Autism Spectrum Disorders: Offending and the CJS

November 17th, 2013

Dr. Jessica Jones, C. Psych
Clinical & Forensic Psychologist
Associate Professor of Psychiatry & Psychology
Clinical Director of DD Consulting Program
Acting Chair Division of Developmental Disabilities
Department of Psychiatry
Queen's University

Outline

- Introduction to the literature on offenders with Autism Spectrum Disorder (ASD)
  - prevalence and characteristics
- Overview of the clinical risk issues for this population in the CJS
- Case examples

Why important to identify?

- Increased recognition that offenders with ASD require unique environmental and risk management approaches
  - high prevalence of mental health issues
  - Despite core symptoms, range of intellectual ability
  - limited efficacy of social consequential approaches
- Present specific challenges and vulnerabilities within the mainstream CJS for police, courts and corrections

Why important now?

- Social inclusion has exposed individuals with ASD to the ambiguity of our social world
- Integration into developmental services may lead to false or distorted assumptions of care needs
- Fiscal and resource restraints have caused criminalization of mental health problems; including offenders with ASD
- Gradual intolerance for challenging behaviour
- Low threshold for offending behaviour

What is Autism & ASD?

- Autism Spectrum Disorders (ASD) are defined as a continuum or spectrum of disorders (prev PDD)
- Individuals exhibit a continuum of diverse characteristics with similar underlying impairments in ***social interaction, communication*** and ***behavioural interests***
- Better to define as the degree of expression of impairment in each of the three areas hence latest DSM-V nosology changing from categorical approach to symptomology range

Triad of Impairments

Identification based on presentation of communication skills, social interactions and pattern of skills and abilities

I. Communication:

Impairment in verbal and non-verbal communication

II. Social Relationships:

Impairment in reciprocal social interaction

DSM-V

III. Imagination and Rigidity:

Impairment in imaginative play and limited interests

DSM-V: ASD 299.0 (F84.0)

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history

- 1. Deficits in social-emotional reciprocity
- 2. Deficits in nonverbal communicative behaviors used for social interaction,
- 3. Deficits in developing, maintaining, and understanding relationships,

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history

- 1. Stereotyped or repetitive motor movements, use of objects, or speech
- 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns
- 3. Highly restricted, fixated interests that are abnormal in intensity or focus
- 4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspect

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay

**Severity is based on social communication impairments and restricted, repetitive patterns of behavior* – *requires support or substantial support or very substantial support*

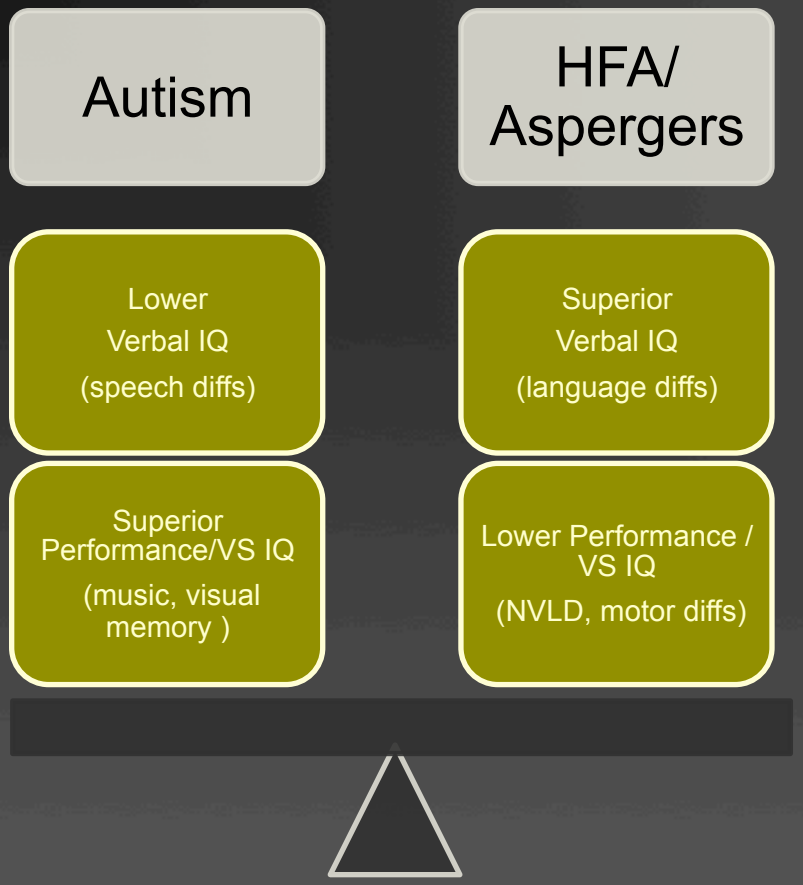
DSM-V…

- **Note:** Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.
- *Specify* if:
- **With or without accompanying intellectual impairment**
- **With or without accompanying language impairment**
- **Associated with a known medical or genetic condition or environmental factor**
- (**Coding note:** Use additional code to identify the associated medical or genetic condition.)
- Associated with another neurodevelopmental, mental, or behavioral disorder
- (**Coding note:** Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
- **With catatonia** (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition) (**Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

ASD Spectrum

DOMAIN	AUTISM		HFA/ASPERGERS
I. COMM	No speech / vocalizations	Verbal ⟷	Mature/Odd language (semantic/pragmatic)
II. SOCIAL	World of their own	Social ⟷	Misfit in socially focused world
III. IMAG	Non-functional objects	Imagination/ Repetitive Behaviour ⟷	Non-bizarre routines/interest "extreme hobbyist"

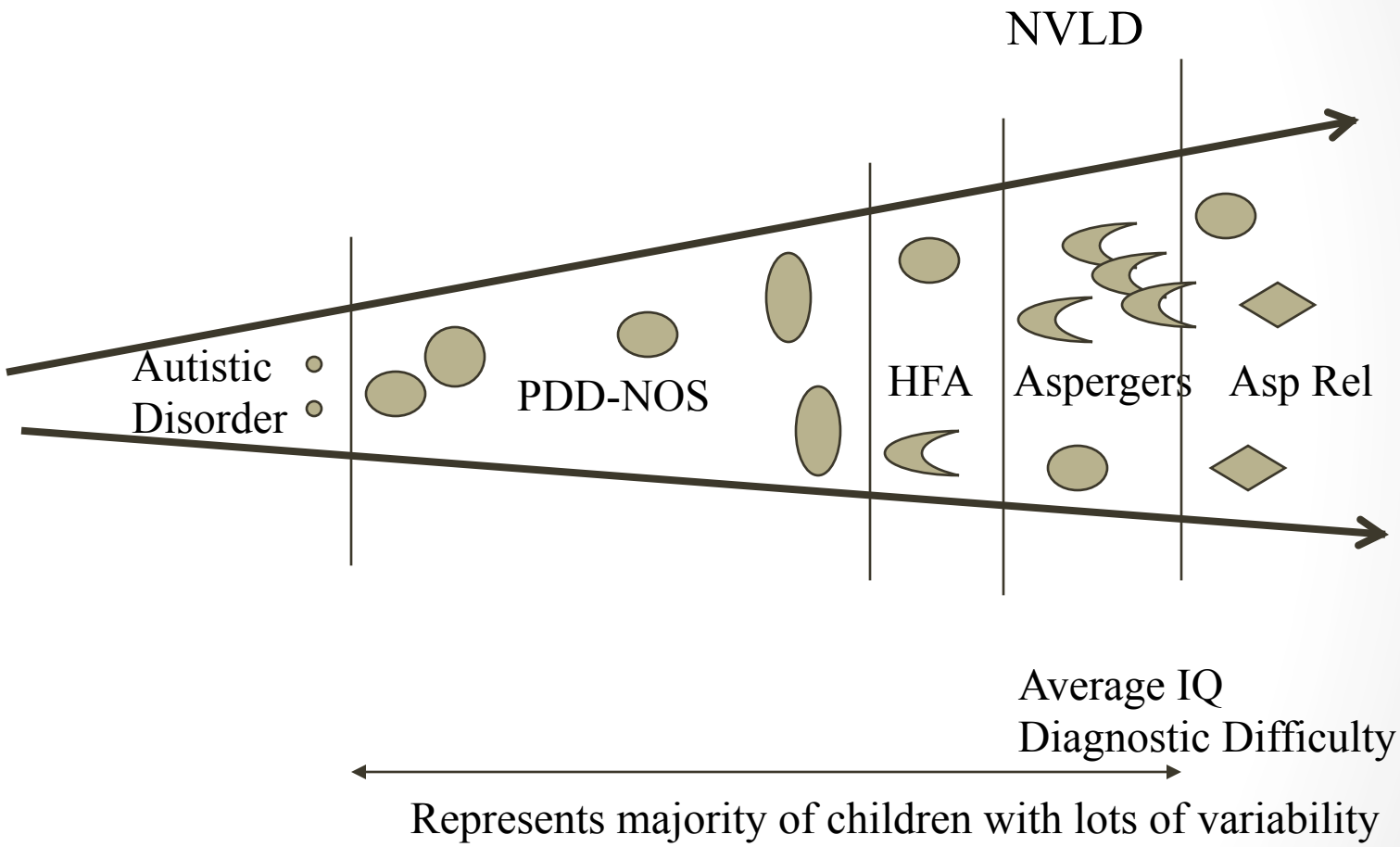
ASD Cognitive Profile



Beyond Diagnosis: "*Moving Targets*"

- Heterogeneity of ASD
  - no one individual is alike therefore generalisation of specific profile is difficult and misleading
  - Cognitive verbal and performance profiles can assist diagnosis (ie ASD, NVLD)
  - Developmental Trajectory: clinical profile can change over time alongside symptomology (ie Autisic to HFA or Aspergers)

ASD Spectrum (DSM-IV)



Adapted theoretical Framework: Dr. Rosenn

Differential Diagnosis

- Co-morbidity and nosology overlap
  - Difficult with ID due to similar behavioural characteristics and high co-morbidity (50%)
  - SOCIAL ANXIETY/OCD: define etiology of anxiety and social motivation or intent vs ‘preference for sameness’
  - SCHIZOPHRENIA: differentiate positive/negative symptoms from social deficits and similar thought disorder
  - PERSONALITY DISORDERS: differentiate quality and intent of social interactions vs lack of social perspective taking
  - DEVELOPMENTAL: differentiate between ‘normal’ pattern of expected behaviour and developmental disorder

ASD Offenders: Prevalence

- Prevalence studies reflect around 3% of mentally disordered offenders in community (Siponmaa 2001)
- Higher rates of HFA and AS in secure hospitals
  - (Hare, 3% ASD/90% AS, 1999)(Scragg, 1.5% ASD)
- Vulnerable due to unique neuropsychiatric symptoms and behavioural phenotype of ASD

Phenotype of ASD and Risk

- Social impairment:
  - Interpreting social cues and interactions (distorted intentions)
  - Socially and emotionally unusual behaviours (b/w rules)
  - Poor insight or concern about consequences (empathy, TOM)
- Verbal /Non-verbal communication:
  - Awkward expressive language (concrete)
  - Superficial comprehension (perceived by others)
  - Dysprosody/affect modulation (extreme emotions)
- Routines and repetitive activities:
  - Obsessional rote pursuit of circumscribed interests
  - Impulsive high risk behaviours, poor self-control
  - Adherence to rules, lack of flexibility

RCP (2006) Risk Variables in ASD

- More likely male
- Executive dysfunction difficulties (stickiness)
- Social naivety with interpersonal difficulties (context)
- Impairment in social judgment of others (intuition)
- Difficulty with empathy and remorse (emotions)
- Acquiescent to others (social traffic/rules)
- History of impulsivity and/or ADHD
- Chronic anxiety and attachment problems

Vulnerabilities in the CJS

- Rule-based behaviour: no understanding of grey (obstinent; oppositional)
- Consequences focused on self (narcissistic, shallow)
- Lack of insight into others behaviours (indifferent, uncaring)
- Poor empathy or social understanding (callous, unfeeling)
- Emotional dysregulation (extreme reactions, poor control)
- Sense of injustice/entitlement (paranoid, suspicious)
- Sophisticated language masks lack of comprehension
- perseverative, ‘sticky’, obsessive
- Inflexible and resistant to compromise
- Inability to generalize experiences
- Susceptible to anxiety and agitation when uncomfortable

Offence Type

- Range of offences:
  - Physical Aggression and/or Verbal threats
  - Public Nuisance
  - Sexualized Offences ie stalking, harassment
  - Criminal Damage
  - Fire-setting
  - Homicide

(Murphy et al, Howlin et al, Attwood)

- Precipitating Reasons
  - Isolation
  - Social rejection
  - Sexual rejection
  - Bullying
  - Family conflict
  - MH instability
  - Life event
  - Bereavement

(Allen, Evans et al)

Aggression and ASD

- Anger and aggression can present as:
  - Immediate Behavioural Reaction (impulsive act)
  - Distorted Emotional Response (perceived threat)
  - Sensitivity Reflex (overstimulation)
- May be communication of underlying '*symptom*' of mental health problem and/or sensory impairment

Assault and ASD

- Revenge (*justified anger)*
- Exclusion *(perceived marginalization)*
- Default identity (*deviant membership*)
- Special Interest (*fascination with extremes*)
- Reactive (*environmental/sensory defensiveness*)
- Gaining Recognition (*guaranteed response)*

*

Sexual Behaviours and ASD

- Higher risk and vulnerability due to:
  - more likely to experience abusive sexual events
  - less likely to have experiences that enhance sexual health
  - more likely to have distorted/inflexible knowledge of sexuality
- Paraphilias are rare but may also be related to fixed interests e.g. fetishism
- Offenders more likely to exhibit sexually inappropriate behaviours due to 'sexual rule ambiguity'(i.e. stalking, sexual harrassment) however can escalate quickly due to dichotomous expectations

*

Sexual Offences and ASD

- Lack of normative experiences (*comp. group*)
- Impaired social perspective-taking (*advance*)
- Projected social assumptions (*intimacy)*
- Rote learners and concrete rules (*past exps)*
- Lack of flexibility in social interpretations (*fluidity*)
- Rigid expectations (*dichotomy)*
- Persistence/rumination provoke re/shp change

CJS Vulnerabilities

- Unlikely to be recognised
- Temporal time problems
- Differentiate accountability of self vs others
- Misinterpret sequence of events (literal)
- Misjudge re/shps (advocate vs support)
- Undue compliance or rule rigidity
- Uncautious honesty & unemotive about facts
- Sophisticated language without meaning
- False deterrent - like structure/routine of CJS

CJS and ASD interactions: perceptions of intent and purpose….

- ‘no remorse, callous’ – poor insight
- ‘oppositional, non-compliant’- inflexibility
- ‘attention seeking’ – diffs with nuisance
- ‘fradulant’ – sophisticated language
- ‘no responsibility/account.’ – b/w thinking
- ‘won’t learn from cons.’ – diff generalizing
- ‘looks guilty’- anxiety, motor diff (clumsy)

ASD Offending Behaviour Treatment…

- Individually tailored rather than ‘blanket’ approach
  - MUST be based on comprehensive risk assessment and management plan
  - substantial research on ABA intervention programs
  - communication: signing, PECS, visual boards
  - social stories, cartoons & social perspective taking
  - behavioural rehearsal, role-play & skill acquisition
  - sensory integration assessments
  - psychopharmacology (SSRI’s, anti-psychotics, anti-convulsants, anti-anxiety, stimulants)
  - psychotherapy depending on cognitive level (CBT, DBT and systemic)

CJS Cases: ASD & Aggression

- Rule-based world
  - Strict routine and Intolerance to ‘exceptions to the rule’
  - 42 yr old with multiple physical assaults
- Extreme social experiments
  - Avoids ‘live’ confrontation and elicits extreme reactions due to inability to read non-verbal cues
  - 22 yr old with verbal harassment charges
- Entitled aggression
  - Lack of empathy, TOM and insight leads to egocentric righteous attitude and justified extreme response
  - 30 yr old with threats and arson charges

CJS Cases: Sexual Behs & ASD

- Poor insight and self-identify
  - Unrealistic expectations exacerbate romantic failure
  - 19 yr old with trespassing and stalking charges
- Greys of Relationships
  - Inability to interpret social nuisance and context
  - 25 yr old with sexual solicitation over internet
- Rigid expectations
  - Paucity of romantic exp and rule generalization
  - 17 yr old female with sexual harassment behs at school
- Acceptance: non-judgmental, social immature, un-complex

Thank you!

Email: jonesj@queensu.ca