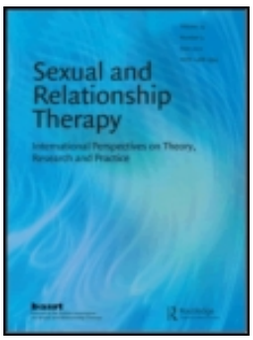

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S. Michael Plaut

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LEADING COMMENT

Sexual misconduct by health professionals: rehabilitation of offenders

Sexual contact with a patient or client is considered by many to be one of the most egregious acts possible for a health professional. However, because there are different types of offenders and offenses, disciplinary actions vary according to the specific circumstances surrounding each instance of exploitation (Gill, 1996). Although stern measures such as license revocation are sometimes called for, there are times when corrective measures can enable a provider to return to practice with reasonable confidence that a repeat offense will not occur (Plaut, 1997). The key to effective rehabilitation is ensuring that confidence (Schoener, 1995).

The case for selective rehabilitation

At least one author (Pope, 1990) has raised doubts about whether rehabilitation of sexually exploitative psychotherapists is appropriate or possible. Others (Gabbard, 1995; Gonsiorek, 1995; Schoener, 1995) assert that some sexually exploitative professionals can be successfully rehabilitated, but they point out that certain types of offenders have more favorable prognoses than others, whereas some should not be placed in rehabilitation at all. Unfortunately, there have been no scientifically rigorous studies of the effectiveness of rehabilitation efforts for sexually exploitative practitioners (Gonsiorek, 1995; Nugent, 1996b), and it is imperative that such efforts be undertaken. However, studies of other types of sexual offenders do show that those who are treated are less likely to re-offend than those who receive no treatment (Independent Task Force, 1991).

Sanctions that may be imposed when a licensee is found to be in violation are set forth in licensing statutes and normally include reprimand, fine, suspension and revocation. Rehabilitation may also be imposed, typically as part of a consent agreement between the board and the licensee. Rehabilitation measures may include psychotherapy, remedial education, limited practice, or clinical supervision, all undertaken at the licensee's expense. These sanctions may be used in any

Correspondence to: S. Michael Plaut, Ph.D., Department of Psychiatry, University of Maryland School of Medicine, 22 S. Greene St.—Box 351, Baltimore, Maryland 21201, USA; e-mail: mplaut@som.umaryland.edu.

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combination that suits the situation. Thus, a license may be suspended, and requirements such as supervision and education may be additionally imposed as conditions for termination of suspension or probation. In any case, the sanctions must be such that there is a clear message to both the licensee and the public that the issue has been seriously addressed (Gill, 1996; Plaut, 2000).

Determining an offender's potential for rehabilitation

Professionals who sexually exploit clients can have a range of motivations, and the circumstances surrounding their ethical transgressions are unique to each situation. However, despite the complexities of each individual case, it is possible through careful assessment to distinguish those offenders who are likely candidates for rehabilitation and possible return to practice from those who are not (Nugent, 1996a).

Schoener and Gonsiorek (1988), Schoener (1995), Gabbard (1995), and Gonsiorek (1995) have developed classifications of sexually exploitative professionals. Even in similar professional–client situations, however, there may be a wide range of offender characteristics (Gabbard, 1995). For example, some offenders can be classified as having narcissistic or sociopathic personality disorders and are engaged in what amounts to a ruthless predation of a variety of vulnerable patients. Others may be experiencing a recent loss in their own lives or are depressed for some other reason and have become caught up in something inappropriate that they may almost immediately regret.

Based on his extensive experience in the area, Schoener (1995) has suggested that an assessment for rehabilitation be undertaken only if the following conditions are met: (a) the practitioner admits wrongdoing and understands that there was harm to a client; (b) the practitioner believes that he or she has a problem that requires rehabilitation; and (c) the practitioner is willing to agree to the assessment and realizes that its outcome may not be favorable.

Components of a rehabilitation program

The specific factors that caused or contributed to the professional's misconduct should be identified, and a rehabilitation plan designed to address each of these specifically. Psychiatric and psychological evaluation should be done by individuals approved by the referring board who are not likely to be biased and who understand the issue. The same is true for those who serve as therapists or as clinical supervisors for offenders (Gonsiorek, 1995). Remedial education must be undertaken with some assurance that relevant issues are covered and that the offender understands them once the process is completed (Plaut, 1995). The public will have greater confidence in the use of such measures by licensing boards if these practices are objective, coordinated and effective.

The US State of Maryland Plan

The Maryland Task Force to Study Health Professional–Client Sexual Exploitation was the first body of its kind to examine licensure discipline, education, and rehabilitation of offenders, as well as other aspects of the problem (Plaut & Nugent, 1999). Discrepancies in how allegations were addressed were observed among the different boards in that state. These differences led the Task Force to recommend that licensing boards that had developed expertise in handling sexual misconduct cases serve as resources to the boards with less experience in that area. The Task Force concluded that there should be a standardized protocol for assessing all Maryland health professionals who have sexually exploited clients and for establishing and monitoring rehabilitation plans for them. Such a standardized process would provide protection to the public, as well as an opportunity for rehabilitation to a practitioner who, at its conclusion, might be able to return to practice (Nugent, 1996b).

Under this plan, a Rehabilitation Consultants Group (RCG) would be established under the auspices of the state's Department of Health and Mental Hygiene. This group would consist of health professionals and consumers with specific expertise in the area of sexual misconduct. For any one case, an *ad hoc* Rehabilitation Oversight Panel (ROP), consisting of a case manager, an assessment specialist, a same-discipline member and a consumer member drawn from the RCG, would oversee each case. ROP rehabilitation plans might include but need not be limited to personal psychotherapy, educational activities, clinical supervision, and practice limitations. The ROP would establish a procedure for monitoring the practitioner's adherence to the prescribed rehabilitation plan (Nugent, 1996b). Since the successor Implementation Committee to the Task Force needed to set priorities regarding which of the 53 Task Force recommendations would be implemented first (Plaut & Nugent, 1999), the rehabilitation proposal has not yet been realized in Maryland. However, an increasing number of licensing boards have been made aware of resource people from other disciplines and have utilized their services in rehabilitation programs.

Psychotherapy

The Task Force recommended that the course of personal psychotherapy for the practitioner in rehabilitation would, minimally, focus on helping the professional to (a) recognize the harm done to the victim and his or her family; (b) develop empathy for the victim's plight; (c) assume full responsibility for his or her exploitative behavior; (d) understand the power dynamics in helping relationships; (e) develop an understanding of personal issues that may have contributed to the offending behavior; and (f) be able to identify high-risk situations and develop a plan to avoid, reduce or ameliorate risk factors in the future.

For a number of reasons, the mental health professional providing such treatment would not be the same provider who performed the initial clinical assessment (Nugent, 1996b). First, a forensic evaluation done to determine

potential for rehabilitation is not the same as a clinical evaluation (Gonsiorek, 1995). Second, an evaluation might be considered self-serving if there was the potential that the evaluator would conduct the recommended therapy. Finally, the kind of psychotherapy recommended might vary depending on the needs of the individual.

The impact of sanctions experienced by the offender often far exceeds what a licensing board may impose. Other consequences may include loss of partner, practice, liability insurance and hospital privileges, not to mention one's reputation in the community. The legal process itself may be overwhelming and takes its own emotional toll. Therefore, the period of suspension and rehabilitation is likely to be a very stressful time for the offender, and those conducting the rehabilitation program should take this into account by providing appropriate therapy and support.

One tendency often seen in offenders is an excessive withdrawal from touch or personal conversation with patients for fear that any suggestion of a boundary crossing might constitute a chargeable offense. Therefore, another function of the rehabilitation process can be to help the offender find the balance between sensitivity and caring on one hand, and appropriate professional distance on the other.

Remedial education

A professional who sexually exploits a client often has limited or erroneous knowledge about the nature and dynamics of the clinical relationship or lacks information about other related issues. Therefore, rehabilitation programs resulting from disciplinary action by licensing boards often include an educational component (Abel *et al.*, 1992; Plaut, 1995; Pope, 1989; Schoener & Gonsiorek, 1988). Because the subject of professional-client boundaries often has not been discussed at length during the normal professional education process (Gartrell *et al.*, 1992; Plaut & Ginter, 1995; Pope *et al.*, 1986), such a course may be the professional's first formal exposure to the topic.

Offenders are frequently asked to complete a course in professional ethics. Such a requirement, although well intended, does not ensure either (a) that the course includes subject matter relevant to the offense in question or (b) that the professional has satisfactorily mastered relevant concepts. One way to maximize the assurance that the professional in rehabilitation acquires knowledge to remediate specific learning deficiencies is to require that the offender undergo a tutorial experience designed to meet specific objectives relevant to the professional's individual situation (Plaut, 1995; Plaut & Shank, 1996). Many resources are available to assist in this process of education (Schoener, 1999).

The author conducts such tutorials for licensing boards in a number of disciplines. All relevant documents (e.g. charging documents, consent agreements, final orders) are first obtained from the board, the case is discussed with the respondent, and readings, videotapes, websites or other relevant resources are recommended that address the situation at hand. A sample resource list is shown in Appendix 1.

Face–to-face discussions of the material are held as needed. The final

requirement of the course is a professionally prepared paper which includes the following sections: (a) a discussion of the factors that led to the need for the course; (b) the respondent's understanding of the ethical and clinical issues involved, especially as they pertain to his or her situation; (c) a discussion of what he or she would do in the future if confronted by the situation that led to the need for the course; and (d) a recommendation of what might be done in general (e.g. by the profession) in order to minimize the incidence of the problem in question. In completing Section (b) of the paper, the respondent is expected to address at least the following issues: (1) the basis for the need for professional–client boundaries, including considerations of power, vulnerability and consent; (2) risk factors for both patients and providers that tend to lead to boundary violations; and (3) potential harm to both providers and patients resulting from boundary violations. A single tuition payment is expected in advance, thus eliminating even the appearance that the process might be extended for financial gain to the person conducting the tutorial.

Conclusion

Even when offenders have met the technical requirements imposed upon them, those involved in the rehabilitation process may have certain reservations about their ability to practice without further risk. It is important that any reports to the referring board include those concerns and the basis for them, so that they may be taken into account in its future deliberations.

In summary, health professionals who cross sexual boundaries can often be safely returned to practice. Imposing certain rehabilitative measures in addition to any other sanctions can most effectively achieve this goal. Such measures may include psychotherapy, tutorial education, limited practice and clinical supervision, all customized for the individual situation and conducted in a coordinated manner by skilled professionals approved by the licensing board.

S. Michael Plaut
Department of Psychiatry,
University of Maryland School of Medicine,
Baltimore, MD, USA

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Contributor

S. MICHAEL PLAUT, PhD, *Associate Professor; Chair, Maryland (USA) Task Force to Study Health Professional–Client Sexual Exploitation, 1994–1996.*

Appendix 1: Boundaries between professionals and clients

Possible Initial Readings for Tutorial Course

ASSEY, J.L. & HERBERT, J.M. (1983). Who is the seductive patient? *American Journal of Nursing*, *4*, 531–532.

BISBING, S.B., JORGENSON, L.M. & SUTHERLAND, P.K. (1995). *Sexual abuse by professionals: a legal guide*. Charlottesville: Michie.

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