Recognizing and Responding to Developmentally Appropriate and Inappropriate Sexual Behaviors of Children

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Introduction

A concerned parent visits a pastor unsure what to make of her kindergartner touching the genitals of his baby brother. A youth minister overhears a confirmand making explicit jokes about sexual assault with his friends. A Sunday school teacher walks into a women's restroom and discovers a seven-year-old girl licking the vaginal area of a five-year-old girl.

These are all actual cases arising in myriad faith communities. When these and similar cases come to the attention of faith leaders, we are often unsure how to respond and, as a result, faith communities may ignore concerning behaviors and over-react to behaviors that are developmentally normal.

Although this paper cannot fully address the complexities involved in the sexual behaviors of children, it can provide an overview of the subject and offer guidance for obtaining additional information. To this end, this paper introduces the reader to quality resources that can help faith leaders when addressing this issue. The paper also provides an overview of normal and concerning sexual behaviors among children. When the behaviors are concerning, guidance on appropriate interventions or treatment is offered. Finally, there is a discussion of factors to consider when a juvenile has been removed from his or her home because of sexual misconduct and is being re-integrated into a home or church.

The critical importance of accessing quality resources and expertise

When confronted with the sexual behaviors of youth, faith leaders and the families they serve should take two critical steps. First, it is important to review quality information about the sexual behaviors of children. The National Center on the Sexual Behavior of Youth (NCSBY),[2] the National Child Traumatic Stress Network (NCTSN),[3] and the American Academy of Pediatrics[4] have all published free, online materials that can help in determining when a behavior is concerning enough to warrant professional intervention. The SMART[5] Office of the United States Department of Justice has published a free, online summary of the peer reviewed studies on juveniles who commit sexual offenses and evidence-based treatment.[6]

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Second it is important to consult one or more experts on the sexual behaviors of youth. Reaching out to hospitals that are part of the National Child Traumatic Stress Network or Child Advocacy Centers[7] accredited by the National Children's Alliance[8] are good places to start; they can likely direct you to an expert in this area who can assist a faith leader or family struggling with this issue. Indeed, faith leaders should make these contacts long before a crisis arises so that when concerning behaviors present themselves, a list of referrals to area experts is readily at hand.

1. Victor I. Vieth is the president of the Academy on Violence & Abuse, the senior director and founder of the Gundersen National Child Protection Training Center, and previously served as executive director of the National Center for the Prosecution of Child Abuse.

2. For additional information, visit the NCSBY website at: http://www.ncsby.org/ (last visited March 29, 2018).

3. *See* "Sexual Development and Behavior in Children," *The National Child Traumatic Stress Network,* available online at: http://nctsn.org/nctsn_assets/pdfs/caring/sexualdevelopmentandbehavior.pdf (last visited March 29, 2018).

4. Nancy D. Kellogg, "Clinical Report—The Evaluation of Sexual Behaviors in Children," *Pediatrics* 124 (2009): 992–998, available online at: http://pediatrics.aappublications.org/content/124/3/992 (last visited March 29, 2018).

5. SMART stands for Office of the Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking.

6. The literature review is called the "Sex Offender Management Assessment and Planning Initiative" and can be accessed online at: https://www.smart.gov/SOMAPI/index.html

7. Nancy Chandler, "Children's Advocacy Centers: Making a Difference One Child at a Time," *Hamline Journal of Public Law & Policy* 28 (2006): 315–337.

8. To find an accredited Child Advocacy Center in your state, visit the National Children's Alliance website at: http://www.nationalchildrensalliance.org/ (last visited March 29, 2018).

Developmentally appropriate sexual behaviors: pre-adolescence

More than half of children will engage in sexualized behavior before they turn thirteen with some research placing this number much higher.[9] Most of this behavior is "informational gathering" as children "explore each other's bodies by looking and touching (e.g., playing doctor) or exploring gender roles (e.g., playing house)."[10] Adults see sexual activity based on our grown-up experiences of sexual desire and orgasm-seeking behaviors. While pre-teens may be motivated by more adult-like desires, "this is rarely true of young children."[11] Instead, these children view private parts as a "mystery and secrecy that inspires them to discover what they are all about."[12]

Children below the age of four

Applying this knowledge to children less than four years of age, all of these behaviors would be developmentally normal:

- Exploring/touching private parts in private or public
- Rubbing private parts with a hand or against objects
- Showing private parts to others
- Trying to touch a mother's or another woman's breast
- Removing clothes and wanting to be naked
- Attempting to see others undressing
- Talking to same-aged children about "poop" and "pee"[13]

If, then, a toddler likes to run through the house naked after a bath or peeks in on a parent when they are showering, or giggles when talking about body functions with other children at his preschool, there is little to be alarmed about.

Children ages four to six

For children four to six years of age, the NCTSN finds all of these behaviors to be common and developmentally normal:

- Purposely touching his or her genitals
- Attempting to see others naked or undressing
- Mimicking dating behavior (kissing, holding hands)
- Talking about private parts and using "naughty" words they don't understand
- Exploring private parts with children their own age (playing doctor, "show me yours, I'll show you mine")[14]

Assume, for example, an adult walks into a room and discovers three girls, all five years of age, with their panties off and giggling at and pointing toward and touching each other's genitals.[15] Applying the research above, an appropriate response would simply be to tell the children that it's not a good idea to touch each other's private parts and to inform them that others are not allowed to touch their private parts.[16] With this simple education, the behavior is unlikely to repeat itself.

As another example, assume a kindergartner signed up for tee-ball gets a protective cup and comments "I'm so glad we got the cup, you have to protective the family jewels." In all likelihood, the child has no idea what he is talking about but has likely heard a phrase from television or an older youth and is simply repeating something he sees as "naughty" or perhaps funny. Asking what the child meant, and then answering any questions he may have about the cup is the proper parental approach.

Children seven to twelve years of age

For children in this age range, the NCTSN concludes the following behaviors are common and normal:

- Masturbation but usually in private
- Playing games with children their own age (truth or dare, playing family, playing boyfriend/girlfriend)
- Looking at pictures of naked people
- Viewing/listening to sexual content in media (TV, movies, games, the Internet, music)
- Wanting more privacy (when undressing, etc.)
- Beginnings of sexual attraction to peers

If, then, a youth minister walks in on two pre-teens exploring each other's bodies, he or she has likely walked in on developmentally normal behavior. In this instance, it would be appropriate to discuss with them the responsibilities of sexual activities, to let them know they are too young to be making babies, and to facilitate a healthy dialogue with their parents.[17]

Concerning sexual behaviors: pre-adolescence

Although it is true that most children exhibit sexual behaviors, some behaviors are less common and may pose concerns. In a study of 1,142 non-abused children, researchers found the following behaviors were relatively uncommon:

- Placing child's mouth on a sex part
- Asking to engage in sex acts
- Masturbating with object
- Inserting objects in vagina/anus
- Imitating intercourse
- Making sexual sounds
- French kissing

9. Kellogg, "Clinical Report—The Evaluation of Sexual Behaviors in Children," 992.
10. Toni Cavanaugh Johnson, *Understanding Children's Sexual Behaviors: What's Natural and Healthy* (2018), 1.
11. Ibid., 5–6.
12. Ibid., 6.
13. The National Child Traumatic Stress Network, "Sexual Development and Behavior in Children," table 1.
14. The National Child Traumatic Stress Network, "Sexual Development and Behavior in Children," table 1.
15. Johnson, *Understanding Children's Sexual Behaviors: What's Natural and Healthy,* 8.
16. Ibid.
17. Ibid., 9–10.

- Asking to watch sexually explicit behavior
- Imitating sexual behavior with dolls[18]

In one case, a school teacher at a Christian school walked into a bathroom and discovered a seven-year-old girl performing cunnilingus on a five-year-old girl who was pinned against a wall with tears running down her cheeks.[19] Applying the research above, this would be an unusual sexual act for a child so young. In addition to the explicit nature of the act, the two-year age difference and the appearance of some force (pinned against the wall) as well as harm (tears running down a cheek) raise a number of valid concerns.

In another case, a five-year-old boy was observed going up to girls on a playground and asking them to "suck my dick." When other children declined, he punched them in the stomach. The explicit request, combined with violence is unusual and concerning.

Although concerning sexual behaviors can be attributable to sexual abuse,[20] there are also multiple other factors that could be driving the behavior including exposure to pornography and observing adults engaged in sexual activity.[21] If these other potential sources of unusual sexual knowledge are eliminated, the possibility of sexual abuse increases.[22]

In cases of concerning sexual behavior such as the two cases described above, the National District Attorneys Association recommends screening for the possibility of sexual abuse, noting "the younger the child is in age, the more likely he is mimicking behavior seen or repeating behaviors the child has experienced."[23] Young children exhibiting concerning behaviors should not be charged as juvenile delinquents but if parents are unwilling to provide treatment or other necessary services, the government may consider filing a child protection petition to compel the parents to do so.[24]

Developmentally appropriate sexual behaviors: adolescence and teenage years

In her summary of the literature, Dr. Anna Salter notes the following behaviors to be common and normal among adolescents and teenagers:

- Sexually explicit talk with peers
- Obscenity/jokes within cultural norm
- Sexual innuendo, flirting, courtship
- Interest in erotica
- Solitary or mutual masturbation
- Hugging, kissing, holding hands
- Foreplay, even intercourse with consenting partner[25]

In describing these behaviors as normal, this is not to say that parents or faith leaders should not intervene when young people are making inappropriate comments or engaging in sexual activity. Obviously, young people need moral training and assistance in making sexual decisions. This is simply to say that the behaviors above do not warrant a call to the authorities or professional intervention.

Developmentally inappropriate/deviant sexual behaviors: adolescence and teenage years

In terms of inappropriate sexual behaviors among adolescents and teens, Dr. Anna Salter categorizes three levels of deviance with each level becoming increasingly problematic.

Deviant level one

The lowest level of deviance but which nonetheless presents concerns includes the following behaviors:

- High degree of preoccupation/anxiety
- Frequent use of porn/sex shows
- Indiscriminate sexual acts with multiple partners
- Sexually aggressive remarks, obscenities, graffiti
- Embarrassing others with sexual remarks
- Pulling skirts up, pants down
- Violating others space[26]

At a minimum, behaviors of this type should not be ignored and they are worthy of a conversation in the hope of providing appropriate boundaries. If the behaviors are extreme, some professional intervention may be appropriate. Some of the behaviors, such as indiscriminate acts with multiple sexual partners are associated with having endured trauma.[27]

18. John E.B. Myers, *Myers on Evidence in Child, Domestic and Elder Abuse Cases* (New York, N.Y.: Aspen Publishers, 2005), 383; William N. Friedrich, Patricia Grambsch, Daniel Broughton, James Kuipers, and Robert L. Beilke, "Normative Sexual Behavior in Children," *Pediatrics* 88 (1991): 456–464.

19. This is a case the author consulted on.

20. Kathleen Coulborn Faller, "Understanding and Assessing Child Sexual Maltreatment, Second Edition (Thousand Oaks, Calif.: SAGE, 2003), 182; William N. Friedrich, "Sexual Victimization and Sexual Behavior in Children: A Review of Recent Literature," *Child Abuse & Neglect* 17 (1993): 59–66.

21. Myers, *Myers on Evidence in Child, Domestic and Elder Abuse Cases,* 383.

22. Ibid.

23. Ann Ratnayake, "Juvenile Sex Offenses: Finding Justice," *Update* 23(9) (National Center for Prosecution of Child Abuse, 2013).

24. Ibid.

25. Anna Salter, "Normal and Deviant Adolescent Sexual Behavior," adapted from the work of Dr. Robert Prentky & Dr. William Friedrich, available online at: http://www.annasalter.com/annasalter/Slides.html (last accessed March 29, 2018).

26. Ibid.

27. Vincent J. Felitti and Robert F. Anda, "The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare," in *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic,* eds. Ruthe A. Lanius, Eric Vermeten, and Clare Pain (Cambridge Medicine, 2010), 77.

Deviant level two

The middle tier of deviance includes these behaviors:

- Compulsive masturbation
- Degradation/humiliation of self or others with sexual overtones
- Attempting to expose genitals of others
- Chronic preoccupation with sexually aggressive porn
- Sexually explicit conversation with young children
- Sexually explicit threats
- Obscene phone calls[28]

In one case, a teenager was hospitalized after tying a fish line so tightly around his nipples it would take surgery to remove. In therapy, the child shared the only way he could be sexually aroused is to harm or humiliate himself. As the case progressed, it was discovered the child had been sexually abused by seventeen different adults and he himself had sexually abused multiple younger children.[29] All of these revelations were made possible because professionals realized the concerning sexual behavior of the teenager at the outset and sought professional help.

Deviant level three

The most egregious level of adolescent and teenager deviance includes these behaviors:

- Genital touching without permission
- Sexual contact with significant age difference
- Forced sexual contact or penetration (vaginal/anal)
- Sexual contact with animals
- Causing genital injury to others[30]

The sexual behavior described above would be a crime if committed by an adult and warrants a delinquency petition and full assessment.[31] To get a sense of these types of cases, consider the following three examples.

First, a fourteen-year-old boy has been warned at a church summer camp about sexually aggressive remarks directed toward a girl his age. When he walks past the girl at a youth activity, he takes a pencil and forcibly pokes the girl's breast, causing her pain.[32] There are multiple concerning factors in this scenario. The child's remarks were sexually aggressive and, when warned, he elevates the conduct by promptly committing a sexual assault. The church must take immediate action to protect the victim, report the conduct to the authorities, and insist on a complete assessment that will aid in determining how best the church can work with the youth going forward.

Determining the cause of sexually abusive behaviors is difficult. Factors contributing to this behavior range from sexual curiosity to serious mental health problems.

Second, four sixteen-year-old boys from the local Christian school basketball team are at a hotel for a basketball tournament. Three of the boys gang up on a boy who is often picked on. While two of the boys hold him to the ground, the third boy attempts to "tea bag" him by putting his testicles in the boy's mouth. The victim's yelling causes the basketball coach to walk into the room.[33] Obviously, this is a serious sexual assault that warrants immediate action. The victim needs to be protected and supported. The offenders need to be reported to the authorities and, working with the authorities, the church can decide how best to support the assessment and treatment of the offenders.

Third, a church member has a thirteen-year-old son who has invited several of his teenage friends to his house. The boy persuades his younger sister, only six years old, to lie down on the bathroom floor with her pants and panties off. He promises he won't let his friends into the bathroom but he promptly breaks this promise and he and his friends have a "good laugh" about the matter.[34] Without training, this scenario could easily be dismissed as a silly prank. However, there are numerous factors of concern—the significant age difference, the degree of planning involved, and the intentionality of humiliating his sister in a way that has sexual overtones.

What causes adolescents and teenagers to commit sexual offenses?

Determining the cause of sexually abusive behaviors is difficult. Factors contributing to this behavior range from sexual curiosity to serious mental health problems.[35] According to the Association for the Treatment of Sexual Abusers:

> Adolescent sexually abusive behavior is influenced by a variety of risk and protective factors occurring at the individual youth, family, peer, school, neighborhood and community levels. Consequently, policies and practices should include evaluations that consider a range of

28. Anna Salter, "Adolescent Sex Offenders," available online at: http://www.annasalter.com/annasalter/Slides.html (last accessed March 29, 2018).
29. This is a case the author consulted on.
30. Salter, "Adolescent Sex Offenders."
31. Victor I. Vieth, "When the Child Abuser is a Child: Investigating, Prosecuting and Treating Juvenile Sex Offenders in the New Millennium," *Hamline Law Review* 25 (2001): 47–78.
32. This is a scenario the author consulted on.
33. This is a scenario the author consulted on.
34. This scenario is modified from a case scenario contained in Vernon R. Wiehe, *Sibling Abuse: Hidden Physical, Emotional, and Sexual Trauma* (Lexington Books: Lexington, Ma., 1990), 55.
35. David Finkelhor, Richard Ormrod, and Mark Chaffin, "Juveniles who Commit Sex Offenses Against Minors," *OJJDP Juvenile Justice Bulletin* (December 2009).

potentially relevant factors that might be related to the development or possibility of repeated sexually abusive behavior in a given youth and that can guide effective intervention.[36]

A juvenile offender's own history of sexual victimization may play a role particularly when the abuse occurs at young ages, involved multiple incidents, there was a long waiting period before reporting the abuse, and there was low level of perceived family support.[37] As a whole, though, a history of physical abuse or neglect has a stronger correlation to later sexual misconduct.[38] Keep in mind that when a child is maltreated they are often abused in multiple ways.[39] In a study of 667 boys and 155 girls who had committed sexual offenses, nearly all of them had "highly dysfunctional" families and high degrees of physical abuse, sexual abuse, emotional abuse, and neglect.[40]

Treatment for juveniles who commit sexual offenses

There are multiple options for treating a juvenile who has committed sexual offenses. Treatment with some support in the literature includes cognitive behavioral therapy, relapse prevention, sexual trauma therapy, and psychosocial education.[41] Multisystemic Therapy (MST), which operates on the premise that individual, family, and environmental factors all play a role in sexual misconduct, has also proved effective in lowering recidivism.[42]

Although clergy and other faith leaders cannot be expected to know the nuances of these various treatment options, they can advise parents to seek treatment that is supported by research. Clergy can also reach out to experts in the field for guidance in working with a juvenile in the congregation who has committed a sexual offense (see resource section above). When a juvenile has committed a serious offense and is being brought back into the church, faith leaders should require appropriate releases be signed so that they can discuss with the juvenile's treatment team his or her risk for re-offense and what type of safety plan is warranted.

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The risk of re-offense

Since recidivism is measured by whether or not an offender gets caught again, the actual rate of an adult or juvenile offender's recidivism is always higher than the numbers reported by researchers. This is because, in all likelihood, some offenders commit additional offenses but don't get caught. Nonetheless, it is encouraging that juveniles who commit sexual offenses have relatively low rates of recidivism (7-13 percent). We also know from research conducted at ten- and twenty-year intervals that juveniles who underwent some form of evidence-based treatment, had lower rates of recidivism than did juvenile offenders who did not receive any treatment.[43] This is true whether recidivism was measured by another charge for a sexual offense, a non-sexual violent charge, or a charge for any offense at all.[44]

There are some factors that increase or decrease the risk a juvenile will commit another sexual offense. The following factors elevate the risk of recidivism:

- Deviant sexual fantasies with an interest in prepubescent children and/or sexual violence
- Committing sex crimes despite prior charges or convictions
- Multiple victims
- Targeting strangers
- Social isolation/unwillingness or inability to form peer relationships

36. "Adolescents Who Have Engaged in Sexually Abusive Behavior: Effective Policies and Practices," adopted by the ATSA Executive Board of Directors on October 30, 2012.

37. John A. Hunter and Aurelio Jose Figueredo. "The Influence of Personality and History of Sexual Victimization in the Prediction of Juvenile Perpetrated Child Molestation," *Behavior Modification* 24 (2000): 241–263.

38. Cathy Spatz Widom and Christine Massey, "A Prospective Examination of Whether Childhood Sexual Abuse Predicts Subsequent Sexual Offending," *JAMA Pediatrics* 169 (2015), published online at: https://jamanetwork.com/journals/jamapediatrics/fullarticle/2086458 (last accessed March 30, 2018).

39. Heather A. Turner, David Finkelhor, and Richard Omrod, "Poly-victimization in a National Sample of Children and Youth," *American Journal of Preventive Medicine* 38 (2010): 323–330; David Finkelhor, Richard K. Omrod, Heather A. Turner, "Poly-victimization: A Neglected Component in Child Victimization," 31 *Journal of Child Abuse & Neglect* 31 (2007): 7–26.

40. Deborah J. Cavanaugh, Ann Pimental, and Robert Prentky, "A Descriptive Study of Sexually Abusive Boys and Girls—Externalizing Behaviors," in B.K. Schwartz, ed., *The Sex Offender: Offender Evaluation and Program Strategies,* vol. VI (Kingston, N,.J.: Civic Research Institute 2008), 12-1–12-21.

41. Lorraine R. Reitzel and Joyce L. Carbonell, "The Effectiveness of Sexual Offender Treatment for Juveniles as Measured by Recidivism: A Meta-analysis," *Sexual Abuse: A Journal of Research and Treatment* 18 (2006): 401–421.41

42. Elizabeth J. Letourneau, Scott W. Henggeler, Charles M. Borduin, Paul A. Schewe, Michael R. McCart, Jason E. Chapman, and Lisa Saldana, "Multisystemic Therapy for Juvenile Sexual Offenders: 1-year Results From a Randomized Effectiveness Trial." *Journal of Family Psychology,* 23 (2009): 89–102.

43. James R. Worling, Ariel Littlejohn, and David Bookalam, (2010)"20-year Follow-up Study of Specialized Treatment for Adolescents Who Offended Sexually," *Behavioral Sciences and the Law 28 (2010):* 46–57; James R. Worling and T. Curwen, "Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction," Child Abuse & Neglect 24 (2000): 965–982.

44. Ibid.

- Unwillingness/inability to participate in treatment[45]

On the other hand, these factors are associated with a lower risk of recidivism:

- Positive family functioning
- Positive peer social groups
- Availability of supportive adults
- Commitment to school
- Pro-social, non-criminal attitudes[46]

The church can play a role in lowering the risk of recidivism by helping a child develop healthy adult relationships and positive peer groups, and by providing appropriate supervision. To the extent a child's personal history of trauma has played a role in sexual misconduct,[47] developing a healthy spirituality can lower the effects of an abusive childhood.[48]

Re-uniting siblings when there has been a sexual offense

When a child commits a sexual offense against a brother or sister which results in a removal from the home, the issue of reunification is complex. At a minimum, the child committing the offense must have made meaningful progress in treatment as determined by the treatment provider.[49] Assuming this threshold is met, an appropriate safety plan can be considered that includes the following elements:

- Close supervision of the child committing the offense
- Prohibiting the child from babysitting or supervisory authority
- Prohibiting the child from bathing or dressing other children
- Requiring the child to be fully dressed in public areas of home
- Prohibiting the child from accessing sexualized materials

Even if the child who has committed the offense has progressed in treatment and a strong safety plan is in place, the needs of the victim must always come first.

- Prohibiting the child from sharing a room with younger children
- Prohibiting the child from going into other children's rooms
- Prohibiting the child from hugs or kisses with victim which, among other things, may bring back memories of the sexual assault
- Prohibiting horseplay, wrestling or tickling with children[50]

Even if the child who has committed the offense has progressed in treatment and a strong safety plan is in place, the needs of the victim must always come first. Accordingly, he or she must be able to emotionally handle the return of the offender to the home. If this is not the case, the pastor or other faith leader can help a juvenile who has sexually offended in understanding that even with repentance and improved behavior, there are earthly consequences for our conduct and that putting the needs of those we have harmed first is a critical lesson to master.

Conclusion

When Hagar's child faced death in the desert, we are told that God "heard the boy crying" and intervened, staying "with the boy as he grew up."[51] In applying this lesson to the sexual behaviors of children, faith leaders today must be with the children who are sexually abused by siblings or other children to make sure that they are protected and their needs fully met. Faith leaders must also be with the children exhibiting sexual behavior problems or committing sexual assaults in the hope that they will be held accountable for their conduct, appropriately treated, and grow up to be healthy adults.

45. Ann Ratnayake, "Juvenile Sex Offenses: Finding Justice," *Update* 23(9) (National Center for Prosecution of Child Abuse, 2013).

46. "Adolescents Who Have Engaged in Sexually Abusive Behavior: Effective Policies and Practices," adopted by the ATSA Executive Board of Directors on October 30, 2012.

47. Jill S. Levenson, Gwenda M. Willis, and David S. Prescott, "Adverse Childhood Experiences in the Lives of Male Sex Offenders: Implications for Trauma-Informed Care," *Sexual Abuse: A Journal of Research and Treatment* 1–20 (2014).

48. Katia, G. Reinert, Jacquelyn C. Campbell, Karen Bandeen-Roche, Jerry W. Lee, and Sarah Szanton, "The Role of Religious Involvement in the Relationship Between Early Trauma and Health Outcomes Among Adult Survivors," *Journal of Child and Adolescent Trauma* (2016) 9: 231, https://doi.org/10.1007/s40653-015-0067-7; Thema Bryant-Davis, Monica U. Ellis, Elizabeth Burke-Maynard, Nathan Moon, Pamela A. Counts, and Gera Anderson, "Religiosity, Spirituality, and Trauma Recovery in the Lives of Children and Adolescents," *Professional Psychology, Research and Practice* 43 (2012): 306–314; Donald F. Walker, Henri Webb Reid, Tiffany O'Neill, and Lindsay Brown, "Changes in Personal Religion/Spirituality During and After Childhood Abuse: A Review and Synthesis," *Psychological Trauma: Theory, Research, Practice & Policy 1* (2009): 130–145.

49. Barbara L. Bonner, Ph.D, *Taking Action: Support for Families of Adolescents with Illegal Sexual Behavior* (Safer Society Press, 2009), 33–38.

50. Ibid.

51. Gen 21:14–21 (NIV).