DIFFERENTIATING PROBLEMATIC SEXUAL BEHAVIOR RELATED TO AUTISM SPECTRUM DISORDER (ASD) VERSUS PARAPHILC DISORDERS: PART 2 ADULTS – APRIL 6, 2017

Kim Spence, Ph.D. – Coordinator of Educational & Training Programs

Center for Autism & Related Disabilities (CARD)

University of Central Florida

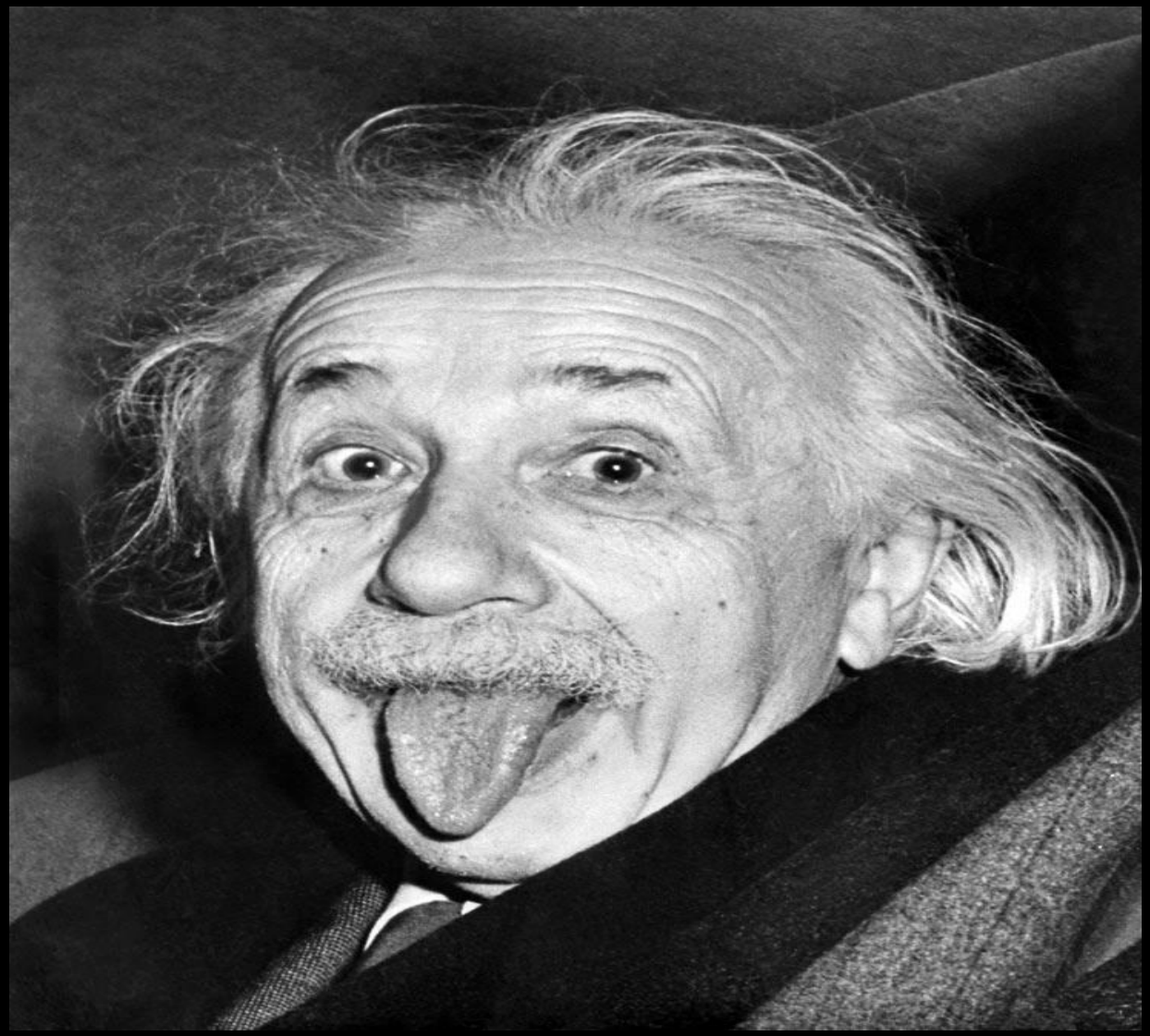
Eric Imhof, Psy.D – President/Director of Clinical Services

Specialized Treatment & Assessment Resources PA

COMMON MISCONCEPTIONS ABOUT ASD AND SEXUALITY

- People with ASD have no desire to engage in intimate physical relationships
- Having a diagnosis of ASD implies a person will only be attracted to "characters"
- Individuals with ASD are only attracted to younger kids
- Under appreciation of homosexuality and/or bi-sexuality and sexual attraction in general

LITERATURE RELATED TO ASD & SEXUAL OFFENDING



ASD & OFFENDING

- Scragg & Shah (1994) reviewed the issue of ASD and offending in Broadmoor Psychiatric Hospital in the UK (out of 392 male patients 17 were identified for the study) and suggested ASD was over-represented in a secure psychiatric setting
- Hare, Gould, Mills, & Wing (1999) examined numbers of people with ASD in secure hospitals in the UK (Ashworth, Rampton, & Broadmore) and found 31 individuals with ASD across all hospitals (21of whom had an AS diagnosis) and reported an over-representation of people with ASD; particularly AS, in offenders within special hospitals in the UK
- Scragg & Shah (1994) and Hare et al. (1999) failed to acknowledge that risk factors commonly associated with offending within the general population (social circumstances or co-morbid mental health issues) may have explained specific offending behavior
- Woodbury-Smith et al. (2006) conducted a study within the community and found the level of offending by those in the ASD group (N=25) slightly lower than their neuro-typical peers (N=20) despite the small numbers they found folks with ASD had a higher propensity towards "criminal damage" and acts of violence (similar findings in Allen et al. 2008)
- Mouridsen et al. (2008) conducted the first large-scale study to examine the relationship between PDD (ASD) and all types of offending (933 neuro-typical – of those 168 (18%) had offended & 313 ASD – of those 29 (9%) had offended) and concluded "serious crime is a rare occurrence in people with PDD" (Mouridesen, 2012)

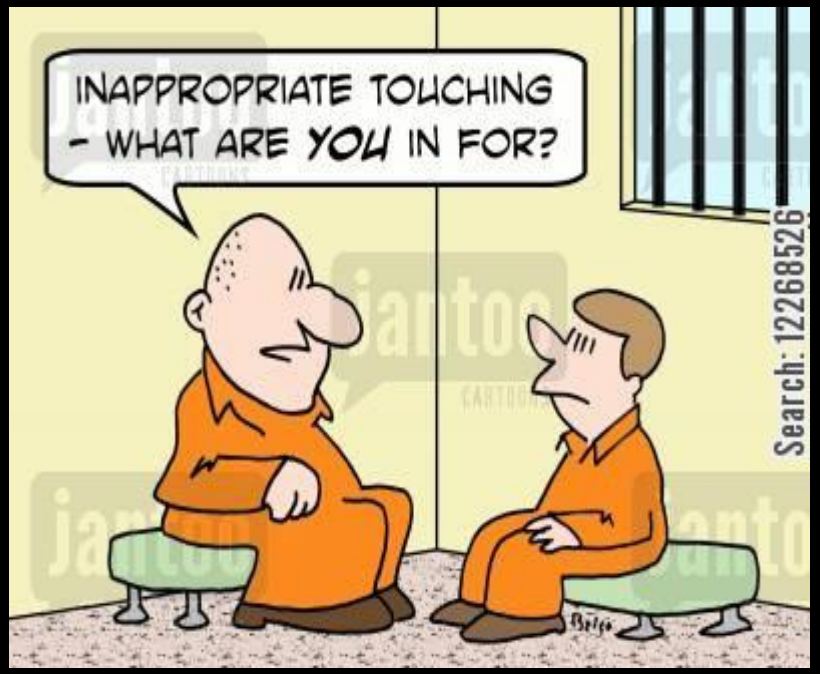
ASD & OFFENDING

- Few published reviews have employed methodological rigor (Allen et al. 2008; Gomez de la Cuesta, 2010; King & Murphy, 2014; & Mourisden, 2012)
- Browning & Caulfield (2011) "That there exists a poor understanding of AS and other ASDs within all of the agencies involved in the criminal justice process is inarguable, and is a fact supported by the academic literature, media reporting of trials of offenders with ASDs of varying severity and in the views and professional experiences of the authors." (p. 176)
- ASD does not make you more likely to offend (Browning & Caulfield, 2011; Gomez de la Cuesta, 2010; Higgs & Carter, 2015; Langstrom et al. 2009; Lerner et al. 2012; Mouridsen, 2012; Mouridsen et al. 2008; Sondenaa et al. 2014; Woodbury-Smith & Dein, 2014; & Woodbury-Smith et al. 2006)
- According to the literature to date, people with ASD do not seem to be disproportionately represented within the offender population (Allen et al, 2008; Browning & Caulfield, 2011; Gomez de la Cuesta, 2010; Higgs & Carter, 2015; & King & Murphy, 2014)
- Arson, criminal damage, and sexual offenses appear to be most common offenses by those with ASD (Gomez de la Cuesta, 2010; King & Murphy, 2014; Kumagami & Matsuura, 2009; Mouridsen et al., 2008; Mouridsen, 2012; & Sondenaa et al. 2014)
- Empirical data assessing recidivism among offenders with ASD is very limited (Higgs & Carter, 2015)

SEXUAL OFFENDING WITH ASD

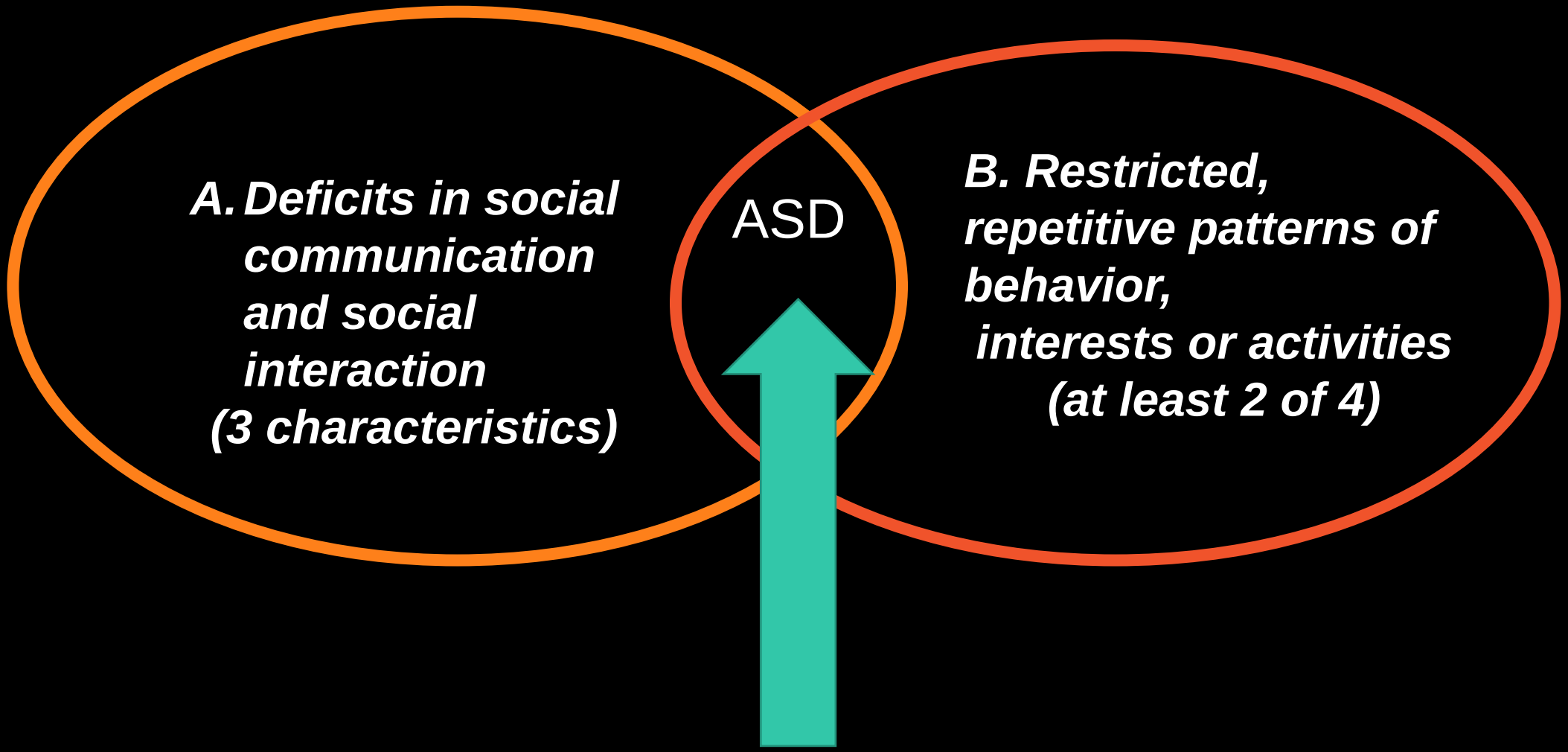
- Characteristics of ASD (related to an offense) should be interpreted with caution – like their neuro typical peers it is important to look at co-morbid psychiatric disorders, adverse environmental factors (e.g. physical or psychological abuse, domestic violence within the home, or parental neglect) (Higgs & Carter, 2015; Kumangami & Matsuura, 2009; Langstrom et al 2009; & Mouridsen, 2012)
- General factors ***that appear*** to contribute to people with ASD sexually offending include: deficits in empathy; maladaptive sexual behaviors; restrictive, repetitive behavior patterns; and the potential role of co-occurring paraphilias (many hypotheses across the literature)
- Insufficient empirical evidence that ASD is related to an elevated risk in sexual offending (Higgs & Carter, 2015; Langstrom et al. 2009)
- In a study of 422 in-patient psychiatric subjects with ASD only 2 (0.004%) were convicted of a sexual offense (Langstrom et al. 2009)

FREQUENT REFERRALS RELATED TO INAPPROPRIATE SEXUAL BEHAVIOR BY INDIVIDUALS WITH ASD:



- Inappropriate touching (self and others)
- "stalking"
- Intense desire to interact with and/or touch hair, feet, faces, and elbows
- What appears to be voyeuristic behavior
- Deviant sexual arousal
- Inability to understand the impact of arousal on people in the community

AUTISM SPECTRUM DISORDER DSM-5



DSM-5: SOCIAL COMMUNICATION AND SOCIAL INTERACTION

1.Deficits in social-emotional reciprocity

2.Deficits in nonverbal communicative behaviors used for social interaction

3.Deficits in developing, maintaining, and understanding relationships

MISINTERPRETING SOCIAL & COMMUNICATION DEFICITS

Deficits in social-emotional reciprocity:

- Difficulty interpreting different tones of voices and interpreting non-verbal cues
- May only understand questions or comments in a very literal way
- Often fails to grasp implied meaning of communication

MISINTERPRETING SOCIAL & COMMUNICATION DEFICITS

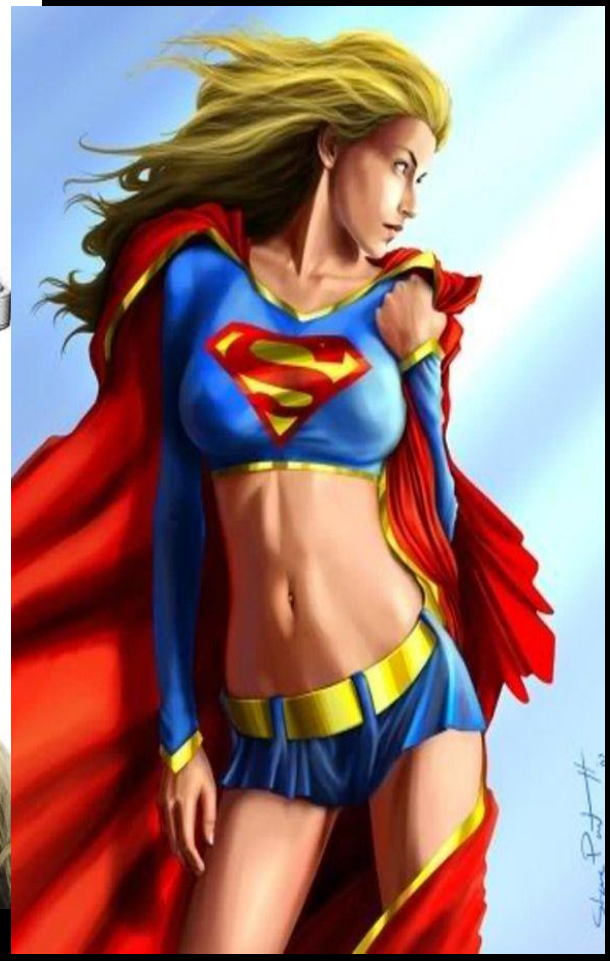
<u>Deficits in nonverbal communicative behaviors used for social interaction</u>:

- Inability to recognize fear, discomfort, disdain, or other clear signs of concern in a communicative partner
- Socially inappropriate actions (verbally or physically) in various settings
- Universal failure to understand the rules of engagement

MISINTERPRETING SOCIAL & COMMUNICATION DEFICITS

<u>Deficits in developing, maintaining, and understanding relationships</u>:

- Desperate for friendships of all kinds
- Extremely gullible
- Overall lack of understanding about various types and levels of friendships and the rules associated with making and maintaining them
- Inability to appreciate that same-aged peers are often not interested in special interest areas



DSM-5: RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR, INTERESTS, OR ACTIVITIES

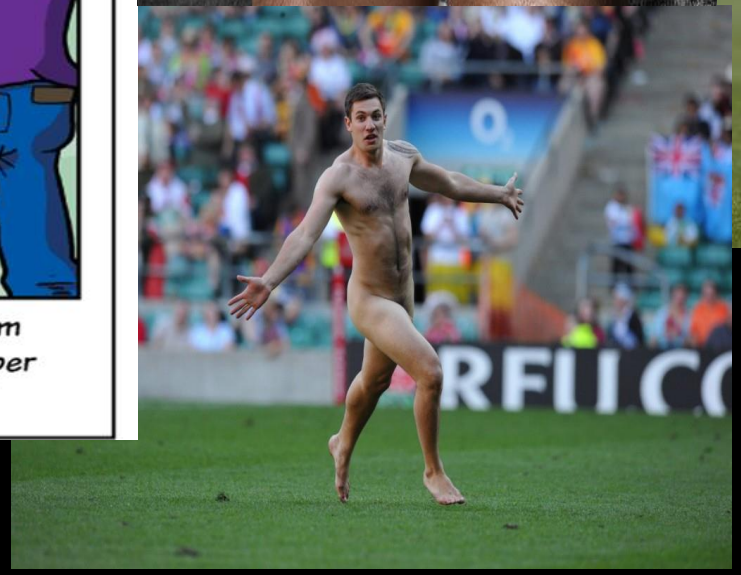
1. ***Stereotyped or repetitive motor movements, use of objects, echolalia, idiosyncratic phrases***
2. ***Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior***
3. ***Highly restricted, fixated interests that are abnormal in intensity or focus***
4. ***Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment***

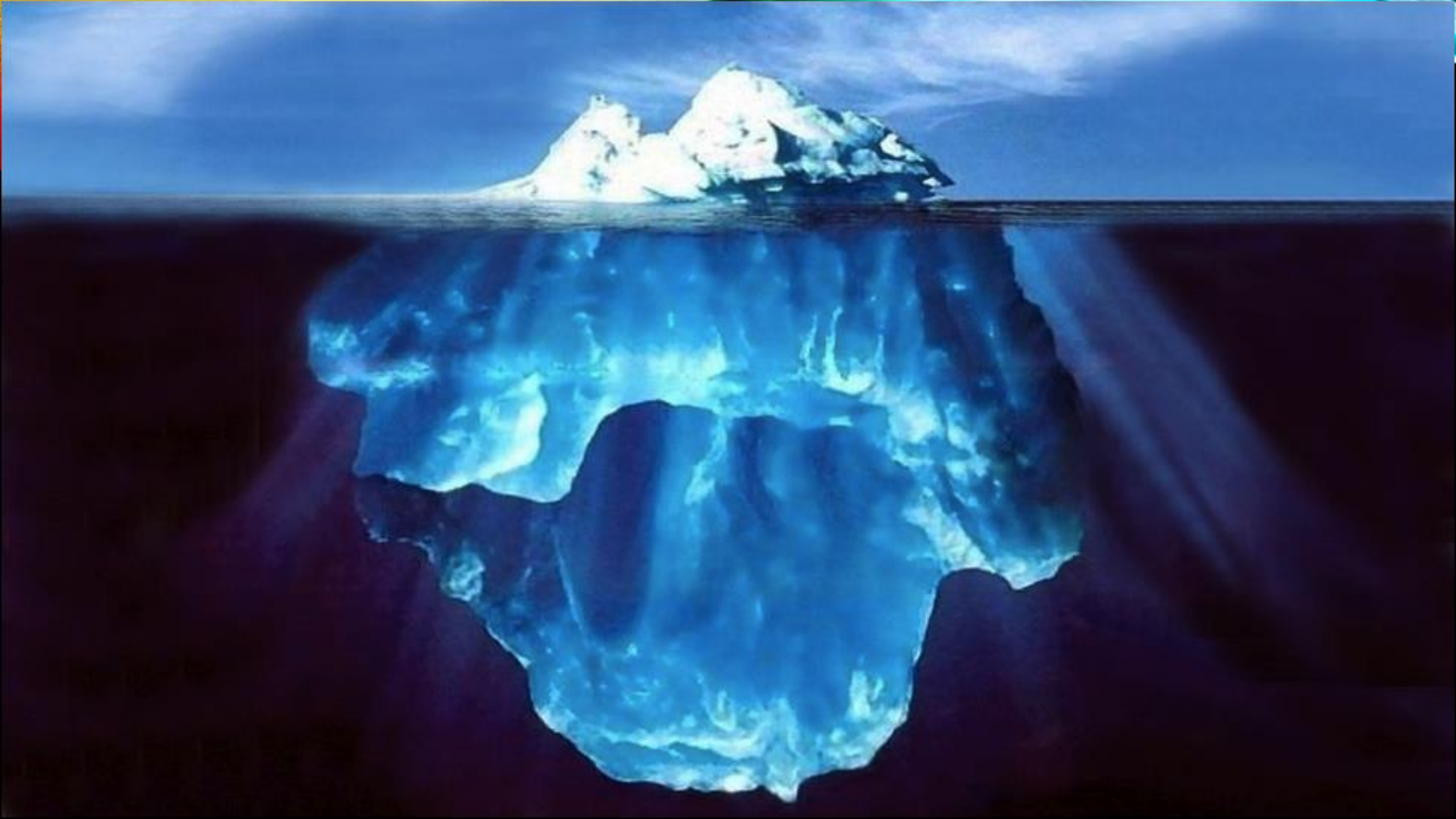
MISINTERPRETING RESTRICTED, REPETITIVE AND STEREOTYPED PATTERNS OF BEHAVIOR CHALLENGES

- Perseveration and/or highly fixated interests
- Strong attachments to objects or images
- Over-attending to usual topics or items

MISINTERPRETING RESTRICTED, REPETITIVE AND STEREOTYPED PATTERNS OF BEHAVIOR CHALLENGES

- ✓ Over adherence to rules
- ✓ Rigidity and need for routine
- ✓ Sensory Issues






Paraphilia

PARAPHILIC DISORDERS

Criterion A –

Over a period of at least six months, recurrent and intense sexual arousal from non-human objects or specific focus on non-genital body parts, the suffering or humiliation of oneself or one's partner, or children or other non-consenting person as manifested by fantasies, urges, or behaviors

Criterion B –

the individual has acted on these sexual urges [generally with a nonconsenting person] or the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

Criterion C –

in some paraphilic disorders minimum age limits or other unique specifiers are imposed

VOYEURISTIC DISORDER

- Observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity.

- The individual experiencing arousal and/or acting on the urges is at least 18 years of age

EXHIBITIONISTIC DISORDER

Exposure of one's genitals to an unsuspecting person

FROTTEURISTIC DISORDER

Touching or rubbing against a nonconsenting person

SEXUAL MASOCHISM DISORDER

Arousal from the act of being humiliated, beaten, bound, or otherwise made to suffer

SEXUAL SADISM DISORDER

Arousal from the physical or psychological suffering of another person

PEDOPHILIC DISORDER

Sexual activity with a prepubescent child or children (generally age 13 years or younger)

The individual must be age 16 years or older or at least 5 years older than the child or children

- Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old

FETISHISTIC DISORDER

The use of nonliving objects or highly specific focus on non-genital body part(s)

The fetish objects are not limited to articles of clothing used in cross-dressing (as in tranvestic disorder) or devices specifically designed for the purpose or tactile genital stimulation (e. g., vibrator)

TRANSVESTIC DISORDER

Cross-dressing

- With fetishism – if sexually aroused by fabrics, materials, or garments
- With autogynephilia – if sexually aroused by thoughts or images of self as female

OTHER SPECIFIED PARAPHILIC DISORDER

- Presentations in which symptoms characteristic of a paraphilic disorder cause clinically significant distress or impairment but do not meet the full criteria for a paraphilic disorder and the clinician chooses to communicate the specific reason the presentation does not meet the criteria of any specific paraphilic disorder

OTHER SPECIFIED PARAPHILIC DISORDER

Examples include, but are not limited to:

- Telephone Scatologia (obscene phone calls)
- Necrophilia (corpses)
- Zoophilia (animals)
- Coprophilia (feces)
- Klismaphilia (enemas)
- Urophilia (urine)

UNSPECIFIED PARAPHILIC DISORDER

Presentations in which symptoms characteristic of a paraphilic disorder that cause clinically significant distress or impairment but do not meet the full criteria for a paraphilic disorder and the clinician chooses to NOT communicate the specific reason the presentation does not meet the criteria of any specific paraphilic disorder

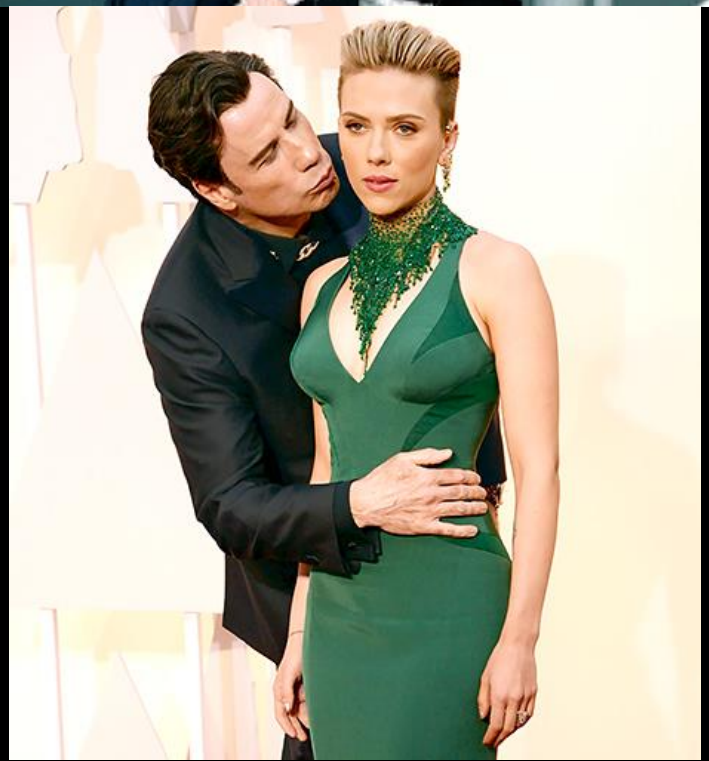
MILLION DOLLAR QUESTION

- How do we make the discrimination between ASD-related maladaptive sexual behavior versus paraphilic disorder or correctly identify the presence of both?


A STUDY LINKING AUTISM TO CHILDHOOD VACCINATIONS HAS NOT ONLY BEEN DEBUNKED, BUT IT IS AN "ELABORATE FRAUD." WE TRUST THAT THIS ENDS THE MATTER.
LA LA LA!!
ANTI-VACCINE ACTIVISTS

REFERRAL CONSIDERATIONS WITH ASD

- Careful consideration of the description of the problematic behavior
  - ✓ Operational Definition of behavior
  - ✓ Is there a clear function of the behavior?
  - ✓ How long has the behavior occurred?
  - ✓ Is there a history of maladaptive behavior across settings?
  - ✓ Contribution of ASD
- Cognitive and adaptive functioning level of the client
- Previous treatment attempts
- Possible history of abuse (Maltreatment???)
- Gender Dysphoria
- Sexual Orientation
- Identification of possible client insight



AUTISM & CP

- Client is originally referred in September of 2000 – 13 years old attending his neighborhood Middle School. He was diagnosed with depression, sleep problems, and "Sensory Integration Dysfunction" and has an IEP to address learning disabilities.
- Significant evidence of the client being bullied at school; long history of being disruptive at school, not doing his school work, social problems at school, SIB (hitting his face) across settings, and alleged sexual abuse by his father
- Neuropsychological evaluation in 2002 indicates AS diagnosis and a FSIQ of 99
- At 15 years of age the client's mother and school-based staff express concerns about him viewing "pornography". Later that year, after an extended period of refusing to go to HS the client dropped out of school
- Client was re-referred in the Spring of 2016 at 29 years of age after being convicted on 79 counts of CP possession

FORENSIC INTERVENTION

- ASD diagnosis confirmed
- Confirm or rule out sexual interest in children; assessment for other co-morbid mental health issues; conduct risk assessment and make recommendations for mitigation of risk and/or treatment
- Comprehensive evaluation including: interview of client and consultation with ASD forensic expert about client's history. Assessments included: AASI-3, PCL-R, and MMPI-2-RF
- Dx with Pedophilic Disorder and Persistent Depressive Disorder. Deemed Low Risk
- Initial sentence was a "life sentence"; with new lawyer and team client was sentenced to 3 years

CAUTION REGARDING CP & ASD

- NO evidence to support the theory that ASD makes one more likely to view CP – "The ASD made him do it" defense
- Noteworthy – all of the young men we have worked with and evaluated have understood viewing CP is "wrong" and expressed remorse for their actions (many of whom demonstrated embarrassment)
- In most cases a single issue polygraph is recommended to rule out any hands-on offending and is extremely helpful in defending the client

CASE: I LOVES ME SOME TOES!

- 23 year old male with an ASD diagnosis and an IEP when he attended public school
- Client has a long history of being "attracted" to female toes, specifically those with brightly colored polish
- Client has a long history of inappropriately attempting to view woman's feet in all settings – including family members
- Referral: Mother called requesting assistance in "making [the client's] foot fetish go away before he gets arrested"

Forensic Questions:

- Is he engaging in this behavior with adults or children?
- Is there evidence of sexual arousal?
- Is he masturbating at the time he is looking at the toes/feet or to thoughts after viewing?
- Is there a pattern of interest across settings?

ASD Questions:

- Clear description of the behavior in question (strong emphasis on function)
- Is this an LI issue?
- History of the specific behavior in question
- Is he sexually aroused by feet and/or toes?
- Is he masturbating to feet or toes?

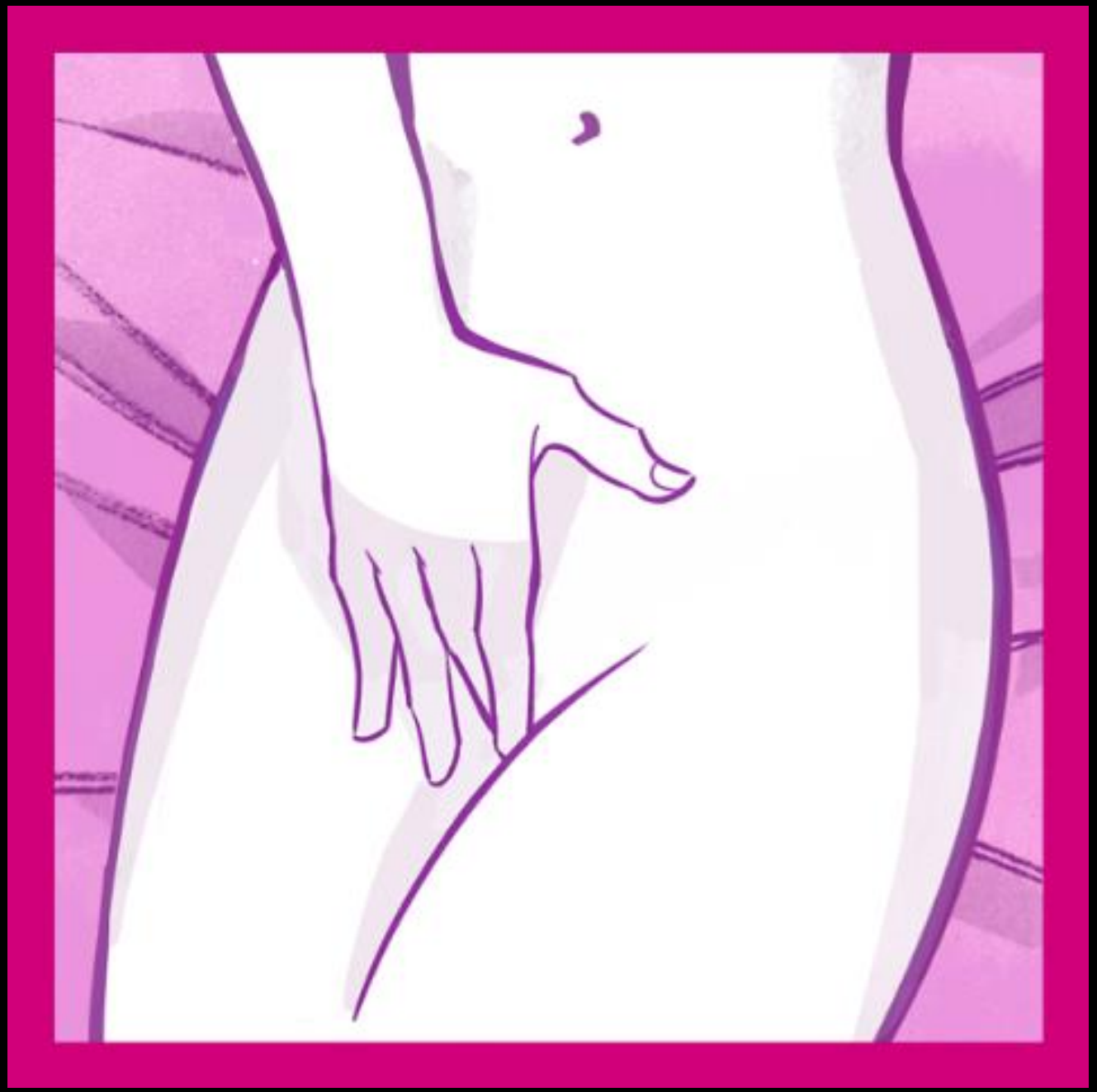
RECOMMENDED INTERVENTION

- Appears to be non paraphilic
- Recommended behavioral and social intervention planning by treatment team
- Recommended social skills instruction to address: attraction to women, how to approach and communicate with women he is interested in, acceptable versus non-acceptable community behavior related to interacting with women he may be attracted to, and "rules" related to talking to women about their toes/feet
- Behavioral intervention with client and his family to address appropriate boundaries and using language that is age-appropriate and correct; legal ramifications of behavior that may appear "scary"

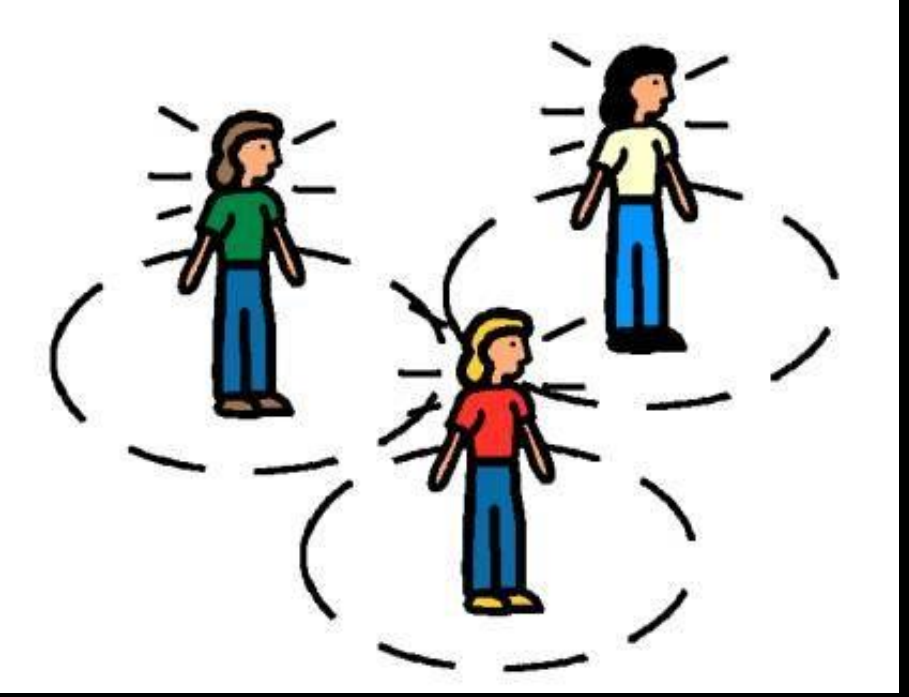
GENERAL INTERVENTIONS FOR ASD RELATED BEHAVIOR

- Visual supports developed to address attraction to others; sexual arousal at school/in community; general boundaries (self and others); "adult-rated" topics, etc.
- Social Stories
- Video Modeling (self, model, or POV)
- Specific focus on generalization of information (must move beyond acquisition phase of learning)

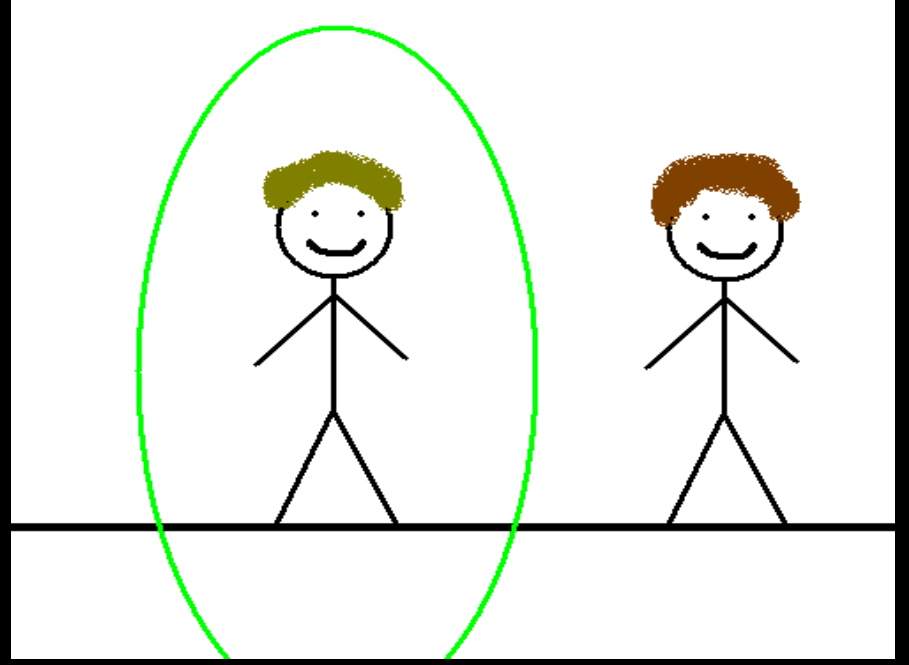

Touching my penis in public is illegal
and if I do this again I will be arrested
and I will go to jail.

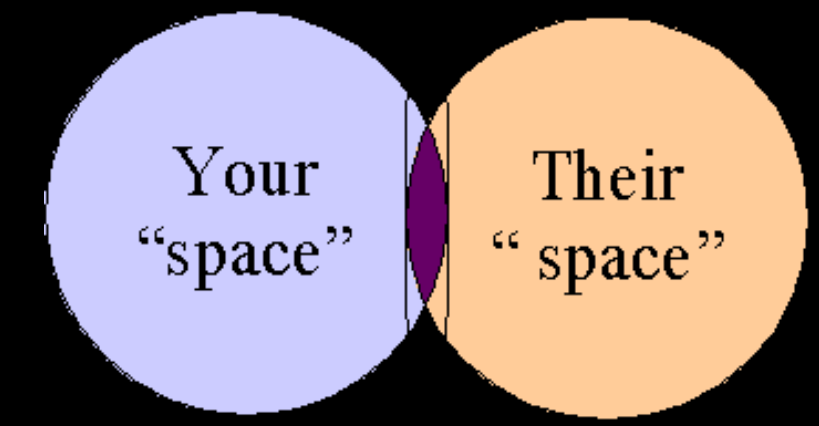


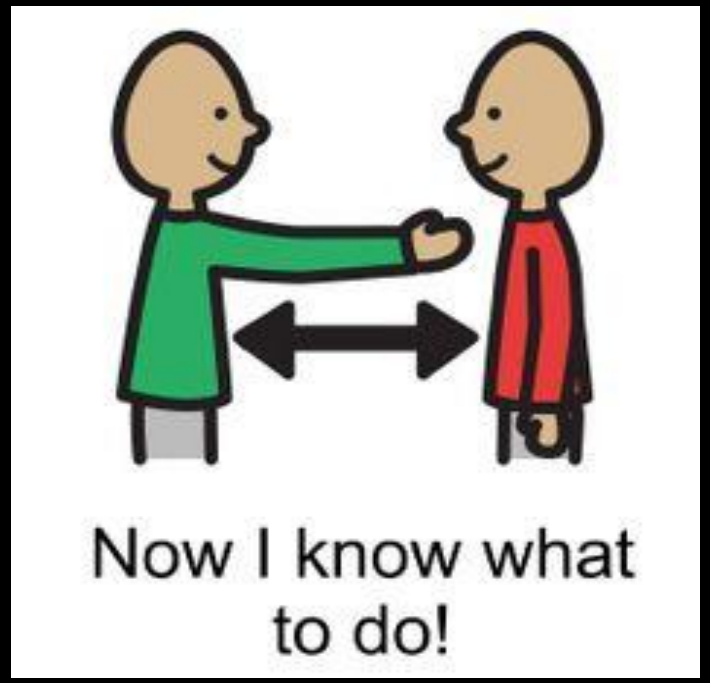
I can masturbate in my bedroom at home with my door closed.




MY PERSONAL AREA
Don't stand in it!!




Your "space"
Their " space"

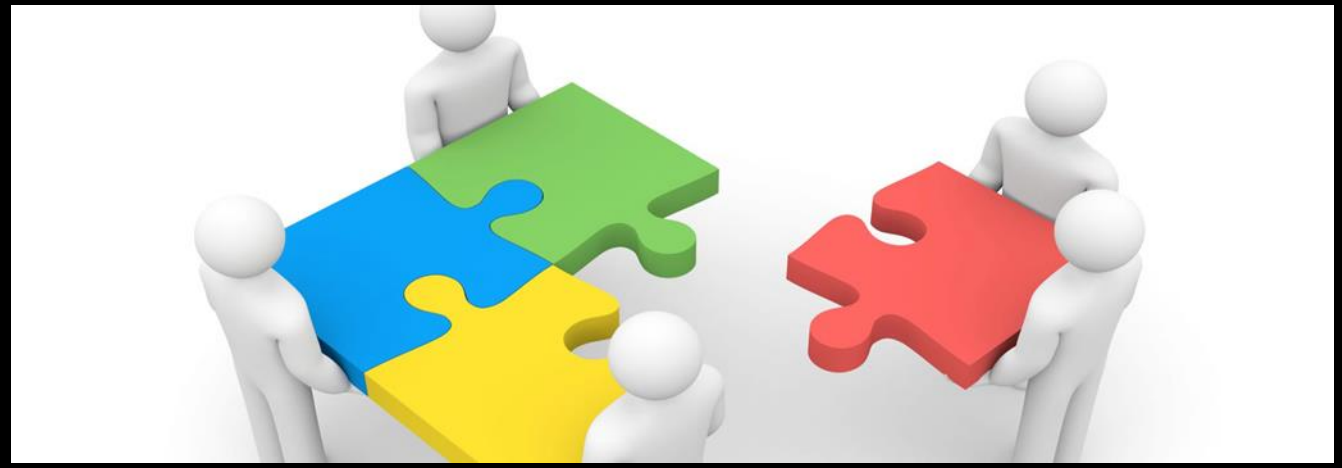

Now I know what to do!


dangerous
outer limits
limit
general
you

FINAL THOUGHTS…

- Don't assume sexual deviance at face value
- Don't "write off" behavior as being related to ASD
- No empirical support that ASD causes aberrant sexual acting out or problems
- Multi-disciplinary consultation and specified assessments as prescribed by team members
- No evidence to suggest that standardized assessments are not applicable with clients with ASD
- Recommended team members may include: forensic psychologist, ASD specialist, neuropsychologist, board certified behavior analyst (BCBA), therapist, SO treatment provider

THANK YOU FOR PARTICIPATING!



Kim Spence, Ph.D.
Kimberly.Spence@ucf.edu
321-212-8997

Eric Imhof, Psy.D
star_ei@bellsouth.net
954-646-6141