Profiles of impaired health professionals

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There are numerous studies that describe the characteristics of impaired health professionals and the types of professional misconduct leading to licensing board action. These studies have two fundamental limitations. The first is the sampling procedure, and the second is that they typically do not examine health professionals who are currently in treatment. This study describes the problems that lead health professionals—comprising psychiatrists, nonpsychiatric physicians, psychologists and social workers—to seek treatment and the sources of referral for treatment. A total of 334 health professionals were studied who sought out an evaluation or treatment at The Menninger Clinic between 1985 and 2000. The findings indicated that the participants' therapist was the largest referral source and that the most commonly cited problems leading to referral were marital and emotional difficulties rather than substance abuse, boundary violations, or prescribing problems. Licensing and regulatory agencies can take proactive steps to identify professionals with social and emotional vulnerabilities who may be at greater risk for unethical and negligent behavior. (Bulletin of the Menninger Clinic, 68[1], 60-72)

Numerous studies describe the characteristics of impaired or distressed health professionals, including psychiatrists, nonpsychiatric physicians, psychologists, and social workers, and the types of professional misconduct, including boundary violations, substance abuse, negligence, and personal or work factors, that lead to licensing board action (Dehlendorf & Wolfe, 1998; Enbom & Thomas, 1997; Hughes, Baldwin, Sheehan, Conard, & Storr, 1992; Mahoney, 1997; Morrison & Wickersham, 1998; Neukrag, Milliken, & Walden, 2001; Pope, 1993; Reamer, 1992; Sherman, 1996; Thoreson, Miller, & Krauskopf, 1989).

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The data gathered from these studies emerge primarily from two sources: licensing board summary statistics and self-report questionnaires that are randomly mailed out and returned on a voluntary basis. For example, two recent studies focused on physicians disciplined by state medical boards and physicians disciplined for sex-related offenses (Dehlendorf & Wolfe, 1998; Morrison & Wickersham, 1998). In a study of 375 physicians in California, Dehlendorf and Wolfe (1998) found that the largest source of physician discipline was negligence or incompetence, followed by alcohol/drug use. In the Morrison and Wickersham study, sex-related offenses were reported as rising from 1989 to 1996, and physicians in the specialties of psychiatry, child psychiatry, obstetrics, gynecology, and general practice were more likely to be disciplined.

Studies describing the level of impairment and distress in psychologists often involve self-report questionnaires that are mailed out to licensed psychologists from a national database, such as a specialty division within the American Psychological Association. The questionnaires are returned on an anonymous and voluntary basis. Sherman and Thelan (1998) found that relationship problems, particularly divorce and major personal illness or injury, caused the most distress and impairment while work restrictions imposed by managed care and malpractice claims were particularly troublesome. Sherman (1996) reported that distress and impairment may be observed in the clinician's depressed or anxious moods, physical complaints, confusion, and helplessness.

The data and information from these studies and many like them are invaluable because they provide critical information about the precipitating factors and environmental situations that lead to distress, impairment, physician health program involvement, and possible licensing board action. These studies summarize the difficulties encountered by health professionals, such as depression, marital-relational conflict, and work-related problems, that can interfere with and impede professional functioning. The results of these studies have led to the creation of preventive education measures and to the identification of potential high-risk clusters of health professionals. That is, particular profiles have been identified, such as a physician or psychologist in a certain age group who is experiencing high levels of work stress and marital problems and who may be prone to impairment, such as a boundary violation or substance abuse.

However, although these studies provide valuable information, they have two fundamental limitations. The first is the sampling procedure. A questionnaire, for example, may be mailed to 1,000 psychologists belonging to a specific affiliation within the American Psychological Association. Focusing on one group or organization limits the

generalizability of the findings. A related limitation is that those who respond to the questionnaires are self-selected and may represent a specific group that is not representative of the discipline or profession. Licensing boards attend only to those problems reported to the board and thus may miss important data for those health professionals in treatment or for those never reported to a licensing board or physician health program. A second limitation is that these studies typically do not examine health professionals who are currently in outpatient or inpatient treatment and thus may miss data on what prompts health professionals to seek psychiatric or psychological treatments. There may be, for example, a large group of health professionals who are in treatment but are not included in studies because they do not receive questionnaires or are not followed by a licensing board.

One study surveyed 800 psychologists to identify, among many aspects, whether they were in treatment, what prompted them to seek treatment, their view of the helpfulness or unhelpfulness of treatment, and whether psychotherapy was seen as an important part of training or graduate school (Pope & Tabachnick, 1994). The researchers reported a 60% response rate, and the respondents indicated that a major area of focus during their treatment was related to depression or general unhappiness followed by marital problems and divorce. The most often cited benefits of therapy were increased self-awareness, self-understanding, self-esteem, and improved skill as a therapist. Of particular interest was that 70% of the respondents said "absolutely yes" or "probably" to answer the question of whether personal therapy should be required in graduate school for students training to be therapists. Eighty-seven percent said "absolutely yes" or "probably" to whether licensing boards should be able to require therapists who have violated professional standards to obtain therapy as a condition of their continuing or resuming practice.

In this article, we report on a study that had two goals. The first goal was to describe the problems that lead health professionals to seek treatment. The second goal was to identify the sources of referral for treatment. We hope to understand who refers health professionals for treatment and the types of problems that lead these professionals to treatment.

METHOD

Participants

Participants were health professionals operationalized as psychiatrist, nonpsychiatric physician, or other mental health professional (psychologist, social worker, psychiatric nurse) seeking an evaluation and/or treatment at The Menninger Clinic Outpatient, Inpatient, and

Residential Treatment Programs between 1985 and 2000. Demographic data were collected at the time of admission while the referral source and specific reason for seeking treatment were recorded by chart review.

Procedure

Three raters systematically and independently reviewed participants' charts, including the Triage Note completed by the Admissions Office, collateral information received prior to and during treatment detailing past psychiatric history and reason for admission, and clinical documents operationalized as Psychiatry Admission Note, Psychiatry Discharge Note, Psychosocial Admission Note (summary of immediate family problems, situation, and brief history of the family of origin), and Psychological Testing Report.

The raters scored the following items for each participant: work status, referral source, and reason for referral. Work status was classified into six categories: working, in training, reentry, retired, previously practiced, and not practicing. Each work status category was operationalized to help the rater to make the correct rating. For example, work status was defined as "a professional currently working, including part time; may include professional facing possible licensing problems or allegations of ethical violations, or professional seeking an evaluation and/or treatment to determine their ability to continue practicing, and/or those seeking an evaluation/treatment to determine the conditions for continued work."

Raters next scored the sources of referral, which were classified into nine categories: licensing board, professional health program (e.g., state psychological associations, physicians' health programs), employer-risk management, pending litigation, colleagues, self, therapist or psychiatrist, family/friend, and general practitioner/physician. For each of these, the rater scored either a Yes, No, or Suspected/Implied. A score of "Yes" meant that there was clear documentation that this was a source of referral. A score of "No" meant that this referral source was not mentioned in the documentation. A score of "Suspected/Implied" was used when a reference was made about a referral source but it remained unclear whether this was the direct referral source. For example, a therapist may have referred a patient for treatment, but in the documentation, reference is made to the patient's licensing board preparing to suspend or revoke a license if treatment is not sought.

Raters next identified the types of problems leading to the current referral for treatment. The types of problems were as follows: drug abuse/dependence, alcohol abuse/dependence, problems with prescribing, boundary violation, poor anger management, sexual harassment,

sexual behavior problems, marital and relational problems, work problems (e.g., lapses in professional functioning, financial problems, defiance of authority/rules), brain-based cognitive dysfunction, suicidal ideation or behavior, and bizarre or psychotic behavior. Each of these was operationally defined with a guidance note containing numerous examples. For example, "poor anger management" was defined as "temper explosions, throws objects in ER/OR, yells at staff, use of profanities, poor bedside manner in tolerating questions from patient and patient's family, impatient and intolerant of patient and family questions leading to raising voice, making angry gestures." (Please see appendix for rating/scoring sheet.)

A score of "Yes" meant that there was clear documentation that the problem led to the referral. A score of "No" meant that the problem was not mentioned in the records. A score of "Suspected/Implied" was used when a reference was made about a problem but it remained unclear whether this was a problem leading to the referral. Raters scored only those problems that led to the current treatment episode, and did not score items that were reported as being problems in the past but did not lead to the current treatment episode. Raters did not score something as a problem that the participant began working on during the course of treatment or that was recognized for the first time during treatment, but was not mentioned as an original reason for seeking treatment. The score of "Yes" was given when a problem was uncovered during the course of treatment that the patient was hiding or lying about prior to admission, such as prescribing medication to self, using alcohol on the job, or having sex with a patient.

Demographic information was recorded from an already existing database that included gender, age, marital status, diagnosis (for descriptive purposes only), previous psychiatric treatment, and family-of-origin marital status.

Statistical analysis

Descriptive demographics and summary statistics for work status, referral source, and reasons for referral are presented. Interrater reliability was established by having every tenth chart rated by four raters. Three of the four persons were also the ones who systematically and independently reviewed participants' charts.

RESULTS

The sample consisted of 334 impaired health professionals. The basic demographic results are presented in Table 1. The sample was 67% male (224) and 33% female (107). There were 55 psychiatrists (17%),

Table 1. *Basic demographics by professional affiliation*

	Psychiatry	Nonpsychiatric physician	Other mental health professionals
Gender**			
Male	45	165	14
Female	10	44	53
Total	55	209	67
Age* M (*SD*)	48.71 (1.26)	45.05 (.65)	42.66 (1.14)
Marital Status*			
Never Married	3 (6%)	18 (9%)	14 (21%)
Married	29 (53%)	110 53%)	23 (34%)
Remarried	3 (6%)	20 (10%)	6 (9%)
Divorced	14 (26%)	39 (19%)	20 (30%)
Separated	5 (9%)	20 (10%)	1 (2)
Widowed	1 (1%)	1 (1%)	2 (3%)

*$p < .05$, **$p < .001$.

209 nonpsychiatric physicians (63%), and 67 other mental health professionals (20%). The average age was approximately 45. There was a significant difference in age among the three groups, $F(2, 238) = 6.40$, $p < .002$. The psychiatry group was the oldest ($M = 48.71$, $SD = 1.26$), followed by the nonpsychiatric physician group ($M = 45.05$, $SD = .65$) and the other mental health professional group ($M = 42.66$, $SD = 1.14$). A disproportionate number of the psychiatry and nonpsychiatric physician groups was men, 81% and 79%, respectively. However, 79% of the other mental health professionals were women. Other mental health professionals, predominately female, were significantly younger than psychiatrists, who were predominantly male.

There were overall significant differences in the participants' marital status, χ^2 (12, $N = 331$) = 25.06, $p < .05$. Other mental health professionals had the highest rate of never being married (21%), were the least likely to be currently married (34%), and had the highest rate of divorce (30%). Twenty-six percent of the psychiatrists and 19% of the nonpsychiatric physician group were currently divorced. No significant differences were noted for the participants' parents' marital status.

Seventy-one percent of the entire sample was working. There were no significant differences in work status among the groups. The most often recorded DSM-IV principal diagnostic category was mood disorders (47%), followed by substance/alcohol abuse at 15% and personality disorder at 15%.

Table 2. *Mental health treatment history by professional affiliation*

	Psychiatry	Nonpsychiatric physician	Other mental health
Previous hospitalization**			
None	34 (62%)	138 (67%)	25 (37%)
Elsewhere, past	20 (37%)	56 (27%)	35 (52%)
Elsewhere, current	1 (2%)	10 (5%)	7 (10%)
Previous outpatient*			
None	10 (18%)	52 (25%)	5 (7%)
Here	2 (4%)	3 (1%)	3 (5%)
Elsewhere, past	18 (33%)	39 (19%)	15 (22%)
Elsewhere, current	25 (46%)	108 (52%)	40 (60%)
Here and elsewhere	0	3 (1%)	3 (5%)

*p <.05, **p < .001.

Overall, approximately 75% of the participants had some type of outpatient psychotherapy, and approximately 39% had had previous hospital treatment (see Table 2). Significant differences among the three groups were detected for hospitalization, χ^2 (6, N = 329) = 23.74, p < .001, and outpatient therapy χ^2 (10, N = 330) = 19.82, p < .05. The other mental health professional group had significantly higher rates of past and current hospitalizations. The nonpsychiatric physician group was more likely to not have any previous outpatient therapy, but they were more likely than the psychiatry group to be in a current outpatient therapy process. The psychiatry group was the most likely to have had past outpatient therapy. Other mental health professionals were the most likely to be in a current therapy process.

The participants' therapist was the largest referral source, followed by physician health program, family/friend, self-referral, licensing board, colleagues, pending litigation, risk management, and general practitioner (see Table 3). The referral rate by participants' therapist was twice that of the next highest referral source, physician health program. The higher rate of referrals from physician health program was influenced by the presence on the staff of one of the few psychiatrists with a national reputation for evaluating and treating boundary violations in psychiatrists, and thus there was a possible overrepresentation of referrals from physician health programs for these types of problems. A comparison of the three groups showed that psychiatrists were significantly more likely than the nonpsychiatric physicians and other mental

Table 3. *Sources of referral*

	Yes (Rank)	S/I (Combined Rank)	No
Licensing board	39 (5)	7 (5)	288
Physician's health program	72 (2)	1 (2)	261
Risk management	13 (8)	0 (8)	321
Pending litigation	16 (7)	7 (7)	311
Colleagues	31 (6)	0 (6)	303
Self–referral	45 (4)	3 (4)	286
Therapist	157 (1)	2 (1)	175
Family/Friend	54 (3)	3 (3)	277
General practitioner	7 (9)	0 (9)	324

health professionals to be referred by a physician health program, χ^2 (4, N = 331) = 21.83, suggesting an overrepresentation of the psychiatry group being referred by a physician health program. Three of the top five sources of referral were made by a treating professional, family member, or self rather than an external regulatory agency. There was a very low rate of referrals from an employer or a risk management committee, both of which are responsible for assuring quality assurance and customer care.

The three most commonly cited problems leading to referral (see Table 4) were suicidal behavior, marital problems (which was operationalized as "separating, verbal conflict, domestic violence, abuse, fears that spouse will leave, problems based on lying/deceptiveness, planning to harm spouse"), and work problems. Boundary violations were the fourth most often cited problem leading to referral while alcohol and drug abuse were the sixth and fifth most cited problems leading to referral, respectively. When the categories of yes and suspected/implied were combined, the most often cited, problems remained relatively stable. Marital problems were most often cited followed by suicidal behavior. The rate of referrals for marital problems and suicidal behavior was almost twice as high as that for work problems and boundary violations. Given the special circumstances of the presence of a nationally known expert in evaluating boundary violations, the psychiatry group was significantly more likely than the nonpsychiatric physician and other mental health professionals groups to be referred for boundary violations, χ^2 (4, N = 331) = 17.07, $p < .005$.

Table 4. *Overall summary of reasons for referral*

	Yes (Rank)	S/I (Combined Rank)	No
Drug abuse	51 (6)	15 (6)	268
Alcohol abuse	56 (5)	12 (5)	266
Prescribing problems	36 (8)	14 (8)	284
Boundary violation	66 (4)	3 (4)	265
Poor anger management	44 (7)	12 (7)	278
Sexual harassment	12	2	320
Sexual behavior problems	22 (10)	5	307
Work problems	78 (3)	11(3)	245
Marital problems	129 (2)	30 (1)	175
Financial problems	20	10 (10)	304
Defiance of authority	20	5	309
Brain-based cognitive dysfunction	5	5	324
Suicidal behavior	132 (1)	26 (2)	176
Bizarre/Psychotic behavior	35 (9)	11 (9)	288

DISCUSSION

This study aimed (1) to describe the problems leading health professionals to seek treatment and (2) to identify the referral sources for treatment. The current findings suggest that among health professionals who seek treatment, the most common referral source is a health professional's therapist. A high number of professionals sought mental health treatment on their own volition rather than at the behest of a licensing board or regulatory agency. With the exception of the overrepresentation of boundary violations among psychiatrists, the problems prompting a referral for further treatment and evaluation were relationship oriented and difficulties resulting from emotional distress. The three most commonly cited problems among those professionals seeking treatment or an evaluation in this sample were marital problems, suicidal ideation behavior, and work problems, which included irresponsible/inaccessible behavior. This was consistent with previous research findings (Pope & Tabachnik, 1994; Sherman & Thelan, 1998) suggesting that relationship problems and depression-related symptoms, particularly, suicidal ideation, were important factors leading to distress.

There are some important limitations to the design of our study that may restrict the generalizability of our findings. First, The Menninger Clinic is a tertiary referral center. In other words, many patients in the study already had some form of treatment and possibly sought out additional mental health care because expertise in diagnosis, evaluation, and treatment was needed, with an eventual return to the current therapist. Second, the high incidence of boundary violations and referrals from physician health programs may have been largely determined by the unique expertise of one of the senior psychiatrists who worked at The Menninger Clinic during the time of this study. Third, without a control group, it is difficult to make definitive statements about the characteristics of professionals who seek treatment.

Despite these potential limitations, our data indicate that health professionals are receptive to seeking mental health treatment to manage difficulties that may impinge on their work. Among those seeking treatment, these difficulties are centered on interpersonal, relational, and emotional concerns rather than on substance abuse, alcohol abuse, boundary violations, prescribing problems, and sexual behavior problems. This has important implications inasmuch as physician health programs, licensing boards, and employers characteristically wait until something has occurred before intervening, which may be too late and come at the expense of the patient's safety and welfare. By primarily focusing on external behavior, these regulatory agencies and employers are prone to miss the interpersonal, social, and emotional elements that bring professionals to treatment and that may contribute to work impairment and unethical behavior.

We conclude from our findings that two common misconceptions need to be dispelled. First, impaired health professionals who seek treatment are most often referred by their therapist rather than disciplinary or regulatory agencies. Second, despite the frequent assumption that "impaired professional" is a phrase referring to substance abuse problems, those professionals who seek treatment are more likely to have difficulties centered on interpersonal, relational, and emotional concerns than around substance abuse. This finding has important implications inasmuch as physician or other professional health programs, licensing boards, and hospital risk management programs should be geared to address a wide array of interpersonal and psychological problems rather than limiting themselves to a focus on chemical dependency. Moreover, by waiting until overt actions or external behaviors occur, these agencies may miss the opportunity to intervene earlier and more effectively on less "noisy" problems that may create a good deal of personal and professional distress.

We hope that regulatory agencies take proactive steps to identify professionals with social and emotional vulnerabilities who may be at greater risk for unethical and negligent behavior, rather than intervening after ethical violations. Moreover, the surprisingly low rate of employer-risk management referrals is of particular concern because these groups are in a position to observe the professional on a daily basis. Employers and risk management groups can implement psychoeducational programs for health professionals, teaching them how to identify early signs of distress and impairment, as well as how to put into place referral systems for confidential treatment before the emergence of disruptive behavior. Finally, it is important to dispel the myth that "impaired health professional" simply implies an individual who violates a boundary, suffers from substance abuse problems, or has problems with anger management. This myth encourages health professionals to believe that they are not in distress or impaired until they have acted in an inappropriate manner, rather than helping them identify early warning signs, the predisposing and precipitating factors that contribute to disruptive behavior.

Appendix

Status

☐ 1. Working ☐ 2. In training ☐ 3. Reentry ☐ 4. Retired ☐ 5. Previously practiced ☐ 6. Not practicing

Sources of referral	Yes	No	Suspected/Implied
Licensing board	☐	☐	☐
Professional health programs	☐	☐	☐
(state psychological associations, physicians health programs, psychoanalytic societies/organizations)			
Employer, risk management	☐	☐	☐
Pending litigation	☐	☐	☐
Colleagues	☐	☐	☐
Self–referral	☐	☐	☐
Therapist or psychiatrist			
(current or past, may include clinician from treatment facility patient in now)			
Family or friend	☐	☐	☐
General practitioner/physician	☐	☐	☐
(Non–psychiatrist)	☐	☐	☐
Types of problems leading to referral			
Drug abuse/dependence	☐	☐	☐
(includes street, prescription and OTC drugs; if abusing self–prescribed drugs, also score for "problems with prescribing")			

	Yes	No	Suspected/Implied
Alcohol abuse/dependence	☐	☐	☐
Problems with prescribing	☐	☐	☐
(any problems with prescribing medications, self–prescription, self–prescribing to detox, prescribing to a friend, neighbor or significant other, adjusting own medication, write prescription for self using another physician's name, making up names for prescription, passing out samples of controlled substance, sharing prescriptions between patients, writing prescriptions for employees)			
Boundary violation	☐	☐	☐
(dual relationships, financial transactions with patients other than the fee, meeting patient for meals outside the treatment setting, sexual relations with patients, requesting sex for medications, exchanging treatment for sexual relations, telling patients personal problems, taking patients to dinner, helping them move their home, sending a patient love notes, paging a patient at home, buying patients gifts, etc.)			
Poor anger management	☐	☐	☐
(temper explosions, throws objects in ER/OR, yells at staff, use of profanities, poor bedside manner in tolerating questions from patient and patient's family, impatient and intolerant of patient and family questions leading to raising voice, making angry gestures)			
Sexual harassment	☐	☐	☐
(inappropriate comments to opposite/same gender staff, inappropriate touching)			
Sexual behavior problems	☐	☐	☐
(if present, please specify type: frotteurism, exhibitionism, voyeurism, pedophilia, compulsive masturbation, fetish, phone sex; some of these may occur alongside boundary violation; may occur with nonpatients)			
Workaholic/Type A behavior/Burnout	☐	☐	☐
(working excessive hours, working on weekends, driven behavior, overscheduling, excessive exercise causing self–injury)			
Work problems/Lapse in professional functioning	☐	☐	☐
(errors in judgment in which person/thing harmed is not oneself, impaired clinical judgment that lowers professional skill, breaching confidentiality, directing racial slurs at a patient, making fun of a patient's appearance, weight, and/or height, not on time, poor record keeper that endangers, canceling and rescheduling appointments, not showing up for meetings, lack of concern for patient welfare, not responding to calls, not returning pages, writing wrong orders or prescriptions, frequently calling in sick)			
Marital/Relational problems	☐	☐	☐
(separating, verbal conflict, domestic violence, abuse, fears that spouse will leave, problems based on lying and deceptiveness, planning to harm spouse)			
Financial problems	☐	☐	☐
(mounting debt, unable to pay bills)	☐	☐	☐
Defiance of authority/rules	☐	☐	☐
(noncompliance with expectations and rules, switching urine samples, diluting urine samples, noncompliance with drug screens, falsifying documents)			
Brain–based cognitive dysfunction (dementia, delirium, closed–head injury)	☐	☐	☐
Suicidal ideation or behavior	☐	☐	☐
Bizarre or psychotic behavior	☐	☐	☐
Miscellaneous (e. g., lies under oath) _____			

References

Dehlendorf, C.E., & Wolfe, S.M. (1998). Physicians disciplined for sex-related offenses. *Journal of the American Medical Association, 279,* 1883-1888.

Enbom, J.A., & Thomas, C.D. (1997). Evaluation of sexual misconduct complaints: The Oregon Board of Medical Examiners, 1991-1995. *American Journal of Obstetrics and Gynecology, 76,* 1340-1348.

Hughes, P.H., Baldwin, D.C., Sheehan, D.V., Conard, S. & Storr, C.L. (1992). Resident physician substance abuse by specialty. *American Journal of Psychiatry, 149,* 1348-1354.

Mahoney, M.J. (1997). Psychotherapists' personal problems and self-care patterns. *Professional Psychology: Research and Practice, 28*(1), 14-16.

Morrison, J., & Wickersham, P. (1998). Physicians disciplined by a state medical board. *Journal of the American Medical Association, 279,* 1889-1893.

Neukrag, E, Milliken, T, & Walden, S. (2001). Ethical complaints made against credentialed counselors: An updated survey of state licensing boards. *Counselor Education and Supervision, 41,* 57-70.

Pope, K.S. (1993). Licensing disciplinary actions for psychologists who have been sexually involved with a client. Some information about offenders. *Professional Psychology, Research and Practice, 24,* 374-377.

Pope, KS, & Tabachnick, BG. (1994). Therapists as patients: A national survey of psychologists' experiences, problems and beliefs. *Professional Psychology, Research and Practice, 25,* 247-258.

Reamer, F.G. (1992). The impaired social worker. *Social Work, 37*, 165-170.

Sherman, M.D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. *Clinical Psychology Review, 16,* 299-315.

Sherman, M.D., & Thelen, MH. (1998). Distress and professional impairment among psychologists in clinical practice. *Professional Psychology: Research and Practice, 29*(1), 79-85.

Thoreson, R.W., Miller, M., & Krauskopf, C.J. (1989). The distressed psychologist: Prevalence and treatment considerations. *Professional Psychology: Research and Practice, 20,* 53-158.