Putting the Pieces Together: Enhancing Prevention & Treatment for Youth with Developmental Disabilities and on the Autism Spectrum

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Center for Integrative Psychological Services, Inc.

Laurie L. Guidry, Psy.D.

and

Brian Malbon, LICSW

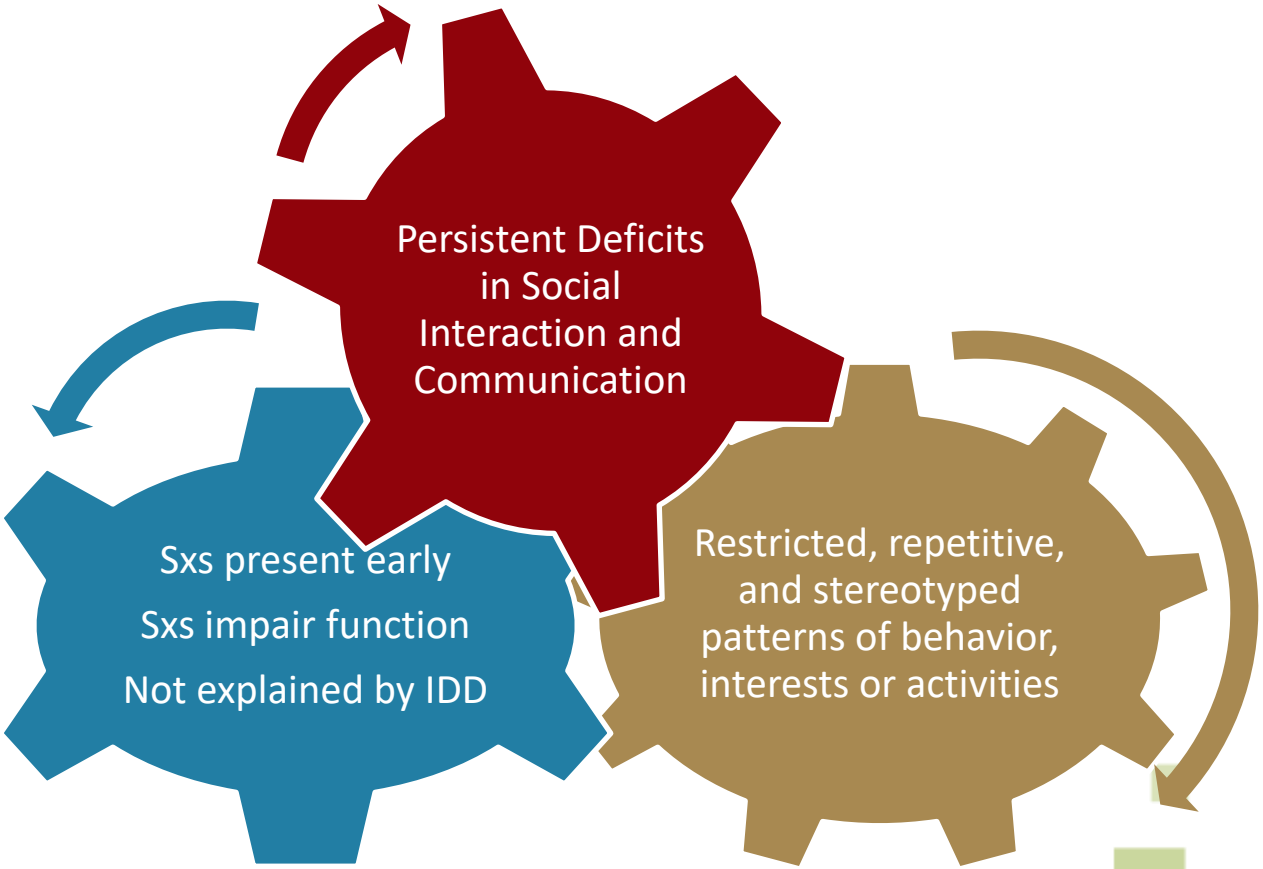
Session Objectives:

1. Introduce participants to a deeper appreciation of the lens through which those on the autism spectrum perceive the complex socio-sexual environment they are born into and attempting to navigate.

2. Identify and review the key elements of a comprehensive, best practice psychosexual risk assessment for neuroatypical children, youth and adolescents who have engaged in problematic sexual behaviors.

3. Consider treatment options for neuroatypical children, youth and adolescents

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

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!**

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...

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

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*

(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 2011** 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
-

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.

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

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

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" (1991 Hingsburger, Griffiths, & Quinsey)
- 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

Sexuality in Autism (Schottle, et al 2017)

- Research is mixed but suggests those with ASD:
- Seek relationships and have a spectrum of sex experiences and behaviors
- Sexuality matters

Sexuality in Autism (Schottle, et al 2017)

- First to study gender-specific aspects of hypersexuality and paraphilic fantasies and bx in cohort of hfx individuals with ASD in comparison with matched control group
- N=96 ASD; 96 HC's
- 56 males/40 females
- Matched on age, school, sexual orientation
- Measures: Autism Spectrum Quotient Short Form, Hypersexual Behavior Inventory (HBI-19)
- Questionnaire about Sexual Experiences and Behavior

(Schottle, et al 2017)

- Women-less pronounced social and communication deficits
- Special interests that are more compatible with their neurotypical peer group
- They apply coping strategies (imitate social skills of peers)
- Engage in more dyadic relationships though have lower sexual desire
- Lower level of sexual functioning
- Vulnerable to victimization

(Schottle, et al 2017)

- “sensory sensitivities can lead to overreaction and underreaction to sensory stimuli in the context of sexual experience”

Schottle, 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

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 <u>shared social identity</u> 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 comprehensiverehabilitative 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

Contact info:

Laurie L. Guidry, Psy.D.
Center for Integrative Psychological Services, Inc.
lguidry@cipsinc.net
413.427.6903
Brian Malbon, LICSW
bmalbon@cipsinc.net
www.cipsinc.net