Journal on Developmental Disabilities
Le journal sur les handicaps du développement
JoDD

Pedophiles: The Quest for Comprehensive Treatment

Author

Peter R. Johnson

Rainbow Clinic,
Surrey, BC

Correspondence

peterrj@shaw.ca

Keywords

pedophilia,
clinical research,
sexual offences,
cognitive-behavioural therapy,
intellectual and developmental disabilities

Abstract

This paper extends recent descriptive statistics on sex offenders with intellectual disabilities (Johnson, 2008) by presenting clinical evidence on the treatment of pedophiles. With the safety of children as a primary concern, the misdiagnosis of Pedophilia is discussed, along with the examples of the different possible outcomes of comprehensive and piecemeal services. The use of cognitive-behavioural therapy in the reduction of community supervision for these men is also highlighted.

There can be little doubt that pedophiles with intellectual disabilities are a small, under-served population. Understandable revulsion at the idea of adult men engaged in sexual interactions with innocent children ensures little in the way of advocacy for this group of offenders. Perhaps only people who know the men well, see the human being behind the repellent behaviour.

The sparse research literature on this group seems to make no distinction between the abuse of children and other kinds of sexual offences. The few studies tend to focus on very small groups of men and discuss supervision and treatment as ways of reducing the risk of recidivism for sexual offenders with intellectual disabilities in general (Nottesdad & Lineker, 2005; Riches, Parmenter, Wiese, & Stancliffe, 2006; Craig, Stringer & Moss, 2006; Lindsay, Hastings, Griffiths, & Hayes, 2007). Unfortunately, in these studies, treatment is only described in the most general terms.

The present paper seeks to discuss the treatment needs of pedophiles with intellectual disabilities by expanding upon recent statistical information concerning these men (Johnson, 2008). This report provided information on a group of sex offenders with intellectual disabilities (N = 86) who had been referred to a community-based psychology clinic for assessment and treatment over a 12-year period. Their ages ranged from 14 to 42 years, but 79% were in the 18 to 24 years age group. Approximately 65% of the men had IQ scores of less than 70, with the remainder falling in the Borderline category. Additional disabilities, such as autism spectrum disorder and Fetal Alcohol Syndrome were noted in 70% of the group. However, only about 10% met the DSM-IVR definition for Pedophilia (Exclusive Type).

The present paper points out the treating clinician's responsibility for the safety of children, before going on to highlight the important distinctions between pedophiles and other sexual offenders with intellectual disabilities. There are then two

clinical descriptions of successful and unsuccessful treatment, which include the description of a cognitive-behavioural strategy which attempts to decrease the likelihood that these pedophiles will re-offend while unsupervised in the community.

Responsibility for the Safety of Children

Professionals who are assessing and treating pedophiles need to maintain an awareness of the complex ethical issues often arising from this kind of work. These concern the rights of children to a safe and nurturing environment, and the rights of pedophiles to competent and humane treatment. In cases where these issues conflict, it is the rights of potential victims which must be given priority. This issue is highlighted in the following case history.

Mr. X was a small, angry-looking man who was brought to a community-based clinic by a street worker. At first, his monosyllabic responses were thought to be due to his sullen demeanour. Later, it became clear that they were the result of his intellectual disability. Like many of his peers, Mr. X's receptive language skills were significantly better than his expressive abilities.

In a brief conversation, the therapist tried to tell Mr. X about the kind of help he might get at the clinic, (e.g., assistance with sexual problems). He was also given some information about the privacy of the sessions and the limits of confidentiality. It is doubtful that Mr. X fully understood this information. He remained quiet and sullen, but agreed to return for another appointment.

At the beginning of the next session, this man produced about twenty sheets of paper. There was a drawing on each one. As the therapist looked through them, it became clear Mr. X had produced a cartoon sequence of the sexual fantasies he was unable to articulate verbally.

The drawings were startling in their depictions of violence. They showed Mr. X sodomizing three little boys, each of whom was screaming in pain. From subsequent discussions, it became clear that this man was not interested in co-operative victims. He was sexually aroused by violence. More worrying was the fact that these potential victims were not anonymous. Mr. X knew their names and where each one of them lived.

To his credit, Mr. X asked to be cured of these sexual fantasies before he acted on them. The therapist tried to explain to him that he couldn't be cured, but he could be helped in learning to control his thoughts and behaviours. Again, it is unlikely that he really understood what was being said. He remained sullen and angry, before eventually leaving the clinic.

Within a few minutes, the therapist called the sexual offences unit of the local police force, and told them of his concerns for the safety of the three boys. Mr. X was arrested within the hour. The police officer told the clinic that Mr. X had already been charged with a non-violent, sexual touching offence and now they would keep him in custody until his trial. The therapist had no doubt that it was his moral, ethical and professional responsibility to contact the police. However, he remain troubled by the thought that he had turned in a man who had trusted him enough to ask for help.

Mr. X was sentenced to an indefinite period of living in a secure group home, under round-the-clock supervision. Later the therapist became part of this treatment team, and they began the long process of trying to rehabilitate this troubled man.

It is difficult to work with pedophiles. Most of us feel disgust at their sexual proclivities. Furthermore, some pedophiles, even those with intellectual disabilities can be wily and deceitful. While we may grow to like them during treatment, it seems wise to remain cautious regarding their veracity. The safety needs of their potential victims must remain our foremost concern.

Classification of Offenders

Quite early in our work with sexual offenders, we became concerned about how they were being classified. Inefficient learning, emotional disturbance, and the lack of normal outlets for sexual feelings all seemed to be factors which were contributing to offending behaviours. As a result, it seemed that the term "pedophile" was being overused and some men were being falsely labeled in a manner which could have very serious consequences.

Eventually, we began to put our sexual offenders into three categories (Johnson, 1996). The first group included men whose learning problems were a factor in their offences. Typically, these were men who had one or two incidents of fondling the genital area of a small child, or who had masturbated in public. Generally, individual psychotherapy and education seemed to be successful with these men. They comprised 30 (35%) of our original population of 86, and of the 23 treated, only one had re-offended (Johnson, 2008).

Many of this group of men had no outlets for the expression of their sexual feelings. Sometimes this need was deliberately blocked by others, but more often it was ignored. It seems that for men with intellectual disabilities, positive expressions of sexuality need to be promoted by families and caregivers. For example, the booklet that we use to teach the consequences of unwanted touching, also teaches about when it *is* appropriate to touch another person in a sexual manner (Johnson, 2000).

The second group of men (n = 47) were those who were experiencing multiple problems. While they had all committed sexual offences, many against children, some also had committed a number of non-sexual offences, been diagnosed with a mental illness, or presented with questionable behaviour. For example, one man deemed capable of independent living kept his garbage in the shower, and spent hours sitting on a plastic chair while spitting on the walls. He had committed two sexual offences where he touched the buttocks of children on public transit in front of their parents. This group of men were difficult to treat and, as a group, had the highest incidence of recidivism.

The third group (n = 7) was comprised of those men who met the DSM-IV criteria for a diagnosis of Pedophilia–Exclusive Type (First, 2000). Essentially, these are men who are sexually aroused only by pre-pubescent children. While they are the main focus of this paper, these pedophiles represented only about 10% of our original population of sex offenders. This suggests that people should be cautious in assigning this stigmatizing label to men with intellectual disabilities who have committed sexual offences.

The Lack of Comprehensive Treatment Services

Due to the threat that pedophiles with intellectual disabilities pose to children, some services are available through the corrections and forensic departments of governments. However, while they include supervision and treatment, these are usually based on probation orders. When the order expires, this can mean the termination of these support services. Furthermore, even this level of service can be severely disrupted in times of recession and budget short-falls.

Mr. Y was referred to a community-based clinic by his probation officer. He was an obese young man with a borderline intellectual disability and a speech impediment. He was on probation after pleading guilty to sexually touching a three year-old girl.

After an initial assessment, Mr. Y joined a therapy group for sexual offenders with intellectual disabilities. As required by the program, he described his offences and took full responsibility for them during his first session with the group. The other men seemed to like him and he appeared to have made a reasonable start to treatment. Nevertheless, it soon became clear that he harboured some of the cognitive distortions which are not unusual in pedophiles. For example, this man believed that his two year-old niece was in love with him.

Unfortunately, after Mr. Y had attended three or four group sessions, the provincial government announced financial cutbacks to some social programs. The clinic's contract with the government was terminated abruptly, and Mr. Y's treatment came to a sudden end.

Following this, Mr. Y was not seen for more than five years. Then a psychologist was retained by Mr. Y's lawyer, in order to complete a psychological assessment and provide expert testimony in court. Mr. Y was in custody, having been charged with a number of sexual offences against little girls, and the Crown was seeking to have him declared a Dangerous Offender. If they were successful, it would mean that Mr. Y would be incarcerated in a federal prison for an indefinite period.

When assessed in jail, Mr. Y was essentially unchanged. He had received no further treatment for pedophilia, and still evidenced the same cognitive distortions about little girls. In court, it was argued

that Mr. Y should be sentenced to receive psychological treatment while in federal custody. In fact, the federal corrections system had a prison treatment program for sex offenders with intellectual disabilities. However, the judge decided that Mr. Y was a Dangerous Offender and sentenced him to an indefinite period. Of course, he would be held in protective custody, due to the risk of him being assaulted by members of the general prison population.

Some 10 years later, there was a riot at the prison where Mr. Y was being held. He was the only prisoner who died during the uprising. At first, it was thought he had been killed by the other prisoners. However, it was later revealed that he died from a drug overdose. It seems likely that the overdose was deliberate and, in fact, Mr. Y had committed suicide.

There is no doubt that Mr. Y was a pedophile and therefore a danger to children. However, it can be argued that he deserved the opportunity to benefit from the best treatment programs which are available to men with this mental illness.

Successful Treatment

Due to the lack of systematic research on the treatment of this population, programs tend to be based on the specific clinical skills and experience of the team members. In our work, treatments have comprised various combinations of individual counselling, group therapy, cognitive behavioural therapy and supervision, with each of these elements being adapted to the learning needs of people with intellectual disabilities. While many gaps in services are apparent, as in the case of Mr. Y, sometimes an appropriate combination of treatments has been available to individual men.

Mr. Z did not seem a likely candidate for successful treatment. A childhood accident had left him with brain damage and a mild intellectual disability. He grew up in a family where inter-generational abuse seems to have been the norm. From the age of eight to twelve years, Mr. Z was regularly sexually abused by his father and uncle.

As a young adult, he married a woman who also had a mild intellectual disability. She had a two year-old daughter from a previous marriage. Mr. Z started to babysit this child, along with many others in his low-income housing complex. By the time he was arrested for sexually abusing children, the police estimated that he had about 150 victims.

Mr. Z served five years in a federal prison. No treatment programs were available to him. As he served his full sentence and was not paroled, on leaving prison he was free to live his life without supervision.

Mr. Z tried to settle in two towns. However, the local media made sure the people knew what kind of man had moved into their neighbourhood. Following violent confrontations in each town, Mr. Z fled for the relative anonymity of the big city. It was here that several government departments combined to provide a range of services for this man.

Perhaps largely due to fear, Mr. Z was now ready to comply with any restrictions imposed by his treatment team. This meant that he agreed to live in a group home under round-the-clock supervision, even though there was no legal means of enforcing this. Furthermore, he agreed to attend all the treatment programs which were available to him.

His psychological treatment began with a number of sessions of individual psychotherapy which focused on Mr. Z's family history and details of his offences. Later, he joined a therapy group for sex offenders with intellectual disabilities. Quite quickly, Mr. Z became an effective and respected member of this group. He was very open about taking full responsibility for his crimes and readily confronted other members who were less forthcoming. After several months, Mr. Z had met al.l the treatment goals and graduated from the group.

The next issue became how to maintain the progress Mr. Z had made to date, and how to reduce his supervision in a manner which kept children safe while providing him with a meaningful life. After a good deal of discussion, the treatment team decided to try to reduce supervision in a systematic manner, thus allowing Mr. Z to engage in some meaningful activities in the community.

The first phase concerned this man's journey from his home to the clinic, a journey of about 45 minutes on public transit. At first, Mr. Z sat beside his worker, looked out the window, and did not stare at children. When it was clear he was able to do this consistently (i.e., three consecutive successful trials), his worker walked behind him on the street and sat apart from him on the bus, while watching Mr. Z's behaviour. After he had successfully demonstrated that he could behave appropriately with this level of

supervision, the worker only checked in with him at certain points along the way. For example, they met as Mr. Z left home, at each transit point where he had to change, and at the clinic. At this stage, the worker drove a car along behind the bus.

The next phase of the program involved using observers who were unknown to Mr. Z. They would travel the whole journey with him, but he did not know who they were. After each journey, he would receive a simple report of the person's observations.

The final stage involved the intermittent use of observers. Some days somebody would be following and watching him. However, he was not told when this would happen. He simply received a report on his performance.

Following Mr. Z being able to demonstrate that he could travel safely from his home to the clinic, other journeys were undertaken using the same cognitive behavioural strategies (e.g., his journey from home to his social worker's office, and from home to his family doctor's office). Eventually, the program incorporated all of Mr. Z's activities in the community. He knew an observer might be watching him, whenever he left his apartment.

It is twelve years since the beginning of Mr. Z's treatment. He now lives in his own apartment in a rental complex, where he supplements his disability pension income by assisting the janitor with various maintenance jobs. He has a small number of adult friends in the neighbourhood whom he visits on a regular basis. Mr. Z is still supervised for a few hours each week, and more frequently when he is feeling stressed. While he continues to be offence-free, he knows that his behaviour in the community remains subject to occasional monitoring by an unknown observer.

Summary

This paper has discussed the lack of systematic research and comprehensive treatment services available to pedophiles with intellectual disabilities. In doing so, it has sought to add a clinical aspect to the descriptive statistics reported in Johnson (2008).

In spite of the common revulsion to the sexual proclivities of pedophiles, it is important to remember that this condition is classified as a mental illness (First, 2000). Because a cure seems unlikely, the goal of treatment is to produce a "dry" pedophile. Such a person could be described as a man who no longer acts out his sexual attraction to children.

Clinical evidence suggests that comprehensive treatment services can be successful in bringing about behavioural changes in pedophiles with intellectual disabilities. This brings us closer to the twin goals of keeping our communities safe for children, while improving the quality of life for these men. On the other hand, the clinical evidence presented in this paper describes the possible tragic consequences for both victims and offenders when treatment services are offered piecemeal or not at all.

This paper also urges caution with the use of the diagnostic label of Pedophilia. Out of a relatively large number of sex offenders with intellectual disabilities (N = 86), only about 10% met the DSM-IV criteria for a diagnosis of Pedophilia—Exclusive Type. It is suggested that some men with poor social learning skills or severe emotional disturbance may be misdiagnosed as pedophiles.

Table 1. Stages of Withdrawal of Supervision For Specific Journeys in the Community

1. Worker travels with offender, and makes sure he knows the route.
2. Worker walks behind offender and sits apart from him on public transit, while still observing him.
3. Offender checks in with worker at key points along the route.
4. Unknown observer follows offender. Offender knows he is being observed.
5. Unknown observer follows offender. Offender never knows for sure whether or not he is being observed.

N.B. The criterion for stages 1 to 4 is 3 consecutive successful trials with 100% success. An error automatically returns the offender to the previous stage. Stage 5 is ongoing

It is perhaps easy to dismiss the needs of a small group of men such as the pedophiles described here. However, it can be argued that the manner in which we treat them is a reflection of society as a whole. In an indirect, but very real way, the lack of advocacy for this group leaves all of us vulnerable to the lack of much-needed mental health services.

References

Craig, L. A., Stringer, I., & Moss, T. (2006). Treating sex offenders with learning disabilities in the community. *International Journal of Offender Therapy and Criminology, 50,* 369–390.

First, M. B. (Ed.) (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, D.C: American Psychiatric Association.

Johnson, P. R. (1996). Sex offenders: Typology, treatment and prevention. In R. Friedlander & D. Sobsey (Eds.), *Proceedings of the 13th Annual Conference of the National Association for the Dually Diagnosed* (pp. 269–275). Kingston, NY: NADD.

Johnson, P. R. (2000). *Who can I touch?* Vancouver, B.C.: Davies and Johnson Associates.

Johnson, P. R. (2008). Sexual offences of men with intellectual disabilities: A view from private practice. *Journal on Developmental Disabilities, 14*(2), 79–86.

Lindsay, W. R., Hasting, R. P., Griffiths, D. M., & Hayes, S. C. (2007). Trends and challenges in forensic research on offenders with intellectual disability. *Journal of Intellectual and Developmental Disability, 32*(2), 55–61.

Nottesdad, J. A., & Linaker, O. M. (2005). People with intellectual disabilities sentenced to preventive supervision – Mandatory care outside jails and institutions. *Journal of Policy and Practice in Intellectual Disabilities, 2*(3–4), 221–228.

Riches, V. C., Parmenter, T. R., Wiese, M., & Stancliffe, R. J. (2006). Intellectual disability and mental illness in the NSW criminal justice system. *International Journal of Law & Psychiatry, 29*(5), 386–396.