HEADER LEVEL ONE: Chapter 5: Autism and Sexual Crime

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ABSTRACT

This chapter begins by introducing autism, outlining the main diagnostic features and emphasising its highly heterogeneous nature. Potential links between autism and sexual crime are considered, with particular focus on how some features of autism can contribute to specific types of sexual crime. This chapter discusses the implications of, and challenges surrounding, autism in sexual offending rehabilitation, with specific references to adapted treatment pathways and group treatment formats. The chapter concludes with a summary of key points and recommendations, for practitioners working with autistic individuals who have sexual offence convictions, and a call for more research in this area.

KEYWORDS

Autism, ASD, Asperger's Syndrome, Sexual Crime, Heterogeneity

HEADER LEVEL ONE Introduction

Autism Spectrum Disorder (ASD), as defined in the 5th edition of the Diagnostic and Statistical Manual of mental disorders (DSM-V, American Psychiatric Association [APA], 2013), is a lifelong neurodevelopmental condition characterised by social communication and interaction difficulties, and restrictive and repetitive patterns of behaviour, thought and interest (RRB). Sensory reactivity differences are commonplace, which can manifest as both hyperreactivity and hyporeactivity to particular sensory stimuli.

The DSM-V classification of autism as a single spectrum condition, characterised by a dyad of features, replaced what were previously presented as four distinct pervasive developmental disorders (*Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder- Not Otherwise Specified*), that shared a common triad of features: social and emotional difficulties, language and communication difficulties, and inflexibility of thought (imagination) (DSM-IV-TR, APA, 2000; see Wing & Gould, 1979 for a discussion of the original triad of impairments). The conceptualisation of autism as a single condition in DSM-V is representative of its wide ranging and diverse

nature. Whilst the two core features form the basis of a diagnosis, how these features are experienced varies significantly between each individual and between different contexts, hence the term ‘spectrum condition’.

Collapsing the diagnosis into a single ‘autism’ label, and removing Asperger’s syndrome as a distinct condition from the DSM-V was controversial for some individuals who had previously received an Asperger’s diagnosis since they felt its removal was synonymous with their identity. Although original diagnoses of Asperger’s syndrome will not be altered to fit the new diagnostic labelling, those receiving a diagnosis since the introduction of DSM-V will receive the umbrella term ‘autism spectrum disorder’.

Although ASD is the most current diagnostic label, provided by the DSM-V (APA, 2013), the alternative term ‘autism’ will be used for the purposes of this chapter. This represents a more neurodivergent conceptualisation of autism, moving away from the medical model perspective that characterises autism as a disorder or deficit (Woods, 2017). Additionally, aligning with contemporary research conducted with the autistic community regarding their preferred approach to labelling (Kenny et al., 2016), this chapter refers to individuals diagnosed with autism as ‘autistic individuals’, rather than the person-first approach to labelling, ‘individuals with autism’, commonly found in academic and practitioner literature.

As previously noted, autism is highly heterogenous, including a broad range of intellectual functioning among autistic individuals. Some features of an individual’s autism only become apparent in certain contexts, and are masked in other contexts. For a reliable, accurate and comprehensive diagnosis, multiple sources of information must be considered. These may include clinician observations, caregiver history and self-report (when possible) in order to generate a holistic picture. The DSM-V criteria state that both of the core trait domains must be present, to some degree, from an early period of development, and that such traits must cause clinically significant challenges in functioning (including social, occupational and other important areas of daily functioning). This negates a commonly held belief that an individual who demonstrates some, but not all, of the core traits associated with autism can be on the autistic spectrum. Whilst the behaviours associated with autism are wide ranging, for a formal diagnosis to be appropriate, some elements of the core trait domains should be present. The DSM-V further highlights that the presence of core autistic traits might not become apparent in the early developmental period if they are masked by learned

compensatory strategies, or until social demands (which increase with age) exceed and reveal limited capacities.

For each of the core diagnostic features, the DSM-V requires that clinicians determine the impact of traits on an individual's functioning, and assign individuals to one of three levels, depending on the level of support required. The severity levels are: severity level 1: "requiring support"; severity level 2: "requiring substantial support"; and severity level 3: "requiring very substantial support". This is to ensure adequate support is allocated to each individual, based on their needs.

HEADER LEVEL TWO: Social Communication and Social Interaction

Under the social communication and interaction domain of autism, the DSM-V presents examples of manifestations of this feature, which can be current or historical in the diagnostic assessment process.

The first manifestation refers to challenges in social-emotional reciprocity. Within social interactions, this refers to the typical back-and-forth of conversations which, in autistic individuals, can be either atypical or altogether absent. The DSM-V highlights that this particular manifestation is more evident in children, and is particularly identifiable by a lack of behavioural imitation of others. Language use may be one-sided, with language used only to label or request, rather than to actively engage in social interactions, converse and/or share feelings. In adults it can be more difficult to recognise social-emotional reciprocity difficulties, as many autistic individuals develop compensatory strategies for social challenges, continuously consciously calculating what neurotypicals (individuals not on the autistic spectrum, *see glossary*) typically find socially intuitive. Thus, their difficulties may only become apparent in novel or unsupported situations.

The second cited manifestation of this domain is an absence, or reduced use, of nonverbal communicative behaviours during social interaction. This can be recognised by a diagnostician as atypical eye contact (relative to cultural norms). There may be a lack of eye contact, atypical use and/or poor understanding of body language, and/or limited understanding of gestures in social communication and interactions. Verbal and non-verbal communicative behaviours may be poorly integrated; for example, there may be an abstruse use of language or atypical use of speech intonation. There can be a notable lack of facial

expression use and poor nonverbal communication. Again, this has early childhood indicators, such as a lack of pointing, not sharing interest in objects with others, and failure to follow another person's pointing behaviour.

The final indicative manifestation of the social communication and interaction feature refers to specific difficulties in both developing and understanding relationships (APA, 2013). Autistic individuals may demonstrate difficulties in socialising with peers, making friends, and/or imaginative play. For example, in children, this could emerge as inflexible play, and insistence on playing within the realm of rigid rules. In adulthood, autistic individuals might not intuitively understand appropriate behaviours across different social situations. The degree of this social disconnectedness varies widely between different autistic individuals. Those who present with less prominent autism-related support needs (i.e. those who previously will have been diagnosed with Asperger's Syndrome [AS]) often present as more socially connected (Higgs & Carter, 2015).

HEADER LEVEL TWO: Restricted, repetitive patterns of behaviour, interests or activities

The DSM-V states that at least two of the four following manifestations of restricted, repetitive patterns of behaviour (RRB) must be present, to some degree, for the diagnostic domain to be regarded as satisfied.

The first manifestation of RRB is defined as repetitive motor movements, use of objects or speech (APA, 2013). Examples provided in the DSM-V include, but are not limited to, stereotyped or repetitive; motor movements (e.g. simple motor stereotypes like finger flicking), use of objects (e.g. lining up toys, spinning objects), and speech (e.g. echolalia).

The second RRB manifestation is a preference for routines, or ritualised patterns of verbal or nonverbal behaviour (APA, 2013). Examples of this manifestation include; high levels of distress at minor changes, difficulties with handling transitions, and a strong preference to eat the same highly regimented and specified meals each day.

The third potential RRB manifestation is "highly restricted, fixated interests that are abnormal in intensity or focus" (APA, 2013). Examples of this manifestation include excessively circumscribed interests and/or a strong preoccupation with unusual objects, for example a toddler with an intense preoccupied interest in vacuum cleaners (Turkington & Anan, 2007).

The final RRB manifestation presented in the DSM-V is hyperreactivity (i.e. increased reactivity) or hyporeactivity (i.e. reduced reactivity) to sensory inputs and/or "unusual interest in sensory aspects of the environment" (APA, 2013). This can take the form of extreme, adverse responses to specific sounds, excessive touching of particular objects and/or a visual fascination with lights or movement. Or it can take the opposite form of an apparent lack of attention and indifference to sensory stimuli that would be expected to arouse a response (hyporeactivity) e.g. indifference toward painful stimuli or extreme temperatures.

HEADER LEVEL TWO: Common associated features

There are other characteristics and behaviours that are commonly observed in autistic individuals, but are not required to be present for a clinical diagnosis and are not part of the DSM-V criteria. For example, language and verbal abilities vary across individuals on the autism spectrum, from individuals with a complete lack of speech (mutism) to those who are verbally fluent. Additionally, it is common for language production to notably fall behind comprehension of language during development. There is frequently a notable gap between intellectual and adaptive functional skills in autistic individuals. For example, motor-related difficulties are common, such as an atypical gait, clumsiness and occasional catatonic-like states, whereby an individual appears to freeze or slow mid-action. Self-injurious behaviours are also common, for example head banging and wrist biting.

Autistic individuals across the spectrum can vary widely with regards to intellectual functioning; nevertheless, autism is a distinct neurodevelopmental condition. As such, clinicians must be cautious not to conflate or miscategorise an autism diagnosis as synonymous with intellectual difficulties (ID) or learning difficulties (LD). However, it must be highlighted here that co-occurring ID are extremely common in autistic individuals (70% co-occurrence of autism and ID reported in Bourke, Klerk, Smith & Leonard, 2016), and this can contribute to the common misinterpretation that autism is an ID or LD.

HEADER LEVEL ONE: Autism and Sexual Crime

Current research asserts that autistic people are no more likely to offend than the general population (de la Cuesta, 2010), and are more likely to become victims of crime. In cases where autistic individuals do engage in offending behaviour, it has been suggested that traits of their autism contribute to the lead up to those offences (Allely & Creaby-Attwood, 2016;

Browning & Caulfield, 2011). The current research that has investigated types of offending behaviour by autistic individuals reports that sexual crime, criminal damage, and/or arson seem to be the most prevalent types of crime committed by autistic individuals. However, more data is required to confirm this (de la Cuesta, 2010; Mouridsen, 2012). Existing literature has described ways that an individual's autistic traits can contribute to the lead up to a sexual crime, which is discussed later in this chapter. There is a paucity of research conducted with autistic individuals as a distinct population within in the Criminal Justice System (CJS), particularly concerning those with sexual convictions. Consequently, this chapter will be partially limited in scope by its reliance on the small number of sources currently available on the topic of autism and sexual crime. However, there has been increasing recognition that advancements in research, policy, and practice, regarding autism and the CJS, are necessary (see Hollomotz, Talbot, Gordon, Hughes & Harling, 2018, for a briefing paper with recommendations to improve outcomes for autistic individuals and/or learning disabilities with sexual offence convictions).

Some studies that have investigated prevalence rates of autism spectrum conditions (ASCs) in secure settings (notably Broadmoor, Rampton and Ashworth; Hare, Gould, Mills & Wing, 1999; Scragg & Shah, 1994), with a particular focus on Asperger's syndrome (AS), found a comparably higher prevalence of AS in secure forensic settings than the general population. Scragg and Shah (1994) and Hare et al. (1999) reported that the prevalence of ASCs in secure psychiatric settings was approximately 2%. In their 2010 review, de la Cuesta theorised that this overrepresentation might not be attributable to autism specifically, but attributed instead to co-occurring psychiatric conditions in those populations. It was however accepted that, within the autistic spectrum, those diagnosed with AS *are* more likely to offend than those with Classic Autism or those who present with more prominent autistic traits, who are *much* less likely to offend than the general population. Nevertheless, de la Cuesta (2010) held the position that AS and ASCs in general did not make an individual any more likely to offend than the general neurotypical population.

When considering that some autistic individuals also have an ID, it is important to note the counterfeit deviance hypothesis of ID and sexual offences. The counterfeit deviance hypothesis is one of the few specific theories relating to sexual offending in individuals with ID. The term was first coined in 1991 to describe a subgroup of individuals with ID whose behaviours appeared like paraphilia but which served a function that was not related to paraphilia sexual urges or fantasies (Hingsburger, Griffiths & Quinsey, 1991, updated by

Griffiths, Hingsburger, Hoath, & Ioannou, 2013). This hypothesis proposes that sexual crime, committed by individuals with ID, might be influenced by a lack of sexual knowledge, difficulties in developing social relationships or limited opportunities to develop sexual relationships, all factors which can also be associated with autistic individuals. This theory was developed to enable clinicians to provide interventions which are designed to specifically treat the underlying factors that contributed to the offence for a given individual. It may therefore be useful to consider counterfeit deviance in the treatment and assessment of autistic individuals with sexual convictions.

This chapter will now explore the purported relationships between specific core features of autism and sexual offending behaviours, which have been theorised and reported in extant research literature.

HEADER LEVEL TWO: Social communication and interaction

A number of the social communication and interaction challenges that are faced by autistic individuals have been identified as possible contributing antecedents of sexual offending behaviours, in some cases including those with average (or above average) intellectual functioning (Higgs & Carter, 2015). The first of these examples relates to differences in the interpretation of verbal and non-verbal cues from others, theory of mind ability (i.e. the ability to read the mental states of others), and general social naïveté (de la Cuesta, 2010). These, combined with a misconstrued understanding of appropriate socio-sexual conventions, have been theorised to contribute to sexual offending behaviours in some autistic individuals (de la Cuesta, 2010; Higgs & Carter, 2015). Thus, an individual who has difficulties understanding and intuiting socially acceptable ways to express their sexual desires towards another person may make inappropriate, unwanted sexual advances. To compound this, an autistic individual, who has difficulties in recognising and accurately interpreting the thoughts and feelings of others, could misconstrue behavioural indicators of consent, or fear and distress, in another. Cumulatively, these difficulties have the potential to lead to a sexual offence in some cases.

Further, linked to differences in social understanding, is the possibility of autistic individuals engaging in private and/or sexual behaviours, such as masturbation, when it is not socially acceptable, e.g. in a public space (Allely & Creaby-Attwood, 2016). Some researchers argue that this type of behaviour makes up the majority of autism-related sexual

crimes (Sevlever, Roth & Gillis, 2013). In some cases, an autistic individual may, without malice or ill intent, have an urge to masturbate when in public, but fail to recognise the inappropriateness of masturbating in a public space, and thus find themselves in contact with the CJS for sexual offence charges (Sevlever, Roth & Gillis, 2013). Equally, some autistic individuals may be at an increased risk of being manipulated or exploited by others into performing inappropriate sexual behaviours, such as exposing themselves in public (Allely & Creaby-Attwood, 2016; Sevlever, Roth & Gillis, 2013). This could be related to a desire to establish friendships and relationships, partnered with difficulties in recognising the inappropriateness of their actions, and identifying the manipulative motives of others.

Establishing and maintaining appropriate, consenting friendships and relationships can be another source of challenge for autistic individuals, leading, in some cases, to offending behaviour (de la Cuesta, 2010; Higgs & Carter, 2015). Challenges in social communication and interaction mean that some autistic individuals struggle to socialise with others, which can lead to social isolation. Whether by choice, or not, isolation is a commonly cited contributing antecedent to sexual offending, particularly when paired with sexual frustration, sexual preoccupation or a deeper desire for interpersonal attachment (Allely & Creaby-Attwood, 2016). It has been highlighted that in cases where an autistic individual has committed a sexual offence against a child, it could be linked, in part, to a desire for interpersonal attachment coupled with difficulties in accurately judging age (Archer & Hurley, 2013). Many autistic individuals have average or above average levels of intellectual functioning, which may not be equalled by social and emotional maturity. In some situations, this can lead to interacting with, and befriending, children or individuals younger than themselves, because such interactions and relationships would likely be less challenging (Sevlever, Roth & Gillis, 2013).

Allely and Dubin's (2018) systematic review highlighted potential links between autistic traits and child sexual abuse image related offending behaviours. Linked to the social interaction challenges autistic people can face, some autistic individuals do not experience the normative sexual education that comes from interactions with peers in typical development. This may be compounded as children with developmental conditions, such as autism, may be less likely to receive the same sexual education opportunities in school, compared to neurotypical students (Surgue, 2017). Moreover, some parents of autistic children are unwilling to engage in sexual education discussions with their child, falsely believing that a child who shows a lack of interest in social relationships will be equally

uninterested in sex (Gougeon, 2010). However, despite potential impeded sexual knowledge development in some cases, research posits that levels of sexual interest are typically no different between autistic and neurotypical populations (Turner, Briken, & Schöttle, 2017). Additionally, a number of autistic individuals lack experience of intimate relationships; Allely and Dubin (2018) posit that, cumulatively, this can lead to difficulties for some autistic individuals in expressing their sexuality in appropriate relationship contexts.

A lack of intimate relationship experience and underdeveloped sexual knowledge, combined with a drive to satisfy sexual needs, leads some autistic individuals to seek sexual knowledge and outlets from alternative sources. The internet is frequently used for this (Dubin, Henault & Attwood, 2014), especially for those who already utilise the internet as their "preferred conduit to the outside world" (Sugrue, 2017, p.117). Internet pornography may be a seemingly readily accessible source of sexual knowledge acquisition. However, pornography can present distorted impressions of socio-sexual conventions, such as an unrealistic representation of courtship, consent, and sexual scripts, which may be problematic for an individual relying on such a source to acquire sexual knowledge (Allely & Dubin, 2018; Higgs & Carter, 2015).

Allely and Dubin (2018) suggested that some autistic individuals utilise child sexual abuse images as a means of understanding sex and relationships, rather than being an indicative precursor of sexual offending toward a child. The authors described how some autistic individuals may inadvertently view and download child sexual abuse images, and not be aware of the criminality in doing so. Allely and Dubin (2018) postulate some of the explanations for this, such as; difficulties in recognising facial expressions in images (e.g. fear and distress), difficulty in making accurate judgments of both the age of children in images and distinguishing minors from adults, and not understanding the broader implications of viewing such material. This can be compounded by difficulties in understanding the criminality and wrongdoing in downloading and viewing material, if it is freely accessible via the internet (Mesibov & Sreckovic, 2017).

HEADER LEVEL TWO: Restrictive and repetitive patterns of behaviour, thought and interest (RRBs)

Extant literature has highlighted a relationship, in some cases, between RRBs (the second core feature of ASD under the DSM-V) and sexual offending behaviours. The potential link

between sexually abusive behaviours and RRBs has been cited as an issue as early as Kanner (1943) and Asperger (1944). Asperger linked impulsiveness to sexual behaviours, claiming that sexuality in autistic individuals could be divided between those with a complete sexual disinterest, and those with early signs of strong sexual activity in childhood. Kanner also linked fixed preoccupations and interests with intensively and overtly practiced masturbation, referred to as masturbatory orgastic gratification. Kanner postulated that, when coupled with a disregard for the social rules, this desire could lead to exhibitionist masturbation in public, with outright refusals to desist.

In the contemporary literature, there is a particular emphasis on narrow interests and preoccupations of thought, particularly if these are sexual and/or deviant in nature, or are simply directed at a particular individual or group of individuals (de la Cuesta, 2010; Higgs & Carter, 2015). In some instances, stalking behaviours have been attributed to autism-related preoccupied interests, particularly if they are partnered with social naiveté and misinterpreting social cues of romantic disinterest (Allely & Creaby-Attwood, 2016; Sevlever, Roth & Gillis, 2013; Archer & Hurley, 2013). Additionally, Hollomotz et al. (2018) provided an illustrative case example of an autistic individual who was arrested and charged for a sexual crime, which seemed to be linked to an autism-related circumscribed interest in collecting children's clothing.

Research has specifically highlighted how, in some autistic individuals, the RRB trait could contribute toward downloading child sexual abuse images from the internet. Related to the discussion earlier in this chapter regarding autism and child sexual abuse image related offences, Mesibov and Sreckovic (2017) noted that some autistic individuals develop a compulsive and excessive interest in downloading child sexual abuse material. Allely and Dubin (2018) illustrate this by highlighting that in many cases where autistic individuals are caught in possession of child sexual abuse images, collections of such material tend to be large, with many files unopened. This can have implications for understanding risk in autistic individuals who commit child sexual abuse image related offences. Level of risk in child abuse image offences is often determined, in part, by the number of images an individual possesses; as it is assumed that more images indicate a greater obsession, and therefore a higher risk of acting on related urges (Surgue, 2017). However, this may not be entirely appropriate when viewing risk in autistic individuals, as it does not necessarily consider a relationship between the volume of material collected and the individual's RRB traits (Allely & Dubin, 2018).

It is important to emphasise here that although sexual offending behaviours have been linked to some autistic traits, autism is rarely contended to be the sole cause of offending in those cases. As with neurotypical individuals who sexually offend, the aetiologies of sexual offending behaviours in autistic individuals are likely to be multifaceted, but currently remain mostly unexplored. The majority of existing literature on associations between autistic traits and sexual offending behaviours are currently limited to smaller-scale qualitative studies, clinical case studies, and anecdotal reports.

HEADER LEVEL TWO: Sexual Offending Risk and Protective Factors

Childhood experiences of sexual abuse have been associated with an increased risk of sexual offending behaviours later in life (Lee, Jackson, Pattison & Ward, 2002). Autistic individuals, particularly those with co-occuring Learning Disabilities (LD) and Intellectual Difficulties (ID), have been recognised as being at increased risk of being victims of sexual abuse (Sevlever, Roth & Gillis, 2013).

The increased risk of sexual abuse has been attributed, in part, to difficulties in recognising abusive behaviour, and discriminating appropriate from inappropriate behaviours. Sevlever, Roth and Gillis (2013) gave the example that some autistic individuals become familiar with service providers aiding them with adaptive skills, such as toileting and showering; which may impact on their ability to distinguish what constitutes appropriate and inappropriate touching. Similarly, some autistic individuals are frequently encouraged to comply when they are requested to do certain things, which lead them to become less likely to decline inappropriate requests from others. Equally, if an autistic individual *is* aware of the abuse, their difficulties in social communication and interaction can make it difficult for that individual to effectively report the abuse to the appropriate person e.g. the caregiver (Archer & Hurley, 2013). Moreover, a caregiver might attribute concerning behaviour changes, such as self-injury, to an individual's autism, rather than recognising them as indicative of abuse (Sevlever, Roth & Gillis, 2013). It has been reported that autistic individuals have more difficulty in effectively processing and coping with traumatic experiences of abuse, which could contribute to an increased risk of sexual offending, particularly if the abuse was sexual in nature (Bleil Walters et al., 2013).

On the other hand, it has been theorised that an autism diagnosis can serve as a protective factor against sexual offending (Sevlever, Roth & Gillis, 2013). Many autistic

individuals, particularly those with high support needs, are closely monitored by family or service providers in their daily lives. This regular supervision may limit any opportunity to commit a sexual offence, and close monitoring could serve as a protective factor, reducing the likelihood of an autistic individual experiencing abuse (Sevlever, Roth & Gillis, 2013). Additionally, Sevlever, Roth and Gillis (2013) have noted that many autistic individuals struggle to successfully deceive others, due to the social communication and interaction features of their autism. This could act as a protective factor in that they could struggle to successfully implement precursor behaviours to sexual offending e.g. establishing trust with a victim or convincing them into particular situations to facilitate offences.

HEADER LEVEL ONE: Appropriate Assessment and Treatment

A number of theories postulate what constitutes effective rehabilitation for individuals with sexual convictions. These range from the more traditional deficit-focused approaches such as 'Relapse Prevention' theory (Marlatt & Donovan, 2005) and 'Risk- Need-Responsivity' (Bonta & Andrews, 2007), to contemporary strength-based, goal-oriented approaches, such as the 'Good Lives Model' (Ward, 2002). As such, there has been a corresponding shift in rehabilitation programmes for individuals with sexual offence convictions. These have moved from an exclusive risk-reduction focus, towards a focus on an individual's strengths, an approach that is posited to reduce the risk of recidivism.

A key concept, underpinning most treatment approaches, has been "responsivity" in the delivery of interventions, i.e. the style, mode and delivery of treatment should be adequately adapted to respond to a service user's unique learning style and capacity (Marshall, Marshall, Serran & O'Brien, 2013). Despite the emphasis on responsivity in theory, it has been suggested that, in practice, current sexual offending rehabilitation programmes are not appropriately adapted for autistic individuals (Higgs & Carter, 2015).

A systematic review conducted by Melvin, Langdon and Murphy (2017) highlighted an absence of offence-related treatment approaches that have been specifically adapted for autistic individuals who have committed offences more generally, and a scant amount of literature that directly addresses offence-related treatment effectiveness for autistic individuals. Higgs and Carter (2015) noted how there is a scarcity of research on treatment of autistic individuals who have sexually offended (AISOs) as a client group, and an absence of treatment programmes specifically adapted for AISOs.

Consequently, a number of authors have posited that research into the usefulness of current treatment programmes, and development of specifically adapted treatment approaches for AISOs should be high priorities, to ensure that AISOs can engage with rehabilitation more effectively and to ultimately reduce recidivism (de la Cuesta, 2010; Higgs & Carter, 2015; Melvin, Langdon & Murphy, 2017). The scant amount of literature that does exist on this topic is largely theoretical in nature, but indicates that there are a number of barriers and challenges to the effective treatment for AISOs, related to features of their autism.

HEADER LEVEL TWO: Adapted treatment pathways

A primary challenge for clinicians in the current treatment climate is the direction and allocation of AISOs to appropriate treatment programme pathways. Autistic individuals have heterogeneous, and often uneven, neurocognitive profiles, which can present challenges when formulating treatment plans (Melvin, Langdon & Murphy, 2017). For example, some autistic individuals possess average (or above average) levels of intellectual functioning, and present with a verbal ability that, prima facie, indicates good comprehension, yet they experience underlying difficulties in adaptive or social functioning (Melvin, Langdon & Murphy, 2017). This can make it difficult for professionals to decide whether or not an adapted treatment programme pathway would be most appropriate for AISOs.

Currently, adapted programmes are specifically designed to be responsive to the communication styles and abilities of individuals with IDs (Hollomotz et al., 2018), and the selection of individuals for these programmes is primarily determined by assessments of intellectual functioning. As such, in some cases, AISOs who have average (or above average) intellectual functioning are directed toward standard treatment programmes, which have not been specifically adapted for individuals with ID. While many AISOs possess the requisite levels of intellectual functioning for standard, non-adapted programmes, these programmes may not be delivered in a way that is sufficiently responsive to autistic individuals. Programmes often utilise a verbal, at-the-front style delivery, at a moderate pace. However, this could be difficult for autistic participants, who may be otherwise intellectually capable of understanding the programme content, but struggle with delivery styles that largely rely on verbal-processing (Haigh et al., 2018; Vinter, Dillon, Winder & Harper, 2019). Such individuals would likely benefit more from programmes delivered at a slower pace, which

utilise a wider range of learning modes, such as visual and kinaesthetic approaches (Vinter, Dillon, Winder & Harper, 2019).

Alternatively, due to these responsivity needs, some AISOs are directed towards programmes that are adapted for individuals with ID. Adapted programmes traditionally incorporate a wider variety of learning modes and are delivered at a slower pace, to accommodate those with ID, and may be more responsive to the needs of AISOs compared to standard programmes. Moreover, co-occurring IDs are common in autistic populations (Bourke, Klerk, Smith & Leonard, 2016; Melvin, Langdon & Murphy, 2017).

However, there are arguments in the literature that these adapted programmes are not appropriate for AISOs as a specific client group, who have unique treatment needs that differ from those who have ID. For instance, it has been highlighted that some AISOs, who are allocated to adapted programmes and have average or above average intellectual functioning, feel patronised or experience boredom due to the slower pace and simplified material (Vinter, Dillon, Winder & Harper, 2019). Furthermore, some studies have highlighted that treatment effectiveness for individuals with an autism diagnosis and co-occurring IDs were lower, compared to those with IDs and no autism diagnosis (Heaton & Murphy, 2013). Additionally, in studies that sought to address harmful sexual behaviours, presence of an autism diagnosis was linked to higher recidivism rates and increased risk of recidivism (Heaton & Murphy, 2013). These issues have been further exacerbated and conflated by the tendency for many to include autistic individuals in broader ID or neurodevelopmental disorder groups (Melvin, Langdon & Murphy, 2017), which do not necessarily reflect or represent the needs of, and challenges faced by, autistic individuals specifically.

In the current absence of accredited interventions adapted specifically for AISOs (Hollomotz et al., 2018), it has been asserted that autism-specific interventions (or supplementary autism-specific adaptations to existing programmes) should be developed, with a view to improve treatment experiences and outcomes for AISOs (Vinter, Dillon, Winder & Harper, 2019). However, understanding of effective rehabilitative practice and treatment options when working with AISOs is still in its infancy (de la Cuesta, 2010; Hollomotz et al., 2018; Sevlever, Roth & Gills, 2013), and further empirical evidence will be required for appropriate, informed autism-specific treatment adaptations to be effectively designed and developed.

HEADER LEVEL TWO: Group programmes

Treatment programmes that address sexual offending most commonly incorporate group Cognitive Behavioural Therapy (CBT) type formats and exercises (McGrath, Cumming, Burchard, Zeoli & Ellerby, 2009; Schmucker & Lösel, 2015), designed so that individuals can discuss, explore, and understand thoughts and behaviours that led to their offending with peers and facilitators (Yates, 2013). It is postulated that understanding these thoughts and behaviours, with the help of the group, can be used to identify new ways of thinking and behaving to enable the management of problematic thoughts and behaviours, and guide them towards a life that is more fulfilling and incompatible with offending (Yates, 2013).

However, it has been argued that group programme formats may not be appropriate for AISOs (Higgs & Carter, 2015; Melvin, Langdon & Murphy, 2017). It has been reported, by AISOs and rehabilitation staff, that participation on group programmes can be stressful, anxiety inducing experiences for autistic individuals (Vinter, Dillon, Winder & Harper, 2019). Group-based treatment necessitates engagement in social interactions with multiple individuals, and benefit from good group cohesion. However, it has been postulated that this necessity for social interaction and integration is not congruent with the learning style of AISOs (Higgs & Carter, 2015). Furthermore, AISOs can feel overwhelmed in group environments as they are required to manage, follow and process multiple social interactions and discussions. They may experience sensory difficulties relating to noise during discussions, physical proximity to others in a group room, and reactivity to fluorescent lighting in some rooms, and may be required to 'open-up' about sensitive topics and life experiences (Vinter, Dillon, Winder & Harper, 2019). As such, some propose that the effectiveness of group interventions for AISOs could be compromised because they are not sufficiently responsive to autistic individuals (Higgs & Carter, 2015). Some case studies have advocated the removal, or adaptation, of group programmes for AISOs (Melvin, Langdon & Murphy, 2017). Some have advocated the benefits of one-to-one treatment approaches when working with AISOs. However, while one-to-one treatment approaches may seem, prima facie, to be more beneficial, a purely one-to-one approach can mean that some AISOs miss out on the advantages of practising social interactions, and insight from peers. Furthermore, some positive experiences of AISOs engaging in group programmes have been reported (Vinter, Dillon, Winder & Harper, 2019). Therefore, in light of the heterogenous nature of this client group, each case should be evaluated individually to determine the most useful approach for that specific client.

HEADER LEVEL TWO: Challenging treatment and assessment content

Extant literature has highlighted some of the challenges that AISOs face in sexual offending rehabilitation in relation to treatment programme and assessment content. Content relating to emotions, perspective-taking and hypothetical thinking can be particularly challenging when working with AISOs (Vinter, Dillon, Winder & Harper, 2019).

Sexual offending treatment programmes often incorporate role-play exercises (also known as 'skills practices'). In these programmes, participants act out hypothetical situations and deconstruct them, to discuss and understand what others in those situations may think or feel, and practice positive approaches to problem-solving in those types of situations. A number of authors have highlighted that these types of tasks are difficult for AISOs to engage with, compared to neurotypical clients, due to difficulties in social-perspective taking, theory of mind difficulties, weak central coherence, cognitive inflexibility and empathic difficulties related to their autism (de la Cuesta, 2010; Melvin, Langdon & Murphy, 2017). AISOs and rehabilitation staff have reported specific experiences of these challenges, in that a number of AISOs found role-play exercises difficult to grasp, particularly regarding the hypothetical thinking and perspective-taking elements; consequentially, some would actively avoid engaging with such exercises (Vinter, Dillon, Winder & Harper, 2019). Similarly, drawing broader generalisations can be challenging for autistic individuals. In treatment AISOs may struggle to understand how the rules and social conventions taught in these types of exercises should, and can, be applied across various social situations. Additionally, some AISOs become overly focussed on a particular detail of a scenario or their offence.

Historically, acknowledgement and acceptance of accountability for past offences was a crucial first step of many sexual offender treatment programmes. However, for AISOs this is a much greater challenge, compared to a neurotypical clients. It has been reported that AISOs can have difficulty discussing and reflecting on their own thoughts and feelings on the lead up to their offence (Vinter, Dillon, Winder & Harper, 2019). When discussing offending behaviours, insight may only extend to factual reporting, and they might find it difficult to identify past emotions, appreciate other interpretations of their behaviour, and acknowledge the inappropriateness of said behaviours (Higgs & Carter, 2015). AISOs and rehabilitation staff have noted how, in their experience, AISOs struggled to remember the emotional aspects of past experiences during assessments and treatment, and sometimes also struggled

to identify and distinguish emotions they felt in the present (Vinter, Dillon, Winder & Harper, 2019). AISOs can also have difficulty in appreciating or foreseeing how their initial actions impacted their victim, how or why their actions led to their eventual arrest and incarceration, and why they are on a treatment programme (Melvin, Langdon & Murphy, 2017; Woodbury-Smith & Dein, 2014). These difficulties could present problems in treatment, particularly in more traditional treatment approaches, which encourage accountability for consequences and impact of their offences (de la Cuesta, 2010).

Cumulatively, these difficulties present challenges for clinicians if assessing risk, delivering treatment and gauging treatment progress using approaches that are designed for neurotypical clients, and not specifically adapted for AISOs. There has been some promising work on developing supplementary aid guidelines for the forensic assessment of risk and protective factors in autistic individuals, for example the HMPPS designed Framework for the Assessment of Risk & Protection in Offenders on the Autistic Spectrum (FARAS; Al-Attar, 2019). The FARAS provides supplementary guidance for assessors on seven facets of autism ('*circumscribed interests*', '*visual fantasy v limited social imagination*', '*need for order, rules, routine and predictability'*, '*obsessionality, repetition and collecting'*, '*social interaction and communication difficulties'*, '*cognitive styles [difficulties and strengths]*', and '*sensory hyper and hypo-sensitivity'*), and how they may be relevant regarding risk, protection and interviews (Al-Attar, 2019). As an example of the typical guidance provided by the FARAS, relating to the repetitive and restrictive interests facet of autism; the FARAS highlights that an autistic individual's obsessive research tendencies and intense pedantic focus can be channelled safely and constructively in study and employment; thereby serving as a potential protective factor against harmful offending behaviours. While the FARAS is a promising development in supporting rehabilitative work with autistic individuals with convictions, it is currently very new, and there are yet to be empirical evaluations of its usefulness and outcomes in practice.

CONCLUSION

To conclude, when working with autistic individuals, it is crucial to recognise heterogeneity. Autism is highly heterogenous, including intellectual functioning, challenges or difficulties they encounter, and personal strengths. Therefore, to work effectively with AISOs, it is important that each person is recognised, understood and appreciated as an individual. A

collaborative approach between rehabilitation staff, an AISO and their wider support network can be valuable in understanding that individual, and ensuring positive treatment experiences and outcomes (see Hollomotz et al., 2018, p.24, for a description of an individual-centred 'whole system approach').

Education and increased awareness around autism can be beneficial in this pursuit, providing clinicians and other rehabilitation staff with a core understanding of autism can act as a foundation for understanding each client individually. It must be reemphasised that each autistic individual is unique. While an underlying awareness and knowledge of autism can be helpful when working with AISOs, clinicians must avoid relying on assumptions of what an autism label entails (including assumptions regarding intellectual functioning).

Very little empirical research has explored the links between autism and sexual crime, and what constitutes effective rehabilitative practice when working with AISOs, therefore understanding currently remains limited. It is likely that explanations of sexual offending behaviour, understanding of risk and protective factors, what works in rehabilitation, and experiences of the criminal justice process for AISOs differ, compared to neurotypical and ID sexual offending populations. Further investigations should be conducted into autism and sexual crime, and greater consideration should be given to the implications of autism in forensic rehabilitative policy and practice.

GLOSSARY

Atypical (development): A developmental trajectory or path that differs from the typical sequence of development.

Neurotypical: Label (often used by the autistic community) for a non-autistic individual. An individual wbo does not present with autistic patterns of thought or behaviour.

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