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Autism spectrum disorder and sexual offending: Responsivity in forensic interventions

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ABSTRACT

Research concerned with autism spectrum disorder (ASD) and criminality has grown in recent years. While having ASD does not increase risk of sexual offending behavior, an association has been recognized between ASD and sexually abusive behaviors. Despite this association, inadequacies in much of the criminal justice system to respond to the needs of this client group have been raised. A proportion of those people within the criminal justice system convicted of sexual offenses will have ASD. Given that group based interventions require participants to carry out introspection, sharing personal information and interacting in a group, all activities that an individual with ASD will invariably find challenging, efforts need to be made to develop interventions to work responsively, safely, appropriately and effectively with this client group to reduce risk of sexual recidivism. This review sets out to consider research on ASD and sexual offending in order to make practical recommendations on working responsively to raise the possibility of therapeutic interventions being effective when engaging with this client group. The status of research on ASD both generally, as far as the scope of this review allows, and in relation to offending is discussed and practical guidance is offered.

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1. Introduction

Clinicians and practitioners have become increasingly aware of autism spectrum disorders (ASDs) and the affect on individuals across the lifespan. Historically, a lack of expertise in identification could have meant that base rates were underestimated in prevalence studies. Although there have been increased rates of diagnosed cases, studies using inadequately representative sampling methods have contributed to problems in understanding the epidemiology of ASDs. Through a systematic review and meta-analysis of epidemiological data adjusting for between-study variance, The Global Burden of Disease Study found that prevalence rates have been relatively stable over the past two decades, with figures indicating that in 2010 there were an estimated 52 million cases of ASDs worldwide (Baxter et al., 2014). Baxter et al. (2014) reported that this equates to a prevalence of 7.6 per 1000 or one in 132 persons. Their findings suggested that ASDs were at least three times more common in males than females. There was little regional variation in the prevalence of ASDs, although it should be noted that there was a lack of data available from developing countries.

Despite research findings concluding that people with an ASD diagnosis are no more likely to offend than people without such diagnoses (Gómez de la Cuesta, 2010; Mouridsen, 2012), there is suggestion in the literature that ASD individuals may be over-represented in offender populations (Browning & Caulfield, 2011; Haskins & Silva, 2006). For example, in the UK it is unclear exactly how many offenders with ASD are detained or managed within prison and probation services; there are no official statistics of this kind and little research has addressed the issue. Within secure psychiatric settings in the UK, the prevalence of Asperger's Syndrome has been found to be significantly greater than in the general population (Hare, Gould, Mills, & Wing, 1999; Scragg & Shah, 1994). Gender differentiation in ASD appears to be exaggerated in offender populations. Hare et al. (1999) reported that in the three high-secure psychiatric hospitals in the UK, among the individuals who they identified as having or likely to have ASD, males outnumbered females at a ratio of 15.5 to 1. Hare and colleagues note that this ratio likely reflects the confound of fewer females diagnosed with ASD in the general population, and the lower base rate of female offenders. Following a systematic review considering prevalence in the Criminal Justice System, King and Murphy (2014) concluded that while direct comparisons were problematic due to the variability of design, "it can be concluded so far that people with ASD do not seem to be disproportionately overrepresented" (p.2717).

Alongside arson and criminal damage, sexual offenses appear to be more common than other types of crime committed by offenders with ASD (Gómez de la Cuesta, 2010; Mouridsen, 2012). While features of individuals with ASD could both reduce (King & Murphy, 2014) and raise (Howlin, 2004) risk of offending, empirical data assessing recidivism among offenders with ASD is limited. There are contradictory accounts of recidivism reported via small sample or single case studies. Through the analysis of a relatively small sample, an outcome study and follow-up data from sex offender treatment for men with intellectual disabilities suggested that a diagnosis of autism was the only variable of those considered that was associated with further sexually abusive behavior, other than behavioral indicators of the likelihood of further sexually abusive behavior such as writing a love letter to a stranger (Heaton & Murphy, 2013; Murphy, Powell, Guzman, & Hays, 2007). However, further high quality research is required before any firm conclusions about whether an ASD diagnosis is related to a raised risk of sexual offending and recidivism.

Qualitative research has highlighted the negative experiences that are perceivably typical for individuals with ASD who find themselves facing criminal charges (Allen et al., 2008). The present review is intended as a move towards addressing concerns that the needs of those with ASD are inadequately met within forensic settings (Allen et al., 2008; Browning & Caulfield, 2011). It is hoped that a summary of the clinical features of ASD and an overview of developments in understanding the etiology of the condition will be useful. Forensic practitioners working with clients presenting with traits that suggest the presence of an ASD despite no formal diagnosis (Katz & Zemishlany, 2006; Talbot, 2009) may benefit from an overview. Following this, the main aim of the review is to begin to provide an empirical basis for understanding the relevance of ASD in the context of offending behavior, in order to work towards improvements in terms of assessment, management and treatment. Finally, recommendations will be made for further research to enhance responsivity in treatment with this client group.

1.1. Terminology, diagnostic criteria and characteristic features

Widespread clinical attention to ASD – where individuals present with difficulties in social interactions, a range of communication problems and a rigid and fixed pattern of behaving – faltered despite recognition of this condition in the 1940s. Austrian-born child psychiatrist Leo Kanner (1943) and Viennese physician Hans Asperger (1944) made independent observations of traits, now recognized as forming a spectrum of autistic conditions. However, it was not until Wing's (1981) seminal review that these earlier findings were brought together. Kanner had identified a unique condition he described as an autistic (referring to the insular, egocentric nature of the disorder, from the Greek *autos*, meaning *self*) disturbance of affective contact, in a small group of children. Kanner suspected that the characteristics of this small group represented a larger group. Despite the manifestation of the disorder in early childhood, in the absence of a more accurate clinical diagnosis the group in question was regarded as either 'feebleminded' or schizophrenic. Although Asperger was noticing similar characteristics in some of his patients, these cases differed from Kanner's, and the disorder Asperger described he referred to as 'autistic psychopathy' (Frith, 1991). A core triad of impairments became recognized, with differing degrees of severity and effect; Kanner's autism associated with the most severe impairments, and the term Asperger Syndrome coined to describe the profile within the spectrum more comparable to Asperger's original descriptions (Wing, 1981).

In 2013, the American Psychiatric Association (APA) published the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). The autistic spectrum under DSM-IV-TR (American Psychiatric Association, 2000) included a range of pervasive developmental disorders interchangeably referred to in the literature as "autism spectrum disorders" (ASDs) or "autism spectrum conditions" (ASCs). Asperger's disorder, or Asperger syndrome (AS) was a distinct diagnosis from autistic disorder (American Psychiatric Association, 2000). ASC has sometimes been considered synonymously with "high-functioning autism" (HFA), as well as representing some overlap with pervasive developmental disorder — not otherwise specified (PDD-NOS) (Gaus, 2007; Mattila et al., 2011). AS shared what were the three essential diagnostic features of autistic disorder, these being: 1) markedly abnormal or impaired social interaction, 2) impaired communication, and 3) restricted, repetitive and stereotyped behavior, interests, and activities (American Psychiatric Association, 2000). Therefore, there has been some debate as to whether there is a qualitative difference distinguishing AS from autism, or whether AS is best described as one extreme on the same continuum as autistic disorder (Leekam, Libby, Wing, Gould, & Gillberg, 2000). Several experts raised concerns during preparation of the draft DSM-5; individuals with ASCs are a heterogeneous group meaning disagreement on core features and whether subgroups should be retained (Mattila et al., 2011; Wing, Gould, & Gillberg, 2011). However, the DSM-5 committee concluded that there was sufficient scientific consensus upon a single condition and therefore made changes to the triad of impairment diagnostic criteria. Autism Spectrum Disorder (ASD) was introduced to replace autistic disorder, Asperger's disorder, and PDD-NOS.

This new single condition is characterized by two core domains: 1) deficits in social communication and social interaction, and