A SEX EDUCATION MANUAL FOR THE JUVENILE SEX OFFENDER

by

ELIZABETH C. LIBERATORI

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by

Elizabeth C. Liberatori

has been approved

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APPROVED:

[Signatures]

ACCEPTED:

[Signature]

Director of Graduate Studies
This study encompasses the latest research on the juvenile sex offender and addresses what is needed to assist him in becoming a sexually healthy, well adjusted non-offending adult in our society. A study of the literature, interviews with the professionals in the field and conversations with researchers of this current issue has revealed the necessity for sex education for the youthful offender. We can no longer ignore the fact that deviant sexual acting out by the children in our society is not experimental play, but in many cases learned behaviors that must be replaced with appropriate sexual behaviors. Along with intense programs developed with this population in mind, we must take the responsibility to replace the unlearning of deviant sexual behaviors with appropriate sexual behaviors by educating this population about their own sexuality, what is healthy and normal behavior and what is unacceptable and hurtful to others. We must incorporate every means to reduce the number of victims who suffer at the hands of the juvenile sex offender.
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CHAPTER ONE

THE PROBLEM

Introduction to the Study

During the 1994 Arizona Psychological Association's Annual Convention: Sex and Violence-Critical Issues in the '90s held October 7-9 at the Tucson Convention Center in Tucson Arizona, Judith Becker, Ph.D. and John Hunter, Ph.D emphasized the need for a sex education curriculum for the juvenile sex offender. There were four specific topics mentioned by Drs. Becker and Hunter:

1. male anatomy and physiology;
2. female anatomy and physiology;
3. adolescent sexuality and sexual development; and
4. homosexuality (Becker and Hunter, 1994).

Among other topics dealing with sex education, the topics mentioned above are included in the Sex Education Manual developed for this thesis.

In April of 1994, in a personal interview with Paul Gerber, the Director of the Juvenile Sex Offender program at the Hennepin County Home School in Minnesota, Paul emphasized the need for sex education as a critical part of their program at the School. He discussed the sex education program developed for use at Hennepin.
Judith Kaufman, (1983) in a paper presented at the annual convention of the National Association of School Psychologists in Philadelphia stated, "the rapid physical changes that occur in the course of "normal" adolescent development can cause confusion, questions, and temporary or transitory disruptions in development. The effects of additional elements of stress, such as early or late maturation or episodes of sexual abuse, may seriously impair body image, leave marked psychological scars and create long-lasting, negative attitudes about sexuality and self. Therefore it is critical for the clinician to recognize the "normal" disruptions and concerns of non-normative or atypical adolescent sexual development. Through such knowledge, professionals are in a better position to develop programs and treatment interventions to meet adolescents' needs and address their confusion over sex and sexuality" (Kaufman, 1983).

Even though most sex offenders have been more sexually active than their peers in the general population, their knowledge of sexual behavior and values are quite distorted. This phenomenon is particularly true of offenders who have been sexually molested at a very young age. Similar deficits in sexual knowledge and values are found in juvenile sex offenders who have never been sexually active (no molestation or abuse) or have had very limited experience (Johnson, 1987).
Background of the Problem

Until the fall of 1973, when the University of Washington School of Medicine's Adolescent Clinic was asked to evaluate and treat a group of juvenile and adolescent sex offenders, evaluation and treatment designed specifically for this age group had not been undertaken in the United States in a coherent and comprehensive fashion. Since that time, treatment programming for youthful sex offenders has increased steadily; to date, approximately 450 treatment providers offering services to these young offenders have been identified nationwide. Though not guided by any systematic development or testing of treatment approaches and outcomes, this field is evolving rapidly into a highly specialized discipline (Knopp, 1987).

The extraordinary growth in the number of specific services for this young population reflects the growing awareness on the part of mental health and criminal justice professionals of the importance and appropriateness of offense-specific treatment for sexually aggressive youth. There is now recognition that early remedial intervention in sexual offenses offers a strong potential for changing such behaviors (Knopp, 1987).

Arizona Juvenile Corrections has recently joined the ranks, offering offense-specific treatment in their correctional facilities. This change resulted from a class action suit (Johnson v. Upchurch) against the State of
Arizona by which the Department of Juvenile Corrections became a separate institution apart from adult correction, and has become known as Arizona Department of Youth Treatment and Rehabilitation (ADYTR).

On September 10, 1985 Matthew Davey Johnson was adjudicated to Arizona's Department of Corrections and incarcerated at Catalina Mountain Juvenile Institution (CMJI). Much of his incarceration was spent in cottage isolation, including 50 consecutive days on "motivational hold," a program developed by Superintendent James Upchurch.

On August 22, 1986, Johnson filed a civil rights lawsuit in U. S. District Court naming then Superintendent Upchurch as defendant. The suit alleged that Johnson's constitutional rights had been violated (Johnson v. Upchurch, 1986, 195).

On July 27, the court certified a class in Johnson v. Upchurch, consisting of all juveniles incarcerated in CMJI on or after the class certification date, except juveniles who elected not to participate. Certification allowed the action to go forward (Center for the Study of Youth Policy, 1992).

The plaintiff class alleged that the Department of Corrections (DOC) violated the constitutional rights of juveniles in:
- disciplinary practices, particularly use of isolation and isolation unit conditions;
- use of handcuffs and shackles;
- rehabilitative care and treatment;
- educational programming;
- inappropriate placement, evaluation, and classification;
- visitation, correspondence, and access to counsel;
- parole revocation procedures (Johnson v. Upchurch, 1986).

As a result of the class action suit, juvenile corrections underwent some drastic changes, one of which was the "split" from the adult correctional system. A Task Force needed to be created and their first meeting was held on July 31, 1990. The Arizona Department of Juvenile Corrections was formed on July 1, 1990, with Carol Hurt appointed as Director by Governor Rose Mofford.

On February 26, 1991, following a run-off election, Fife Symington became Arizona's new Governor. In May of 1991, Governor Symington issued a new executive order continuing the Task Force and clarifying its role. He appointed Alice Snell as Task Force chair. In June 1991 he signed House Bill 2326, and when the new law went into effect, ADJC became the Department of Youth Treatment and Rehabilitation (DYTR). The name change reflected a new commitment to providing youth with the opportunities they need to become successful adults. The new law also gave DYTR the flexibility to treat youth as individuals (Center for the Study of Youth Policy, 1992).

Out of all of these changes within the Agency was born the commitment to create specialized treatment cottages to
meet the needs of the youth in the care of DYTR. There will be three offense-specific treatment cottages and the first one that has been established is the Journey Cottage for juvenile sex offenders with a violent offender treatment cottage and a substance abuse cottage to follow.

This study is based on a needs assessment of the juvenile sex offender's sex education and values as a conjunct to the therapeutic program outlined in the Journey Program developed by Dr. Matte Ferrara, Ph.D. at the request of the Department of Youth Treatment and Rehabilitation (DYTR), to treat juvenile sex offenders in the care of DYTR at Adobe Mountain School (AMS) and Catalina Mountain School (CMS).

Violence is a major problem in the United States and has reached epidemic proportions. The Bureau of Justice Statistics (1988) reports that more than 1 million children older than 12 years of age suffered injuries because they were assaulted. In the United States, the homicide rate of young males is the highest among 21 developed countries surveyed. It is also indicated that 20% of rape and approximately 40% of child abuse cases are committed by adolescents (Uniform Crime Reports, 1985).

Young males are not only the victims of violence, but also perpetrate violence. One form of violence perpetrated by adolescents is sexual violence and abuse. Until recently, there has been a paucity of research on the
adolescent sex offender (University of Arizona, 1993). The need to focus on juvenile sex offenders, however, was underscored by data presented by Abel et. al. (1985), who report that 58% of the adult sex offenders they interviewed reported the onset of their deviant sexual patterns before age 18.

Although available evidence suggests that mental illness is not a common correlate with juvenile offender behavior, research pertaining to the intellectual functioning of juvenile sex offenders supports the notion that these offenders typically have low average or borderline intellectual functioning (Atcheson and Williams, 1954).

More than half of America’s teenagers have had sexual intercourse. One million become pregnant each year, while one in seven contracts a sexually transmitted disease (STD) (Contemporary Sexuality, 1991).

Factors that predispose an adolescent to commit sexual offenses have yet to be established (Davis and Leitenberg, 1987). Clinical findings must continue to be pursued in research. Thus far the major predeterminant that the majority of adolescent sex offenders have been demonstrated to share is a history of physical abuse. Contrary to the assumption that the major cause of sex offending is a history of sexual victimization, Davis and Leitenberg (1987) did not observe a statistically significant prevalence of
victimization in the history of adolescent offenders. Bera (1989) refers to the belief that all offenders must be victims of sexual abuse as the "vampire syndrome," and argues that this assumption insults the large number of adult victims who have never offended (Bera, 1989).

Numerous intraindividual and familial factors have been suggested as having etiological significance in the development of adolescent sexual offenders. For example, offenders have been described as having minimal social skills; very low self-esteem; limited ability to effectively express anger; feelings of powerlessness; very distorted, highly stereotyped notions of sexuality and intimate relationships; and childhood exposure to aggression and dominance in the form of sexual, physical, or emotional abuse (Davis and Leitenberg, 1987; Jackson, 1984).

In a study of adult sexual offenders seen on an outpatient basis, the 411 sex offenders reported that they had completed 218,900 sexual crimes (Abel, Mittleman and Becker, 1985). The total number of victims was 138,137. On the average, each offender attempted 581 crimes, completed 533 crimes, and had 336 victims. Furthermore, 58% of the adults began their deviant sexual behavior during their adolescence.

Two recent studies have described populations of adolescent sexual offenders (Fehrenbach et. al, 1986; Becker, Cunningham-Rather and Kaplan, 1986). Fehrenbach et.
al. (1986) evaluated 305 adolescent sexual offenders. More than 60% of the adolescent offenders had sexually victimized a child younger than 12 years of age.

Sixty one percent of a group of 80 adolescent sexual offenders (mean age of 15 years) seen on an outpatient basis for evaluation or treatment had engaged in sexual behavior with children. The majority of victims were unrelated to the offenders and younger than 8 years of age. The 49 adolescents who involved themselves with young children had completed a total 70 deviant sexual acts involving a total of 60 victims. For the majority of adolescents, however, the official records noted only one offense per adolescent. The next largest category of offenders were rapists (16 had raped females, and 5 had raped males). These 21 adolescents had completed 42 rapes involving 16 victims and had attempted 14 rapes involving 14 victims. The rapists who raped female victims used (on the average) more physical coercion than necessary to commit the crime and more aggression than the other diagnostic groups (Becker et. al., 1986).

**Statement of the Problem**

Review of national crime statistics reveals that the incidence of reported sex-related offenses committed by preadolescents and adolescents has been increasing at an unprecedented rate over the last decade. According to the
Uniform Crime Report, the incidence of sexual offenses perpetrated by minor-age males continues to grow at the rate of nearly 10% per year (U.S. Department of Justice, 1988, 1990a, 1990b). In Utah, according to the Utah Network on Juveniles Offending Sexually, the reported incidence of all sex offenses perpetrated by juveniles increased by 55% during the five-year period from 1983 through 1987 (NOJOS, 1989). The number of rapes perpetrated by adolescent males in 1990 was 30% higher than in 1988 (Department of Public Safety, 1990). Other states report similar increases for the same time period. Furthermore, researchers (Knopp, 1982; Longo and Groth, 1983; Stenson & Anderson, 1987) have observed that adult sex offenders frequently report having begun their sexual offending careers during adolescence, or even earlier.

The Purpose of the Study

The purpose of this study is to design a sex education manual for staff and juvenile sex offenders with a program that will address those specific needs.

Question to be Answered

What is the content of a Sex Education Manual for juvenile sex offenders?
Theoretical Basis for the Study

With all the research on juvenile sex offenders to date, there are only a few sex education programs that have been developed specifically for the juvenile at risk. Unless we can replace the cognitive distortions these youth have toward sexuality with appropriate information, half the work will be left undone. Who were his or her role models? Most sex offenders come from extremely abusive homes and as we know, families play an important role in the development of our youth.

Two distinct family types have been identified and each is associated with a specific type of juvenile sex offender. The Disorganized Family seems to be associated with the juvenile sex offender who engages in child molesting behavior. The Disorganized Family is characterized by physical violence between the parents, physical abuse by the parents of their offspring, many brief marital separations and behavior problems exhibited by siblings. The other type of family was dubbed the Detached Family. The Detached Family evidenced a high rate of juvenile sex offenders who engage in rape. The Detached Family was characterized by parents who showed little commitment to their children, long periods of parental separation and few legal marriages (Awad et al, 1984).

Secondly, research has revealed that the sex offender has low intellectual functioning and has lower I.Q. scores
than other delinquents (Awad, Saunders and Levine, 1984). While it is inconclusive that juvenile sex offenders routinely obtain low I.Q. scores, psychological testing shows a consistency which indicates the sex offender as immature.

Third, the juvenile sex offender, as well as other youth at risk, must acquire a healthy understanding of human sexuality and relationship functioning.

Finally, research has focused on the juvenile sex offender for the last ten to fifteen years. What has been previously thought of as "experimentation" by professionals, is now realized as sex offending behaviors. While some excellent treatment programs are being written and utilized, not only in the private sector and hospitals, but the Juvenile Justice System and correctional institutions are seeing the value in treating the juvenile sex offender and their families. It is still not enough. One needs to look to the juvenile sex offender's sex education as well.

Significance of the Study

The residents of the Journey Program as well as staff would find this study to be significant as an adjunct to the treatment program already in place. Pre-testing and post-testing would enable staff to evaluate the kinds of distortions and thinking errors of the youths and the youths' own perceptions of normal sexualized behavior and
the kinds of values they place on future relationships.
With these values in place there will be a reduction in sex
crimes and therefore fewer victims, which is of primary
concern.

It would be particularly significant to DYTR, parole
officers, the Juvenile Justice System, the family, and the
community-at-large, with whom our first obligation lies.
By adding a sex education program designed specifically
with the juvenile sex offender in mind, The Journey Program
would be utilizing every available resource in the
development and rehabilitation of its youth.

Definition of Terms

ADJUDICATE - To hear and decide by law. To sentence
judicially.

adolescent sex offender - Youthful sexual offender. A
Youthful sexual offender is defined, in
general, as a preadult male or female who
instigates sexual or assaultive sexual
interaction with either a nonconsenting partner
or a child too young to understand the sexual
behavior being consented to.

BORDERLINE - Being just below the average, standard or
normal.

deviant - Differing from a norm or from accepted moral or
societal standards.

DSM-III-R - Diagnostic and Statistical Manual of Mental
Disorders (Third Edition Revised).

paraphilias - Disorders in which the person has recurrent
and intense sexual urges and sexual arousing
fantasies in response to sexual objects or
situations that society deems inappropriate.

recidivism - A tendency to slip back into a previous
behavior pattern, esp, a tendency to return to criminal habits and activities.

**Assumptions and Limitations**

It is assumed that results will be gained by quality participation of the juveniles at Adobe Mountain School and on the cooperation of all members of the therapeutic team as well as adjunct staff.

Factors that may limit the finding of the study include a lack of participative support from group members, inaccurate documentation of necessary data, and the misrepresentation of the dependent variables. Descriptive research lacks external and internal validity, and generalization of results are limited to the specific circumstances in which the research was done.

**Organization of the Remainder of the Study**

Chapter Two of this study is the literature review, which includes statistical research by Judith V. Becker, Ph.D. and John A. Hunter, Ph.D. who are considered foremost authorities in the field. Also included will be an exploration of literature relevant to sex education for the juvenile offender.

Chapter Three of the study presents the methodology that was used to conduct the research. It includes a description of the research and design of the study.

Chapter Four offers an overview of the entire study
including a brief restatement of the problem. There will also be a conclusion and recommendations for future research.

Appendix A will present the Sex Education Test used for pre-and post-testing. Appendix B will present the Teacher’s Sex Education Manual I and II.
CHAPTER TWO

THE LITERATURE REVIEW

Introduction

In the last ten years, there has been extensive study by experts in the field of paraphilias. This chapter will include studies done on the juvenile sex offender, non-adjudicated sex offenders, the female sex offender and the paraphiliac personality as described in the DSM-III-R.

Further research has suggested that one of the essential characteristics of adolescent development is the integration of sexual drives into the psychosocial life of the teenager. The onset of puberty, the development of primary and secondary sexual characteristics, and the accomplishment of sexual and sex-role identity are hallmarks of this period, serving to distinguish adolescence from all other developmental periods. At no other time in life do so many changes occur within such a short time span. The physical and sexual maturity that occurs in both sexes during adolescence can falsely imply concomitant psychological maturity and responsibility to cope with those changes. Parental and peer attitudes and expectations along with the teenager's self-perceptions combine to influence the adolescent's psychological response to sexual maturity.
The social impact of significant others' responses to the developing adolescent's sexual identity may be greater than the biological changes themselves (Kaufman, 1983).

In a survey of 541 adolescents, the most frequently asked personal questions and concerns regarding teenage sexuality concerned abnormality in sexual feelings, followed by emotional concerns (i.e., depression, suicidal ideation), and then moral, ethical, and social concerns (Sondheimer, 1982). Responses to questionnaires like the Inventory of Attitudes Towards Sex (Eysenck, 1970) show marked shifts and changes in attitudes and actual sexual behavior among the adolescent population. The average age of initial sexual intercourse, for example, has lowered for middle-class girls, and puberty is also occurring at a younger age (Kiestenbaum, 1979). Research data from several studies suggest that the more advanced sexual expression (petting and intercourse) are occurring at an earlier age (Miller and Simon, 1974; Zelnik and Kanter, 1977). Overall, more teenagers report more sexual activity. Adolescents assume adult-type roles while they may not attain their educational goals until their mid-to-late 20s (Hass, 1979).

The assessment of issues such as sex-role development is critical in understanding the adjustment as well as the symptomatology unique to the adolescent period. Success or failure in sexual adjustments during adolescence can have dramatic consequences for future relationships and provides
the foundation for adult sexuality. Sometimes adolescents model adult forms of sexual behavior (often with marked distortion) as a vehicle for acting out and asserting their seeming maturity and independence. Multiple sex partners, provocative sexuality, and sexual offending might be seen as examples of such acting out. Often sexuality becomes the symptomatology indicative of more deeply rooted problems. Some adolescents, for example, may become sexually promiscuous in order to reinforce a poor self-image. Others may have questions and concerns about sexual issues that belie more obscure or generalized psychological problems, such as an adolescent concerned about frequent masturbation that in fact fits a more generalized problem of self-abusing behavior (Kaufman, 1983).

Why adolescents commit sexual crimes as well as how their deviant sexual patterns are maintained is unknown. A variety of theories have been proposed to explain the causes of sexually aggressive behavior and the nature of sexual violence (Ford and Beach, 1955; Freud, 1938; Gagnon and Simon, 1967; Groth and Birnbaum, 1979). However, to date there is no empirically derived and tested model to explain why adolescents commit sexual crimes (Becker and Kaplan, 1986).

Much confusion surrounds the identification of juvenile sex offenders. Several researchers have found indications that a significant number of sexual offenders have the onset
of their deviant sexual interest pattern soon after puberty (Abel, Mittleman, and Becker, 1985; Awad, Saunders and Levene, 1979; Groth and Birnbaum, 1979; Longo and Groth, 1983). Some researchers have suggested that the early onset of deviant behavior in male adolescents may have been simply a matter of innocent sex play and experimentation or that the sexual offenses were due to the normal aggressiveness of the sexually maturing adolescent (Finkelhor, 1979; Gagnon, 1965; Reiss, 1960; Roberts, Abrahams, and Finch, 1973). Chatz (1972) suggested that these adolescent offenses are mostly minor and non-dangerous offenses and that they rarely repeat their behaviors. Recent research has suggested otherwise. Groth (1977) described the characteristics of 26 convicted adolescent sex offenders. The majority (86%) had previous interpersonal sexual experiences prior to the sexual assault.

Becker, Cunningham-Rathner, and Kaplan (1986) reported that the adolescent offenders surveyed had engaged in non-deviant genital sexual behaviors beginning at ages ranging from 6 to 16; 41% reported never having engaged in non-deviant genital sex relationships. In a separate study of 22 adolescent incest offenders, it was found that they had begun engaging in non-deviant sexual behaviors prior to engaging in incestuous behavior. These findings seem to challenge the assumption that adolescents are mainly experimenting with sexuality when they engage in deviant
sexual behaviors (Becker, Kaplan and Cunningham-Rathner, 1986).

In 1992 the Safer Society Program in Brandon, VT, conducted a nationwide survey of juvenile and adult sex-offender treatment programs and models. Some of these programs use the polygraph with juvenile sex offenders. A study was done between August 1991 to April 1993, and the sample group included 36 adjudicated adolescent sex offenders. There were 35 males and 1 female in the sample (Chambers, 1993).

The Washington Institute of Public Policy did a five year follow-up study of reoffense behavior of juvenile sex offenders (Malloy, Schram, and Rowe, 1991).

**Juvenile Sex Offender Recidivism**

<table>
<thead>
<tr>
<th>Description</th>
<th>Rate</th>
<th>(Follow-up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Offense Rearrest Rate</td>
<td>12.2%</td>
<td>(Five year)</td>
</tr>
<tr>
<td>Sex Offense Reconviction Rate</td>
<td>10.2%</td>
<td>(Five year)</td>
</tr>
<tr>
<td>Non-Sex Offense Arrests</td>
<td>50.8%</td>
<td></td>
</tr>
<tr>
<td>Non-Sex Offense Convictions</td>
<td>47.7%</td>
<td></td>
</tr>
</tbody>
</table>

**Characteristics of Non-reoffenders:**

1. Generally older youth.
2. Less likely to have had prior contact with the justice system.
3. Less likely to have school problems.
4. Did not have a history of truancy.
5. Less likely to have been sexually abused.
6. Less likely to have siblings who had been sexually abused.
7. **More** likely to have deficits in social skills.

8. Less likely to blame their victims.

9. Less likely to have deviant arousal patterns (Malloy, Schram, and Rowe, 1991).

Further research of 118 incestuous fathers and 116 control fathers (50% Navy) has revealed that in the no abuse group, persons with youth sex offenses were seven times more likely to be incestuous fathers (Finkelhor, 1984).

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**Role of Abuse in Adult Incestuous Behavior**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Crude Odds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any childhood sexual abuse</td>
<td>5.32</td>
</tr>
<tr>
<td>Severe sexual abuse (Penetration, force, sev. perps)</td>
<td>7.2</td>
</tr>
<tr>
<td>Other abuse or neglect</td>
<td>5.32</td>
</tr>
<tr>
<td>Youth sex offenses</td>
<td>5.44</td>
</tr>
<tr>
<td>Lonely teen</td>
<td>11.0</td>
</tr>
<tr>
<td>Marital dissatisfaction</td>
<td>4.21</td>
</tr>
<tr>
<td>Adult with no close friends</td>
<td>8.0</td>
</tr>
</tbody>
</table>

When conducting an evaluation, it is important that clinicians are trained to be aware of normal and abnormal sexualized behaviors for different age groups.
### Sexual Behavior Standards for Ages 0-12

<table>
<thead>
<tr>
<th>Age</th>
<th>Normal Behaviors</th>
<th>Abnormal Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td>Touching own genital. Discussing body functions. Interest in looking at other’s bathroom activities. Touching another person’s genitalia, but quickly responding to re-direction. Showing genitals to peers.</td>
<td>Genital kissing. Oral-genital sex. Simulated intercourse Penetration with finger, object, or penis into mouth, anus, or vagina of another. See additional abnormal behaviors below.</td>
</tr>
<tr>
<td>6-10</td>
<td>Touching own genitals Masturbating Interest in viewing other’s bodies. Using sex words, sexual jokes. Seeking information about sex.</td>
<td>Genital kissing. Oral-genital sex. Simulated intercourse Penetration with finger, object, or penis into mouth, anus, or vagina of another. See additional abnormal behaviors listed below.</td>
</tr>
<tr>
<td>10-12</td>
<td>Masturbating. With peers, consensual: kissing, fondling, sexual penetration and/or same sex activity.</td>
<td>Sexual activity with children two or more years younger than subject. See additional abnormal behaviors below.</td>
</tr>
</tbody>
</table>

Abnormal Behaviors for all Age Groups:

- Verbal threats and/or
- Use of force and/or
- Physical restraint (Friedrich, 1991).

The following treatment goals are standard for most juvenile sex offenders when preparing their Individual Development Plan (IDP). The IDP is developed by his Treatment Team with the youth’s input and his goals and objectives foremost in mind.
Treatment Goals for Young Sex Offenders

1. Accept full responsibility for all abusive and criminal behavior.

2. Develop a clear understanding and sensitivity to the effects of sexual abuse on victims.

3. Develop an understanding of the thoughts and feelings that led to the offense and identify key parts to the offending cycle.

4. Learn to meet sexual and social needs without hurting others.

5. Increase appropriate sexual arousal and decrease deviant sexual arousal.

6. Identify high risk situations that could lead to further offending.

7. Develop an offense prevention plan, share it with others in the support system.

8. Learn and demonstrate responsible day-to-day behavior which includes avoiding high risk situations.

9. Parents will believe the offense occurred, and will understand that a reoffense is possible.

10. Parents will understand the treatment process, and show the ability to effectively monitor the youth’s behavior (Kahn, 1993).

Sexual offenses do not just "happen." A series of events occur before a sexual offense is committed. These events are called "preconditions." These conditions must exist before a sexual offense is committed. For each precondition to exist, one had to have broken through or gotten over some barrier or wall that ordinarily prevents people from committing sexual offenses. Teaching the juvenile offender is about him learning how to stop going over or through the walls and barriers. He must learn about
his preconditions for abuse and how to build up the barriers to prevent himself from offending again. This theory is called "Four Preconditions: A Model" and the four preconditions are: (1) motivation, (2) internal barriers, (3) external barriers, and (4) the victim's resistance (Finkelhor, 1984).

Juvenile Sex Offenders

Recently, 73 published articles on juvenile sex offenders were identified and reviewed. The majority of these articles identified characteristics of juvenile sex offenders, followed by treatment issues and characteristics of parents and others relevant issues. The majority of articles were descriptive in nature and did not use comparison or control groups (Becker & Hunter, 1993).

Adolescent sex offenders have engaged in hands off behavior (voyeurism and exhibitionism) and hands on behavior (fondling; oral, anal, or vaginal penetration). Their victims have been children, peers, adults, and in some cases animals (Becker & Hunter, 1993).

Juvenile sex offenders are a heterogeneous group, and to date there is no profile of a juvenile sex offender or a comprehensive, empirically derived typology of juvenile sex offenders. The development of such a typology would guide our assessment and be helpful in terms of evaluating treatment outcome studies (Becker & Hunter, 1993).
To date there is not an empirically derived theory to address the cause of juvenile sex offender behavior. Two models, however, are described in the literature. Ryan, et. al. (1987), described a sexual assault cycle, which is based on a cognitive-behavioral dysfunction cycle. Another model incorporates individual, familial, and social environmental factors. This model addresses "paths" a juvenile may follow after commission of the first sexual offense (Becker & Kaplan, 1988).

Individual factors that have been identified include lack of social competence skills (Awad, 1989; Fagan, 1986; Katz, 1990; Smith, 1987), prior delinquent behavior (Kavoussi, Kaplan and Becker, 1988), psychopathology (Becker et. al., 1986; Becker et. al., 1991), low academic performance (Schram, Malloy and Rowe, 1991), and lack of impulse control (Smith, Monestersky and Deisher, 1987).

The type of offense committed by the juvenile sex offender does not appear to be affected by his youthful age. That is, juvenile sex offenders appear capable of committing the same type of offense as older adult offenders. This should come as no surprise given that many adult offenders began their exploitive behavior while an adolescent (Ferrara, 1993). It is disconcerting that most juvenile sex offenders tend to have more than one offense, and usually progress to more serious types of sexual exploitation before they are apprehended (Wasserman and Kapple, 1985; Saunders
The juvenile sex offender is defined as a youth, from puberty to the legal age of majority, who commits any sexual act with a person of any age, against the victim's will, without consent, or in an aggressive, exploitive or threatening manner (Ryan, 1986). Historically, juvenile sexual offenders have not been dealt with in an accountable manner (Groth and Loredo, 1981). In many cases, rape has been minimized by a "boys-will-be-boys" attitude, with token punishments and admonitions to behave. Molestation of children by teens has been labeled "curiosity" or "experimentation," and many sexual offenses termed "adolescent adjustment reactions." Even in the cases where the offender's behavior was clearly sexual and criminal, many systems have been reluctant to label a juvenile as a sex offender. Family and community systems alike ignored early warning signs, minimized exploitive behaviors, and denied the deviant nature of sexual assaults by teenagers (Ryan, 1986).

Within the last decade, many clinicians have begun recognizing and assessing the seriousness of juvenile sexual offenses, inspired in part, by recent findings which suggest that most incarcerated adult sex offenders began committing sexual crimes in early adolescence (Longo and McFaddin, 1981; Longo and Groth, 1983).

Because experience to date indicates that sexually
abusive behaviors develop steadily over time, early intervention is clearly indicated, both for the prevention of multiple victims and to interrupt the reinforcing nature of the behaviors. While the sexual offender may always be at risk for sexual assault there are many tools to offer the offender to enable him to control his deviancy if he chooses to do so. Only through involvement in a program specifically for sexual offenders can these tools be made available to him. To withhold the opportunity for treatment from the youthful offender, therefore, is irresponsible and only invites further victimization (Knopp, 1985).

Non-Adjudicated Sex Offender

Most victims of molestation do not report their molestation (Russell, 1986). This means that most sex offenders get away with repeated assaultive behavior without consequence. And while information is being gathered on convicted and/or incarcerated sex offenders, very little is known about the majority of sex offenders who are never confronted or adjudicated (McIvor, 1994, p.28).

Wenet and Clark's Sexual Attitude Scale was administered to a non-adjudicated, sex offending client (McIvor, 1994). He strongly agreed with the statement "I have never taken part in any kind of sexual activity I would consider to be immoral or wrong." When reminded what the item meant and that he was seeing Dr. McIvor for multiple
sexual offenses, he stated, "Oh yea, I forgot for a moment." This is a very clear example of how effortless it is for a sex offender to compartmentalize as large a chunk of reality as needed to protect one's self or minimize discomfort. When confronted on this kind of behavior, offenders often respond with something like, "I don't dwell on unpleasantries" (McIvor, 1994).

The Female Offender

Reconstructing the female sex offenders sex history prior to arrest, it was found that lying by omission, compartmentalization, denial, minimization, and great skill in avoiding detection (McIvor, 1994). Why did the females sexually molest children? Sexual arousal to the children, excitement, ability to control and manipulate the children, and a sort of personal flattery. It was flattering to the female offenders that they could arouse a sexual response from a nine to a 16-year-old boy or girl (McIvor, 1994).

Conducting a properly designed experimental study with non-adjudicated and adjudicated sex offenders would be difficult (Giarretto, 1983). Giarretto (1983) states, "however, I think we can learn about treating non-adjudicated sex offenders by what we have learned about treating adjudicated sex offenders. For example, many adjudicated sex offenders complete treatment when given the choice of treatment or incarceration and relatively few of adjudicated offenders who have completed treatment reoffend."
Most investigators have noted that non-adjudicated sex offenders who volunteer for treatment never complete treatment. Therefore, it would seem to unfortunately follow, as the examples presented here indicate, that non-adjudicated offenders will continue to offend if not adjudicated. By using denial, compartmentalization, and rationalization, they will not see the harm in sexual abuse (Giarretto, 1982).

**Paraphiliac Personality Disorder**

There is a substantial body of data in clinical case studies, court reports, and criminal statistics, to support the existence of a paraphiliac personality disorder. It is characterized by excessive preoccupation with sexuality by fantasy or behavior that deviates from societal norms and values and is physically and/or psychologically harmful to victims. Major features are low personal and social controls, unwillingness to conform to legal and social standards, lack of empathy for victims, cognitive distortion, and denial or minimization of deviant sexual behaviors. In recent years there has been increased concern that deviant sexual behavior is far more complex than has been assumed (Heins, 1988; MacHovac, 1993; Youngstrom, 1992). Typologies specific for one type of sex offense have expanded but do not include crossover across several types of offenses (Knight & Prentky, 1990). Offender
Psychodynamics can be highly individualized, more complex than sexual typologies suggest. The DSM-III-R list of paraphilias is incomplete (American Psychiatric Association, 1987) and the DSM-IV newly published has added more.

PSYCHOPATHIC PERSONALITY DISORDER VS. PARAPHILIAC PERSONALITY DISORDER

Personality disorder is defined as a persistent pattern of behaviors and traits rooted in the history and development of the individual personality. Current diagnosis criteria (DSM-III-R, 1987) describe personality traits as "enduring pattern of perceiving, relation to, and thinking about the environment and oneself... in a wide range of important and cultural contexts" (p.335). Clinical case studies and court reports support the hypothesis that using and abusing others sexually is an enduring perception of self and others in social and cultural contexts.

DSM-III-R describes how personality disorders develop from pathological traits that become "inflexible and maladaptive and cause significant functional impairment or subjective distress" (p.335). They are "often recognized by adolescence or earlier and continue throughout most of adult life" (p.335).

The history of personality disorder as a diagnostic category has many references to deviant sexual behavior (Hinsie & Campbell, 1973). Character and personality disorders were seen as similar, evolving from Prichard's
"moral disorders" (cited in Hinsie & Campbell, 1973). Master diagnostician Emil Kraepelin (cited in Hinsie and Campbell, 1973) described the four features of this disorder as excitability, impulsivity, lying, and criminality. Adolf Meyer (1905) described it as developing from "traits acquired early and thoroughly ingrained in the personality" into a psychopathic personality or disorder of primary, non-organic, idiopathic behaviors and "seriously irresponsible conduct" (p. 617).

Inappropriate sexuality in paraphilic personality disorder is usually of early onset, in infancy and early childhood. It can be learned and conditioned by the offender's own victimization. It is a historical disorder, rooted in the past, and is both acute and chronic. Erotic fantasy, deviant and individualized, directly contributes to sexually acting out, repeated and reinforced, escalating into rape, incest, or molestation. The offenders own victimization, real, feared, fantasized, or perceived as real by inept therapy, provides a model for future offenses. A study of 1149 randomly selected sex offenders in Virginia showed that about half of them were under age 13, had multiple offenses, and one in four had been sexually assaulted themselves (Department of Criminal Justice Services, 1993).
CHAPTER THREE
METHODOLOGY

INTRODUCTION

In this chapter the methodology used to conduct the research is presented. Also included is a description of the research and design of the study.

Purpose of the Study

The purpose of this study is to determine the sex education needs of the juvenile sex offender and to design a sex education manual for the acquisition of an understanding of human sexuality and relationship functioning.

Research Methodology

The research follows the descriptive methodology.

Description of the Methodology

Descriptive research was used in this study. Its purpose is to describe systematically the facts and characteristics of a given population or area of interest (Merriam and Simpson, 1989). Results of research are intended for immediate application by those engaged in the research or by those for whom the research was intended.
The design of descriptive research includes identification of problems, product evaluation and comparison of experience between groups with similar problems to assist in future problems and decision making.

Descriptive research was used to solve the specific problem of obtaining knowledge that will contribute to the development of a sex offender sex education manual.

Source of Data

Twenty-three juvenile sex offenders were selected to participate in treatment based on evaluation and extensive assessment. These youths have already been adjudicated as sex offenders and placed in incarceration for treatment of the offenses and will be the subjects for research without interruption of their treatment by selective sampling.

Data Collection

Dr. Mathew Ferrara, a clinical and forensic psychologist, has been engaged by the Arizona Department of Youth Treatment and Rehabilitation (ADYTR), to design a program of treatment for the juvenile sex offenders under their care called the Journey Program. Much of the program addresses the cognitive distortions of the juvenile offender and the purpose is to increase self-awareness and learn to recognize their own thinking errors. This is accomplished partly by keeping a Thought Journal on a daily basis. There
are workbook assignments to address the cycle of abuse and deviant arousal patterns. There is a strong focus on recognizing deviant sexual urges, the behavior cycle, victim restitution, a clarification letter to the victim, victim empathy, and relapse prevention. These worksheets along with a sex offense synopsis would be presented and confronted in daily treatment groups which would address the cognitive distortions of the juvenile sex offender.

Recent data from The Pines Treatment Center in Tucson states that of the 65 percent of youths who completed the program, there was a recidivism rate of 7.3 percent while 35.05 percent of youths who did not complete the program had a recidivism rate of 37.55 percent (Becker and Hunter, 1994).

The procedure for conducting the research will be scheduled during assessment and orientation upon admission into the Sex Offender Cottage, by Treatment Team members with minimal disturbance of the daily routine.

In addition to clinical assessment, there will be a pre- and post-test administration of the Sex Education Test, created by the clinical staff of the Hennepin County Home School, Minnetonka, Minnesota. It would be the goal of all residents to achieve a score of at least 75% correct responses on this instrument by the end of the sex education program (Gerber, 1994).
There are two sections to the sex education program, Sex Education I and Sex Education II, which is more advanced, that youth will go through before completion of the Journey Program. A post-test will be given to the youth after each of these sections have been completed. The times of completion will depend on the progress of the individual youth.

Significant results should be evident after six months of youth participation in the sex education program.

The design of the sex education curriculum will be based on a needs assessment of the sex offender and data collection will be monitored by a coordinator.
CHAPTER FOUR
SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to determine the needs of the juvenile sex offender and to design a sex education manual to meet those specific needs. It is further to determine if contemporary sex education programs will adequately serve the juvenile sex offender as does the non-sex offender.

To date, the literature review assimilated two decades of research focusing on youthful sexual offending. Research addressing sexual offending suggested that this phenomenon cuts across all socioeconomic classes, religious orientations, and ethnic groups. With the recent clinical presentation and legal adjudication of the preadolescent sexual offender, an expansion on the term adolescent sex offender was suggested, namely, youthful sexual offender. It should be noted, however, that definitions vary from study to study. For purposes of this research, the adolescent sex offender was defined as a youthful sexual offender or preadult male or female who instigates sexual or assaultive sexual interaction with either a non-consenting partner or a child too young to understand the sexual
behavior being consented to. Consequently, sexual offending can now be conceptualizes as spanning a significant portion of the life cycle from prepubescence (4-12 years of age), through adolescence (13-21 years of age), and into adulthood (22 years of age and older (Family Relations, 1993, 42, 222-226).

The review of the literature also suggests that increased attention toward youthful sex offending has encouraged a culture-based ideological values shift from that of accepting such behavior as normal exploratory behavior to that of accepting the reality of the devastation suffered by victims of sexual offense (Family Relations, 1993, 42, 222-226).

The findings of this study indicate that there is a need for a sex education curriculum as an adjunct to the treatment programs provided for the incarcerated adolescent sex offender. Sex education programs in our schools are controversial at best, and unavailable to most of the population in this study because of the high rates of truancy and school drop-outs.

The Sex Education Manual developed in two sections, Section I for new residents, and Section II for advanced study, is presented in Appendices A and B. The first section introduces a general overview of sexuality featuring social and cultural influences, anatomy and physiology, and AIDS with an introduction to the Sexual Abuse Cycle and a
focus on relapse prevention.

Section II begins with a discussion of sexual orientation and covers areas such as, gender identity, victim empathy, healthy/positive sexuality, an individual sexuality plan, dating issues, repayment to the community, and more on relapse prevention.

CONCLUSION

There are many who feel the sexual revolution has altered the entire fabric of society and created the "death of innocence" (Janus, 1981). The underlying premise is that there are no parameters for acceptable behavior remaining and that those relaxed standards can have tragic consequences for the adolescent. There is no question that sexuality and knowledge about sexual issues is having an impact on children at increasingly earlier ages. Instead of playing childhood games, many children are playing sexual games, long before they are ready for them. Clinicians cannot avoid these issues and their consequences.

Adolescents in general, by virtue of theoretical, empirical, and clinical data, can be viewed as an "at risk" population. However, not all adolescents are vulnerable and susceptible. Vulnerability is dependent on the interaction of a number of factors. A multifactorial approach is critical to the assessment of adolescent sexuality, a vital component of the teenager's adjustment. Good assessment
should evaluate the individual based on the integration of three primary dimensions: (1) the personal, which includes developmental history, intrapsychic and personality factors, and physical factors; (2) the interpersonal, which includes peer group involvement, familial relationships, and perception of the family structure; and (3) social-contextual, which includes social supports, networks and demographics. The earlier an adolescent is identified as having problems adjusting physically and sexually, the more likely one can intervene and enable that individual to move on to a healthy, sexually well-adjusted adulthood (Kaufman, 1983).

The researcher has met with Dr. Jon McCain, Chief of Psychology for the Arizona Department of Youth Treatment and Rehabilitation (ADYTR), and discussed implementation of the sex education program. Dr. McCain suggested a second format be designed to include all ADYTR youth.

Initial implementation of this program will be on a trial basis, receiving feedback from staff and the residents. This feedback will be used to identify and make necessary revisions.

Clinical staff will be trained to conduct the sex education program to maintain the therapeutic milieu.

The investigator hopes that the results of this study will help convince clinicians of the need for special sex education for all youth at risk.
RECOMMENDATIONS

Further research is suggested to discover how sex education as a part of treatment will benefit the juvenile sex offender. Implementation of a sex education program designed specifically for the juvenile sex offender is relatively new and there is little data to date as to the effect of sex education on this population. The Hennepin County Home School in Minnetonka, Minnesota has implemented a sex education program as has the Pines in Tucson, Az.

Future research should focus on whether adolescent sexual offenders differ from "normal" adolescents on a host of variables including individual, social, environmental and family variables. Such data could allow us to speak to etiology and then prevention. According to Becker and Kaplan, lacking in the studies reported to date have been matched comparison groups (Becker and Kaplan, 1988).

It is further recommended by this investigator that additional research address this area and more data be generated to encourage development of sex education curriculum in all residential treatment centers as well as outpatient programs for the non-adjudicated offender.
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BIBLIOGRAPHICAL SKETCH

Elizabeth Cecelia Liberatori was born in Philadelphia, Pennsylvania. She received her elementary education in the Philadelphia parochial school system. She attended West Catholic Girls High School in Philadelphia. She married and moved to New Jersey where she resided for 29 years and is the mother of five children. In 1988 she moved to Phoenix, Arizona and returned to school, attended Rio Salado Community College in the Chemical Dependency Program and later transferred to Glendale Community College. She completed her Bachelor of Arts Degree in Psychology in 1994 from Ottawa University. In 1994, she began her Graduate Program at Ottawa University. She is a member of Phi Theta Kappa Honorary Society and is published in the National Dean’s List 1992-93. She is a member of the Arizona Counselors Association and the American Group Psychotherapy Association. She is employed by the Department of Youth Treatment and Rehabilitation and is a clinical specialist in the Juvenile Sex Offender Program at Adobe Mountain School in Phoenix, Arizona.
APPENDIX A

SEX EDUCATION TEST
Sex Education Test

NAME______________________________________ DATE_________
K#__________________________________________ TIME_________

1. List five qualities that you would look for in a good relationship.
   1.________________________________________
   2.________________________________________
   3.________________________________________
   4.________________________________________
   5.________________________________________

2. To have a good relationship two people must spend the most time on developing good__________________________.

3. Make a list of ten feeling words. Circle two that describe how you feel much of the time.
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

4. Explain the difference between infatuation and love.

5. How does how we feel have an effect on how we act sexually? Give at least one good example.
6. Sexuality begins at_________ and ends at_________.

7. The most important part of any relationship is two-way_____________________________.

8. What part of the female sexual anatomy is the same as the penis as far as sexual pleasure is concerned?

9. What is it called when the girl says NO and the boy continues to have sex with her anyway?

10. Why does it seem so hard for boys and girls to understand each other?

11. What combination of things makes for the most effective birth control and protection against disease?

12. Give two reasons why it is important to talk to your partners and get to know them before you have sex with them.
13. Give some reasons why masturbation is sometimes a better idea than having sex.


How do people go about setting boundaries in their lives?

15. List four signs of unhealthy boundaries that were listed in the handout.

16. Give an example of a young man violating the sexual boundaries of a young woman.

17. Give an example of a parent violating the boundaries of a child.

18. What happens when parents set boundaries for their
children and then do not enforce them?

19. Why does it make people uncomfortable to set boundaries with the people in their lives?

20. What effect does pornography have on the sexual ideas of young men in our society?

21. What effect might pornography have on the way women are treated and looked upon in our society?

22. Give me two examples of situations in your life that you might feel guilty about.

23. Give me two examples in your life that you might feel shame for.
24. When a child has been shamed sexually by their parents, how might that shaming affect them when they are adults?

25. When a person has an AIDS test and it comes back negative, what should that mean in terms of their future behavior?

26. When a person is HIV positive—they want to keep their __________ count up above 300.

27. When the count falls below this number what kind of danger does this put him/her under?

28. Name three ways that AIDS is spread.
   1. ____________________________________________
   2. ____________________________________________
   3. ____________________________________________

29. What is the one sure way that you can keep from getting AIDS?

30. What do the letters STD stand for?
31. How are STD's and AIDS the same?

32. You are thinking about entering into a sexual relationship with someone. You want to know if your partner has any sexually transmitted diseases. Describe how you will approach the topic and what you will say to your partner to find out if he/she has a STD. (Paragraph)

33. Your friend Susan is very upset. A few years ago she was infected with genital herpes. She hasn't been involved sexually with anyone since that time. Susan has been dating your best friend Mark. Susan's and Mark's relationship is becoming serious; both want to begin a sexual relationship. Susan is not sure she should tell Mark she has herpes. Susan comes to you for advice. What will you say to her? (Remember, right now there is no cure for genital herpes).

34. Give three of the rules for a healthy pregnancy.
   1. ___________________________
35. Name the part of the woman’s body that the baby develops within.

36. The opening in the woman’s body that stretches to 10cm so a child can be born is called?

37. Where are sperm made in the male body?

38. About how many sperm are made in a day?

39. The average penis length is?

40. How important is penis length for sexual pleasure?

41. Place an F before the statement if it is a FACT. Place an M before the statement if it is a MYTH.

______Homosexuals are born that way.

______Men need sex more than women.

______Making love comes naturally.

______Guys can tell if a woman is not a virgin.

______A woman can’t get pregnant the first time she has sex.

______Both women and men know when they have gonorrhea.

______Genital warts can be cured with Wart-Off.
A woman is most likely to get pregnant between 10 to 14 days from the start of her period.

Pornography is enjoyed by most men and women.

If a young child stared at my penis as I showed it to him/her, it would mean that the child liked looking at it.

Some people are shy about asking for sex so they really want you to force them.

Having sex with a child may hurt the child later in life.

42. Give a definition of exploitation.

43. Explain and tell why pornography is harmful to both men and women.

44. Name two places you can go to receive free information/treatment on birth control and STD’s.

Note.... Now re-read your test. Make sure that you have given complete answers to all the questions. Make sure that your answers can be read. The better your answers, the more credit you get for them.