

# Sex Offender Law Report™

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## Landmark Report on the Causes and Context of Sexual Abuse in the Catholic Church

by Alissa Ackerman

*Editor's Note: On May 18, 2011, a research team from John Jay College of Criminal Justice, led by SLR editorial board member Karen Terry, presented its report, entitled "Causes and Context of Sexual Abuse of Minors by Catholic Priests in the United States, 1950–2010," to the United States Conference of Catholic Bishops (USCCB). The report was the culmination of a multiyear investigation undertaken at USCCB's initiative to comprehend and address the problem of sexual abuse within the Catholic Church across the nation.*

*This brief article presents the context and key findings of this landmark report. SLR will be exploring perspectives and reactions related to the report and its conclusions in upcoming issues. To this end, reader opinions and perspectives on the report are welcome. The report, along with background supporting at material, may be accessed on the USCCB website (<http://USCCB.org/mr/causes-andcontext.shtml>).*

Until the Boston Globe ran a series of investigative reports about child sexual abuse in the Boston Archdiocese in 2002, little attention was given to this serious, but silent issue. The

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## Assessing the Sex Offender With Asperger's Disorder: A Forensic Psychological and Neuropsychological Perspective

by John Matthew Fabian, Psy.D., J.D., ABPP

David, a 24-year-old white male with a history of Asperger's Disorder (AD), was charged in federal court with possessing child pornography, based on approximately 1,500 child pornography pictures and videos found on computer hard drives in his possession. Along with these items, the hard drives also contained hundreds of graphic anime images. Concurrent with his federal charges, David was also charged by state authorities with attempted sexual assault of a 13-year-old girl.

The federal public defender in the case requested an evaluation of the defendant's psychological and neuropsychological functioning, as well as his psychosexual history, with a request that the evaluation address his likelihood of future sex offending and offer treatment recommendations in light of his history of Asperger's Disorder. The attorney aimed to provide the federal judge at sentencing with information that could shed light on the etiology and causative factors of the defendant's criminal sexual behavior through a mitigating lens under U.S.C. § 3553. In particular, the attorney was attempting to litigate a downward departure claim from the Federal Sentencing

Guidelines by ultimately explaining the nexus of his offending behaviors with his AD condition.

David's case, and others involving defendants suffering from Pervasive Developmental Disorders (PDD) such as AD, present a unique array of challenges to those involved in litigation and evaluation of sexual offense cases. The goal of this article is to explore the range of issues and considerations involved in evaluating these cases, and to discuss the mechanisms through which symptoms of PDDs (and in particular AD) can place individuals at risk to engage in sexually inappropriate behaviors, including Internet child pornography and hands-on sex offenses involving child and adolescent victims. The article will discuss the nature and diagnostic criteria of PDDs and AD, and will examine how these behavioral symptoms relate to criminal behavior in general and sex offending in particular. Following this general discussion, guidance is provided for evaluators and legal actors involved in cases involving diagnosed or potential PDDs.

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### Pervasive Developmental Disorders

Pervasive Developmental Disorders, also known as Autism Spectrum Disorders (ASDs), are characterized by delays in the development of socialization and communication skills. PDDs exist along a spectrum of severity, with Autistic Disorder deemed the most severe and debilitating.

**Autism.** Autism is characterized by unusual social development, inability to imitate and respond to emotions, social communication delays, and repetitive and restricted behaviors including stereotyped, compulsive, ritualistic, restricted, and self-injurious behaviors. Risk of autism is associated with several prenatal factors, including advanced parental age and diabetes in the mother during pregnancy, as well as several genetic disorders including epilepsy. (E. Caronna, J. Milunsky, and H. Tager-Flusberg, "Autism Spectrum Disorders: Clinical and Research Frontiers," 93 Arch. Dis. Child 518-23 (2008); Gardner, Spiegelman, and Buka, "Prenatal Risk Factors for Autism: Comprehensive Meta-analysis," 195 Brit. J. Psychiatry 7-14 (2009).) Co-morbid conditions associated with autism include genetic disorders such as chromosome abnormalities and mild mental retardation, anxiety disorders, epilepsy, metabolic defects, and minor physical anomalies. Other co-morbid diagnoses include Social Anxiety Disorder, ADHD, Oppositional Defiant Disorder, and Tourette's Syndrome. (E. Simonoff, E. Pickles, A. Charman, S. Chandler, G. Loucas,

and T. Baird, "Psychiatric Associated Factors in a Population-Derived Sample," 8 Am. Acad. Child & Adol. Psychiatry 921-29 (2008).)

**Asperger's Disorder.** Asperger's Disorder (AD), as part of the PDD/ASD spectrum, also involves significant difficulties in social interaction as well as restricted and repetitive patterns of behaviors and interests. In contrast with autism, however, individuals with AD exhibit more intact language and cognitive development. While AD prevalence rates are wide ranging, studies are fairly conclusive that the condition is between two and 16 times more prevalent than autism, and approximately four times more prevalent among males than females. (S. Ehlers and C. Gillberg, "The Epidemiology of Asperger Syndrome: A Total Population Study," 8 J. Child Psychol. & Psychiatry 34 1327-350 (1993); E. Fombonne and L. Tidmarsh, "Epidemiological Data on Asperger Disorder," 12 Child & Adol. Psychiatry Clinics N. Am. 1-7 (2003).) Family studies suggest an increased frequency of AD among family members of individuals who have the disorder. (P. Szatmari, R. Brenner, and J. Nagy, "Asperger Syndrome: A Review of Clinical Features," 34 Can. J. Psychiatry 554-60 (1989).)

### Effects on Social Interaction and Communication

PDDs are characterized by abnormalities in social interaction and communication that impair an individual's functioning, and are typically coupled with restricted and repetitive

interests and behaviors. This may be manifested in a failure to develop proper social relationships and friendships, diminished abilities to interpret and react to social cues, and an inability to seek shared enjoyments with others. While those with AD are not as withdrawn and socially isolated as those with autistic disorder, their social ineptness presents them as being awkward around others. They are likely to misunderstand or fail to recognize others' feelings, emotions, and reactions. While they often present as egocentric and narcissistic, this is not due to a personality disorder per se, but rather an innate incapacity to understand and relate to others. (J. Barry-Walsh and P. Mullen, "Forensic Aspects of Asperger's Syndrome," 15(1) J. Forensic Psychiatry & Psychol. 96-107 (2004).)

### PDD/AD in Criminal Justice Populations

Several studies have addressed the presence of AD in forensic settings, indicating that PDDs are substantially higher in forensic populations than in general community samples. (D. Murrie, J. Warren, M. Kristiansson, and P. Dietz, "Asperger's Syndrome in Forensic Settings," 1 Int. J. Forensic Mental Health 59-70 (2002); P. Scragg and A. Shah, "Prevalence of Asperger's Syndrome in a Secure Hospital," 165 Brit. J. Psychiatry 679-82 (1994).) Research has also indicated that violent individuals with PDDs are more likely diagnosed with AD than autistic disorder. (M. Langstrom, V. Grann, G. Ruchkin, S. Sjostedt, and S. Fazel, "Risk Factors for Violent Offending

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in Autism Spectrum Disorder: A National Study of Hospitalized Individuals,” 8(24) *J. Interpersonal Violence* 1358-370 (2009).)

**Co-Existing Psychiatric Disorders.** Of particular relevance to forensic evaluators, the overwhelming number of AD cases have co-existing psychiatric disorders. (S. Newman and M. Ghaziuddin, “Violent Crime in Asperger’s Syndrome: The Role of Psychiatric Co-morbidity,” 10(38) *J. Autism & Dev. Disorders* 1848-852 (2008); M. Palermo, “Pervasive Developmental Disorders, Psychiatric Co-morbidities, and the Law,” 48 *Int. J. Offender Therapy & Comp. Criminology* (2004).) This is consistent with the general literature suggesting that AD diagnoses may often be confounded by co-morbid conditions including depression, ADHD, epilepsy, learning disorder, Tourette’s Syndrome, Bipolar Disorder, Obsessive Compulsive Disorder, and anti-social behavior. (M. Cederlund and C. Gillberg, “One Hundred Males With Asperger Syndrome: A Clinical Study of Background Associated Factors,” 10(46) *Dev. Med. Child Neurology* 652-60 (2004); C. Gillberg and E. Billstedt, “Autism and Asperger Syndrome: Coexistence With Other Clinical Syndromes,” 10(46) *Acta Psychiatrica Scandinavia* 652-60 (2000).)

**Underdiagnosed in Offender Populations.** This co-morbidity may explain, in part, the repeated finding that AD has been underdiagnosed in offender populations. One study assessing AD prevalence within a forensic inpatient sample found that only

one-third of the Asperger’s patients had a previous diagnosis of AD, suggesting that many AD-diagnosed adults did not carry the diagnosis during developmental periods. (P. Scragg and A. Shah, “Prevalence of Asperger’s Syndrome in a Secure Hospital,” 165 *Brit. J. Psychiatry* 679-82 (1994).) Another research study screened 1,305 subjects in English special forensic hospitals and found a 2.4% AD rate, with only 10% of these individuals having a previous diagnosis. (D. Hare, J. Gould, R. Mills, and L. Wing, *A Preliminary Study of Autistic Disorders in the Three Special Hospitals of England* (2000).) A third study examining detailed developmental histories for all presentencing evaluations in a cohort of young adult males with personality disorder NOS identified prevalence rates of 15% for definite AD and an additional 12% for probable AD. (L. Siponmaa et al., “Juvenile and Young Adult Mentally Disordered Offenders: The Role of Child Neuropsychiatric Disorders,” 29 *J. Am. Acad. Psychiatry & L.* 420-26 (2001).)

### **PDD/AD and Criminogenic Risk**

While most individuals with AD do not become criminally involved, certain features associated with the disorder may be associated with elevated risk of such involvement. A 2003 study suggested that these features fall into two broad domains, namely:

1. Deficits in theory of mind (i.e., the ability to estimate the kind of perceptual affective life of others as well as of self); and
2. Abnormal and repetitive narrow interests. (A. Abu-Akel, “A Neurologi-

cal Mapping Theory of Mind,” 43 *Brain Res. Rev.* 29-40 (2003).)

Indeed, individuals with AD may experience deficits in their ability to understand that another person has a different emotional cognitive experience of a shared event, and thus may be cognitively unable to read the necessary interpersonal cues to disengage from a particular social encounter. This, in turn, may lead to engagement in criminal behavior related to excessive preoccupation with highly focused internal interests and neglect of social and legal consequences. It has been further proposed that deficits in internal coherence, and associated compartmentalizing characteristics of individuals with PDDs, may lead to inner preoccupations and fixations that, if left unchecked by normal awareness of social laws and constraints, may lead to maladaptive fantasies. (J. Silva, G. Leong, and R. Smith, “Analysis of Serial Homicide in the Case of Joel Rifkin Using the Neuropsychiatric Developmental Model,” 26 *Am. J. Forensic Psychiatry* 25-55 (2005).)

### **Sexual Offending and PDD/AD—General Factors**

Given the previously discussed dimensions of PDD/AD, assessments should consider these four primary factors concerning the nexus between social impairments found in PDDs and criminal sexual offending:

1. Deficient empathy;
2. Maladaptive sexual behaviors;

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3. Restrictive repetitive behavior patterns; and
4. The potential role of co-occurring paraphilias.

The discussion of these factors may be facilitated by the accompanying case example. (See "Case Study of Sex Offending and Asperger's Disorder.")

**Deficient Empathy.** The most consistent evidence of the effect of severe and sustained impairments in the social interaction criteria for AD is related to deficient empathy. In case studies, men with AD charged with sex offenses and murder seemed generally unaware of the harm they caused their victims. (D. Murrie et al., *supra*.) While such deficiencies may be easily attributed to inherent psychopathic traits, in AD cases they may also be linked to a form of interpersonal naiveté. Specifically, AD clients may have impoverished understandings of human relationships and a tendency to seek interpersonal contact in misguided ways—a confluence of factors that may lead to sexual offending behaviors. In the case study above, the offender was oblivious to the perceptions, thoughts, and feelings of a young girl he attempted to molest. He had a consistent history of social rejection during his childhood and adolescence and had never participated in socially and age-appropriate relationships with female peers.

**Maladaptive Sexual Behavior.** Another manifestation of social impairments relates to maladaptive sexual behavior. Individuals with PDDs often are interpersonally less equipped to initiate or sustain intimate relationships commonly associated with consensual sexual contact. In fact, many AD individuals may have difficulty judging the age of others, which may lead to illegal relationships, sexual relations with minors, and illegal possession of child pornography. Emerging literature has revealed that a defective capacity to attain socially sanctioned release can underlie certain sex offenses in some individuals with AD. The use of pornography is one way these individuals may experience their sexual outlets. In the accompanying case study, Frank was also attracted to anime pornography and was interested in Pedobear (Internet meme portrayed as a pedophilic bear) rather than age-appropriate sexual relationships.

**Restrictive Repetitive Behavioral Patterns.** A third critical factor for consideration involves the development of

## Case Study of Sex Offending and Asperger's Disorder

Frank R. has a history of inappropriate sexual relationships with children and has gravitated to child pornography, anime pornography (animation), and hentai pornography. Diagnosed with AD as a youth, Frank historically had been interpersonally rejected by same-age peers and consequently had intimate relationships with younger aged peers. He lacked an emotional capacity (social reciprocity) to consider that the girl (victim) had a different perception of their relationship than his. His recurrent and indiscriminate soliciting of sexual touching with the young girl was consistent with a fundamental inability to appreciate socially appropriate behavior rather than evidence

of a paraphilia and/or sophisticated criminal sexual behavior. In fact, he posted a clip on YouTube and presented as odd with an aloof indifference to others, condoning his behaviors and attraction to young girls, while lacking an ability to cognitively and emotionally appreciate his message, as he was disconnected with his social environment. While he knew right from wrong, he lacked the appreciation that the girl would be offended by his behaviors, as well as the illegal nature of his propositioning. While some could perceive this offender as being psychopathic with a deficiency in empathy, this impairment should be seen as a neurobiological deficit. ■

restricted repetitive patterns of behavior, interests, and activities that may lead to criminal behavior in some individuals with PDDs. Abnormal receptive and narrow interests may be associated with criminal activities of AD offenders. (B. Haskins and J. Silva, "Asperger's Disorder and Criminal Behavior: Forensic-Psychiatric Considerations," 34(3) *J. Am. Acad. Psychiatry & L.* 374-84 (2006).) Specifically to sex offenders, these individuals have difficulties with human relations and become preoccupied with stimuli that objectify humans, such as pornography, dolls, and artificial vaginas for example. These offenders have sexualized preoccupations and/or inappropriate sexual relations with people, such as showing pornography to young girls or filming them. As mentioned, the sample offender engaged in a number of focused, obsessive, compulsive, and recurring inappropriate sexual behaviors as substitutes to typical sexual relations with adults.

**Role of Paraphilias.** While the aforementioned factors suggest that the reasons for sexual offending among AD clients may be linked to a range of social deficits, motivations for such offenses may be paraphilic in nature. (Y. Kohn, T. Fahum, G. Ratzoni, and A. Apter, "Aggression and Sexual Offense in Asperger's Syndrome," 35 *Israel J. Psychiatry & Related Sci.* 293-99 (1998); J. Silva, G. Leong, and M. Ferrari, "A Neuropsychiatric Model of Serial Homicidal Behavior," 6(22) *Behav. Sci. & L.* 787-99 (2003).) However, PDD psychopathology appears to motivate

sexual abnormalities and sex offending behavior. (Haskins and Silva, *supra*.)

In our cited case study, Frank had hidden the girl and her sister's panties in his room (fetishistic behavior), a process that focuses on the objectification of others. Similarly, his obsessive use of pornography and anime was a function of both repetitive and compulsive ritualistic interests and objectification of others. This AD offender's obsessive preoccupation with pornography is consistent with the literature as a coping mechanism to deal with and avoid negative emotional states such as depression, boredom, anxiety, depression, emotional loneliness, and rejection. (J. Fabian, "How To Utilize Forensic Psychological Evaluations Within Internet Online Solicitation and Pornography Sex Crime Cases," 36(5) *Tex. Crim. Def. Law. Assoc.* 16-21 (2007); E. Quayle, M. Vaughan, and M. Taylor, "Sex Offenders, Internet Child Abuse Images and Emotional Avoidance, the Importance of Values," 11 *J. Aggression & Violent Behav.* 1-11 (2006).)

### Assessing Sex Offender With Asperger's Disorder

Particularly given the aforementioned rates of underdiagnosis of PDD/AD, the forensic evaluation of AD or potential AD defendants in sex offense cases should consist of both a diagnostic assessment of the AD and its dimensions, as well as consideration of sex

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offender-specific evaluations of risk. Regarding the former, the evaluation should consider several domains of functioning, namely:

- Social and emotional functioning;
- Neuropsychological functioning; and
- Adaptive behavior functioning.

Where indicated, AD-specific testing should be considered for inclusion in the overall assessment.

**Assessment of Social, Emotional Functioning.** In the social domain, the evaluator's focus should be on examining social abilities and interactions of the individual, as these areas are delayed and deficient in nature within an individual with AD. Areas of focus may include the following:

- Observation of social presentation;
- The quality of attachment to family members;
- Development of peer relationships;
- Friendships and social networks;
- Level of insight into social problems;
- Ability to identify the feelings of others;
- Quality of emotional and social reciprocity;
- Awareness of social codes of conduct; and
- Inquiry into empathy and social cueing. (L. Wing and J. Gould, "Severe Impairments of Social Interaction and Associated Abnormalities in Children: Epidemiology and Classification," 9 *J. Autism & Dev. Disorders* 11-29 (1979).)

Assessment of emotional functioning should be aimed at discerning the following:

- The affective presentation of the person;
- Ability to express emotions both verbally and nonverbally;
- Descriptions of typical emotional expressions, such as reactions to novelty and distress;
- Discussion of the subtlety of emotional expression and reaction to reassurance or rejection;
- The presence of empathy; and
- Ability to understand others' intentions and their emotional expressions. (D. Brendel, J. Bodkin, B. Hauptman, and A. Ornstein, "I See Dead People:

Overcoming Psychotic Numbness," 10(3) *Harv. Rev. Psychiatry* 166-78 (2002).)

To assess these and related dimensions, the forensic expert may consider the Mayer-Salovey-Caruso Emotional Intelligence Test (MSCEIT), which evaluates the person's understanding, communicating, generating, and processing of emotions and their function. (M. Brackett, S. Rivers, S. Shiffman, N. Lerner, and P. Salovey, "Relating Emotional Abilities to Social Functioning: A Comparison of Self-Report and Performance Measures of Emotional Intelligence," 4(91) *J. Personality & Soc. Psychol.* 780-95 (2006).) Both the Awareness of Social Inference Test (TACIT) and the Advanced Clinical Solutions Social Cognition Test assess an individual's ability to understand nonverbal communication and social interactions and examine poor understanding of emotional expressions and difficulty integrating the contextual information that is part of normal social encounters.

**Assessment of Neuropsychological Functioning.** A neuropsychological evaluation is indicated in an AD individual to assess for neurocognitive functioning. (S. Baron-Cohen et al., "Social Intelligence in the Normal and Autistic Brain: An fMRI Study," 11 *Euro. J. Neurosci.* 1891-898 (1999); C. Grady and M. Keightley, "Studies of Altered Social Cognition in Neuropsychiatric Disorders Using Functional Imaging," 47 *Can. J. Psychiatry* 327-36 (2002).) Typically, AD clients exhibit IQs within the normal range, often with a verbal versus performance discrepancy favoring greater verbal skills. This known psychological profile may, for example, reveal an advanced verbal comprehension with poor performance on similarities, comprehension, and picture arrangement. Clients may have intact cognitive functioning, but the assessment should include evaluation of motor skills, visual and motor coordination, visual-perceptual skills, visual-spatial construction, visual memory, facial recognition, concept formation, and executive functioning. (H. Khouzam, F. El-Gadalawi, N. Pirwani, and F. Priest, "Asperger's Disorder: A Review of Its Diagnosis and Treatment," 3(45) *Comprehensive Psychiatry* 184-91 (2004).)

Along the lines of executive function, an assessment of ADHD should always be considered due to its high rate of co-morbidity with AD. Impulsivity stemming from this executive disorder may be related to sex offending and criminal behavior. Notably, executive dysfunction hypothesizes that autistic behavior results in part from deficits in working memory, planning, inhibition,

and other forms of executive dysfunction. (L. Kenworthy, B. Yerys, L. Anthony, and G. Wallace, "Understanding Executive Control in Autism Spectrum Disorders in the Lab and in the Real World," 4(18) *Neuropsychol. Rev.* 320-38 (2008).)

Although AD does not generally entail the level of language impairment commonly associated with autism, a communication assessment may nevertheless be indicated. Some AD individuals experience language delays. A communication assessment could include tests on reticulation, vocabulary, sentence construction, verbal comprehension, and evaluation of speech content, including a tendency to persevere on circumscribed topics of interest. While many AD individuals have developed language syntax, they lack a pragmatic sense of language and communication. Stereotyped behavior and special interests should be evaluated, including assessing an individual's description of special interests, activities, conversation topics, and daily routines and patterns through the various stages of development.

**Assessment of Adaptive Behavior Functioning.** The assessment of adaptive functioning needs to identify particular deficits that are relevant coping and compensatory skills that the individual uses to adapt to their environment. (F. Volkmar et al., "Asperger's Disorder," 157 *Am. J. Psychiatry* 262-67 (2000).) Again, use of objective adaptive functioning instruments such as the Scales of Independent Behavior-Revised (SIB-R) can be helpful, even if administered retrospectively, to understand the offender's emotional and behavioral adaptive functioning. Evaluators should be mindful that in offenders with AD, the overwhelming number of cases have co-existing psychiatric disorders. (M. Palermo, *supra*.) These disorders are likely to include depression and anxiety disorders, and may include ADHD, learning disorders, personality disorder, and substance abuse—all factors that may place the individual at risk to commit sexual crimes.

**PDD-Specific Psychological Testing.** The expert should consider employing specific standardized diagnostic instruments pertaining to the assessment of PDDs. The Autism Diagnostic Interview-Revised (ADI-R) is a semi-structured investigator-based interview for caregivers of children and adults, appropriate for children with mental ages from about 18 months to adulthood, and is associated to ICD-10 and *DSM-IV* diagnostic criteria. (C. Lord,

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M. Rutter, and A. LeClutdur, "Autism Diagnostic Interview-Revised: A Revised Version of a Diagnostic Interview for Caregivers of Individuals With Possible Pervasive Developmental Disorders," 5(24) *J. Autism Dev. Disorders* 659-85 (1994).

The Autism Diagnostic Observation Schedule-Generic (ADOS-G) is a similarly structured standardized assessment of social interaction, communication, play, and imaginative use of materials for individuals suspected of having PDDs, and can be interpreted to differentiate Autistic Disorder from PDD NOS. (A. Klin, F. Volkman, and S. Sparrow, *Asperger Syndrome* (2000).) The Social Responsiveness Scale (SRS) measures the severity of social impairment associated with autism spectrum disorder. As some of these standardized measurements of PDDs focus on children and adolescents, it is this author's recommendation that one should attempt to interview the defendant, even if they are an adult, and their parent, using one of these assessment instruments as a qualitative measure. It is important to obtain collateral developmental information as to the presence of PDD in the defendant during childhood and adolescence.

### Sex Offender Risk and Treatment Assessment

When considering the sex offender element of the assessment of a defendant with AD, the forensic expert must consider risk assessment, diagnostic, and treatment amenability issues. When retained as an expert witness, the expert should consider these issues in a mitigating light at sentencing.

**Risk Assessment Considerations.** When considering the risk assessment, the expert should utilize actuarial assessment when appropriate, but maintain a focus on dynamic and changeable risk factors and treatment-related issues that are relevant to the client's neurocognitive disorder. Many AD offenders will be hands-on offenders against children or adolescents, crossover offenders in these categories, noncontact offenders with histories of child pornography possession, and Internet solicitation of minors offender types. As previously referenced, distinguishing the etiology of the sexually abnormal behaviors based on paraphilias, personality disorder, PDD traits, hypersexuality issues, or a combination will be critical to the forensic evaluation.

The primary challenge in this portion of the evaluation will be integrating the sexual behaviors and empirically related

sexual recidivism risk factors to PDD/AD symptomatology. For example, many of the research studies on dynamic risk factors in sex offending include factors that are common in PDD individuals. The Sex Offender Need Assessment Rating (SONAR) risk factors that are common traits of AD individuals may include intimacy deficits and negative mood states (depression and anxiety). Similarly, the Stable 2007 and Acute 2007 dynamic risk instruments have risk factors potentially aligned with PDD symptoms, including emotional identification with children, capacity for relationship stability, lack of concern for others, poor problem-solving skills, negative emotionality, sexual preoccupations, and sex as coping.

As stated, AD offenders have characteristics that elevate their risk in certain circumstances to commit sexual offenses. These characteristics, which should be assessed as part of the evaluation, include:

- Deficits regarding stable emotional relationships;
- Proneness to social rejection;
- Nonverbal communication deficits;
- Failure to develop peer-appropriate relationships;
- Lack of social/emotional reciprocity;
- Poor empathy;
- Pervasive preoccupation with stereotyped and restricted patterns of interest of abnormal intensity and focus;
- Persistent preoccupation with parts/objects; and
- Language communication deficits and delays.

Other risk factors consistent with AD individuals include identification with fictional characters in child pornography and emotional loneliness and isolation. (A. Elliott, A. Beech, R. Mandeville-Norden, and E. Hayes, "Psychological Profiles of Internet Sexual Offenders: Comparisons With Contact Offenders," 21 *Sexual Abuse: J. Res. & Treatment* 76-92 (2009).)

**Treatment Considerations.** The expert witness examining the AD sex offender should also address treatment issues and a risk management program to be employed when the offender is placed on community supervision. When contemplating treatment of the AD offender, the expert must keep in mind a global approach to treatment, including addressing all co-morbid psychiatric conditions such as obsessive-compulsive

disorder and depression. Such treatment can include cognitive-behavioral therapies and psychopharmacological treatments geared toward diminishing obsessive behavioral and cognitive preoccupations, and improving intimacy deficits, lack of empathy, social skills, and lack of social/emotional reciprocity. (J. Raven and S. Hepburn, "Cognitive and Behavioral Treatment of Obsessive-Compulsive Disorder in a Child With Asperger Syndrome: A Case Report," 7 *Autism: Intl. J. Res. & Practice* 145-64 (2003).)

### Mitigating Evidence for Downward Departure

When considering mitigating evidence in AD sex offender cases, legal actors should acknowledge that most individuals with PDDs do not commit criminal offenses. However, when considering mitigation at state or federal sentencing, it must be recognized that AD-related diagnostic symptoms—e.g., lack of social and emotional reciprocity, failure to develop peer relationships appropriate to developmental level, delays in language, persistent preoccupation with objects rather than people, narrow and restricted obsessive interests, executive functioning deficits, and comorbidity with a variety of psychiatric disorders—serve as risk factors to predispose an individual to abnormal behaviors, sometimes sexually maladaptive in nature.

In federal court, counsel may choose to present the aforementioned mitigating evidence with hope of a downward departure through U.S.C. § 3553 or through U.S.C. § 5K2.13 and the diminished capacity scheme. Specifically, diminished capacity can be argued as relevant to the defendant committing the offense(s) while suffering from a significantly reduced mental capacity such as a PDD; and the significantly reduced mental capacity contributed substantially to the commission of the offense. Similarly, if a departure is warranted under this policy, the extent of the departure should reflect the extent to which the reduced mental capacity contributed to the commission of the offense.

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