ASSESSMENT and TREATMENT of CHILDREN AND ADOLESCENTS on the AUTISM SPECTRUM

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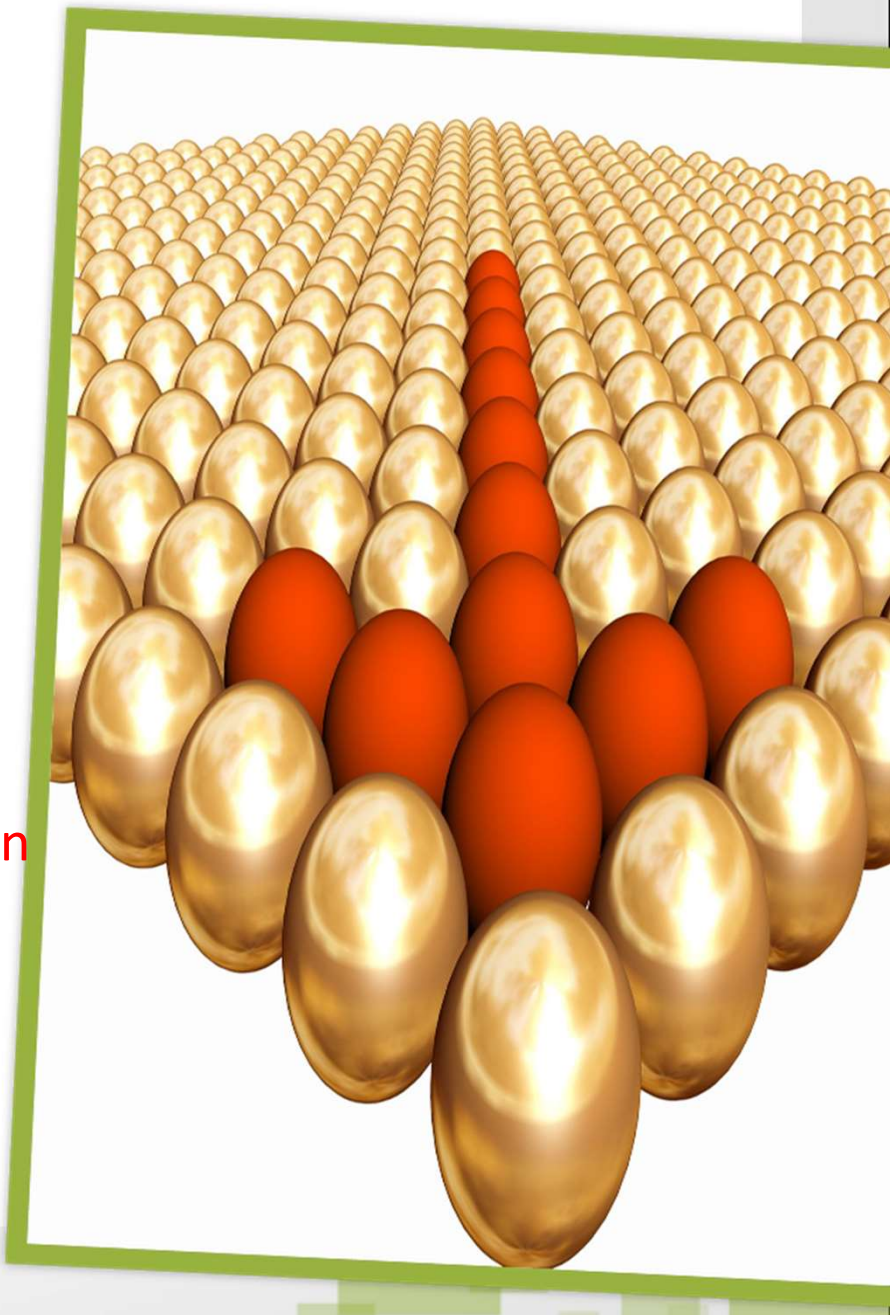
Focus

- INTRODUCTION
  - A WORD ABOUT LANGUAGE and LABELS and RESEARCH!
- DSM-V: ASD DX
- Drilling Down:
  - Some Essential Features To Consider
- IMPLICATIONS FOR PSYCHOSEXUAL ASSESSMENT FOR CYA on the AUTISM SPECTRUM
- IMPLICATIONS FOR TREATMENT FOR CYA on the AUTISM SPECTRUM
- Discussion/Q & A



Social Skills?

Stranger in a Stranger Land

VisualBee

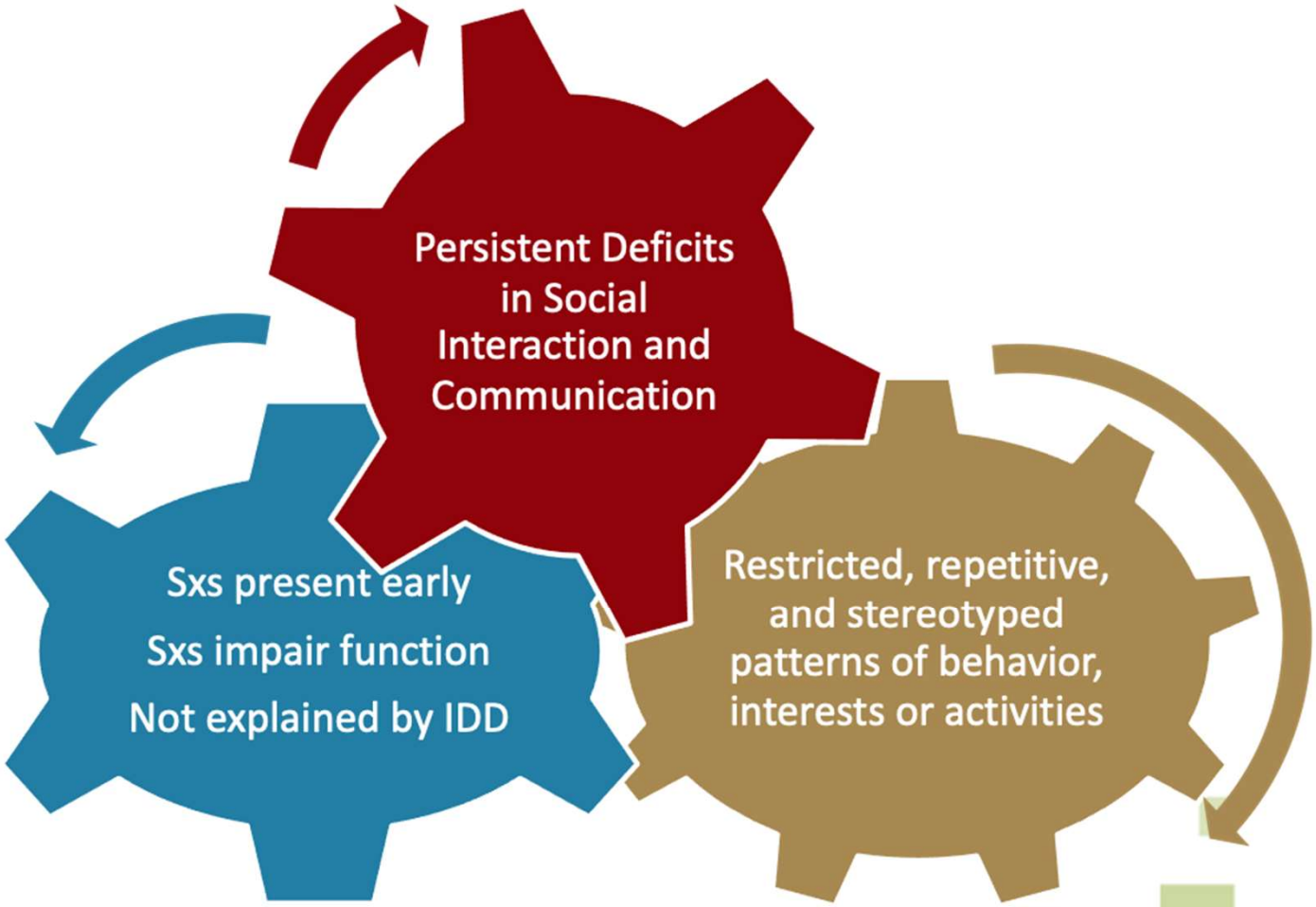
Frick, 2011

Many have stated…

"When you've seen one person with autism,
you've seen one person with autism."

VisualBee

Autism Spectrum Disorder: DSM V, 2013



A. Persistent deficits in social interaction and communication (x3):

1. Deficits in social-emotional reciprocity:

- inability to initiate or respond to social interactions
- inability to share affect, emotions, or interests
- difficulty in initiating and sustaining a conversation

2. Deficits in nonverbal communicative behaviors used for social interaction

- abnormal to total lack of understanding and use of eye contact, affect, body language, and gestures
- poorly integrated verbal and nonverbal communication

3. Deficits in developing, maintaining, and understanding relationships

- Difficulty in adjusting behavior to social contexts
- Difficulty making friends
- Lack of interest in peers

Spence & Imhof, 2019

Communication Issues

- Superficially perfect, formal language
- Speech lacks prosody
- Difficulty interpreting tones of voice and nonverbal cues
- Literal understanding
- Fail to grasp implied meaning
- Frequently use questioning as a form of responding

Social Skills Issues

- Difficulty maintaining employment
- Tense and stressed trying to cope with social demands in most settings
- Difficulty understanding implied meaning
- Reciprocity problems
- Difficulty picking up nonverbal social cues
- Difficulty with eye contact/appearance of inattention
- Poor hygiene
- Does not understand rules of engagement

B. Restricted, repetitive, and stereotyped patterns of behavior, interests, or activities

1. Stereotyped a repetitive speech, motor movements or use of objects

- Motor stereotypies or mannerisms (lining up toys)
- Echolalia, stereotyped, or idiosyncratic speech

2. Excessive adherence to sameness, routines, or ritualize patterns of verbal or nonverbal behavior

- Transitional difficulties
- Greeting rituals
- Rigid patterns of thinking

3. Highly restricted, fixated interests that are abnormal in intensity or focus

- Preoccupation was excessively circumscribed or perseverative interests

4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment

- Sensory integration issues
- Apparent indifference to pain/temperature
- Excessive smelling, touching, or visual fascination with lights or movements

Restricted, repetitive patterns of behaviors, interests or activities (RRBs) may include:

- finger flicking
- flapping
- full body rocking or swaying
- spinning
- idiosyncratic language
- ritualistic behaviors
- intolerance to change
- preoccupations or the fixated pursuit of circumscribed interest

ASD & Co-Morbidity

- **Anxiety!**
- Depression
- Mood Disorders
- Bipolar Disorder
- ADHD
- Obsessive-Compulsive Disorder
- Eating Disorders (among females)

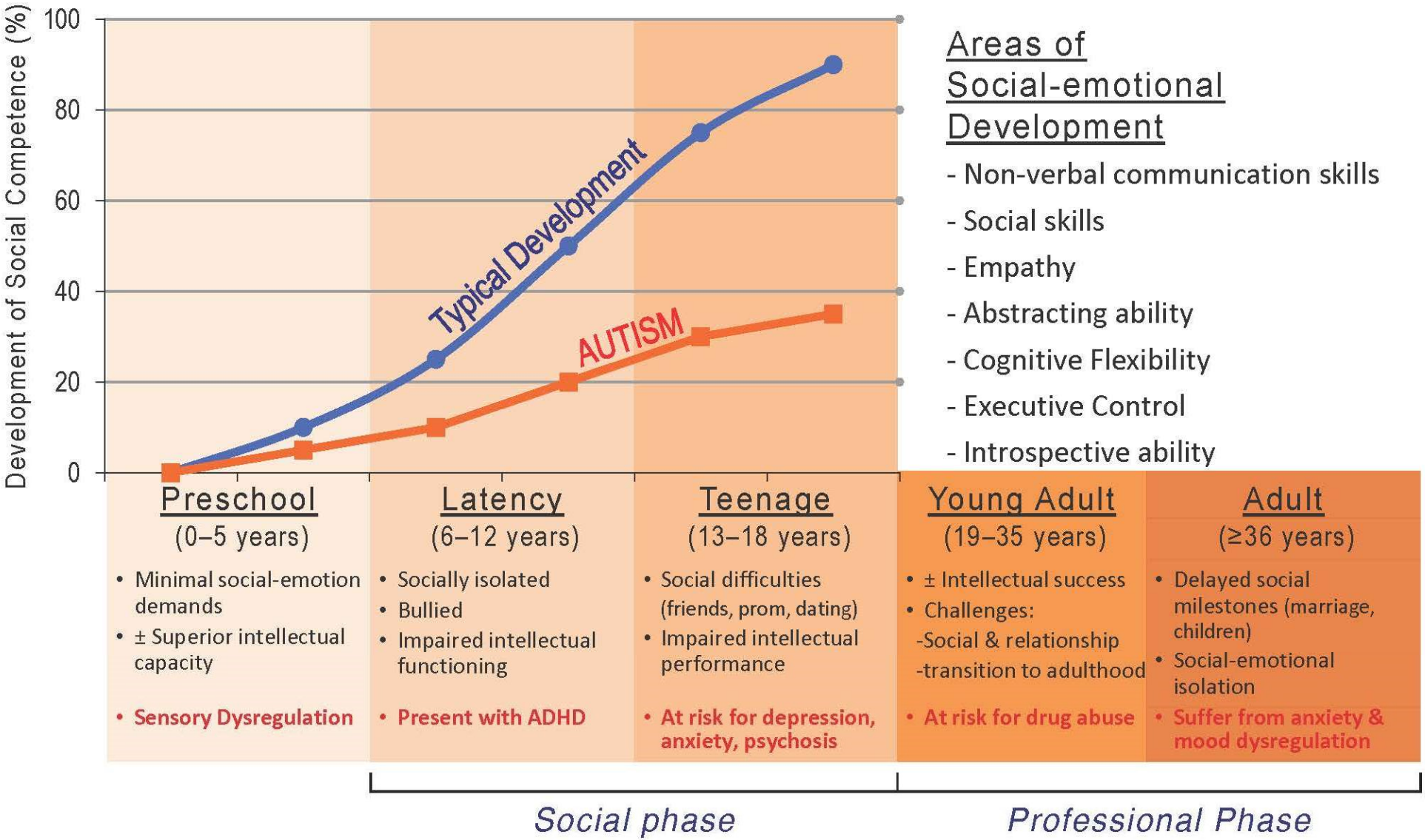
Data, data, data…

- Prevalence of ASD: Meta-analysis consistently estimate 60/10,000 (Latham, 2014)
- Prevalence of ASD: 2000→ 1/150 children
- 2014→ 1/59 children (Spence & Imhof, 2019)
- Male/female ratio ranges 4:1 to 9:1 (western countries)

Cultural differences:

- **African American compared to White**
- DX at lower rates, later, likely to be misdiagnosed, less likely to receive a developmental evaluation prior to age 3, if eligible, likely to receive services
- **Hispanic mothers compared to White mothers re: ASD diagnosis (Lopez, et. al., 2018)**
- N=44 Latino & 52 white mothers
- All expressed intense emotional reactions
- White= relieve of guilt; Latino= increase feelings of guilt, had limited knowledge of ASD

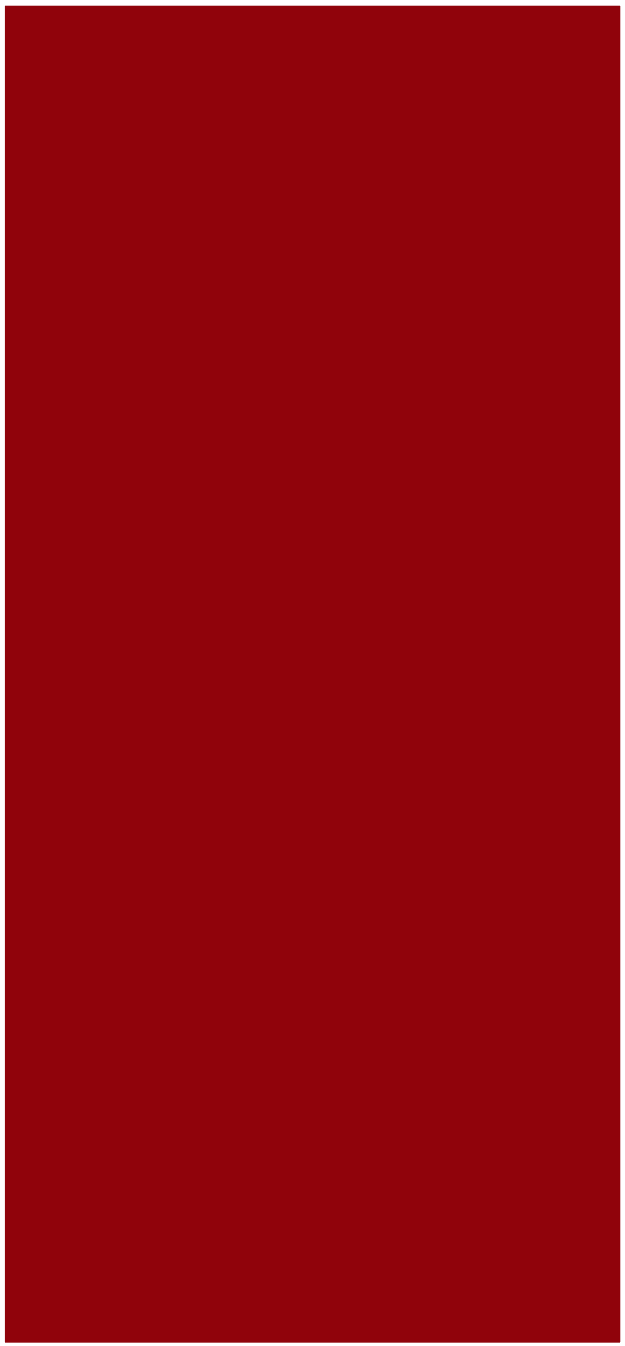
Social-emotion Competence Across the Lifespan



The Alan & Lorraine Bressler Program for Autism Spectrum Disorder

(Mass General Department of Psychiatry, 2016)

Some explanations...



Biopsychosocial factors in ASD (Higgs & Carter, 2015)

Cognitive explanations: social cognition deficits and atypical non-social domain general processing

- i.e., executive functioning problems such as working memory and inhibitory control or weak coherence which is the tendency to process part rather than perceiving the whole
- Hypothesized strengths→analyzing and constructing systems
- Weaknesses→'**Mind-blindedness**' (absence of theory of mind/TOM) -inability to imagine thoughts and feelings of others-failure to recognize behavior as inappropriate; affective empathy (difficulty recognizing emotional states in others)

Biopsychosocial factors in ASD

- **Language** processed differently secondary to impaired receptive processing
- **Visual** cognitive style with enhanced efficiency in processing visual stimuli and superior visual acuity
- **Environmental** factors: parental age, low birth weight, multiple births, maternal infections during pregnancy require investigation
- **Fetal androgen** theory hypothesizes levels of fetal testosterone may lead to ASD vulnerability

Biopsychosocial factors in ASD

- Evidence emerging to determine role of **genetic heritability**→

Chromosomal and gene disorders→ 5-15% (Higgs & Carter, 2015)

Constantino (2018)

- has determined autism is predominantly influenced by additive genetic factors
- Even sporadic cases in families is substantially influenced by the aggregation of recessive or additive genetic risk
- **Presents overwhelming evidence for the influence of additive genetic risk accounting for a majority of the population-attributable-risk for autism**
- Autism recurs in autism-affected families 20 times more commonly than in the general population

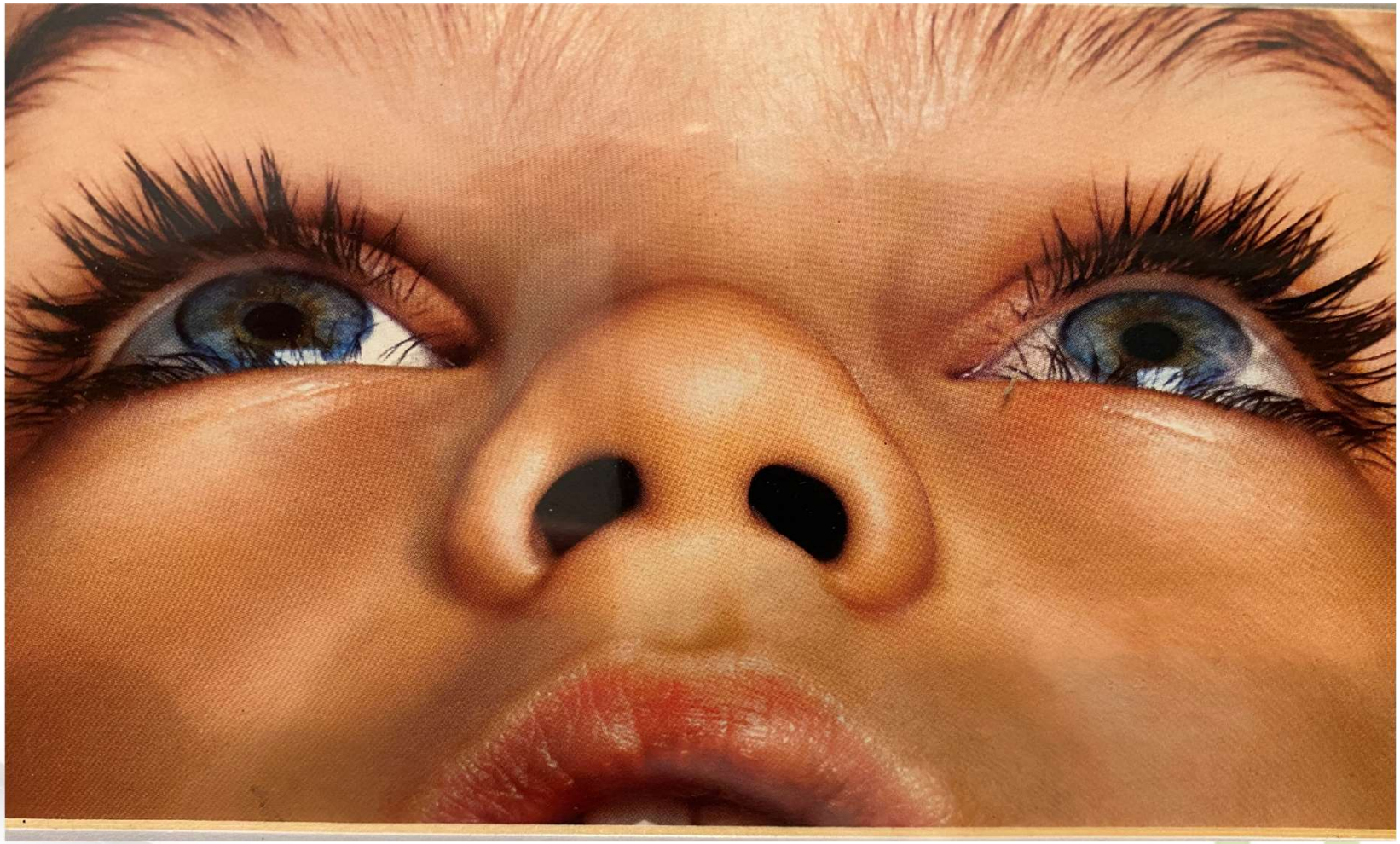
Biopsychosocial factors in ASD

Causes and developmental trajectories are complex

- A purely “social” theory of understanding ASD is inadequate. However, independent genetic and neurobiological accounts are also not sufficient to fully inform how this neurodevelopmental disorder emerges...

- A complex biopsychosocial model will best account for ASD

Drilling down below ‘poor social skills’…



VisualBee

Drilling Down-Let's start at the beginning…(Constatntino, et al. 2017)

- **Social Visual Engagement:**

"Long before infants reach, crawl or walk, they explore the world by looking: they look to learn and to engage, giving preferential attention to social stimuli, including faces, face-like stimuli and biological motion"

- **Social Visual Engagement:**

"…shapes typical infant development from birth and is pathognomonically impaired in children affected by autism"

- **Social Visual Engagement:**

"…including preferential attention and the timing, direction, targeting of individual eye movements, is strongly influenced by **genetic factors**, with effects

- **Social Visual Engagement:**

"Moreover, the characteristics that are most highly heritable, preferential attention to eye and mouth regions of the face, are also those that are differentially decreased in children with autism.

Failure to see the social world:

- A combination of neurological differences in the brain conspired to blind the individual to learning from social interactions which is common sense to most of us about the feelings and intentions of others

- Many individuals on the spectrum simply do not see those countless cues and expressions, intonations, and body language that give meaning to social interactions and understanding to communications (Mahoney, 2019)

EYE→BRAIN

- Individuals with ASD register faces in the portion of the brain used to process OBJECTS
- Focus is on the mouth to the exclusion of other cues
- **They miss the full tapestry of information!**

VisualBee

The ASD BRAIN

- **Neuroanatomical** differences, disrupted neural connectivity and atypical neurological responses to social and emotional cues observed (Higgs & Carter 2015)

The ASD BRAIN

- **MRI**→points to lack of integration of distributed functions and disruptions in the way the brain function and is modulated in relation to changing task demands

  →increase in white matter in tracts important for language and social cognition (Latham, 2014)
- **ATYPICAL SOCIAL BRAIN RESPONSES!**
- Exhibit reduced activation in prefrontal cortex during executive functioning tasks
- **NEURODEVELOPMENTAL TRAJECTORIES ARE NOT HOMOGENEOUS**…but inhibitory control and higher cognitive levels are preserved in some individuals with high fx ASD.

"Gifts" of ASD Brain Organization

Latham (2014)

- Intense focus
- Good memory for facts
- Good sense of direction, fascinated by maps and routes
- Hard worker when job is good match
- Ability to see patterns
- Advanced skills in select areas
- Attention to detail
- Honesty
- Loyalty to a small group of friends or employer

Latest research re: differences in brain structure (Pretzsch, et.al, 2022)

- ASD symptoms impact adaptive behavior related to “the development and application of the abilities required for the attainment of personal independence and social sufficiency.”

More neurodiversity identified:

- However, across the lifespan, some with ASD improve, some regress and some remain largely unchanged…
- Problematic for a “one-size-fits all” approach
- More targeted approaches are necessary…

EU-AIMS Longitudinal European Autism Project (LEAP)

- Largest longitudinal sample worldwide
- Current study:
- N= 483 (204 w/ ASD, 279 neurotypical)
- Ages 6-30 at two time points: 12 and 24 mths
- Measures included the Vineland Adaptive Behavior Scale-II, MRI DATA, Neuroimaging (cortical volume, cortical thickness and surface area)

Aim of the study:

- Compare neuroanatomy between groups (i.e., increasers vs decreasers vs no-changers)
- Examine if deviations from the neurotypical neuroanatomical profile are associated with individual outcomes
- Explore the neuroanatomical differences' potential genetic correlates

In a nutshell outcomes among:

Increasers vs decreasers vs no-changers:

- Widespread neuroanatomical differences between increasers and decreasers in cortical volume, cortical thickness and surface area.
- Decreasers and no-changers differed in cortical volume and surface area.
- Greater neuroanatomical deviation predicted worsening in adaptive behavior.
- Genetic underpinnings supported= greater polygenic variation

Respond Differently to meds

- Benzodiazipines=may do nothing, may increase, may decrease
- Antipsychotics= psychosis may be transient episode→ can stop
- Beta blockers-=may be best because they prevent the body from responding to the experience of adrenalin—can't stand touch-body sensations most difficult
- Risperdol and Abilify=best for assaultive and out of control behaviors
- Oxytocin=latest research→ enhances bonding between human

Latham (2014) identified: "Challenges of ASD Brain Organiztion"

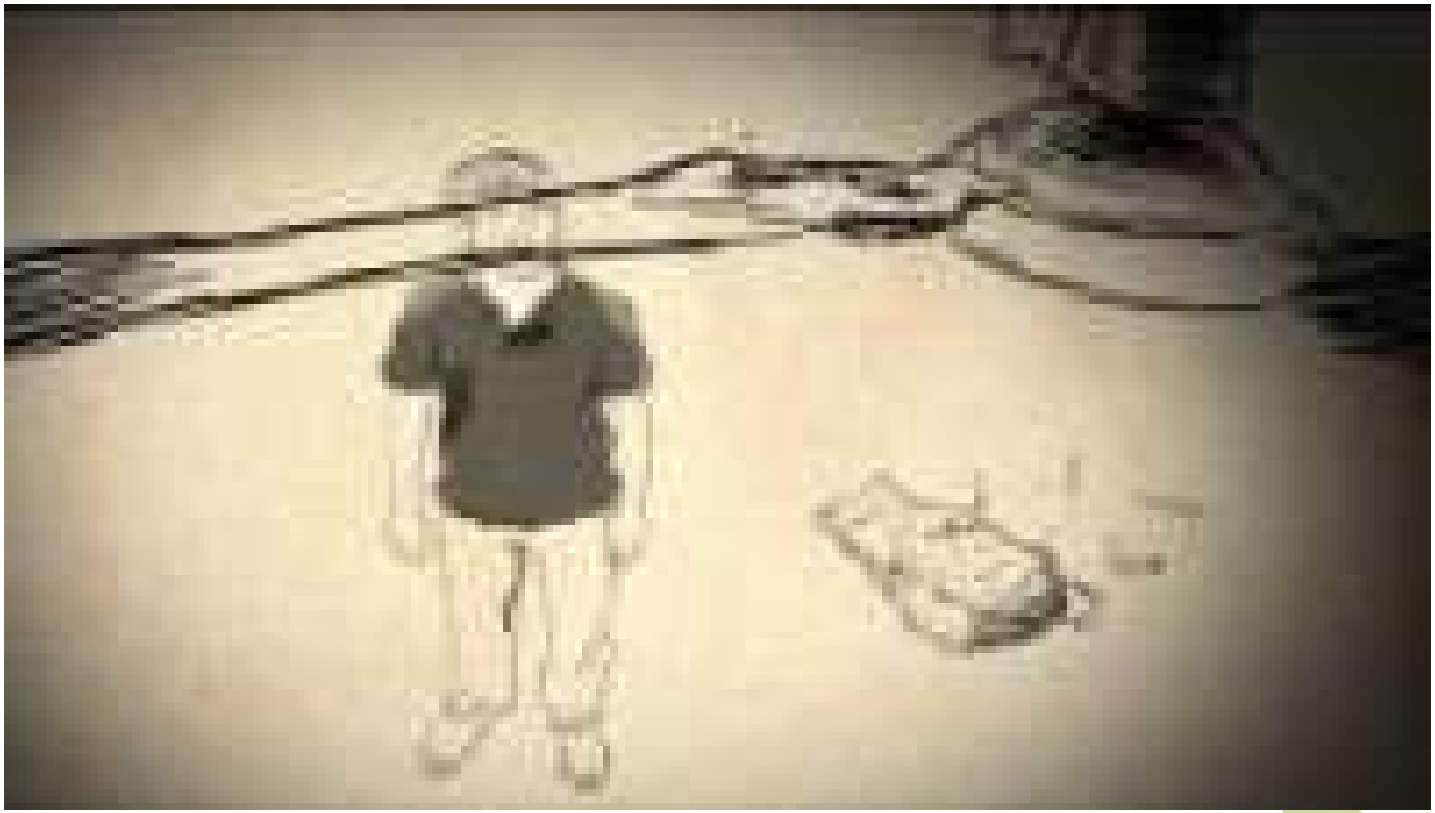
ASD Brain Challenges

- Usually ignore eye gaze, facial expression, body language and gestures that inform social interactions
- Lives in a world of facts, not emotion (neurotypicals=both)
- Can seem aloof and uncaring
- Difficulty judging personal space; often clumsy
- Sensitivity to the environment: sounds, smells, tastes, textures, light & temperature often too much or too little
- Difficulty with practical aspects of verbal communication-monologue s dialogue

ASD Brain Challenges

- Inflexible about key routines
- Difficulty understanding others, so interactions can be very one-sided (parallel play vs cooperative play)
- Difficulty compromising or negotiating because unaware of the needs of others (no TOM)
- Adherences to rules rather than flexible problem solving
- Limited ability to tolerate life outside of their comfort zone (melt-downs)
- Intense focus on limited interests

Sensory Integration Theory (Ayers, 2005)



7 senses:

- **Sight** (Vision)
- **Hearing** (Auditory)
- **Smell** (Olfactory)
- **Taste** (Gustatory)
- **Touch** (Tactile)
- **Vestibular** (Movement)
- **Proprioception** (Body Position)

Sensory Integration Theory (Ayres, 2005)

Sensory integration is the process by which we receive information through our senses, organize this information, and use it to participate in everyday activities.

Autonomic Dysregulation

Autonomic Regulation in ASD (Sugarman et al, 2013)

- Posits “Autonomic dysregulation may be a more basic deficit from which the core symptoms of autism spectrum disorder originate“
- Anxiety generally viewed as "emergent" or “comorbid”
- Proposes that focusing on the early-developing autonomic nervous system (ANS) instead of the late-developing frontal dysfunctions provides a starting point for cascading effects that branch out to higher-level systems and accounts for comorbid ASD symptoms
- Notes lasting effects of ANS development

Autonomic Dysregulation Theory

social engagement*

communication*

cognitive flexibility*

autonomic regulation*

Where did Sugarman start?

1. Began by examining RRBs as COMPENSATORY for increased sympathetic arousal
2. Then explored neurophysiological manifestations of sympathetic arousal observed in individuals with ASD
3. Finally, positing that hyperarousal is a manifestation of autonomic dysregulation, he described how autonomic abnormalities can account for the core symptoms of autism spectrum disorder and common comorbidities

(Sugarman , et al. 2013)

- Restricted and repetitive behaviors in ASD can be viewed as part of a continuum of stress reducing activities observed throughout the animal kingdom- seen as a displacement behavior in response to stress
- These behaviors are described as "without perceptible purpose of the context in which they occur" other than to reduce stress
- Ritual behaviors in humans have been associated with apprehension of dangers and is correlated with anxiety and fearful traits.
- Further, increase displacement behaviors provide a better measure of anxiety and negative affect than verbal statements and facial expression

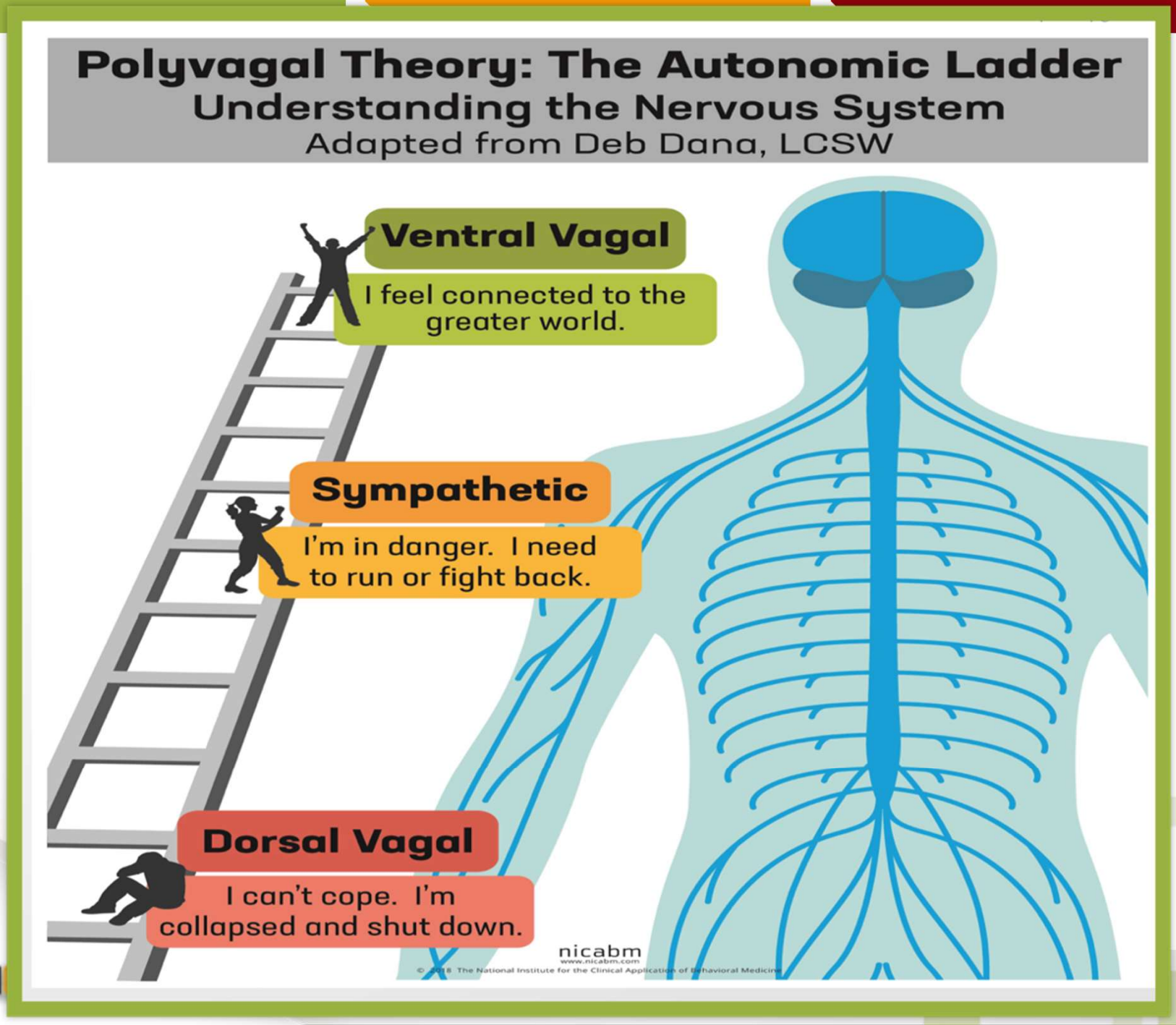
Over-arousal is integral to autism spectrum disorder

- Extant research has established that anxiety is ubiquitous in autism spectrum disorder, particularly when confronted by novel stimuli and increases with environmental novelty
- Sugarman reports evidence that people with autism spectrum disorder have elevated sympathetic arousal even at rest,
- **"Their autonomic engine" idles high**
- Sympathetic over arousal results in the conscious feeling of state anxiety
- Neurophysiological findings involving the amygdala and oxytocin support the observation of over- arousal in ASD
- Oxytocin is further implicated in social brain activation in individuals with ASD
- Knowing that social deficits are a primary component in ASD, and taken the view that over-arousal is also core, it is expected that oxytocin is measured at lower levels in people with ASD than controls-this proves true

ANS dysregulation is a governing principle

- Given the evidence of increased sympathetic tone and autonomic dysregulation is what may be the basis for autonomic imbalance and how might it provide an explanation for ASD
- **Porges 2021** implicates impaired functioning in the vagal system (a part of the ANS) He proposes that the mammalian vagal system has to include three anatomic and functional branches serving behaviors:

  1) immobilization 2) mobilization 3) social engagement
- the mature vagal system also influences cranial nerves that subserve facial expression, extraction of human voices from background noise, gaze fixation, head turning and prosody
- these cranial nerves in turn communicate with the same path through the inhibitory vagal system that lowers heart rate, lowers blood pressure and increases emotion regulation
-


Polyvagal Theory: The Autonomic Ladder
Understanding the Nervous System
Adapted from Deb Dana, LCSW
Ventral Vagal
I feel connected to the greater world.
Sympathetic
I'm in danger. I need to run or fight back.
Dorsal Vagal
I can't cope. I'm collapsed and shut down.
nicabm
www.nicabm.com
© 2018 The National Institute for the Clinical Application of Behavioral Medicine

NOTE: further support…

- Comorbidities of sleep disorders, gastrointestinal dysfunction, tic disorders may also relate to autonomic dysregulation and the support is causal role
- the vagal system is implicit in all three of these problems

Building Blocks of Healthy Relationships

Social Engagement + Social Bonding

Safety→Proximity→Contact→Bonds

Features of Autism

- Difficulty feeling 'safe' with others
- Difficulty being in physical proximity with others
- Difficulties being touched or touching others
- Difficulties establishing 'trusting' social relationships

X Safety→XProximity→XContact→XBonds

VisualBee

TOM

- Classic Definition: the ability to attribute mental states-beliefs, intents, desires, pretending, knowledge, etc.--to oneself and others and to understand that others have beliefs, desires, and intentions that are different from one's own

(Premack & Woodrufff, 1978)

TOM

- Lack of visual social engagement leads to ‘mindblindedness’
- In turn leads to failure to develop social intuition, including the ability to intuit social norms
- Individually and in combination can be...

CATASTROPHIC!

Given all that…

What do we do?

A Look At Normative and Problematic Sexual Behaviors (PSBs) Among C,Y,A with ASD

How easy was your own sexual development?

- Confusing?
- Overwhelming?
- Ever receive a mixed message?
- Ever make an error in your sociosexual judgment?

General Statement re: Sexuality Among Those with Disabilities:

- Individuals with disabilities experience sexual interest and needs for interpersonal intimacy
- They often have limited information and/or normative developmental trajectories that allow for or serve to cultivate adaptive sexual experiences
- A disability does not preclude one to problem sexual behavior; it can make one more vulnerable to sexual exploitation and consequential errors in judgment that lead to what is perceived as sexual misconduct or illicit sexual behavior.

Common sexual activities among non-clinical samples of children

- Pretending to be the opposite sex
- Masturbating with hand
- Looking at nude pictures
- Exposing genitals to adults
- Touching genitals in public
- Interest in opposite sex
- Looking at people undressing
- Touching breasts
- Kissing non-family children
- Kissing non-family adults
- Sitting with crotch exposed
- Undressing in front of others
- Walking around nude or in underwear
- Undressing in front of others
- Touching genitals at home
- Scratching crotch

(Friedrich, et. al., 1991)

Uncommon sexual activities among non-clinical samples of children

- Activities associated with adult sexual practices and knowledge rare
- Oral sex
- Asking to engage in sex
- Masturbating with objects
- Inserting objects in anus or vagina
- Imitating intercourse
- Sexual sounds
- Open-mouth kissing
- Undressing other people
- Asking to watch sexually explicit movies
- Imitating sexual behavior with dolls

Friedrich, et. al. (1991)

Juveniles with PSB and ASD

(Baarsma et al., 2016)

- Belief in “abnormal sexual development” among adolescents with ASD
- Study designed to:
    1. Examine sexual development
    2. Sexual behavior
    3. Stability of ASD-like symptoms over time

Study:

- Prospective longitudinal
- Screened for ASD, not diagnosed with ASD
- N=44 adolescents arrested for sexual misconduct between 2003- 2006
- Assessed at start, and re-assessed 8 years later
- Measures:
  - Sexuality and sexual development assessed retrospectively
  - ASD assesses longitudinally
  - Follow-up: Adult Social Behavior Questionnaire

Summary Findings:

- Sexual developmental milestones = among Juveniles with ASD and controls

  - similar in terms of sexual development, attitudes and peer communications about sex

- Scored lower than controls on sexual knowledge
- Scored higher on sexual victimization related to verbal sexual intimidation

  - Degree of sexual victimization related to extent of ASD-like symptoms

  - however, increased ASBQ scores in victimized group 2x as high as those not victimized

Summary findings:

(continued)

- Observed social difficulties persist and may be life-long
- NO relation found between PSB and ASD symptoms

Commonly reported problematic sexual behaviors (PSBs) among ASD CYA:

- Violating interpersonal boundaries, such as standing too close, hugging, or touching in an overly familiar manner
- Talking about sex with people who are not interested or with whom a conversation about sex is inappropriate
- Unwanted and uninvited sexual touching
- Staring at the genitals or breasts of others
- Exposing their genitals in public
- Touching their genitals in public

(Latham, 2014, anecdotal data)

Developmental insults that can lead to PSBs:

- Sexual abuse
- Physical abuse
- Emotional abuse
- Neglect
- Caretaker instability
- Witnessing physical or sexual abuse
- Exposure to pornography or sexually inappropriate material
- Indiscriminate exposure to adult pornography

Vulnerabilities that limit coping:

- Developmental delays or disabilities
- Poor social competence

Resiliency factors that enhance coping:

- Stable attachments
- Social Competence
- Affective regulation and adaptive self-soothing skills

(Latham, 2014)

8 Common PSB narratives observed among CYAs:

1. Normal sexual exploration
2. Sexually reactive
3. Extensive mutual sexual behavior
4. Children who are sexually aggressive
5. Severely traumatized children
6. Developmentally delayed
7. **ASD**
8. Mentally ill children

(Latham, 2014)

9 Factors unique to PSB narratives observed among CYAs with ASD:

1. Single stimulus, not necessarily explicit or provocative, can trigger a cascade of sexual impulses and behaviors
2. Lack of awareness of appropriate sexual behavior
3. Indiscriminate sexual arousal
4. Lack of social skills to pursue friendships or intimate relationships
5. Failure to take in relevant data to make decisions about sex (i.e., age, relationship to sexual partner, time, place, etc.)

(Latham, 2014)

9 Factors unique to PSB narratives observed among CYAS with ASD (continued):

6. In ability to anticipate consequences of punishment
7. Inability to anticipate disruption of family relationships
8. Lack of social reciprocity or empathy
9. Executive function deficits: impaired impulse control, impaired ability to anticipate consequences before acting, inability to shift focus from one idea to another, limited problem-solving skills, perseveration in ineffective behavior

(Latham, 2014)

Unique PSB risk mitigators among CYAs with ASD: (Latham, 2014)

- Infrequent deviant arousal (BUT frequent indiscriminate arousal!)
- Rule-oriented behavior
- Willingness to follow routines

Important to recognize in CYAs with ASD/PSBs:

- Rigid about routines
- Rigid and perseverative style may include PSBs
- Inflexible problem-solving style
- Inflexible coping skills, tantrums or bizarre behavior when overwhelmed
- Expressive language far exceeds ability to understand and use language to help change behavior
- Literal use of language (can limit use of metaphor/humor)
- Difficulty distinguishing relevant from irrelevant detail

(Latham, 2014)

Important to recognize in CYAs with ASD and PSBs: (continued)

- There may be no history of trauma and little, if any, developmental insult
- CYAs with ASD rarely have PTSD in response to trauma
- Odd motor behaviors and poor eye contact are not deliberate
- Limited social interaction, 'parallel play' may be all they can manage
- Lack of emotional reciprocity or egocentrism characteristic of ASD and is not narcissism

(Latham, 2014)

Ok, now what…?

Psychosexual Risk Assessment for CYA on the Autism Spectrum

Key psychosexual assessment elements for CYAs with PSBs:

- Referral question
- ASD DX and co-morbid dx
- Developmental and psychosocial hx
- Psychosexual hx and detailed account of PSB(s)
- FBA
- Distinguish between paraphilia and ASD-related motivation (CD!)
- Measures

Referral Questions?

- Clinical?
- Forensic?
- AGE; cognitive and adaptive functioning level
- Prior assessment? ASD Diagnosis?
- History of abuse?
- Description of current PSB of concern? Prior hx?
- Prior Interventions? Effect?

Sources of information:

- Prior testing
- Prior records detailing PSB
- Collateral source interviews
- Client self-report
- Current testing
- Abel Screen
- Sensory Profile

Assess for ASD and co-morbid disorders through extensive Developmental and Psychosocial History

- Detailed developmental course from birth to current age, emergence of ASD symptoms and effects, and onset of co-morbid symptoms, adaptive behavioral function across developmental course, socio-relational development.
- Can use structured interview measures

Psychosexual History and PSB

- Detailed account: early, normative sexual play, sexual abuse, family mores regarding sex, access to sex education, sociosexual behavior prepubertal, pubertal development, relational/dating experience, sexual orientation, gender identity, paraphilic interests
- Emergence of PSB and detailed accounting of PSB of concern

Functional Behavioral Analyses (Latham, 2014)

Critical to understand and assess the FUNCTION of the problem sexual behavior in individuals with ASD

1. All behavior serves a purpose
2. People do similar things for different reasons
3. Problematic behaviors tend to be solutions or adaptation to some problem

FOUR FUNCTIONS OF PROBLEM BEHAVIORS

- **ESCAPE**→in response to specific person, event or request to perform activity
- **TANGIBLE** →occurs when something has been taken away or denied, not person or event specific
- **ATTENTION**→ occurs when specific individuals are present
- **SENSORY**→ occurs anytime, anywhere, may occur more often under stress

FBA (Latham, 2014)

Outcomes of FBA:

- Operational definition of undesirable behavior
- Predictions of times and situations of undesirable behavior
- Definition of function
- Identification of variables that maintain undesirable behavior
- Identification of suitable replacement behavior

Finding a Positive Replacement Behavior (Informs treatment)

- Identify value of behavior from client's perspective
- Does he understand what he is supposed to do as well as what he is not supposed to do?
- Does he have the necessary skills to behave as expected
- Does he have ability to self-control or will he require external supports
- Is client willing to use a positive replacement behavior

Paraphilia vs Counterfeit Deviance

Paraphilia:

- The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving 1) nonhuman objects, 2) the suffering or humiliation of oneself or one's partner, or 3) children or other non-consenting persons that occur over a period of at least 6 months. The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM-V. 2013

DSM-V

- Exhibitionism
- Fetishism
- Frotteurism
- Pedophilia
- Masochism
- Sadism
- Transvestic Fetishism
- Voyeurism

- Paraphilia NOS:

  Telephone scatologia
  Necrophilia
  Partialism
  Zoophilia
  Coprophilia
  Urophilia
  klismaphilia

Paraphilic Disorders

Counterfeit Deviance

- “People do similar things for different reasons” – Fred Berlin

- “People are aroused to similar things for different reasons”

MAHONEY (2009) Counterfeit Deviance

- CD occurs when an individual engages in behavior that "topographically look[s] like a Paraphilia but lack[s] the recurrence of and pathological use of sexual fantasies, urges, behaviors" (Hingsburger, Griffiths, & Quinsey, 1991)
- Instead the behavior is explained by "experiential, environmental or medical factors rather than of a Paraphilia"
- DSM-IV =no differential dx of CD
- DSM-ID=CD as a differential dx for paraphilia "based on an evaluation of the in dividual' environment, sociosexual knowledge and attitudes, learning experiences, partner selection, courtship skills and biomedical influences"
- CD is a differential dx for ASD individuals accused of deviant sexual behavior
- Careful assessment

Counterfeit Deviance

- Lack of sexual knowledge and appropriate courtship scripts
- Reflect ASD sxs: RRBs, inappropriate use of speech, fixation on objects or people
- Naivete of courtship
- Inability to handle rejection
- Inability to grasp social mores re: sexually appropriate behavior

Schöttle, et. al. (2017)

"…restricted and repetitive interests, which may be non-sexual in childhood but can transform in to and result in sexualized and sexual behaviors in adulthood"

Chesterman & Rutter (1993)

- Described a case of an adult male fixated on washing machines and would masturbate as he watched them in use
- He was later arrested for burglary as he tried to break-in to a neighbor's residence to access their washing machine—
- Behavior = ASD symptoms not malice

Some tools…

- Neuropsychological testing
- Vineland Adaptive Behavior Scales
- ADIOS interviews
- Social Responsivity Scale
- Personality measures
- Abel Screen
- Sensory assessment
- IQ testing

Then what…?

Treatment

Exploring 3 Core Psychological when Treating Adolescents on the Autism Spectrum... (Genovese, 2021)

- Developmental challenges in adolescence:

  (...in case you forgot!)
- Social expectations mount and relationships: become MORE COMPLEX
- Tasks include: adjustment to puberty, completion of growth, assuming a sexually mature body, expanding cognitive abilities, achieving a greater degree of independence, and establishing a greater sense of independence and a **clearer sense of personal identity.**

GENERAL ADOLESCENT TASKS:

IDENTITY DEVELOPMENT CAN BE MORE DIFFICULT FOR ADOLESCENTS WITH ASD

'Identity'→ a person's sense of self defined by physical, psychological and interpersonal characteristics:

- View themselves as less socially or physically competent
- Endorse lower self-esteem
- Assume a negative self-concept based on perception by peers as 'different'
- self-esteem
- ***In process of forming identity ,adolescents with ASD are developing their shared social identity when perceiving themselves in a minority group***

3 Core Psychological Elements:

Developmental tasks to consider specifically for ASD adolescents:

- Self-awareness
- Gender identity
- Sexuality

Treatment for CYA with ASD and PSBs

Latham (2014) recommends:

- Medications do not cure but can help with symptoms of co-existing conditions (i.e., depression, anxiety, OCD)
- Social skills and sex education training based on "scripts" that teach rules for comfortable social interaction
- CBT to help manage emotions and limit obsessive interests and repetitive behaviors (i.e., J. Brown DATE!)
- Occupational or PT for for sensory integration problems or poor coordination
- Speech/language therapy to aid pragmatics of speech→ the give-and-take of normal conversations
- Parent and support staff training to educate re: ASD and teach behavioral techniques

AVOID!

(Latham, 2014)

- Process Groups!
- Emphasis on suppression of negative behaviors (Just say ‘no’!)
- Talk of past trauma except to assure child is safe now
- Focus on past behavior and ‘why’ questions
- Relapse Prevention as primary intervention

Emphasize!

(Latham, 2014)

- Structure, order and routine
- Approach goals over avoidance goals
- Teach compensatory strategize that help organize life, manage complexity and reduce misunderstandings
- Enhance practical social skills with teaching and practice
- Use multi-sensory approaches

Also emphasize! (Latham, 2014)

- Teach empathy as an operational behavior, not as we might feel it
- Healthy sexuality education that recognizes cognitive and emotional limitations
- Use positive behavioral support plans when necessary
- Use a strength-based approach to help plan a safe life as an ASD adult with realistic social and vocational goals
- Identify any behavioral obstacles to a productive life and develop a comprehensive rehabilitative plan

Adults who are successful with ASD clients: (Latham, 2014)

- Listen, analyze the CYA's needs, and adapt the task to the CYA to accomplish the task
- State expected behavior and provide examples
- Use matter-of-fact and unemotional tone to redirect
- State rules as universal that apply to everyone
- Behave in a predictable and dependable manner
- Use short sentences
- Limit the number of instructions at one time
- Provide adequate wait time for processing
- Provide structure that is predictable

UK Case studies study

(Schnitzer, et. Al., 2019)

- Systematic literature review
- 6 case studies identified examining interventions with adolescent with Autism conditions and PSBs
- Interventions included:
    1. detailed assessment
    2. staff training
    3. peer support
    4. medication
    5. adapted CBT

Outcomes:

- Limited by methodology and inability to generalize but:
- Quantitative results indicated a decrease in sexual arousal, absconding, PSBs, and support found for masturbation to deviant fantasies
- Anecdotal support found for increased insight, flexibility, ability to open up and re-integration

Additional tx:

- Social Stories!
- Good Lives Model

(Yates & Prescott, 2011)

- The Emotion Regulation Skills System

(Brown, 2016)

- Alaska University: Friendship &Dating


LIVING WITH
AUTISM

Romantic Relationships and Adults with Developmental Disabilities

- Ward, Bosek & Trimble (2010) conducted a study of relationships among adults with developmental disabilities in Alaska.
- 85% were or had been in a romantic relationship after high school.
- Partnered relationships are important in the lives of adults with developmental disabilities.
- For many participants, the time spent with their girl/boyfriends was limited, and they wanted to spend more time together.

Interpersonal Violence

- 60% of those who reported having been in a relationship reported violence
  - 70% among women
  - 50% among men
- Types of abuse reported
  - Emotional (50%)
  - Physical (35%)
  - Sexual (15%)
- Almost 40% did not seek assistance from anyone

Friendships & Dating Purpose

- To prevent violence in relationships and to teach social skills necessary to develop healthy, meaningful relationships for adults with intellectual and developmental disabilities.
- Created by the University of Alaska Anchorage Center for Human Development.

Friendships & Dating Format

- 20 session program – 1.5 hour sessions twice a week over 10 weeks
- Odd numbered sessions focus on skill building using a group process
- Even numbered sessions focus on skill building using experiential learning in a community setting.

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Friendships & Dating Session Topics

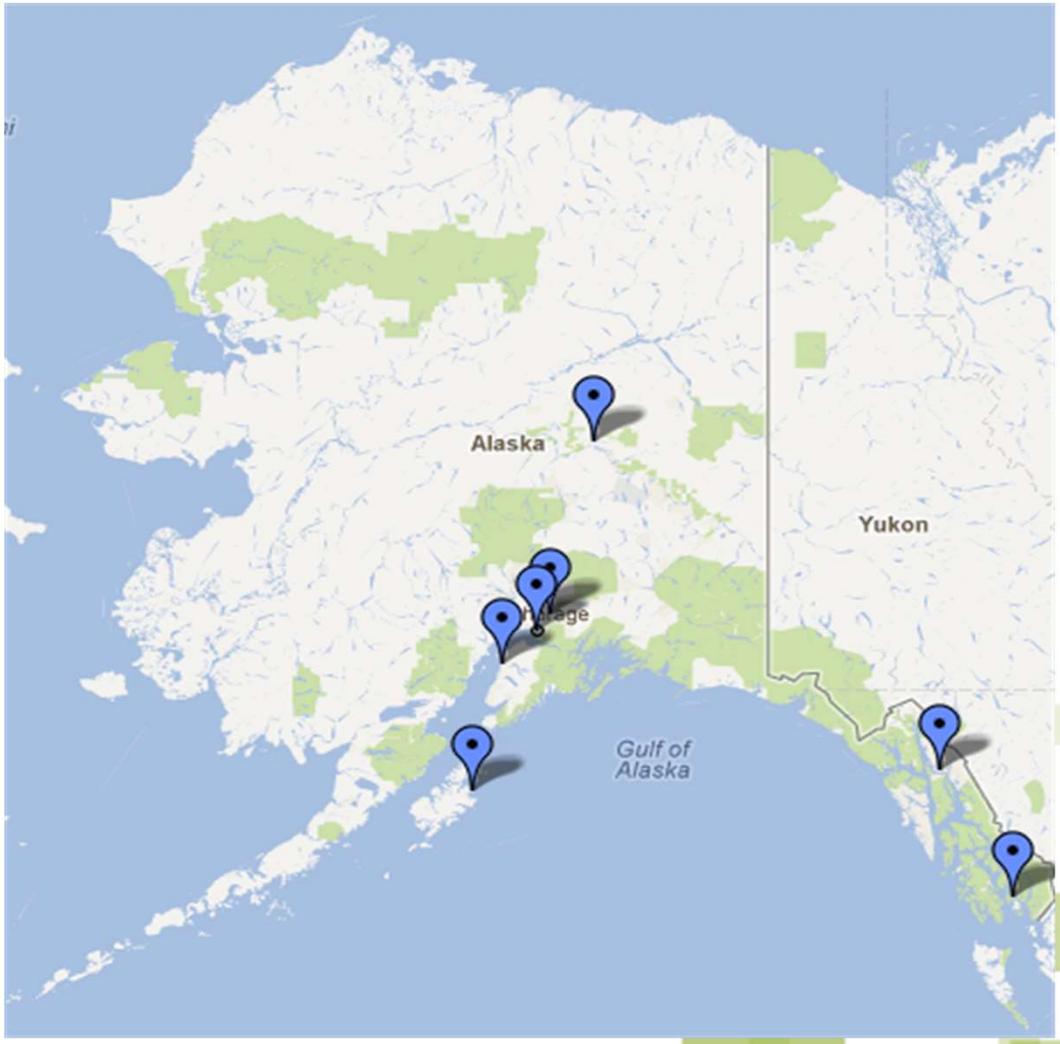
- Introduction
- Feelings and emotions
- Types of relationships
- Potential dates
- Boyfriend/girlfriend
- Boundaries
- Public vs. private displays of affection
- Assertiveness
- First impressions
- Communication
- Non-verbal social cues
- Planning an activity or date
- Dating rights
- Personal safety
- Sexual health
- Gender differences
- Breaking up
- Conflict resolution

Facilitator Training

- Recruit community agencies who serve individuals with intellectual and developmental disabilities
- Agencies send 2 or more staff members to be trained
- Facilitators attend a 2-day training on the program
  - Introduction to program
  - Attitudes and values clarification
  - Teaching strategies and learning approaches
  - Mandatory reporting laws
  - Friendships & Dating manual overview
  - Evaluation procedures

Friendships & Dating To Date

- 7 Communities – Anchorage, Fairbanks, Juneau, Mat-Su Valley, Kenai Ketchikan, & Kodiak
- 13 Agencies
- 24 Groups
- 48 Facilitators
- 136 Participants



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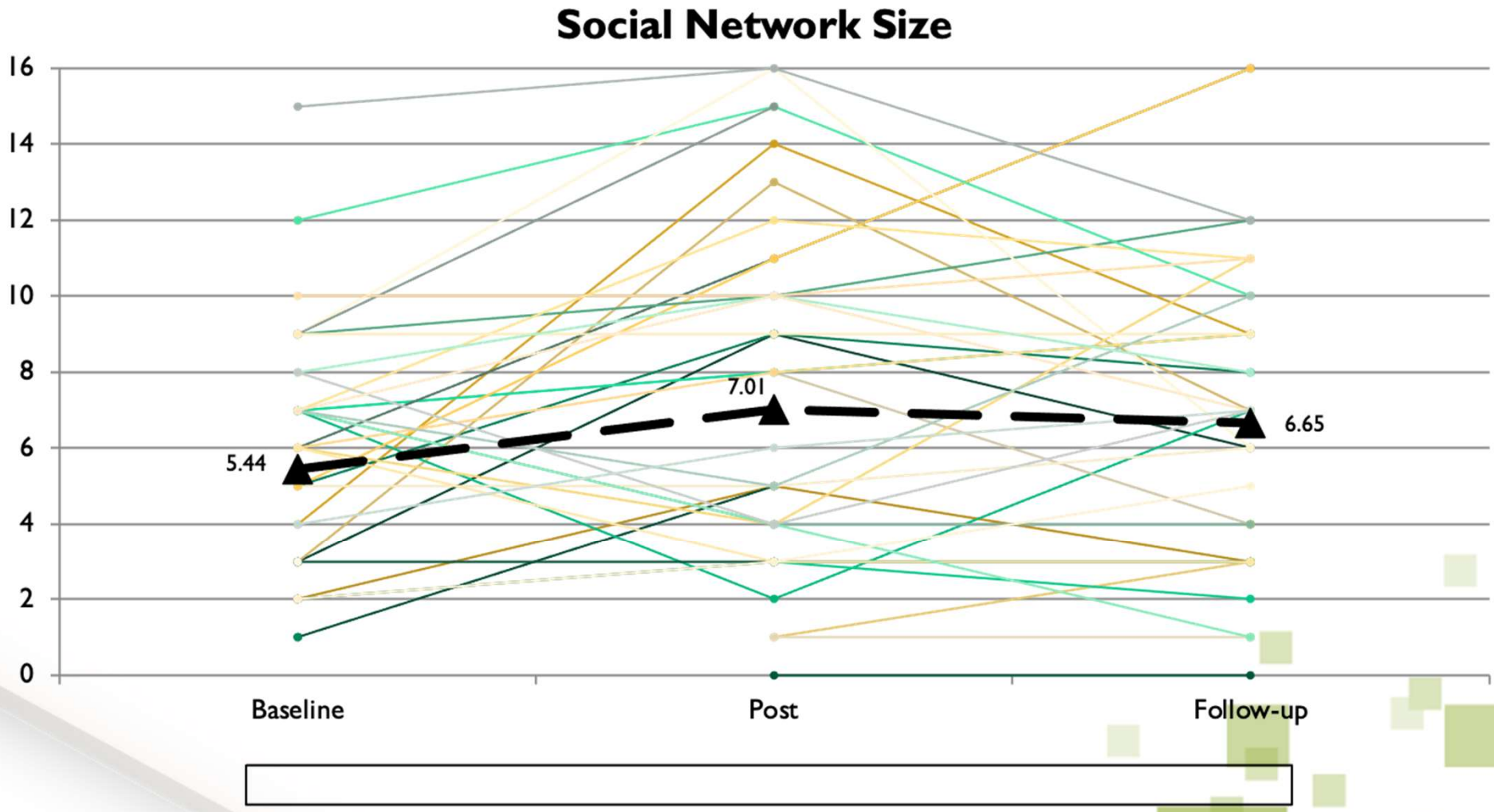
Evaluation and Data Collection

- Outcome Data
  - Social Network Assessment
    - Examines network size, composition, frequency of interactions, and type of social interactions
  - Interpersonal Violence Interview
    - Developed using a modified Delphi-Technique
    - Conducted as a semi-structured, 30 item interview
  - Outcome data collected at baseline, post, and 10-week follow-up
- Process Data
  - Process Evaluation Model (PEM) to document treatment fidelity
  - Process data collected weekly during delivery of program

Findings: Social Networks

- A hierarchical linear model was used to analyze the data.
- The modeled results showed an average social network size of 5.44 at baseline that was significantly increased by 1.57 (p = 0.007) to 7.01 at the conclusion of the FDP. At the 10-week follow-up, there was an insignificant reduction of 0.36 (p = 0.554) resulting in a modeled average social network size of 6.65.

Findings: Social Networks



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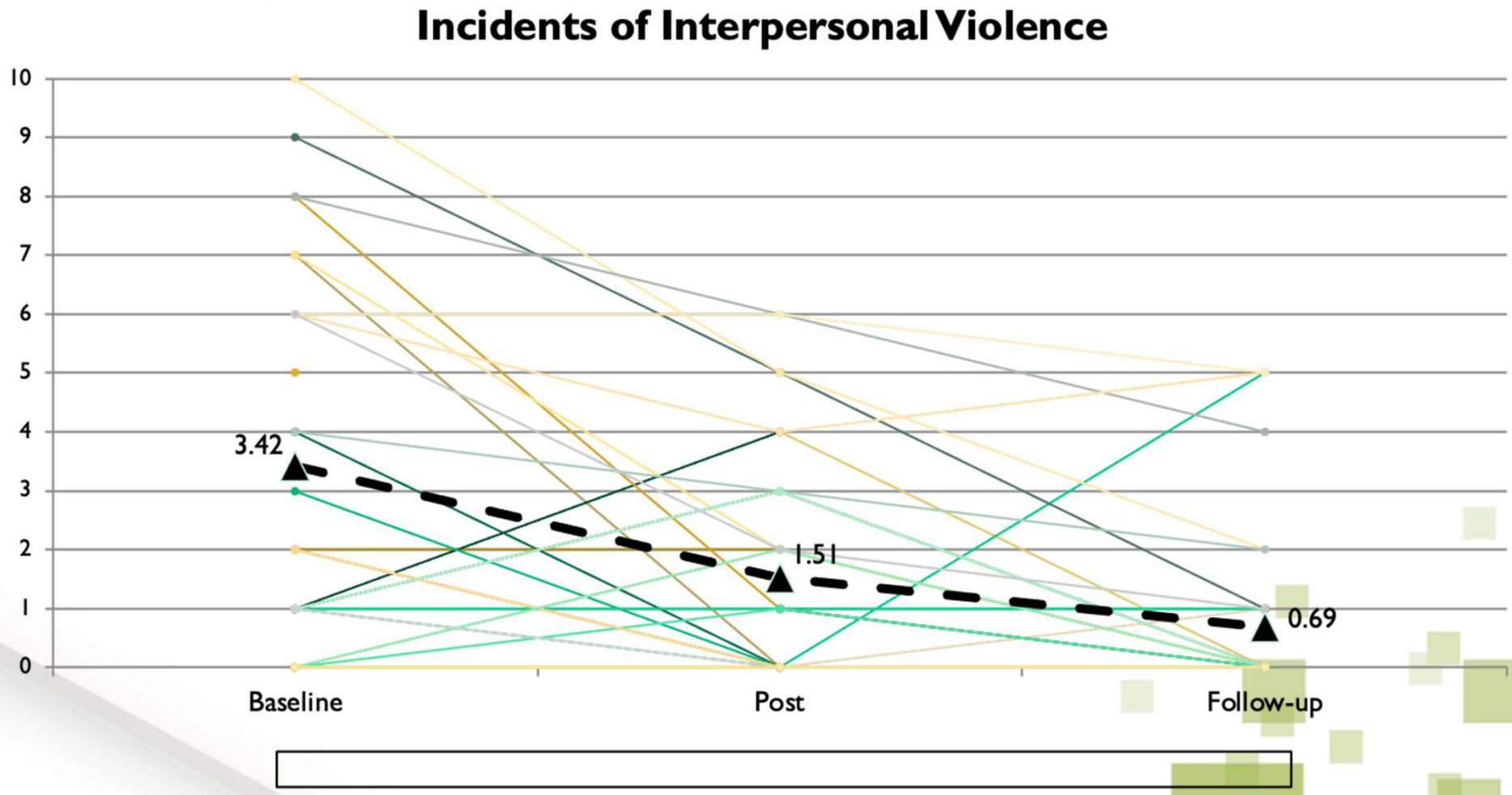
Findings: Interpersonal Violence

- A hierarchical linear model was used to analyze the data.
- The modeled results showed an average incidence of interpersonal violence of 3.42 at baseline that was significantly decreased by 1.91 (p = 0.000) to 1.51 at the conclusion of the FDP. At the 10-week follow-up, there was a significant reduction of 0.82 (p = 0.003) resulting in a modeled average incidence of interpersonal violence of 0.69.

Findings: Interpersonal Violence



Findings: Treatment Fidelity

- Direct service personnel can deliver the program with a high degree of fidelity
- Participants engage at high rates over the course of the 10-week program
- Facilitators delivered content as intended
- Facilitators followed the Friendships & Dating Manual
- PEM results have been similar across all sites
- PEM results strengthen outcome results

Participant Feedback

- “I wanted to learn more about building healthy relationships and friendships.”
- “My favorite part is that I am hanging out with my friends from class.”
- “I met my girlfriend here in this class.”
- “I am in a relationship right now and it’s going okay, but it’s kind of rocky and I think that I can use what I have learned to make it better.”
- “I have been here all this time in [community] and I never knew there was a trail in [that] field.”

Facilitator Feedback

- “I think they enjoyed the socialization part and sharing… They’ve got more of a social connection. A lot of them are doing things together… they are all coordinating their bowling [schedule].”
- “We had a great time doing the Friendships and Dating class. I think all of us are going to miss meeting each week. As a group we talked about getting together for fun in the future.”
- “I got more out of facilitating the class than the participants taking it. Thank you for the opportunity.”

Care Provider Feedback

- “I think that the interaction with people their age that have the same situation going on, as far as learning how to date… is very important.”
- “I think my client learned how to turn a boy down in a positive way. I think she was comfortable letting someone know that hey, she is not ready to date. Because before she used to get frustrated … and she wouldn’t tell someone that she didn’t want a boyfriend, and then after the class she dealt with it in a different way.”
- “Thank you for doing this because there is such a need for this.”

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Recommendations

- Safety training alone is not enough to prevent interpersonal violence, people need opportunities to develop and engage in healthy relationships.
- More research needs to be conducted on meaningful relationships and sexuality for people with developmental disabilities.
- Programs should use process or treatment fidelity measures to document delivery of intervention components.

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