Addressing Sexual Acting Out Behaviors with Adolescents on the Autism Spectrum

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Abstract: Adolescents with autism spectrum disorders (ASDs) have similar sexual desires and relationship needs to their neuro-typical peers. However, they may be more likely to demonstrate problematic sexual behaviors as they mature, due to lack of education about sexuality, vulnerability to sexual abuse, deficits in social communication and understanding, restricted and repetitive interests and behaviors, and sensory interests. Treatment for sexual acting out behaviors in adolescents with ASD has not been explored and current recommendations focus on prevention through sexual education, which provides little guidance to clinicians working with adolescents who are already displaying sexual acting out behaviors. Adapting treatments for problematic sexual behaviors in neuro-typical children and adolescents may be the first step, although adaptation is complicated by developmental abilities that may not match an adolescent’s chronological age. A thorough developmental and sexual assessment is the first step to designing an appropriate treatment plan. Further research should focus on adapting and applying current treatments for sexual acting out by the ASD population.

Keywords: Autism Spectrum Disorder, ASD, adolescents, treatment, sexual behaviors, sexual acting-out.

1. INTRODUCTION: SEXUALITY AND ADOLESCENTS ON THE AUTISM SPECTRUM

Autism spectrum disorders (ASDs) are becoming increasingly common in clinical contexts, with estimates of prevalence ranging between one in 45 children (Centers for Disease Control and Prevention (CDC), 2015) and one in 68 children (CDC, 2014). Clinicians who treat children and adolescents will treat individuals on the autism spectrum as part of regular practice. Helping parents to cope with their child’s changing physical, emotional, and social landscapes as they progress through puberty is part of a clinician’s role.

Individuals on the autism spectrum have similar sexual and relationship needs when compared to their neuro-typical peers (Dewinter, Vermeiren, Vanwesenbeeck, & van Nieuwhuizen, 2013; Kellaher, 2015). Typical sexual development is a process that includes curiosity, fulfillment, and enjoyment. Sexual development, like other aspects of development, transition through stages across the lifespan and continues to develop from birth to death (DeLamater & Friedrich, 2002). Childhood sexual development, from birth to 7 years, is marked by curiosity and social norms and includes behaviors like sexual play (i.e., playing house), self-touch, gender identification, and gender socialization (DeLamater & Friedrich, 2002). Preadolescent development, ages 8-12, is marked by playing with the same gender peer groups and first sexual attraction experiences (DeLamater & Friedrich, 2002). Adolescent sexual development, ages 13-19 years, includes biological changes associated with puberty, sexual behavior changes similar to those experienced in adulthood, and psychosocial sexual development where
adolescents learn how to resolve conflict and explore intimate relationships (DeLamater & Fried-richt, 2002). Sexuality includes more than genital sex and includes aspects of psychosocial sexual development, including abilities to experience intimate social relationships and social goals like marriage, children, and adult sexual experiences (Murphy & Elias, 2006). However, children on the autism spectrum face increased challenges during maturation that may result in problematic sexual behaviors that need to be managed effectively for the wellbeing of the child, his or her family, and others with whom he or she comes into contact. Clinicians who work with children and adolescents need to be prepared to address sexuality with patients who have ASD.

2. SEXUAL ACTING OUT BEHAVIORS

Children on the autism spectrum may be more likely to demonstrate problematic sexual behaviors as they struggle to navigate the physical, emotional and social challenges inherent in exploring their sexuality. Although there are no exact statistics to describe the prevalence of sexual acting-out behaviors in children on the spectrum or in their typically-developing peers (Dewinter et al., 2013), there are multiple parent-report studies in which parents and caregivers indicate high rates of problematic sexual behaviors in their children with ASD (Hellemans, Colson, Verbaeken, Vermeiren, & Deboutte, 2007; Hellemans, Roeyes, Leplae, Dewaele, & Deboutte, 2010; Kellaher, 2015; Ruble & Dalrymple, 1993; Stokes & Kaur, 2005). These behaviors can range from relatively innocuous behaviors such as inappropriately talking about sex, to more socially inappropriate or harmful sexual behaviors like masturbating in public or sexually acting-out aggressively against others (Dewinter et al., 2013).

It is understandable that adolescents with ASD would struggle to express their sexuality in appropriate ways. Children on the autism spectrum receive significantly less and poorer quality education about sexuality and dating than other teens (Brown-Lavoie, Viecili, & Weiss, 2014; Holmes & Himle, 2014; Stokes & Kaur, 2005; Travers & Tincani, 2010) and they miss out experiences to learn about socially-appropriate dating behaviors from peers due to difficulty making friends (Stokes, Newton & Kaur, 2007; Travers & Tincani, 2010). They are at a greater risk of being sexually abused themselves (Brown-Lavoie, Viecili, & Weiss, 2014; Howlin & Clements, 1995; Mansell et al., 1996; Travers & Tincani, 2010) which may lead to a greater likelihood of displaying problematic sexual behaviors (Mandell, Walrath, Manteuffel, Sgro, & Pinto-Martin, 2005).

The social deficits experienced by individuals with ASD create even more barriers to interact appropriately in romantic contexts. Adolescents with ASD have difficulty following and understanding dating rules, such as how to pick an appropriate partner, how to approach that person, and how to perceive and accept rejection (Hellemans et al., 2007; Stokes, Newton & Kaur, 2007; Travers & Tincani, 2010). There have been instances of individuals on the spectrum engaging in behaviors that rise to legal levels of concern and can lead to long-term consequences resulting from difficulty understanding the social rules of dating. In addition, the very nature of the restricted and repetitive behaviors and interests that are a hallmark of ASD may create difficulty for individuals who may be perseverating on a sexual interest (Kellaher, 2015). Parents with children on the spectrum often complain that their child may be only interested in one topic, for example only talking about dinosaurs or Pokémon despite their parents’ efforts to change the subject. If this interest becomes sexual in nature, it could be difficult for others to intervene or divert the individual’s attention. Difficulties with sensory integration and responsiveness could result in sexually stimulating behaviors that are hard to discourage (Kellaher, 2015).

3. CASE EXAMPLE

Edward, a 17-year-old Caucasian male with mild autism spectrum disorder, presented at the psychiatry clinic due to his parent’s concerns that he is “obsessed with childish things.” Although he had been diagnosed with ASD 10 years prior, his parents had very little understanding of the disorder or the ways in which their son’s difficulties with social communication and restricted interests were impacting his functioning.

Edward’s mother did not mention any concerns about problematic sexual behaviors. However, once his mother left the room, Edward proceeded to ask the female psychologist for a “special kind of hug where our fronts touch each other.” He explained that another woman had hugged him that
way and he had enjoyed it. The clinician calmly and clearly explained that it was inappropriate to ask her for a special hug because she was his doctor and she did not want to give him a special hug. She further explained that she would never give him a hug and that he could not ask her again. He perseverated on this interest and asked the clinician repeatedly for a “special hug” despite her repeated statements about the inappropriateness of his request and her assertions that it would never happen. He ignored the clinician’s statements about her feelings and social explanations (“See how I’m sitting with my arms crossed? That’s because I am uncomfortable and frustrated that you keep asking for a hug after I said ‘no’”) and did not stop asking until the clinician told him that she would inform his mother.

When the clinician described the patient’s behavior to his mother, she revealed that Edward had recently asked a 7-year-old girl in their apartment building for a kiss and had repeatedly asked her over and over. The child’s mother had told Edward’s mother and she was concerned that Edward could get in trouble for similar requests in the future.

Edward’s actions illustrate some of the difficulties faced by teenagers on the autism spectrum. Edward clearly struggled to identify appropriate dating partners (asking both his psychologist and a child for inappropriate physical touch) and did not understand the social cues that meant he was being rejected, despite the clinician’s very explicit description of her discomfort with his repeated overtures and explanations of social rules. The request became repetitive and it may have been difficult for Edward to stop focusing on his interest at the time. In addition, lack of understanding about sexuality and how sex is perceived in American culture could have contributed to Edward’s problematic sexual behavior. It is possible that Edward did not understand the difference between the clinician’s reaction of telling him “no” to a “special hug” and his mother’s reaction of telling him “no” to buying a new action figure at the store. In his experience, if he begged his mother she would give in and buy the toy. He may have thought that the clinician would be similarly easy to persuade. He did not understand the implications of asking a child for a kiss and how negatively others would react to this request from a young child. The most concerning factor in Edward’s behavior was his refusal to respond to “no” and clear lack of understanding of consent. If the child had agreed to a sexualized behavior with Edward, that could have been damaging for the child and resulted in legal repercussions for Edward.

Addressing inappropriate sexual behavior with Edward was necessary in order to protect him and others as well to promote appropriate romantic relationships in the future. Unfortunately, there is no specific treatment for children with sexual acting out behaviors who are also on the autism spectrum readily available. The current literature emphasizes prevention of inappropriate sexual acting out behaviors in individuals with ASD through sexual education (Sevlever, Roth & Gillis, 2013). However, if the behavior is not prevented, the literature does not identify any concrete treatment approaches for addressing problematic sexual behaviors when they come to clinical attention. Providers who treat children on the autism spectrum need to have real tools for addressing these behaviors and guiding parents that extend beyond “preventative” sexual education or social skills acquisition. It is necessary to evaluate effective treatments for problematic sexual behaviors in neurotypical children so that they can be tailored or adapted for children on the autism spectrum.

### 4. TREATMENT FOR PROBLEMATIC SEXUAL BEHAVIORS IN NEURO-TYPICAL CHILDREN

Emphasizes on the prevention of inappropriate sexual acting out behaviors in individuals with ASD through sexual education (Sevlever, Roth & Gillis, 2013). However, if the behavior is not prevented, the literature does not identify any concrete treatment approaches for addressing problematic sexual behaviors when they come to clinical attention. Health care providers who treat children on the autism spectrum need to have real tools for addressing these behaviors and guiding parents that extend beyond “preventative” sexual education or social skills acquisition.

A key aspect when considering treatment approaches for children with problematic sexual behaviors can be the developmental age and conceptualization of the origin of the problematic sexual behaviors. When considering problematic sexual behaviors it is important to remember that in the neuro-typical population, children with problem-
Adolescents with problematic sexual behaviors form a diverse group of children between the ages of 8 and 12 who initiate a specific set of behaviors involving sexual body parts (i.e. buttocks, genitals, anus, breasts) that is developmentally inappropriate and/or potentially harmful between peers and/or adults and related to curiosity, anxiety, imitation, attention seeking, self-soothing, or other reasons (Silovsky & Bonner, 2003). The Association for the Treatment of Sexual Abusers (ATSA) task force summarized a wide variety of factors contributing to the development of problematic sexual behavior including maltreatment, access to explicit media, parenting practices, exposure to family violence and/or living in a sexualized environment (Chaffin et al., 2008). Treatment for children with problematic sexual behaviors can effectively be delivered in short-term CBT that involves caregivers and children in the outpatient setting (Chaffin et al., 2008). Effective components of outpatient treatment include: 1) Identifying and recognizing inappropriate sexual behavior and apologizing for actions (note: this is omitted for children under 7), 2) Learning and practicing rules about sexual behavior and physical boundaries, 3) Age-appropriate sex education, social skills, coping/self-control strategies, and safety skills. Parents and caregivers should receive education on supervision/safety planning, problematic sexual behaviors, parenting approaches for behavior problems, and ways to reinforce child self-monitoring, coping skills, privacy rules, and positive peer groups (Chaffin et al., 2008).

Adolescents with illegal sexual behaviors are typically between the ages of 13 and 18 whose sexual behavior breaks the laws established by their current jurisdiction. They differ from adult sexual offenders because 1) they have fewer victims and perform less aggressive acts (Miranda & Cocoran, 2000), 2) they do not meet criteria for pedophilia nor do they report the same types of sexual fantasies as adult offenders (Bonner, 2008), and 3) they are more responsive to appropriate treatment than adult offenders (Bonner, 2008). Adolescents with illegal sexual behavior may or may not have other psychological problems, may or may not have been sexually abused, and come from a range of families from well-functioning to abusive (Bonner, 2008). Effective treatment for adolescents with these behaviors entails weekly outpatient group treatment ranging in duration from 8-24 months (Burton & Smith-Darden, 2000). Treatment components are supervision plans and a variety of psychoeducational and cognitive-behavioral topics including empathy building, social skills, relationship skills, responsibility taking, education and prevention of future illegal behavior, and family support skills.

5. TREATMENT ADAPTATION FOR CHILDREN ON THE AUTISM SPECTRUM

There are some specific challenges when adapting treatments designed for neuro-typical adolescents for the ASD population. The first challenge would be deciding which treatment approach to adapt. In neuro-typical children, treatment approaches for sexual acting out behaviors are very different in focus and delivery depending on an individual’s age (Bonner, 2008). Adolescents on the autism spectrum may not fit clearly into one of three separate population groups because of a discrepancy between the individual’s emotional/psychological development and his or her chronological age. In the case example, Edward, who is chronologically 17 years old, was functioning with similar developmental abilities to that of a 10-year-old. In addition, his sexual acting-out behaviors appeared to be related more to curiosity and imitation, which are similar to those observed in the child sexual acting out population. His behaviors did not appear to be specifically sexually motivated behaviors like those observed in neuro-typical adolescents. Edward may benefit from the CBT treatment approach used for younger children while another 17-year-old with ASD who was developmentally more mature and displayed more severe sexual acting-out behaviors might require the treatment modality used with the adolescent presentation.

Given the heterogeneous population of children with ASD, a thorough assessment of the child’s developmental level, cognitive and intellectual functioning, and problematic sexual behaviors would likely be beneficial in determining the best treatment approach for a child or teen with ASD. The Treatment of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems released a report in 2008 that outlines assessment approaches for children with sexual behavior prob-
lems (Chaffin et al., 2008). While every case should be evaluated on an individual basis with regard to the family context and presenting problems by a qualified professional, there are some basic guidelines that an assessment should include. Areas for consideration in assessment are 1) the caregiver-child relationship as well as the social environment in which the child resides, 2) broad psychological and behavioral functioning, 3) a qualitative interview of sexual behavior problems from parents and an interview of the child, and 4) formal testing using a measure like the Child Sexual Behavior Inventory–III (CSBI-III; Friedrich, 1997) for children ages 2 - 12 (Chaffin et al., 2008). A qualitative interview about the problematic sexual behaviors would include information regarding frequency, the type of behavior, the chronological account of this behavior, its response to caregiver intervention, whether or not the behavior was mutually decided upon, whether impulsivity was a factor or if it included aggression, and the social circumstances in which it occurred (Chaffin et al., 2008). This information should be taken into account when determining the best treatment approach.

FUTURE DIRECTIONS & CONCLUSION

Treating sexual acting out behaviors in adolescents with ASD is a new direction for clinical practice. At this time, there is no evidence-based approach for intervening when adolescents present with sexual acting out behaviors, despite the fact that this issue is prevalent in individuals with ASD and may cause significant personal and legal problems. Challenges both in assessing problematic sexual behaviors and creating an appropriate treatment plan will need to be addressed. Clinicians will need to familiarize themselves with and navigate between the different effective treatments already created for neuro-typical children and adolescents. In addition, adapting current materials to fit the intellectual and learning style of adolescents with ASD will be necessary. Future research should focus on adapting these modalities and exploring their efficacy with adolescents on the autism spectrum. Clinicians who work with adolescents on the autism spectrum may benefit from educating themselves about sexual acting out behaviors and applying behavioral strategies with families.

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