Effects of Practitioners' Sexual Misconduct: A Follow-Up Study

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A clinic population presenting with problems related to practitioner sexual misconduct was surveyed to describe their characteristics, distinguish the impact of the sexual misconduct from preexisting problems, and identify factors helpful in recovery. Using a 180-item anonymous questionnaire, subjects described their situation before and after the misconduct. The Impact of Event Scale and Vinson's instrument measured posttraumatic symptoms among respondents. The population comprised 107 women. Participation was 63 percent (55 of 87) of delivered surveys. Mean age at the time of the sexual contact was 31.6. Posttraumatic stress disorder, Major depressive disorder, suicidality, use of prescription drugs, concern over use of alcohol and/or nonprescription drugs, disrupted relationships, and disruptions in work or earning potential were all reported to be increased after the practitioner misconduct. When survey respondents sought help for problems related to the sexual misconduct, they contacted an average of 2.36 professionals before obtaining "satisfactory" assistance. Eighteen percent of respondents reported sexual revictimization by subsequent professionals. Most respondents reported substantial (at least 100 hours over the course of three or more years) use of professional mental health services. Many women who seek treatment following practitioner sexual misconduct can be expected to exhibit significant symptoms of mental illness and functional impairment. They require both intensive and extensive subsequent treatment, yet are vulnerable to professional revictimization.

Concerns about physicians taking sexual advantage of their patients were first recorded in the fourth century B.C. in the *Corpus Hippocratum*. Reports of clergy sexual contact with parishioners appeared in the Middle Ages. Despite subsequent examples in popular literature, cinema, and professional groups, the topic of professionals' sexual misconduct received little systematic review until the 1970s, when surveys first documented the prevalence of professionals' sexual misconduct (e.g., among mental health professionals in general and including physicians, psychologists, psychiatrists, and social workers).[1–5] The extent of the problem was recognized in the early 1980s, and it included the clergy.[6] In response to this situation, since 1984, 14 states have enacted statutes naming sexual misconduct a felony for health care professionals and/or clergy.[7]

Damage to patients from counseling

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and health care professionals' sexual misconduct has been described in victims' and clinical reports, reports of subjects recruited by public advertisements, and in national surveys of treating professionals.[8] However, there is little systematic work on clinic populations, and there is a dearth of research to distinguish between problems that are preexisting and those that follow practitioner misconduct.

The current study describes a large, well-defined clinic-based population of consecutive clients presenting with complaints related to practitioner (clergy and/or health care professional) sexual misconduct. Factors explored included: demographic, clinical, historical, perpetrator, legal, treatment, and outcome characteristics. Using these data, the study sought to characterize clients and the impact of the practitioner sexual misconduct. It identifies implications for policy and practice.

Materials and Methods

Subjects Subjects were drawn from a clinic population of 110 consecutive female clients (107 white, 3 African American) who had been evaluated and/or treated by the author between 1980 and 1994, in either a family service agency or out-patient private practice, for emotional problems related to sexual contact by health care or clergy practitioners. Referrals were from a variety of sources, including self-referral, health care professionals, social service agencies, hospitals, clinics, religious organizations, and attorneys. Three cases were discarded from the study because clients' statements were internally inconsistent and/or the statements lacked corroboration from other sources, including the alleged offending practitioners themselves, clients' family members, partners, friends, and/or other complainants. Four males who had also been evaluated and/or treated by the author during the same period were excluded from the study because of the small number.

Practitioner sexual contact was defined as any physical contact of a sexual nature performed by a professional in a position of trust and greater power. Physical contact of a sexual nature included kissing on the lips, long hugs, oral sex, masturbation, intrusions into either anal and/or genital openings of the body, or touching of the "bikini area" of the body while clothed or unclothed.

A questionnaire and letter explaining the purpose of the survey and procedures for establishing confidentiality and anonymity were mailed to the 107 subjects, of whom 104 were white and 3 were African American. To protect the subjects' privacy and to prevent coercion by the researcher, who had provided clinical services, surveys contained no identifying markers and signed consent was not requested. Three follow-up reminder notes were mailed to all subjects at one-month intervals. Twenty surveys were eliminated after they were returned by the post office when a current address could not be found. Of the remaining 87 surveys, 55 (63%) were completed and returned.

Instruments The 180-item questionnaire included demographic characteristics of patients and practitioners, mental health history, experience with the practitioner, family relationships, experience

with the legal system, and subsequent therapy. They were designed not to lead the respondent. Most were in a check-list format. For questions intended to differentiate between premorbid and postmorbid problems, response options included the following: (1) has not been a problem; (2) existed previously but remained the same during and after the misconduct; (3) existed previously but became worse during and after the misconduct; and (4) emerged as a *new* problem during and after the misconduct. Individual responses were tabulated. Four semistructured questions asked subjects what suggestions, if any, they would make for improvements in complaint mechanisms and for improvements in services to victims and their families; and also asked subjects to give examples of what had been least helpful and most helpful in their healing from problems stemming from practitioner misconduct. Subjective answers were reviewed by mental health professionals who had neither evaluated nor treated the subjects.

Two standard instruments were used: Vinson's instrument[9] measured symptoms of posttraumatic stress disorder (PTSD) experienced during or after the practitioner sexual misconduct and current symptoms of PTSD; the Impact of Event Scale[10] was used to identify current distress related to events associated with the practitioners' conduct. Both instruments measure intrusive thoughts and avoidant behaviors that are central to the diagnosis of PTSD (DSM-III-R). Respondents were instructed to "consider the events associated with the practitioner misconduct" in their responses to these two instruments.

Results

Respondent Characteristics Table 1 describes respondents' demographic characteristics. All respondents were white females. At the time of the sexual contact with the practitioner, they were between the ages of 5 and 57 (mean, 31.6 years). Three were under 18 years old. Respondents' age range was between 30 and 85 years (mean, 45 years) at the time of the survey. Respondents' reported level of education was higher than the Minnesota average.[11]

Before age 18, 20 percent had parents who had died; 16 percent had parents who were divorced; and 6 percent had been placed in a foster home.

Sixty percent reported that, by the age of 18, they had experienced unwanted sexual touching by an adult or older child. Sixty-four percent reported they had been the recipient of physical violence (defined as hitting, striking with a belt or other object, slapping, pushing, or pinching) by an adult or older child.

Prior to the practitioner sexual contact, most of the survey respondents had received some kind of outpatient counseling services for personal and relationship problems. Of the three who were under age 18 at the time of the practitioner sexual contact, two were attending the accused clergyperson's church and one was receiving medical services from a pediatrician.

Practitioner Characteristics Most practitioners (95%) were male. The age of the practitioners at the time of the

Table 1
Respondents' Demographic Characteristics

	At sexual contact	Current
Mean age (years)	31.6 (5–57)	45.9 (30–85)
Marital status		
Single	24%	2%
Married	44%	49%
Living with significant other	2%	7%
Separated or divorced	22%	31%
Widowed	4%	9%
Other and missing	5%	2%
Education		
Less than high school	11%	0%
High school graduate	14%	6%
Vocational school	2%	0%
Some college	33%	30%
College	25%	26%
Postgraduate	15%	39%
Missing	0%	2%
Income		
<$15,000	36%	15%
$15,000 to $29,999	16%	25%
$30,000–$44,999	33%	13%
>$45,000	13%	4%
Missing	2%	5%

misconduct ranged from 29 years and younger to 60 years and older. Approximately one-half were health care professionals, and the remainder were clergy counselors (Table 2). Seventy percent of the health care professionals were reported to be licensed; 29 percent unlicensed; and for 1 percent, the status was unknown.

Characteristics of Sexual Contacts Nearly all respondents (93%) reported multiple (mean, 7) types of sexual contact with the practitioner. Most of the survey respondents (82%) reported kissing or intentional touching by the practitioner of any of the following: groin, genital area, inner thigh, buttocks, breast; or of the clothing covering these body parts. Over half (56%) reported that the practitioner had induced them to kiss those same parts of the practitioner's body. Three-quarters (75%) reported genital penetration, with 55 percent reporting vaginal intercourse. All who reported some kind of genital penetration also reported multiple types of other sexual contact.

Duration of sexual contact ranged from one day to 84 months with a range of frequency from daily to monthly. Nearly half (49%) reported the sexual contact occurred both during the course of and after professional services had ended. Twenty-nine percent reported sexual contact during services only; 13 percent reported sexual contact only after services ended. Most respondents (76%) reported

Table 2
Practitioners' Type of Profession

Clergy (51%)	%
Assembly of God	3.6
Baptist	1.8
Catholic	20.0
Christian Missionary Alliance	1.8
Evangelical Covenant Church	1.8
Greek Orthodox	1.8
Interdenominational	1.8
Lutheran	14.5
Presbyterian	3.6
Health care professionals (49%)	
Marriage or Family Therapist	5.5
Nurse	1.8
Physician	3.6
Psychiatrist	10.9
Psychologist	16.3
Social Worker	1.8
Substance Abuse Counselor	7.2
Other	1.8

that they thought the practitioner had sexually exploited others.

Most respondents reported (71%) that sexual contact had occurred in both professional settings (clinic, hospital, social service agency, professional building, and church) and personal settings (hotel, home, and/or motor vehicle). Twenty-four percent reported the sexual contact occurred in professional settings only; 5 percent reported sexual contact occurred in personal settings only; 42 percent reported the practitioner took them on trips and/or asked them to meet him/her in another city.

Nearly all (95%) reported that the practitioner had coerced them to engage in sexual contact. Over half (56%) reported that the practitioner used therapeutic deception (e.g., the practitioner said that sexual contact would be "therapeutic" or, in the case of clergy, that it was "God's will." Over half (53%) reported emotional coercion (e.g., the practitioner stated it was part of the respondent's "problem" that she did not want to engage in sexual contact); 20 percent reported use of physical force; and 18 percent reported the practitioner's use of mind-altering chemicals (e.g., prescription and nonprescription drugs or alcohol).

Respondents also reported other behaviors: 56 percent of practitioners persuaded the respondent to distance herself from family, significant other, and/or friends; 38 percent made unwelcome sexual jokes or comments; 38 percent violated confidentiality (e.g., told others about information respondents had disclosed to the practitioner in confidence without obtaining respondents' consent); 36 percent asked respondents to perform personal services for them (e.g., typing, shopping, house cleaning); and 15 percent "stalked" the respondents by making relentless and unwelcome phone calls and visits to their homes or places of work or leisure activity.

Effects of Practitioner Sexual Misconduct Effects of practitioner sexual misconduct were evaluated by comparing recollections of problems experienced before the sexual misconduct versus those reported following the misconduct. Nearly all (95%) of the survey respondents reported sufficient symptoms of hyperarousal, intrusion, and constriction, specifically related to events with the practitioner, to meet DSM-III-R criteria for posttraumatic stress disorder. The incidence of major depressive disorder (MDD) more than doubled from 40 percent to 93 percent ($p < .0001$) following the sexual contact with the practitioner.

Table 3
Comparison of Pre- and Postmorbid Suicidality

	Premorbid (%)		Postmorbid	
	Yes	No	Yes	No
	%		%	
Suicide ideation Chi square = 18.2, $p < .0001$	38	62	80	20
Suicide planning Chi square = 12.2, $p < .0005$	24	76	58	42
Suicide attempts Chi square = NS[a]	25	75	27	72

[a] NS, not statistically significant.

The prevalence of suicidal ideation and planning more than doubled following practitioner misconduct (Table 3). Over half of the suicide attempts in the postmorbid period were initial attempts.

Before the practitioner sexual contact, 27 percent of the respondents reported a history of psychiatric hospitalization, whereas 40 percent reported hospitalization following the event. Even though the increase was not statistically significant, it is noteworthy that 64 percent of those psychiatrically hospitalized in the postcontact period had never been previously hospitalized.

Before the sexual contact, 20 percent reported concerns about their alcohol and/or nonprescription drug use, whereas 45 percent reported such concerns afterward (NS).

Survey respondents also reported multiple disruptions to their significant relationships and in their daily functioning subsequent to practitioner sexual contact. Nearly all (87%) reported a negative effect on their feelings about themselves as sexual partners, and nearly half (46%) reported a negative effect on their feelings about their sexual orientation. A majority (61%) reported a negative effect on their earning ability. Nearly half (42%) reported that the practitioner sexual contact had been a contributing factor in the dissolution of their marriages or relationships with partners. Over one-third (35%) reported that events with the practitioner were a significant reason prompting a change of residence. And 36 percent reported changing religious affiliations following the events.

Most (87%) respondents blamed themselves for the events with the practitioner, and most (89%) suffered problems knowing how to deal with their anger toward the practitioner. Two respondents reported physically assaulting the practitioner.

Nearly all of the respondents (96%) reported that they had felt reluctant to tell persons close to them (e.g., spouse or partner, parents, children, other family, or friends) about the practitioner's misconduct, for one or more of the following reasons: they had felt ashamed or responsible for the conduct (90%); they would not be understood if they told (85%); they didn't know how to tell others (56%); the

practitioner told them they should keep it a secret (55%); they would hurt their partner if they told (49%); the practitioner would retaliate against them (45%); and they would hurt the practitioner's family members if they told (37%).

Two (4%) participants reported that pregnancies resulted from the sexual contact.

Respondents reported that practitioner sexual misconduct had also harmed people close to them, particularly partners and children. Commonly cited problems for partners included symptoms of MDD, PTSD, anger, and confusion. Most (67%) of the respondents with children reported that their children had suffered problems as a result of the practitioner sexual misconduct: most children (66%) suffered confusion about the mother's behavior; nearly half (41%) suffered anxious mood; over one-third (36%) worried about their parents' marriage problems; one-third (33%) witnessed parental conflict stemming from the practitioner sexual misconduct; over one-third (35%) worried that their parents might separate or divorce; over one-third (35%) experienced impairment in their school performance; 27 percent suffered impairment in peer relationships; and 31 percent experienced problems related to loss of their religious community.

Experience with Subsequent Professional Help Respondents sought help for problems related to the practitioner sexual misconduct from less than six months to 45 years—nearly half (49%) within 24 months—after termination of the sexual contact. Most respondents reported receiving multiple types of subsequent counseling help such as diagnostic assessment; information and referral; individual, marriage and/or family or group counseling; and/or advocacy (e.g., professional assistance in making a complaint).

The amount of subsequent professional services (excluding legal help) respondents reported receiving ranged from only a few sessions to over 100 hours of professional counseling over a period ranging from less than 1 year to as long as 10 years. Most (68%) received at least 100 hours of professional counseling or consultation during a period of three years or more.

An unexpectedly high number (18%) of respondents reported that they had experienced sexual misconduct by more than one practitioner. Respondents reported difficulty finding adequate subsequent care; they had seen an average of 2.36 subsequent professionals before obtaining satisfactory help.

Experience with Legal, Administrative, and Other Complaint Options Most respondents (98%) reported that they had made some type of complaint (i.e. to an institution affiliated with the practitioner, a professional organization, regulatory board, and/or civil or criminal courts). Seventy-five percent (21 of 28) of clergy cases made a complaint to the denomination administrative leader. Fifty-one percent made a complaint to supervisory or administrative personnel in the practitioners' workplace. Length of time required for completion of complaint processes varied according to the complaint type, ranging from less than two years for a criminal complaint, one to four years for a regulatory complaint, and one to five years for a civil complaint. All

22 respondents with completed civil cases reported receiving a financial settlement. Of the seven completed criminal cases, five reported verdicts of guilty and two not guilty.

Most respondents (73%) reported they had confronted the practitioner concerning the harm they had experienced as a result of his or her misconduct, either privately or with one or more persons present (e.g., in a meeting, legal deposition, or courtroom). Nearly all respondents reported that these meetings had been helpful.

Respondents were more likely to be satisfied with the outcomes of regulatory board complaints than with the outcomes of complaints to institutions or professional organizations. They were least likely to be satisfied with the outcome of their complaints to religious leaders. They reported problems with legal or other public complaint processes, including length of time required, humiliation and exposure, and loss of control over focus on feelings. Breaking the silence by telling about the traumatic events and the experience of being believed were often cited as more important than taking action and confronting the offending practitioner, although this too remained important for many of the respondents.

Discussion

This study documents the widespread, devastating and enduring impact of practitioner sexual misconduct on a clinic population. Whereas previous studies have not distinguished between symptoms and complaints related to practitioner sexual misconduct and preexisting conditions, this study systematically compares conditions in the respondents lives before and after the practitioner misconduct, as recalled by the respondents.

The respondents presented to the offending practitioner with complaints and conditions similar to patients observed or reported in studies of a general outpatient counseling population with the following exceptions: there was a higher prevalence of previous psychiatric hospitalizations, childhood history of sexual and physical abuse, and MDD. These exceptions in premorbid conditions may support the conclusion that they may be more *vulnerable* than the typical outpatient population to practitioner sexual misconduct.

Following the practitioner sexual misconduct, respondents reported greater levels of suicide risk, PTSD, MDD, abuse of substances, and disruptions in significant relationships and functioning than the general outpatient clinic population. Compounding their serious problems, most had trouble finding appropriate subsequent professional care, and an alarming number were sexually revictimized by other helping professionals.

Generalizability of Survey Results

The study is based upon a clinic population of predominately white women who identified problems related to practitioner sexual misconduct and who also obtained subsequent professional help for such problems, and its generalizability is limited to that group.

Like many studies that gather information on clinical populations, there are some methodological shortcomings such as the limitations of retrospective self-report or recall bias, which may be en-

hanced by litigation; potential selection bias in a referred clinic population; potential selection bias in survey response; and absence of a control group.

The strengths of this study, however, include a spectrum of victims and practitioners, an unusually high response rate for this type of study, first-hand recollection from victims rather than second-hand recollection by subsequent treating professionals, and systematic comparison of pre- and postmorbid conditions by means of a structured survey.

A comparison with the results of other studies provides insights into the population. Demographic characteristics of respondents are roughly similar to those of a typical Minnesota outpatient clinic. Even though all of the respondents were white, in contrast to the original patient population, which had also included African Americans, Minnesota has a relatively small minority population. Self-reported prevalence of childhood sexual and physical abuse is higher than in a general outpatient clinic population and higher than in a study of a chronically ill female outpatients.[12] Prevalence of MDD is higher than in a general clinic population.[13] When compared with previous case study reports of clients sexually victimized by practitioners, the prevalence of childhood sexual abuse in these data is higher.[14]

The low number of males in the original patient population is consistent with others' findings that victims who report practitioner misconduct are usually women.[6] However, the prevalence of male victims of practitioners is unknown. Whereas many child and adolescent boys may, in addition to girls, be sexually abused by clergy, what is known about male victims is primarily from published media reports and forensic cases. Clinical information is sparse because male sexual abuse victims usually don't seek mental health services.[15, 16] Difficulties in obtaining permission from attorneys to study males seen in forensic cases presented an obstacle to the author's plan to conduct a separate study of male victims for purposes of comparison.

Practitioner gender is consistent with studies of professionals that estimate the prevalence of female therapists engaging in sexual contact with patients to be between two and four percent.[6] The variety of types of professions represented in these data appear consistent with surveys of professional groups[6] that suggest that sexual misconduct can be expected in any health profession. The low number of social workers represented in these data are consistent with Gechtman's study.[5]

Data on the prevalence of practitioners' "stalking" of clients are not reported elsewhere, but are consistent with previous clinical observations of the "predator" category of practitioners.[17]

Data that the practitioners' sexual misconduct took place in the context of role reversals and multiple other types of boundary violations are consistent with previous clinical reports that have drawn parallels between practitioner sexual misconduct and parent/child incest.[18, 19] These data are also consistent with observations of a progression from other types of boundary violations to sexual involvement with patients.[20, 21]

The prevalence of subsequent psychi-

atric hospitalizations and suicide attempts is higher in these data than reported in surveys of subsequent treating professionals. Hospitalizations are nearly four times higher.[14, 22] Prevalence of suicide attempts following practitioner sexual contact was 14 percent higher.[22] Postmorbid suicide ideation in this study was 47 percent higher than that reported in Vinson's study.[9]

These data indicate that when patients obtained subsequent professional help following the practitioner sexual contact, they presented with significantly greater problems than they had originally presented to the offending practitioner. The prevalence of depression, suicidality, substance abuse, need for psychiatric hospitalization and psychotropic medications, social isolation, and distrust in self and in the ability of professionals to be of help are significantly higher than in the general outpatient clinic population.

These data indicate that persons close to patients are also negatively affected by the problems related to the practitioner conduct and may also be in need of professional services for themselves. These observations are consistent with previous clinical case reports on secondary or associate victims.[23, 24]

Repeated sexual revictimization by multiple helping professionals is not reported elsewhere but is consistent with reports of revictimization in persons who have suffered other types of sexual abuse.[25] These data are also consistent with recent clinical observations and theoretical discussions that describe professionals' potential for role responsiveness and reenactment of patients' previous life experience.[26, 27] These data are also consistent with previous clinical reports of intense countertransference reactions in work with patients who report sexual misconduct by other professionals (e.g., wish to be a "better therapist than the previous therapist," to "rescue" sexually exploited patients by acting in noncustomary ways, such as waiving professional fee expectations).[28, 29] In addition to the reasons previously cited for practitioners' possible breaching of professional boundaries,[17, 30, 31] these data suggest that subsequent practitioners may experience a parallel process with their patients' own inabilities to integrate overwhelming stimuli related to the previous professionals' boundary violations.

The prevalence of complaint actions in this population appears higher than in reports on other types of sexual abuse victim populations and in other reports on persons who were sexually abused by practitioners.[9] This could be explained by various factors unique to Minnesota. Professional recognition of the problem of sexual abuse came relatively early. By 1986, the state legislature enacted statutes prohibiting psychotherapists from sexual contact with clients, making it more possible for patients to take legal action and exciting media attention. In addition, relative to other states, Minnesota has enjoyed greater access to professional referral, consultation, and assistance in exploring complaint options and/or making complaints. Finally, unknown referral factors, including clients' self-selection of helping professionals with a community presence regarding such issues, may reflect this population's wish to speak

openly about their experience. Any or all of these factors may provide a supportive social context for taking complaint action.

Data showing a greater satisfaction with regulatory board decisions than with actions taken by religious organizations may appear inconsistent with data indicating that participants experience regulatory board actions as ponderous and time-consuming. However, the higher level of satisfaction with regulatory boards may be related to the perception that the regulatory boards, while slow, are more likely than religious or other organizations to ultimately take consumer complaints seriously and enforce sanctions.

Implications These data have implications for practice and policy in the following areas: (1) health care; (2) third party payers; (3) legal and regulatory board services; and (4) religious institutions.

Health Care Practice and Policy Patients with histories of abuse in their childhood and/or adolescence may be at greater risk for sexual exploitation by counseling and other health care practitioners. These data suggest that treating practitioners and mental health organizations should routinely identify clients with abuse histories and ensure adequate safety measures, including consultation and support to professionals who treat them.

Preventive measures should also include attention by institutions to the early identification of professionals who may be at increased risk for professional boundary violations. Consideration should be given to those clinical reports and studies that have identified risk factors.[17, 30, 31]

Because these data documented that instances of sexual misconduct occurred within the context of multiple types of professional boundary violations, mental health organizations and individual practitioners should also take responsibility for professional education regarding boundaries in general; not only sexual contact, but also confidentiality, self-disclosure, home visits, receiving and giving gifts, touch, language, timing of appointments, and dual roles. Because professionals may find themselves unexpectedly treating clients with histories of practitioner sexual misconduct, there should be training regarding countertransference reactions. Providing information to prospective clients about appropriate clinical boundaries would also be a valuable preventive measure.

These data strongly indicate that clients who present with histories of practitioner sexual misconduct have specialized treatment and safety needs. Not only do these clients subsequently present with more severe problems than the general outpatient population, but they are also at risk for revictimization. Special attention to other safety issues for such patients is also necessary, including suicide assessment and exploration of possible stalking behavior by the former practitioner so protection can be sought. Safety is generally accepted as a prerequisite for healing from traumatic events.[32] These data support the need for an interdisciplinary mental health team approach to adequately address both the biological and psychosocial needs presented by such patients.

Third-Party Payers This study indicates that despite the severity of their

conditions in the postmorbid period, patients reported significant improvements when they were able to obtain knowledgeable long-term care. However, a factor frequently cited as an impediment to healing was the lack of funds for the necessary continuity of care. Health care insurers can play an important role in such patients' healing through understanding their special needs and by authorizing payment for the duration and range of services needed.

Legal and Regulatory Services These data indicate that the most important issue in recovery from the effects of practitioner sexual misconduct was to be understood and heard, and although for many, legal and regulatory board complaint options were helpful, for many others they were troublesome. They promoted a sense of insecurity and delayed progress in treatment.

Given the nature of the problem and the legal and regulatory procedures, it is unlikely that they could be modified to be a pleasant experience. These data suggest, however, that clients would benefit greatly if such procedures could be shortened. Alternative dispute services, such as arbitration, should also be made available in lieu of the traditional adversarial legal process.

Religious Institutions Religious organizations have historically had the same trouble implementing preventive and intervention policies and procedures as health care professions and organizations. Because of the separation of church and state, however, churchgoers who are exploited as adults typically lack the formal legal complaint options that are available to victims of health care professionals and are consequently dependent upon the ability of individual religious institutions to respond appropriately. Religious organizations have a particular need to develop and implement preventive strategies and helpful responses for complainants.

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