COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
COMMITTEE ON JUDICIARY

In re: House Bills 894, 895, 896 and 897
Abuse by Professionals

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Stenographic report of hearing held
in Room 140, Majority Caucus Room,
Main Capitol Building, Harrisburg, PA

Thursday,
June 13, 1991
10:00 a.m.

HON. THOMAS R. CALTAGIRONE, CHAIRMAN

MEMBERS OF COMMITTEE ON JUDICIARY

Hon. Kevin Blaum
Hon. James Gerlach
Hon. David W. Heckler
Hon. Robert D. Reber
Hon. Karen A. Ritter

Also Present:

Galina Milahov, Research Analyst
Mary Woolley, Republican Counsel
Mary Beth Marschik, Republican Research Analyst
Katherine Manucci, Committee Staff

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CHAIRMAN CALTAGIRONE: I'd like to open today's hearings on House Bills 894, 895, 896 and 897.

We have submissions for the record from Majority Leader Bill DeWeese, he will not be able to join us, but we do want to enter for the record his comments, and also the comments of Anna Fleck, who had a prepared statement that she also wanted to have entered.

At this time, I'd like the members present to introduce themselves, and the staff, and there will be other members joining us but I want to get started with the proceedings.

Karen.

REPRESENTATIVE RITTER: Karen Ritter from Lehigh County.

CHAIRMAN CALTAGIRONE: Tom Caltagirone, Berks County.

MS. WOOLLEY: Mary Woolley, Counsel to the committee for the Republican Caucus.

REPRESENTATIVE REBER: Bob Reber, Montgomery County.

MS. MILAHOV: Galina Milahov, Research Analyst for the Democratic Caucus.

MS. MARSCHIK: Mary Beth Marschik, Research Analyst for the Republican Caucus.

CHAIRMAN CALTAGIRONE: If you care to introduce yourself for the record, we will begin the testimony.

MS. BACKENSTOSE: Mary Beth Backenstose.

MS. BALLENTINE: Barbara Ballentine.

CHAIRMAN CALTAGIRONE: Okay, you may proceed.

MS. BACKENSTOSE: Mr. Chairman and members of the House Judiciary Committee, I am Mary Beth Backenstose, President of the Pennsylvania Coalition Against Abuse by Professionals and a psychotherapist in private practice for the past 17 years. I wish to thank you for this opportunity to provide testimony in support of House Bills 894, 895, 896 and 897. My testimony will be brief and introductory in nature.

Sexual exploitation of patients by health care professionals has become a serious problem across the United States. In the past eight years, insurance carriers have paid out over $3 million in claims against counselors, with half the claims and two-thirds of the payments being for sexual misconduct. Psychologists have also experienced an increase in sexual misconduct claims against them.

Surveys show that about 10 percent of all

reporting psychologists and psychiatrists engage in sexual relations with their patients, and the coalition has reason to believe, based on reports of sexual exploitation which we have received, that this percentage can apply to all health care professionals. Eighty percent of reporting offenders acknowledge having sexual contact with more than one patient. Sixty-five percent of reporting psychiatrists report treating patients who have been sexually involved with previous therapists. Over 95 percent of reporting psychiatrists who treat sexually exploited patients assess the previous contact as always harmful to their patients. However, only 8 percent of our respondents filed reports with professional associations or legal authorities.

A distinct clinical syndrome has recently been identified for patients who have been sexually exploited by health care professionals called the therapist-patient sex syndrome. The most distressing symptom is that the patient frequently develops suicidal tendencies.

The coalition was formed in the fall of 1985 by a group of psychotherapists in order to address the problem of sexual exploitation of patients by health care professionals. Our membership is made up

of professionals, consumers, and survivors of abuse by health care professionals. Our goals include educating professionals, survivors of abuse, and consumers about the problem. Secondly, to provide support services for the survivors. And thirdly, to pursue legislation aimed at stopping such abuses. Hence, these four bills are being proposed as a first step to that goal.

With the enactment of these bills, we predict that 50 to 75 percent of all abusing psychotherapists will discontinue these unethical and criminal activities. The remaining 25 to 50 percent should be prosecuted to the fullest extent of the law, expelled from all professional organizations, and never permitted to practice again.

I would like to include in my testimony the following quotes:

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

"I swear by Apollo the physician and by Aesculapius to keep the following oath: I will prescribe for the good of my patients and never do harm to anyone. In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction, and

especially from the pleasures of love with women or men, be they free or slaves," and that is from the Hippocratic oath.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you for your testimony. There are no questions.

MS. BALLENTINE: Okay, shall I proceed?

CHAIRMAN CALTAGIRONE: Yes.

MS. BALLENTINE: I am Barbara Ballentine. I was a victim of therapist-client sexual abuse from 1975 to 1977. Thank you for this opportunity to express my support of these bills today.

I contacted the Pennsylvania Coalition Against Abuse by Professionals in November 1990 to find out what I could do to further my recovery. Although I knew of the Coalition's existence since 1985, I was so imprisoned by fear and shame about my experience of sexual victimization that I could not talk about it until recently.

Here's a brief description of what happened to me, and I have a more complete description of the therapy attached to my testimony on the back, if you're interested.

I went into therapy in 1975. I was in my late twenties. My husband had been out of law school

for a few years and we were considering starting a family. It was a time in my life when it was important for me to be helped to overcome past limitations, anxiety, depression, low self-esteem. I wanted to be guided into a broader arena of life, motherhood, career, greater self-expression. I believed that was the purpose of psychotherapy.

I set aside my own perceptions and judgments and followed my therapist's advise, which I trusted was based on professional knowledge of my best interests. Eventually, part of the therapy consisted of sex in the therapy hour, for which I paid. Two years later, in 1977, I left therapy having lost my marriage, my job, all financial security. What had been occasional anxiety was now overwhelming fear. What had been moderate depression and low self-esteem was now despair and self-hatred with continual suicidal thoughts that would last another eight years.

I discovered that my therapist was an unlicensed entrepreneur and there was nothing I could do either to see justice done for myself or stop him from harming others. The Coalition has information that he exploited 20 more women, breaking up 10 more marriages, some with children, using the exact same modus operandi.

It's still hard for me to understand how that experience could have changed me so much from a person with many interests and talents and every opportunity for a bright future to someone nearly destroyed and living at the lowest survival level of life. Today, at age 44, I am still coming to terms with how extensively damaged I was by that relationship and by my subsequent revictimization by a social environment that blames the victim. I have not recovered what I lost. I live with my injuries. I have not remarried, nor had children. I have spent many thousands of dollars on therapies of all kinds.

The reason I am now able to speak about my experience is that the results of nearly 20 years of research are available to the public in a book by a psychiatrist, Peter Rutter. This research affirms my personal experience. I have begun my own research, which has included phone conversations with the nation's three leading experts on therapist-client sexual abuse. All of them emphasize the need for enlightened legislation such as the bills under consideration today.

I would like to share with you what the researchers have found, because the truth is quite different from what most people believe, and it

confirms the need for these laws.

One myth is that this is a small problem limited to a few less-principled men interacting with a few especially vulnerable women. The truth is that sexual exploitation of professional relationships is epidemic in our society. Dr. Rutter's most conservative estimate is that there are at least several million women in this country who have been sexually victimized by professionals. Officials in more than one State have declared sexual exploitation of professional relationships to be a major public health problem.

Sexual exploitation by men of women under their care or tutelage is not unusual, and in actuality is quite common. Dr. Rutter also found that sexual exploitation is not a special liability of the marginal, barely competent man. In most of the over 1,000 case histories he gathered for his book, the victimizer had been considered an outstanding member of his profession.

Is there a type of woman who becomes sexually involved with her therapist? No, the experts agree. Clients involved sexually with their therapists are not like each other in any classifiable way, and after 15 years' experience working with these clients,

psychologist Gary Schoener has concluded, "If one were searching for the least single predictor as to whether a client and therapist might become sexually involved in a given community, thus far we have only one which would have any predictive value: the name of the therapist."

Why don't we hear more about it? One reason is that the victims tend to be too ashamed or afraid to reveal it, and the percentage of men willing to admit to their own sexual misconduct is minuscule. We also don't hear more about it because of the silence of the victimizer's colleagues.

An article in the American Journal of Psychiatry says, "...the majority of psychiatrists have knowledge of such cases but do not intervene."

An article in the American Psychological Association's newspaper states that a whistleblower in the psychological profession is considered deviant. The author says that whistleblowing in the eyes of one's colleagues is comparable to treason, in that whistleblowing undermines the profession of its claim to independence from external control.

We don't hear more about it because the professional associations suppress the information in order to maintain a favorable public image.

Professional organizations of doctors, therapists, lawyers and clergy rarely make information about sexual misconduct by their members available to the public for fear that the reputation of the profession itself will be damaged. Some professional organizations will get there only by public pressure and by new legislation that mandates disclosure of sexual and ethical misconduct.

As it now stands, many religious organizations simply transfer sexually abusive clergy to other locales, with no public admission of misconduct. Health professionals who are discharged from hospital staffs for unethical behavior can move to another State and set up shop there. They can move to Pennsylvania.

Because most men who sexually exploit women are repeaters, these men are likely to continue sexually exploiting their positions of power. When doctors, therapists and lawyers are sued for sexual misconduct, insurance companies will often pay settlements if the injured woman agrees to maintain secrecy about the incident. These agreements are extremely harmful to the effort to fight against sexual exploitation.

Another misconception is that the victim

is not seriously harmed. Thousands of case studies show that the damage is extremely severe, long-term, affects the victim's family, friends and employers.

The magnitude of damage must be understood in terms of similarities to rape and incest. The emotional currents in human relationships can apply the strongest forces imaginable, especially if the relationship has a parent-child quality to it. Victims experience the pattern of symptoms called rape trauma syndrome - overwhelming depression, fear, guilt, and shame.

A recent finding is that the victims fail to bear children. Dr. Rutter writes, "...although all the women (over 1,000) interviewed for this book have spent years trying to find their way back to recovery from their injuries, not one of them has yet borne a child since her experience..." of sexual victimization."

Add to this damage the professionals' and public's tendency to blame victims. One expert writes, "Patients reporting seduction and sexual intimacy with former therapists have been so consistently disbelieved and blamed by many traditional psychotherapists that they've tended to retreat into self-blame and isolation with their secret."

Another says, "...sexual exploitation of women by therapists was until recently widely considered to be fabricated. If a woman made such a claim, she was often dismissed as having fantasized it, or she was blamed as the alleged seductress." I have encountered similar attitudes in therapists that I've gone to for help since my victimization, and this has been extremely painful and has impeded my recovery.

Add to this the pain to endure if the victim attempts to see justice done. Women who report any of these violations are often subjected to further humiliation and brutalization as they try to enlist the aid of authorities in bringing their victimizers to justice. So the victim is betrayed by the professional she trusted, betrayed again by the silence of his colleagues, and betrayed again by our legal system and social environment to protect the victimizer and blame the victim. Many women never recover, and some commit suicide.

And my comments on the legislation are these:

Clergy should be included in these bills. My psychotherapist was also a minister. Researchers who are knowledgeable in this area believe that the incidence of sexual exploitation among male clergy

exceeds the 10-percent estimate for male psychotherapists. And a therapist who works with sexual abuse victims has found that sexual abuse from a religious representative is especially destructive.

Regarding House Bill 894, this legislation is essential to break the silence that protects the victimizers. A key element in the perpetuation of sexual abuses by professional men is the public silence of their colleagues.

As for fears of false reporting, this is still a minuscule problem compared with the actual abuse by men of professional relationships. It's extremely unlikely that a man who is innocent of sexual exploitation will be found guilty. The problem remains that even men who are guilty almost never have to answer for it.

Regarding House Bill 896, the six-month interval after terminating a therapist-client relationship in order to have sex is too short. Sexual exploitation of relationships of trust is so psychologically similar to a violation of the incest taboo that the rule against sexual intimacy almost always should, as it does for father and daughter, last a lifetime.

Regarding House Bill 897, a 10-year

statute of limitations would be more appropriate. It has taken me 14 years to be able to speak publicly about my experience, and according to the research, it is taking women 10 to 20 years to recover enough to be able to take any action on their own behalf.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you.

Representative Ritter.

REPRESENTATIVE RITTER: Thank you, Mr. Chairman.

Referring to the subject that you brought up of clergy members not being included in the bill, I had circulated to the members of the committee, and I will mention here, that I have prepared an amendment for the time that the bill is going to be before the committee at a regular meeting an amendment that will add social workers and members of the clergy under the definition of psychotherapists for the reasons that you mentioned. I also had circulated to the members of the committee at that time a letter from the Council of Churches which supports that amendment. Reverend Paul Garris from the Council of Churches is here to indicate his support as well.

Now, the only other issue on that particular amendment, while I haven't heard from them

directly, I understand that the Catholic Conference has some objection to that amendment, and before the time that we have a meeting to consider this bill I would hope to hear what those objections might be, because I certainly can't imagine what they might be.

And I do intend to offer the amendment and I do hope that, given the testimony that we've had so far, and I'm sure we'll have the rest of the hearing, on the urgency and the need for this legislation, I would hope that we can schedule this for a meeting very soon so that we can pass this on to the floor. During this time of the year, of course, budget considerations are primary and it might not be something that we can move before the budget is passed, but I would certainly hope that at the first opportunity we can consider the bill to add that amendment.

A second amendment I'm also going to be offering will delete the language "without the patient's knowledge" when it describes administering drugs. That was a suggestion from the Pennsylvania Coalition Against Rape which says that a patient might very well consent to having drugs administered during the treatment for whatever reason, but certainly that doesn't imply any consent to any sexual activity that

would be undertaken while those drugs are in effect. And so at their suggestion I also have an amendment that will remove the language that says -- that requires the drugs to be administered without the patient's knowledge, I believe is the language in the bill.

So I want to thank you both for your testimony, for being willing to come forward and address the need for this type of legislation, and certainly the suggestion that you've made in terms of changes to the bill I think are very valuable.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you.

Questions?

Dave.

REPRESENTATIVE HECKLER: Thank you, Mr. Chairman.

One perhaps somewhat technical provision of the bill that I had picked up on in looking at it, really wasn't sure whether it represented a problem or not, is the definition of psycho -- I believe it's psychotherapy services. It refers to professional services. I'm wondering if you folks have some idea whether to what extent services are provided either on a pro bono basis, as one would expect, for instance,

the relationship with a clergy would be, but even in the case of, for instance, organizations but people who might be employed so that they are paid by an organization but the organization makes their services available to either needy people in the community or just people generally in the community. Are there folks out there at least with whom you are dealing who haven't been in a traditional paying relationship with the abuser?

MS. BACKENSTOSE: I think the answer to that is yes, we have many cases where a client has gone to an organization for services, she or he does not pay directly the therapist but pays at the front desk or something like that or doesn't pay because they can't pay.

REPRESENTATIVE HECKLER: That's what I'm concerned with, the situation where the service may be offered for free either because that particular service is offered traditionally for free or because the organization is essentially charitable in its nature.

MS. BACKENSTOSE: Um-hum. That happens also.

REPRESENTATIVE HECKLER: Okay. Thank you.

CHAIRMAN CALTAGIRONE: Are there any

other questions?

(No response.)

CHAIRMAN CALTAGIRONE: I want to thank you both personally for your fine testimony.

MS. BACKENSTOSE: You're welcome.

CHAIRMAN CALTAGIRONE: Anita Brown. If you would, please, introduce yourself and who you represent for the record.

DR. BROWN: My name is Dr. Anita Brown. I am the President-Elect of the Pennsylvania Psychological Association.

DR. KNEPP: And I am Dr. Samuel Knepp, and I'm Professional Affairs Officer with the Pennsylvania Psychological Association.

DR. BROWN: Good morning.

The Pennsylvania Psychological Association, PPA, which represents 2,600 psychologists across Pennsylvania, welcomes the opportunity to comment on House Bills 894, 895, 896 and 897, which address the issues of sexual exploitation of patients by psychotherapists and health care professionals. PPA had endorsed previous versions of these bills and PPA endorses House Bills 894, 895, 896 and 897 and urges their passage.

PPA supports this legislation because we

care about our patients. We admit, however, that our support has a pragmatic basis as well. This practice tarnishes the reputation of an otherwise public-minded profession. In addition, sexual misconduct accounts for about one-half of the defense and payment costs of the American Professional Agency, which is the primary malpractice carrier for psychologists.

It is with great regret that we acknowledge that a small minority of psychologists sexually exploit their patients. Numerous surveys conducted over the last 15 years have verified anecdotal information that sexual exploitation does occur. These surveys and anecdotes have found that the health care professionals and psychotherapists most often exploit women. Although some researchers believe that the rate of sexual exploitation is decreasing, it is still too common to be ignored.

Furthermore, recent research suggests that sexual exploitation can seriously harm patients. Cases have been documented where the sexual exploitation has precipitated psychiatric hospitalization or even suicide. Because this problem is so important, PPA has carefully reviewed these bills and is commenting on specific topics addressed within them.

Endorsing definition of "former patient." PPA believes that House Bills 896 and 897 have an acceptable definition of "former patient or former client." It is without controversy that sexual relations between current patients and therapists is unethical.

It is more difficult, however, to write legislation that adequately deals with the issue of sexual relations between former patients and therapists. A few argue that the sexual relations between a former patient and therapist can be ethical and appropriate, and that the termination of therapy should eliminate the ban on sexual activity. The problem with this position is that some therapists have been known to terminate therapy with the intent of starting a sexual relationship. In addition, a recently terminated patient may still have strong positive feelings or transference with the therapist and still be vulnerable to their influence.

Others argue that a patient is always a patient; that is, they believe that the status of having been a patient will always prohibit sexual contact between the two parties no matter how much time has elapsed. In balance, it appears that both sides have some merit. Although any specific time line is

arbitrary, the six-month period is probably the best that can be established, and we urge the committee to keep it. We add that the Ethics Committee of the American Psychological Association is in the midst of rewriting the ethics code for psychologists and is struggling with the same issue. We do not know how the issue will be resolved, but we know that they will establish some kind of arbitrary time period within which a psychologist can be disciplined for sexual relations with a former patient.

Endorsing codification of civil liability. House Bill 897 codifies existing common law in regards to the civil liability of psychotherapists who sexually exploit their patients. PPA believes that House Bill 897 contains reasonable provisions that control the admission of evidence into court about the past sexual history of the plaintiff.

Endorsing reporting procedures within House Bill 894. PPA notes with pleasure that House Bill 894 has removed the mandatory reporting provisions found in earlier versions of these bills. PPA believes that the control over confidentiality should rest entirely with the patient. Although confidentiality should be waived in extreme instances, such as when a life is in immediate danger, the assurance of

confidentiality is essential in order for persons to seek treatment.

We are pleased that House Bill 894 has an immunity provision for good faith reports made by psychotherapists who become aware of sexual exploitation. We also believe that the permitted delay found in Section (1)(f) is reasonable and shows sensitivity to the situation of the patient.

Suggesting rehabilitation of impaired professionals. PPA would, however, like to see section 3 of House Bill 894 dealing with automatic revocation of licenses to be amended tso read, "upon a second conviction of a practitioner of the healing arts or psychotherapist." Research on abusing professionals shows that a minority of professionals engage in abusive conduct as a consequence of a mental impairment such as substance abuse or severe depression. Under our proposed amendment, most initial offenders would have their licenses revoked, and repeat offenders would be subject to automatic revocation. Nevertheless, the minority of impaired professionals could be dealt with on an individual basis. We believe that most of these impaired professionals can be rehabilitated through treatment and supervision.

In summary, the Pennsylvania

Psychological Association thanks the House Judiciary Committee for the opportunity to testify in support of House Bills 894, 895, 896 and 897. We believe these bills will protect the public. PPA hopes that the House Judiciary Committee will consider our amendments as an effort to improve the quality of these bills.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you, Doctor.

Do you have any statements that you would care to make?

DR. KNEPP: No.

CHAIRMAN CALTAGIRONE: I must comment on your analysis of the bills and the one amendment that you're urging be put in. I want to clearly understand that you're saying that you're hoping that through some type of rehabilitation that somebody that commits this type of offense should be given a second chance?

DR. BROWN: More so that their license should not be automatically revoked but that under consideration on a case-by-case basis there may be an opportunity through rehabilitation and treatment of that impaired psychologist for them to amend and correct their behaviors.

DR. KNEPP: We believe this would apply to a small minority of the offending psychologists, and

they would still be liable to the same criminal penalties and civil penalties. But the studies on the nature of the offending psychologists show that the majority of those who do it are what we call personality disorders, sociopathic individuals who are not capable of being rehabilitated and should have their licenses revoked. There's a minority, however, who might have an active addiction or severe depression who are otherwise competent, responsible people and with treatment they can be rehabilitated. So this is dealing with just a minority of people covered under these bills.

CHAIRMAN CALTAGIRONE: The problem that I personally have with that is after somebody's had their life completely ruined, a patient or patients, to allow any professional, whoever he or she may be, to continue to practice in that profession allows for additional exposure and possible relapse. I can't say strongly enough that those of us that serve the public in official capacities, we get out of line and we're penalized very severely for it. We're put out of office. And I daresay that the public holds us accountable for that. I think professions, any profession who gets out of line I think should suffer no less a consequence, my own personal opinion. I

think that when somebody's life is completely ruined because of the actions of another person, especially in a profession, they should be made to pay the ultimate price that they never be allowed to practice in that profession again. That's my own personal feeling.

Members have any comments?

Representative Heckler.

REPRESENTATIVE HECKLER: Mr. Chairman, I'd just like to add to your comments.

A couple of us here are lawyers. While the present system of discipline for our profession leaves a good deal to be desired, it would certainly be my view that the fundamental trust which a lawyer bears to his client which tends generally to be of a financial or confidential nature, that if that's breached, a lawyer who steals from a client ought never to practice law again. I can't tell you right now that that's necessarily the case in this Commonwealth, but it certainly should be. And I would think that maintaining a sexual liaison with a patient strikes so at the heart of the fundamental obligation a psychologist or medical professional has to his or her client, or patient I should say, that it is very difficult for me to see a situation in which it would be appropriate that that person, whatever the reasons

for that conduct, be given another opportunity.

Now, I think, and again, I think the reaction you're getting might be an indication to you that at least a number of members of the committee would need to see an awful lot of documentation, for instance from other States, some practical demonstration that in fact this sort of system you're proposing works is appropriate, adequately protects future patients, because my sense would be that while certainly professional education and professional practice is something very substantial to lose, there are certain fundamental transgressions that warrant no second chance.

REPRESENTATIVE REBER: Mr. Chairman?

CHAIRMAN CALTAGIRONE: Representative Reber.

REPRESENTATIVE REBER: I, like Representative Heckler, am an attorney, and I, like Representative Heckler, engage in an adversarial proceeding a lot of times, and I think I would like to give you an opportunity to amplify, if you will, your concern for the second chance, and my thought is this, and correct me if I would be incorrect in this particular hypothetical situation: A practitioner, after a longstanding, bonafide treatment process goes

on with a patient-client, perhaps after a very, very successful treatment this individual comes in to that individual's office, this practitioner's office, and as I read some of the criminal statutes and the definitions contained therein as far as being prohibitive conduct, the practitioner and the patient have established obviously during the treatment process a relationship on a personal basis, and because of some manifested exhibition by the patient that there is a tremendous, what's the word I'm looking for, successful completion of the concerns that were being treated, there is a spontaneous kissing by the doctor, if you will, on the cheek of the patient exhibiting gratification and nothing more than a simple acknowledgement of that, is that prohibitive conduct that could theoretically lead to the removal of that individual on a lifetime basis from practicing? Do you see that? Is that a concern of yours? That type of observation that may be taken out of context by some overzealous prosecutor and, yes, there could be a prima facie case made and there could be a conviction ultimately established and that could lead to -- is that the kind of concern that you're worried about or is it strictly where you do have someone who has some type of disorder, mental or otherwise, that you feel is

totally treatable and ultimately curable?

DR. KNEPP: It's with the latter. It's with people who have actual, verifiable disorders. And I think Representative Heckler has a very good point of the need for documentation, and we didn't bring it with us today but we do have evidence about impaired professionals. And the American Bar Association has been very advanced in treating impaired attorneys and developing programs for them, and actually we're following a lot of their models, and we will bring to the committee some information about impaired psychologists and the treatments that they're working on for them.

REPRESENTATIVE REBER: Okay, my concern was that there wasn't something other than that exact area that you were concerned about and you just referenced?

DR. KNEPP: No, this is for a small minority of people.

REPRESENTATIVE REBER: All right, shifting gears now, that was just a reaction to some of the earlier testimony. It was not really a question that bothered me.

Let me ask you, have you, as an association, taken any type of position in

establishing, and I guess for lack of a better way of putting it, similar to the necessity by the police to give a Miranda warning, if you will, at the immediate outset of arrest procedure, have you established any type of way of requiring practitioners to, at the outset of a treatment, delineate to the individual that if for any reason they feel that there is some violation there is somewhere within the profession elsewhere you can go and not deal with this professional on a one-on-one, and if a false hopes scenario develops, that they could, in essence, pick up a hotline number and contact your association and say that I've had this particular type of treatment, if you will, suggested by professional X. Is this conduct that is a standard and common practice within the industry for the type of problems that I have expressed to him that I am experiencing and seeking treatment for? Have you gone that particular mile to establish any type of way that a person who practices would be required to, in essence, at the outset of the treatment make this known to the patients? And if not, could you develop such an idea that may be incorporated into this?

I'm a firm believer that a lot of times things can be stopped before they get started. It

amazes me that a person could undergo treatment for a number of years and not seek a second opinion. I mean, I was at the doctor's a few weeks ago and got a headache from the medication and I went to anothe doctor and asked him, you know, should I be continuing to take this because the one doctor was saying, don't worry about it, it's a side effect that's known, and it was driving me crazy. It's that type of scenario that bothers me, and is there any suggestion or thought on your part?

DR. BROWN: Although there's no structured mandate from our association that says that therapists should do this kind of a thing, certainly in the process of training clinical psychologists in the profession we talk about such things as advising your clients upfront about a number of various issues, including billing, scheduling, the proper conduct in psychotherapy of both the therapist and the patient, but no, there is no formatted or structured way of doing that. As I said, it's certainly a part of good training of psychotherapists and psychologists.

REPRESENTATIVE REBER: It would almost seem to me that if there appears to be this type of conduct, and I don't want to use the word running rampant but that does exist on more than an isolated

incident or occasion, that you may very well desire some formal requirement, if you will, or maybe we should design some formal requirement that would absolutely and specifically at the outset require this type of admonishment, warning, however you want to characterize it, to be given. It would seem to me that our ultimate goal is not to prosecute, our ultimate goal is to stop the harm from being brought about in the first instance in the legislature, and that's the reason that I move towards that particular type of thought.

If you would have any thoughts on that or would have any ideas that that type of concept could be embodied into any of these and would have any remedial language that you might suggest that would be acceptable, I would be pleased to have you forward that to us for our consideration. Okay? Thank you.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: If there are no further questions, thank you for your testimony.

DR. KNEPP: Thank you.

CHAIRMAN CALTAGIRONE: Dr. Abram Hostetter.

If you would please identify yourself for the record.

DR. HOSTETTER: Good morning. My name is Abram M. Hostetter, M.D. I am a practicing psychiatrist in Hershey, and I am here speaking on behalf of both the Pennsylvania Medical Society and the Psychiatric Physicians of Pennsylvania. In the 1970's, I helped organize the program of the Medical Society for impaired physicians, and I now chair the board which oversees that program, and I also chair the Ethics Committee of the Psychiatric Physicians of Pennsylvania. So I have considerable exposure to the kind of problems your bills address.

Both the Medical Society and the Psychiatric Physicians support the efforts of the Pennsylvania General Assembly to address the problem of inappropriate use of the special relationship between a professional and a patient or client seeking that professional's services to sexually harass or abuse that individual. House Bills 894 through 897 begin a process to bring such practices to light and to investigate the alleged misconduct, taking decisive actions if warranted by the facts. The proposed legislation balances the need for prompt, corrective action with protections for the alleged victim as well as others affected.

The issue of a sexual relationship

between a health care professional and his or her patient has been addressed by most professional associations through their statements of ethical policy. The American Medical Association's House of Delegates, at its interim meeting in 1990, accepted the report of its Council on Ethical and Judicial Affairs on Sexual Misconduct in the Practice of Medicine. That report states that, "sexual conduct which occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being," end quote.

That report cites a number of studies which have tried to establish the incidence of physician-patient sexual contact. Since much of research is based on self reports by physicians, it is likely that the incidence of patient-physician sexual conduct is underreported.

My specialty, psychiatry, has been particularly diligent in examining and analyzing the occurrence of sexual contact with patients. Our

studies indicate that 5 to 10 percent of the survey respondents have reported having sexual contact with patients at some point during their careers. While data is not as readily available for other medical specialties, it is suggested that the percentage is likely comparable.

Sexual contacts with patients can develop in several ways. Physicians may become involved in personal relationships with patients which are concurrent but independent of treatment. Some physicians may use their position to gain sexual access to their patients by representing the sexual contact as part of care or treatment. Others may assault patients who are incompetent or unconscious.

Most physicians so involved regret the sexual contact with their patients, recognizing the actual or potential harm which a sexual relationship poses to a patient. As a result, many seek or are amenable to treatment or rehabilitation which would preclude future misconduct. Initiatives such as the Physicians' Health Programs of the Pennsylvania Medical Society can assist physicians and other health care professionals in obtaining the necessary help to prevent further misconduct.

However, for some physicians and other

professionals inside or outside of the health care professions, sexual misconduct is a conscious, and usually repeated, use of their professional positions in order to use or exploit their patient's vulnerabilities for their own gratification. Most physicians who represent sexual contact to patients as part of treatment would belong in this category. Certainly, self-gratification is the only basis for the behavior of physicians who engage in sexual contact within competent or unconscious patients. It is for the purpose of detection and discipline of such individuals that House Bills 894 to 897 are designed.

House Bill 894 provides for the reporting by a subsequent practitioner or psychotherapist. Unlike previous versions of the legislation, this bill affords the opportunity for the alleged victim and the professional to discuss the allegations and to mutually determine whether and when the alleged victim is willing and able to move forward with the complaint. The bill protects patient confidentiality by providing the alleged victim with the opportunity to provide an informed consent for release of information shared with the subsequent treating professional. It permits the subsequent treating professional to use discretionary judgment as to whether his or her patient or client is

capable of proceeding with the complaint. Such language protects all potential parties to the alleged complaint from unfair abuse.

We would object to any amendment which would return the process to one where the alleged victim would remain anonymous. As previously introduced, the legislation would have required a subsequent treating professional to initiate a complaint without requiring supporting evidence from the alleged victim, thus making the subsequent treating professional the reporting party. Prevented by the professional-patient privilege, the professional could not release information gained from the patient. This would greatly reduce the likelihood of a successful investigation and prosecution and could lead to sanctions and lawsuits against the reporting professional.

Voluntary organizations such as the Medical Society and Psychiatric Physicians have little authority over such illegal practices, however, since the most organizations can do is expel a member disciplined for such action. Likewise, the various State agencies, including professional licensing boards, have had difficulty encouraging parties with knowledge of such activities to come forward. The

requirements of due process and competing civil and criminal proceedings have made the disciplinary process of these agencies less functional. These bills would permit existing voluntary and State agency activities to continue and provide a link with those processes and the criminal investigation system.

Victims of alleged sexual abuse are likewise hesitant to come forward because of the stigma associated with such behavior. They are unaware of the procedures for handling of complaints and often are discouraged from pursuing a complaint by friends, family, and others. Professionals who subsequently come into contact with the individual are placed in the difficult position of having to determine if the allegations are legitimate or a manifestation of the individual's illness, or a dissatisfaction with the services received from the professional against whom the allegations are made. The professional is further hampered by ethical responsibilities to protect the confidentiality of his or her patient or client. These bills make clear the treating professional's responsibilities first to his patient-client, and then to society.

House Bills 895, 896, attempt to draw the distinction between the offenses when transference has

occurred. House Bill 897 provides for civil action in cases of sexual abuse.

I would urge this committee and the General Assembly to consider expanding the provisions of these bills to include all those who, during the course of rendering professional services, have dealings that require the trust and dependence of individuals rendered vulnerable by their circumstances. The bills should include social workers who deal with persons going through coping with issues of life. The legislation should also encompass the practices of accountants, lawyers, the clergy, even stockbrokers. Each of these professionals are placed in situations where they have the opportunity to use their influence to accomplish a desired goal. If that goal is sexual abuse, they fall outside the ethical standards of their professions and should be held accountable.

I am aware of the reluctance to include these additional categories of professionals, but I am also aware of the growing frequency of allegations of such behavior against lawyers, the clergy, and others.

As an example, if a lawyer becomes sexually involved with a client during a divorce proceeding, should he be disbarred? If after the sexual involvement the client wanted to go back to her

husband and the lawyer counseled her professionally that this would not be wise, would he be behaving unethically? If these were the actions of a psychotherapist, where is the difference?

I would also like to offer two suggestions which would clarify this legislation. In House Bill 894, Section 4, page 4, lines 21-22, the language would require the district attorney, upon a conviction, to report the practitioners to the United States Department of Health and Human Services. More correctly, it is the National Practitioners Data Bank within HHS which should receive the report. Since the district attorney may not be familiar with Federal laws dealing with this reporting mechanism, the clarification would be helpful.

The more appropriate alternative is to make reporting the responsibility of the Bureau of Professional and Occupational Affairs, since it is their duty under Federal law to make such reports.

My second suggestion relates to the definition of, quote, "sexual exploitation," unquote, contained in House Bill 897, page 2, lines 13 to 30, and page 3, lines 1 to 19. Specifically, the language on page 3, lines 16 to 19, include as an act of sexual exploitation the observation by a therapist of a

patient or client engaging in self-stimulation. The situation where the therapist engages in such activities in front of the patient or client also occurs and should be included in the definition of the offenses.

I would like to thank the members of this committee for the opportunity to present the views of organized medicine to you.

CHAIRMAN CALTAGIRONE: Thank you.

Do you have a comment?

MR. McCOY: No, I do not.

CHAIRMAN CALTAGIRONE: Questions from the members?

BY REPRESENTATIVE RITTER: (Of Dr. Hostetter)

Q. Thank you, Doctor.

Going back to the issue that had been discussed previously in terms of members of the clergy, what would be your judgment in terms of damage to a victim of this type of activity with a clergy, a member of the clergy, as opposed to a psychotherapist or other covered professions in the bill? Do you see any difference, any reason why clergy should not be included in the bill?

A. No. We believe that clergy who are doing counseling should also be covered by this bill. Now,

there are involvements where the clergyman may not say he is doing counseling and becomes involved with a parishioner, and that's also a violation, we believe, because the person has a trust, a dependency relationship to the clergy and that relationship should not be violated.

Q. So your judgment -- I know you had mentioned in your testimony that you felt the clergy should be included.

A. Yes.

Q. And that's based on your judgment that that sort of relationship between a member of the clergy and a parishioner is the same as a relationship with any other counselor or therapist in terms of the nature of it that would cause the parishioner, the victim, at some point to have a higher degree of trust than in another sort of relationship, is that what you're saying?

A. I would say it is just as damaging as for a psychotherapist to violate the relationship. I have treated women who have had such relationships with clergy and it's very devastating to them not only about their mental health but their religious faith. That's damaged also.

Q. That's the additional aspect of it that I

would see causing losing trust in the religious organization.

A. Right.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Representative Reber.

BY REPRESENTATIVE REBER: (Of Dr. Hostetter)

Q. Doctor, do you find it commonplace that a professional might treat his spouse or her spouse?

A. With medication or counseling or advice?

Q. All of the above or any of the above. And I guess I'm being somewhat unfair because what I'm leading up to is the language in the criminal statutes, "...or within six months of the termination of the relationship." I guess what I'm concerned about is a situation developing where just that type of relationship takes place and the treatment, for whatever reason, successful or otherwise, is concluded, and within that six-month period the people have some kind of conduct or contact that is prohibited under the act or triggers a potential criminal relationship, and I guess to some extent my mind is sparked by the fact that during the six-month period terminating the treatment relationship there may be domestic problems that develop even further, and it's been my experience

at least in domestic cases, anything goes. And there may -- even to the point where some attorneys have vigorously used the criminal process for harassment purposes in a domestic case to extract monetary benefits.

So I guess what I'm getting at is if you tell me that it is not ridiculous for me to consider that a professional might treat his or her spouse, I have some concerns about a potential scenario developing where abuses could be used within that domestic situation, vis-a-vis the statute where we have a licensed professional who falls within the purview of these pieces of legislation.

A. Well, in general, it's very unwise to treat the members of your own family with medication, certainly with surgery, and for formal psychiatric or psychological counseling. You cannot be objective. Therefore, that should not be considered to be within our ethical practice of our profession.

Q. That's unethical? That's considered unethical practice?

A. Well, it's unwise, and there have been charges of unethical behavior brought by members of family against physicians because of treatment relationships.

Q. Let me ask the question in another way. Do you think that I'm overreacting or that the scenario I developed is so absurd or ridiculous that it could not or would not happen?

A. Oh, I think anything can happen, based on my experience.

REPRESENTATIVE REBER: All right.

Thank you, Mr. Chairman.

BY REPRESENTATIVE HECKLER: (Of Dr. Hostetter)

Q. Doctor, you mentioned, and it's a provocative idea that lawyers and accountants and such folks be included in the purview of this legislation. Have you encountered, either in your practice or in the literature of cases of, for instance as you say women involved in divorce situations being taken advantage of by their legal counsel?

A. Yes, I have.

Q. And that has had a similar impact?

A. It probably is a different kind of impact than if the person came for psychotherapy, but it still obviously is devastating for that person to go to a professional for one kind of help and then it turns into a sexual relationship which is harmful and damaging. So yes, there's a lot of harm that comes from that kind of thing.

REPRESENTATIVE HECKLER: Thank you.

REPRESENTATIVE REBER: Mr. Chairman, may I indulge with a follow-up question?

CHAIRMAN CALTAGIRONE: (Indicating in the affirmative.)

BY REPRESENTATIVE REBER: (Of Dr. Hostetter)

Q. I am absolutely intrigued by the legislature always, in its infinite wisdom, taking periods of time out of the air and putting it into a statute. The language I'm speaking about again is "or within six months of the termination of the relationship." I think you're familiar with the phraseology and the portions of the statute, the proposed legislation, I should say, where that appears.

A. Yes.

Q. In your opinion, is that a timeframe that has any plausibility to reality and should in fact be used and looked upon as being sanctum sanctorum for if the conduct appears after six months it is not violative conduct or harmful conduct or a conduct that should be prohibited?

I guess what I'm getting at, is it extremely speculative for us to take a period of time after the termination of a professional relationship and otherwise continue some form of culpability or

criminality to that conduct simply because we determine it to be so, and is that based upon any type of professional standard that you can see or suggest to us?

A. Okay. I've been in arenas where we've argued this. Most psychiatrists would feel two years would be more reasonable, but there are other people who have said at least six months. So, you know, we usually end up, okay, anything that happens within six months is still part of the treatment relationship, and as noted in some other testimony, some people would say if you've had that person in psychotherapy with you, that person is your patient for life. And I have had people come to me 20-some years later to see me again, you see, about some new problem. Well, I didn't consider them a patient during those 20 years but they still saw me as their psychiatrist, and so I personally lean toward not having any involvement with former patients, but from your standpoint you probably can't say for the rest of--

Q. Are you married, Doctor?

A. Yes.

Q. Okay, well, then you share the same concerns I think that I would, too. But there's just something intriguing to me about the freedom of

association and things of that nature, and obviously I'm being the devil's advocate on this and I appreciate the concern and what have you, but it just seems to me that there's something there that just doesn't sit well with me as being arbitrary and to some extent could come back to bite somebody the wrong way.

A. But there probably has to be a timeframe, I would think, and most people would say six months is reasonable.

Q. Well, that's the reason I'm asking it, and I feel better listening to your analysis of a timeframe than potentially that of some of my colleagues, and that's the reason that we want to get it on the record.

MR. McCOY: I think it's also important to remember that these laws also have to be looked at in the context of the spousal rape law and the sexual abuse laws that are there so that if the performance does not fall within the confines of these four bills, you still have the other base of law to deal with.

REPRESENTATIVE REBER: Well, I've always been a firm believer and an individual that's been very comfortable with a lot of the laws that we've had since time immemorial that have, you know, really evolved through the whole common law process and everything

relative thereto, and I always find it somewhat concerning that when we create so-called new causes of action, be they civil or criminal, that we're not also creating a whole other set of discriminatory practices, if you will, and I always like to tread rather slowly when we're moving in that direction.

Thank you, Mr. Chairman.

Thank you, gentlemen.

REPRESENTATIVE HECKLER: One other question, Doctor.

As I look specifically through the various definitions contained in House Bill 897, I confess not to know much about the treatment of sexual dysfunction, but I'm just wondering whether there are any legitimate medical practices which would be potentially infringed upon by this language in terms of appropriately treating folks with sexual dysfunctions and helping them to--

MR. McCOY: I think that's one of the reasons for the phrase, "for the purpose of gratification." Obviously, examination of a breast or other parts of the body are appropriate to certain physicians during the course of their examination. However, if it is proven that the reason for that was for gratification and not for professional reasons,

then that would fall within the definition of this act.

REPRESENTATIVE HECKLER: Well, that term is used in sub--

MR. McCOY: Sub ii?

REPRESENTATIVE HECKLER: Right, or whatever you call that, which has to do with touching. The section--

DR. HOSTETTER: Page 3?

REPRESENTATIVE HECKLER: Right. The section dealing, and I'm trying to find it myself now. Actually, you called it to my attention, Doctor, in terms of the business of observation. Say Section 3, observation by a therapist of a patient engaging in self-stimulation. I don't think that contains what I call sort of a mens rea section. Now, I don't know whether there are situations which could occur that would be legitimate.

DR. HOSTETTER: Nobody has raised that question, and as Don says, when you add the arousal/gratification stimulation qualification to that, to these behaviors, then that's what is the illegal part and not the legitimate examination.

REPRESENTATIVE HECKLER: Well, as I read, again, I'm just looking at this. As I read this, that particular, you know, requirement doesn't apply to

Section 3, so maybe, you know, obviously we're not voting these bills today. I would suggest that your organization take a good look at this. Happily, I haven't engaged in such therapy. I don't know what may be appropriate professional conduct that, you know, that everybody would be comfortable being within proper professional bounds, but I can tell you, at least my opinion, I think factually that that sub (3) language does not include the requirement of, you know, any sexual gratification motive by the practitioner, or for that matter by the patient. That's just strictly a factual if you watch your patient, you know, stimulate those areas you have committed an offense, and it occurs to me that from my limited knowledge there might be situations under which that could be a proper professional thing to do, so.

DR. HOSTETTER: Well, the patient then would be unlikely to make the charge if they understood it. But if they do, one would hope the physician would prevail.

REPRESENTATIVE HECKLER: Well, you're a doctor, I'm a lawyer. I'm telling you as a lawyer, that's not a loose end you want floating around in this legislation. So I would urge that you folks who, you know, I'm sure that's a very difficult and delicate

area and I'm sure that you have professional standards for conduct for what's accepted conduct and what's not accepted conduct, but I suggest that you look at it.

And I'm coming at this also from the standpoint that I, for instance, prosecuted a case involving a hypnotist who wasn't, you know, licensed, there's no structure, as far as I know. I don't know that there still is any structure for hypnotists by themselves or counselors, so that I think when we pass this bill it's important that it include not only the recognized professions but anybody who holds themselves out to the public in any way, shape, or form as someone who I can help you. And that's where we're going to wander into some areas that may be not recognized and in fact are vehemently opposed by your organization but nevertheless are permitted, you know, it isn't a crime to hold yourself out to the public doing these things. I think those folks may need even more supervision than -- in fact, I think they clearly need more supervision than the professions which, you know, while maybe the disciplinary system isn't entirely satisfactory, it certainly serves considerably to govern the members of the profession to weed out wrongdoers. So at any rate, I'd urge an examination of that because I will tell you that that gratification language only applies, as I see

it, to sub 2.

DR. HOSTETTER: Um-hum.

REPRESENTATIVE HECKLER: Thank you.

DR. HOSTETTER: Okay, thank you.

CHAIRMAN CALTAGIRONE: No other questions?

(No response.)

CHAIRMAN CALTAGIRONE: Thank you, gentlemen.

I'd like at this time to call Doctors James Pedigo and S. Michael Plaut, if they would please come forward.

Would you please identify yourself and who you represent for the record, and you can start your testimony.

DR. PEDIGO: I am James M. Pedigo, M.D., and I am Chief Psychiatrist of the Joseph J. Peters Institute. I thank you for your invitation to deliver testimony this morning on House Bills 894 through 897.

The Joseph Peters Institute is a licensed, outpatient psychiatric clinic which exclusively treats sex offenders and victims of sexual abuse. These services were initiated by Dr. Peters in 1955, which makes our agency the oldest of its kind in our community. My involvement with the program goes

back to 1964, initially a staff psychiatrist, providing group treatment for sex offenders. Since 1982, I have been the Chief Psychiatrist of the agency. During my 27 years of involvement with JJPI, I have treated thousands of sex offenders.

The Joseph Peters Institute is located in center city Philadelphia. Annually, we provide psychiatric treatment to more than 200 sex offenders and more than 100 victims of sexual abuse. Of the sex offenders we treat, approximately 100 are inmates of Graterford State Maximum Security Prison. The others are either on parole or probation. In 1986, we started a new program in our agency, the Impaired Professionals Program. Here we treat professionals who have sexually abused those persons whose care was entrusted to them. In this program we also offer treatment to the victims of impaired professionals and to the offenders, spouse or significant other.

As chief psychiatrist at JJPI, I have personally treated more than 25 impaired professionals, coming from a wide variety of professions, such as physicians, dentists, psychologists, teachers, clergy - Protestant as well as Roman Catholic.

We at JJPI strongly believe that sex offenders should be held accountable for their

offenses. We also believe that they are emotionally disturbed persons who need psychiatric treatment. Because of the criminal nature of the sex offense, we support the role of the criminal justice system. Likewise, we recognize the importance of the codes of ethics of the various professional licensing boards and other professional organizations. In the treatment of impaired professionals, we insist on communication with the patient's licensing board or other regulatory body, in addition to the parole or probation board if they're involved.

We have researched the professional organizations which prohibit their members from engaging in sexual behavior with their patients or students. We've learned that all the major psychotherapy organizations, 13 of them, prohibit such sexual involvement. We also found that most of the non-psychotherapy, healing professional organizations do not forbid this behavior. Most don't mention sexual involvement, much less prohibit it. But the psychotherapy organizations all do mention it and all do prohibit it.

Since approximately 6 or 8 percent of therapists anonymously admit this behavior, this is an enormous problem. The great damage done to the victim

by this sexual involvement makes the behavior reprehensible.

We believe that sexual contact with patients or clients is made unethical by the fact of the dependency which the patient develops on the therapist. Psychotherapy is arranged in such a way that dependency is fostered and is almost always an integral part of the treatment. This dependency impairs the judgment of the patient to such an extent that it becomes part of the therapist's task to refrain from exploitation. Thus, patient consent to sexual involvement with the therapist is not a mature, reasoned consent. This leaves the patient in a position similar to that of a child in many ways. Thus, just a child's consent is not adequate to justify adult-child sexual involvement, patient consent is not adequate to justify therapist-patient sexual involvement.

It's our experience that sexual offenders, even more than other offenders, have extreme difficulty in admitting and dealing with their responsibility for their illegal or unethical behavior. They almost never voluntarily submit themselves to treatment. Not only must they be coerced into treatment, they must be mandated to continue their

therapy, or else they leave treatment. Similarly, professionals who engage in sexual behavior with their patients must usually be coerced into treatment. The psychodynamics of these offending therapists are similar to those involved in incest and pedophilia, child sexual abuse. Although the offenders often suffer great remorse concerning their unethical behavior, they are usually incapable of getting themselves to deal maturely with their sexual involvement with these victims. They use many excuses, and unfortunately they believe them.

Although professional organizations do much to insure that their members do not exploit the public, there's been much resistance to their vigorous pursuit in these situations. Frequently, the offending member threatens a lawsuit, frightening the organization, whose officers are almost always volunteering their time and have little desire to subject themselves to a lawsuit. These organizations need the help of the criminal justice system to enforce the compliance of their offending members in engaging in treatment for their offense. The reporting provision of Bill 894 will be extremely helpful in getting these offending members into treatment. Without this requirement and its good faith protection,

colleagues are extremely reluctant to report each other, and are frequently advised by lawyers to avoid filing such reports, despite the fact that some of their codes of ethics require it. Currently, it's very risky for one professional to report another to their mutual organization. These bills would make it easier for the process to be initiated.

Concerning the issue of post-treatment sexual behavior, which has been talked about quite a bit this morning, only one psychotherapy organization prohibits sexual involvement with ex-patients or ex-clients, and that is the American Psychiatric Association. They recently have included in their code of ethics that sexual involvement with ex-patients is, quote, "almost always unethical." They didn't quite go the total distance and say once a patient, always a patient, but they say it's almost always unethical. The other organizations don't mention it.

In our judgment, post-treatment sexual behavior is also exploitive. The primary justification for this belief is that although patients do generally become less dependent on ex-therapists as time goes by, the remaining dependence may impair their judgments for years. Hence, we strongly support House Bills 896 and 897, with some specific recommendations which I will

offer now.

House Bill 894, the reporting act, on page 2, lines 3 and 4, seems to require the reporting of any sexual assault by any practitioner of the healing arts or any psychotherapist, not just those who assault their own patients. Now, thus, if a practitioner or psychotherapist is also the patient of another professional, someone not in his care, this act seems to require the reporting of that. We believe the act was intended to refer to the reporting only of those professionals who assault their own patients and clients and recommend that this be clarified in the act.

In the same bill, page 3, lines 13 through 23, if the patient or client wishes the assault reported but the treating professional judges that, quote, "immediate reporting would be detrimental," closed quote, may the treating professional have the right to delay the reporting? That seems unclear to me. In this case, is the professional obligated even to ask the patient or client if she or he wishes to have the report made? It seems useful to require the professional to inquire about the reporting and to report if the client wishes the reporting to be done, regardless of the professional's judgment that it's too

soon.

Only if both agree to delay the report should it be delayed, and if the patient or client does not wish it reported, it should not be required. That is currently part of this bill.

In the same bill, page 4, lines 1 through 4, upon the conviction of the offending professional, the court is required to, quote, "order the automatic revocation of the license or certification" of the convicted professional. Although this may be the safest way to protect the public, and it may be the most effective punishment, it doesn't seem to us to always be the best way to deal with the situation. By removing motivation, it would most likely prevent rehabilitation. If the license could be restrictive so that the professional could no longer treat those of the same gender as the victim, and if the offender were required to be in supervision and in therapy, with the further requirement that the supervisor and the therapist be required to report to the licensing board or other mandating agency, this would most likely protect the public as well as automatic revocation of the license. It would have the advantage of utilizing the skills of the professional, of providing significant protection to the public, and would provide

incentive for rehabilitation.

It's been my experience in treating these offenders that those who are sexually active with males are not -- do not abuse females sexually, and those who are sexually active with females do not abuse males sexually, so that they are not tempted to cross that gender line and could practice safely with the other gender, as long as they were in treatment and in supervision, and the treating therapist and the supervisor knew of the situation and were required to report it to the licensing board or the mandated body.

Although we believe that there are professionals for whom rehabilitation is unrealistic, we believe there are others for whom it's a realistic goal, and that that option should be available. A minimum time period, such as three to five years, could be specified for the restriction. After that, the board could re-evaluate.

In House Bill 895, the practitioner of the healing arts sexual offenses bill, I would suggest that the wording be changed. It now requires that the drugs or treatment administered be for the purpose of preventing resistance. This means that you have to prove that the administering therapist intended to decrease the resistance by giving the drugs or the

treatment. And if it were changed to read, "the treatment means to be expected to prevent resistance," then you wouldn't have to prove motivation, just that you could get an expert who would say, yes, this treatment means or this drug could be expected to prevent resistance, and this seems to me a much easier thing to prove and a better protection for the patient.

For the same bill, we would also suggest inclusion of a section which prohibits sexual relations between the practitioner and his or her patient during the course of a hospice or hospital visit, regardless of the presence of these drugs or treatment methods which might prevent resistance. It's generally accepted that physicians -- it's unethical for a physician or other practitioner of the healing arts to have a sexual involvement in the office with a patient during a patient visit, or in a hospital with a patient during a patient visit, regardless of the drugs or treatment methods. And so my suggestion would be that you include that for further protection of the public.

In House Bill 897, the psychotherapist sexual exploitation act, on page 2, lines 23 and 24, seems to prevent psychiatrists, who are medical doctors, from what might be a legitimate medical examination, such as checking a patient's tongue for

the side effects of psychotherapeutic drugs. It says any instrument introduced into the oral cavity, or these other cavities, regardless of the purpose violates this sexual statute, and although psychiatrists don't have many legitimate reasons for entering those cavities, that's one that they do have, and it seems to me that that shouldn't be prevented. That's a legitimate need at times, and an exception could be made for legitimate medical purposes.

The same bill requires that an action for sexual exploitation be commenced within five years of the last incident of sexual exploitation. In a situation which the victim was under 18 years, I'd recommend that the 5-year limitation begin with the 18th birthday. For example, a 14-year-old girl who is fondled by her therapist, has her breasts fondled, is typically not mature enough to deal with this openly and not willing to confront the therapist, and so likely within that 5-year period the statute of limitations would expire. She would become 19 and might at that time be mature enough, but many, many aren't. If the statute began at 18, that would mean it would run until she was 23.

Finally, we at the Joseph Peters Institute commend your committee for its efforts to

protect patients from the suffering caused by their sexually abusing therapists and appreciate the opportunity to testify.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you, Doctor.

If we could go right to the next piece of testimony from Dr. Plaut, and that's attached to your agenda. So if you just refer to your agenda, it's the last two pages.

Doctor.

DR. PLAUT: Thank you.

My name is Michael Plaut, and I'm pleased to be invited to testify before you today. I am an Associate Professor at the University of Maryland School of Medicine, where I also teach the sexuality course for the medical students. I am a certified sex therapist, and I am a former chairman of the Board of Examiners of Psychologists in the State of Maryland, which is where I began getting my first experience and concern about this issue.

Since my tenure on the board, which ended in 1985, I have worked in a number of capacities on this issue, including consulting to both patient and licensing boards, testifying at hearings, publishing papers on this area, and so forth.

Rather than read my comments specifically, I would like to present in a less formal way integrating some of the comments that have come up in previous discussions.

I want to say that I'm very pleased by the support of the mental health professions on these bills. I think it is very important to the passage or this kind of legislation that it be a community effort, and I think that's going to make the legislation a lot stronger, the fact that the two major mental health professions at least are supporting the legislation.

I would like to consider each of the bills in turn. I'm going to do them in reverse order because of the nature of my reactions to them.

Starting with 897, I am supportive of the bill regarding a civil cause of action. Taking some of the specific points, I think that the definition of sexual exploitation is a good one. I know that it differs somewhat from the definition in the criminal bills, and I might point out that when we talk about the issue of mandatory revocation, this is the kind of issue that comes up, because there are different levels of sexual contact with people, and the point raised earlier by one of the committee members about professional involvement with one's spouse and what

implications that would have for sexual contact. These are the kinds of innuendoes that require some judgment on the part of an adjudicating body, and I would be reluctant to strip a licensing board of its discretion in making certain exceptions to what might result in a revocation in most instances, so that I think that that should be considered quite carefully.

With regard to the statute of limitations, perhaps picking up on Dr. Pedigo's concern, it might be five years after discovery, rather than five years after the event, but I do agree that a minor child might have difficulty, and even adults sometimes when they are abused in a subtle way by a gynecologist, for example, and it may be some time and after discussion with other patients of the same physician that they realize that something wasn't right in that examination, and I think some time needs to be left for that discovery to occur.

The definition of former patient at six months, I agree that it's a very, very controversial issue. I think six months is a good compromise. What normally happens in these cases is that a therapist who has abused a patient will terminate the therapy because they feel that if the sexual activity begins after therapy has been formally terminated, then it is more

acceptable. Any kind of an interim period would prevent that from occurring with the same impact that it does now. I recently testified in a case where that was a major issue.

I would recommend that it be considered that mandatory reporting to professional agencies be included in the civil bill, just as it is in 894, because there has been a tendency, especially on the part of private attorneys, to encourage patients to bring civil action. Perhaps there is some personal gratification on the part of the attorney in some cases, and I also find that attorneys sometimes are not as aware of the licensing laws as they might be, but what often happens is that even if a civil action is successful, it still does not provide any assurance that future patients will be protected, so that it might be useful to have a mandatory reporting clause in the civil bill.

I wonder also why there is not a companion civil bill which would include professions other than the mental health professions, just as there is in the criminal bill. I just raise that as a question, and perhaps someone could answer that later if that has been considered.

Turning now to the criminal bills, I

think that these, too, are very good bills, especially comparing them with the other 8 or 10 States that have considered this kind of legislation.

I am concerned that nurses are not included. Nurse practitioners are, but nurses are not, and although the occurrence may be very low among nurses, not to include them could suggest sex discrimination, at the very least, and I think it would be wise to include nurses as well.

I am pleased with the suggestion that social workers been included, because they also were omitted, and I want to support strongly the inclusion of pastoral counsel or clergy. Reverend Cole will speak about that later, and the two of us spoke about that. We both serve on a committee with the Episcopal Diocese of Maryland and discussed this issue in that setting.

I might mention from my own experience that when I was on the Board of Examiners, over the 3 years I was on the board I dealt with 12 cases of sexual involvement, patients at various stages, 10 of those involved male perpetrators. Of those 10, 6 were also ordained clergy in addition to being licensed psychologists. Just an indication of how widespread the problem is among the clergy, and I think it's time

that we dealt with it.

It is very important, I think, that the other professions beyond mental health are being included in these bills. One of the things which has prevented this has been an interpretation of sexual contact with patients using a transference model, which comes out of psychoanalytic tradition. Lately, a different type of model has been proposed where rather than looking at transference as a focus, we look at what can or should occur in any fiduciary relationship, any trust-based relationship, and that, of course, could extend to many professions, as has already been pointed out today.

One very good discussion of that is in a newly published book which I've just been asked to review for a psychiatric journal, Sexual Dilemmas for the Helping Professional, by Edlewich and Bronsky. It was published a few years ago. It has been greatly expanded and revised, including many of the legal issues that have come up over the last 10 years or so, and I commend this to you as a further resource.

Another recent book which also deals with the fiduciary relationship in a broad sense is a book edited by Gabbard, G-A-B-B-A-R-D, which came out about two years ago.

One other suggestion I would have with regard to the criminal bills is that in the -- in 895, which relates to non-mental health professionals, that that should also include a definition of patient, which it currently does not. There are times, as was suggested earlier, when someone may prescribe drugs, for example, as a friend to a patient. Is that a professional relationship, even though there's no financial transaction? It muddies the boundaries.

And there's one aspect of a psychology ethics that I might mention which deals with this whole issue of the extent to which one treats a friend or family member. The psychology ethics discussed at length, the issue of dual relationships, that is, it is unethical for a psychologist to engage in a personal relationship with the same person at the same time that he or she is involved in a professional relationship, the boundaries get very muddy and the patient becomes confused as to what a relationship really is.

Turning finally to Bill 894, which requires reporting of sexual offenses, I probably differ from most of the people here in that I am not terribly supportive of the idea of mandatory reporting by subsequent therapists. One concern I have specifically about this bill which has not been brought

up, and I hope I am interpreting this correctly, and that is on page 3, lines 15 to 18, it says that, "he may defer reporting until he believes that reporting the alleged offense will not harm the treatment process or for a period not to exceed one year...."

Now, that implies to me that reporting is required to occur regardless of whether the patient has granted a consent. I don't think that should ever be the case. I think that is a violation of confidentiality, and one of the things I'm very concerned with is that especially in the psychotherapeutic situation, there were reasons the patient was in psychotherapy before the offense occurred, which have to do with perhaps traumatic experiences in her own life before, very often sexual abuse by people in her own life, parents or whatever. That condition still needs to be treated. I would be reluctant, I would hate to see a patient refuse to go for subsequent therapy for that initial concern because of a fear of reporting a sexual offense by a previous therapist. And I think we need to protect the patient in that regard.

In a broader sense, I have a problem with requiring reporting even with a patient's consent. I think if a patient is ready to give consent, she is

ready to report herself. I also agree with Dr. A.A. Stone, who is a forensic psychiatrist, whose paper I have referenced in my written statement, who feels that the therapeutic relationship should not be compromised in the sense that the therapist ever acts as an advocate for the patient outside the therapeutic setting. What he recommends is that the patient be referred to a more objective consultant, whether it's an attorney or another health professional, and I have often served in that capacity where I don't have a therapeutic relationship with a patient or client but I can advise her about avenues that could be taken and ways to go about that, phone numbers, whatever it takes.

I would favor more strongly a bill such as the one passed by California which would require that the therapist or the health provider provide certain information to the patient. And they have prepared a brochure which is distributed by law to patients who report such an offense. And I think that sort of document could be prepared in any State, given the guidelines that have come from other States.

Wisconsin has more of a compromised position in that they require reporting without identifying the patient. That, although it seems like

a more acceptable compromise, may have some other problems, especially if the patient is the only victim of a particular therapist, it could result in harassment from which he would have to be protected, and that, too, could deter her seeking subsequent therapy. So I think we need to be careful about even anonymous reporting, but it is another option.

That pretty much wraps up the specific comments I had on the bills. I would just like to commend this group for continuing to deal head-on with this very difficult issue. I was last here in 1988 when it was considered the last time, and I'm pleased to see the progress since that time, and I wish you all the luck in coming through with legislation which is workable and which helps us to prevent this problem from being as extensive as it has been in the past.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you, Doctor.

Questions?

Mary.

MS. WOOLLEY: Doctor, if I can respond to one of your questions.

Your legitimate criticism of the fact that the one bill kind of doesn't fit in with the rest of the package, the crimes, the offenses committed by

practitioners of the healing arts, that bill in prior session was not a part of this package, and so it was never incorporated and there really is a problem in terms of its drafting and not fitting in with the scheme of the other bills, and that is something we will be looking at. We had an incident in Montgomery County of a neurologist being charged with the rape of a patient, and the inadequacy of our rape statute to facilitate a conviction was a strong concern of the law enforcement community, and that's why we tried to draft that separate piece of legislation, so there is a need to work on it further.

CHAIRMAN CALTAGIRONE: Jim.

BY REPRESENTATIVE GERLACH: (Of Dr. Pedigo)

Q. Dr. Pedigo, sorry to mispronounce that, you indicated at the outset of your testimony that you do treat and have treated other professionals that have been perpetrators of offenses, sexual offenses. Approximately in your experience, how many patients of that nature have you treated or been treated at your institute?

A. Since we started this program about 5 or 6 years ago for impaired professionals, I have treated 25. Prior to that, without separating them from the others, they came to me only when they had violated a

criminal statute and were convicted, not if they had done something unethical but that was not illegal, so of those, probably 10. So 35 over the years probably.

Q. Okay. Based on that treatment experience, have you been able to ascertain what the success rate has been or lack of success rate has been after the treatments have been completed of those individuals you have come in contact with?

A. Good question. And I have a "yes" and "no" answer for it.

About half of those individuals I have judged not currently treatable, that I recommended that they not continue in their profession and that they not -- that they not attempt rehabilitation because I didn't think that would be successful. For the other half where I have recommended that they attempt rehabilitation, those who had been in treatment and had been required to stay in treatment by the mandating bodies, over the five years or so that I have run this program, there have been no instances of recidivism so far as I know. But that's a brief period of time, and what will happen when they leave treatment, as only a few have so far because of the time period, it's something for further research, and I really don't have the answer to that.

Q. Okay. Is there any body of research out there in the profession that deals with the repeat offending or offenses by professionals such as those that you've treated? Is there anything you know of about that?

A. I don't know of anything like that. I don't think there is any significant follow-up with that.

Q. The purpose for my questioning is really dealing with the automatic revocation provision of 894.

A. Yes.

Q. And whether or not it ought to be a permanent revocation or whether although it's an automatic revocation, if there's a conviction under that section, the licensing body for that particular profession may have its own regulations that permit a reapplication for a license even though it had been revoked before.

A. Let me give you a scenario that would be included in automatic revocation that I believe probably should not be. Say that a therapist, a psychotherapist, is in his mid-'40's and going through a divorce, depressed, turned to alcohol at times, has an attractive patient whom he wants, fondles. Now, he's clearly violated, and I think validly these bills

refer to that. So as far as I'm concerned, he's a violator and he needs to be treated, he needs sanctions. He will need for some period of time not to treat women. But I don't know that I would want to say that if this is the only example of his offense that this should prevent him from continuing to practice psychiatry or psychology or social work. So I think there are minimal kinds of offenders who if they aren't sociopathic, if they don't have organic brain damage, if they're not psychotic, if they have things that can be treated can be rehabilitated over time, and I would like the option available for those.

Q. Okay.

DR. PLAUT: If I may, I would like to explore an anecdote which picks up on this. I am currently working on a rehabilitation assignment with a gynecologist in the State of Maryland who was referred to me by the Board of Physician Quality Assurance. He comes from another culture, he was not aware of some of the boundaries that maybe American physicians, although many American physicians aren't either, which is not necessarily an excuse, but he became involved with the kind of person we in the mental health profession would call a borderline patient. He became involved in a brief affair with her outside the practice setting.

She brought a complaint in not because of that initially but because he refused to prescribe drugs that she demanded in return for not blowing the whistle on him. Once the sexual offense was discovered he was disciplined for that but the board determined that his remorse was of the sort that with proper education he would understand the reasons not to become so involved again.

He has been extremely cooperative to the point where just last month he informed me about another offender at the hospital he works at and asked what he could do to help the victim and to report the offense. I think this is another example of the kind of thing that would be very subject to rehabilitation and is not likely to result in any kind of a relapse on the part of the professional.

REPRESENTATIVE GERLACH: So you both are speaking toward a clarification of the automatic revocation provision to not mandate that that automatic revocation constitute a permanent revocation, because there may be instances where a perpetrator might be able to be rehabilitated at some point after a conviction of a particular offense and rejoin the profession that he or she is involved in, is that right?

DR. PLAUT: (Indicating in the affirmative.)

REPRESENTATIVE GERLACH: Is there any way to, on the opposite of that spectrum, be able to predict that if a person is allowed to rejoin the profession that in a certain number of instances or certain percentages or certain scenarios additional harm won't happen later on down the road, and that therefore a permanent revocation, if that were installed, would be a better protection against the consuming public whoever uses those services?

DR. PLAUT: I think it's anybody who has a license revoked can always reapply, even in another State, even though they are supposed to report that, so I don't think that that in and of itself would solve the problem.

I would like to see, I think the professional boards, which are really agencies of the State, are taking this more seriously, and I myself have revoked licenses, even though I've been involved in rehabilitation. I think that if we're going to appoint boards of examiners, we need to support their discretion, and I must say, too, that even though as Ms. Backenstose points out, by self-admission 80 percent of offenders are repeat offenders, I am not

aware of an offense that occurred after a person had been adjudicated. I have never heard of such a case. So I think that needs to be taken into consideration.

I would also prefer, even if we did end up with mandatory revocation, I would prefer that it came out of a licensing statute rather than a criminal statute, because there's another important message there, and that is that it's a message from the profession to the professional that this is indeed taken very seriously, so that where these clauses appear it's also very important to have the professionals themselves see it if they are going to have a deterrent effect.

REPRESENTATIVE GERLACH: Okay, thank you.

CHAIRMAN CALTAGIRONE: No other questions?

(No response.)

CHAIRMAN CALTAGIRONE: Thank you, gentlemen.

We will next turn to Myron Ebersole and Ann Begler, if the two would please come forward.

We will start off with Myron, if you would identify yourself for the record and who you represent.

MR. EBERSOLE: I am Myron Ebersole,

Chaplain and Director of Pastoral Services at the University Hospital of the Milton S. Hershey Medical Center at Hershey, Pennsylvania. Inasmuch as neither the University Hospital nor the Medical Center itself has taken an official position on these bills, I appear as an individual and to lend my support for their adoption, and I want to urge in addition the inclusion of clergy and religious practitioners in the professional groups to which the bills apply. I am also a member of the Board of the Central Pennsylvania Coalition Against Abuse by Professionals.

Among other professional associations, I am an ordained minister of some 30 years, a certified supervisor of the Association for Clinical Pastoral Education, a Fellow in the College of Chaplains. I'm a clinical member of the American Association of Marriage and Family Therapists, and in these contexts have provided marriage counseling as well as individual counseling to many couples, and including clergy couples, a portion of whom have experienced a range of sexual difficulties and sex offenses.

I am going to, since my paper is too extensive to read here, I am going to reduce and refer to only particular parts of it.

In the second part of the paper I speak

in support of the House Bills 894 through 897 and would support many of the things that have already been said, rather would not like to take the time here to read over material which has essentially been already spoken to.

I would like to go to page 3, where I speak to a recommendation that the bills be amended to include clergy and pastoral care specialists. I am pleased that that is already being considered and will be considered in the future. And if I may read briefly.

Now I should like to add my support of the bills as written, a strong recommendation that they be amended to include clergy and religious practitioners of all faith groups, including ordained and commissioned leaders in the local parish or congregation. Further, I would urge the inclusion of those who function in specialized ministry, including pastoral counselors, pastoral psychotherapists, supervisors, and teachers of such specialized ministers, and the chaplains in health care institutions, institutions for the developmentally disabled, and prisons.

And now if I may turn to page number 4, it is to be admitted that it is difficult, if not

impossible, to secure accurate statistical representation of the incidence of such misconduct by clergy. However, it is well known to mental health practitioners, as well as religious leaders, that the incidence has increased and is becoming a major concern in the religious communities, and I might add as in society as a whole. One knowledgeable church official estimates that the number of clergy who become involved in this issue at some point in their careers is at least 10 percent. In most instances, this involves male clergy with female parishioners or counselees. It has also been suggested that slightly under 2 percent of female practitioners have been involved in sexual offenses. There are numerous instances which also involve children.

I draw attention to one person who has become nationally known in this area in the middle paragraph on page 4, the Reverend Marie Fortune, the author of, "Is Nothing Sacred? When Sex Invades the Pastoral Relationship." She has written a number of other books and articles that are reliable resources in terms of the incidence and the problems related to sexual acts by the clergy.

She cites, the last sentence in that paragraph, four areas in which sexual encounters

violate ethical pastoral conduct: The violation of the role, misuse of authority and power, taking advantage of vulnerability, and absence of meaningful consent.

While full discussion is not possible here, religious professionals are called to function in ways defined by specific standards as well as the expectations of their religious communities and of society generally. Sexual contacts signify a lover role which is widely divergent from the pastoral role. Because the pastoral role carries with it significant authority and power related to training, experience, charisma, and so on, it is a misuse of the pastoral identity and office to persuade any person seeking help to engage in sexual relationships. The latter is closely related to the vulnerability of the one seeking help relative to the person's position as well as the crisis for which help is sought. The religious community is called to express compassion and support for the sojourners, widows, orphans and others of inferior status and vulnerability. Religious leaders who exploit such relationships for their own sexual gratification violate the basic tenets for which their communities are founded. Finally, meaningful consent to sexual activity requires a context of mutuality, equality, and absence of coercion which is not possible

in such relationships due to the imbalance of power and differences in role.

Again, while it is not possible to fully discuss here the implications, there are other factors which must be mentioned. Pastors and pastoral counselors, because of their role in the religious community, are dynamically similar to parent figures. It is the expectation of parishioners and counselees that they will be protected during their times of vulnerability. Though the latter are adults, they rightly expect the pastor and the counselor to protect them from their sexual impulses, as do children in relation to siblings and parents.

The psychological and spiritual impact of sexual misconduct is devastating to the victims and to the religious community. This is especially true in that those seeking help often suffer from low self-esteem and/or depression related to the crises of their lives. While they may be flattered and encouraged by the attention given in a sexual relationship, they are also aware that they are being denied the pastoral assistance for which they came to the pastoral figure. They are often further victimized by their fear of the effects of accusing or blaming the pastor due to his or her power and wide respect in the

community.

Beyond this psychological bind, the pain, anger and confusion takes on cosmic proportions as the victim experiences betrayal by the very person who represents God. More than the destructiveness of one trusted individual, this breach makes it difficult to trust any other persons or community or one's existential experience in the world. Indeed, how, in the light of such betrayal, can one trust God or the divine power?

The dilemmas created by sexual abuse by clergy and pastoral practitioners in the fields named above must be met by practices consistent with the principles of the religious communities. This calls for compassion and for the goals of healing, forgiveness and restoration for both the victim and the perpetrator. This concern must, however, I suggest, give priority to the victim of sexual offenses of pastoral leaders.

Beyond that primary concern, the pastoral leaders and practitioners also deserve just and fair treatment and opportunity for forgiveness and restoration. Some examples may demonstrate the difficulty of that task, and I give several illustrations here which I will not take the time to

read, but in the instances given, unfortunately none of those people who have been treated have responded very effectively.

Now, the next to the last paragraph. While it is difficult to measure the effectiveness of the treatment of people who have engaged in such behavior, it is known that the recovery rate of child sexual molesters is extremely low, probably less than 5 percent. Though generalizations on such behavior or such responses are dangerous, it must be noted that the repetitive behavior often represents characterological disorders in people who do not respond to treatment and are often poorly motivated to change. Others have spoken more effectively and with more authority to the nature of character disorders, personality disorders, and so on.

The church has, in keeping with its own standards of compassion, been concerned with the careers of clergy with histories of misconduct. It is important, however, that consideration be given also to the responsibility to potential future victims. While the church or religious community can set limits and frequently remove them from ministry in their own denomination, it is important that these people know that if they do not respect appropriate behavioral

boundaries, they will be prosecuted by the State law. The inclusion of clergy and religious professionals under the same legal constraints as those which apply to the practitioners of the healing arts and psychotherapists, as outlined in the aforementioned House Bills, will do much to restrain the misconduct of such individuals and will provide support to the leaders in the religious communities in the enforcement of their codes of ethical practice of ministry.

Thank you, Mr. Chairman, members of the committee. I would be glad to answer any questions.

CHAIRMAN CALTAGIRONE: I would like to have Attorney Begler go next, and then we will open for questions.

MS. BEGLER: Thank you, Mr. Chairman, members of the committee. I am very honored to appear today on behalf of the Pennsylvania Coalition Against Rape acting as their legal counsel. Rather than reading my written comments that are quite extensive, I would ask that you formally make all of my written comments part of the official record, and I will just try to address several provisions of the bills that you're proposing in a way that I hope will be helpful.

By way of background, my career in working with victims of sexual assault started about 16

years ago when I first became an attorney and I worked in the Crimes Persons Unit in the Office of the District Attorney of Allegheny County prosecuting numbers of cases involving a variety of different kinds of sexual offenses. I had also clerked for a number of years earlier in my career in a Court of Common Pleas of Allegheny County where I spent an extensive period of time in the civil division, so that, along with my general practice, makes me quite familiar with the court system and the adversarial process and how victims are affected in that process. I also have worked for the past 10 or 12 years with rape crisis centers in Allegheny County and across the State primarily on issues related to confidentiality and other issues that are emerging, and most recently for the past several years as legal counsel for the statewide coalition.

Along with being an attorney, I have 4 years of training in gestalt therapy and 2 years of training in body work, and 10 years of experience as a mediator, so there are a wide range of places that my profession has been touched by these issues. I also have worked most recently with a range of mental health professionals in Allegheny County who are attempting to begin a task force in the area of sexual abuse by

profession.

I think what strikes me most, before I talk about the bills, is just the incredible vulnerability these particular victims bring to us not as therapists but as legal counsel. In my office we're involved in a number of cases that involve if not direct sexual abuse by professionals, the violation of a number of other kinds of boundary issues that involve things like dual relationships. We find, as testimony prior to mine has indicated, that a number of the clients who come to us and a number of the victims of this kind of assault are also adult survivors of child sexual abuse, so that what happens for this particular client, and I'll speak in terms of "she" for this purpose but there certainly are males who are abused in this process. But what often happens for this particular kind of client is that she's suffering not only the trauma of this particular abuse and betrayal, but also an exacerbation of trauma that existed from early childhood, and what happens with this particular kind of abuse is that it seems to replicate those incidents which occurred for her when she was a child, because we're really not talking about sexual misconduct, we're really talking about an abuse of power and betrayals by one who is certainly more

powerful and in a more powerful position.

The cases are very, very difficult to approach. As legal counsel, I have to say that these clients are difficult to work with because they come to us as other professionals, after having just been abused by a person who has been a professional, and so the relationship is one that's very -- that has to be handled very carefully, where communication has to be very clear. We're often faced with these cases having clients who have no funds, who come expecting to have cases handled on a contingency basis, who have no finances to hire the kinds of experts who are needed in this area to prepare for trial and for litigation. I can tell you that the range of costs for experts to assist in this kind of litigation is incredible. We have one case in our office we're handing that involves negligence in the treatment of hypnotherapy where the national expert we talked to charges $400 an hour and $4,000 a day.

I say that because I think it's important to realize that the legislation is critical, and in drafting and passing legislation we have to have legislation that recognizes the incredible cost to the victim financially and the kind of hostile environment that's created in the adversarial process, and we have

to try to create legislation that is as supportive as possible.

With regard to the particular bills that are proposed, I had one question primarily with regard to House Bill 894 which I think could stand some clarification, and that's an incident where someone is a client of a particular therapist and she makes a revelation about abuse by a prior therapist. There is some disagreement about reporting, and then for whatever reason therapy is terminated, then a year passes where the patient or the client would request that a report be made but the therapist thinks that reporting would be adverse to the client, so it's a situation that falls within that ambit of where reporting is detrimental or the passage of a year, whichever first occurs.

In a typical situation, if therapy continues, I think what the bill provides is that if I were a therapist and the client said to me, I want you to report, in the exercise of my discretion I thought that would be detrimental, I chose not to do so, a year passes, I have to report anyway. But what if that person is no longer my client? What if somewhere in that one-year period therapy is terminated and at month 3 I had been requested to report and I made a choice

not to do so in the exercise of my professional judgment, therapy ends in month 4, and then month 13 comes and that person is no longer a client, it's unclear to me as to whether or not an obligation still exists.

I'm also very supportive of other testimony that's been given with regard to other types of health care professionals and other sorts of professionals. It seems to me that there is a wide gap, as you addressed, with regard to the criminal legislation in that it differs so greatly and does not cover just basically sexual activity that occurs between other kinds of health care professionals or other sorts of professionals like clergy, or sadly to say attorneys, and their clients, and I think that it really should be a goal of the committee to expand the criminal legislation so that we're not talking with regard to healing arts practitioners, just about conduct that involves the administering of drugs or other treatment but does involve sexual activity of a variety of kinds. I think that bill also needs to provide that consent is not a defense, as it does in the bill dealing with psychotherapists, and as Representative Ritter addressed the issue of knowledge is also an important one that you look at and that you

omit.

With regard to House Bill 896, I would suggest that the six-month statute of limitation perio after treatment, both in 896 and 897, is too short. And while I know that this is an ongoing dialogue among a number of professional organizations, my reading really reveals that there is a strong inclination on the part of a lot of associations and organizations to go beyond the six-month period, and what we find in our practice is that those psychotherapists or professionals who are inclined to become sexually involved with their clients and patients are the same professionals who are also inclined to create other kinds of dual relationships, whether it be taking a person who has been a client and making her an employee, making her a supervisor, making her a co-therapist in some context, and so it would be very easy to avoid the intent of this bill, which doesn't address other kinds of dual relationships by having, for instance, a psychotherapist who didn't become involved sexually with a client, take that client and have her become an employee for a period of time. Where there's an ongoing kind of relationship that would violate certain ethical standards set by professional standards set by professional standards

set by professional associations such as the American Psychological Association, and then after that period of time become involved with that client sexually.

I also find from working in this area as a private practitioner that that psychotherapeutic relationship extends long beyond termination of treatment, and I think you would be very remiss to think that a six-month period is really a sufficient length of time for someone who has been so vulnerable, so dependent in that psychotherapeutic relationship to always make a clear choice. And it would be our recommendation that you seriously consider a two-year period as an appropriate time after termination if there is to be any time period at all.

The other matter I want to address was the 5-year statute of limitations, and that we would wholly support with regard to victims who are under the age of 18 the statute clearly not beginning until the 18th birthday. I would also suggest that you attempt to codify in some way utilization of the discovery rule. This has been an ongoing issue in the courts in Pennsylvania with regard to issues related to child sexual abuse where we really don't have any case law yet, but it's certainly emerging in a number of other States. I think it would be important to attempt to

codify in some way that the statute of limitations begins when the incident occurs when a victim first remembers that incident, or even from the time upon which that victim is first mentally able to take some type of legal action.

One of the great costs that's involved in this area of litigation as well as in that litigation that involves adult survivors of child sexual abuse is trying to prove that the discovery rule should even be applicable. So not only do victims need a wide range of professional expertise to deal with the standards and breach of standards of care that deal with the abuse, but then you need this other wide range of experts who can help you deal with just the discovery rule and when a person remembered or was capable of filing suit. And I think that codification would at least remove that issue to some degree from the court and would be a clear enunciation from this body about your intent.

Which leads me to one other thing that I think needs to be looked at, and that is in the definitional section of 897 where you went to great length to identify certain body parts. The kissing or intentional touching of body parts. I mean, I just have to note that there are certain body parts that

you've omitted. Like what makes it violative to touch the thigh as opposed to the calf or the foot? And nothing really covers the touching of the neck. And I say that because I think that you might consider removing all of that language and just talking about any intentional touching that's done for the purpose of sexual gratification. I say that after having struggled for 12 years at the appellate level in this court system several times with the court attempting to understand what this body meant when it crafted legislation regarding issues of confidentiality, and the court, for whatever reason, has been taking a very conservative approach in the statutory construction of statutes related to areas involving sexual assault. And so I could see several disputes arising wherein the courts had to decide whether or not this body intended kissing that didn't involve some intrusion into the oral part of the mouth as something that violates this statute, and the courts taking a very, very strict approach in constructing this statute, and I think that we don't want the issues to be tainted that way because we don't want that to be where the fight really is.

The other thing I have to say is that you addressed in your comments the attempt on the part of the insurance industry to limit insurance coverage in

this area that involves sexual exploitation, and while that's certainly not part of the legislation as it stands, I would encourage you to seriously consider legislation that would not allow that to happen, that would deal directly with the insurance industry's attempt to limit coverage in this area, because again, I have to say that if the legislation is here to be preventive, as with many other areas of the law, it only is going to be preventive if someone has to pay some costs. And there just is not often enough a pot to go to, which means that people can't find lawyers because they can't pay on an hourly basis. We're talking very much, even though we know how pervasive the problem is, about cutting edge legislation. Very difficult to think about handling, and we have got to create some resources for victims in order for the legislation to really, really be effective.

Thank you very much.

CHAIRMAN CALTAGIRONE: Karen.

REPRESENTATIVE RITTER: I have a question for each of you, two different questions, I guess.

First, Attorney Begler, in terms of confidentiality, you have a lot of experience in that area, obviously. The bill requires the patient's consent to reveal this information that's discussed in

therapy, and it has this one-year limitation which I agree, and I don't know if you've mentioned it specifically, but I believe that that one-year limitation should be removed and that there shouldn't be any reporting requirement unless the patient consents, whether it's a year later or two years later, whatever.

Now, my question is, in terms of confidentiality and in terms of the amendment that I have suggested or that has been suggested by others to include the clergy in this, how does this confidentiality law affect the confessional relationship that would exist in the Catholic church specifically, and in other churches I'm sure as well have the same considerations. If the bill requires that a parishioner in that case would consent to the revealing of this information and if there's no provision that it needs to be revealed without that consent, how does that apply?

MS. BEGLER: I don't think the privilege statutes are affected as long as there's consent on the part of the victim. Because all of the privilege statutes have a provision, whether embodied in the statute or through evolution of case law, that the person who is the client holds that privilege and has

the right to waive that privilege.

I read the statute a little differently. I didn't think that the statute required as written reporting after a one-year period unless at that time the victim also consented. What I thought the statute meant and intended was that where the client says to the psychotherapist, I want you to report, and the psychotherapist says, no, I don't think you're ready, I don't think you can really appreciate the kinds of ramifications that might come from reporting, I won't do it. That the psychotherapist can take that position for a one-year period, but at that point it clearly becomes the choice of the client and reporting must occur.

REPRESENTATIVE RITTER: Well, I would agree with that interpretation and maybe that would be the amendment would be to clarify that the reporting is never done without the consent, is that what you're saying?

MS. BEGLER: Well, that's what I think. Now, I think this statute means that, yes, that you never report without consent.

REPRESENTATIVE RITTER: Right.

MS. BEGLER: But with consent you must report after a period of a year. But I would also say,

I wouldn't say this on behalf of the Coalition because I don't think the Coalition has taken this position--

REPRESENTATIVE RITTER: No, I'm just asking you as an attorney what your interpretation would be.

MS. BEGLER: But I would also say as an attorney who has become very sensitive to abuse by psychotherapists and other professionals around other kinds of boundary issues that I also have some concern about mixing up that relationship and having any kind of reporting requirement. Because I think that there is some truth to some potential harm that exists where a client, if I were a psychotherapist and a client comes to me and I hear about prior abuse, at any time I become involved in an advocacy role for that client, I now have changed the boundary that existed and that was intended when that client first came to me. And, you know, I always talk with mental health professionals about why they are so geared up to go to court and testify for clients, you know, because I tell them often when your client wants you to testify and you think you're going to be helpful, you don't know what your client will experience when you're sitting on a witness stand. You know, you can be on a witness stand and have a piece of spinach caught in your tooth and

your mouth looks funny and the client thinks it's because of something the client did, and I think that those dynamics are really, really fragile. And so I have to say that I'm torn myself about whether or not I think reporting should ever be required, even when the client wants it, because I'm not sure the client can always appreciate at that stage and at that level how fragile that boundary is and what can happen when it's crossed.

REPRESENTATIVE RITTER: I see your point on that. That is something we'll probably have to look at a little more closely.

I was just concerned in terms of, and the question I wanted to address to Reverend Ebersole has to do with freedom of religion and government interfering in that activity and what's your opinion of this particular, this amendment that I want to offer which would include the clergy in this bill? Do you feel that that in some way violates, you know, your right to practice your religion? Is that some governmental interference do you think that's inappropriate? I mean, obviously you think it's appropriate. You're asking for it.

REVEREND EBERSOLE: Yes.

REPRESENTATIVE RITTER: But I would like

your opinion as a religious--

REVEREND EBERSOLE: I have given some thought to that because I have been aware that people have raised that kind of objection. I wonder how far such concern would go in exempting clergy from observation of other laws, and it seems to me that the same thing applies. I can see no reason for exempting clergy on the basis that you're suggesting is considered by some.

REPRESENTATIVE RITTER: And do you have an opinion, as a religious professional, the same question that I asked Attorney Begler as an attorney, regarding the confession relationship, if there is permission given or consent granted by the parishioner to reveal this information, do you feel that that in any way is violative of that type of relationship?

REVEREND EBERSOLE: I do think that the confessional is a significant boundary which should be protected. If permission is given, I believe that most clergy would, -- well, I should not speak for most, but I believe that it would be in order for clergy to participate in reporting that would help to set the limits that we have so much difficulty setting.

My own preference would be that clergy functioning with people who have suffered this kind of

abuse would in some way assist those people in their reporting rather than take the responsibility of being the reporter.

REPRESENTATIVE RITTER: Okay.

REVEREND EBERSOLE: But that is not a--

REPRESENTATIVE RITTER: And that's similar to what you were suggesting as well, it seems.

MS. BEGLER: Yeah. I think the other thing that is true is that any time we deal with waivers or we deal with consent, we're talking about consent that's given freely and voluntarily, and, I mean, the thing that we have to be cautious about is making sure that that consent is really coming from the client, and, I mean, just like in the area of confidentiality that we've been dealing with with rape crisis centers, sometimes it's easier to try to get somebody to consent than it is to think about going through five years of litigation. And so it's always a struggle not to do that, and I can imagine that there will be psychotherapists who will be very invested, for whatever reason, in having a client make a report, and we don't want to have a situation where clients are pressured to consent so that reporting can happen. I think it's a fragile area and however much we struggle I don't think we can ever get away from the fragility

that's really there because it's just the nature of the relationship.

REPRESENTATIVE RITTER: How would you, if the language would change somehow to require that the offending professional, whatever profession, would be required to assist the client, patient, parishioner, inmate from not reporting himself or herself, what my concern is that then we're taking away some of the leverage we have against this subsequent professional who is hearing about the abuse by a previous professional, what leverage do we have over that person to make sure that in fact they are not using their position to protect the other?

MS. BEGLER: I don't think we ever have -- I think we can draft anything we want and we're just not going to have that assurance.

REPRESENTATIVE RITTER: So even with the language the way it is, putting the reporting requirement on the professional doesn't really guarantee that that's going to not occur?

MS. BEGLER: I don't think so.

REPRESENTATIVE RITTER: And you would agree?

REVEREND EBERSOLE: I agree.

REPRESENTATIVE RITTER: Thank you.

REPRESENTATIVE HECKLER: Just a question or two for Ms. Begler.

BY REPRESENTATIVE HECKLER: (Of Ms. Begler)

Q. I think in line with what Representative Ritter has just indicated, you heard testimony, I believe, earlier about a California statute which simply requires the delivery of a form to the victim. Does that strike you as a possible appropriate way in which to maintain the boundaries of the relationship?

A. Yeah, it does, as does I think as the possible referral to an outside consultant, not necessarily an attorney but an outside psychologist who can help someone go through an ethics process, you know, with the Pennsylvania Psychological Association or whatever organization might be appropriate. And I do know of instances where those referrals have been made, where a treating therapist has said, this can't be my job. I'm your therapist, but I'm going to refer you to X and go talk about this situation in the context of ethics.

Q. Well, this body of bills has evolved, as you're probably aware, from what I think initially a couple of years ago was really an ill-considered kind of reporting requirement, even -- well, reporting requirement which I think violated professional

confidentiality requirements to what I hope will be one which empowers victims and encourages victims to take appropriate action but keeps the focus where it ought to be, which is on the public entities, the licensing and prosecutorial agencies who should be there and should be prepared to respond when a complaint is made, but that I think the closer we stick to the traditional model of a victim making a complaint on an appropriate public authority and then that authority being certainly geared to take the proper investigative and prosecutorial action is appropriate.

To get to another point, we have both been prosecutors at one time or another. I hear what you're saying about six months being too short a period of time in terms of the termination of the professional relationship. I wonder, however, in criminal matters, juries are the ultimate arbiters of what's a crime and what isn't, and I just wonder whether you think it's realistic to say in all cases, and again, that's what we're doing with a criminal statute, if we extend this to a year or two years, that in every case where somebody who had a professional relationship subsequently has a romantic relationship, has sexual relations with a former patient, that that's a crime, a very serious crime, and we're going to prosecute that.

I just wonder, practically speaking, whether we're not handing prosecutors another hot one, that they are going to have to try and evade by plea bargaining, ARD, you know.

A. I think that it would be unreasonable to think that there wouldn't be some time limit and that this would be open ended. And I think that for another reason. I mean, I think the reality is that we hope, through providing therapy, that clients become empowered and become whole human beings and heal from those traumas they've suffered, and so I don't think that I would even want to see legislation, and I don't think professional organizations would support it, that didn't at some point in time recognize that a client is a person who can make a choice about her life or his life. I think the question is what period of time, and I just think a six-month period is very, very short in the context, the kinds of relationships we're talking about.

Q. Well, again, and--

A. It will always be arbitrary.

Q. Yeah.

A. I mean, the time period you pick will always be arbitrary. I just think that six months isn't sufficient.

Q. And again, the concern, I suppose, that I have, we have this illusion up here that when we pass, especially criminal statutes, the world just starts rotating in a different direction immediately, and, you know, my concern is, A, there are folks out there who have to actually prosecute cases brought under these statutes; and B, that we have to draw lines between what is clearly such outrageous behavior that it deserves a criminal sanction and that behavior which we could all probably take a poll and in this room agree is torrid, inappropriate, inadvisable, but is not necessarily going to look like criminal behavior when a jury has to consider.

The final point on which I suspect we will differ, I want to explore with you a little bit this business of insurance exclusions and say upfront I favor medical malpractice reform. I don't view the civil Bar as an appropriate guardian of the well-being of society. I view them as largely rapacious, self-interested folks who are -- who obviously want to have deep pockets available to them but primarily for their own economic aggrandizement, and I'm concerned that, you know, insurance is a collective means of protection. I think we agree, no matter how much more widespread and underreported this conduct is, that it's

certainly limited to a small minority or a relative minority, let's say, of practitioners in any of these fields. If we mandate that insurance companies can't provide an exclusion, then we're saying that no matter how appropriate I conduct myself as a professional, I'm going to be paying increasingly steep malpractice coverage fees, again to provide coverage for this minority of folks who, as far as I'm concerned if they harm somebody deserve to lose their house.

A. I guess I don't think that's necessarily true, because I don't think that we'll see an increase in litigation just because we've tried to regulate the insurance industry in that way in cases that don't merit litigation, and that would really be the only way there would be increased costs, I think, because, you know, victims aren't going to go through this kind of an adversarial process and through five years of civil litigation and issues being resolved in the appellate courts if these aren't real issues, and I think the dilemma we face is that unless we can try to create some way of funding, whether it's by creating some type of regulation over the insurance industry, maybe it's at some point expanding the Victims Compensation Fund to include some kind of pain and suffering damage. I mean, I don't really know. What I do know is that

victims can't afford to hire attorneys to handle these cases at rates ranging anywhere from $60 to $300 an hour. They can't afford to hire experts, and if we're not going to find some way to create some resources and we're going to allow the insurance industry to inhibit the availability of resources, then what good is the legislation? I mean, I think it's very problematic.

Q. Well, again, I'm more inclined where criminal conduct has been involved to see the criminal justice system as the appropriate venue. I believe both of the criminal bills provide for restitution. Don't you think that's at least a significant measure and appropriate?

A. Depending on what restitution means and how collectible it is and whether it's ever paid. I mean, I know lots of criminal cases where restitution is ordered and the criminal clerk of courts is sitting around with a lot of bills waiting to figure out how to collect.

Q. Well, I hear you, but I think that -- and frankly, it's, as far as I'm concerned, abusive behavior by our profession which has led to the problems we see in so many other areas of litigation, from product liability to whatever. I, for one, would be loathe to guarantee that there be a deep pocket out

there, especially given the highly inflammatory nature of these charges, whether or not founded, and the difficulty of proof, you know. Medical malpractice case, you've probably got X-rays, you've got some kind of tangible evidence that at least experts can argue about. Here, you know, this isn't a case with many sex offenses, and one of the problems with prosecuting them and deal with them, you're largely talking about oath on oath, at least in many cases, and corroborative evidence is tough to come by. I just have some concern.

A. I just don't see that you're going to see members of the Bar having an ability to encourage clients to undergo and take on this kind of litigation where there aren't real issues. I just don't think this is an area. This is not like being in an automobile accident. It's not like being in the hospital and being a victim of medical malpractice. I mean, there isn't anyone who wants to go through depositions related to this kind of conduct. It's very, very hard for these kinds of clients to even think about suing a psychotherapist because the client is very, very protective of that relationship and very protective of that person to start with, and I just don't see clients of the Bar being vulnerable to that

kind of insistence.

Now, if I might, there was one other thing I wanted to mention, and that had to do with the discovery and admissibility of evidence section where you provide in the statute what is something tantamount to the rape shield law and then you try to give the courts discretion to determine what's relevant about the past sexual history of this particular kind of victim, and I guess an issue I wanted to raise is why is that ever relevant when it's not an issue that's first raised by the plaintiff in a case?

I mean, I could imagine that if the plaintiff makes an allegation that there's some kind of sexual dysfunction that was caused by this particular trauma it would be relevant to explore whether or not that particular plaintiff ever suffered sexual dysfunction before, but other than where that's raised as an issue in a claim for damages by the plaintiff, I don't see the relevance as to past sexual conduct, particularly where it didn't involve this person prior to the psychotherapeutic relationship.

And again, I want to say that I have great concern about the way the courts are dealing with issues involving sexual assault, and I think that now we're going to put victims through in camera

proceedings, determinations as to issues of relevancy with regard to past sexual history that has nothing to do with this particular psychotherapist or professional, where the plaintiff has never made a claim about any sexual dysfunction, and I think that, again, that's really causing the victim to go through unnecessary hostility and an adversarial process that really shouldn't be necessary because it shouldn't be an issue in these cases, and I suggest that that's something that would be worth rethinking. I just don't trust the courts to deal with this issue.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Karen.

REPRESENTATIVE RITTER: Yeah. I thought of another question I wanted to ask. I guess maybe both of you with different viewpoints.

Currently, the law requires reporting by certain professionals of evidence they find of child abuse. How would this type of reporting requirement relate to that? In other words, these professionals, if they see evidence, are required to report it, and I would assume that, I don't remember now, does the law apply to clergy members as well? How does that compare to what this bill is requiring and how does it also relate to the aspect of a confessional again? Is

there--

MS. BEGLER: I'm not sure I understand what you're asking.

REPRESENTATIVE RITTER: Well, this bill is going to put some new reporting requirements for certain -- this is going to require reporting of testimony from the victim that this crime occurred, whereas that I guess also requires evidence that the crime did occur, whether or not the victim has discussed it. I mean--

MS. BEGLER: Well, the Child Protective Services statute requires particular kinds of professionals to mandatorily report if they have a reasonable basis to believe, based on the exercise of their professional judgment, that there has been child sexual assault, which I think is very different from this kind of reporting requirement. I don't see them as being related.

REPRESENTATIVE RITTER: Okay.

REVEREND EBERSOLE: It seems to me that you raise an important issue, at least in terms of the logic of the development of the requirement of clergy reporting. I must say that the reporting in relation to child abuse often places the clergy in a spot where they are not, because of their reporting, able to

provide support to other members of the family when they may be the only advocates for that family, of which the abuse is really a symptom of many other problems in which they do need help. So I think there's not an easy problem to solve here. I guess my own feeling is that one still needs to give priority to the care of the victim over the perpetrator.

REPRESENTATIVE RITTER: And so you would see this, these sets of bills that we're discussing now, as being in a similar, you know, that it's a difficult situation, but that--

REVEREND EBERSOLE: Difficult, yes.

REPRESENTATIVE RITTER: --but the victim needs to be protected.

Thank you.

CHAIRMAN CALTAGIRONE: Thank you. Thank you both.

MS. BEGLER: Thank you.

CHAIRMAN CALTAGIRONE: I'd like to next call the Reverend Carol Cole Flanagan, and Attorney JoAnn Clough. If you would please present yourself and identify yourself.

At this time I have to exit. I have a meeting with the Attorney General and the Chairman of Appropriations, and I'd like to turn the remainder part

of the hearing over to Representative Heckler, if you don't mind.

(Whereupon, Representative Heckler assumed the Chair.)

ACTING CHAIRMAN HECKLER: Okay, if we could resume. I thank everybody for their patience.

It is my understanding that Reverend Flanagan, who is the next listed witness, is enroute from Baltimore, so that we will proceed at this point with Ms. JoAnn Clough, who is the Chief Counsel for the Coalition Against Abuse by Professionals.

MS. CLOUGH: I would first like to apologize. I don't have my written statement here, but our copier at our office jammed at around 9:15 this morning and I'm not adept at how to fix it when it gets jammed in the portion it did, so I'll send those up to you. I'm not going to really read from my written statement anyhow.

I would just like to start by saying, in 1985 I initially became involved in forming the Central Pennsylvania Coalition Against Abuse by Professionals when I was asked to speak at a predecessor group of that organization about legal rights and legal avenues available to victims, and we met at Holy Spirit Hospital one evening and there were a number of victims

that showed up of this type of abuse to listen to the comments of the numerous people that were speaking, and as the only lawyer on the panel, as frequently happens I find myself not mentioning what I do for a living at cocktail parties, I was really shocked at the outrage and the anger from the victims in the group and their questions directed at me about the inadequacies of our legal system to handle these type of abuse problems. And since before that specific evening I had never dealt with a client who had been through this abuse, I had done some research and was ordered by a superior to go and give a speech on the topic. Since then I became very actively involved in the Coalition and in trying to make some changes in the law and represent victims who have been through this process.

I do practice civil law, and I am not the type of attorney, and I don't think the other attorney who spoke earlier, Ann, was either, who thinks we're going to get rich on cases like this. We don't get anywhere on most of our cases like this because our legal system is so horrendous in helping people or providing an avenue of relief available.

There's three ways these clients can basically go. One is administrative, if the type of person that abuses them this way happens to be

licensed, which a lot of them aren't. And I have my own feelings, which isn't in the legislation here today, about the terrible inadequacies of that process. I have had clients injected with drugs, rendered unconscious, raped, and four years later, after four separate investigative offices of the licensure board recommended prosecution, that doctor still is treating patients without anybody even interviewing them or disrupting his daily practice. I don't think that avenue works most times, even when they are licensed.

The second is criminal, and as you know, being a prosecutor, it's hard enough to take a date rape case through under our rape statutes. It is virtually impossible to convince a district attorney to take one of these cases forward, when the judge is going to be duty bound to instruct them on our current crime statutes in Pennsylvania. Try to explain to a jury of 12 people that a female patient could actually make a pass at her therapist, chiropractor, doctor, or whoever you end up including in these bills, and then have that person be criminally responsible for it. They'll never understand that under the current law because you have to get around that consent issue and you have to do it with expert testimony, like some of the physicians you've had in here today testifying. We

need a statute in Pennsylvania that specifically says, if that psychotherapist or that health care practitioner, that clergyman, has sexual contact with that patient, sex is the crime. We don't even get into the issue if there is any consent involved. It has to be statutory, otherwise it can never be understood by a jury under our current laws the way they are written.

In the past six years, I have dealt with more than 10 clients that have been abused. Some are abused by optometrists while being fitted for contact lenses. That girl testified here four years ago. I don't know if you remember her. She was 14 when it happened. At age 16 she underwent a criminal trial. The man was acquitted. She then went to a licensure board hearing where four other victims came forward and testified to identical sexual abuse and the hearing officer found that while he personally believed he probably was a pedophile, he really had some sincere doubts that these patients actually would have continued to go to this man for eye treatment when they had been sexually molested because he, a law school professor, couldn't understand this problem. Couldn't understand the way it happens enough to these victims to find fault there.

I have had a number of clients that were

abused by clergymen. Until we have enough courage to make our statutes say this is illegal criminal conduct, the professionals out there are all policing themselves, and they're doing a terrible job of it. A recent client of mine, after 12 years of sexual abuse by a priest, finally went, took her a lot of courage, she had left the church, she finally went back to a church to report the offender. He said he'd have to talk to the Bishop about what to do about it. He came back to her and told her if she could simply go through an annulment of a marriage she had happened to be divorced from he was sure she could again take God into her heart and the church would accept her back and she should just put this abuse behind her. That was the advice she was given by going to that organization to handle that problem. And we, as a society, don't help these people handle that any better when we don't even recognize this behavior as criminal on our books.

I've had people abused by general practitioners, by nurses in facilities that take it upon themselves to give psychotherapy when they're not even on staff to do that and sexually abuse people, then they're caught in this gray land - where do they go? These cases never get criminally prosecuted unless there's a string of victims. The neurosurgeon case -

there is a string of victims. The dentists, there have been some in Lancaster and some other cities. The police will go after them if they have a string of victims, but the sole victim, and they are usually not the sole victim but they are the one bravest enough to come forward and try to do something about it, or finally able enough to do it, has no recourse under our criminal process without these laws.

I'd like to comment on a couple of things that were talked about here this morning. First of all, the six-month termination of patient relationship. I also feel that has to be expanded. I understand the problem. It's tough enough, and it still will be even if we get this legislation passed, to prosecute people under these statutes because you're going to always have the proof problem, did the sex take place? But I would urge a two-year section on that, too, mainly because most people don't even come to see me until many, many more than two years after the incident has occurred. They are psychologically incapable, through the victimization, of even taking that step to talk to anybody yet. And I think that a lot of the victims out there need a longer than six-month cooling off period. Plus, it's not only in there for a cooling off period. Doctors use it as a cooling off period. Then you will

be in a huge litigation when that patient-therapist relationship stopped. Many clients don't keep regular therapy appointments. They are in and out of therapy. They may make regular appointments, they may not be able to afford regular appointments. So, you know, you're going to find yourself as prosecutors litigating this six-month issue in those cases. Maybe they only went 3 times in the past 2 1/2 years, then they went 7 months later. Maybe there was longer than a six-month gap before that. I don't think that's sufficient to say that was a former patient.

I would also urge that you don't fall to pressure from lobbying groups or other of your co-workers in the House or the Senate to change the 5-year statute of limitation in a civil case. Many, many, many of my clients that have come to see me come to see me after five years from when this happened. It is extremely difficult for victims of this type of abuse to take any action to help themselves, especially because it involves going to another professional. I do a lot of divorce work, and I have a lot of very difficult divorce clients. My most difficult divorce clients are a picnic compared to most of my victims that I have helped in sexual abuse cases because their trust in a professional has been shattered to the point

that they are so suspicious of their own attorney, their own new therapist, everybody that they come in contact with, it's very difficult for them to take any action, and I think you really have to have a 5-year statute of limitations on this type of a civil situation.

I also believe that we need to expand the discovery portion for the statute of limitations, too. A number of my clients have repressed the sexual abuse, especially if it happened when they were children. At least when they're children you can extend the statute of limitations to their majority age, but sometimes they suppress it and frequently don't remember it until maybe after a first divorce and they start going to therapy. Maybe they were sexually abused as a child, then they start going to a therapist or a doctor who repeats the behavior to them, they suppress that, too, and they literally don't remember it until later. Those cases are very difficult to prosecute, but I believe they should be entitled to have their statute of time begin to run when they realize they were abused.

And there are some cases. There's one in Rhode Island, some incest cases where two attorneys, they were successful in defeating preliminary

objections because two adult women remembered in adulthood their father's sexual abuse of them, and I think we can get a lot of guidance in drafting some of these laws from some case law in some of the incest cases, because we don't have a whole huge field of these therapist abuse cases to look at to research.

I also think it's imperative that you have the patient's consent before you report. I would love the name of every single one of these people reported somewhere so everybody could check. And every meeting I go to, I tend to be the only lawyer, even when I was on a national talk show on this, one lady said, I have a question for you, the lawyer. Why don't you just give us the name of the doctor that did this to your client? Well, then I, the lawyer part of me kicks in, and the same problems professionals have in reporting on each other, oh, my gosh, what about the liability if this person turns around and sues us for saying this? Because the type of people that do this abuse are egotistical enough to do that. They firmly believe they're not going to get caught and they would turn around and sue or bring actions against people for falsely reporting them.

And the problem is extremely widespread across the United States. My involvement with it

though in central Pennsylvania, just the number of cases I have seen here in the last five years is unbelievable. I get calls from all over the country from lawyers that find out my name through somebody who knew my name through somebody to talk about this issue, and I think lawyers are beginning to become more aware about it, but the legislature has to take the step, particularly with the criminal bill, to get this on the books. Then you don't have to spend the first two or three days of a civil trial educating the jury and the judge why this behavior is illegal. You'll already have it a law on the books. Maybe the victim never elected to go forward or went forward with the criminal process, but at least we can show that this behavior is not only unethical in the profession itself but it's criminally prohibitive, and it's a starting point for victims to go forward civilly.

I have my own concerns about the civil bill. I don't like to take sometimes common law things and codify them because I think the insurance industry and other interests have a way of weaseling in amendments to that process. I helped try to draft a civil bill about four or five years ago when we initially introduced them here and I had trouble with that, so I'm kind of torn as a lawyer that maybe we

should leave it alone, but you have Common Pleas courts that don't really recognize a common law action against certain types of people for this. In Lebanon County a few years ago there was a victim of prison abuse with clergymen and the judge threw it out and said he did not think that was actionable in Pennsylvania. There's a lot of discussion I know around a lot of divorce lawyers whether it's actionable to sue your divorce lawyer for being sexually involved with you.

And so, there's good parts to making a civil law to specifically state it out, but you have to be careful that you don't limit the rights that are already out there because they aren't enough. And definitely in my practice the people I've seen, it's almost worse for them after victimized when they come forward and they attempt to take a step that the justice system just shuts down on them. They don't get criminal relief, they don't get civil relief most of the time. There aren't a lot of lawyers out there that are willing to take these cases. I think there's a lot of lawyers out there that would still advise these people there isn't a case. They don't even understand it enough to know that there could be one. People aren't -- civil Bar is not getting rich on cases like this. Occasionally there are some big verdicts you see

against churches where they have taken a known abuser and moved him to another parish and not warned the people, or a therapist where, you know, his practice knew he had abused a prior patient and he still had other patients seeing him and he abused the second one. It's always the second, third, or fourth known victim that makes out in cases like this, but people need help.

And I also believe most of my victims do not pick the civil route and the monetary route. Most of them will be most happy if the person stopped treating other patients and if somebody stood on the steps of the Capitol or the courthouse and said, yes, he did this to them. They don't want the money. The money is the only thing we're able to get them sometimes, unfortunately, and it's always with a secrecy clause. Two cases I settled in the last three years were for large amounts of money, and they were with secrecy clauses. One of my clients had a complete mental breakdown about two months after she signed it because it wasn't what she wanted. She got it, but it wasn't what she wanted, and that doctor has never missed a single day, except the day he signed the settlement agreement, of practice because of what he did to her. And it's kind of embarrassing as a lawyer

to have to explain to victims that there isn't too much to do, but the criminal statute is extremely necessary because district attorneys' hands are tied about them. They can't go after these people without that law. But I encourage that we add clergy and other significant professionals to it as well.

ACTING CHAIRMAN HECKLER: Thank you very much.

I would suspect, just my perception of human nature, that the vindication, the open finding that this event has occurred and obviously the appropriate condemnation for it would be a part of the healing experience for them and, you know, I thank you for your testimony, and hopefully we will be moving forward promptly, particularly with the criminal bills.

MS. CLOUGH: I mean, you can do more against these doctors if they steal their patient's money or do Medicare or insurance fraud on their claims than if they sexually molest them in their office, and the patient then pays them for that session, and there's something very wrong with a society that has their criminal law structured that way. We have to fix that.

ACTING CHAIRMAN HECKLER: Thank you. Thank you very much, and we will look forward to your

written testimony when you submit it.

MS. CLOUGH: Thank you.

ACTING CHAIRMAN HECKLER: I believe that our next witness is indeed with us at this point.

Reverend Flanagan?

REVEREND FLANAGAN: Yes.

ACTING CHAIRMAN HECKLER: Great. Thank you for being with us today.

REVEREND FLANAGAN: Thank you for asking me.

My name is Carol Cole Flanagan. I am a parish priest of the Episcopal Church, and I am the Vicar of the Church of the Holy Evangelists. And my purpose in being here today is to ask that members of the clergy be added to the list of non-licensed professionals covered by this proposed legislation and to ask that the protection that it offers victims be strengthened in two respects.

I ask that the legislation include clergy because over the past 10 years I have seen more victims of sexual misconduct by clergy than for any other single cause in my ministry. The people who have confided these experiences probably number in excess of two dozen, although I don't generally document pastoral conversations.

One person I am currently seeing is a teenage woman, three have been men, and the balance have been adult women. Some of them have been abused by clergy as adults, some as children or adolescents. Many are lay members of congregations, but more than a third I would estimate are now members of the clergy themselves. Some of these are people who were exploited during the canonical process which leads to ordination by seminary faculty members, by supervising clergy, clinical pastoral education supervisors, and others.

One victim survivor is a former Roman Catholic nun who was abused by a priest. Some have experienced sexual harassment and were able to extricate themselves before they were really victimized, but most were not. Some were able to recognize the exploitation only years after it happened, with the help of therapy.

The Episcopal Church is currently awakening to the seriousness of the phenomenon and to the history of churches generally in maintaining silence, in ostracizing and blaming victims, and in protecting offenders. There is now a movement within our denomination and in others to break the silence and to fashion a response which is more in keeping with the

gospel that we're called to proclaim.

Last October, with the support of my bishop, I attended a training conference for bishops and other clergy in Minneapolis, together with a male colleague, and as a result, this past April we held a two-day conference for the clergy of our diocese to raise their consciousness and to begin educating ourselves in the pastoral care of victims, but also in the patterns of our training, our lifestyles, and our ministries which make clergy particularly at risk for sexual boundary violations.

In addition, I serve on a diocesan task force on human sexuality which will be continuing to work in the area of continuing education and in the training of victim advocates to assist victims in becoming survivors.

What clergy share in common with the other professionals mentioned in the legislation is that our relationships often contain the same power differential, and people come and seek our advice and counsel at times in their lives when they are frequently most vulnerable. It is crucial to the church and to society, I think, that those relationships be safe from abuse and betrayal.

The power held by clergy comes in part

from our training, credentials, skills, and congregational leadership. Another layer of power is added by the fact that we live in a society in which most clergy are still male and most victims are still female. Women in churches are expected generally to acquiesce to male clergy and to adapt to meet clergy expectations.

The power differential can take on larger than life expectations because the priest can always threaten to leave the relationship, and whether or not that threat is ever spoken, the person in need of help lives with the fear of abandonment. Further, because the power of clergy is legitimized by the church and institutionalized within it, it can be virtually impossible for a parishioner or congregant to overcome. Within the confines of the church, we sometimes hold considerable moral and spiritual authority and represent not simply the church but God.

We are learning that sexual exploitation by clergy has many similarities to incest and that clergy victims are not uncommonly survivors of incest. Like children of incest, vulnerable adults struggle to make sense of what is happening to them, and the internal monologue is very similar: This must be okay, he's a priest; he knows what's best for me and I don't

right now; he has my best interest at heart; there must be some reason for this that I'm just not capable of understanding yet; he represents God and knows God's will for me better than I do.

Because of the power differential, vulnerable adults, like children of incest, may be incapable of withholding consent. The cost of saying no is the loss of the pastoral relationship, in some cases the loss of self-esteem or reputation, the loss of the church and its network of relationships, and for some people finally estrangement from God.

As a member of the clergy, I think we need to be accountable for the manner in which we use the power of our office and for the setting and maintaining of boundaries, which is always the responsibility of the one in power.

Along with several other denominations, the Episcopal Church is currently working to provide pastoral support and justice for victims and survivors to identify, remove, and treat offenders, to care for the families and congregations affected by clergy misconduct, and to develop strategies for education and prevention. To include members of the clergy in this legislation would strengthen the movement which is already underway in the churches.

At the outset, I mentioned that there are two ways in which I would like to see this legislation strengthened. First, what is proposed would ask me to report an incidence of sexual exploitation with the written consent of the victim, and here I'm looking at House Bill 894, Section 2, subsection (f). If the victim does not consent, reporting may be delayed one year. My concern is that disclosure always carries the risk of revictimizing the victim. So if we are to provide support for victims, I think that the victim needs to have the right to determine when that information is disclosed.

It also means that in order to protect victims, professionals are likely to avoid asking the crucial questions about misconduct and exploitation so as not to trap the victim or to break trust with the victim in terms of reporting.

The teenager I am currently seeing was lied to, manipulated and assaulted by a psychiatrist one year ago. She was sexually exploited by a priest six months ago when she came to me. Having been twice betrayed, she is currently unwilling to risk therapy again, which she knows, I believe, that she needs. If I were required to obtain her consent within one year of learning of her abuse, I think she's not likely to

give it. Disclosure for her in this instance would mean the end of her relationship with her parents, from whom she's already estranged. It would estrange her relationships with church members loyal to her clergy abuser and polarize the congregation which she sees as her only real means of support at the moment.

I think she needs therapy before she takes those risks, and I think it's going to be much more than one year before she'll be willing to risk therapy again.

To protect and strengthen the safety of professional relationships, I would hope that you could delete the one-year requirement for reporting and allow the victim to determine what the duration of confidentiality is.

The second area in which I would like to see the proposed legislation strengthened concerns the statute of limitations, and here I'm looking at House Bill 897, Section 6. In it's current form, a report may be made within five years of the last incidence of exploitation. Many victims, as you probably have heard, especially children and adolescents, do not recall the abuse or recognize its damage until many years after it's occurred. While adult women sometimes know that their sexuality makes them vulnerable to

sexual offenses, the same is not generally true of children and adolescents, and it is also, interestingly, not true of men. They often will be injured and not know how to name what occurred to them because they don't think that sexual exploitation is a crime that can happen to men.

One individual, for instance, that I'm seeing at the moment who was abused as a child and again as a young woman is in therapy 30 years after the fact, and this has gone on and off for most of her life, and she's now in her mid-'50s.

Five years from the last incidence of exploitation I think is probably not of much use to survivors. I do understand that a growing number of States are using a discovery of injury rule so that the statute of limitations begins when the individual discovers the damage done however many years later and then has five to seven years from discovery to report the offense. This is a much stronger provision, I think, and one which takes a more realistic account of the post-trauma progress.

To summarize, I encourage the inclusion of clergy among the non-licensed professionals covered by this legislation, and I believe it will be strengthened by giving victim survivors the right to

determine when to report, by requiring the written consent in all cases, and by basing the statute of limitations on a discovery of injury rule rather than on the basis of the last incidence of exploitation.

Thank you.

ACTING CHAIRMAN HECKLER: Thank you very much.

Some of the testimony we have heard earlier this morning, in fact some of it specifically from Dr. Plaut, a fellow Marylander, mentioned the California statute as a model we might consider. Apparently, their procedures involve the subsequent professional who would encounter a victim of abuse providing a form and essentially making a referral to an appropriate public agency, whether it be the local prosecutor or whoever, and in appropriate cases referring to a neutral non-treating professional who could advise dispassionately without being in a therapeutic relationship. I think a number of us who heard that testimony and in some subsequent discussion with other witnesses think that may be a better way to go than the bill as presently drafted. What would your thoughts be?

REVEREND FLANAGAN: Yeah, I think that's probably stronger, too. I'm not as familiar with the

California bill as Michael is, but, yeah, that sounds to me like better protection for the victim. Yeah.

ACTING CHAIRMAN HECKLER: I think it seemed to us at least to address the dual concerns of one tampering with or disturbing what may be a very delicate relationship between the practitioner and the person who has previously been victimized, and of course it does put the victim in complete control.

REVEREND FLANAGAN: Right.

ACTING CHAIRMAN HECKLER: I mean, obviously, if he or she chooses not to fill out the form and make a report, that's something that's within his or her control.

REVEREND FLANAGAN: Um-hum. I think that's stronger, especially because I think victims feel as though they've been rendered totally powerless in the course of the exploitation. So I think we don't want to make them powerless again. We want to leave them whatever power we can, I think.

ACTING CHAIRMAN HECKLER: I would think that it would be more favorable from the professional standpoint in that you're now giving objective advice about action which the client or patient can or can't take, will or won't take, depending on their decisionmaking power, so that you can, without being

implicated either from the standpoint of potential liability, you or your motivations, you can be in the same posture as to that matter as I presume you would be as to all of the other matters of like that you would be.

REVEREND FLANAGAN: Right.

ACTING CHAIRMAN HECKLER: Or that can help a person.

REVEREND FLANAGAN: Agreed.

ACTING CHAIRMAN HECKLER: Well, thank you very much.

REVEREND FLANAGAN: Thank you.

ACTING CHAIRMAN HECKLER: And I believe that we are adjourned.

(Whereupon, the proceedings were concluded at 1:25 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause, and that this is a true and correct transcript of the same.

Ann-Marie P. Sweeney

ANN-MARIE P. SWEENEY

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