact or if a physician's nonsexual touching behavior may be leading to sexual contact, then the contact should be avoided.

Termination of the Professional Relationship

It is of course possible for a physician and a patient to be genuinely attracted to or have genuine romantic affection for each other. However, any relationship in which a physician is (or risks) taking advantage of a patient's emotional or psychological vulnerability would be unethical. Therefore, before initiating a dating, romantic, or sexual relationship with a patient, a physician's minimum duty would be to terminate his or her professional relationship with the patient.[16] In addition, it would be advisable for a physician to seek consultation with a colleague before initiating a relationship with the former patient. Termination of the professional relationship would also be appropriate if a sexual or romantic attraction to (as opposed to contact with) a patient threatens to interfere with the judgment of the physician or to jeopardize the patient's care.

SEXUAL CONTACT AF TERMINATION OF THE RELATIONSHIP

Posttermination Relationship May Also Be Unethical

Termination of the physician-patient relationship does not eliminate the possibility that sexual contact between a physician and a former patient might be unethical. Sexual contact between a physician and a patient with whom professional relations had been terminated would be unethical if the sexual contact occurred as a result of the use or exploitation of trust, knowledge, influence, or emotions derived from the former professional relationship. The ethical propriety of a sexual relationship between a physician and a former patient, then, may depend substantially on the nature and context of the former relationship.

In most patient-psychiatrist relationships, the intense and emotional nature of treatment makes it difficult for a romantic relationship between a psychiatrist and a former patient not to be affected by the previous professional relationship. The American Psychiatric Association has accordingly stated that "sexual involvement with one's former patients generally exploits emotions deriving from treatment and is therefore almost always unethical."[4]

Relationships between patients and other types of physicians may also include considerable trust, intimacy, or emotional dependence. The length of the former professional relationship, the extent to which the patient has confided personal or private information to the physician, the nature of the patient's medical problem, and the degree of emotional dependence that the patient has on the physician, all may contribute to the intimacy of the relationship. In addition, the extent of the physician's general knowledge about the patient (ie, the patient's past, the patient's family situation, and the patient's current emotional state) is also a factor that may render a sexual or romantic relationship with a former patient unethical.

Prohibiting Sexual Contact With Former Patients

Some commentators have suggested that the amount of time that has elapsed since the termination of the professional relationship and the initiation of the sexual or romantic relationship may be pertinent to the ethical propriety of physician–former patient relationships.[2]

It may be that a sexual or romantic relationship that immediately follows the termination of the physician-patient relationship may be more suspect than one that occurs after considerable time

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has passed. Yet, some emotions and dependencies that were created during the professional relationship may not disappear even after a considerable amount of time has passed. Research on psychotherapists has shown that patients experience strong feelings about their therapists for 5 to 10 years after the termination of treatment.[25,31,33,35,42]

For these reasons, it is not useful to determine the appropriateness of a sexual relationship between a physician and a former patient based on the amount of time that has elapsed since the termination of the professional relationship. Rather, the relevant standard is the potential for misuse of emotions derived from the former professional relationship.

PREVENTION AND DISCIPLINE OF SEXUAL MISCONDUCT

Education

There is evidence that the issue of sexual misconduct and sexual or romantic attraction to patients is not adequately covered in many medical training programs.[23,36] However, almost all commentators agree that the issues surrounding sexual misconduct need attention during medical education.[24,33,37,43]

Education may serve to distinguish sexual or romantic attraction to patients, which is a common and normal experience, from inappropriate behavior, such as acting on the attraction or allowing the attraction to jeopardize the care of the patient. Education may also promote appropriate responses to sexual attraction to patients, such as seeking consultation with colleagues or counseling, when patient care is potentially jeopardized.[24] Obviously education about sexual misconduct would also inform physicians and medical students about the ethical implications of physician-patient sexual contact as well as the potential harm to patient well-being.

Detection and Reporting of Sexual Misconduct of Colleagues

Sexual misconduct is unlikely to be brought to the attention of the proper authorities by many of the usual means of exposing deficiencies in the practice of medicine. Other transgressions can be detected through the analysis of records or may be brought to the attention of the authorities by hospital staff or peer review processes. However, the discovery and investigation of sexual misconduct is unlikely unless victims of sexual misconduct initiate and pursue disciplinary or ethical review procedures.[37]

Unfortunately, patients who have had sexual contact with their physicians may be hindered from reporting the misconduct. There is some evidence that offenders tend to refer patients to colleagues whom they know to be sympathetic to their actions.[37] Patients may thus be discouraged from reporting instances of sexual misconduct. Also, while the rate of dismissals of cases alleging sexual intimacy between psychologists and clients is decreasing, many psychiatrists continue to express misgivings about the effectiveness of disciplinary bodies in this area.[26,35,42,44,45]

Further, some patients may not be able emotionally to report instances of sexual misconduct or to undergo the process of review and investigation required to discipline an offending physician. When the sexual relationship was a result of the physician's mishandling of the emotional influences of the professional relationship, the patient may not be able to recognize that the physician's behavior was improper or inappropriately motivated. Victims of sexual misconduct through medical deception may be incapable of reporting the offense because of the emotions of shame, humiliation, degradation, and blame that also often make it difficult for victims of sexual assault to report their assaults.

One of the few remaining avenues for identifying offending physicians is reporting by colleagues. Consequently, reporting of transgressions by peers is especially important in the case of sexual misconduct. Unfortunately, physicians are often reluctant to report instances of sexual transgression by their colleagues. A 1987 survey of 1423 practicing psychiatrists (a response rate of 26%) revealed that 65% of them reported treating patients who had been sexually involved with previous therapists, and 87% of those psychiatrists believed that the previous involvement was harmful to the patient. However, only 8% of them reported their colleagues' behavior to a professional organization or legal authority.[47]

Literature that has studied the reporting practices of physicians indicates that reluctance to report may involve concerns over confidentiality, either in the physician-patient relationship or among colleagues. Reluctance to take action contrary to a patient's wishes or concern that a patient's recovery process may be damaged also may affect the reporting practices. Some physicians may also regard the patient's allegations as hearsay and therefore unreportable.[37] Other physicians may feel that reporting laws lack sufficient clarity or immunity for good-faith reporting.

The American Medical Association includes among its Principles of Medical Ethics the standard that a physician shall . . . strive to expose those physicians deficient in character or competence, or who engage in fraud or deception." Because the nature of sexual misconduct is such that most victims are rendered reluctant or unable to report the misconduct on their own, physicians should be particularly vigilant in exposing colleagues who commit sexual misconduct. Presently, four states have mandatory reporting laws specific to the reporting of sexual misconduct by colleagues.[42] The Council on Ethical and Judicial Affairs believes that physicians who learn of sexual misconduct by a colleague must report the misconduct to the local medical society, the state licensing board, or other appropriate authorities. Exception may be made if a physician learns of the misconduct while treating the offending physician for the misconduct, provided that the offending physician is not continuing the misconduct and does not resume the misconduct in the future. An exception may also be made in cases in which a patient refuses to consent to reporting or in cases where the treating physician believes that reporting would significantly harm the patient's treatment. Physicians who make good-faith reports of the sexual misconduct of a colleague should be protected from potential legal, professional, or personal repercussions.

Discipline

Some commentators have expressed concern that existing disciplinary bodies have not been sufficiently effective in dealing with sexual misconduct.[47] While the frequency of false accusations of sexual misconduct seems to be extremely low[42,48] (and *Boston Globe*, June 18, 1990:29, health science section), the rate at which practitioners are disciplined for ethical violations of this kind does not seem commensurate with the number of accusations.[47-49] There may be myriad concerns that limit the efficiency of investigative and disciplinary bodies, including the difficulties inherent in ensuring procedural fairness to the accused physician while remaining sensitive to the needs of the patient who reports physician sexual misconduct. For instance, procedural mechanisms must be in place that would prevent the leveling of baseless accusations against innocent physicians. However, procedures must also be flexible and sensitive enough so that victims are not so daunted or intimidated by the procedural requirements that they decline to proceed with complaints.

There are some ways, however, to structure disciplinary bodies that would

maximize both effectiveness in detecting and disciplining offenders and sensitivity to patients who report sexual misconduct. For instance, some research has shown that women who experienced sexual contact with male psychotherapists showed an increased distrust both of men and of psychotherapists.[17] Patients should therefore be given the option of a preliminary interview with a member of the disciplinary board with whom or with whose gender they feel most comfortable. In addition, it is important that a disciplinary panel hearing sexual misconduct charges have equal gender distribution among its members.

Members of disciplinary bodies that deal with reports of sexual misconduct should undergo training and education specific to the problem.[17] Patients may face greater obstacles in reporting and pursuing legal action in the case of sexual misconduct than with other medical transgressions. Some institutions may consider establishing a special disciplinary body to handle allegations of sexual misconduct, one whose members are educated and sensitized to the particular difficulties facing victims of sexual misconduct.[32] Alternatively, an institution might establish special procedures for handling sexual misconduct complaints.

Finally, physicians who commit sexual misconduct must be able to get help. Physicians are subject to many pressures and influences, including attraction to patients, the emotional influences of the physician-patient interaction, and the effect of their own emotional problems or conflicts on their professional lives. Many physicians who commit sexual misconduct may benefit from rehabilitation for their problem. Currently, there is virtually no research regarding the efficacy of therapy for physicians who engage in sexual misconduct. However, programs similar to those that help other kinds of physician impairments, such as alcohol and drug addiction, should be developed and made available for sexual misconduct offenders.[21,33]

CONCLUSIONS

The Council on Ethical and Judicial Affairs concludes that sexual contact or a romantic relationship with a patient concurrent with the physician-patient relationship is unethical. Sexual or romantic relationships with former patients are also unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

In addition, education on the issue of sexual attraction to patients and sexual misconduct should be included throughout all levels of medical training. Disciplinary bodies must be structured to maximize effectiveness in dealing with the problem of sexual misconduct. Physicians who learn of sexual misconduct by a colleague must report the misconduct to the local medical society, the state licensing board, or other appropriate authorities. Exceptions to reporting may be made in order to protect patient welfare. It should be noted that many states have legal prohibitions against relationships between physicians and current or former patients.

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Health Care Providers and Sexual Misconduct

IRWIN S. DREIBLATT, PH.D.

Dr. Schneidman asked me to tell you all I know about working with Health Care Providers and Sexual Misconduct in thirty minutes. I have divided the topic into fourteen points — fourteen two minute points; I hope this will address your needs.

POINT ONE:

The prohibition against sexual involvement with patients is not new at all.

Hippocrates addressed the topic in 500 B.C., as did Villanova during the middle ages. I have always liked the quote from Hippocrates, "Enter only for the good of the patient. . . Keep yourself far from all seduction and especially the pleasures of men and women." All health care professions have standards which prohibit sexual involvement with patients. Despite this, we repeatedly hear offending practitioners state that they did not know it was wrong to get sexually involved with patients.

POINT TWO:

It should not be a surprise that there is a significant rate of sexual abuse perpetrated by health care providers.

Most sexual abuse involves a perpetrator exploiting a position of trust and victimizing a vulnerable individual. Physicians have a unique position of trust with vulnerable patients. In addition, they:

1) Have access to private information about patients.
2) Are in a physically intrusive position.
3) Can feel invisible and invincible because of their status and special relationship with patients.
4) Can rationalize that the patient's interest in them is personal rather than a by-product of the unique doctor-patient relationship.

POINT THREE:

There has been an increase in the reporting of sexual misconduct involving all professional helpers.

I know of no statistics, overall, regarding health care providers that engage in sexual misconduct with patients. Research regarding practicing psychologists and psychiatrists indicate that approximately seven to ten percent of these professionals report sexual involvements with patients. Of those who do engage in such misconduct, eighty percent reoffend.

I have seen an increasing number of health care providers who have engaged in sexual misconduct. The main physician groups have been psychiatrists, family physicians, and internists. Why these specialties? It is possible that they have broader and less structured roles and are more likely to engage in counseling patients. Patients are therefore more likely to discuss matters such as personal relationships, marriage, and sex in this private, doctor-patient environment.

POINT FOUR:

It is my impression that health care providers who engage in sexual misconduct are little different than other educated, middle class perpetrators.

The offenses they commit vary in scope and severity. The offense is sometimes, but infrequently, an isolated misjudgment. More often, the offense is part of a continuing, albeit uneven, pattern of conduct — the tip of the iceberg.

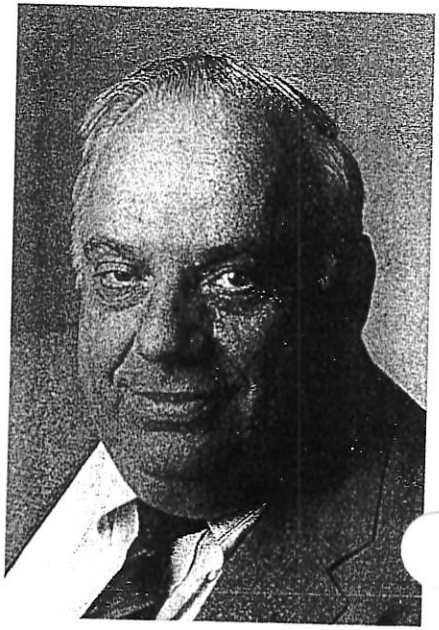
In practice, one sees perpetrators who are relatively healthy and stray across the line of appropriateness. One sees rather immature, neurotic, needy people. Some perpetrators have serious personality disorders. Others are compulsive sex offenders. One sees borderline or psychotic providers who engage in misconduct. Most often you see a blend of disorders. It is important to recognize that providers who engage in sexual misconduct are a heterogeneous group of people; there are no specific defining characteristics. There is no profile that you can look at to identify them — they generally defy our stereotypes. They tend to be senior professionals who often have attained prominence in their fields. They are often married, religiously affiliated, and professionally competent.

POINT FIVE:

The sexual offenses that are committed vary considerably.

They include:

1) Affairs with vulnerable patients



Dr. Dreiblatt

Dr. Dreiblatt is a clinical psychologist who practices in Seattle, Washington. This presentation was made during the April 25, 1991 session of the annual meeting of the Federation of State Medical Boards of the United States, The Westin Hotel, Seattle, Washington.

2) Inappropriate sexual touching (massage, masturbation)
3) Inappropriate affectionate behavior (kissing and hugging)
4) Unnecessary sexual talk with patients (talking about irrelevant sexual conduct, orgasms, masturbation)
5) Exposing to patients
6) Forcible rape of patients
7) Taking pictures of patients for sexual purposes
8) Peeping on patients undressing
9) Utilizing vulnerable patients to gain sexual access to their children
10) Sexual involvement with staff, or students or residents that they supervise.

POINT SIX:

Risk behaviors include: serious boundary problems; undue physical touch; sensual comments; dual relationships with patients (getting involved recreationally, financially, or romantically); becoming too narcissistic (taking one's importance to patients too seriously); fostering excessive dependence on patients; focusing practice on highly vulnerable clientele; and undue self-disclosure with patients (discussing marriage, family problems, sexual life of the provider, past sexual abuse, financial life). In addition, unusual office practices (practicing when staff are not around, late hours, house calls) and practicing when impaired can become problematic.

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POINT SEVEN:

Sexual misconduct tends to become chronic over time.

The following statistic does not come from research with health care providers but it is noteworthy because a psychiatrist, Gene Abel, studied a large group of men who had engaged in sexual misconduct. He studied 567 of them. Those 567 men accounted for 291,000 separate acts of legal sexual misconduct, and 195,000 victims. I make the point, because it underscores the issue of chronicity. There is the "fallacy of the single offense." When health care providers get into trouble, they tend to want to tell you, "Yes, indeed, I did something wrong but this is the only time it happened." Undoubtedly, for some it is true. More often, it is a chronic offense, it has happened before; you are seeing the tip of the iceberg.

Over time, sexual msiconduct tends to escalate; we see increased rates of offending, more intrusive behavior, and more daring behavior. Perpetrators are unlikely to stop the misconduct without legal or quasi-legal intervention. As Board members talking with people in trouble for this kind of conduct, beware of statements like: I've learned my lesson," I've learned it wasn't worth it," "I'm sure it won't happen again," "I feel terrible about what I've done."

POINT EIGHT:

Those who engage in misconduct tend not to define the problems themselves.

You do not see physicians or health care providers coming forth and saying, "I have a problem of this kind and I need help." Generally, they are identified when a third party has complained. They almost never seek help on their own. Once help is initiated, they do not remain in treatment without some kind of leverage.

POINT NINE:

Defensiveness is the hallmark of people who engage in sexual misconduct.

People are not forthright about their inappropriate sexual behavior. They deny it happened. They minimize its importance. They rationalize and justify why they have done it. They will flee into religion and say, "Now I've seen the light and it won't happen again." Again, as Board members, you need to beware of the rationalizations and distortions that these providers present. These include statements such as:

"Well it happened, but it was her idea — she seduced me."

"Or, in terms of a physician who masturbated 200 patients, that "they didn't really know what I was doing." Somehow, he had cloaked his misconduct in some medical mantel.

Or, "I know that it was inappropriate to have sex with this young girl — even though she was twelve, she really looked like she was eighteen.

Or, another physician who engaged in blatant and bizarre sexual behavior, explaining about how he was helping this person with her self-esteem. That is, it was a planned treatment intervention.

Or, "I only did it because there was trouble in my marriage."

Or "My wife doesn't have sexual relations with me."

Or, "Yes, I'm involved with this person but he or she is no longer my patient." I sometimes like to joke about this one because it always seems absurd, but I know cases where physicians, just prior to getting involved sexually with the patient, go to their office, open the file, and write off the patient.

Or, "I don't see what's wrong with it, I didn't do it in my office, I did it in the basement of my office."

Or, "I didn't do it during office hours, so it's not professional misconduct."

All of those are statements that come directly from health care providers who have offended.

POINT TEN:

There is no single cause for health care providers engaging in sexual misconduct.

This kind of behavior is a very complex phenomenon. Beware of people giving single cause explanations: that this person's marital life was bad, and that is why it happened; his or her sexual life was bad; or he or she is under such stress; or he or she is using alcohol. It is a complex phenomena and it is

never caused by one single factor.

It is useful to think about this problem as being a behavioral, addictive-like disorder. People acquire the vulnerability toward sexual misconduct in complex ways through their lives. The individual often becomes hooked on: illicit sexuality; power; narcissism. The problem is strengthened by repetition and fantasy about the conduct. People who engage in misconduct spend more time thinking and fantasizing about it than doing it. The behavioral potential for this kind of conduct remains with the person throughout his or her lifetime. And if you are going to intervene on this type of problem and help this individual, the focus has to be on helping him or her learn to manage his or her behavior, not "cure" the problem. Future risk is ever present, and the perspective for helping and monitoring these people must be very long-term.

Although I am using the term "addiction" as a descriptive metaphor for this type of problem, one should not assume that these problems are well addressed in twelve step programs.

POINT ELEVEN:

False sexual allegations by patients are a very low frequency occurrence.

Victims often appear to have little credibility because offenders often select vulnerable and impaired patients to become involved with. Often the patient appears to have elected to participate. We do not have the time to get into it today, but there are special considerations regarding the victim selection and the nature of the doctor-patient relationship that bear on that issue. Victims often do not present well, mainly because of the adverse effects of the victimization that has occurred.

You need to be aware that sexual abuse by health care providers has serious, long-term effects on the victims.

POINT TWELVE:

The evaluation and treatment of health care providers is a very narrow specialty.

Competent non-specialist mental health providers make serious errors in judgment with this population. Why is that? One reason is that there is a major difference in assumptions in working with this population versus the general mental health patient population. Perpetrators of sexual misconduct are people who are in trouble, they have not identified the problem; they are not seeking help; the context of helping them is very different. When we work with general mental health patients, we rely heavily on the self-report of the individual. When you are dealing with perpetrators of sexual misconduct, there is much impacting these individuals which leads them to be dishonest and distort the facts. As a result of leaning heavily on self-report, professionals who do not have specialized knowledge tend to obtain distorted and limited information. One of the things you find is that specialists utilize a very broad data base.

Often general mental health providers do not have the knowledge of victimology to assess the case circumstances, and do not have the awareness, perhaps, of the biases that all of us intrude into working with this population. Bias affects all of us. It is very hard for any of us to consider that a competent physician would engage in very destructive sexual behavior with patients. We often believe that competency cannot accompany sexual deviancy, but it does. It is very hard for people to understand why a physician, who sees people nude all the time, would engineer his or her office with mirrors so he or she can watch women undress. It is hard to realize that physicians can be hooked on illicitness, in a sexual sense.

It can be easy, when you deal with perpetrators, to normalize their behavior — to say, "perhaps they are just having an affair," or, "I've seen patients who come on to me and maybe they are no different." In fact, the perpetrators are different.

POINT THIRTEEN:

Specialized evaluations are the cornerstone for effective decision-making about perpetrators of sexual misconduct.

Good evaluations are problem and offense focused. They require a broad and varied data base and are clinically time consuming and therefore expensive. Thor specialized evaluations will inc careful review of all the collateral case material, investigative materials, past discipline history, and past suit history of that individual. It will involve extensive interviewing of that person. You need to understand that when you are working with someone who has been engaged in sexual misconduct, you will find that generally, 1) if you don't ask, you don't find out; 2) you don't ask several times, you won't get the answer; 3) if you don't ask specifically, you'll get an answer to something else; 4) that you must go beyond the initial answer you get. So, when someone says to you, "I've never been involved with other patients," and you stop asking you will believe that they have never been sexually involved with other patients. But if you are interviewing them, you have to ask, "Does that mean you never did this with any of the people you see?" . . . and on and on. I saw a physician who had bee involved in molesting a number of young boys. In terms of the specific complainant, he said, "I never molested that boy." If you stop there, you would think "he didn't do it," right? Well, you have to ask the question three or four times and in different ways. What you would learn is that he never molested that boy. He showered with that boy, he massaged that boy, ran around nude with that boy, he never "molested" that boy. Clearly, the interviewing of perpe-

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trators in this situation is rather tricky and requires much skill.

In addition to interviewing, I believe that psychological testing is a valuable assessment asset, although it does not tell you anything in particular or specifically about sexual misconduct. It provides key information about personality traits, coping style, etc. Sometimes, specialized evaluations of these kinds involve polygraph testing and plethysmograph assessment. They, too, can be assessment assets.

THE LAST POINT:

Do not overestimate the effectiveness of treatment or the end product of the treatment process.

Specialized treatment can be an effective intervention with physicians who engage in sexual misconduct if one selects the candidates carefully. Not every perpetrator is a candidate for continuing to practice and for treatment. Sometimes, the nature of offending does not lend to control and containment, and monitoring. The disturbance can be so severe, or defensiveness and denial so great, that it precludes treatment. An advocacy model does not work. Effective treatment involves problem-specific, cognitive-behavioral psychotherapy. You mainly help practitioners: 1) who demonstrate some modicum of admission of responsibility; 2) when this is generally the first intervention for this kind of behavior; 3) now that they have been caught, they demonstrate some motivation for change; 4) they are not overwhelmed by life problems; and, 5) the risks presented are definable and limitable.

Treatment is broad-based and deals with personality issues, personal life issues, and professional issues.

Keep in mind that effective Board interventions involve: thorough investigation; very careful, specialized assessment; establishing practice restrictions and limitations (such as arena of practice, type of practice, hours of practice, type of patients). It also demands: practice style and practice organization changes; practice supervision; mentoring; continuing oversight; specialized problem-specific treatment; and long-term follow-up. It is a very complex and long-term process.

There are a number of rather monumental dilemmas that Boards have to deal with, and perhaps at another time and another place we might discuss them. One issue involves the challenge of educating health care providers around sexual ethics and practice in this realm. I am struck that most of the health care professions tend not to deal with this type of issue in their training — perhaps the time has come.

Thank you for your invitation.

1001 Broadway — Suite 315
Seattle, Washington 98122