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Developing good practice in autism and harmful sexual behaviours (HSB)

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Abstract

This research aims to support the development of good practice guidance in relation to autistic children and adolescents with harmful sexual behaviours (HSB). The need for adapted guidance for this population had been identified by frontline practitioners in a range of agencies. The objectives of the research were to contribute to the limited research knowledge base; to understand what guidance the front line practitioners required and to develop, peer review and pilot practice guidance on autism and HSB to meet their needs.

An action research framework was used to include the practitioners in two phases of work. First phase, the development of theoretical concepts re autism and HSB, using the literature review, surveys and interviews and second phase an external review of draft practice guidance through peer review and specialist HSB teams who piloted the guidance in practice. Both the peer review and pilot processes included autistic professionals. Being part of the research has already had an impact on the HSB practice of those involved, with the practice guidance providing a starting point for further development in this emerging area of work.

The key findings from the research led to the creation of theoretical constructs on the similarities and differences when working with autistic children and adolescents with HSB, with regard to their family backgrounds; trauma/abuse experiences and the meaning, motivation and intent of their sexual behaviours and how HSB practice can be adapted to facilitate better communication and engagement in assessments and interventions. This is the first study reporting on autistic children and HSB and also to consider the challenges of working with undiagnosed individuals with possible autistic characteristics. It highlights what already works in HSB practice, as well as the need for more preventative, detailed sex and relationship education for autistic individuals. The research raises areas for further research particularly with regard to autism and recidivism in terms of the current HSB risk criteria with the potential for overestimation of risk.

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Chapter One – Introduction

1.1. Introduction

The title of this research is Developing Good Practice in Autism and Harmful Sexual Behaviours (HSB), as this is an emerging field of research and practice involving two very distinct and separate knowledge bases. This chapter lays out the background to why this research is needed, the purpose of the research and the key research questions. It also covers the terminology which will be used throughout this thesis and finally it provides a positionality statement as I have had a long career and am well known in the field of HSB, so I was mindful of the potential impact of this on the research, particularly as I was a sole researcher.

1.2. Background

The need for the development of good practice guidance in relation to autistic children and adolescents with HSB, was identified by front line practitioners in a range of agencies, such as social workers, youth offending officers, education staff, CAMHs [1]staff and specialist services for HSB. Many of these practitioners identified that they had growing numbers of autistic children and adolescents on their caseloads, including some without a diagnosis but with possible autistic characteristics. They expressed that they had little knowledge or understanding of autism in general and most did not have ongoing access to those with clinical experience in working with autism.

They had been unable to find guidance on how to assess the sexual behaviours of autistic children and adolescents and were concerned that their assessments may not be proportionate and either over or under identify potential risks for their client and other people. I was approached as the Director of The AIM Project (AIM) [2] to

[1] CAMHs – Child and adolescent mental health services
[2] The AIM Project (AIM) one of the leading UK and international charities in children and adolescents with HSB

ascertain whether or not the established sexual assessment frameworks for adolescents such as AIM3[3] (Leonard and Hackett, 2019) and for children the AIM Children Under 12 [4](Carson, 2019) were applicable for use with autistic individuals.

At that point, I also had limited knowledge and understanding of autism and for my own learning, as well as to provide practice guidance for others, I undertook a brief, initial review of the research and practice literature prior to this PhD to see if any practice guidance had already been written. It was clear that there were no validated sexual assessment frameworks for autistic children and adolescents, as well as significant gaps in the research and knowledge base. There were also no studies looking at this subject from a frontline practitioners' perspective as most studies were in specialist juvenile justice, clinical or residential settings. As they had identified the problem, the practitioners were also keen to be involved as a community of practice, seeking solutions and because of this, an action research methodology was used (Levin, 2012; Greenwood and Levin, 2007; Zuber-Skerritt and Fletcher, 2007;Somekh, 2006;).

1.3. Aim and Objectives of this Research

The **Aim** of this research was to contribute to the development of good practice in relation to Autism and HSB. The objectives of this research to achieve this aim were:

Objective 1: To contribute to the current academic research knowledge base which was limited in relation to autistic children and adolescents with harmful sexual behaviour (HSB);

Objective 2: To look at this practice issue from the perspective of community based front line practitioners to determine what guidance they require and what constitutes good practice;

[3] AIM3 – The AIM Project's adolescent sexual assessment framework
[4] AIM Children under 12 – The AIM Project's child sexual assessment framework

Objective 3: To develop, peer review and pilot practice guidance on Autism and HSB to address the immediate practice need identified by the community based front line practitioners.

1.4. Objective 1: Research Knowledge Gaps

In the brief initial literature review, there were several identified gaps in the research literature and this study, although small, aimed to contribute to the research knowledge base in relation to these. The gaps were particularly around the lack of sexual assessment models appropriate for autistic individuals and around understanding the rise in caseload numbers of autistic individuals or those with possible autistic characteristics. There were also gaps in the research knowledge around the backgrounds of autistic children and adolescents in terms of their family environment and any potential trauma, abuse or victimisation they may have experienced. There was nothing at all within the research literature on autistic children with HSB and I believe that this research is one of the first to address this population specifically.

Two other gaps in the research literature were around recidivism[5] and potential differences with the children and adolescents involved in online sexual abuse, known as technology-assisted harmful sexual behaviour – TA-HSB. With regard to recidivism, understanding this would require large scale, longitudinal studies but this study has contributed through the analysis of similarities between autistic traits and recidivism factors and sub-groups identified in the HSB literature and poses some questions for future research. With regard to TA-HSB, this study was able to provide information in terms of family backgrounds of the adolescents in this study, but it provided a contrasting picture to the wider professional understanding of why those engaged in TA-HSB are a distinctly different sub-group of HSB.

[5] Recidivism – the tendency of a convicted criminal to re-offend

1.5. Objective 2: Community Based Practitioner Perspective

1.5.1. Diagnosed and possible autistic characteristics

The focus of this aspect of the objective was to get information about the practitioners' caseloads, particularly around the issue that they had identified of having increasing numbers of referrals of children and adolescents with an autism diagnosis and that they were holding almost as many cases where there were possible autistic characteristics but no diagnosis. The lack of a diagnosis was significant as it made it harder for them to be able to get appropriate support and resources for their client.

Conversely, they were also concerned about potential over-identification of autism due to an increase in autism awareness, when there were other potential causes for the behaviours displayed, such as trauma, attachment or speech and language difficulties. This perception of increasing referrals and high caseload numbers of both diagnosed and possible cases is not addressed in the academic research literature so I believe this is the first study to have this as a focus.

1.5.2. Comparable caseload information

The focus of this part was to look in more detail about the children and young people the practitioners had on their caseloads, particularly re their ages, gender identity, family backgrounds, potential own trauma, abuse or victimisation and then the types of sexual behaviours they themselves were displaying. This case data was then compared with the usual case profiles in HSB practice to consider similarities and differences.

1.5.3 Challenges and what works

In the absence of guidance, the practitioners were still having to work with these children and adolescents, so the focus of this part was to learn from the practitioners about the challenges they faced and what guidance they felt they needed, as well as

what they had found worked, so that good practice could be shared to both affirm and develop future practice.

1.6 Objective 3: To develop, peer review and pilot Practice Guidance

This research as well as contributing to the wider knowledge base also needed to address an immediate problem for the practitioners – what constitutes good practice in assessments and interventions with autistic children and adolescents? The aim was to develop practice guidance which would then be peer reviewed and piloted to check if the theoretical constructs and information provided in the Guidance would support more informed and proportionate decision making by increasing practitioners' confidence and competence in this area of work.

It was envisaged that this could then be a starting point for the development of good practice.

1.7. Research Questions

The research questions which relate to these objectives are:

a) How many children and adolescents with diagnosed or possible autistic characteristics were on practitioners' caseloads?

b) What was the age, gender identity and type of sexual behaviour of those children and adolescents?

c) What was their family environment like and have they experienced any trauma, abuse or victimisation in their lives?

d) What are the similarities and differences between autistic and non-autistic children and adolescents?

e) What did practitioners find were the most challenging aspects of working with autistic children and adolescents with HSB and what works in terms of assessments and interventions?

f) Do the theoretical constructs and the content included in the Practice Guidance reflect the research participants' and the autistic community's views and experience and does the Practice Guidance support practitioners in developing more informed and proportionate assessments and interventions for autistic children and adolescents?

1.8. Terminology

1.8.1 Harmful Sexual Behaviour (HSB) / Sexual Offences

What constitutes a sexual offence is determined by law and can change according to prevailing social constructs and dominant views on sexuality (Bumiller, 2008; Foucault, 1978). Sexual offences range from lower level offences, such as exposure of genitals in a public place to more serious offences such as rape and sexual assault. Not all individuals who commit a sexual offence are prosecuted, but they may still pose a risk to the wider community.

With regard to HSB, Hackett's (2010) continuum is the mostly frequently used guide to defining different sexual behaviours on a continuum of increasing concern. The continuum covers behaviours from normal and inappropriate which require little or no intervention from practitioners, through to problematic, where there are some concerns but potential to change with some direct interventions and then finally abusive and violent, which include sexual offences of rape and sexual assault, with additional risk factors such as the misuse of power, the use of violence etc.

The law is black and white about what constitutes a sexual offence, however, HSB work is focused on more contextual factors, so while sexual offences of rape and sexual assault would be within the abusive/violent parts of Hackett's continuum, other sexual offences such as exposure of genitals in a public place may be

considered to be more in the inappropriate or problematic part of the continuum, dependent on the individual's ability to understand their sexual behaviours and the social, moral and legal rules.

HSB is defined as those behaviours primarily in the problematic, abusive or violent parts of the continuum, which have the potential to be harmful to the individual themselves or to others and all require an intervention (Hackett, 2014). The term is also used to define empirical risk factors derived from research and practice:

a) Causal factors for their behaviour, such as their own trauma;
b) Behavioural traits, such as intent to cause harm or deficits in remorse or empathy;
c) Factors that indicate a higher risk of recidivism, such as attitudes, values and beliefs supportive of the abusive behaviour or a lack of evidence to show that the young person is motivated or able to change their behaviour (Quadara et al., 2020).

1.8.2. Neurodiversity

Identity

I acknowledge the debate within the autistic community about person first or autism first language in relation to their identity. Some prefer the term an autistic person, stressing that autism is central to their identity and how others view them (Kenny et al., 2016), while others prefer the term a person with autism, more similar to the disability rights arguments of being seen as an individual first (Fletcher-Watson and Happé, 2019; Autistic Self-Advocacy Network, 2011).

For the purposes of this thesis, to make things more accessible for the reader, I have chosen to use only one term rather than both and having discussed it with the study participants, I have chosen the term an autistic person, in acknowledgement of the preferred term used by the autistic adults who worked with me on this research.

Non-autistic

In this thesis the term non-autistic is used when differentiating between autistic children and adolescents and their non-autistic peers. It is used rather than ‘neurotypical’, which implies that autism is the difference. There are no ‘neurotypical’ individuals, rather there are many different neurodiverse ways of thinking and being. Both those who are and who are not autistic may also be neurodiverse in other ways (Hughes, 2022; Fletcher-Watson and Happé, 2019).

Co-existing rather than co-morbid

I have adopted the language of co-existing conditions rather than co-morbidity, (Bouzy et al., 2023) partly to make the language more accessible to the wider range of front line practitioners engaged with this research, who were confused with the medical terminology, but primarily to reflect a change in emphasis in autistic practice moving away from medicalised deficit models towards expressing autism as a difference, with acknowledgement that while autistic traits can be challenging for the individual, many difficulties they experience are also related to environmental issues and how professionals choose to engage with them.

1.9. Positionality Statement

The need for this research was initially identified to me because of my role as the Director of The AIM Project (AIM), one of the leading national and international charities in the field of children and adolescents with HSB, which provides resources, training and consultancy and has a key role in developing guidance on emerging areas of HSB practice. I have been working in the field of HSB for over 30 years, initially concurrently with my professional career in social work and safeguarding children which began in 1985 and during which I have held various different roles including social worker, manager, education advisor, specialist in complex assessments, to my final post in a senior management role as the Head of Safeguarding Children in a large English local authority.

In terms of my HSB career, I have been involved in training, consultancy and practice development and have written chapters and articles in professional publications and a book for children ‘Johnny and the Sparkles in his Pants’ (Carson, 2021), as well as several of the AIM publications - AIM Children Under 12 Model, 3rd edition (Carson, 2019); Guidance for Education Staff now in its 4th edition (Carson and Aujla, 2021).

My interest in HSB practice began in the 1990s when the acceptance that adolescents could cause sexual harm (Delap, 2015; Hackett, 2014; NCH, 1992) led to a rise in the numbers of adolescents with HSB on practitioners’ caseloads. These cases were invariably considered ‘complex’ and to many practitioners ‘unworkable’ due to the limited research knowledge base on HSB and a lack of professional confidence at that time. I was intrigued by them and worked with colleagues to help to deconstruct the ‘complexity’ by understanding how they were similar and different to our usual social work practice; what familiar skills, tools and resources could we use and what would we have to create or adapt?

In addition, collating information in one place from research and practice about causal and specific risk factors, also helped to demystify HSB and increase awareness and confidence that achieving positive outcomes and healthy developmental pathways for these adolescents was achievable. It was like when the curtain in the Wizard of Oz (Baum, 1900) was pulled back and the mechanisms of HSB were understood and practitioners were given a language to talk about it and understand it, the fear of the unknown receded and practitioner confidence and competence grew.

In the late 1990s, I began the process over again, this time looking at children, as there were now rising numbers of children being referred to statutory services with concerns about their sexual behaviour. This was at a time when there was also a strong societal belief about children being asexual and ‘innocent’, lacking sexual intent and therefore could not possibly have problematic or harmful sexual behaviours. Children’s behaviours were often minimised or if extreme the child was often demonised. Again trying to develop good practice in relation to children was

considered to be too complex: it would create ethical issues; it could damage a child by talking to them about sexual behaviour; there was resistance from some parents and professionals; children acting sexually usually raised child protection issues about the family.

Since these children were on practitioner caseloads, the practitioners were asking for guidance on how they should understand and manage them. Should they simply apply their knowledge from adolescents or did they have to change their practice? How could they talk to children about sexual matters? How much did children understand? To meet that practice need, I undertook some practitioner research (Carson, 1996) and wrote the first edition Children and HSB Practice Guidance, which has now been shaped and informed over the years by ongoing dialogue, feedback from practitioners and the developing research and practice knowledge base. It is now the AIM Children under 12 Model, 3rd edition (Carson, 2019) and is used by practitioners in a wide range of agencies nationally and internationally. My work and the work of others has now led to working with children being an established part of HSB practice.

The rise of numbers of autistic children and adolescents or those with possible autistic characteristics on practitioner caseloads is raising the same concern about complexity making it too difficult to create guidance and frameworks for practice. The complexity this time is in relation to some practitioners feeling deskilled as they have limited knowledge about autism; each individual's experience of being autistic is different; some have co-existing conditions; concepts of their sexual innocence and lack of sexual intent; can you apply knowledge from research and practice with non-autistic adolescents or do you have to change practice? Given my experience of deconstructing 'complexity' by collating the current knowledge base and analysing the similarities and differences to usual practice, this research was my contribution to the development of good practice in relation to Autism and HSB.

1.10. Thesis Structure

Chapter One: Introduction. This chapter has provided an introduction to the background to this research; its aim and objectives; the terminology used throughout the study and the structure of the thesis, which is somewhat unusual in that the methodology chapter comes before the literature review. This is due to using an action research framework as the most effective way of engaging with the front line practitioners in a community of practice, to do the research and develop the Practice Guidance (Greenwood and Levin 2007; Zuber-Skerritt and Fletcher 2007). Action Research has iterative, hermeneutic cycles of reflection and action (Dick, 2000) and the literature review was the first cycle in this process. Therefore putting the methodology chapter before the literature review chapter is to enable the cycles of work to flow logically in sequence from Cycle 1 to Cycle 4.

Chapter Two: Methodology outlines the benefits and limitations of choosing an action research framework. It provides an overview of the two phases of work and cycles of reflection and action, with Phase One focused on development of theoretical concepts and the draft Practice Guidance. Phase Two focuses on external review of the draft Practice Guidance through peer review and piloting to check if the theoretical concepts and content, supported practitioners in developing more informed and proportionate assessments and interventions for autistic children and adolescents.

Chapters Three and Four: Literature Review. These chapters cover the information gathered in Phase One Development, Cycle 1 Literature Review. The literature review is split over two chapters to separate out the information from two huge research knowledge bases (understanding autism and understanding HSB) from the smaller research base combining both subjects (autism and HSB). It was important when developing the theoretical constructs about similarities and differences to have an in depth understanding of both autism and of HSB separately, as well as the limited research on autism and HSB.

Chapter Five: Findings from the surveys and interviews. This chapter covers the information gathered in Phase One – Development, Cycle 2, from the surveys and interviews on the practitioners' views and experiences of working with autistic children and adolescents. This information was then combined with the literature review to generate the theoretical constructs re autism and HSB; to raise some important questions for HSB practice and to create the draft Practice Guidance.

Chapter Six: External Review. This chapter focuses on Phase Two of the work which was to review the Practice Guidance through peer review (Cycle 4) and piloting it in practice (Cycle 5). These processes led to further refinements of the Guidance.

Chapter Seven: Discussion Chapter - this chapter discusses the findings from both phases of the work in relation to the aim and objectives of the research, in order to determine the learning for HSB practice and whether or not the Practice Guidance supported the development of good practice in relation to autism and HSB.

Chapter Eight: Conclusion – this chapter reflects on this as an emerging area of practice and how the research has attempted to increase the confidence and competence of practitioners working with autistic children and adolescents, in order for them to engage in informed and proportionate assessments and interventions. It looks at the new information provided on autistic children and it raises challenges for current HSB practice in terms of the knowledge base and issues around recidivism.

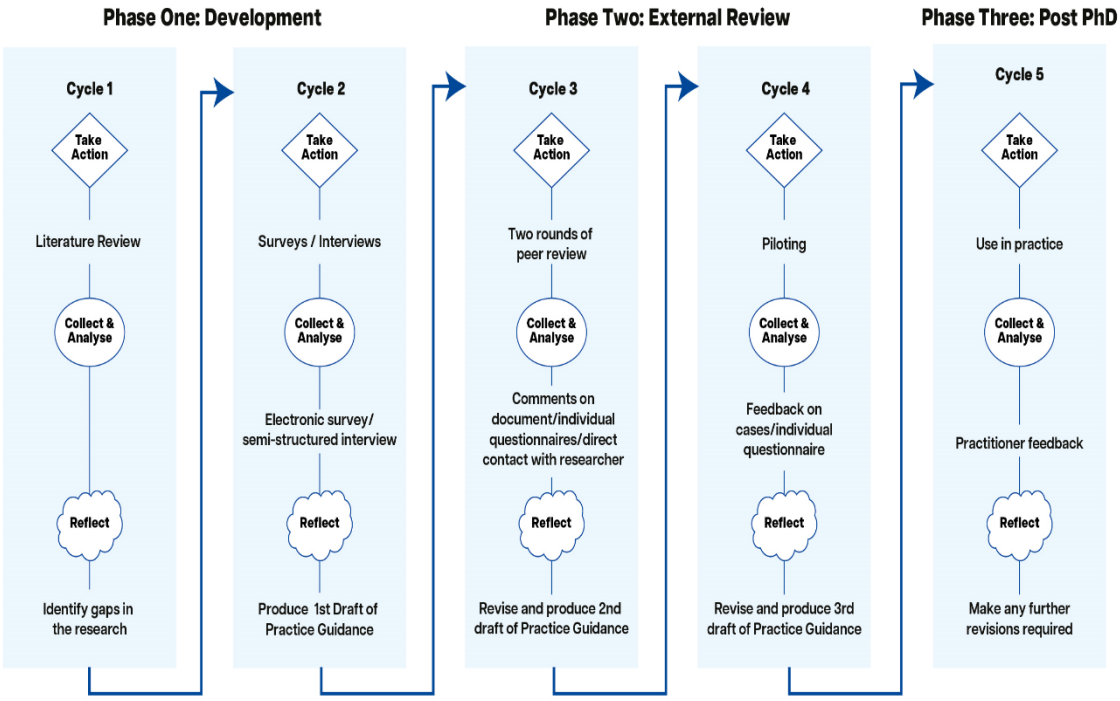
Chapter Two - Methodology

2.1. Introduction

This chapter looks at the methodology and the use of an action research framework for this research. It provides the rationale for my choice of ontology, epistemology and methodology and the benefits and possible limitations of that choice. It includes the structure of the research, through hermeneutic cycles of reflection and action; how the data was collected and analysed to ensure academic rigour and the creation of Practice Guidance which was then peer reviewed and piloted. It concludes with changes to the original proposal and how ethical issues were managed.

This research had two phases of work: Phase One – Development and Phase Two – External review, in a hermeneutic spiral of five cycles of reflection and action (Dick, 2000) *(see Figure 1)*, with a third Phase to take place after this PhD.

Figure 1: Phases and cycles of the research



To increase the academic rigour, trust worthiness and authenticity of this research (Morse, 2015; Lincoln and Guba, 1985; Guba and Lincoln 1981), multiple data collection methods were used throughout the phases of work, such as surveys and interviews, peer review and pilot processes. Each involved a different practitioner group to address potential researcher bias and to gain different perspectives on the theoretical constructs and efficacy of the Practice Guidance.

2.2. Pragmatic paradigm, ontology and epistemology

This research uses the pragmatic paradigm and an action research framework. A key principle of pragmatism is to use whatever method suits best to attain the desired outcome for research and practice and as such it embraces both positivism and constructivism as equal ways in which to conceive of reality and to conduct inquiry ‘as a form of social action, rather than as abstract philosophical systems’ (Morgan, 2014, p1049; Guba and Lincoln, 2005). This allows the social actors to define and pursue issues that have meaning for them. Morgan (2014) also highlights how pragmatism acknowledges the real world in which people live is often complex and messy emotionally and socially and if research is to have value, it has to be relevant to the real world.

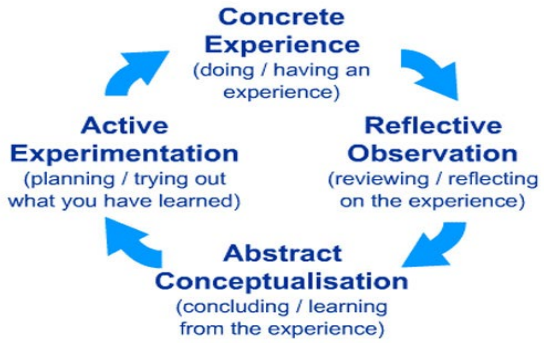
The use of pragmatism as a paradigm in social research methodology is increasing (Coghlan, Coughlan and Shani 2019; Zuber-Skerritt and Fletcher 2017; Patel, 2015; Greenwood and Levin 2007; Dick, 2000), partly because it suits the use of a mixed methodology approach and its focus on practice issues. The need to focus on practice is also echoed in the greater expectation on academics to ensure value for public money funded research by testing its impact in practice, beyond academia (20/21 Research Excellence Framework (Part 3, Section 3, Para 297).

2.3 Action Research Framework

An action research framework was chosen primarily because of its hermeneutic spiral of cycles of reflection and action (Dick, 2000), which strive to keep improving understanding and practice by applying up to date theories and research to practice

knowledge to generate newer, more nuanced understandings. These then in turn support further research and practice development (Zuber Skerrit and Fletcher, 2007; Dick, 2000). It also resonated with other familiar reflective models which I have previously used in my social work practice, such as Kolb's experiential learning cycle (1984).

Figure 2: Kolb's experiential learning cycle



A core function of this research was to find a solution to a practice problem, through the creation and piloting of draft Practice Guidance on good practice in autism and HSB. The practitioners who had identified the problem also wanted to be part of the solution, forming along with myself as the researcher, a collaborative 'community of practice'. This allowed both the process of generating theory along with the capability of testing it out to reconstruct and transform practice and as such a research framework which had responsivity and flexibility at its core was needed (Fern, 2010; Greenwood and Levin, 2007; Zuber-Skerritt and Fletcher, 2007; Somekh, 2006; Dick, 2000).

The action research methodology also enabled me to provide a practical solution to the identified problem along with providing an original contribution to the research knowledge base. This was achieved by examining the subject of autism and HSB through the knowledge and experience of community based frontline social work, youth justice, education and specialist HSB practitioners, as the majority of the research in the literature review had focused on clinical and criminal justice specialist populations. These frontline staff were already sharing their practice experiences

anecdotally with me thus using an action research methodology facilitated making this ‘tacit knowledge explicit’ (Somekh, 2006). Working with the frontline practitioners and discussing their case examples helped to gather information on the identified gaps in research such as autistic children, family backgrounds, trauma, autism and recidivism, TA-HSB specific cases etc. (Greenwood and Levin, 2007).

The flexibility of the action research framework also allowed for a mixed methodology approach. Although some would argue that quantitative and qualitative research paradigms are fundamentally different, this does not mean that they cannot be combined to complement each other’s strengths. In fact, mixed method research studies are common (Quinn Patton, 2015) and it can be argued that, together, they add an additional depth and perspective, particularly in areas where the knowledge base is in an emergent stage and therefore limited (Morgan, 2014; Cresswell and Plano Clark, 2007). Although this is primarily a qualitative study, the survey was an embedded design to gather some quantitative data to provide a basis for the generation of theoretical constructs in relation to autism and HSB.

A further attraction of the action research framework was the concept of the three levels of inquiry which reflected the three elements within the research - my own learning and development regarding autism; the collaborative nature of the research with the front line practitioners and the need to create something which added new theoretical constructs and developed practice (Reason and Bradbury, 2001).

First person Inquiry

The two main aspects of first person inquiry were my own ‘learning-in-action’ journey and also how I demonstrated my understanding of the need to manage my closeness to the information and the professional network, given my extensive HSB experience (Coughlan, Coughlan and Shani, 2019). One of the main drivers for this research was to develop my own understanding of autism, and then to reflect on the similarities and differences with the non-autistic child and adolescent HSB populations. The phases of work and cycles of dialectic and hermeneutic reflection (Goulet, Jacques and Pigeon, 2009; Dick, 2000), allowed me to pause and reflect at

each stage of the process sometimes returning to earlier cycles to deepen my understanding of this subject. This process not only increased my understanding of autism and HSB but led to me questioning some of the previous theory and knowledge base on HSB itself.

I held both an insider and outsider position within the research in two ways: firstly that I was an expert in HSB but a complete novice regarding autism and secondly the duality of positions was necessary for the different stages of the study to have credibility (Holmes, 2020). Initially my insider position of being grounded in the HSB knowledge base enabled me to generate the theoretical constructs around the similarities and differences in relation to autistic and non-autistic children and adolescents and HSB. Then, to ensure the trustworthiness and authenticity of the research (Lincoln and Guba, 1985; Guba and Lincoln, 1981) and to balance out any potential researcher bias, I changed to an outsider position through the use of a multiple-method strategy with three different sets of practitioners and three stages of field work - the survey and interview group; the peer review group and the pilot group, to triangulate different perspectives and views in order, to challenge my interpretations and theoretical constructs (Morse, 2015).

Second Person Inquiry

This aspect focuses on the need for a ‘collaborative inquiry’ (Coughlan, Coughlan and Shani, 2019; Fern, 2010) and this research involved working with practitioners in a ‘community of practice’ with me as the researcher, to combine current knowledge and practice with the findings from this study, to contribute to the development of good practice in autism and HSB. This is different to the concept of the distant, external, neutral/objective role of the academic researcher as the ‘expert’, doing to, or for practitioners or societal groups (Greenwood and Levin 2007; Zuber-Skerritt and Fletcher 2007).

Having a dual role of being both an experienced practitioner in the field of HSB as well as undertaking academic research of the subject, sometimes referred to as being a ‘pracademic’ (Posner, 2009) has both positives and challenges for the

research, the positives were being able to bridge both worlds to facilitate the transfer of learning from one to the other and being able to tailor written work to either audience, for example, in writing both this thesis and also the Practice Guidance for the practitioners. The challenges for the research were of competing demands for time; the need to be able to switch flexibly between both mind sets and practice disciplines and the potential danger of finding what I expected to find, based on pre-conceived ideas, due to subject expertise (Morse, 2015).

Third person inquiry

Third person inquiry aims to show how the previous work has meaning for a wider audience than those who were involved with the research; it has an explicit aim to develop theory as well as practice (Coughlan, Coughlan and Shani, 2019). The Practice Guidance created as part of this research was peer reviewed and piloted, with the practitioners and autistic peer reviewers confirming that the information and theoretical constructs reflected their views and experiences and that it supported more informed and proportionate decision making by increasing practitioners' confidence and competence in this area of work. The pilot process showed that it could be used by different professionals from different agencies, even in different countries, to achieve similar professional decision making.

2.4. Methodology – Structure, Process and Data Collection

This research had two phases of work: Phase One – Development and Phase Two – External Review. In Phase One: Cycle 1, information was gathered through a critical narrative review of what was already known about autism and HSB and autism/HSB combined. In Phase One: Cycle 2 surveys and interviews were used to gather the views and experiences of HSB practitioners who were working with autistic children and adolescents. The information from both cycles was then combined with my own knowledge and experience in HSB to generate theoretical concepts about good practice in autism and HSB. In Phase Two: External Review, Cycle 3: Peer Review and Cycle 4: Pilot Process involved two different groups of practitioners to triangulate

the data from different perspectives and to evaluate the credibility, trustworthiness and authenticity of the research.

This section outlines the structure, process and data collection methods in this complex study as autism and HSB are different professional disciplines and the research had to support the practitioners in developing an understanding of each other's knowledge base, in order for them to have an informed context in which evaluate the credibility of the theoretical constructs and content provided.

2.5 Phase One: Cycle 1 – Literature Review

Prior to the decision to undertake this research, I had carried out a brief initial review of the research and practice literature to determine if good practice guidance was already available. I could not find any guidance but had identified some key gaps in the research knowledge base about autistic children and HSB; a lack of profile information of family backgrounds, trauma and abuse histories etc. that are used in HSB assessments; autism and recidivism and autism and TA-HSB. Also, there were no studies on the perspectives of community based frontline practitioners of the challenges they experienced, particularly around working with children and adolescents without a diagnosis but with possible autistic traits; what they perceived to be the gaps in knowledge and what have they found has worked, therefore the need for this research was generated from that initial review.

The focus in Cycle 1 was to undertake a critical narrative review of the literature in relation to the three research silos of autism, HSB and HSB/autism combined using a wide range of academic databases as well as other sources including grey literature (*See Appendix One for data sources and search terms used*). The use of grey literature was important for this study due to this being an emerging practice issue with the practice knowledge being ahead of the academic research base.

The purpose of the critical narrative review was to analysis and synthesise the current research and practice information to compare and contrast the knowledge from each of the silos, in order to develop new theoretical constructs of the

similarities and differences between autistic and non-autistic children and adolescents with regard to HSB (Sukhera, 2022; Greenhalgh, Thorne and Malterud, 2018; Grant and Booth, 2009).

The main search themes involved several different combinations within search strings (*see Appendix One*), then following up citations in key articles/books identified. The intention was to identify firstly the broad knowledge base around HSB, relevant comparable information from the broad autism knowledge base and then specifically what was written in relation to autism/HSB combined. I also undertook specific searches with regard to the key gaps identified by the initial review, around autistic children; diagnosed and possible autistic traits; autism and recidivism and autism and TA-HSB.

In relation to these gaps, no matter what combination I used, I could only find one study which focused on autistic children and analysed the causes and types of their behaviour (Fourie, Kotzé and Van der Westhuizen, 2017). There were several studies which talked about children but were meaning adolescents. There was also limited information on diagnosed and possible cases; autism and recidivism and autism and TA-HSB. To ensure that I had not missed any relevant literature, I asked the Queen's University Librarian to check my search terms and to make suggestions for additional search terms, but she found nothing in addition to the articles I had already identified.

In an interpretivist study there are arguments both for and against beginning the research with the literature review first. The argument against doing it first is that it can begin to shape the researcher's thinking and may influence what they then analyse from the practitioner surveys and interviews, the idea being that the learning should be inductive from the practitioners' views first and then the literature review should be used to confirm or challenge these views (Scotland, 2012; Costello, 2003). The converse argument is that there is merit in understanding what is already known about the chosen subject, to identify gaps in the research knowledge and how others have treated the problem, before developing a focus for the research (Greenwood and Levin, 2007; Dick, 2000).

As one of the drivers for the research was to support my own learning about autism it was essential that I had developed my own understanding before the interviews, as I needed to be able to identify the nuances of what might be different from their usual HSB practice. Starting with an in-depth critical narrative literature review was appropriate to enable me to develop my own conceptual framework of autism and HSB, which I then used to compare and contrast with the inductive analysis of the practitioners' views and the case data from the surveys and interviews. This then helped me to develop theoretical constructs around the potential similarities and differences with non-autistic HSB practice.

The benefit of the action research framework meant that although the main part of the literature review was undertaken at the beginning, my learning continued throughout the research, requiring me to revisit it several times as new practice themes emerged from the dialectical reflection with the practitioners during the interviews, peer review and pilot processes (Dick, 2000).

An example of this was in relation to executive functioning and alexithymia *(see Appendix Three for details)* which were not mentioned by the HSB practitioners in the survey and interview processes but were raised by two of the autistic peer reviewers. Even with my extensive HSB experience, I had never heard of these terms, yet they were common concepts in autism practice, although they are not specific to autism. By taking time to learn about them, it increased my understanding of autism and the potential relevance of these factors to why autistic individuals may have harmful sexual behaviours.

It also helped me realise the value this knowledge had to broader HSB practice, as many of the children, adolescents and families involved with HSB practitioners may also have these conditions, which if present would have significance for both assessments and interventions. The Practice Guidance was revised to include these concepts and participants in the pilot process noted that having this information had been beneficial for their HSB practice generally.

2.6 Phase One: Cycle 2 – Surveys and Interviews

2.6.1 Surveys

Sampling Frame and Recruitment

The sampling frame for the surveys and interviews was targeted at a niche and not easily identifiable group of practitioners, i.e., those who would have considerable experience in HSB practice and were also working with autistic children or adolescents. The importance of this was that they would be able to articulate what differences in practice they had found, if any, in working with both populations. This is a niche professional population as autism and HSB are two different professional disciplines with no current shared knowledge or practice base. One of the unique elements of this research was that it focused on community based frontline practitioners so I wanted a range of agencies and different geographical areas, to be able to compare their perspectives and caseloads with the primarily single setting environments in the literature review.

Although this was a small study with a niche group of participants, I wanted those involved in this part of the study to be self-selecting rather than imposing a sampling selection that would be too closely related to my professional network. Two sampling methods were used - responding to requests from practitioners wanting to be involved in the research and by snowball sampling. I acknowledge that it is unusual for practitioners to request to be involved in research, but it illustrates how important the need for practice guidance was to frontline practitioners, that they not only identified the problem but were also keen to be part of the solution. These 'early identifiers' [6]formed the basis of the self-selected sample. To reach other professionals in this niche area of work, snowball sampling was also employed, with early identifiers being asked to share the survey with colleagues whom they felt might be interested (Quinn Patton, 2015; Tracy, 2013).

[6] Early identifiers – this was the terminology that I used for the practitioners who had approached me prior to the research about the need for good practice guidance and/or who in early stages of discussing the possibility of research and development of the guidance were keen to be involved.

There were approximately 40 people in the initial group of potential participants including early identifiers and those from the snowball sampling process. Due to delays related to personal circumstances at the onset of fieldwork for this study, some of the 40 people who had expressed an initial interest did not respond to the first email with the survey and the information sheets, therefore two subsequent follow up emails were sent. It became clear that a substantial number of people had become unable to be involved due to pressures of work or had become uncontactable through change of job, retirement or maternity leave. The survey was left open until the data analysis commenced as there was no time sensitive information and interest from the snowball sample had come in intermittently.

This resulted in 22 people completing the survey questionnaire, 15 of whom were 'early identifiers' and seven were identified via snowball sampling; there were 13 females, eight males and two where the gender was not known. The respondents were from a range of professional backgrounds including specialist HSB services, education, youth justice, children social care, forensic CAMHs, CAMHs. They came from different geographical locations across UK and Ireland.

Electronic survey questionnaire[7]

An electronic survey questionnaire was created using Jotform, an online form builder platform. It was envisaged that it would take approximately two to three hours to complete due to the need to retrieve case data. The respondents could remain anonymous if they chose to do so and there were no incentives given, to evidence that they were not under pressure to complete the questionnaire.

[7] *See Appendix Five for the survey questionnaire*

2.6.2 Interviews

Sampling Frame

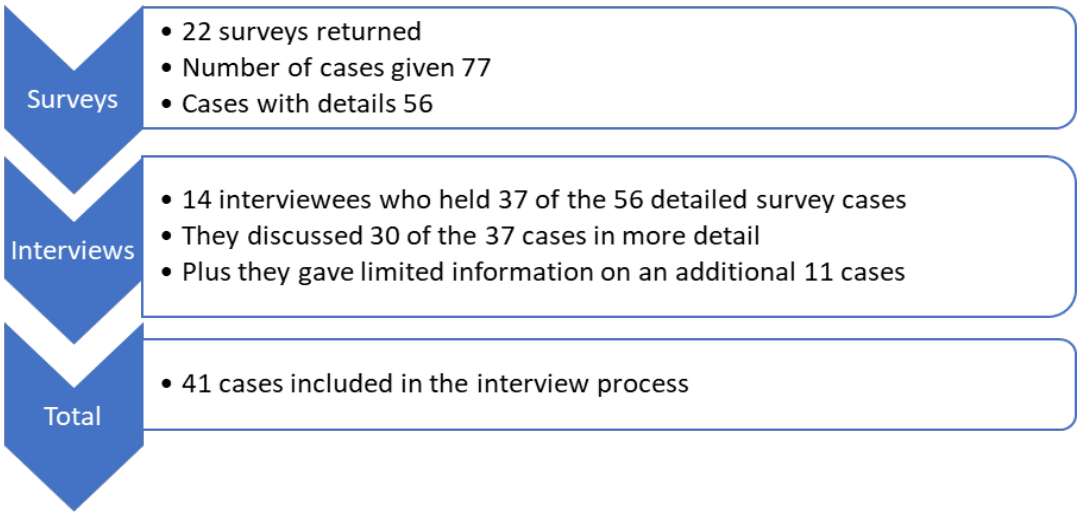
The survey respondents were able to self-select if they wished to take part in a semi-structured interview, by ticking a box on the survey questionnaire and providing their contact details. This was to evidence that the practitioners were not under any pressure or influence from me regarding their engagement with the research.

Of the 22 survey respondents, some chose not to be interviewed; some were unable to be interviewed due to their organisations' data protection policies and some had to drop out due to pressures of work, leaving 14 interviewees, two of whom were from the same organisation, so were interviewed together. This meant that the interviewees were all from a group of very experienced practitioners in the survey process and came from a range of agencies. All the interviewees received a second copy of the interview information sheet and were again asked to check with their organisation for any further approvals needed to discuss their cases in more detail. Due to data protection issues, while some organisations approved their member of staff to take part in the interviews, they could not talk in detail about cases but instead talked about themes from practice.

Cases discussed in the interview

The survey respondents had given information on a total of 77 cases, 21 of which where the information was so limited due to some agencies' data protection requirements, so were not included, leaving a cohort of 56 cases with details. The 14 interviewees had provided details on 37 of the 56 detailed cases from the surveys. In their interviews they talked in more depth about 30 of those 37 cases and added information on a further additional 11 cases, albeit some of this was brief, meaning a total of 41 cases were explored in the interview process.

Figure 3: Cases discussed in the interviews



Interview Process

Due to both the geographical distance between myself and the interviewees and Covid restrictions at that time, the interviews were carried out either by telephone or video calls. Each interview took approximately one hour with the shortest being 40 minutes and the longest 1 hour 20 minutes. All of them were audio recorded with the consent of the interviewee and I also took contemporaneous notes. The interviews were transcribed and anonymised with each interview being identified only by a number. Once transcribed I used the MaxQDA system for coding into themes and sub-themes by collating sections of transcripts into folders which allowed me to review the data quickly in each phase of the coding.

Semi-structured interview schedule [8]

I chose to use a semi-structured interview schedule because one of my research objectives was to listen to the practitioners' perspective and experience on autism and HSB, the challenges it posed for them and what they had found worked. Therefore, I needed a flexible structure to be able to respond to information emerging from the practitioners about areas that had not been covered in the literature review and to explore several areas where I wanted to get a fuller

[8] (*See Appendix Six for a copy of the semi-structured interview schedule*)

understanding to ‘develop a thick description’ of the subject (Linneberg and Korsgaard, 2019; Nowell et al., 2017; McNiff and Whitehead, 2012; Thomas, 2006). An unstructured interview may have provided more flexibility and spontaneity in the interviewees’ responses but may not have addressed some of the issues I had already identified that I wished to know more about, and it could have made identifying similarities and differences with the non-autistic population more difficult (Morse, 2015; Quinn Paton, 2015; Robson, 2002).

Using a semi-structured interview schedule gave the practitioners the flexibility to tell their stories of what they had been experiencing in practice, the challenges and the solutions they had already found and what they needed from the Practice Guidance. This process of ‘story telling’ (Paranjpey, 2017) enhanced their engagement with the research and mitigated any unintentional impact from me as a researcher (Davydd, Greenwood and Levin, 2007).

Once the interviews had been transcribed, to ensure that I was not leading the interviewees when exploring the additional areas I wanted to know more about, I took a sample of one of the interviews where I was unsure if my questioning at that point could have been considered leading and asked one of the peer review group to read that segment. They responded that it was clear what I wanted to know about but that the interviewee was able to give their own perspective and had elaborated on this without further prompting from me.

2.6.3. Coding and Data Analysis

An inductive analysis process (Scotland, 2012; Zuber-Skerritt and Fletcher, 2007; Reason and Bradbury 2001) used the information from the surveys and interviews to compare this with the information from the critical narrative literature review and my prior knowledge and experience with regard to HSB, to begin to develop themes about the similarities and differences between autistic and non-autistic children and adolescents with regard to HSB, to develop new theoretical constructs around autism and HSB for the Practice Guidance and also to contribute to the research

knowledge base of all three silos. The Practice Guidance was then externally reviewed through the hermeneutic cycles of peer review and piloting (Dick, 2000). The first stage of the coding process was to give descriptive attribute codes to segments of the interviews initially under the broad headings of the research questions and the interviewees' professional experience. As the analysis of the interviews progressed more sub-codes were created and in some cases sub-sub codes (Gioia, Corley and Hamilton, 2013).

The second stage of the coding process took the large number of codes and sub-codes which had been generated and began to define the themes emerging (Linneberg and Korsgaard, 2019). This meant some codes being merged, particularly where information was duplicated and identifying some minor themes that were not replicated throughout the other interviews but related to a practice issue which needed to be raised, such as links with radicalisation online re terror offences and also about a growing and disproportionate number of autistic adolescents ending up in forensic psychology services and the secure estate. [9]

The third stage of the coding process was to further fine tune the themes and emerging theoretical perspectives about autism and HSB, for example moving similarities and differences between autistic and non-autistic children and adolescents from being a separate theme to integrating it into the other headings and subheadings (Nowell et al., 2017; DeSantis and Ugarriza, 2000). The final 4th stage of coding linked the research questions to the themes and provided the framework for the development of the Practice Guidance.

2.7. Phase Two – External review

Phase Two - External review incorporates Cycle Three – the Peer Review and Cycle Four - the Pilot process, as data triangulation methods (Spoto et al., 2023; Noble and Heale, 2019; Carter et al., 2014) used to increase the auditability and confirmability

[9] The secure estate – secure establishments were juveniles are held either because of the severity of their offending behaviours and a high level of risk to other people, or because of high levels of concern for their own welfare and the need to protect them, usually during mental health crises.

of the research (Guba and Lincoln, 1981). These helped to mitigate the risk of researcher bias given that I was a solo researcher, doing all the coding and analysis and the Practice Guidance was my interpretation of the theoretical constructs around autism and HSB.

In Cycle Three, the peer review process, a draft of the Practice Guidance was given to the peer review group, who were a different set of practitioners from those who had participated in the survey and interviews. This was to see if my interpretations of the data and the theoretical constructs had validity and confirmability or if there were weaknesses or omissions. It was also to see if it resonated with their experience of this field of practice (Koch, 1994) and whether they felt that it would support further development of their practice.

In Cycle Four, after two rounds of peer review and revisions of the Practice Guidance, the pilot process then tested it out in terms of actual applicability to practice with yet another different set of practitioners. Again, this was to test if the Practice Guidance resonated or was dissonant with their practice experience and if they felt there were any weaknesses or omissions (Dick, 2000). It was also checking if they felt the Practice Guidance supported the development of good practice and was transferable, in that it could be used by different practitioners outside of the research.

In light of the feedback from the pilot process the Practice Guidance was fine-tuned and further amendments were made. The fifth Cycle of this process is outside of the PhD timeframe and will involve a range of practitioners using the Practice Guidance over a longer period of time, with a view to further establishing the trustworthiness and authenticity of this research and the confirmability, dependability and transferability of the Practice Guidance itself (McNiff and Whitehead, 2012).

2.7.1 Phase Two: Cycle Three - Peer Review Process

Selection of participants

It was a conscious decision in the design of the research that none of the peer review participants would have been directly involved in the survey and interview processes (Flick, 2018). This was important to ensure that the Practice Guidance was reviewed by professionals with a fresh perspective and provided evidence of the trustworthiness of the research in terms of confirmability, dependability and transferability. (Noble and Heale, 2019; Morse, 2015).

There were eight participants in the peer review group; half of whom had extensive experience of HSB, either through academic research or practice in a range of settings including youth offending, psychology and independent practice. The other half of the group had either lived experience of being autistic or extensive experience of working with the autistic community. They included:

- Professor and leading academic in HSB;
- Assistant Director of Youth Offending Services;
- Senior Psychologist with experience in HSB and autism;
- Leading independent HSB expert;
- Autistic academic working in a university;
- Autistic academic leading the research department in a large autism charity;
- Chief Executive Officer (CEO) of a national autism charity;
- Speech and Language therapist working in a service for autistic children and adolescents.

All the HSB specialists and the CEO of a national autism charity were known to me and had been asked to become involved because I had previous experience of them independently peer reviewing other pieces of my development work. In that role, they had previously demonstrated their ability to critically review and challenge my practice. They also had the experience to be able to determine if the Practice Guidance was reflective of practitioners' and the autistic community's views and

experiences and that the theoretical constructs and information provided in the Guidance would support more informed and proportionate decision making by increasing practitioners' confidence and competence in this area of work.

The remaining three in the autistic peer review group were not previously known to me and became involved in this study following an approach I had made to the research department of a charity working with the autistic community. One of their researchers who was autistic herself, agreed to be involved and then through snowball sampling, recruited two others who were in her professional network and whom she knew would be interested in being involved in this research subject, one of whom was also autistic. This had two advantages for the research: that the autistic peer reviewers and those who worked with the autistic community were able to evaluate the Practice Guidance in terms of its representation of autism in relation to HSB and also that as they did not previously know me, they were not limited in their ability to critically evaluate the Practice Guidance and to challenge me if necessary (McNiff and Whitehead, 2012).

Pre-Peer Review Briefing Session

As the two disciplines of autism and HSB are so separate, with professionals in both disciplines not necessarily having a good understanding of the other's research and practice knowledge base, I had to address this in the peer review process. To help the HSB practitioners to feel more confident in their understanding of autism, the Practice Guidance contained a detailed overview of autism, diagnostic criteria and how the traits related to sexual behaviours. The peer review enabled me to test out if the level of information given was adequate for the HSB specialists to feel sufficiently informed.

For the autistic peer reviewers I ran a pre-peer review briefing session on the knowledge base of HSB practice and the AIM3 model (Leonard and Hackett, 2019) which were core elements in the Practice Guidance, so that they had a context for what they were going to review. The exception being the CEO of the autism charity

who already had considerable HSB knowledge. They were also provided with a copy of the AIM3 model for comparison.

Structure of the Peer Review

There were two rounds of peer review. In the first the peer reviewers were given six to eight weeks to review and return the Practice Guidance with their comments and to complete a questionnaire. In the second round, a revised version of the Guidance was sent out to those who had selected to continue with the peer review. The purpose of the second round was to ensure that I had properly understood and reflected the meaning of the changes they identified. They could then accept the amendments or identify any further changes required.

First round of Peer Review

In the first round of peer review, the data collection methods involved the eight peer reviewers being sent an electronic version of the draft Practice Guidance which had been amended following suggestions made by the autistic peer reviewers at the pre-peer review briefing session. The peer reviewers were asked to make any questions, comments or changes on the document itself and then to return it to me. I followed some of these up verbally, either by telephone or video call for further clarification, to ensure that I had understood the meaning and nuances of the adaptations and changes they had wanted me to make. The verbal follow ups were either at my request or were requested by a peer reviewer, particularly the autistic peer reviewers. The action research framework actively encourages these dialectical reflections and discussion to shape practice (Dick, 2000).

All eight participants in the peer review were also asked to complete a short questionnaire about their opinion of the theoretical constructs and the information provided in the Guidance - were they reflective of practitioners' and the autistic community's views and experiences? Would the Guidance support more informed and proportionate decision making by increasing practitioners' confidence and competence in this area of work?

The questionnaire had broad questions and was designed to be non-directive to enable the peer reviewers to give their honest opinion about the Practice Guidance, and what further amendments or additions were needed, if any. The questionnaire included:

a) What is your overall critical reflection of the Practice Guidance?
b) What works well and why?
c) What does not work and why?
d) Is there anything inaccurate – what amendments should be made?
e) What do you think has been missed, or what would you have liked to see more about?

Some peer reviewers, because of time pressures, rather than complete the questionnaire chose to give me brief feedback by email and some of the autistic peer reviewers requested to speak to me directly to discuss their observations in more detail.

Second round of Peer Review

The written and verbal feedback from the first round of peer review confirmed that overall the theoretical constructs in the Guidance were generally considered to be valid; the structure made the information accessible and the content was considered to be informative, it met the needs of practitioners and supported the development of confidence and competence in this aspect of HSB practice. There were suggestions for further amendments to be made. These amendments and some of the questions which had arisen in discussions meant I revisited the literature review to deepen my own understanding following which I rewrote a few sections and made other minor amendments.

An electronic version of this revised 2nd draft of the Practice Guidance was then sent back out to the peer review group for the second round of peer review. Five of the eight peer reviewers participated in this second round, the other three were unable to be involved due to work pressures or personal circumstances. The purpose of the second round of peer review was to confirm that the amendments and changes

made reflected their comments and concerns, rather than my own interpretations of what was relevant, as a further quality assurance measure of the Practice Guidance and to manage any potential researcher bias.

All five of the peer reviewers involved in the second stage responded by email to confirm that they felt that the changes had addressed the areas of practice or concerns that had been raised and they were happy with this version going forward to the pilot process. They added some additional areas for consideration in future developments of the Guidance, which included the voice of autistic adolescents and more information on interventions. I agreed with both of these aspects of practice but unfortunately the amount of additional work required was not feasible in the timeframe for the PhD. However, the learning was retained and will influence the next hermeneutic cycle of action and reflection in Phase Three, following this PhD.

2.7.2 Phase Two: Cycle Four – Pilot Process

The pilot process – was the 4th cycle and final part of part of the data triangulation for this research (Noble and Heale, 2019; Carter et al., 2014) and used another different set of practitioners. Again this was to test the trustworthiness and authenticity (Lincoln and Guba, 1985; Guba and Lincoln, 1981) of the research and to address any researcher bias.

The pilot process involved the application of the Practice Guidance to real cases, both retrospective and current and to a fictional case study; to review the impact of using the Practice Guidance on the practitioners' understanding of autism and HSB and whether it made a difference to their analysis and decision making. There was no time within the PhD timeframe to consider the potential impact on their interventions.

As the pilot process involved eight teams from different agencies and different geographical locations, including England, Ireland and New Zealand, it was also used to check the transferability of the Guidance to different practice settings to see if it was capable of being used more widely in practice (Morse, 2015; McNiff and

Whitehead 2012; Somekh, 2006; Lincoln and Guba, 1985). This section gives an overview of the selection of participants and the structure of the Pilot process, including briefing sessions, timeframes and the data collection methodology.

Selection of participants

There were eight different HSB specialist services involved in the pilot, which were geographically diverse, involving services in England, Ireland and New Zealand. It was not part of the research design to look at geographical and cultural differences; these services had self-selected to be involved as they wished to contribute to the development of good practice. They were aware of the research as some of them had also been part of the original practitioners who had raised the need for good practice guidance on autism and HSB. All the services had received the information sheets re consent, confidentiality and ethical approvals. Due to the use of real cases as part of the pilot, the decision about their involvement in the Pilot had to go through their agencies' ethics processes but all eventually had approval from their services *(see Appendix Seven for the information sheets for Phase Two).*

The eight different services were:

- Three specialist HSB assessment and therapeutic intervention services in New Zealand;

- Two services from England, one a specialist HSB service in a large local authority and the other a forensic CAMHs service which included both prison and community populations;

- Three services from Ireland both north and south, one youth justice and two specialist HSB assessment and therapeutic intervention services.

There were no limits on how many from each service could be involved in the research, this was dictated by the services themselves in terms of their practitioners' time and caseloads. Within the eight services, there were a total of 39 practitioners who had expressed an interest in being involved in the Pilot, had attended the

briefing sessions and received a hard copy of the Practice Guidance. Of the 39 practitioners, I had only previously known 16 of them with the remaining 23 being colleagues in their services, whom I had never met. I was not in a working relationship with any of them or where there were any status dynamics which would have influenced their ability to give me feedback. On the contrary, this was something that they had desperately wanted and if it had not met their needs, they would have been very clear about its deficits.

Only 4 of the 39 participants had been involved in the survey and interviews, the vast majority (35) had had no previous involvement in the research. Whether or not they had been previously involved did not seem to make a difference in their feedback. This provided further evidence of the trustworthiness and credibility of the research, in that the smaller part of the group who had been involved in the surveys and interviews were in a good position to be able to judge whether my interpretation had accurately reflected their views and their practice experience and that the larger part of the group were coming to the information with a fresh perspective (Nowell et al., 2017).

Structure

The structure of the pilot process was to provide initial briefing sessions for each of the services prior to the pilot period which ran for two months in the autumn of 2022. The participants were asked to use the Practice Guidance with current or retrospective cases or on a fictional case study if neither of these were available in that time frame.

Feedback from the pilot was taken by practitioners giving written reflections on the impact of using the Practice Guidance in relation to their own case examples and/or the fictional case study and an individual questionnaire about the credibility of the Practice Guidance. The reason for having two feedback processes was that some of the participants had worked in pairs or as a team and had given joint feedback on their case/s, but I also wanted to know how each individual pilot participant had experienced using the Guidance.

Briefing Sessions

Pre- pilot briefing sessions were set up to explain the pilot process, how the participants could be involved, what feedback was required, an overview of the process of the development and the content of the Practice Guidance and how it related to the AIM3 model (Leonard and Hackett, 2019). Six sessions in total took place either by video or in person, with the three New Zealand teams joining together in one online session. Each participant received a hard copy of the Practice Guidance in advance, so they could bring any immediate questions or comments to the briefing session for clarification, meaning that the briefings were a further opportunity to hear about useful additional practice questions or nuances.

2.8 Data collection for the pilot process

2.8.1 Case examples/ fictional case study

The participants were asked to use real cases either current or retrospective, as part of the ethical agreement for the pilot process. They were not expected to give details of the cases, only a reflection on their own practice, so no personal information of the clients was shared. If neither current nor retrospective cases were available or appropriate, then a fictional case study was provided.

The participants were given two months to pilot the practice guidance and a free choice as to whether they worked individually, in pairs or groups, or as a whole service. They could use cases which were online or direct contact (or both) and cases with or without a diagnosis of autism. Where there was no diagnosis but they believed there were possible autistic characteristics, there was an additional question about the factors on which they were basing their view. This was to see if there were similarities with the information from the interviews.

The fictional case study [10]

Completion of the fictional case study was the minimum requirement for the pilot participants and was a pragmatic and practical solution to them potentially not having a current or a retrospective case that was appropriate within the pilot period. It was also suggested that the participants completed it, even if they had other cases. Their feedback was provided through the completion of the AIM3 Domain Sheets with the rationale for their analysis and the outcome graph (*See Appendix Nine for a brief overview of the AIM3 model, Leonard and Hackett, 2019).*

Using the fictional case study had the added advantage of seeing how very different practitioners in different agency settings approached the same case in relation to the knowledge they had gained from the Practice Guidance. It was not intended to examine inter-rater reliability as the AIM3 model itself is a holistic model supporting practitioners' analysis rather than being an actuarial or psychometric model.

I created the fictional case study of an autistic adolescent male called Sam from my own learning in developing the Practice Guidance. I undertook my own analysis of the case study using the AIM3 model along with the Practice Guidance and completed the rationale of the analysis and outcome graph. To check and reduce my own potential bias, I then asked two colleagues with experience in autism and HSB to independently use it to produce their rationale of the analysis and outcome graph. Following comparison of our independent analyses and discussion with them about any differences in opinion or rationale, we agreed on a final composite copy of the analysis and graph, which was then used to compare with the pilot group responses for similarities and differences in their analysis.

Case examples - application of the Practice Guidance to previous or current AIM3 assessments

Retrospective application of the guidance to previous AIM3 assessments was to check similarities and differences with their original understanding and decision

[10] *(see Appendix Eight for a copy of the case study)*

making. But it was stressed in the briefing sessions that ethically as the Practice Guidance was untested and not legally valid, for retrospective cases the original assessment would remain as the legally valid assessment. For current cases, an AIM3 would be completed as normal and used for any decision making, with the use of the Practice Guidance in a shadow capacity only.

The feedback process for the **retrospective cases** was to answer the following questions:

a) If there was no diagnosis but you felt that they had possible autistic characteristics – what made you come to that conclusion?

b) Did your overall analysis and the graph change?
If it did, what were the parts of the assessment where the Practice Guidance impacted or changed your understanding of the autistic adolescent and appropriate interventions and why?

c) If your overall analysis and the graph did not change, why do you think that was? Where there any parts of the assessment where the Practice Guidance impacted or changed your understanding of the autistic adolescent and appropriate interventions?

The feedback process for the **current cases** was to answer the following questions:

a) Do you feel that using the practice guidance along with AIM3 made any difference to your analysis and decision making?

b) If so, what difference did it make?

c) If not, why not?

Individual Questionnaire

As well as the feedback on the cases or fictional case study, all the participants were asked to complete a questionnaire created by using Jotform to get their individual views on the theoretical constructs and the content included in the Practice Guidance, the impact on their own practice and also to explore any additional themes that might not have been raised in the previous rounds of the research. They were asked to do it individually as some of them had worked in pairs or as a team on the case examples and/or fictional case study and having individual testimonies of whether their practice had been impacted is considered another way of creating credibility and dependability in an action research study (McNiff and Whitehead, 2012; Dick, 2000).

The individual questionnaire initially asked two questions to enable the matching of the responses to the appropriate service and to identify if there were any themes in relation to professional roles.

a) Which specialist HSB service do you work for?
b) What role do you have in that specialist HSB service?

Then there were three broad open questions:

a) Which aspects of the Autism and HSB Practice Guidance work or do not work and why?

b) What has been the impact of using the Autism and HSB Practice Guidance on your own understanding and practice?

c) Are there any practice themes re working with this population of children and adolescents that you feel have not been covered by the Autism and HSB Practice Guidance?

2.8.2 Feedback from the Pilot Process

Most of the feedback was given in written form, but one service requested an online video meeting to give their feedback verbally, as they felt that using the Practice Guidance had had a significant impact on their practice already and wanted to share that more comprehensively with me.

There were 18 individual questionnaires returned from the total group of 39 who attended the briefings. There were returns from seven of the eight services so there was a good overview of the different practice settings. With regard to the fictional case study, all eight services used the Practice Guidance with the case study. The majority of the returns had been completed by an individual, several where it had been completed in pairs and one which had been undertaken by the whole team together. Several services provided more than one return for the case study as some of their staff had completed it individually and some had done it in pairs. In addition to the returns on the fictional case study, half of the services were able to use the Practice Guidance with a retrospective or current case example.

2.9. Challenges and Responses re using the Pragmatic Paradigm and an Action Research Framework

2.9.1 Challenges

Using the Pragmatic paradigm and an action research framework posed challenges for me in ensuring that my study had academic rigour and that the findings from the research had validity both academically but also in practice (Davydd, Greenwood and Levin, 2007). The main criticisms of the pragmatic paradigm and an action research framework are the potential lack of a strong ontological or epistemological foundation, particularly when using multiple methods research (Lincoln, 2010). Also, as action research is a comparatively new research method compared to the more traditional quantitative studies methods, which have been debated and refined over a considerable period of time (Levin, 2012; McNiff and Whitehead, 2012; Reason and

Bradbury, 2001; Dick, 2000), there can be a perception that it is somehow not as ‘valid’ or as ‘academic’ as other forms of research.

Some of this criticism is related to perceptions that action research uses collaborative inquiry to find solutions to practical problems and thus favours responsiveness over replicability (Dick, 2000). Also, that it is often undertaken by practitioner-researchers studying in their own fields of interest and experience, which can make them potentially more subjective or biased, or their research inexperience can mean that they are more focused on the practice part rather than the academic research element, or that their small scale settings are not generalisable to wider populations (Levin, 2012; Zuber-Skerritt and Fletcher 2007; Greenwood and Levin 2007; Reason and Bradbury, 2001;). These together with current criticisms of qualitative studies that they lack the academic rigour of validity, reliability and generalisability usually found in quantitative studies (Hackett, 2022; Nowell et al., 2017; Morse, 2015; Levin and Greenwood, 2011; Greenwood and Levin 2007) made using an action research framework a challenge for my research.

2.9.2 Responses

The pragmatic paradigm

Despite the criticisms of the pragmatic paradigm, I feel that this research has a clear constructionist ontology and interpretivist epistemology (Zuber-Skerritt and Fletcher 2007; Somekh, 2006; Costello, 2003). My professional experience of almost 40 years in social work and HSB practice leads me to believe that there are no absolute realities for individuals or societies. In my view, the real world and human beings are complex and heterogenous and that reality is shaped and changed by new paradigms, for example about children and sexuality or how we understand HSB (Foucault, 2008; Dominelli, 1989; Foucault, 1978; Freud, 1905).

Reality is constantly renegotiated, debated and interpreted in light of its usefulness in new unpredictable situations (Patel, 2015) and that actions and beliefs influence each other in a cyclical fashion (Morgan, 2014; Dewey, 1925). Individuals in their

own lives react and adapt (sometimes dysfunctionally) to situations they experience, with their realities and understanding of life being shaped by these events (Mercer, 2020; Guilhermino and McCarlie, 2019; Van der Kolk, 2014; Creedon, 2009; Perry, 2009; Crittenden, 1995).

Societal concepts of reality are also not fixed, they are continuously being shaped by new developments conceptualising how society and individuals should think and behave. This is sometimes in response to perceived threats to the dominant groups in society through categorising those who are acceptable and unacceptable and developing self and group policing processes (Foucault, 2008).

Freud's psychoanalytical theories have had an enormous impact on how sexual development and sexuality is conceived (Freud, 1905). Challenges to the dominant groups and discourses such as feminism's challenge to the patriarchal societal structure have also changed practice and behaviour (Scott, 2001; Hooper and Humphreys, 1998; Dominelli, 1989). Changes to societal perspectives on sexuality have changed attitudes towards homosexuality and are now going further and challenging traditional binary concepts of gender and sexuality (Jackson-Perry, 2020; Jack, 2012; Bumiller, 2008).

Action Research Framework and Qualitative Studies

With so much criticism about the use of an action research framework, I reflected on whether or not to use this for my research; while it appeared to be the most appropriate framework to address the research questions for this study and it fitted with my previous research and practice experience, I acknowledged that it potentially could open my research to be challenged as not having sufficient academic rigour, particularly as my research was also a primarily qualitative study. I therefore needed to ensure that my methodology was strong enough to address these concerns.

As one of the concerns of action research was whether or not participants are truly taking part voluntarily or may be influenced by the researcher being of more senior status either within or external to their organisation (Zuber-Skerritt and Fletcher,

2007), this was an issue I needed to address. Although I was not in a formal ongoing working relationship with any of the participants, so there were no status, organisational and power dynamics which might have influenced their feedback or challenges, I am an acknowledged expert in my field and therefore I needed to reduce any impact that my professional status may have on the participants.

As described in the data collection sections I did this in several ways - in the survey and interview processes, participants self-selected to become involved. In the peer review process, the people who knew me had all critically peer reviewed my work before and I had no professional relationship with the others. In the pilot process, there were a number of teams and individuals with whom I had never worked nor who would have heard of me professionally.

Each peer reviewer or pilot team fed back to me individually and all feedback was treated equally, so there were no power dynamics created by the previous relationships I had with some of the group members. I responded to comments and questions, which had arisen for them and clarified parts of their feedback when I was unsure of what they were meaning.

2.10. Academic Rigour

Academic rigour in qualitative and action research studies is usually described as the trustworthiness or authenticity of the research through confirmability that the researcher's interpretations and findings come from the data and there is clarity about how they were reached (Nowell et al., 2017), which creates credibility, dependability and transferability (Lincoln and Guba, 1985; Guba and Lincoln, 1981). Newer evaluation criteria are emerging of coherence, contribution and significance of the research (Tracey, 2010; Cohen and Crabtree, 2008), rather than specific strategies but these are more subjective terms (Morse, 2015), so this study focused on credibility, dependability and transferability.

Trustworthiness of this study was evidenced in a number of ways, as multiple methods of data collection were used, in the different cycles of the research

(Cresswell, 2012). Initially in the survey and interview processes credibility was created by prolonged engagement and the development of ‘thick description’ in relation to the subject matter. This was through my experience in the field of HSB and connections in the HSB networks which meant that the survey respondents and interviewees were able to trust and respond to me more openly and I was able to understand the nuances in their responses and to ask more insightful, in depth questions (Kostova, 2017).

This created a more authentic, richer and valid ‘thick description’ (Holmes, 2020; Geertz, 1973), which when combined with the knowledge from the literature review and my own HSB practice experience contributed to the development of the theoretical constructs and the Practice Guidance (Costello, 2003).

The credibility of the Guidance in representing the actual phenomenon being studied (Robson, 2002) and its dependability and transferability to general practice was evidenced through triangulation using two further methods of peer review and piloting, each with different participants and different perspectives (Noble and Heale, 2019; Morse, 2015), in an iterative dialectic process of cycles of reflection and action (Quin Patton, 2015; Dick, 2000). The ultimate decision about the validity of the research and the Practice Guidance will be from its use in practice, if practitioners perceive that the theoretical base is sound and the Guidance supports their practice and decision making (McNiff and Whitehead 2012).

This multiple method approach of triangulation (Flick, 2018; Guion, 2002) also addressed the dependability aspect of the trustworthiness criteria with clear descriptions provided of the different cycles of this research process and details of the survey questionnaire, semi-structured interview format, peer review questionnaire, case study for the pilot phase of the research and pilot review questionnaire (Noble and Heale, 2019; Carter et al., 2014; Guba and Lincoln, 1981).

Although this could facilitate future studies attempting to replicate the research, their findings particularly through the use of the questionnaires and the semi-structured interview schedule would be unlikely to be exactly the same as mine, as they were

based on the views of those particular practitioners and were interpreted using my extensive experience in HSB practice (Morse, 2015; Koch, 1994), neither of which can be exactly replicated. However, the themes and theoretical constructs from the 'thick description' on which the Practice Guidance is based were tested in the piloting process and that process could be replicated in future studies to check for congruence or dissonance in findings to further test the transferability of the Guidance to general practice (Morse, 2015).

Lincoln and Guba (1985) described factors required for authenticity in qualitative research as fairness, ontological, educative, catalytic and tactical authenticity. The following are questions posed by Schubotz (2022) in relation to Lincoln and Guba's criteria for authenticity, along with how I feel I have addressed these in my research:

a) *Fairness: Is it a fair representation of different viewpoints?*
The use of multiple methods was used to gather several different practitioner viewpoints and in particular of those in the autistic community;

b) *Ontological: does it lead to a better understanding of the social milieu?*
As this is an emerging area of study, I think it creates a better understanding of autism and HSB, which has been endorsed by the feedback from the peer review and pilot processes in the research;

c) *Educative: Is it appreciative of other perspectives?*
The literature review merged the two large and complex research knowledge bases of Autism and of HSB to consider the similarities and differences between them. The fieldwork was multi-method to accommodate potential differences in perspectives from the different practitioner groups involved. The inclusion of members of the autistic community was consciously done to include their particular perspective;

d) *Catalytic: Is it an impetus for change?*
This research was driven by practitioners who desired to have guidance for their practice in relation to autistic children and adolescents. The development of the

Practice Guidance has raised questions and challenges for our HSB practice overall, not simply specifically in relation to autism;

e) Tactical: Does it empower to make changes?

The practitioners were the impetus for the research and the use of the action research framework was to include them. The feedback from both the peer review and pilot groups is that just going through those processes had empowered them and enlightened their practice. They stated that they were already making changes to their HSB practice to better enable children and adolescents, both autistic and non-autistic, to engage in the assessment and intervention processes.

2.11. Ethical Considerations

This section focuses on the ethical considerations addressed in this research around the recruitment of participants, ensuring anonymity and confidentiality, seeking informed consent, how data was obtained and stored and managing the impact on participants of being involved in the research.

2.11.1 Recruitment of participants

Apart from some participants in the peer review group, who had been asked by me to become involved, all the participants in both the Development and the External Review Phases had self-selected to be part of the research. They were not offered any incentives but described their interest in being involved was to enhance their own understanding of a practice issue, with which they were currently struggling. They were all independent from my charity AIM, so there were no organisational hierarchies which could have compromised their ability to be open and honest. (Noble and Heale, 2019; Morse, 2015).

2.11.2 Anonymity and confidentiality

In Phase One, the surveys were designed to provide anonymity for the respondents, so they could express their views freely. Those who wished to be interviewed, self-selected by ticking a box on the survey to express their interest.

I did not seek direct contact with autistic children or adolescents or their families, nor access any confidential information on case records about them. All the case data provided through the surveys and interviews was coded and anonymised, so no individual practitioner or agency could be identified which was important in a small sample. Broad themes from the surveys and interviews were generated in relation to the research questions and the development of the Practice Guidance, which then went through a peer review and piloting process focused on the validity of the theoretical constructs and information given in the Guidance rather than on the practice of individuals, agencies or local authorities. Some themes were illustrated through the use of short examples of aspects of some cases, but no information was used that could lead to identification of any individual, their family or where they live.

2.11.3. Informed consent

Phase One: Development – Surveys and Interviews [11]

All the participants who had indicated their interest in being involved in the surveys were sent information sheets on both the survey and the interview processes so they could make an informed choice about whether or not they wanted to be part of the interview process, or just the survey. The information sheets outlined how the information would be gathered, anonymised, stored and used in the research. It was made clear that the surveys would be asking for some limited anonymous case information and that the interviews would be exploring this case data and practice themes in more depth. The information sheet for interviews also included a caution

[11] *(see Appendix Four for details of information sheets for Phase One)*

that if during the interview, illegal activity was mentioned that had not already been reported, that they would be advised to report that activity.

It was stated that ethical approval for the research had been given by the Research Ethics Committee of the School of Social Sciences, Education and Social Work (SSESW), Queen's University Belfast and potential respondents for the survey and the interviews were advised that they should also check with their own organisations if there were any other ethical approvals or data protection requirements needed. Consent was evidenced by the completion and submission of the survey and by the ticking of a box on the survey to be contacted about the interview.

All the organisations were satisfied with the ethical approval from Queen's University Belfast, but some survey respondents and interviewees were limited in what information they could share because of their organisation's data protection policies.

Phase Two: External Review – Peer Review and Pilot processes[12]

All the practitioners involved in the peer review were sent the information sheets about the ethical permission from Queen's University Belfast, confidentiality, how the information would be anonymised, used and stored and suggesting that they seek ethical approval from their organisations. It was made clear that they would be reviewing the Practice Guidance and would not be expected to share any case data. They were all given permission by their organisations to be involved.

For the pilot process, information sheets were sent to organisations, which had previously indicated that they were interested in the research, to ask permission for their workers to be involved in the pilot. They were free to identify how many workers they would allow to be involved. The organisations were granted permission to be involved by their research and ethics boards but for some there were clear restrictions on the sharing of any case data arising from the application of the adapted AIM3 model (Leonard and Hackett, 2019) to retrospective or current cases.

[12] *(see Appendix Seven for Information Sheets for Peer Review and Pilot processes)*

It was stressed in briefing sessions for the pilot participants that ethically, as the Practice Guidance was untested and not legally valid, for retrospective cases the original assessment would remain as the legally valid assessment. For current cases, an AIM3 would be completed as normal and used for any decision making, with the use of the Practice Guidance in a shadow capacity only.

2.11.4. Data collection – Security of Data

Information derived by this research was anonymised so that no individual or agency or child/adolescent or family member is identifiable. The information will be kept confidentially and securely on the Queen's University Network Server in an electronic medium and will be password protected. In line with Queen's University SSESW Data Handling and Security Policy the data will be stored securely by Queen's University for at least 5 years after the end of the research project, after which it will be securely destroyed.

During the pilot process, the practitioners were within their own work settings and were covered by their workplace risk assessments, data protection and confidentiality policies.

2.11.5. Impact on Participants

Most of the practitioners involved in the research had already been working in the field of HSB for many years, therefore the nature of the subject was not shocking or distressing for them and they did not report any detrimental effect on their welfare. However, I was conscious that this was a controversial and sensitive subject for the autistic peer reviewers who had not been involved with HSB before. I therefore made it clear in the initial approach via the information sheet sent to the autism organisation, that I would understand if it was too difficult or sensitive a subject for them to discuss and that I could make changes to my methodology to let them be involved in a different way.

In the two video calls I had with the potential autistic peer reviewers, I discussed how they might feel about reading information which can be graphic and upsetting and

what support they had if they needed it. In all my subsequent verbal communications with them, I checked how they were feeling, which they said they appreciated. They also did not report any detrimental effect on their welfare.

2.12 Changes to the Original Proposal

Listening to the practitioners' views in both the survey and the interviews, the focus of the development of the Practice Guidance changed from not only adapting the AIM3 model (Leonard and Hackett, 2019) for use with autistic adolescents, but also to include the need for more information on autism generally and guidance on how to work more effectively with autistic children and adolescents.

The scope of the original research proposal, which had intended to have sufficient time for the Practice Guidance to be piloted with new cases, had to be narrowed due to the impact of Covid, which significantly delayed the process and reduced the time period available, therefore this was altered to primarily applying it retrospectively to previous assessments. This actually had the benefit of being able to compare outcomes to see what impact, if any, the Practice Guidance had on previous decision making. Quinn Patton (2015) describes both these changes as being evidence of ongoing reflection and re-evaluation of the project as emergent design flexibility, where the researcher is open to adapting the inquiry as the understanding deepens and/or situations change and is essential to the credibility of the research.

I had also intended to have a focus group of autistic adolescents to discuss their experiences of puberty, sexuality, developing romantic and/or sexual relationships and what they would like practitioners to understand or to do differently when working with them. My initial search of the research literature and practice experience of others (Attwood, 2007; Greene and Hill, 2005; Punch, 2002) raised concerns that in terms of the timeframe for this research, the complexity of developing question formats which would make sense to the adolescents involved could be time consuming and potentially unsuccessful. Involving them would also raise ethical issues about the benefits for the adolescents themselves as HSB is a

sensitive subject even for adults and the Practice Guidance was to be designed for practitioners to use. I was therefore concerned that involving them would be possibly tokenistic.

However, studies I read later in the literature review showed clear benefits in having autistic adolescents' self-reports on their sexual development and behaviours over their parent/carer reports (Greaves-Lord et al., 2020; Mehazabin and Stokes 2011) even though they took more time to set up. This, along with it being a future area of development suggested by the autistic peer reviewers and my own developing confidence of how practice can be adapted appropriately means consideration of how to include their views will be in the next rounds of development of the Practice Guidance, post the PhD.

2.13 Conclusion

The use of the pragmatic paradigm and an action research framework in a qualitative study fitted with the aim of this research to develop good practice in Autism and HSB and to achieve this aim by engaging with the practitioners who had raised the need for it, in a 'community of practice' with me as the researcher (Morgan, 2014). However, the methodology also created challenges for me as a researcher in terms of establishing the trustworthiness and authenticity of the research, particularly in an emerging field of research with limited precedents to critique or replicate.

I was conscious that because I was trying to develop theoretical constructs about similarities and differences between non-autistic and autistic children and adolescents with regard to HSB, I needed to add in an additional phase of external review. This was achieved using two different groups of practitioners in the peer review and pilot processes to triangulate their data and perspectives with those of the interviewees to ensure that my interpretations of the learning from the surveys and interviews accurately reflected their experiences and needs (Flick, 2018; Guion, 2002). This also allowed those theoretical concepts to be tested and challenged in practice, to evidence the credibility, dependability and transferability of the research.

The autistic peer reviewers were essential to the credibility of this research and the practice guidance, helping me to learn about autism and how we need to think about adapting our practice to better meet the needs of the children and adolescents with whom we work. They also helped me to be more sensitive to the lived experiences of autistic people and the potential for how the information in this research may be perceived in the wider community.

The following two chapters focus on Phase One: Development: Cycle 1 which is the literature review. They provide a more in depth look at the two large research and practice knowledge bases of autism and of HSB and the slightly smaller research base on Autism/ HSB combined.

For the ease of the reader, the information from the Literature review is divided into two chapters: Chapter Three focuses on the research and practice knowledge bases around understanding HSB and understanding Autism. Chapter Four focuses on understanding Autism and HSB combined. It not only looks at that research base but uses the knowledge from the previous two chapters to begin to understand this particular aspect of HSB practice and develop the theoretical constructs.

Chapter Three - Literature Review: Understanding HSB and Understanding Autism

3.1 Introduction

This chapter provides an overview from the critical narrative literature review of the current understanding in research and practice, firstly with regard to HSB and secondly with regard to autism. The 1980s was a seminal decade in the discovery and beginning of our understanding in both these different research areas, so this chapter will cover how current understanding has developed over the last 40 years, since the 1980s, particularly around sexuality and sexual behaviours and including the rise in the use of the internet and social media. It will also look at the changes in language and definitions over those 40 years and the theoretical perspectives which have underpinned practice in both fields (Dekker, 2019; Fletcher-Watson and Happé, 2019).

3.2 Understanding HSB

3.2.1. The impact of the feminist movement

Prior to the 1980s there was no real understanding of child sexual abuse within family settings and the long term damage to children, but in the 1980s this changed radically, influenced particularly by feminist theories of male power in relation to sexual abuse of women and children (Hooper and Humphreys 1998; Dominelli, 1989; Masson, 1984). The feminist movement criticised concepts of 'innate male sexual drives' or 'uncontrollable sexuality' stating that they absolved men of responsibility for their abuse of others (Lovett et al., 2018; Delap, 2015; Barter, 2006; Green, 2005; Hooper and Humphreys 1998, Dominelli, 1989).

Listening to women's stories about being abused as children (Boon, 1986) led the feminist movement to advocate for powerful messages about children not being to 'blame' for their own abuse and that they should be believed, messages still resonant today (Lovett et al., 2018), It also addressed mother blaming narratives that child abuse was the result of family dysfunction, collusive mothers and their failure to protect (Lovett et al., 2018; Delap, 2015). This led to feminism being described as the "…point of origin for contemporary concern over child sexual abuse" (Scott, 2001, p349).

The resulting changes to professional practice (Delap, 2015; Scott, 2001; Dominelli, 1989; Boon, 1986) created societal tensions with traditional views about male roles in families, resulting in strong opinions that social workers were on a crusade, overzealous and creating a moral panic (Lovett et al., 2018; Delap, 2015; Scott, 2001, Campbell 1988), reinforced by the Cleveland Crisis when over 100 children were removed from their families (Butler-Sloss Report, 1988). Nonetheless, by the early 1990s the acceptance of child sexual abuse as a legitimate area of concern had enabled practice to move onto considering that adolescents can also be sexually abusive (Campbell et al., 2016).

3.2.2. The development of research in the UK

In 1992 the seminal NCH[13] (1992) *The Report of the Committee of Enquiry into Children and Young People who Sexually Abuse Other Children* was published. It was the first UK study, building on work started in the 1980s in America and was the beginning of a whole new emerging field of research and practice (Delap, 2015; Hackett, 2014), with the focus mostly on adolescents as there was still resistance to the concept of children being sexually abusive, given societal constructs of children being asexual or sexually innocent (Carson, 2019).

Hackett (2014) highlighted in a review of the research knowledge that although the number of research studies has increased since the 1980s, developing consistency in our understanding is undermined by the absence of agreed definitions of what to call the behaviour, both in research and in practice and also limitations in the methodology of some of the studies, with many being practice led and therefore less academically rigorous (New et al., 1999). Ethical concerns around asking children and adolescents to talk about such a sensitive subject and inconsistent use of control groups, has meant that there are less outcome studies and randomised control trials.

Many of the studies have been based on small, specialist clinical populations of already identified high risk adolescents, so are not representative of the wider community generally or even the wider population of those with HSB. Therefore, although there now is a body of clinical theory and expertise in relation to causal and developmental characteristics of adolescents who sexually harm and theories regarding recidivism, this has not been tested using rigorous research methodology with little replication of other studies for comparison, in order to be able to refine and validate risk assessment models (Edwards et al., 2012; Chaffin et al., 2002; Zolondek et al., 2001).

With different definitions being used and the lack of replication of studies this has meant that the HSB research field is accumulating ‘practice lore’ which is not

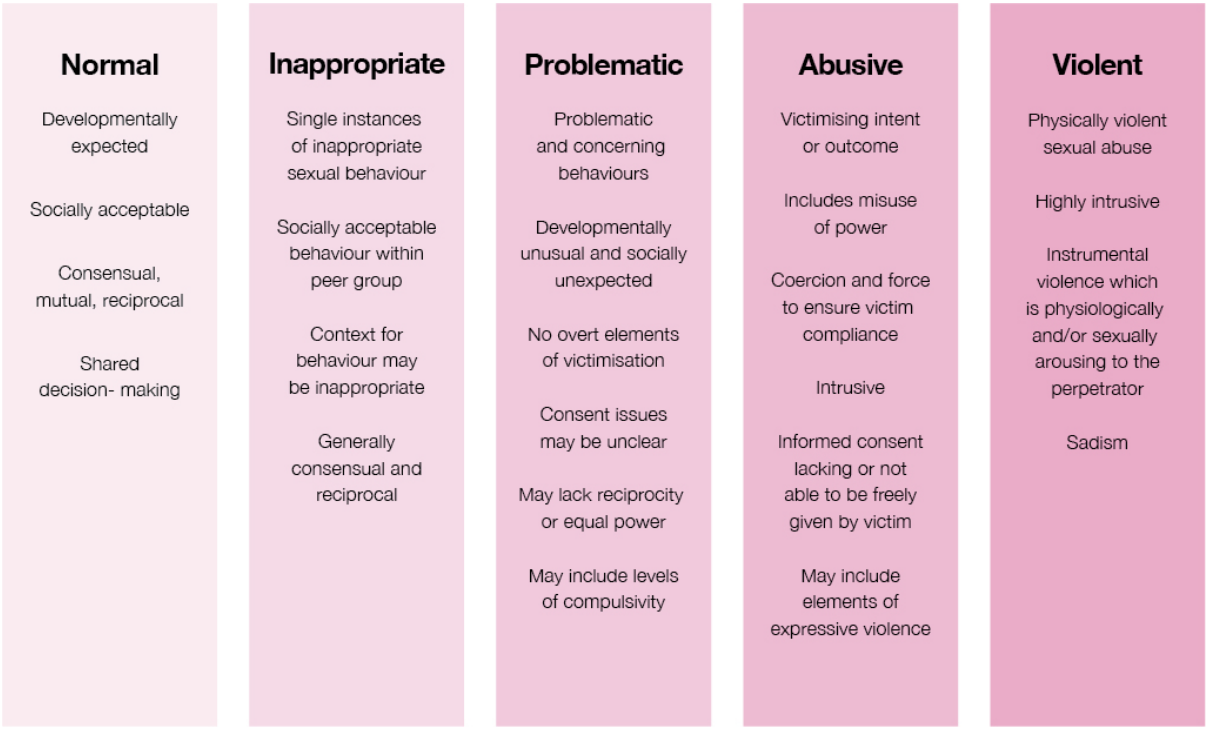
[13] NCH – National Children’s Home – a children’s charity which then became Action for Children

internally disputed to any real degree; although beneficial for front line practitioners in understanding the adolescents with whom they are working, it leaves the HSB practice field unable to establish with any degree of certainty, clinically valid criteria for HSB. As Hackett concludes “So, despite the increasing attention given to research in this area, we have what amounts to not so much as a knowledge base, as a knowledge pile” (Hackett, 2014, p12).

3.2.3. Language and Definitions

There are ongoing debates in HSB practice about language, but in more recent years the terminology, ‘harmful sexual behaviours’ has developed with HSB being used as a short hand reference within the research and practice population. Hackett’s (2010) continuum *(Figure 4)* is currently widely used to differentiate levels of concern with (HSB) being defined as including problematic, abusive and violent sexual behaviours, which lie at the top end of Hackett’s continuum, as they may be harmful to the individual themselves or to others.

Figure 4: Hackett’s (2010) continuum



3.3. Characteristics of adolescents who have engaged in HSB

Adolescence is a time of immense physical, psychological and emotional change, when individuals have to cope with hormonal surges, negotiate relationships in new ways including romantic and sexual and define themselves in terms of their sexuality. (Fernandes et al., 2016; Ray, Marks and Bray-Garretson, 2004). Adolescents who sexually harm are a heterogenous group, with their sexual behaviour being only one aspect of their lives. Other factors such as personality, resilience, supportive families or networks are equally important alongside theoretical concepts of trauma and attachment when beginning to understand why an individual has crossed social, moral and legal boundaries to cause sexual harm to another person (Hackett, 2014; Edwards et al., 2012).

3.3.1. Prevalence – age, gender and ethnicity

It is believed that approximately one third of all cases of child abuse in the UK are by adolescents, predominantly males and many are cases of intra-familial abuse (Yates and Allardyce, 2021; Balfe et al., 2019; Hackett, Branigan and Holmes, 2019; Ghani and Barnardos, 2016; Hackett, 2016, 2014; Smith et al., 2014; Edwards et al., 2012; Hackett et al., 2012; Stop it Now, 2007; Almond, Canter and Salfati, 2006), but these are cautious figures as shame prevents many individuals disclosing (Mercer, 2020; Masson, 2001) and are primarily based on offender statistics, yet many adolescents are diverted away from the criminal justice system.

HSB is overwhelmingly a male problem, with consistent figures from research and criminal justice statistics showing that approximately 93-95% of those involved in HSB and sexual offending are male (Youth Justice Board, 2023; Hackett et al., 2013; Finklehor et al., 2009; Bunting, 2007;Taylor, 2003). Prevalence for females varies in different studies from 2.6% to 8-12% (Hackett, Branigan and Holmes, 2019). Gender socialisation theories go some way to explain the low prevalence of females, along with societal attitudes that females are nurturers and unable to commit sexual harm due to their biology. Therefore their sexually abusive behaviours are often reframed as being indicative of their own vulnerabilities and they are diverted away from the

criminal justice system, leading to low referrals for adult and adolescent females (McCartan et al., 2011; Bunting, 2007; Saradjian, 1996; Cutler and Nolen-Hoeksema, 1991). Females who sexually harm are more likely than males to have high levels of physical and sexual trauma in their backgrounds and attachment difficulties from a young age (Hackett, Branigan and Holmes, 2019; McCartan et al., 2011; Hickey et al., 2008; Ford, 2006; Gray et al., 1999).

There is limited information on the ethnicity of adolescents with HSB, studies mostly compare British, American and European cultures and are of predominately white males (Kellogg, 2010). Hackett et al's (2013) study of nine specialist HSB services across the UK found that 93% of the adolescents were white, 1% were black, 3% were Asian and 3% were mixed race. The relevance of ethnicity and cultural factors to HSB or how the adolescent and their family are regarded by their community requires more research (Carson and Aujla, 2021; Hackett, 2000; Ghani and Barnardos, 2016).

3.3.2. Family Backgrounds, Abuse and Trauma

Taylor's (2003) study of 227 adolescents with HSB, in a large city in the UK, found family backgrounds characterised by high levels of involvement from health and social care professionals due to chaotically functioning families and factors like parental mental health, drug and alcohol abuse and high levels of parental conflict and domestic abuse. Adolescents had experienced loss of people in their networks who had been significant 'social anchors' for them, or discontinuity of care and insecure attachments (Hackett, 2014; Craissati, McClurg and Browne, 2002). Attachment difficulties are considered highly relevant to the development of HSB, although Creeden (2013) cautions that research so far has not yet been able to state this conclusively.

Studies vary widely indicating between 66% to 92% of adolescents who sexually harm have also experienced at least one form of abuse or trauma i.e., physical, emotional, sexual, neglect, family breakdown, or they live in families characterised by chaos and issues like parental mental health, (particularly maternal histories of

depression) (Mutale, 2003; Kelly et al., 2002; Skuse et al., 1998) drug and alcohol misuse or domestic abuse (Pullman and Seto, 2012) or parents own experience of abuse as a child (Hackett et al., 2019; Leonard and Hackett, 2019; Bellis et al., 2016; Hackett et al., 2013; Vizard, 2013; Vizard et al., 2007; Salter et al., 2003 (Bentovim, 2002).

Living in highly sexualised environments with early exposure to sexual imagery and sexual violence, intensive use of pornography or where sex and aggression are linked to distorted views of male and female power, can be influential on their psycho-sexual development (Malovic et al., 2020; Seto and Lalumière, 2010; Ward and Seigert, 2002).

Some have experienced peer abuse and bullying whether this is in school or community settings or increasingly now online (Carson and Aujla, 2021; Allotey and Swann, 2019; Hamilton-Giachritsis et al., 2017), or through involvement with groups and gangs (Berelowitz et al., 2013) which at such a sensitive developmental stage can have a devasting effect on their emotional and psychological wellbeing.

3.4. Children who have engaged in HSB

3.4.1. The development of the knowledge base in relation to children

Even though the NCH Report (1992) referred to children, at that time, some would have struggled to acknowledge that children could be sexually abusive given societal constructs of children being sexually innocent. These constructs still remain in practice today and even though there is now more widespread acceptance that children can display problematic and some abusive sexual behaviours (Hackett, 2010, ATSA, 2008) when it is clear that a child has caused harm, societal reactions can be to define them as ‘unnatural or evil’ children (Carson and Aujla, 2021; Carson, 2019; Scott, 2001; Hay, 1995).The impact of this is that denial and minimisation by parents is common in HSB practice.

By the mid to late 1990s, there were rising numbers of children on practitioners' caseloads with problematic or harmful sexual behaviours creating a need for research and guidance to know how to assess and work with this age group (Elkovitch et al., 2009; Carson, 2008; 2006;1996). Many initial studies were based on a few case examples with large scale studies being conceived as problematic in terms of ethics about having control studies and concerns about how to talk to a child about sexual behaviours for fears it may traumatise them or create other sexual problems, because of their level of cognitive understanding (McLeod, 2023; Carson, 2019; Piaget 1932).

Minimisation of children's sexual behaviours is reflected in the choice of language parents and professionals often use, with terms such as 'sexualised', 'problematic' or 'inappropriate', 'sexual experimentation' etc. (Knopp, 1982). This relates to some societal views that a child cannot have a sexual intent or an intent to cause harm as they are too young and lack that level of understanding (Lovett et al., 2018: Martin, 2014).

3.4.2. Children and sexuality

The debates about children and sexuality are driven by two totally opposite constructs - the sexually innocent child and the innately sexual child (Lovett et al., 2018; Taylor, 2017; Delap, 2015; Gutting, 2005). The sexually innocent child is believed to have no sexual intent in their behaviour as they are too young to understand, the innately sexual child is depicted as being capable of making sexual choices (Delap, 2015), might seek out sexual activities, or lie about abuse (Lovett et al., 2018; Delap, 2015).

The concept of the innately sexual child is still present in discourses around child sexual exploitation (CSE), with references to the girls knowingly taking 'risks', or that the sex was 'in exchange' for goods, money or attention, which some felt implied the child was in a barter relationship. The language was eventually changed in the Sexual Crime Act 2015 section 68 to sexual exploitation of a child (Department of Justice Northern Ireland, 2020; McAlinden, 2014; Berelowitz et al., 2013). It is also

still present in the current developments around technology assisted – harmful sexual behaviours (TA-HSB).

3.4.3. Characteristics of children who engage in HSB

Prevalence

It has been difficult to establish this in relation to children as prevalence and recidivism studies are usually based on criminal justice statistics. Many of the children are under 10 years old, the age of criminal responsibility in the UK, and even those who are between ten and twelve years old will often be diverted away from the criminal justice system, to protect them.

In adolescent studies, females account for approximately 2.6% to 8-12% of those who have sexually abused (Hackett, Branigan and Holmes, 2019), but in children's studies, for children under the age of seven years old, the figures are approximately 40% dropping to approximately 5% by the time they reach puberty and adolescence. This is believed to be connected to gender socialisation, with boys continuing to act out and girls beginning to internalise negative and traumatic emotions (Hamilton-Giacritsis et al., 2017; Chaplin, 2015; Carson, 2008; Sandnabba, et al., 2003; Silovsky and Niec, 2002; Consentino et al., 1995; Cutler and Nolen-Hoeksema, 1991).

Family Background, Abuse and Trauma

Non-sexual pathways to children's sexual behaviours were found in their family dynamics, particularly in violent or chaotic families where sex was routinely paired with aggression and there were high levels of tension and fear (Carson and Aujla, 2021; Allen, 2017; Elkovitch et al., 2009; Hall et al., 2002). Or with unstable or unpredictable parents/carers creating impaired attachments; changes in caregivers, leaving children with high levels of anxiety and insecurity; or neglectful families where there was little warmth or empathy (Carson and Aujla, 2021; ATSA, 2019; Elkovitch et al., 2009).

Sexual pathways to children's sexual behaviours were either that they had 'witnessed it, experienced it, or lived with it' (Carson, 2019). Those who witnessed it or lived with it, were in highly sexualised environments where they were exposed to sexual activity or information that was beyond their developmental level of understanding, creating confusion and anxiety related to sex, or where they were potentially put in the role of 'pseudo-partner' to their parents, providing emotional and physical comfort for them with blurred boundaries re intimacy. (Carson, 2019;Allen, 2017; ATSA, 2008).

Some had been sexually abused, and many younger children's sexual behaviours were either learned behaviours or they were re-enacting them through distress (Carson and Aujla, 2021; Allen, 2017; Elkovitch et al., 2009; Burton, 2000; Cunningham and McFarlane, 1996; Gil and Cavanagh-Johnson, 1993). For some children sexual abuse had 'eroticised' their bodies, accelerating stronger sexual feelings in their genitals than would be developmentally normal, at a time when they have limited cognitive development, to be able to process and understand what is happening (Carson, 2019; Hamilton-Giachritsis et al., 2017; Yates, 1993).

3.5. Types of sexual behaviours and recidivism

3.5.1. Children's sexual behaviours

Using Hackett's (2010) continuum *(see Figure 4, Chapter Three)* normal sexual behaviours between children are usually spontaneous, mutual, consensual, curious and exploratory in nature, with both boys and girls touching their own and other's genitals, peaking at about age five and then reducing as awareness of 'social rules' develops and then gaining momentum again at puberty (Friedrich et al., 1998) This correlates with Freud's concept of infantile sexuality (Taylor, 2017; Martin, 2014; Freud, 1905).

With regard to HSB practice, the majority of the sexual behaviours displayed by children fall into the inappropriate or problematic parts of Hackett's (2010) continuum, but for older children primarily aged between ten to twelve years old

some can fall within the abusive part of the continuum (Carson, 2019; Chaffin et al., 2002). Children's sexual behaviours do not all have a sexual intent; for most the sexual behaviour is meeting an emotional or physical need and assessments and interventions need to be primarily focused on those needs when trying to reduce or stop the sexual behaviours.

3.5.2. Adolescent sexual behaviours

Adolescents can display a range of behaviours on Hackett's continuum from normal development where they are interested in sexual information and imagery, through to abusive / violent behaviours such as sexual assaults and rape which are criminal offences. HSB research and practice has identified themes which are frequently present, such as it is primarily males, usually with peers, usually male to female and that there is usually a gender preference, i.e., that the individual will either target males or females but not usually both. It has also identified potential sub-groups which share commonalities, as well as factors which are not common and if they are present would increase the risk of recidivism as the individual is less willing or able to desist (Leonard and Hackett, 2019; Edwards et al., 2012; Pullman and Seto, 2012; Finklehor et al., 2009; Parks and Bard, 2006; Hanson and Morton-Bourgon, 2005; Worling and Curwen, 2000).

3.6. Recidivism

Recidivism statistics for adolescent sexual offences show that they are lower than for any other type of offence (Leonard and Hackett, 2019; Chaffin et al., 2002; Prentky et al., 2000). For example, the Youth Justice Board (2023) statistics for 2021/2022 show that recidivism for adolescent sexual offences was (6.8%) (consistent over the last ten years) compared to recidivism rates for theft (37.2%) and drugs (33.3%). Many simply matured, gained consensual sexual partners, had different, new challenges in life, or had a positive interaction with pro-social adult role models or as Hackett referred to them 'social anchors' (Boswell et al., 2014; Hackett 2014; Edwards et al., 2012; Hackett and Masson 2011; Ward 2004).

With recidivism statistics for sexual offences being low at only 6.8% reoffending (Youth Justice Board, 2023) this means there is only a small sub group of adolescents whose HSB was likely to be persistent. HSB research has been focused on identifying the potential characteristics in profiles and behaviours of these individuals that increase the chances of recidivism (Smith et al., 2014; McCann and Lussier, 2008; Parks and Bard, 2006; Salter et al., 2003).

3.6.1. Sub Groups

From research and practice different sub groups within the adolescent HSB population emerged with important distinctions when thinking about their motivation to harm and what form of intervention would be most effective. Beckett and Gerhold (2003) found those who had committed rapes had higher levels of delinquency and criminality but lower levels of being abused themselves. Parks and Bard (2006) identified three groups: those who harmed children; those who harmed peers or adults and those who harmed both types. They found those who harmed both presented a higher risk of recidivism and their level of sexual preoccupation was more pervasive.

Pullman and Seto (2012), using data from Seto and Lalumière's (2010) meta-analysis of 59 studies explored this further and identified what they termed '*generalists'* and *'specialists'*. The *generalists* were deemed to be the majority of adolescents involved in HSB and likely to be also involved in other forms of anti-social or offending behaviours. The *specialists* were less likely to commit other forms of offence and more likely to continue to sexually offend, due to sexual preoccupation. These adolescents often have difficulties with attention, motor skills, speech and language; struggled with the development of intimate relationships, whether friendship, romantic, or sexual and may be socially isolated.

Although not functioning intellectually at a lower level of IQ, they may feel an emotional congruence with younger children as they feel less challenged and more comfortable in their company or feel more able to dominate and control them (Carpentier and Proulx 2011; Chu and Thomas, 2010; Almond et al., 2006; Hunter et

al., 2003; Worling and Curwen, 2000; Ford and Linney, 1995). They are more likely to target siblings and people they know, rather than strangers (Hunter et al., 2003, Rayment-McHugh and Nisbet 2003; Taylor 2003).

Almond et al's (2006) study in the UK of 300 adolescents with HSB found the majority (71%) could be split into one of three groups – impaired - 88 cases (29%); abused 85 cases (28%); delinquent 42 cases (14%). *Impaired youth* were described as having a wide range of emotional, psychological and physical impairments, behavioural problems, educational difficulties, ADHD and learning disabilities; they were more similar to Pullman and Seto's (2012) specialists. *Abused youth* had experienced frequent physical or sexual abuse and their behaviours were often as a result of their trauma. *Delinquent youth* were more similar to Pullman and Seto's (2012) generalists and committed sexual offences but also had other anti-social behaviours and offences.

3.6.2 Contextual high risk, red flag factors relating to the behaviour

Penetration – actual or attempted, particularly if there were signs of distress

Most adolescent HSB does not involve penetration so, when an adolescent has attempted or actually penetrated another person, anally, vaginally, orally or digitally without consent, or has encouraged them to do this online, this is of high concern (Hackett et al., 2013). Often manipulation, threat or coercion has been used to overcome the other person's resistance and it may be indicative of behaviours that have been going on for some time, if the adolescent has been able to groom and subdue the other person. If there has been no previous contact the seriousness of the act in terms of rape or sexual assault may indicate a compulsiveness to their sexual behaviour. If the behaviour continued when the other person was showing distress, especially if the person's distress was increasing the sexual arousal, then this would further increase the concern (Leonard and Hackett, 2019).

Manipulation/ Coercion or Threat

The presence of manipulation, coercion or threat increases concerns as it shows that the individual understands that their behaviour is unacceptable and that the other person is not consensually engaging in the behaviour (Carson, 2019).

Lack of empathy, cold and callous

If the adolescent is perceived to lack empathy for the person they harmed or is unrepentant about the harm they have caused and responds in what is considered to be a cold and callous way, then their engagement in any intervention to get them to desist from the behaviour is likely to be unsuccessful. There are concerns that this may be an indicator of a potential underlying mental health issue such as sociopathy or psychopathy, although these are not diagnosable under the age of 16 years old and there are insufficient studies on these types of cases (Edwards et al., 2012).

Unusual sexual interests/ hyper sexuality

A minority of adolescents in HSB research and practice are interested in unusual sexual acts such as paraphilias, for example exhibitionism (exposing genitals in public) or foot fetishes, most of which are not illegal but they are unusual. Where their HSB is connected to their unusual sexual interests, this would increase the level of concern (Hanson and Morton-Bourgon, 2005; Wilpert, 2018). Those considered to be hypersexual having excessive sexual preoccupations would also be of concern (Leonard and Hackett, 2019; McCann and Lussier, 2008).

3.6.3. Contextual high risk, red flag factors relating to who is targeted

Strangers

Most adolescents target someone known to them, sexual behaviour directed towards strangers is rare, for example, in Finklehor et al's (2009) large study of 12,450 young men who had sexually offended, only 2.6% of the people they targeted were strangers. These sexual acts are more akin to the behaviours of adult rapists who target strangers.

Younger Children / Adults / Mixed age and gender

In the main, adolescents tend to abuse their peers; when they target younger children or adults this raises concerns as it is considered 'deviant' from the 'norm', or to be unusual sexual interests (Edwards et al., 2012; Hanson and Morton-Bourgon, 2005; Worling and Curwen, 2000). Significant age differences with younger children, for example a 14 year old male and a 6 year old female can be indicative of Pullman and Seto's (2012) *specialists* . Those who are indiscriminate with regard to gender or age, targeting children, peers and adults are considered to be higher risk, as their behaviours are often compulsive and opportunistic, making safety planning more difficult to achieve (Parks and Bard, 2006; Worling, 2002).

Male on male

The majority of adolescent HSB is of males to females. In the studies of those who abuse males, it was found that many of them had been abused by older males when they were younger and were replicating their abuse by targeting males of a similar age to when they were abused (Finklehor et al., 2009; Veneziano et al., 2000).

3.7. Technology-Assisted Harmful Sexual Behaviour – TA-HSB

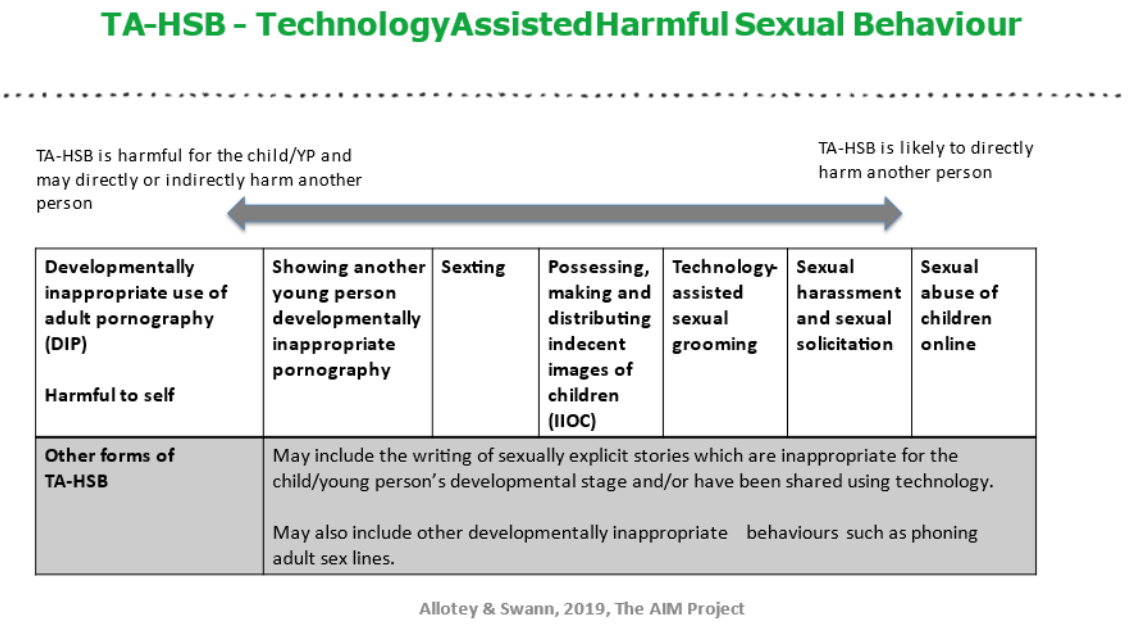
3.7.1. Definitions

Within the last ten years, the increased use of the internet and social media among children and adolescents has led to a new aspect of HSB being identified as technology assisted harmful sexual behaviours (TA-HSB). TA-HSB is defined as one or more children/adolescents using the internet and/or any image-creating/sharing or communication device to engage in sexual discussions or acts which are considered inappropriate and/or harmful given their age or stage of development.

This behaviour falls on a broad continuum *(see Figure 5 below),* from the use of pornography to online child sexual abuse and/ or exploitation including the creation and distribution of indecent images of children (IIOC). It also includes access to

online sexual imagery, some in relation to paraphilias and some including graphic and violent sexual imagery which can be integral to their direct contact HSB (Allotey and Swann, 2019). The terminology of Dual HSB is used for both those who abuse both on and offline and for those who abuse offline but use online pornography online as part of their arousal process (Allotey and Swann, 2019).

Figure 5 : TA-HSB continuum (Allotey and Swann, 2019)



3.7.2. Prevalence

This is another emerging research base with currently more studies based on adult populations than adolescents, so there is limited prevalence or characteristics data (Eke, Seto and Helmus, 2019). TA-HSB has a lower rate of recidivism with two studies showing it as 1.9% compared to direct contact HSB which is approximately 6.8% (Aebi et al., 2014; Stevens et al., 2013), potentially because some adolescents were either unaware of the legal, social and moral boundaries or they were pushing boundaries, but when confronted, this made them desist.

TA-HSB is more likely to be a male activity, with girls over three times more likely to be the target (Hollis and Belton, 2017; Seto et al., 2015; Aebi et al., 2014; Stevens et al., 2013) and the males mostly targeting people they know (Vaswani et al., 2022).

3.7.3. Family backgrounds, trauma and abuse

Belton (2017) found 44% of the adolescents referred to the NSPCC Turn the Page service for TA-HSB had experienced child maltreatment and abuse including bullying by peers, with 25% of them having been groomed and sexually exploited online by adults, which was then replicated in their own behaviours. They had similar family backgrounds to other adolescents involved with HSB. However, other studies which compared TA-HSB and direct contact cases found a strikingly different picture to the usual adolescent profile, with adolescents engaged in TA-HSB generally older, with a better level of education and more stable backgrounds, with less family dysfunction, abuse and neglect (Hollis and Belton, 2017; Moultrie, 2006). Practitioners have also highlighted these profile differences.

3.7.4. Similarities to previously identified sub-groups

Moultrie (2006) found those who engaged in TA-HSB only, had fewer previous convictions and less anti-social behaviour, so were more like Pullman and Seto's (2012) 'specialists' category or Almond and Giles (2008) 'impaired' group, in that they showed a greater level of sexual interest in children, had greater friendship difficulties and displayed more cognitive distortions than offline offenders.

Hollis and Belton's (2017) study found those who had Dual HSB, who abused offline but used online pornography as part of their arousal process had more in common with offline offenders and had similar profiles of disrupted attachments, family dysfunction and abuse, so were more like Pullman and Seto's (2012) 'generalist' category and Almond and Giles's (2008) 'delinquent' group. They also had more difficulties with impulsivity, emotional regulation, anger and aggression to themselves and others and to have other offending behaviours (Hollis and Belton, 2017).

Vaswani et al., (2022) also found that 36% of cases in their study had a vulnerability such as a mental health condition, learning disability or autism, either diagnosed or possible. Two thirds of the autistic adolescents were described as socially isolated. For those described as 'collectors', who had hundreds of IIOC images and traded them, many of them had autistic traits of fixation becoming unhealthily pre-occupied

with the collection and categorisation of the pornography rather than for sexual gratification (Allely, 2022; Brown et al., 2016).

3.7.5. Trauma impacts

As the behaviour is primarily online and not direct contact there is a concern that practitioners view it as less damaging but Leonard (2010) warns that some individuals are left traumatised with serious emotional and sexual problems. Some have sought help but returned to chatrooms and arenas online where they continue to be abused or potentially now abuse others. They may receive less sympathetic responses due to societal views of them being responsible for their own abuse or wanting to be abused; this is linked to the concept of the innately sexual child who is seductive or promiscuous (Hamilton-Giachritsis and colleagues 2017; Leonard, 2010). However, many return as they may have developed sexual needs as a result of their abuse which they cannot resolve through appropriate sexual acts (Hamilton-Giachritsis and colleagues 2017; Leonard 2010).

3.7.6. Impact on psycho-sexual development

Children and adolescents now live in a digital world 24/7, accessing their school, social and leisure interests online, as well as using it to seek sexual information and imagery (Vaswani et al., 2022). A report by the Children's Commissioner (2022) found that by age nine many children had mobile phones and/or iPads and that 10% of them had seen pornographic content, by 11 years old they were on social media sites with sexual content. By the age of 18 years old, 75% of young people have seen violent or illegal pornography, some will have viewed out of curiosity, accidentally or peer pressure (Flander et al., 2009) but frequent users of this type of material are more likely to engage in physically aggressive acts (Hollis and Belton 2017; Martellozzo et al., 2016; Mascheroni and Olafsson, 2014, 2016; Horvath et al., 2013; Häggström-Nordin et al., 2009).

In studies, the pressure to send and receive sexual images whether or not this was consensual was seen as part of adolescent life (McGeeney and Hanson, 2017; Martellozzo et al., 2016; Fixers, 2015; Parker, 2014; NSPCC, 2012; Phippen, 2012;

Ringrose et al., 2012). It was underpinned by sexist and misogynist attitudes and power issues in male peer groups where the 'collection' of nudes can confer status. (Barroso et al., 2023; Vaswania et al., 2022; Belton, 2017; Hamilton-Giachritsis and colleagues 2017; Ghani and Barnardos, 2016; NSPCC, 2012; Ringrose et al., 2012; Kellog, 2010). Sexual harassment on and offline is now a more significant issue for secondary school headteachers than drugs or other forms of bullying (UKCCIS, 2016).

Engagement in chatrooms can normalise unusual or illegal sexual fantasies, shaping attitudes and behaviours (Fixers, 2015; Phippen, 2012). The internet is designed to be addictive through the use of algorithms (Vaswani et al., 2022), which also can have a disinhibiting effect (Lewis, 2018; Moultrie, 2006; Durkan and Bryant, 1995). Frequent viewing of extreme porn could be to indulge fantasies (Lewis, 2018) but it also correlates with sexually coercive behaviours offline, with frequency of use leading to many wanting to try it out (Aebi et al., 2014; Stevens et al., 2013; Svedin et al., 2011; Moultrie, 2006). This has led to an increase in referrals to specialist HSB agencies, for example in Lewis's (2018) study of 92 open cases, 46 had some form of TA-HSB as part of the presenting behaviour.

3.7.7. Radicalisation

Extensive, unsupervised online access has also made children and adolescents more vulnerable to becoming radicalised, through being drawn into forums, chat rooms and websites, particularly around terrorism (Al-Attar, 2017) and male sexuality, either male power sites or incel [14]sites. The incel ideology attracts primarily males who are frustrated or angry with their own perceived lack of ability to have successful romantic and sexual relationships. The incel ideology includes some misogynist views of a sense of male entitlement to have sex and anger with females for not providing it for them (Maxwell et al., 2020; Ging, 2019). They blame social liberalism, feminism and active sexual males for their lack of success and feel that as a result of feminism, females are now too 'fussy' (Sparks et al., 2023).

[14] Incels – Involuntary celibates ideology which

Many of them struggle with loneliness, lack of friendships, difficulties in social skills, social anxiety and depression (Sparks, 2023). There is discussion about the draw of this ideology for some autistic individuals (Sparks et al., 2022; Jaki et al., 2019) and in one study using self-report 40% identified that they had autism or other similar conditions contributing to their isolation and their interest in the incel ideology (ADL, 2020). However, in the incel community the term autism is used more broadly for a range of behaviours such as social awkwardness, therefore the figure may not actually reflect the numbers of those who are diagnosed autistic, (Sparks et al., 2022).

3.8. Related offences

Both arson and violence are offence types that are frequently present along with HSB and would always be considered in HSB assessments. Violence paired with sexual abuse would increase the level of harm and the risk of recidivism (Leonard and Hackett, 2019; Hackett, 2010). There are no clear reasons why arson should be frequently connected to sexual offences. Hypotheses are that fire setting has a sensual element; there are power and control issues with arsonists with some needing to create a crisis, others to destroy evidence of other crimes. For some it may be a trauma response and the significance of the site of the fire should be recorded in assessments (Bladon et al., 2005; Araji 1997; Cunningham and MacFarlane 1996).

3.9. The theoretical perspectives underpinning HSB practice

3.9.1. Psycho-social constructs

Psycho-social constructs are the primary theoretical models underpinning HSB work; they include trauma informed practice and attachment theory (Skuse and Matthew, 2014; Creeden, 2013; Hughes, 2009; Perry, 2009; Crittenden, 1995); deficits and distortions (Ward and Beech, 2016; Thornton, 2002); cognitive and moral development (Piaget, 1932; Piaget, 1936) and denial/minimisation and shame (Taylor, 2017; Smith et al., 2014; Braithwaite, 1989; Foucault, 1978).

Trauma Informed Practice and Attachment problems

It is believed that for many, but not all, their sexual behaviours come from their own abuse. This is not always sexual, it also includes emotional, physical and neglect, or disrupted childhoods and attachments or other adverse childhood experiences (ACEs) (Creeden, 2013; Longo et al., 2013; Randall and Haskell, 2013). Therefore, practitioners often have to deal with the cognitive dissonance of treating the abuse experience of the adolescent they are working with, as well as holding them accountable for the harm they have caused others and getting the balance right between both those opposing demands (Armstrong, 2021).

For some their behaviours may have been learned as the result of conditioning, so their boundaries between sexual acts, attention and affection become blurred (Finklehor and Brown, 1985). For others re-enacting their trauma but in the role of abuser can be a way of managing feelings of helplessness, fear, shame, distress etc (Hawkes, 2011).

Studies have shown high rates of PTSD in adolescents with HSB (McMackin, 2002; Righthand et al., 2001; Bourke and Donohue, 1996). Stress caused by abuse or (ACEs) can have an impact on how the brain develops and affect how the individual deals with future adverse experiences (Bentley et al., 2020; Petchel and Pizzagalli, 2010).

Creedon (2009) described stress from abuse as leading to problems with emotional regulation while experiencing high levels of intense emotions; problems with attention and dissociation; difficulties in communication and initiating and sustaining satisfactory relationships, with individuals with PTSD being so self-consumed they have little insight into the feelings and needs of others nor little sense of the need to prioritise these over their own. PTSD signs include high levels of anxiety, depression, hyper vigilance to potential real or imagined threats. They have trust issues, tending to view the world as aggressive and unlikely to support them (Vizard, 2013; Kellogg, 2009; Swisher et al., 2008; Bonner and Berliner, 1999).

Strong attachments provide security and the foundations for the development of self-esteem, emotional and behavioural regulation. Where there is attachment insecurity this is considered integral to the development of dysregulated or harmful sexual behaviours (Leonard and Hackett, 2019; Hackett, 2014; Creeden, 2013; Longo et al., 2013; Rich, 2006).

Deficits and distortions

HSB often signifies there are deficits in emotional health and intimacy with attachment difficulties, low self-esteem and poor empathy skills (Ward and Beech, 2016; VanderLaan et al., 2014; Ward and Siegert, 2002). They may have problems with emotional regulation and impulsiveness, with sex being used as a coping or soothing strategy, or that it has become pervasive or problematic for them (Leonard and Hackett, 2019; Palermo and Bogaerts 2017; Mehzabin and Stokes 2011; Attwood 2007; Thornton, 2002). Cognitive distortions are where the individual justifies their behaviour to themselves as being appropriate (Finklehor, 1984). Some of these distortions may be based on societal or peer beliefs around gender power and control or misogyny (O'nions et al., 2023; Conroy, 2017; Chaplin, 2015; Dominelli, 1989).

Piaget's theories of cognitive and moral development

Piaget's theories of cognitive and moral development state that children are not simply mini adults and did not think in the same way as adults. Their moral reasoning was shaped as much by interactions with peers as through adult direction (McLeod, 2023; Cherry, 2019; Hammond, 2014; Meadows 1983; Piaget, 1936; Piaget, 1932). His theories became substantially relevant in later discourses about the ability of children and some autistic individuals to understand their own behaviours as sexual or the morality of their behaviours as they would be perceived by others – a concept called 'counterfeit deviance' (Hingsburger, Griffiths and Quinsey, 1991).

Denial / Minimisation and Shame

Denial / minimisation and shame are overwhelming features of HSB work, due to the societal constructs around 'acceptable' and 'deviant' sexual behaviours and the immense social backlash against those deemed to be 'deviant' and the need to control them, primarily through shame (Taylor, 2017; Smith et al., 2014; Braithwaite, 1989; Foucault, 1978). Denial or minimisation by adolescents was initially seen as a high risk factor in HSB work, influenced by the experiences of working with adults. It is only within the last five years that practice has changed with denial being seen as a natural defence mechanism, which does not necessarily prevent work from being effective, but can make it harder to start (Leonard and Hackett, 2019).

Shame also affects those who have been harmed; many people do not report their abuse because of the stigma about being sexually abused (Masson, 2001). It affects families who may be split up as a result of the abuse, or who become stigmatised, isolated, verbally and physically abused or forced out of their homes by community reactions (Hackett et al. 2013; Foucault, 1978).

Minimisation, while linked to denial and shame, may also happen because a parent struggles to believe that their child could do something so shameful, or they fear for them, or that it raises abuse they themselves have experienced. Working with parents to explore and understand what has happened is essential (Carson, 2019).

3.9.2. Biological constructs

Concerns in adult research and practice re mental health issues or disorders such as psychopathy, sociopathy, paraphilias, particularly paedophilia, are contentious with regard to adolescents. Adolescents under the age of 16 years old are unlikely to be diagnosed, due to their stage of development (DSM-5; Tenbergen et al., 2015). Current discourse is that those aspects of the brain which control executive functioning,[15] sexual desire etc are still in development until individuals are in their early twenties (Johnson et al., 2009). Adolescent HSB practice is moving towards inclusivity of these 'older adolescents/young adults' (Worling, 2017).

[15] *Executive functioning – See Appendix Three for more details*

The main biological factors in adolescents with HSB relate to the hormonal changes with puberty, which exacerbates sexual drives and interests regardless of the individual's social, emotional and psychological development and skills. The impact of trauma and abuse in their backgrounds can also have a significant impact on their physical and mental health and development and can be a driver for impulsive, violent or aggressive sexual behaviours (Mercer, 2020; Guilhermino and McCarlie, 2019; Van der Kolk, 2014; Creeden, 2009).

3.10. Assessment and Interventions

3.10.1. Assessment and intervention with adolescents

Although the NCH (1992) report had recommended that there should be a holistic approach to adolescents, focusing on their strengths as well as their sexual behaviours and inclusive of their family and broader environment (Smith et al., 2014), initially adult assessment models and intervention programmes with only minor adaptations were used and the sole focus was on the sexual behaviour.

Until the last five years, HSB adolescent assessment models were actuarial models of assessment trying to predict risk and recidivism, with the goal to prevent further harm by focusing on who was more likely to cause harm. This approach caused stigma for many adolescents considered to be a 'high risk' affecting their lives, educationally and socially, as there were no comparable factors to identify that the 'risk' had changed or been eliminated and 'professional anxiety' about risk management meant that many never had this decision reviewed or rescinded. It also did not give the practitioners guidance on what interventions would be more effective.

The development of theoretical perspectives underpinning the understanding of the causal factors of HSB, what increases recidivism and importantly what supports desistence, began to shape the development of assessment and treatment programmes, with the recognition that adolescence is a different developmental stage (Johnson et al., 2009). Their behaviour and cognitive distortions were not as

entrenched as those of an adult and their motivations were often more about trauma and emotional needs, than purely sexual drives.

Challenges to the welfare first approach and seeing them as adolescents in need, came from support groups for those who had been harmed, who argued that the focus had swung too much towards the person causing the harm and the support they need, leaving less resources and time given to the person who had actually been harmed (Armstrong, 2021).

In the last five years, practice has moved towards more holistic models, understanding the adolescent in their entire context, socially, emotionally and behaviourally and the need to engage and work with their family as well as the individual, for example the AIM3 model [16](Leonard and Hackett, 2019). The goals of the AIM3 model are to understand why the behaviour happened, what needs it met and what would lead to desistence from the behaviour (Mercer, 2020; Hackett, 2014; Smith et al., 2014). This does not create low, medium or high risk outcomes but an overall picture of where the concerns and strengths in the individual and their context lie, giving a clearer direction for what interventions would be more effective. It is also dynamic, capable of being reviewed and updated, giving a visual representation of progress being made which can reduce 'professional anxiety' in decision making.

The reason I chose to use the AIM3 model for the development of the Practice Guidance on Autism and HSB, was that it is the most used model in the UK/Ireland and internationally so provides practitioners with a model they already understand and use in practice, with the added advantage of the model being dynamic so that it can be adapted for different populations. The purpose of this research was to develop theoretical constructs on what was similar and different to the core knowledge in the AIM3 model, so I could 'layer' onto the core model, suggestions of things for the practitioner to consider if the person they are working with is autistic.

[16] AIM3 – An adolescent sexual assessment model providing a holistic overview and directions for interventions (Leonard and Hackett, 2019) The AIM Project

With regard to interventions, there has also been a move away from set HSB programmes which were not adapted for individual learning styles or the needs of that adolescent, so were often less effective. Although it appears progress has been made towards a new way of working, Smith et al's (2014) study of practice and policy in the UK showed that implementation was patchy and adolescents with HSB continue to be criminalised despite the fact they are more likely to desist from the HSB and involvement in the criminal justice system is known to be associated with poor outcomes (Masson and Hackett, 2003).

3.10.2. Assessments and Interventions with children

Assessment and intervention work with children has progressed from simply adapting the adolescent models (Longo et al., 2013). Problematic sexual behaviours are taken seriously as early intervention can be more effective. Current practice is more developmentally appropriate, being based on knowledge of child development, for example, that when younger they are more concrete thinkers and may struggle with theory of mind (TOM) due to being ego-centric (Piaget, 1932, 1936) therefore their ability to express cognitive empathy may be much less than older children or adolescents (Swisher et al., 2008). It also uses more educative, boundary setting and re-directive strategies and includes work with their parents/carers (Carson, 2019).

3.11. Understanding Autism

The knowledge base on autism is vast therefore this section is a brief overview of the development of the current understanding of autism, the theoretical underpinnings of practice and the research base on autism and sexuality.

3.11.1. Definitions and Diagnosis

Autism is a lifelong condition beginning in early childhood. Current diagnostic criteria in DSM-5 [17]and ICD-11[18] have simplified the definition of autism to two criteria:

a) persistent difficulties with social communication and social interaction;

b) restricted and repetitive patterns of behaviours, activities or interests.

These include sensory behaviours and behaviours which are atypical or excessive for an individual's age or sociocultural context (ICD-11).

The diagnostic criteria has also been broadened to acknowledge that autistic females may present in different ways to males (Cridland et al., 2013) and it allows for inclusion of individuals who were not identified at a young age because they may have successfully covered up their autistic traits to try to fit in with their peers, called 'masking' which only then become evident in adolescence when their coping mechanisms become overwhelmed by the additional complex social and communication demands around friend, romantic and sexual relationships and the identification of their own sexuality (Gadsby, 2022; Vinter and Dillon, 2020; Fernandes et al., 2016; Kim, 2015: Cridland et al., 2013; Nicols and Blakely-Smith, 2010). It also acknowledged that some autistic people have co-existing conditions such as learning disabilities, attention deficit hyperactivity disorder (ADHD),

[17] DSM-5 – Diagnostic and Statistical Manual of Mental Disorder 5th Edition – American Psychiatric Organisation
[18] ICD-11 – International Classification of Diseases 11th Edition – WHO – World Health Organisation, version used in the UK

attachment difficulties, executive functioning problems and alexithymia [19](NICE, 2021; Whitewell, 2021; Fletcher-Watson and Happé, 2019; Ratajczak, 2011).

3.11.2. Possible autistic characteristics

Practitioners have increasingly raised concerns about growing numbers of children and adolescents on their caseloads, who do not have a diagnosis but who they feel are showing autistic type characteristics (Edwards et al., 2012) which is one of the research questions for this study and poses some interesting questions for the wider debate about Autism and HSB. There are several reasons why they may not have a diagnosis:

a) They did not meet the previous diagnostic criteria, because their early history was missing;

b) The difficulties of getting a diagnosis due to limited resources, costs and length of waiting times;

c) Some adolescents have learned to mask some of their social and communication difficulties;

d) Other explanations for behaviours such as ADHD, oppositional and conduct disorders, executive functioning, alexithymia, speech and language difficulties are being overlooked, with everything being attributed to autism (Fletcher-NICE, 2021; Watson and Happé, 2019; Hofvander, 2017; Gilmour et al., 2012; Donno et al., 2010);

e) Trauma and attachment difficulties also create similar types of behaviours and reactions as autistic traits.

[19] *Alexithymia – See Appendix Three for more details*

3.11.3. Prevalence

Due to the changes in the diagnostic criteria and increased awareness of autism, the numbers of females and adults being diagnosed later in life are rising and estimates are now that approximately 1:100 people in the UK are autistic (O'nions et al., 2023; Fletcher-Watson and Happé, 2019; NICE, 2019; Gould, 2011). Several studies suggest that autism prevalence may be reaching a plateau (Baxter et al., 2015; Taylor et al., 2013) and there are arguments that the increase is also related to 'diagnostic substitution' with diagnoses of global developmental delay or intellectual impairment having declined (Fletcher-Watson and Happé, 2019).

Changes in diagnostic criteria has meant that the proportion of those with autism and learning disabilities is changing, from levels of 50-80% in some earlier studies (Kalyva, 2010; Frith, 2008; Ghaziuddin et al., 2002), to below 50% in more recent studies (Elsabbagh et al., 2012; Rice, 2009). The previously recorded high levels of learning disabilities are relevant to Autism and HSB as some of the older research indicates that the main behaviours were exposure or masturbation in public and sexual behaviours being displayed towards strangers or care givers, with the behaviours being attributed to their learning disabilities and the absence of sexual knowledge or intent (Realmuto and Ruble, 1999; Haracopos and Pedersen, 1992), therefore their learning disability may have been more relevant than their autism.

The ratio of the numbers of females to males with a diagnosis of autism is currently believed to be approximately 3:1 due to the increase in the numbers of females being diagnosed (Loomes et al., 2017). The change in the diagnostic criteria is welcomed (Gould and Ashton Smith 2011) because it acknowledges that autistic females, particularly those without a learning disability, may present differently to their male peers, for example, they may display stronger social skills, being able to mask and copy social interactions better and are more aware of the pressure to interact socially, although some lack reciprocity in their social play and they can be controlling or domineering. They can benefit from their special interests being more similar to their peers such as celebrities, animals etc. even if they are more intense about these interests (Gould, 2017; Cridland et al., 2013; Baron-Cohen et al., 2011;

Attwood, 2007).They have better imaginations and engage in more pretend play than boys and can have a rich and elaborate fantasy world with imaginary friends but have difficulty separating reality from fantasy.

However, they too may struggle with the additional demands of the complexity of social interactions in adolescence with evidence of their autism emerging at this stage of their life. The mimicking and repressing of their autistic behaviours is said to have resulted in high statistics for autistic women with mental health problems such as anxiety and depression (Gadsby, 2022; Gould, 2017; Yaull-Smith, 2007).

3.12. Potential causes of autism

Initially autism was conceived as having psychogenic rather than biological origins, with a belief that it was caused by cold and unresponsive parenting. Kanner originated the term ‘refrigerator mothers’ in the 1940s (Rudy, 2022; Fletcher-Watson and Happé, 2019), with some children being removed from their mother’s care. This theory was promoted for many decades particularly by Bettleheim (1972) but changed in the 1970s following challenges by parents of autistic children particularly the work of Rimland (1964) and Baron in the 1960’s (Fletcher-Watson and Happé, 2019) who set up the National Autistic Society (NAS).

The impact of this theory and the damage caused still resonates today in the discussions on Autism and HSB, due to attachment difficulties being considered a causal factor for HSB. Autistic authors such as Kim (2015) and the autistic peer reviewers in this study argued that while an autistic parent’s attachment styles with their children may not be the same as other parents they are not inferior nor indicative of attachment problems and in fact makes them better able to meet their autistic child’s needs (Hughes, 2022; Hurley, 2022; Kim, 2015).

Current discourses on autism indicate that the most prevalent causes appear to be genetic and environmental, but there is caution, as autism is still not fully understood (Fletcher-Watson and Happé, 2019). Genetic studies have shown that autism can

run in families with some parents also being autistic. There is 80-90% heritability with a 10- 20% risk of it occurring in more than one child in the family (Fletcher-Watson and Happé, 2019; Hofvander, 2017; Tick et al., 2016; Chaste and Leboyer, 2012). This is a relevant feature for the potential additional stresses which may be in the family backgrounds of autistic individuals with HSB. An autistic parent may also have had struggles in negotiating their own adolescence, social interactions and relationships, which may have shaped the role modelling and boundaries they provide for their children (Kim, 2015).

3.13. The Existing Evidence Base - Theoretical Perspectives

3.13.1. Autism as a behavioural disorder

The view of autism as a behavioural disorder emphasises deficits in executive functioning, thought processing, social and communication skills and having distinct behaviours relating to the need for consistency, fixed interests and repetition. In 1979, Wing published her seminal paper leading to autism being seen as a triad of impairments in social interaction, communication and imagination (Fletcher-Watson and Happé, 2019; Wing and Gould, 1979). As autism is not heterogeneous, Wing began to identify sub groups leading to the term ‘autistic spectrum’ (Wing, 1996). This view of autism as a deficit disorder continued with Baron-Cohen, Leslie and Frith (1985) linking autism traits to deficits in ‘theory of mind’ (TOM) i.e., the inability to conceive that other people have independent thoughts and feelings that explain their behaviour, sometimes also referred to as ‘mind blindness’ (Gadsby, 2022). Diagnostic criteria for autism were therefore based on a medical model of disorders with evidence of deficits through observed behaviours (Fletcher-Watson and Happé, 2019; Jack, 2012).

3.13.2. Theory of Mind (TOM)

Although Theory of Mind (TOM) is one of the most enduring theories about autism, it has been challenged, as TOM also occurs in other groups such as young children under three years old and those with learning disabilities, so is not specific to autism.

Autistic individuals' problems with TOM may be more related to issues with executive functioning and alexithymia (Fletcher-Watson and Happé, 2019; Scott and Baillargeon, 2017; Piaget, 1936). It has also been challenged by the autistic community who are highly critical of TOM being linked to theories that autistic people lack empathy. They argue that while some may have weaknesses in cognitive empathy (mentalising), many have affective empathy (the ability to respond to another's emotions) (Holt et al., 2022).

The belief that autistic individuals have deficiencies in understanding and being able to have insight into how they or their behaviour is perceived by others, has led to perceptions that they cannot meaningfully engage in research about autism, which has led to limitations in methodology, particularly around studies on autism and sexuality, with most earlier studies being based on information from parents/carers and professionals rather than self-reporting. Given that sexuality and sexual behaviour are a sensitive subject for any adolescent and their parents may struggle to conceive of their child as a sexual being, it is unlikely that the parents or carers reports were completely accurate.

3.13.3. Bio-Psycho-Social perspectives

Neurological perspectives began with Asperger in 1944 who originally espoused the extreme male brain theory which was then popularised in 2002 as a concept by Baron-Cohen and the Autism Research Institute (Gould, 2011) and believed to be part of the reason for the lower identification of autistic females (Fletcher-Watson and Happé, 2019). Neurology remains the current, prevalent model for understanding autism and describes variances in how the brain functions and the impact on cognitive processes, with autism being only one example (Pelicano and den Houting, 2022; Fletcher-Watson and Happé, 2019).

A current anomaly in the understanding of autism is that while it is seen as a neurological condition, there are no reliable genetic biological markers for identification (Muhle et al., 2018) therefore diagnosis of autism is through criteria based on observable behaviours and remains defined through a medical model

using a language of impairments or deficits (DSM-5[20]; ICD-11)[21] (Lo Bosco, 2023; Hughes, 2022; Fletcher-Watson and Happé, 2019; Bumiller, 2008).

The term neurodiversity was first coined by Judy Singer in 1998, as part of the establishment of counter arguments to the medical deficit model highlighting that autism is a neurological difference not a deficit (Hughes, 2022; Jack, 2012). With the rise of access to the internet, autism networks and forums online were able to develop their own autistic sub culture and political paradigm (Jackson-Perry, 2020; Dekker, 2019; Sinclair, 1993), citing that autistic difficulties are related to challenges posed by environments which do not enhance their ability to engage and perform well socially and also to professional practice which does not adapt to work with them. For example, Milton's (2012) double empathy theory which posits that breakdowns in communication between autistic and non-autistic people are a two way issue, caused by both parties' difficulties in communication and understanding each other (Zamzow, 2021; Milton, 2012).

3.13.4. Identity and language

The autistic community is as diverse as any other community and there are ongoing debates about identity and language, with some preferring person first language, of being seen as a person first – a person with autism, while others see autism as integral to who they are and how others relate to them and prefer the language of autism first - an autistic person (Fletcher-Watson and Happé, 2019; Frith 2008). Both these perspectives are similar to the debates by disability advocates.

[20] DSM-5 – Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (American version)
[21] ICD-11 - International Classification of Diseases, 11th Revision, World Health Organisation (version used in the UK

3.14. The development of the research knowledge

There is an increasing academic interest in studies on autism and sexuality, Greaves-Lord et al. (2020) noted that from initially there only being five studies in the 1980s (all about autism and asexuality) and 20 studies in the 1990s, there were over 115 studies by 2018 including systematic literature reviews by Hancock et al., 2017; Pecora et al., 2016; Dewinter et al., 2013).

With regard to autism and sexual behaviours particularly those which are considered atypical (paraphilias) or abusive/offending sexual behaviours, there is more of a consensus that there is a dearth in studies on this subject and that this is a relatively new area of clinical and academic research, with clinical practice being ahead of the field of research (Greaves-Lord et al., 2020; Visser et al., 2017; Fernandes et al., 2016; Beddows and Brooks, 2015; Kellaher, 2015).

3.14.1. Research limitations

The limitations as defined by the authors themselves and by meta-analysis or systematic reviews, identify there is a lack of consistency in the methodology with regard to language/definitions. Issues that particularly affected generalisability and the development of empirical factors were:

a) The populations being studied were usually in specialist clinical, residential or criminal justice settings (Visser et al., 2017; Beddows and Brooks, 2015; Sullivan and Caterino, 2008). There were no studies looking at front line practice settings such as education, children's social care, youth offending service, or Child and Adolescent Mental Health Services (CAMHs), or coming from specialist HSB services and this is a gap in the research knowledge base;

b) Limited sample sizes (Visser et al., 2017; Dewinter et al., 2016; 2013; Beddows and Brooks, 2015; Sullivan and Caterino, 2008);

c) Use of case examples - understanding of the more serious sexual behaviours was primarily based on the use of case examples, which limits the ability to understand causal or developmental factors for the behaviours (Greaves-Lord et al., 2020; Visser et al., 2017; Dewinter et al., 2016);

d) Lack of longitudinal and replica studies to confirm theories or findings, leading to a mix of some shared clinical knowledge but no definitive empirical factors (Young and Cocallis, 2023; Greaves-Lord et al., 2020; Malovic et al., 2020; Dewinter et al., 2016; Fernandes et al., 2016; Van Wijk et al., 2006);

e) Lack of, or inadequate, control or comparison groups (Greaves-Lord et al., 2020; Dewinter et al., 2016);

f) Circularity of information - there are fewer studies specifically on autism and HSB so they overlapped, quoting each other's findings, creating a circularity of information, but not replicating each other's methodology, therefore not providing validated factors. For example in meta-analyses, there are nine studies in Pecora, Mesibov and Stokes (2016) and six in Hancock, Stokes and Mesibov (2017) which cover the same information.

3.14.2. Specific issues

Language and diagnostic criteria

In the research studies on autism and HSB there is no consistent language with 'inappropriate' being used for a wide range of behaviours including sexual interest in children (paedophilia) (Fernandes et al., 2016). Sexual development and sexuality are often used interchangeably without clarity as to what aspect of either is being tested or discussed. There is even greater variance in language when related to gender identity. Due to changes in the autism diagnostic criteria between DSM-3 [22]and DSM-5, Palermo and Bogaerts (2017) highlight that these make the forensic and criminological perspectives re causal correlations more complex as previous

[22] DSM-3 Diagnostic and Statistical Manual of Mental Disorders – 3rd Edition

studies were using different definitions such as high functioning, Aspergers, classic etc. and that in the new diagnostic criteria some of the original Asperger cases would not now get a diagnosis.

Age, gender and ability levels

Some of the studies included in the knowledge base on adolescents and sexuality or HSB are based on adults, or young adults (Mezhabin and Stokes, 2011). Without longitudinal studies to track sexuality and sexual development, it is difficult to impute the value of the adult studies to an analysis of adolescent sexual behaviours (Dewinter et al., 2015; Byers et al., 2013; Howlin,2004). There are no studies specifically researching autistic children and sexuality or HSB and this is a significant gap in the research.

Most studies are solely or primarily on males with a few which include both males and females, but their numbers are too small to have any statistical validity (Corbett et al., 2020; Dewinter et al., 2016; Pecora et al., 2016; Kellaher, 2015; Mehzabin and Stokes, 2011). There is more overt gender diversity within the autistic population with studies using varied language and different aspects being focused on, which again created problems for coherence in research outcomes.

There is also a mixture of ability levels in the studies with some having co-existing learning disabilities while others have more cognitive ability and some studies include mixed abilities (Dewinter et al., 2016; Mehzabin and Stokes, 2011). This makes it difficult to generalise results but also creates misconceptions, for example, that the main sexual behaviours of concern for autistic individuals are public exposure of genitals or masturbation, or non-consensual touching of other people because some of the studies have been based on those with learning disabilities, when they are not representative of all the adolescents in HSB specialist services.

Self or parent reports

A key learning point from the literature review was on the involvement of autistic adolescents in the research, particularly on such sensitive issues as sexuality and

HSB. Early studies mostly based their information on reports from parents or professionals, because of ethical concerns about parents not agreeing to their child being exposed to sexual information that would upset them or create problems for them (Lo Bosco, 2023; Fourie, Kotzé and Van der Westhuizen, 2017; Fernandes et al., 2016; Kellaher, 2015; Beddows and Brooks, 2015; Hellemans et al., 2010; Stokes and Kaur, 2005).

Other reasons were related to difficulties in devising or adapting research tools which were accessible for autistic individuals (Kellaher, 2015;Helleman's et al., 2010) or the perception that an individual's autism restricted their ability to report on their own emotions, particularly on sensitive areas like sexuality and their sexual interests and behaviours (Stokes and Kaur, 2005; Realmuto and Ruble, 1999).

This has been changed in later studies due to autism advocates arguing that autistic people should be involved in research about them, and reflections from systemic reviews that the parents and carers views are more indicative of the parents' perspective than accurate reflections of the adolescent themselves, particularly as sexuality, sexual interests and behaviours are a sensitive subject that most adolescents do not usually share with the adults in their lives (Greaves-Lord et al., 2020).

Since 2011, the use of self-report has increased (Mogavero and Hsu, 2019; Visser et al., 2017; Dewinter et al., 2016; Gilmour et al., 2012; Mehazabin and Stokes 2011) with adaptations being made to research tools (Mehazabin and Stokes, 2011) however there are still some limitations for example, they are used mostly with those with more cognitive ability, so not reflective of those with learning disabilities; the individual may be able to make judgement of social situations on a theoretical basis but may not be able to apply this in a real life scenario (Visser et al., 2017); or that there can be an inherent bias of those who volunteer to be involved in sex surveys usually having a high interest in sexuality (Gilmour et al., 2012).

3.15. Existing knowledge base on Autism and Sexuality

The following information is the existing knowledge base on autism and sexuality, including sexual development; specific information on understanding autism and HSB will be covered in Chapter Four.

3.15.1 Healthy sexual development

Adolescence is a period of huge changes, psychologically, physiologically and emotionally (Corbett et al., 2020) when psychosexual development accelerates rapidly, requiring a whole new set of skills and knowledge (Visser et al., 2017) and when social communication and interaction becomes more complex and nuanced (Sala et al., 2020; Ray, Marks and Bray-Garretson, 2004) and may be a point when an autistic adolescent's abilities become overwhelmed (Fernandes et al., 2016), creating an increase in social anxiety, lower confidence and depression (Hamdan, 2022; Magiati, Tayand Howlin, 2014, Bellini, 2006).

While the majority of the research on autism and sexuality is focused primarily on the challenges for autistic individuals (Dewinter et al., 2016; Kellaher, 2015), it is essential to state that many autistic individuals experience fulfilling romantic and sexual relationships and that their sexual interests and experiences are not that different from their non-autistic peers (Greaves-Lord 2020; Dewinter et al., 2017; 2013 ; Strunz et al., 2017; Fernandes et al., 2016; Byers et al., 2013; Tolman and McClelland, 2011; Howlin,2004), although some may have to negotiate with their partners re sensory issues around touch if this is relevant to their autism (Attwood and Garnett, 2018). Several studies indicate that those experiencing positive romantic and sexual relationships are likely to have more cognitive abilities (Young and Cocallis, 2023; Greaves-Lord et al., 2020; Strunz et al., 2017; Dewinter et al., 2017; 2016; 2015; Fernandes et al., 2016; Pecora, Mesibov and Stokes, 2016; Kellaher, 2015; Byers, Nichols and Voyer, 2013; Mezhabin and Stokes, 2011; Stokes and Kaur, 2005).

3.15.2. Asexuality

Prior to the 1980s, very little attention was given in the research to autism and sexuality as it was presumed autistic people were not interested in sex or were asexual (Sala et al., 2020; Fourie, Kotzé and Van der Westhuizen, 2017; Kellaher, 2015; Gilmour et al., 2012; Sullivan and Caterino, 2008; Realmuto and Ruble, 1999). This is possibly because of higher levels of coexisting learning disabilities at that time (Maggio et al., 2022; Weir et al., 2021; MacKenzie, 2018; Fernandes et al., 2016). It might also reflect parents' anxiety and concerns for their children and struggling with their child's emerging sexuality and sexual drives.

Young and Cocallis (2023) queried whether the use of parent reports in early studies may have increased the statistics on asexuality. Lo Bosco (2023) felt that the focus on asexuality was related to the infantilisation of autistic individuals (the sexually innocent child theme again), and a desire to protect them due to a belief that they would be unable to 'fit' into adulthood, particularly sexually (Harfleet and Turner, 2016; Esmail et al., 2010; Rogers, 2009). Things changed and by 2010 onwards there was more emphasis on sexuality and sexual development being a normal developmental task for autistic adolescents (Greaves-Lord, 2020; Hellemans et al., 2007; Stokes and Kaur, 2005).

Since 2010 the research base (primarily on adults) has shown that some autistic individuals self-identify as asexual (Fernandes et al., 2016; Kellaher, 2015; Bejerot, 2014; Gilmour et al., 2012; Marriage et al., 2009). For some this was a life choice as some of them seemed to identify asexuality as being non-partner sex, as some indicated that they used porn and self-masturbation, so were interested in sexual imagery and some types of sexual experiences (Weir et al., 2021; Bush et al., 2020).

3.15.3. Early or late developers

Several studies found no difference between autistic and non-autistic adolescents in relation to the onset of puberty (Weir et al., 2021; May et al., 2017; Ray, Marks and Bray-Garretson, 2004). Others found either early or late onset of puberty, either of which could create a problem for an autistic individual, making them out of sync with

their peers, affecting their ability to absorb peer information on sexual behaviours and socially and legally appropriate boundaries (Attwood and Garnett, 2018; Stokes and Kaur, 2005) and leaving them at increased risk of peer exploitation, relationally, reputationally and sexually (Corbett et al., 2020).

The late developers in the research were all male (Corbett et al., 2020; Attwood and Garnett, 2018; Dewinter et al., 2016; Herguner and Herguner 2016; Attwood, Hénault and Dubin, 2014; Whitehouse et al., 2011; Sullivan and Caterino, 2008; Knickmeyer et al., 2006; Stokes and Kaur, 2005; Realmuto and Ruble, 1999) with some hypotheses that this may be due to uncertainty, anxiety or lack of skills to initiate a relationship or lack of access to suitable partners, for example if they live in all male residential or justice settings (Dewinter et al., 2016).

The early developers were all female (Corbett et al., 2020; Fourie, Kotzé and Van der Westhuizen, 2017; Pohl et al., 2014; Mouridsen, 1989). There is no analysis within the research knowledge base as to why this gender difference may be relevant to the onset of puberty, but it may have connections with the HSB literature on females who sexual abuse, as many of them begin their sexual behaviours at a young age due to the abuse they have suffered and their bodies have been eroticised, accelerating their sexual development (Carson, 2019), for example, Mouridsen (1989) had a case study of a girl aged five years old with harmful sexual behaviours. Being sexual so young could increase their vulnerability to exploitation and further abuse.

3.15.4. Psycho-sexual development

There is a common consensus in the research literature that the problems autistic adolescents experience with romantic and sexual relationships is less to do with their autism and more related to the need to have access to better social and relationship skills education and sex education, including learning the rules of courtship, dating etiquette and recognising signals from others particularly around consent. (Young and Cocallis, 2023; Maggio et al., 2022; Chianese et al., 2021; Greaves- Lord et al., 2020; Mogavero 2020; Sala et al., 2020; MacKenzie, 2018; Baarsma et al., 2016;

Dewinter et al., 2016; Fernandes et al., 2016; Beddows and Brooks, 2015; Kellaher, 2015).

For most adolescents their psychosexual development is shaped by information from friends, family and peers as well as the internet (Attwood and Garnett, 2018; Baarsma et al., 2016; Dekker et al., 2015; Dewinter et al., 2013; Tolman and McClelland, 2011), but autistic adolescents are less likely to get their sex and relationship information from these sources and are more likely to seek it from the internet and online sources (Young and Cocallis, 2023; Mogavero et al., 2020; Sugrue, 2017; Kellaher, 2015; Chan and John, 2012; Mehzabin and Stokes, 2011; Sulllivan and Caterino, 2008), although Dewinter et al., (2016) felt they were no more likely to access the internet for this type of information than their non-autistic peers.

Maggio et al., (2022) noted that use of online sources of information carries the risk of blurred boundaries and misunderstanding, which can lead to inappropriate behaviour (Allely and Dubin, 2018; Higgs and Carter, 2015). Some autistic adolescents have difficulties with differentiating fact from fantasy (Moran, 2015) which can mean they have difficulty in understanding what they view online is not representative of ‘normal’ sexual relationships or of issues of consent.

3.16 Gender and sexual identity

This is a rapidly developing field of study and there is considerably more discussion of differences in self-identification of gender and sexuality within the autistic research base than within the HSB research base. Even within autistic research, Strang et al. (2020) highlight that there are difficulties in interpreting the research literature due to varied methodology, language used and range of gender diversity experiences being measured. A further limitation they feel is that researchers and professionals tend to have specialisms or ‘silos’ in gender or autism but rarely both, making it difficult to determine any similarities and differences.

3.16.1. Gender dysphoria/ trans identities

Due the increasing knowledge base on gender dysphoria the terminology in the DSM-5 and the ICD-11 has been updated to identify gender dysphoria as psychological distress at incongruence between an individual's natal gender and their own gender identity, which is pervasive and affects their everyday life (Sala et al., 2020; George and Stokes, 2016; Glidden et al., 2016) to separate it from gender incongruence or gender inconsistency such as trans-identity or fluidity in gender identity. These are no longer classified as mental health disorders but as sexual health conditions (Bouzy et al., 2023; Maggio et al., 2022; Strang et al., 2022; Kellaher, 2015;Gilmour et al., 2012).

Greaves-Lord et al's (2020) meta-analysis indicated that autistic individuals were previously over represented in gender dysphoria services and statistics (Bouzy et al., 2023) for example, in De Vries et al's (2010) study the figures were 7.8% which was four times higher than that of the general population. However, there are some challenges to this, for example, Strang et al., (2020) make the point that some of the figures on the co-occurrence of autism and gender dysphoria are based on retrospective tests on those attending gender dysphoria clinics such as the Social Responsiveness Scale which can give high scores for autism when there are actually mental health concerns such as anxiety and depression.

Kallitsounaki and Williams' (2022) meta-analysis found that the numbers of studies on trans identity had increased over the last two years. They estimated the prevalence of autism in trans identity people at 11%, with trans men having more autistic traits than trans women. They state not all trans identity individuals also experience gender dysphoria. Bouzy et al. (2023) state that there is no causal link between autism and trans identity but that the conditions influence each other when they co-occur. Chen et al. (2023) found that executive function disorders were more frequent in autistic trans youth compared to non-autistic trans youth.

3.16.2. Gender socialisation

The social conditioning relating to a binary concept of male and female gender roles and power and control, begins at an early age and children learn what is socially acceptable and intolerable in relation to their gender, through observation, role modelling by adults and peers and retributions including ostracisation and bullying (Davidson and Tamas, 2015; Jackson, 2010; Dominelli, 1989; Foucault, 1978). One argument is that autistic people are less aware of and less influenced by social pressures, therefore are potentially less likely to conform to the social norms on gender (George and Stokes, 2016; Glidden et al., 2016; Davidson and Tamas, 2015; Lindsey, 2008). Sala et al. (2020) suggest that it may take longer for an autistic person to develop a sense of stable gender identity. Maggio et al. (2022) talk about those autistic individuals who are gender different as being in a ‘double minority’ and how this might impact on them socially and in terms of relationships.

3.16.3 Autistic perspectives on gender and sexuality

There are strong arguments put forward by autism advocates that the divergence from the social norm of binary gender and sexuality definitions, is less about autistic individuals simply not understanding the social norms, and more about those definitions confine them and do not describe who they are and how they feel (Jackson-Perry, 2020; Sala et al., 2020; Jack, 2012; Bumiller, 2008) and cause them discomfort (George and Stokes, 2016; Glidden et al., 2016).

Influenced by the neurodiversity movement Bumiller, (2008) and Greaves-Lord et al. (2020) talk of a new paradigm emerging where autistic people were developing their own sexual identities and definitions of relationships which were different to their non-autistic peers (Kourti and MacLeod, 2018; Barnett and Maricka-Tyndale, 2015; Bertilsdotir Rosqvist, 2014). The new paradigm describes gender as fluid and multidimensional (Jack, 2012) not a continuum but a ‘copia’ with a proliferation of multiplying possibilities (Bumiller, 2008) and reaching beyond the gender binaries (Jackson-Perry, 2020). Jack (2012) states that this raises a challenge for feminists and gender theorists which is an important point when considering that these

theories underpin much of the discourse on HSB. If they do not have the same meaning for an autistic person, how should they be interpreted?

Gender blindness described by Jack (2012) and Bejerot and Eriksson (2014) as being blind both to their own gender but also the gender of potential partners, meaning they choose their partners on other attributes. Autism and sexuality studies show high numbers of non-heterosexual relationships (Weir et al., 2021; Pecora et al., 2020; Mogavero and Hsu, 2019; George and Stokes, 2018; May et al., 2017; Mogavero, 2016; Bejerot and Eriksson, 2014; Byers et al., 2013; Dewinter et al., 2013; Gilmour et al., 2012; Hellemans et al., 2007; Ray, Marks and Bray-Garretson, 2004) and a greater tolerance of homosexuality or bisexuality than non-autistic peers (Kellaher, 2015; Dewinter et al., 2014). Asexuality was also a choice (George and Stokes, 2018).

Fernandes et al's. (2016) study was one of the few to contradict this as they did not find a higher prevalence of gay, lesbianism or bisexuality, however the study was based on parents' reports and they may be more reluctant to consider this aspect of their child's sexuality. A systematic review by Young and Cocallis (2023) found two other studies which also reported no real difference between the autistic and non-autistic population in relation to numbers of non-heterosexual relationships (Joyal et al., 2021; Dekker et al., 2015) but cautions that there are limitations with both these studies. Most of the studies involved males, with some only having a few female participants, but studies which included females indicated that there were greater levels of non-heterosexual attraction in the autistic female population compared to autistic males (Sala et al., 2020; Kellaher, 2015; Gilmour et al., 2012). In Maggio et al's (2022) study they found that bisexuality was four times more frequent in autistic women than in the female control group.

Chapter Four – Literature Review: Understanding Autism and HSB

4.1. Introduction

All the limitations in the research discussed in the previous chapter also apply to this chapter, with regard to methodology, language, settings, control groups, self-reports etc. This chapter focuses on the research studies which specifically looked at autism and sexual behaviours and provides information on prevalence, characteristics, types of sexual behaviours and the need for adaptations in current assessment and intervention processes. Throughout, where relevant, or available, the information will be compared to the HSB research literature and practice to draw out similarities and differences.

4.2. Prevalence

There are several difficulties in attempting to establish prevalence based on the current research knowledge base. Discussing links between autism and serious crime has been a sensitive area, with some in the autistic community feeling that much of the dialogue, particularly in the media, demonises and further discriminates against them as a minority group (Hughes, 2022; Hofvander, 2017) and Howlin (2004) reported that parents were worried that their children could face further social stigma and rejection.

Prevalence in HSB research and practice is often defined by criminal statistics, however, there are no statistics on the numbers of autistic people charged or convicted for any offence (Youth Justice Board, 2023; NAS, 2022; Kirby 2021; Higgs and Carter, 2015) and many autistic adolescents are not referred or are diverted away from statutory legal services and the criminal justice system (Hofvander et al., 2017; Allen et al., 2008; Attwood, 2007), so this is not a valid measurement.
It is also difficult to establish prevalence from the research data due to variance in the population data, for example:

a) Age - some are focused on adults and may not be relevant to adolescents;

b) Gender – vast majority are focused on males as there are fewer females;

c) Ability level - with some being focused only on more cognitive autistic individuals and some being mixed;

d) Settings - both clinical mental health services and residential settings and criminal justice populations being used, which are not comparable to each other nor to the community based front line practitioners in this research;

e) Ethnicity – although there were many international studies in different cultural environments, only one study by Visser et al., (2017) mentions that sexuality is culture-specific. The lack of focus on ethnicity and culture is also present in the HSB research literature.

(Vinter and Dillon, 2020; Hofvander, 2017; Allely and Creaby-Attwood, 2016; Søndenaa et al., 2014; Bleil Walters et al., 2013; Sevlever et al., 2013; de la Cuesta, 2010; Kumagami and Matsuura, 2009; Långström et al., 2009; t'Hart-Kerkhoffs et al., 2009; Allen et al., 2008; Mouridsen et al., 2008; Ghaziuddin et al., 1991).

4.3 Are autistic adolescents more likely to engage in HSB than the general population?

The problems with identifying the prevalence of autism and HSB and whether autistic individuals are under-or over-identified re HSB is particularly stark when different research populations are compared: for example, those undertaken in criminal justice settings (Baarsma et al., 2016; Bleil Walters et al., 2013; Sutton et al., 2012; Browning and Caulfield, 2011) showed much higher rates of autistic individuals involved in HSB than those studies in primarily clinical, mental health settings, where HSB was noted as exceptions and often evidenced by case studies alone (Young and Cocallis, 2023; Hofvander, 2017; Dewinter et al., 2015; Sevlever et al., 2013;

Burdon and Dickens, 2009; Newman and Ghaziuddin, 2008; Realmuto and Ruble, 1999; Hingsburger et al., 1991).

A problem with the criminal justice studies figures being so high, was that some were retrospective diagnoses carried out by the researchers, therefore there was already a hypothesis that there would be more autistic individuals than previously known and there may have been confirmation bias (McSweeney, 2021). The authors themselves noted limitations with their diagnostic process and reflected they may have been picking up possible autistic characteristics rather than autism (Sutton et al., 2012). Palermo and Bogaerts (2017) also felt that the diagnostic criteria at the time in DSM-4 made it easier to wrongly diagnose autism.

In reviewing the criminal justice studies, particularly those in secure or residential facilities, there is a pattern of higher numbers of autistic individuals within those populations for crimes such as threats to kill, sexual offending, criminal damage and stalking (Allely, 2021; Palermo and Bogaerts, 2017; Allely and Creaby-Attwood, 2016; Sevlever et al., 2013; Haskins and Silva, 2006; Vermeiren et al., 2006; Murrie et al., 2002; Kohn et al., 1998). In terms of 'newer' crimes like cyber-crime, which can include sexual bullying and exploitation, autism is also more prevalent, but the National Crime Agency (NCA, 2017) are cautious as there is currently no empirical evidence for this (Ledingham and Mills, 2015).

The seemingly unconnected offending behaviour of arson was also identified in these studies, as it has been in the HSB literature. Hofvander's 2017 meta-analysis found arsonists were more likely to be autistic compared to other offender groups. Mouridsen (2012) noted that in a study of arsonists 7.1% had autism compared to 2.5% in a comparison group and studies by (Allely, 2021; Palermo and Bogaerts, 2017; Palermo, 2015; Enayati et al., 2008; Mouridsen et al., 2008; Newman and Ghaziuddin, 2008; Siponmaa et al., 2001) also found cases of sexual abuse linked with arson but had not explored why this might be and researchers agree that this needs to be studied further.

4.4 Potential relevance of autism to engagement in HSB

A number of studies identified autistic traits that may make it more likely for an autistic individual to become involved in the criminal justice system for sexual offences (Yu et al., 2020; Allely and Creaby-Attwood, 2016; Higgs and Carter 2015; Browning and Caulfield, 2011). The autistic traits they identified are:

a) *Concept of internal central coherence* – that some see the world from inside their own perspective and do not have a concept of a wider or alternative perspective, therefore they may engage in criminal behaviour because of their excessive preoccupation with that behaviour, oblivious to any social or legal consequences (Greaves-Lord et al., 2020; Sutton et al., 2012; Haskins and Silva, 2006; Frith, 1989). This may make them quick to confess but they may not understand the implications of doing so, or they believe that their emotions are logical, justifiable or appropriate, which may make them appear to be arrogant or without remorse (Allely, 2021; Burdon and Dickens, 2009;Attwood, 2007);

b) *Lower awareness of social norms and lower behavioural control* have also been suggested as explanations for higher rates of paraphilic interests and behaviours in autistic individuals (Schöttle et al., 2017);

c) *Social and communication difficulties* – (Yu et al., 2020; Baarsma et al., 2016; Driemeyer et al., 2013; Sutton et al., 2012; Hippler et al., 2010) may create difficulties with establishing romantic relationships and the individuals experience romantic rejection (Allely, 2022; Sevlever et al., 2013; Hippler et al., 2010). If they struggle socially with their peers and identify with younger children as it is less challenging for them then they may attempt to engage in sexual behaviour with them (Sevlever et al., 2013; Kalyva (2010);

d) *Difficulty decoding non-verbal information* can make it more difficult to understand the ambiguous and multi-layered language of flirtation and sexual responses in terms of consent being given or withheld (Dekker et al., 2015; Sutton et al., 2012: Mehzabin and Stokes 2011);

e) *The internet and social media are easier ways of socialising* particularly if an autistic person is bullied or socially excluded and they may get drawn into graphic sexual content (Allely, 2021; NCA, 2017). They may also have difficulties with determining age and with media and marketing culture blurring boundaries of age appropriate sexuality this can make it difficult for an autistic adolescent to determine what is illegal pornography (Allely, 2021; Mesibov and Sreckovic, 2017). If they are literal thinkers the fact that child pornography is easily available online may make them think it is therefore acceptable (Allely, 2021);

f) *Difficulties with reading emotions and facial expressions* – (Allely, 2021; Uljarevic and Hamilton, 2013; Woodbury-Smith et al., 2006), means they may not recognise that the other person is not consenting or is distressed, and therefore do not stop the sexual behaviour. This would be a high risk, red flag factor in HSB research and practice;

g) *If they have sensory sexual interests* this may lead them to touching others without consent, particularly in relation to paraphilias (Kellaher, 2015; Chan and John, 2012; Hellemans, 2010);

h) *Obsessive and fixed interests* can lead to stalking behaviour (Stokes and Kaur, 2005) or large collections of downloaded sexual images including of illegal images of children (IIOC). They may not understand that these are real people being hurt (Attwood, Hénault and Dubin, 2014);

i) *Experience of the criminal justice process can be intimidating and stressful* for an autistic person (Allely, 2022; Hofvander, 2017; Hippler et al., 2010). If they react by being aggressive this would be viewed negatively in that environment, rather than be seen as an indicator of adjustments that might need to be made for them. Conversely, if they remain passive and show little evident emotion (Kim, 2015), this can make them appear to have no remorse for the behaviour.

4.5 Potential relevance of co-existing conditions to HSB

However, several studies highlighted that often the seriousness of the behaviour or why they were in the criminal justice system was not simply autism, but also co-existing conditions such as ADHD, psychiatric disorders including pathological paraphilias; anxiety and depression and that this could explain some of the gap between clinical and forensic studies (Vinter and Dillon, 2020; Yu et al., 2020; Hofvander, 2017; Palermo and Bogaerts 2017; Baarsma et al., 2016; Palermo, 2015; de la Cuesta, 2010; Burdon and Dickens, 2009; Newman and Ghaziuddin, 2008). Långström et al., (2009) noted that adults with ASD and violent criminality had significantly higher levels of comorbid psychopathology diagnosis. The only study to mention alcohol as an exacerbating factor was Sutton et al., (2012).

4.6. Arguments as to why autistic individuals are less likely to engage in HSB than the general population

When criminal justice populations are included with other research settings, the picture is more mixed, with some studies including systematic reviews (King and Murphy, 2014) indicating that there was no difference from the general population (Brown and Davy, 2023; Kincaid and Sullivan, 2019) but a majority of the studies, and meta-analyses (Ghaziuddin et al., 1991) indicated that autistic individuals were less likely than the general population to engage in HSB (Vinter and Dillon 2020; Yu et al., 2020; Kincaid and Sullivan 2019; Allely and Creaby-Attwood, 2016; Higgs and Carter, 2015; Mouridsen et al., 2012, 2008; Browning and Caulfield 2011; de la Cuesta, 2010; Woodbury-Smith et al., 2006).

Some note that this may be due to autistic individuals being more likely to have charges diverted to participation in a treatment programme in lieu of prosecution as their behaviours are seen as an indicator of their specific needs (Yu et al.,2020; Hofvander, 2017; Cheely et al., 2012). Or that they have supervised and protective environments which are an important protective factor, although there is no empirical evidence to support this (Sevlever et al., 2013; Murrie et al., 2002).

Others posit that an autistic trait of being rule and law abiders and having high moral standards when they know the rules, means they are therefore less likely to engage in HSB if they are given education on appropriate boundaries (Hofvander, 2017; Sevlever et al., 2013; Baron-Cohen, 2012; Woodbury-Smith et al., 2006; Murrie et al., 2002). Several studies refer to recidivism figures for sexual offences being low generally for the adolescent HSB population and note that there is limited empirical data for recidivism among autistic adolescent offenders (Howlin, 2004).

4.7. Characteristics of autistic children and adolescents who have engaged in HSB

4.7.1. Family Backgrounds

In HSB research and practice the family background of the child or adolescent is essential information for understanding what may have caused or contributed to their HSB and their family's ability to support them to make changes. This includes family dynamics and attachments, stress factors the family may be experiencing and their resilience and ability to cope.

When parents/carers are discussed in autism research it is usually in relation to their worries about their child going through puberty and that their child's sexual behaviours would make them vulnerable to being abused, exploited or criminalised (Visser et al., 2017; Ginevra et al., 2016; Brown- Levoie et al., 2014; Cridland et al., 2013; Sevlever et al., 2013; Nichols and Blakeley- Smith, 2010; Stokes and Kaur, 2005; Realmuto and Ruble, 1999; Ruble and Dalrymple, 1993). These concerns underpin the instinctive reaction of many parents and of professionals to protect and potentially minimise the child or adolescent's sexual behaviour (Baarsma et al., 2016; Attwood, 2007; Stokes et al., 2007).

However, with regard to other aspects of the family background such as stability, attachments, stresses and resilience, there is little mentioned. This was a real weakness in the autistic research as the focus was solely on the individuals themselves, particularly in the adult studies, so very little information was recorded

about their birth families. Fourie, Kotzé and Van der Westhuizen's (2017) study in South Africa of 24 autistic children and adolescents considered their demographics and the relevance to their sexual behaviours. The study showed that the majority of the children 18/24 had a stable primary care giver and living environment, yet nine of those 18 had 'abnormal' sexual behaviours, which included public nudity /masturbation, asking others to engage in sexual acts etc.

This study is relevant to a current hypothesis from HSB practice experience that the family profile of many autistic adolescents with HSB differs from those of their non-autistic peers, in that there are higher rates of stability in family dynamics and living environments and more engaged and supportive families; this is even more evident in the backgrounds of those who abuse online, in technology assisted HSB (TA-HSB). The lack of family background information and this anomaly re TA-HSB are significant gaps in the research knowledge base.

4.7.2. Trauma and abuse

In HSB practice, a child or adolescent experiencing trauma or abuse is a frequent causal factor for their HSB (Hackett et al., 2013; Pullman and Seto, 2012; Seto and Lalumière, 2010; Mutale, 2003; Kelly et al., 2002; Skuse et al., 1998). In the autism research there is a mixed picture as to whether autistic children and adolescents are more or less likely to experience trauma or abuse than the general population. As with other aspects of the autism research, there were difficulties with comparison of studies and methodology (Greaves-Lord et al., 2020; Malovic et al., 2020; Mandell et al., 2005) and recruitment methods, such as populations of autistic individuals who were already receiving mental health or social welfare support, which may lead to trauma or abuse being over-represented (Hoover and Kaufman, 2018; Brenner et al., 2017; Hall-Lande et al., 2015).

4.7.3. Studies which suggest autistic adolescents are less likely or no more likely to experience trauma or abuse than the general population

Some studies felt that they were less likely to experience trauma or abuse because of the protection of their parents or caregivers (Fourie, Kotzé and Van der Westhuizen, 2017; Sevlever et al., 2013; Mehtar and Mukaddes, 2011) or that there was little difference with the rates of trauma and abuse in the general population (Brenner et al., 2017; Dewinter et al., 2016;Dekker et al., 2015; Dewinter et al., 2015).

Mandell et al's (2005) study of 156 children was one of the few studies to look at prevalence of sexual abuse - they found that for autistic children, 12% had at least one incident of sexual abuse and 4% had both sexual and physical abuse; when compared to studies of the general population, it was slightly higher than the rates for males which is 6-10%, but it was lower than the rates for females at 16-23% and lower than for the learning disability population at 14%. Dewinter et al's (2015) study did not find as high a prevalence but suggested that Mandell et al's study was in a community mental health setting therefore influenced by the additional needs of that population and Sevlever et al., (2013) noted that the information was based on parental reports rather than self-reports. There was also no clarification of what the incidents of sexual abuse had been and if they were peer or adult related.

Bleil-Walters et al's (2013) study of males in a juvenile sex offender residential treatment setting found no real statistical difference between autistic and non-autistic participants, with the autistic group only slightly higher on emotional abuse and neglect. They highlighted the lack of published research on the occurrence of abuse or neglect on autistic adolescent sex offenders. Sullivan and Knuston's (2000) study reported similar findings and concluded that autistic children may be at a slightly higher risk of neglect and that those who had experienced emotional abuse and neglect had higher depression scores. They indicated that parental stress appeared to be related to the severity level of their child's autism.

4.7.4. Studies which suggest autistic adolescents are more likely to experience trauma or abuse than the general population

Several studies identified autistic traits which may make them more vulnerable to peer abuse and bullying, such as difficulties with emotional regulation and social isolation as well as socio-emotional limitations creating difficulty in interpreting safe and unsafe individuals and what would constitute abuse, particularly if they need physical care and have blurred boundaries about appropriate and inappropriate touch; communication difficulties may mean they are unable to tell their parents/carers (Brenner et al., 2017; Sevlever et al., 2013). Edelson's (2010) study added that if they have difficulties with TOM, they may be less able to detect if someone is manipulating them and having unusual sexual interests or paraphilias may make them more vulnerable to exploitation (Mehzabin and Stokes, 2011; Attwood, 2007; Hénault, 2005).

Some studies highlighted that for autistic people, their autism could increase the impact of any trauma or abuse they experience, leaving a heightened susceptibility to PTSD (Hoover, 2015; Bleil-Walters et al., 2013; Sevlever et al., 2013; Mehtar and Mukaddes, 2011; Evans et al., 2008; Walker et al., 2004; Darves-Bornoz et al., 1998). Conversely, Brenner et al's (2017) study stated that it may have less of an impact due to autistic traits of a narrow inward focus and difficulties describing inner emotional states and TOM may limit their ability to interpret or perceive something as traumatic.

There were also concerns about indicators of PTSD being similar to some autistic traits and given the increased awareness of autism, for the potential for inappropriate diagnoses of or consideration of the potential for autism, *diagnostic overshadowing*, (Fletcher-Watson and Happé, 2019) or overlooking a co-existing condition i.e., autism *and* PTSD (Reiss et al., 1982) or overlooking clinical indicators of abuse by focusing solely on the autism diagnosis (Mandell et al., 2005).

4.8. Types of trauma or abuse

a) Adverse childhood experiences - ACEs

There was very little written about these in the research. One Japanese study by Kumagami and Matsuura (2009) of 428 offenders found two cases (0.46%) where there were high levels of stress and ACEs at home leading to the adolescents taking out their frustrations on others;

b) Social trauma – bullying, exploitation, social isolation

One of the biggest categories of abuse in the research was social trauma through peer bullying, exploitation, social isolation and rejection (Sala et al., 2020; Vinter and Dillon, 2020; Attwood, 2018; Palermo and Bogaerts, 2017; Allely and Creaby-Attwood, 2016). Hoover (2015) found that peer bullying had impacts of anxiety, depression, self-injury, feelings of rejection leading to further social withdrawal compounding the problem, particularly around lacking the social support networks that protect or buffer against bullying;

c) Physical and Sexual Abuse

There was little information within the autism research on physical abuse, with Mandell et al's (2005) study being frequently quoted in the literature. They found 18.5% of the 156 autistic children in a community mental health service had experienced physical abuse and 4% had experienced both physical and sexual abuse;

In contrast, many studies indicate sexual abuse or the potential for sexual exploitation of the individuals in their study but there is a lack of clarity about how they may have been sexually abused and by whom and with little analysis of the relevance of this abuse to their own sexual behaviours, so it is difficult to compare with the HSB research and practice knowledge (Young and Cocallis, 2023; Vinter and Dillon, 2020; Attwood, 2018; Visser et al., 2017; Brown-Lavoie et al., 2014; Bleil-Walters et al., 2013; Sevlever, Roth and Gillis, 2013; Sutton et al., 2012; Edelson, 2010; Ray, Marks and Bray-Garretson, 2004).

The numbers of how many have been sexually abused also varies widely within studies. (Chan and John, 2012; Mandell, et al., 2005; Koller, 2000) found between 12 -25% in their studies and Brown-Lavoie et al's (2014) study found 75%, stating that they were two to three times more likely to experience sexual exploitation, sexual coercion or rape than the general population. Pecora et al., (2016) found that autistic females were over twice as likely to have experienced unwanted sexual experiences than autistic males and autistic males were more likely than non-autistic males to be sexually assaulted. These findings would imply that there is a serious risk of sexual abuse for autistic individuals, however, with the lack of consistency between studies and a lack of replication of findings and problems with findings being specific to the research settings, they have little validity;

d) Emotional abuse and neglect

A few studies have indicated that vulnerability to emotional abuse and neglect may be slightly more prevalent for autistic children and adolescents (Bleil Walters et al., 2013). More recently there has been consideration of the impact on parents of having a child with severe autistic traits, including potential difficulties with bonding and attachments and the stress this may cause for the family, particularly if there is a lack of social support for the parents, (Sevlever, Roth and Gillis, 2013; Sullivan and Knutson 2000; Howlin and Clements, 1995). But there is little empirical evidence for this, Mandell et al., (2005) and Westcott and Cross (1996) caution against treating any type of disability as a stressor or risk factor and that researchers should examine other child, family and social factors that may be more relevant.

4.9. Types of sexual behaviours – Hackett's Continuum (2010)

4.9.1. Language and Definitions

The most frequent terms used in the autism research are 'inappropriate', 'deviant' and 'offence'. Offence is used when the criminal justice system has become involved but 'inappropriate' is used for a wide range of sexual behaviours from low level through to illegal, high level, abusive sexual behaviours, for example, paedophilic sexual interest in children (Visser et al., 2017; Fernandes et al., 2016; Gilmour et al.,

2012). ‘Deviant’ is used to mean both illegal (Greaves-Lord et al., 2020; Fourie, Kotzé and Van der Westhuizen, 2017; Sullivan and Caterino,2008; Realmuto and Ruble, 1999) and socially unusual sexual behaviours, such as sensory sexual fascinations or some paraphilias (Greaves-Lord et al., 2020; Visser et al., 2017;Helleman’s et al., 2010; Stokes and& Kaur, 2004).

To provide a clearer comparison with the HSB research literature, Hackett’s continuum (2010) *(See Figure 4, Chapter Three)* was used to differentiate the sexual behaviours from the autism research in terms of increasing concern and risk. ‘Normal’ healthy sexual behaviours were described in the previous section therefore this part will focus on the inappropriate, abusive and violent parts of the continuum.

4.9.2. Inappropriate

Co-existing Learning Disabilities

Most concerns in the research literature about autistic individuals and sexual behaviours fall within this category (Vinter and Dillon 2020; Allely and Creaby-Attwood 2016; Fernandes et al., 2016; Sevlever et al., 2013; Kalyva, 2010; Längström and Seto 2006; Längström and Zucker, 2005; Realmuto and Ruble, 1999; Ruble and Dalrymple, 1993). They include privacy related issues such as public exposure of genitals and public masturbation, (Kellaher, 2015; Kalyva, 2010; Sullivan and Caterino, 2008; Van Bourgondien et al., 1997; Ruble and Dalrymple, 1993; Haracopos and Pedersen, 1992), inappropriate touching of others without consent including parents and caregivers (Kellaher, 2015) and inappropriately using sexual language; sharing of sexual imagery or talking about sexual acts (Greaves-Lord et al., 2020). As well as potentially causing distress and intimidating others, these types of behaviours can create problems for the autistic child or adolescent themselves, with individuals being bullied, sexually exploited or being set up by their peers (Greaves-Lord et al., 2020; Sevlever et al., 2013).

Public exposure and masturbation and touching others without consent are criminal offences, therefore, whether an individual is charged is dependent on their level of cognitive ability and understanding of the social and legal rules and the question of

intent, i.e., if it was sexual or intended to cause distress or harm to someone else. There is a consensus in the literature that most individuals engaging in these behaviours also have a learning disability or severe social-emotional difficulties along with their autism (Malovic et al., 2020; Fernandes et al., 2016; Timms and Goreczny 2002). Hingsburger et al., (1991) coined the term 'counterfeit deviance' to describe these behaviours to differentiate them from those which would attract a criminal conviction (Young and Cocallis, 2023; Greaves-Lord et al., 2020; Mogavero and Hsu, 2019; Hofvander 2017; Beddows and Brooks, 2015; Dewinter et al., 2015; Franklin, Raws and Smeaton, 2015; Kellaher, 2015; Sevlever et al., 2013; Mehzabin and Stokes, 2010; Sullivan and Caterino, 2008; Ray, Marks and Bray-Garretson, 2004).

Other reasons why autistic individuals may engage in inappropriate behaviours

a) *Emotional regulation* - masturbation performs a similar function as 'stimming', i.e., a movement or noise which they use to regulate intense emotions and to feel safe, for example, rocking, noise making, or flapping. When they are in public spaces they may have sensory overloads and be scared, masturbation may then be a dysfunctional method of dealing with those emotions rather than always being in response to sexual urges (Ray, Marks and Bray-Garretson, 2004);

b) *Delayed development* – If this is present then the individual may be out of sync with their peers and may be a contributory factor to over sharing sexual information in the wrong context, as they try to copy and fit in with their peers, but not understanding the appropriate boundaries of what can be said or shared, making them further socially isolated or exploited (Corbett et al., 2020; Attwood and Garnett, 2018; Dewinter et al., 2016; Attwood, Hénault and Dubin, 2014; Whitehouse et al., 2011; Sullivan and Caterino, 2008; Knickmeyer et al., 2006; Stokes and Kaur, 2005; Realmuto and Ruble, 1999);

c) *Trauma responses* - like *s*ome younger children they may be working out their trauma by re-enacting it, but without the understanding that it is not appropriate

(Fourie, Kotzé and Van der Westhuizen, 2017; Ray, Marks and Bray-Garretson, 2004). Some may have been eroticised, in both the Mouridsen (1989) case of the girl aged five years and another case of a boy aged six years old (Ferahkaya and Bilgiç, 2021), there was no discussion in the studies about the potential for the behaviours to be trauma reactions, and that their bodies may be experiencing stronger sexual sensations than would be expected at their developmental stage (Carson, 2019).

4.9.3. Problematic

In HSB terms problematic means there are some complexities to the sexual behaviour and usually the individual's background, but either it does not require statutory intervention from child welfare or criminal justice services, or work is proposed to divert the individual from the need for statutory intervention. In terms of autistic adolescents, unusual sexual behaviours and paraphilias would fall within this part of the continuum**.** If there is no consent from the other person/s for the activity or there are elements of force, coercion or manipulation, then this would significantly escalate the level of concern into abusive or violent, the highest level of concern on Hackett's (2010) continuum.

Unusual sexual behaviours

These may be sensory, or involve sexual preoccupations, or hyper or hypo sexual arousal or bizarre fantasies. Sensory sexual interests are particularly related to touch, smell and taste, for example in Hellemans et al's (2010) study there were cases where individuals were attracted to the feel of lingerie and soft tissues, while another was aroused by unusual smells such as sweaty feet. Having these interests is not a problem but without consent they can become offensive, distressing and/or illegal, for example, in Helleman's et al's (2010) study, the male took lingerie belonging to their mother. Even if this did not represent sexual arousal to her, the violation experienced by the mother of having her personal intimate clothing being used for masturbation can be distressing (Helleman's et al., 2010; Carson, 2019).

If hyperarousal is an issue then the individual may experience frequent sexual arousal with little impulse control over their sexual behaviours (Hellemans et al., 2010), as well as feelings of distress or lack of control; this may lead to compulsive masturbation regardless of location, or if directed at others, to attempts made to manipulate, coerce or force others into sexual acts without consent. If using the internet to meet sexual needs, desiring newer forms of stimulation (Schöttle et al., 2017) may lead to the individuals accessing more extreme graphic sexual material creating violent sexual fantasies particularly re revenge and retaliation if feeling frustrated and rejected (Palermo and Bogaerts, 2017; Carabellese, Maniglio et al., 2011Buschman et al., 2010).

A potential feature in hypo-arousal problems may be the effect of medication on sexual development, which has been noted in several studies; medications such as anti-depressants or antipsychotics can impact libido, sexual interest or drive which can cause sexual frustrations. It can also make ejaculation less predictable, which can lead to compulsive masturbation and other escalating sexual acts to achieve ejaculation, creating frustrations related to sex and some sexual preoccupations (Greaves-Lord et al., 2020; Dewinter et al., 2016; Dubois, Ameis, Lai, Casanova and Desarkar, 2016; Hellemans et al., 2007; Ray, Marks and Bray-Garretson 2004; Chan and John, 2012).

Paraphilias

There is considerably more discussion of paraphilias in the autism research than in HSB research and practice, even though paraphilias are not exclusively related to autism (Milton et al., 2002). Studies indicate that they are more likely to happen in those with more cognitive ability (Visser et al., 2017; Fernandes et al., 2016; Hellemans et al., 2007; Koller, 2000; Haracopos and Pedersen, 1992), or those with more severe autistic traits, particularly social-communication difficulties, preoccupations and restricted and repetitive interests (Fernandes et al., 2016; Kellaher, 2015; Dozier et al., 2011; Hellemans et al., 2007; Milton et al., 2002; Silva et al., 2002). They appear to be a primarily male behaviour, which may correlate with the severity of the autistic traits (Kellaher, 2015).

Paraphilias[23] are defined by DSM-5 and ICD-11, the difference in most cases between a paraphilic act being illegal or legal are the principals of consent and mutuality, for example, voyeurism and exhibitionism are illegal (Beddows and Brooks, 2015; Ray, Marks and Bray-Garretson, 2004; Milton et al., 2002;), but the sexual practice of 'dogging' which is illegal has elements of consent and mutuality as individuals go to watch people have sex in public, who are getting additional sexual arousal from being watched.

Where consent is not sought, or able to be given, such as with frotteurism (Ray, Marks and Bray-Garretson, 2004), bestiality and zoophilia (Allely, 2020; Kellaher, 2015) and paedophilia, they would all be illegal and would be in the abusive section of Hackett's (2010) continuum. Paedophilia featured in several studies (Baarsma et al., 2016; Fernandes et al., 2016; Dewinter et al., 2013; Hellemans et al., 2010; Robinow, 2009; Ray, Marks and Bray-Garretson, 2004; Murrie et al., 2002; Realmuto and Ruble 1999) but only in small numbers represented primarily by case studies, some of which were adults and was not explored in depth.

The law regarding paedophilia is based on the societal view that a child is not able to mutually engage or consent to sexual abuse. In addition, because of the developmental stage of adolescence, both the DSM-5 and ICD-11 require that for a diagnosis of paedophilic disorder the individual must be at least 16 years old, there must be a significant age difference between them and the child they are sexually aroused to and the arousal pattern needs to be for six months or longer.

Other types of paraphilias found in the research were:

- *Transvestism* (Landén & Rasmussen, 1997);

- *Objectophilia* (Simner et al., 2019; Hellemans et al., 2010; Robinow, 2009);

[23] *See Appendix Two for definitions*

- *Partialism* (Kellaher 2015; Hellemans et al., 2010; Ray Marks and Bray-Garretson, 2004; Haracopos and Pedersen 1992; Freud, 1905);

- *Fetishism* (Visser et al., 2017; Fernandes et al., 2016; Kellaher, 2015; Dozier et al., 2011; Långström and Seto 2006; Långström and Zucker, 2005);

- *Masochism/Sadism* (Schöttle et al., 2017; Kim, 2015).

4.9.4. Abusive

Abusive/violent sexual behaviours

These are the most serious sexual behaviours on Hackett's (2010) continuum, with features of coercion, manipulation, lack of empathy or remorse, selection of individuals based on perceived vulnerabilities and in the most serious cases the presence of violence, particularly where hurting others is part of the sexual arousal. Abusive or violent sexual behaviours such as sexual assaults or rape are mentioned in the autism literature but only as single case studies or given as rare extreme examples rather than as part of the core concerns (Young andCocallis, 2023; Dewinter et al., 2015; Realmuto and Ruble, 1999; Hingsburger et al., 1991) and had a definite or probable co-existing condition such as ADHD or in the adult studies a psychiatric disorder such as psychopathy (Higgs and Carter, 2015; Kumagami and Matsuura, 2009).

The criminal justice system studies of juvenile sex offender populations showed high rates of autistic adolescents (Sutton et al., 2012) but lack clarity as to the types of sexual offending, so it is difficult to compare them to the HSB practitioner caseloads were there are substantial numbers of autistic individuals, some of whom have sexually assaulted or raped someone. Both Kellaher's (2015) study and Young and Cocallis's systematic review (2023) highlighted the need for larger confirmatory studies for abusive/ violent behaviours, with a need for empirical evidence of prevalence or epidemiology and effective treatment outcomes.

The main form of sexual abuse related to autistic traits was of stalking or harassment (Green and Yamawaki, 2024; Stokes et al., 2007; Stokes and Newton, 2004; Howlin, 1997), linked to obsessional pursuits of fixed interests and insufficient skills to initiate relationships or to read the signs that the other person was not interested, leading to them continuing to pursue a romantic interest when there was no response (Hofvander, 2017; Mehazbin and Stokes, 2011).

Another significant group was those who acted alone and/or who targeted young children (Hofvander, 2017; Baarsma et al., 2016; t'Hart-Kerkhoffs et al., 2009) as they potentially found them less challenging and easier to dominate (Vinter and Dillon, 2020). This echoes findings of the Pullman and Seto (2012) *specialists* and Almond et al's (2006) *impaired* group and a correlation between these studies should be explored.

Other abusive sexual behaviours may relate to sensory sexual interests or paraphilias without consent, such as trying to touch someone's hair, or a part of their body, or to lick people's arms or faces without consent (Nichols and Blakeley-Smith, 2009). Or maybe because of peer pressure or exploitation to publicly masturbate or sexually assault another person as a way of being able to be part of a social group (Sevlever, 2013; Sutton et al., 2012).

Planning, Coercion and manipulation

One study (Carmichael and Edwards, 2023) felt autistic individuals were less likely to use force, coercion, grooming or manipulation but several studies gave examples where there was clear evidence of these behaviours (Allely and Creaby-Attwood, 2016; Dewinter et al., 2015, 2016; Søndenaa et al., 2014; Seto et al., 2010; t'Hart-Kerkhoff et al., 2009). In Dewinter et al's (2016) self-report study a small number of boys confirmed having coerced another to do sexual things or had been forced by others. Ray, Marks and Bray-Garretson (2004) gave a case example of a boy who derived sexual gratification with targeting younger, more compliant children and who got a sense of excitement and mastery when he described the planning/setting up stages of his offences. Other studies have shown response or arousal to the

experience of pain in others (Minio-Paluello et al., 2009) while others have found heightened arousal and a lack of prosocial behaviours when experiencing others' distress (Fan et al., 2014; Hadjikihan et al., 2014). In HSB practice this would be a high risk, red flag behaviour if the anticipation of harming someone is also causing arousal.

Empathy

Key risk factors in HSB practice are lack of empathy, not stopping in response to the distress of the other person or presenting as cold, callous or with a lack of remorse. There is a mixed picture from the autism research with some studies with case examples showing that there was a lack of empathy, for example, Hellemans et al's (2016) study had a small group of autistic and learning disabled individuals who did not care if the other person enjoyed the physical contact from them.

Hofvander's, (2017) meta-analysis highlighted that much is made of the alleged autistic empathy deficit but studies also show that while some autistic individuals may not have strong cognitive empathy they can have affective or emotional empathy (Allely, 2021; Trimmer, McDonald and Rushby, 2017; Smith, 2009; Dziobek et al., 2008; Frith and Singer, 2008, Hare, 2003) and when they learn that they have caused another person pain or distress, can be overwhelmed with emotion and regret. Hofvander (2017) also describes other autistic traits which may be relevant to the perception of them being cold and callous, including difficulties with face perception and interpretation of facial expressions and emotions, meaning they may not have understood the person is in distress (Kim, 2015).

Both Allely (2021) and Hofvander (2017) discuss the difficulties autistic individuals may have in being processed through the criminal justice system, where they may not understand questions posed, have limited attention spans and their distress may come across as arrogant, disrespectful, incongruent with the seriousness of the offence. Some do not display emotions facially (Kim, 2015) and can seem cold, callous and therefore in some people's eyes – guilty.

4.9.5. Violence

While there were a few examples of autistic individuals being charged with aggression and violence (Bjørkly, 2009; Ghaziuddin et al., 1991), the general consensus in the research literature is that they are no more likely to be violent, particularly sexually violent than anyone else (Hofvander 2017; Allely and Creaby-Attwood 2016; Bjørkly 2009; Baarsma et al., 2016; Sevlever et al., 2013; Mouridsen et al., 2008; Ray, Marks and Bray-Garretson, 2004; Ghaziuddin et al., 1991). Where aggression or violence was displayed it was felt that this was more likely to relate to rigid behaviours, particularly around sexual interests and distress at being prevented from doing these, or due to frustration at bullying or social exclusion or romantic rejection, so more reactive violence (Hofvander, 2017; Palermo and Bogaerts, 2017; Allen et al., 2008; Bogaerts, Vanheule and DeClerq 2005), rather than classic, gender based misogynistic power and control concepts in the HSB literature, (Attwood, 2007; Ray, Marks and Bray-Garretson, 2004). The risk for violence was also linked to comorbid psychopathology and substance misuse. (Sutton et al., 2012; Längström et al., 2009).

Greaves-Lord et al's (2020) meta-analysis highlighted that studies which showed male individuals with a greater interest in sex and hyper sexuality as well as an interest in more violent forms of sexuality (Schöttle et al., 2017; Fernandes et al., 2016) were often based on parent reports rather than self-reports which may be relevant. One of the biggest difficulties for practitioners is the potential for violent fantasies to be re-enacted in real life situations. There is no research to say that this is more likely within the autistic population than the general population (Allely and Creaby-Attwood, 2016; Murrie et al., 2002). However, there are concerns for the psychosexual development for all children and adolescents, with the increasing access to online graphic, violent, sexual imagery (Hollis & Belton 2017; Martellozzo et al., 2016; Mascheroni and Olafsson, 2014, 2016) with some autistic people having less ability to differentiate between reality and fantasy in visual contexts (Moran, 2015).

4.10. Need for adapted risk assessment models and tools

In HSB practice there are assessment models for adults with learning disabilities but nothing specific for adolescents, yet adolescents have a very different role in their families and communities, are at a different developmental stage and are less likely to have long term distortions of beliefs about their sexual behaviour or entrenched sexual interests (Malovic et al., 2020; Hanson and Morton-Bourgon, 2005). This weakness was also highlighted by the autism research as there was a lack of sufficiently validated assessment tools specifically designed for autistic individuals (Greaves-Lord et al., 2020), although some researchers had attempted changes to the Sexual Behaviour Scale (SBS), the Courting Behaviour Scale and the Interview of Sexuality in Autism (Revised) (ISA-R) (Mogavero and Hsu, 2019; Mehzabin andStokes, 2011; Hellemans et al., 2010).

Malovic et al's (2020) systematic review of assessment measures noted that despite research discourse about autistic adolescents, with or without learning disabilities and HSB, when they searched for published articles on clinical instruments developed or adapted for work in relation to HSB, they could not find any which met their criteria and stated that a "focus of future research needs to be on developing or adapting instruments to offer researchers and clinicians empirical as well as clinical data on this all-too-often-overlooked population of vulnerable youth" (Malovic et al., 2020, p101).

There are some examples of good practice such as the Good Lives Model (Ayland and West, 2007) an intervention programme for those with learning disabilities which moves from being focused on risk, to increasing strengths (Malovic et al., 2020; Worling, 2013) and Al-Attar's (2017) FARAS[24] risk assessment model re violence and terrorism, but the call for assessment and intervention programmes to be created or adapted for autistic individuals in relation to HSB is echoed by many studies (Allely, 2021; Greaves-Lord et al., 2020; Vinter and Dillon, 2020; Melvin et

[24] FARAS – Framework for the Assessment of Risk and Protection in Offenders on the Autistic Spectrum

al., 2017; Allely and Creaby-Attwood, 2016; Higgs and Carter 2015; Sevlever et al., 2013; Sutton et al., 2012; de la Cuesta, 2010).

Any intervention model created or adapted needs to have a good understanding of autism characteristics and experiences of sexual development and functioning and it would be important to include autistic voices in the development process (Greaves-Lord et al., 2020). Assessors need to understand the 'function' of the sexual behaviour, what needs it was meeting and whether or not there was a sexual intent (Allely, 2021) and they need to have a clear understanding of each individual's autistic profile and to adapt and individualise any assessment and intervention work to their needs (Higgs and Carter 2015). This includes taking into account the autistic female perspective (Lo Bosco, 2023). Vinter and Dillon (2020) felt there was a need for a shift in focusing simply on risk reduction and more focus on the individual's strengths, similar to the Good Lives Model (Ayland and West, 2007). All these points would mean a review of the current sex offending programmes (Vinter and Dillon, 2020; Melvin et al., 2017; Higgs and Carter, 2015; de la Cuesta, 2010).

The need has also been identified by practitioners and the driver for this research was the need for guidance in understanding and working with the rising numbers of autistic children and adolescents, and those with possible autistic traits on their caseloads. They too had searched for guidance from the research literature and found none and approached me in my role as Director of AIM to see if it was possible to adapt the current most widely used adolescent HSB assessment model AIM3 (Leonard and Hackett, 2019). The Practice Guidance which was created, peer reviewed and piloted as part of this research included an adapted version of AIM3 with suggestions for different aspects to consider if the adolescent was autistic and suggestions for adaptations to practice in relation to interventions; it was designed to try to meet the practice need, or at least provide a foundation for future development.

4.11. Conclusion

4.11.1. Emerging fields

Autism and HSB are completely different but emerging fields of study with current understanding in both primarily based on research and practice since the 1980s. Both share similar research limitations with lack of consistency in language and definitions, creating problems in interpretations of findings; being based on specialist services and settings from which it is difficult to generalise; group sizes generally being small or based on a few case examples, and in the autism and HSB research, few large scale longitudinal studies.

This would appear to be saying that the research literature is flawed and therefore we can learn little from it, however, this is not accurate. Since the 1980s the understanding of HSB generally, autism and sexuality, and autism and HSB has progressed substantially and considerable clinical experience has been developed as a result of the research, but there is also an acknowledgement that there is still so much more to learn and the need for more empirical research. In many ways both disciplines could be said to be at the same place of having developed a ‘research pile’ rather than a research base (Hackett, 2014) and if the learning can be brought together it could inform the practice of both disciplines (Strang et al., 2020).

4.11.2. What does it tell us about Autism and HSB?

Similarities and differences between autistic and non-autistic populations

It was difficult to compare the two research knowledge bases as they were not always measuring the same things, but the main similarities were about age, gender and ethnicity – there are more adolescents than children involved in HSB and most of them are male and both research knowledge bases lack information on ethnicity and the relevance of culture to the sexual behaviours. Both arson and TA-HSB were present in both research bases including the impact on psycho-sexual development of online sexual activity and the potential for radicalisation re terrorism, male identity and incel sites.

There were also similarities in regard to cases with possible autistic characteristics. The practitioners who raised the need for this research, identified high numbers of children and adolescents on their caseloads with possible autistic characteristics but with no diagnosis. The autism research literature also raised the same issue and how it was difficult to determine if some 'autistic traits' were indicative of autism or were caused by trauma, attachment or communication difficulties (Vinter and Dillon, 2020; Fletcher-Watson and Happé, 2019; Fernandes et al., 2016). Recognising these cases raises questions about how to calculate the prevalence of autistic individuals with HSB, if these cases are obscuring the figures.

However, the most significant area of similarity which needs more exploration but would require large scale, longitudinal studies are in relation to recidivism and the similarities between some autistic traits and high risk, red flag recidivism factors and sub-groups in the HSB research, such as Pullman and Seto (2012*) specialists* and the Almond et al., (2006) *impaired groups.* This raises important questions about whether autism was already integral to the development of the HSB knowledge base, without the researchers necessarily being aware of this connection and also whether or not that implies that the links between autism and HSB are significant.

The main differences between the two knowledge bases were in relation to the number of paraphilic behaviours identified and how frequently they were discussed in the autism research literature and also the prevalence of stalking and harassment behaviours. There was also debate about whether autistic children and adolescents would have the same understanding of their sexual behaviours and if the meaning to them and the intention behind them harming or distressing someone else would be the same as for a non-autistic peer. Some of this is linked to minimisation by parents and professionals to try to protect them, some to the co-existence of learning disabilities and some linked to their autistic traits.

The need for further research

The questions above would require large scale studies to begin to explore some of these in more detail. With my smaller study my focus was therefore on some of the

identified gaps in the research which made it more difficult to be able to compare the autistic and non-autistic populations re HSB to determine similarities and differences which were relevant to practice and the development of assessment and interventions. These were information on family backgrounds; trauma and abuse and types of sexual behaviours, including TA-HSB. There were also specific gaps around understanding the cases with possible autistic characteristics and understanding autistic children and HSB and I believe that this research is the first to specifically include them.

A particular focus of my research was on the involvement of community based front line practitioners. Firstly, they had identified the need for practice guidance and wanted to be part of the research; secondly, previous studies have primarily been on specialist or residential settings, and this was an opportunity to understand the cases of front line practitioners, like social workers, educators, youth justice officers and specialist HSB services and to get the perspective of experienced HSB practitioners on what they perceived to be different in practice when working with autistic children and adolescents. Thus there was a direct comparison of cases, which would enable the identification of similarities and differences.

To gather the frontline practitioner information and to include them in the research, an action research framework as described in the Methodology Chapter was used which has phases and cycles of work. This chapter completes Phase One: Cycle 1 – Literature Review and the next chapter focuses on the final part of Phase One which is Cycle 2 the surveys and interviews.

Chapter Five - Findings from the Surveys and Interviews

5.1. Introduction

The remit of Phase One of this research (*see Figure 1, Chapter 2*) was to collate the information from the literature review with the findings from the surveys and interviews with the front line practitioners. The aim was to develop theoretical constructs about the similarities and differences between autistic and non-autistic children and adolescents in relation to HSB in order to create Practice Guidance. This chapter provides information on the findings from the surveys and interviews in Cycle 2.

The same group of practitioners were involved in both the surveys and the interviews. They were a niche group with dual experience in both HSB and in working with autistic clients. They were recruited through self-selection and snowball sampling. The final group consisted of 22 survey respondents, 14 of whom self-selected to be involved in the interview process. The 14 interviewees held 37 of the original survey cases and discussed 30 of these in more depth, as well providing brief details on 11 additional cases (*see Figure 3, Chapter 2*).

5.2. Surveys – participation and case data

The surveys were used to gather information about the front line practitioners' experience and caseloads when working with autism and HSB, as this was an identified gap in the research. Data collection was through an electronic survey questionnaire created using Jotform, an online form builder platform. (*A copy of the survey form is given in Appendix Five*). The questionnaire is a good example of the development both of this research and in my own learning about autism and the benefit of the flexibility of the action research framework (Zuber-Skerrit and Fletcher, 2007; Dick, 2000). The questionnaire asked the practitioners whether the cases they had were diagnosed or suspected, which was the terminology being used at that time. However, as my understanding of autism developed, particularly about the

challenges to the use of language with negative connotations, my opinion was that 'suspected' sounded negative so I moved to the use of the term 'possible' autistic characteristics throughout the rest of this study

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The surveys focused on the following areas:

- The professional backgrounds and experience of the respondents;
- How many cases did they have within a one-year period;
- How many children and adolescents were diagnosed and how many had possible autistic characteristics?
- What assessment models were being used and who undertook the assessment?
- Information re age, gender and type of sexual behaviour;
- What challenges did they experience in working with autism and HSB and what did they find worked.

5.3. Professional backgrounds and experience

The 22 respondents to the survey, including the 14 who then went on to complete an interview, came from a range of services including specialist HSB services, children's social services, youth justice and psychologists. The initial survey question was designed to provide contextual information about their professional experience with regard to the length of time they had worked with children/adolescents; how much of this was specifically in HSB, and if HSB practice was their primary role or a substantial or occasional part of their role.

Table 1 : Level of HSB work and length of time in practice

	N	%
Level of HSB work		
Primary role	11	50
Only part of role/occasional work	11	50
Length of time in area of work		
5-15 years	10	50
16+ years	12	50

As Table 1 shows, the respondents were a very experienced group of practitioners in terms of working with children and adolescents with more than half having over 16 + years' experience and the remainder having between 5-15 years' experience. Half of the 22 respondents worked with HSB as their primary role (HSB specialists), while the remaining respondents reported working with HSB as either part of their job but it was not their primary role or they only worked with HSB cases occasionally. The non-specialist group comprised social work practitioners, youth justice practitioners and psychologists[25].

5.4. Caseloads – one year snapshot

The data from the original 77 cases in the survey was used to determine the numbers of cases the practitioners held within a one-year period; how many of those were HSB cases; and, of the HSB cases, how many were either diagnosed autistic or had possible autistic characteristics (Table 2). This was in response to the practitioners reporting increasing and disproportionate numbers of autistic children and adolescents on their caseloads, including those without a diagnosis but with possible autistic characteristics. There was no information in the academic or practice research which had looked at this particular aspect, so this study is the first to collate and report these findings.

Table 2: Total Caseloads, Proportion of HSB Cases and Proportion Diagnosed with Autism and Possible Autistics Characteristics

	Total Caseload	**HSB Cases**	**HSB cases with Autism Diagnosis/Possible Autistic Characteristics**
	N	%	%
Specialist HSB Practitioners	164	100	20
Youth Justice practitioners	162	32	55
Psychologists	145	15	50
Social Work Practitioners	31	25	-

[25] Exact numbers per professional group are not reported due to small counts (less than 5), as per University policy.

The specialist HSB practitioners had total caseloads of 164, all of which were HSB cases. Of these 164 cases, 34 (20%) were either diagnosed (17 cases) or had possible autistic characteristics (17cases). The Psychologists had total caseloads of 145 cases, 32% (10) of which were HSB cases. Of those 10 HSB cases, half were either diagnosed or had possible autistic characteristics. The Youth Justice practitioners had total caseloads of 162 cases, 32% (20) of which were HSB cases. Of these 20 HSB cases, 11 (55%) were diagnosed or had possible autistic characteristics. The Social Services practitioners had total caseloads of 31 cases, 25% (8) of which were HSB cases. An exact number cannot be provided in relation to autism diagnoses or possible autistic traits due to small counts.

These figures of between 20% to 55% of the practitioners' HSB caseloads being diagnosed and possible autistic cases seem to support the practitioners' anecdotal claims that they were experiencing increasing and disproportionate numbers of these cases. The figures also support the practitioners' views that the numbers of possible cases were as significant as those with a diagnosis.

A cautionary note however - this is a small study with practitioners who were interested in this research because of concerns about rising numbers of autistic children and adolescents on their caseload, in that respect they may not be a representative sample of these agencies and their caseloads generally. However, their individual practice concern seems to be borne out when their information is collated with that of others in similar positions. It would be useful to have further research on this.

These figures are particularly striking for the Youth Justice workers, whose HSB cases were a small proportion of their overall caseloads but over half of them were either diagnosed or possibly autistic. This may be reflective of more autistic adolescents being drawn into the criminal justice system for sexual behaviours, but it would be useful to have further research on this as well. In the interview section of this chapter, the practitioners gave their views on why this might be happening.

5.5. What assessment models were being used and who undertook the assessment?

A further change highlighted by the questionnaire was in connection to data about which assessment models were being used for autistic children or adolescents with HSB. The field of HSB practice, like the field of autism, is rapidly changing and although this question was initially devised to check out what assessment models were being used beyond AIM2[26] an actuarial risk assessment model, the most common model for adolescents with HSB at that time, the delay to this research caused among other things by Covid, meant that by the time the surveys were being reviewed, the AIM2 model had become obsolete and replaced by AIM3[27], which is a holistic model. The main learning from this part of the survey of relevance to the research, was that there are no assessment models currently being used which were specifically designed to assess autism and HSB and there were no specialists with the knowledge to be able to do these assessments.

5.6 Case Data – Age, gender and type of sexual behaviour

The survey was designed to gather minimal, anonymised information about the diagnosed or possible autistic cases. The specific information required was about the age and gender of the children and adolescents and what types of sexual behaviour they engaged in, to see if this was comparable with their non-autistic peers. This was not to produce statistically viable data but to be the starting point for the development of theoretical constructs on similarities and differences which would be explored in more depth in the interviews. It was also the beginning of collating information in relation to autistic children and HSB, another significant gap in the research knowledge base.

Some of the 22 survey respondents were unable to provide this information due to their agencies' data protection policies, so although there was information in the survey on 77 cases in total, for 21 of those cases this was limited to caseload

[26] AIM2 (Print and Beech, 2012) Adolescent Assessment model for HSB (AIM Project)

[27] AIM3 (Leonard and Hackett, 2019) Adolescent Assessment model for HSB (AIM Project)

numbers and whether or not they were diagnosed or possibly autistic. This left 56 cases where the respondents had provided information on age, gender and type of sexual behaviour.

Age and gender

Within the 56 cases almost all were male with a small proportion identifying as female or other[28]. The age range was from 6-17 years old, with 8% (15) aged 6-11 years old and 92% (41) aged 13-17 years old. The peak age for the behaviours occurring was between 14-15 years old. Of the 13-17 year olds, approximately half (20) had an autism diagnosis and half (21) had possible autistic characteristics. Of the 6-11 year olds, two thirds (10) had a diagnosis of autism and one third (5) had possible autistic characteristics The high numbers of possible cases was supportive of the practitioners' views that this was what they were experiencing on their caseloads. The majority of the children were on the caseloads of HSB specialists, with the remainder being involved with youth justice and psychology services.

Types of sexual behaviours

The types of sexual behaviours that the children aged six to eleven years old had engaged in were primarily sexualised language and gestures, touching other children and some adults inappropriately, all of which happened in the home or school settings. They targeted people known to them and made no effort to be secretive about their behaviours, so were potentially unaware of how others may have perceived their behaviour. There appeared to be no differences between the diagnosed and the possible groups.

The older children aged 12 years old had more concerning adolescent type sexual behaviours, such as engaging in excessive use of online sexual imagery (Hamilton-Giachritsis et al, 2017); exposure of genitals to younger children; masturbation in a public place; distribution of sexually inappropriate material to peers; oral sex; digital penetration; rape; attempted rape. In one case the person targeted was the child's

[28] Other – individuals who do not identify themselves with the binary concepts of male or female

mother. This is an extremely unusual case even for an adolescent. There were elements of coercion, manipulation and planning in many of the cases all of which would be high risk factors for recidivism in HSB practice. There were no significant differences between the diagnosed and possible groups.

For the adolescent group, the most common forms of HSB they engaged in were touching other people's genitals without consent or getting others to manually masturbate them; rape and sexual assault including oral, digital, vaginal and penile penetration; taking, making and sharing sexual imagery including coercing others to create or participate in sexual acts online and recorded; indecent exposure; voyeurism. The impact of the use of the internet/social media and access to porn and sexual imagery was more evident in this age group

In the majority of the cases the person they harmed was known to them through family, neighbourhood and peer relationships, particularly in education settings. Most of the abuse was male to female which is similar to non-autistic HSB but there were some male on male cases. However, a striking feature of the autistic adolescent cases was that there were nine in which adult females were targeted, in one case, two strangers in the street. In the others, adult female carers were targeted, for example, mothers, stepmothers, grandmothers, foster mothers. To even have one case like this in HSB practice would be unusual and considered to be high risk of recidivism, but to have nine of them in one small study needed to be explored further in the interviews.

Other high risk factors in HSB practice emerging from the survey data to be discussed further in the interviews, were around evidence of coercion, threats, force, manipulation, planning; a lack of discrimination re age and gender of those they chose to target; multiple people being targeted and the number of male on male cases.

5.7 What challenges did they experience in working with autism and HSB and what did they find worked

The surveys provided a brief introduction to themes which were elaborated on further in the interviews. The challenges they identified were not knowing enough about autism and feeling disempowered; difficulties in getting a diagnosis but still having to try to work with the child or adolescent and lack of coordinated inter-agency working or support across agency disciplines to skill up practitioners. Dealing with obsessional interests and concerns and how to assess the individual's ability to change their behaviours was also a key feature of their responses.

The things that they had found worked in practice were having sensory awareness of what might make it more difficult for autistic children and adolescents to engage; the need to slow the work down and also to find out what works for each individual rather than use set programmes.

5.8 Interviews – Case Data / Themes

The interviews in Cycle 2 were designed to delve deeper into the information provided by the surveys and the literature review and to explore several areas where I wanted to get a fuller understanding, such as the role of the internet and online access to sexual imagery in the development of, or in actually carrying out, the sexual behaviour; links with learning disabilities; why the practitioners believed some of the clients had possible autistic characteristics if they had no diagnosis. This was to 'develop a thick description' of the subject (Linneberg and Korsgaard, 2019; Nowell et al., 2017; McNiff and Whitehead, 2012; Thomas, 2006). Not all the survey cases were discussed in the interviews, but I compared those not included against the interview themes emerging and there were no anomalies.

The MaxQDA software package was used to support the analysis and coding of the interviews into themes corresponding to the research questions *(see figure 6)*. As research question (b)* was a broad question looking at both age/gender identity and sexual behaviours, this question is presented split over two themes- individual

profiles and types of sexual behaviour. In terms of research question (d)** similarities and differences, this was incorporated into all the themes rather than being a separate theme.

Figure 6: Link between the research questions and the themes

Research Questions	Themes
a) How many children and adolescents with diagnosed autism or possible autistic characteristics were on practitioners' caseloads?	Individual Profiles
*b) What were their ages and gender identity?	Individual Profiles
*b) what types of sexual behaviour did they display?	Sexual behaviours
c) What was their family environment like and have they experienced trauma, abuse or victimisation in their lives?	Family Backgrounds
**d) What are the similarities and differences between autistic and non-autistic children and adolescents?	Overarching theme
e) What did practitioners find were the most challenging aspects of working with autistic children and adolescents with HSB and what works in terms of assessments and interventions?	Developing Good Practice
f) Do the theoretical constructs and the content included in the Practice Guidance reflect the research participants' and the autistic community's views and experience and does the Practice Guidance support practitioners in developing more informed and proportionate assessments and interventions for autistic children and adolescents?	Addressed in the peer review and pilot processes

Some themes were complex requiring several sub-themes and even sub-sub themes to explain them thoroughly (Nowell et al., 2017).

Figure 7: Coding Themes

Themes	Sub Themes	Sub-sub Themes
Individual Profiles	Diagnosed or Possible autistic characteristics	Caseloads Overidentification of Autism
	Co-existing conditions	
	Age	
	Gender	
	Ethnicity	
Family Backgrounds	Abuse/ Trauma	
	Home environments	
	Family Stress Factors	
Sexual Behaviours	Pathways into the sexual behaviours	
	Types of sexual behaviours	Technology Assisted HSB Arson
	Context of the sexual behaviours	
Developing good practice	Challenges	
	Gaps in the knowledge base	
	What worked well	

5.9. Individual Profiles - Diagnosed autism or possible autistic characteristics

5.9.1 Caseloads

In advance of the research, practitioners had indicated that they believed they had increasing and disproportionate numbers on their caseloads of children and adolescents either with an autism diagnosis or with possible autistic characteristics. Of the 56 detailed cases in the survey, over half had a diagnosis of autism with the remainder thought to have possible autistic characteristics. In the 41 cases discussed in the interviews, over half (21) had a diagnosis of autism and 17 were thought to have possible autistic characteristics, with the remainder where it was unclear whether or not they had a diagnosis.

> "So, we see more - considering the amount of the percentage of children in the general population that will have an autistic spectrum condition, the number of children that we have on our caseload is undoubtedly disproportionate." (Interviewee No.7)

5.9.2. Potential reasons for the increase

Several interviewees indicated that due to increased awareness about autism that they felt some adolescents who should have had a diagnosis were probably on their caseloads before but were just not recognised. Some felt for many parents and practitioners it was a way of getting resources which without a diagnosis were often extremely limited or with long waiting lists. However, even with a diagnosis there was little or no guidance as to what it meant for the child or adolescent and how best parents and professionals could support them.

> "…. when I started working in this field all that time ago, I think I was working probably with young people who are on the autistic spectrum who didn't have a diagnosis…. I can think of some specific young people who probably would have had a diagnosis in this day and age" (Interviewee No. 3)

"…we also felt that it was in his interests in terms of getting future services… that he would have a diagnosis, because there was a concern for us that this was a very vulnerable boy ….and when he left care at 18 or 19 could end up homeless very quickly. (Interviewee No. 16)

"… I think a lot of the time, or in my experience, it can either be parents or schools who are rushing for a diagnosis because it almost feels for them that what more do we have to do, nothing is working." (Interviewee No. 6)

"It doesn't mean anything…. That somebody has been diagnosed with autism but there's no explanation of that. There's no reference to a diagnostic report. Nothing at all. So, if you don't have that, schools can't put strategies in place to help that child, and neither can parents be supported to communicate and sort of play with the child in a way they understand that meets their needs. (Interviewee No. 6)

5.9.3. Overidentification of autism

With almost half the cases for both children and adolescents in this study being identified as having possible autistic characteristics and there being nothing I could reasonably compare this to in the HSB research literature, I wanted to explore in the interviews why the practitioners believed these children and adolescents should have had a diagnosis, particularly as some of the practitioners admitted that they had little knowledge about autism.

For some it was due to the use of other assessment models such as Boxall profiles[29] indicating social communication and autistic type issues. Or speech and language assessments for pragmatic language problems which indicated further investigation for autism. For the majority they were identifying common autistic traits, however, these can also be indicative of other things such as trauma, communication and attachment difficulties, learning disabilities or other neurological disorders such as ADHD, or a complex mix of several factors, particularly for those children and adolescents with traumatic life histories.

[29] Boxall Profile – an education assessment tool that assesses the social, emotional and behavioural improvement of children and adolescents

Several interviewees felt that there was now a problem with overidentification of autism in relation to behavioural issues and they emphasised that the behaviours displayed can look very similar, for example, speech and communication difficulties, lack of emotional effect or perceived lack of empathy, and that care should be taken to eliminate other possibilities before suggesting that autism may be a factor.

> "I mean there's a lot of concurrence between sort of attachment style disorders and autistic spectrum disorder. So, there is the potential of that crossover, I guess" (Interviewee No.3)

> "…. there are some children that I would think are very clearly classically autistic and then others that it's this sort of overlap between sort of trauma, attachment issues, autism, potentially learning difficulties, and I think that's the complexity I think, of understanding how much of what we're trying to understand could be explained by their neuro developmental difficulties, and how much by perhaps their attachment difficulties." (Interviewee No.7)

> "Because if you are talking for example about outlooks and particular schema, attitudes and beliefs around a person functioning, where does for example, the dysfunctionality and developmental trauma stop and the autism begin?" (Interviewee No. 14)

> "…also, our children that come particularly into custody have very, very complex chronic trauma histories. …. some of them may have a diagnosis that's perhaps not the best diagnosis…. we've got one boy at the moment where our psychiatrist has rescinded his autism diagnosis." (Interviewee No.7)

5.9.4. Similarities and differences

I analysed the case data but found no significant differences between those diagnosed and those with possible autistic characteristics, in relation to their profiles re age, gender identity, family backgrounds, possible trauma or abuse and the types of sexual behaviours they displayed. Therefore, the information in the following section will not make any differentiations between cases with a diagnosis or with possible autistic characteristics.

5.10. Individual Profiles - Co-existing conditions

The interviewees were clear that it was important to know about any co-existing conditions and the impact they may have on the autistic behaviours generally and specifically in relation to their HSB, as they may be more relevant than the autism or add further complexities which make the HSB more likely to reoccur or harder to change. The following conditions of learning disabilities, behavioural disorders and psychiatric disorders were all present to some degree in the research.

In over half of the interviews there was a significant overlap between autism and learning disabilities One interviewee commented that autistic children and adolescents with additional learning disabilities were still able to access sexual imagery and information online and therefore were themselves vulnerable to exploitation or harming others online. They found that sometimes parents and practitioners believed that the child/adolescent did not have the capacity to do this, so minimised the possibility of risk to them or from them.

> "Yes and another thing that seems to be apparent is, even those with severe to moderate learning disability, can still access sexually explicit material on the internet…. It's amazing what they can do…..They can't put a red and a white brick together and copy that, but they can type sex into the internet" (Interviewee No. 3)

After learning disabilities, ADHD[30] and OCD [31]are the most commonly occurring features in the literature, with ODD[32] occurring less often (Hours, Recasens and Baleyte, 2022). All of them have characteristics which overlap with autistic traits but when combined with autism, can further compound the difficulties the child or adolescent faces. They were a factor in nine of the interviews, the most frequent of which was ADHD, however one interviewee did comment that they felt that ADHD gets over diagnosed, even more so than autism. (FASDs) – Foetal alcohol spectrum disorders were also present in a few cases and are a group of conditions created by

[30] ADHD- (Attention deficit and hyperactivity disorder)
[31] OCD – (Obsessive compulsive disorder)
[32] ODD - (Oppositional defiant disorder)

exposure to alcohol before birth. They can lead to physical problems and problems with behaviour and learning, with behavioural traits similar to autism.

> "…. another one we also see, not as often but it is something that we are certainly screening for more thoroughly now, is the potential for foetal alcohol syndrome.." (Interviewee No. 1)

Interviewees talked more broadly about psychiatric disorders such as anxiety and depression being a practice issue either coming from previous trauma or the challenges the children or adolescents were experiencing trying to 'mask' and fit into a world that does not easily accommodate them.

Several of the interviewees discussed the possibility of sociopathy or psychopathy in the broad themes for practice and of the need to be careful of not confusing autistic presentation for lack of empathy or callousness. There is a difference in a psychopathic behaviour which may have an intent to cause harm to another person and an autistic behaviour which may cause harm without realising it. One interviewee said that most of the children/adolescents they had worked with were overwhelmed with emotions and empathy but had needed it made clear to them the hurt they had caused.

> "But we had a great number of kids who looked like possible psychopathy kids, who were so cold, so callous.. etc, etc and yet they were actually blocked trauma, they had turned it off to cope with something and appeared hard" (Interviewee No. 1)

> "He's basically been in treatment for years and years and years and he just wasn't budging and didn't really see a problem with carrying on as he was….so, you know, you could definitely begin to suspect that this may be something more personality disordered at play, whether that is narcissism or psychopathy, but he would be unusual, I think." (Interviewee No. 3)

> "In the many years that I've worked in this field, I haven't seen many people that would probably fit on the psychopathic kind of, in that sort of trajectory, although there have been some of them, and I wouldn't say that the greater proportion are on the autistic spectrum." (Interviewee No. 3)

5.11 Individual Profiles - Age, Gender and Ethnicity

In the survey data there were 56 cases with ages ranging between 6 years and 17 years old. In the interviews there were 41 cases with the majority of the cases (30) being adolescents, most of whom were between 14 to 15 years old. There were 11 children aged between 6 - 12 years old with just over half of them in the older end of the age range, i.e., 11 or 12 years old. This is similar to the research and practice in relation to non-autistic adolescents where there are more adolescents than children referred to front line services and where the peak age for HSB for adolescents is between 14 to 16 years old and for children between 11 to 12 years old (Leonard and Hackett, 2019; Carson, 2019; Hackett, 2014; Hackett et al., 2013; Finklehor et al., 2009; Vizard et al., 2007).

Of the 56 survey cases the vast majority were male, with the remainder being female or other. In the 41 interview cases (90%) were male, with the remaining (10%) being female or other, due to additional female child cases being discussed in the interviews. These high figures for males are similar to the non-autistic HSB research and practice where figures for males range between 90% to 97% (Hackett et al., 2013; Finklehor et al., 2009; Vizard et al., 2007; Taylor, 2003).

Most of the females were children which is similar to their non-autistic peers, where there are more females below the age of 12 years than in the adolescent group (Hackett, Branigan and Holmes, 2019; Ghani and Barnardos, 2016; Carson, 2006). The individual who identified as other was described as having broader complex psycho-sexual issues, with their sexual interests moving from peers to adults to children and being fluid in their sexual identity; they did not identify as transgender.

The question of ethnicity was not asked in the original surveys, on reflection it should have been, so it was asked in the interviews. In eight of the 41 cases the ethnicity of the child/adolescent or family was relevant to the work required with the parents. This was due to the influence of their cultural and faith beliefs on their understanding of their child's sexual behaviour and autism. In several cases it was due to trauma from war and becoming refugees. It is difficult to compare this to the non-autistic

population, as there is also a significant gap in the research on ethnicity and HSB (Leonard and Hackett, 2019; Hackett et al., 2013; Mir and Okotie, 2002).

5.12. Family Backgrounds - Abuse and Trauma

Some of the children and adolescents in the study had experienced abuse or trauma, only a few had experienced more than one type. Neglect, emotional, physical and sexual abuse were present, but an additional category of social trauma from bullying and social rejection was the most frequently occurring type of abuse/trauma in this study. An unusual category of refugee or war trauma has also been included as these were present in several cases.

5.12.1 Social Trauma

Social trauma such as social isolation, rejection and peer bullying/coercion was present in almost half of the 41 cases in the interviews This was a pervasive factor for them and for many the root cause of their harmful sexual behaviours. It also compounded any other type of trauma or abuse they may have also experienced.

> “I think that the sense of isolation has to be much better understood… because they have… particular difficulties in connecting and with making friends” (Interviewee No.22)

> “There’s definitely a major pattern in terms of social isolation. A reason for maybe why they’ve done what they’ve done. (Interviewee No. 10)

> “…. but also, boys that are very, very emotionally lonely, physically lonely, isolated (Interviewee No.7)

> “So, …. we think he is - another boy who does want to actually be liked, that somewhere deep down inside himself he does, but …he has been bullied horrifically this boy, and ….we formulated that he’s kind of gone beyond the belief

> that he can ever fit, ….and he's become one of those sort of children- we get a few of them at X where they almost hate humanity."
> (Interviewee No.7)

Adolescence is a bewildering time (Corbett et al., 2020; Visser et al., 2017; Fernandes et al., 2016), but especially so for those who already struggle to make connections and friends. It is a time when autistic individuals can feel out of sync with their peers and experience social rejection and isolation. A strong emotionally powerful theme running through many of the cases was the desire on the part of the child or adolescent to belong or fit in with their peer groups. Some use masking and trying to copy what others are saying and doing but without understanding the nuances involved in these complex social interactions and getting it wrong.

> "He clearly wanted like every teenage boy some sense of having friends and belonging and he just couldn't achieve that. And I don't know that he was necessarily bullied but he was excluded. People didn't invite him to parties, they didn't play with him." (Interviewee No.7)

> "So, I think she was desperate to sort of fit in but didn't seem to understand those kind of subtle, social, nuances in relationships around boundaries. About making people feel comfortable. (Interviewee No. 6)

Their sexual behaviours were often features of their attempts to impress others but without understanding the boundaries of appropriate conversations and interactions, which could lead to social consequences of rejection and potential disciplinary or legal action. Two examples from the interviews were of males, one using graphic sexual language in his peer group, which made them feel uncomfortable and they reported him, while the other inappropriately over shared his sexual fantasies and the graphic sex he watched online, when others were talking about sex more generally. Both boys in these examples were confused by being rejected by their peers and in trouble with school, when in their minds everyone was talking about sex.

Within the wider HSB research literature there are adolescents who have committed sexual acts because of peer pressure, either by being part of gangs, under coercion or misguidedly thinking that it was a peer norm and therefore acceptable (Leonard and Hackett, 2019; Beckett et al., 2013; Berelowitz et al., 2013). This also applies to autistic children and adolescents but some of them also commit sexual acts to try to be accepted by their peers because of the above issues around social isolation and loneliness.

Some are vulnerable to social, emotional and physical bullying, particularly if their peers realise their sexual naivety. Similar to some of the cases in the research literature (Sevlever et al., 2013; Sutton et al., 2012) some children and adolescents in this study were set up by their peers to publicly commit sexual acts in order to humiliate them, or for the entertainment of others. One boy was encouraged by his peers to masturbate on a public bus. They had been goading him into making sexual comments and gestures in public over a period of time and dared him to commit the sexual act to see how far he would go. They also filmed it to humiliate him further. In this case he was aware that his behaviour was not acceptable but he desperately wanted to be accepted by them and the pressure to belong was greater than his internal inhibitors.

> “There was a lot of peer pressure for him about I could potentially fit in with these and get in with the cool boys, and they were able to see that vulnerability. And it started off initially it just being really inappropriate like him making comments to members of the public when they were getting on the bus and saying, oh I would shag her. And then when this small group of children were then able to see that by dangling that carrot he was biting all the time, they started to ramp it up” (Interviewees Nos 19 & 20)

> When we looked into it, some of it was all as a dare you know. He was easily exploited and so when they’d say, “We dare you to do this.” He would do it and he wouldn’t have the wit to think otherwise of it” (Interviewee No. 21)

5.12.2. Neglect and Emotional Abuse

Within this study, 13 of the children/adolescents had experienced neglect and 11 had experienced emotional abuse. For some, it was similar to the factors present in usual HSB profiles such as parental mental health, drug and alcohol abuse, parents needing additional parenting support or the difficulty of living in separated families.

> "… there tends to be kind of lots of themes around kind of early traumatic experiences whether it be attachment related stuff, or experiences of abuse …. there's lots of things around emotional neglect with the children that I consult on" (Interviewee No.6)

In this study, an additional stress on parents was living within a new culture having left their home country as a refugee. The factors specific to autism were that some parents struggled to bond with their child; others struggled to understand and manage their child's autism due to a lack of information or support following a diagnosis; some had more than one child with autism, given genetics is a causal factor for autism (Fletcher-Watson and Happé, 2019; Hofvander, 2017;Tick et al., 2016; Chaste and Leboyer, 2012).

> "… I think (it) is quite key that in each of those cases I would feel that the parents did not have an adequate enough understanding of how ASD affects children… let alone how it affects their child." (Interviewee No. 1)

> "…. And I'm always shocked by how little help parents get. ..It's kind of like he or she is autistic, get on with it. And I think then knowing how to parent, how you might need to adapt your parenting for an autistic child, parents are just often left with that. (Interviewee No.7)

When present, neglect and emotional abuse compounded other difficulties the child or adolescent was experiencing in terms of social trauma. For some parents who were struggling to manage their child's autistic behaviours, one coping mechanism was to give their child digital devices to keep them occupied and allowing them to spend long periods of time alone in their rooms, with the parents unaware of what

they might be accessing online, which was a contributory factor to their harmful sexual behaviour.

5.12.3. Sexual Abuse

A striking factor in this study was that experiences of being sexually abused and/or living in highly sexualised environments were low, when these are usually the most common factors in non-autistic HSB research/practice. A significant sexual factor was unsupervised access online which was present in five of the cases which raises a question about the impact of online activity on their psycho-sexual development (Hamilton-Giachristis et al., 2017).

> "… out of the ones that I can think of, there was definitely sexual abuse with one of them and a query with another one. Whereas actually with the other (non-autistic) kids, there's quite often sex abuse somewhere in the network you know, if it isn't their families or sexual offenders within the family network. (Interviewee No. 21)

> "There's a percentage of children who have experienced sexual abuse. A higher percentage in my experience have been exposed to sexual themes beyond their age group. Levels of supervision as well. And lots of things around supervision of device use and stuff" (Interviewee No. 6)

In this study where sexual abuse was identified, the type of sexual abuse or highly sexualised living environment the child or adolescent experienced was replicated in their own sexual behaviours, for example, some children who were sexually touched by peers then tried to touch others in a similar way. The adolescent living in a highly sexualised environment replicated this in their online searches for sexual imagery. For a female who was sexually exploited online, she then coerced others to abuse their siblings online.

5.12.4. Physical Abuse

The number of cases featuring physical abuse were also quite low given that parental domestic abuse was a feature in nine cases. The cases were it was present

were due to physical chastisement either related to cultural parenting practices around disciplinary methods, or frustration by parents not knowing how to understand or manage their child's autistic behaviours or having their own mental health issues and striking out in frustration at their autistic child. In usual HSB practice, physical abuse is often a significant causal factor but, in this study where it was present, it was not directly relevant to why the sexual behaviour happened.

> "Sometimes the ASD could make it more challenging for those parents early on, perhaps that have got challenges of their own, to be able to parent effectively. They may be in some circumstances that leads to the initial problems and increases the chances of abuse and poor parenting and using kind of physical chastisement or such like." (Interviewee No.3)

5.12.5. Refugee/War trauma

This unusual addition to the more traditional forms of trauma given above, is perhaps indicative of current world events, as it was a feature in a small proportion of the cases where the trauma was primarily due to fleeing war or poverty. This had an immense impact re managing loss and change which further compounded or exacerbated the child/adolescent's autism.

5.13. Family backgrounds – Home environments and family stress factors

5.13.1. Home environments

There was a mixed picture in this study which would be similar to HSB practice with some in stable and secure family environments and others with more complex backgrounds. Where family background was given, a slight majority of cases were in secure, stable family environments, with 16 children/adolescents living with parents or in care or adopted, with 15 cases living in separated families.

> "…We have intact families, we have separated families, we have adoption, biological children, you know.. there's just... there isn't any kind of common thread, other than the ASD" (Interviewee No. 1)

There were no children on the child protection register in this study, which one interviewee reflected was not unusual in their practice experience.

> "…there's only one kid that I can think of who we've worked with over the years who was at home and on the child protection register. The rest they would be probably family support, good enough kind of parenting.… you know, there would be a lot of the other kids, the mainstream kids who would be on the child protection register and so on…… there's probably more of them that actually are known to us for child protection concerns or signs of abuse." (Interviewee No. 21)

Although the family backgrounds had similarities to the non-autistic population, the numbers in secure, stable family homes, whether this is at home, in care or adoption, is higher than would usually be seen in HSB practice; this along with no children on child protection plans, echoes practitioners' views that stable backgrounds are one of the main differences they experience in working with autistic children and adolescents.

5.13.2. Family stress factors

The factors of domestic abuse; parental mental health; parental drug and alcohol use featured in slightly more than half (22) of the cases in this study. Due to the emotional impact on children/adolescents, their HSB may be meeting emotional needs rather than sexual. There was also evidence in five cases in this study of chaotic lifestyles; inconsistent boundaries and family criminality which can create extra stress for an autistic person if they need stability and routine.

Attachment difficulties were present in seven of the cases in the study with the child's autism being relevant where parents were struggling with knowing how to support their child or parents not bonding with their child and allowing other family members to take over their care. However, several of the interviewees gave a strong message about the potential for attachment difficulties being confused for signs of autism, or where there is an overlap between the two, the autism becoming the primary focus to the detriment of the attachment issues.

> "Yes, well I suppose it's the stuff I've got here is related to trauma and attachment style, attachment disorders, obviously impact on relationships… Some of that is a kind of cross over. Is it part of the trauma and the attachment disorder or is it ASD? More likely it's a combination of both and how they've interacted and what came first. (Interviewee No.3)

Six of the interviewees identified that the pressure of having an autistic child on parents and families could be unrelenting with some parents/carers having little or no respite, making it difficult for them to access autism resources, even if they were available. It was also a feature in why some of them had physically hit their children, or emotionally disengaged from them. For many, allowing the use of digital devices alone in bedrooms was the main way they gained some respite and they had not understood the potential risks of this for their child.

> ".. it's so difficult with X because it was such a severe case. You know like, talking ten to the dozen, and when you was in the living room with him, and he was sat next to his mum, he constantly had his arms around her. Constantly interrupting.

> You know, it had to all be about him in that room. You know, very, very- a day spent with him, you felt like you'd be exhausted." (Interviewee No.10)

Some had misunderstood the information they had been given leading to them giving confusing messages to their child, for example, a parent told her son that he had no feelings because he was autistic. The agency had to work with both the mother and her son, to help them understand that he did have feelings but that he might have difficulties in expressing those feelings and understanding the feelings of others. Core work on emotions was then used as a baseline for more specific work on the sexual behaviours.

5.14. Sexual Behaviours – Pathways into the sexual behaviours

5.14.1 Own trauma or abuse or co-existing conditions

As discussed previously social trauma, emotional abuse and neglect were the most significant causal factors for the sexual behaviours. Regarding sexual abuse, unsupervised access to the internet in five of the interview cases was a more significant factor than direct experience of sexual abuse or highly sexualised environments which had occurred in fewer cases.

In this study, the interviewees stated that in some of the cases they worked with, the co-existing conditions were more relevant causal factors for the HSB, than the person's autism, particularly learning disabilities, ADHD, anxiety and depression.

5.14.2. Influence of the Internet

In this study both children and adolescents were having extensive time unsupervised on their digital devices and were looking at sexual imagery, with some of them also on chatrooms and the dark web. This happened in even the stable and supportive families, with parents not being aware of what their children were watching. As previously stated some parents who were struggling to cope with their child's autism used their digital devices to keep them occupied but were not overseeing what they

were doing online. Some children told their parents what they were doing, in some cases the parents took appropriate action and in others they did not.

Interviewees felt that the impact on psycho-sexual development of accessing pornography online could be greater for autistic children and adolescents who may have fewer opportunities to learn about appropriate sex and relationships than their non-autistic peers.

> "Oh, there is absolutely no difference in their sexual arousal and interest in sex…. but what we do find is that people don't do sex education with them in the same way. So, they don't talk to them at home about it, they don't talk to them in school about it ….. So, in some ways they'd have even more curiosity but possibly they have less outlets." (Interviewee No.21)

> "….my own hypothesis on the reason it's increased is because of the development of social media and the internet and the dark web and all of that, so we would find that a lot of the young people referred to us now would have begun their engaging in harmful sexual behaviours via the internet or via social media, you know, a lot of them would have accessed child pornography" (Interviewee No. 16)

In this study, in just over half (21) of the interview cases, online sexual activity or searching for pornography was integral to the development of the sexual behaviours. Of those 21 cases, eight were abusing other people online and 13 showed that the type of pornography, or frequency/time spent on searching for and viewing sexual images and acts was relevant to the sexual behaviours they then displayed, particularly the younger children who were using graphic sexual language and gestures in school settings.

The internet is designed to be addictive, to encourage a viewer to engage with a potentially increasing level of graphic content, by offering pop ups and click throughs (Vaswani et al., 2022; Lewis, 2018; Moutrie, 2006; Durkan and Bryant, 1995). Several males in this study who had fixed and obsessional autistic traits had large collections of sexual images including of child abuse. Some began to watch porn because their peers at school did, however, while their peers remained on

mainstream sites like Porn Hub, they became addicted and accessed increasingly more violent and graphic videos, distorting their frame of reference for what was appropriate. A small number of other males became obsessed with accessing porn which continued despite interventions from their parents and practitioners.

> "Like addictive behaviour. It's getting addicted to the internet and PlayStation games, they're all very similar themes that we would have" (Interviewee No.7)

Several of the cases had autistic traits where they struggled with differentiating between fantasy and reality, so they had less ability to understand that the online sexual imagery was not real or appropriate off line. Not all the cases in this study were accessing these sites in the Dark Web, even within 'mainstream pornography' there are adult role play websites. Some autistic individuals may not understand role play and/or believe that if they are on legal sites then the sexual acts must be appropriate (Allely, 2021). One boy, who had abused his sister had put in his search terms about sex with sisters and had been on some of these sites.

> "But the search terms that threw up some concerns was this one about sister and mummy and daddy, things like that he put in. But it was legal, these were being played out… it wasn't illegal sites that he was viewing, they were legal sites, so these were adults that were role playing for want of a better word." (Interviewee No. 14)

> "There is no difference to them watching pornography and the other boys watching pornography. And I suppose learning… thinking that this is okay, and that the girl is going to enjoy it, and it's not a big deal because they see the porn stars doing it." (Interviewee No.7)

Some who had been drawn further into more hard-core imagery became sexually aroused to some of the images, then began seeking them in real life, for example, a male asked people he knew on social media to send him sexual pictures of their younger siblings. In several other cases, the watching of hard core pornography happened just prior to the sexual act, either the individual deliberately watched it to create arousal, for example, in an attack on two adult female strangers, or because

the adolescent had become aroused and then sought to engage in that type of act themselves, for example one individual who had used the pornography which aroused him to groom the person he harmed, before anally abusing him.

The addictive algorithms can draw those with a tendency to obsessional interests and those who spend a disproportionate amount of their time online, into other more dangerous parts of the internet such as the Dark Web, where there is the potential for radicalisation in diverse ways such as the incel philosophy[33], terrorism or paedophilia. There were two cases in this study where this was a concern alongside their sexual behaviours, one of whom was a war refugee and was focused on terrorism and sexual imagery and for the other, he was focused on both terrorism and paedophilia. In the latter case, the male was picked up initially for accessing terrorism sites online and was then discovered to have a vast collection of child abuse images on his computer; he expressed a strong ideation that children could consent. For both, their extremist interests seemed to come from their complex backgrounds and were meeting emotional as well as sexual needs.

> ".. I think in terms of individual formulations that we think about there's perhaps something around obsessional interests…. And, going on the dark web and then- it might not be that they've even gone to look at child abuse images and sometimes these boys have a lot of- they're involved in just accessing lots of highly deviant material. So, it might be terrorist or Nazi propaganda, and what you see with these sorts of boys with autism ..that almost it's perhaps about the obsessional stuff, but also boys that are very, very emotional lonely, physically lonely, isolated and appear to be meeting some need." (Interviewee No.7)

5.15 Minimisation of their behaviours and lack of consequences

The literature review highlighted that parents/carers and practitioners can minimise concerns about autistic children and adolescent's sexual behaviours (Fedoroff et al., 2015; Attwood, 2007). Evidence of minimisation in this study led to multiple incidents

[33] Incel philosophy – incel stands for involuntary celibate, a group, primarily male, who believe that women will not have sex with them, because of societal views on beauty and wealth

happening and the behaviours increasing in seriousness as they had not had clear boundaries explained and enforced.

One reason for the minimisation was the parents/carers/practitioners lacked understanding about the sexual behaviours and therefore consequences for the behaviours were not consistently enforced. In one case a male did receive sanctions from his carers who removed his digital devices but then would quickly give them back to him and he would start again, so there was no incentive to stop.

> "…. after he did it so many more times and the police did get involved, we were saying you've got a concrete thinker here and actually what you're doing is not giving him a concrete sanction. So, by saying this is bad but we're going to give you your stuff back and he understands things fairly concretely, so therefore in his mind how bad can it be." (Interviewee No.7)

> "…He wasn't getting any (consequences), the message he was constantly getting was, actually, I can get away with this. I can keep doing it because actually, school are not doing anything and my parents are not doing anything.." (Interviewee No.3)

Other reasons were that the focus was on the autism rather than the sexual behaviour, with the behaviour being attributed to the fact that they were autistic and that it was not as serious or somehow not really a sexual act. The impact on the other person was also minimised

> "… all autistic children don't have harmful sexual behaviour, so sometimes the kind of idea that he's autistic, that explains it all is just not enough is it? Is the autism even relevant at all or is it only relevant in that we need to adapt how we work with him or is autism at the centre of what's gone on, is it completely about not understanding social norms." (Interviewee No.7) "Or you get the attitude which still exists (that) ….. because of their disability or their ASD that they're not really, it's not really a sexual thing. So, victim impact isn't seen in the same way or the seriousness of the concerns aren't maybe perceived the same way" (Interviewee No. 21)

> “But quite again similar lack of response in the early stages. So, there were some tell-tale signs that- he didn’t get into actual trouble until he requested images from other children but when you looked back it was known that he’d been looking at some dodgy stuff, but again no…very little response on the basis again that he’s not that- he doesn’t understand, that kind of idea.” (Interviewee No.7)

> “So, he was- before being arrested for it he just was getting in trouble at school, and he was found with lower levels, and the professional system and grandparents didn’t really respond. I think on two bases: number one… which is TAHSB is not seen as harm to start with so …but also I do think… his autism did play a role in people not responding because he was seen as different” (Interviewee No.7)

The minimisation can mean that the child/adolescent does not learn that their behaviour is unacceptable and has consequences and therefore they are not deterred from doing it again. For example, one male who had been reprimanded on numerous occasions for sexual behaviours was shocked when his uncle reported him to the Police.

> “… he kept saying, “But you know what I’m doing.” Because he had been caught it turned out so many other times doing the same thing and he was (sent to) his room for an hour and then nobody talked about it. So, when something crossed the line in that case…..for an uncle or something. ….and this kid was like, “Why are you being stressed, I just go to my room for an hour.” And he wasn’t being smart ass, he genuinely just knew that was the consequences. We’ll never talk about it again; I’ll go to my room for an hour and I’ll be fine. (Interviewee No. 21).

5.16. Sexual Behaviours - Types of sexual behaviours

5.16.1. Autistic Children

The literature review had highlighted a specific gap in the research knowledge base about autistic children and HSB, so this was one of the key areas for this research to study. There were 15 children in the survey and 11 of them were discussed in the interviews along with one additional female child.

Children aged six to nine years old

The main sexual behaviours for this group were touching others without consent and inappropriate and graphic sexual language and gestures which would be inappropriate or problematic on Hackett's (2010) continuum (*see Figure 4, Chapter Three)* and are similar to the types of sexual behaviours shown by their non-autistic peers. Most of them had learned the language and gestures from accessing sexual imagery online or being exposed to it in their home environments by their parents openly watching pornography. Most of those children had been socially isolated or rejected by others and found using graphic sexual language or gestures got them attention from their peers and adults. For example, one boy used graphic sexual language and exposed his genitals and got very giddy because the other children were laughing. He did not understand the context of his behaviour and was horrified when he had to talk to an HSB specialist about what he had done.

Children aged 11 or 12 years old

This group had sexual behaviours which would have been within the problematic/ abusive part of Hackett's (2010) continuum (*see Figure 4, Chapter Three*). Their behaviours included the use of graphic sexual language, exposure of genitals or masturbation in public and non-consensual touching. While all of these behaviours are similar to the younger children group, the 11 -12 year olds are at a different developmental stage cognitively, physically and sexually. This age group were more actively online looking at sexual imagery and using graphic sexual language more

consciously to shock others or to try and fit in with their peers; their language also indicated learned misogynistic attitudes to females.

There were cases of exposing their genitals to younger siblings and of public masturbation due to peer pressure and wanting to be accepted by 'the cool kids.' The interviewees felt that some were unaware of the boundaries around discussing this type of information in public or of the need for consent when touching others – the counterfeit deviancy argument (Hingsburger et al., 1991), but some were cognitively aware of what they were doing and that it was not acceptable.

Many older children and adolescents are interested in, ask for and share sexual material including images of themselves or others, which can create problems with sexual bullying, harassment, coercion and intimidation and is classified as potentially problematic or abusive sexual behaviour in HSB research and practice, dependent on context. In relation to the children in this study who were sharing sexually inappropriate material, one was trying to fit in with a social group and two others were deliberately using it to groom younger children into sexual acts such as oral sex. One case involved the sharing online naked pictures of a mother in the shower and the use of her soiled knickers to masturbate. The last case was particularly unusual as it crossed the dynamics and boundaries within the mother-son dyad and in a non-autistic HSB case this would be considered an elevated risk for recidivism.

Some cases involved attempted or actual penile or digital penetration of younger family members including siblings and cousins. Some had accessed porn online prior to the sexual behaviours or used porn to groom the children. Other methods used were ensuring that adults were not around, describing the abuse as a 'game' and coercion to keep the behaviours secret, all of which indicate a level of cognitive understanding that the sexual behaviours were not appropriate and that there was a risk to themselves of being caught.

5.16.2 Autistic Adolescents - Types of sexual behaviour

Sexual touching without consent was present in 19 of the interview cases, this was targeted at peers in school or neighbourhood, or younger family members and in some cases the behaviour was directed at adult females such as mothers, foster mothers, a stepmother, a grandmother and a female teacher. These appeared to be exploratory behaviours out of curiosity and potential sexual interest without being aware of social, moral and legal boundaries. In five of the interview cases indecent exposure had occurred alongside other sexual behaviours.

In this study eight of the interview cases involved sexual assault including attempted or actual digital, vaginal or anal penetration of younger females, involving sisters, neighbours and children of family friends. In one case a 17 year old male assaulted two adult female strangers in the street, by trying to touch their breasts. In five of the 77 survey cases there was evidence of, or allegations of rape, most of which were not discussed further in the interviews, but in the interview cases there was one male who had attempted to rape his mother.

Technology assisted HSB (TA-HSB), such as taking, making and sharing sexual imagery including coercing others to create or participate in sexual acts online was a feature in nine of the interview cases and included the only adolescent female, who had been sexually exploited online herself. Some coerced or pressured others for sexual images of themselves or of their younger siblings, some of which were used for grooming younger children and coercing others into further behaviours.

Several were involved in sending indecent images of themselves or others, including one case where the male sent pictures of his sister as a swop for images he wanted and another who was sending inappropriate images of his mother to his friends. Others were accessing the Dark Web to view sexual imagery of children with two cases amassing extensive collections of child abuse images. With one it was felt that this had more to do with his tendency to take things to an extreme and was more about the collection than a specific sexual interest in children. With the other one, he

had a clear schema that children can consent and struggled with why other people think it is a problem.

Fixated sexual behaviours in four of the interview cases included a male being fixated romantically on a family member who they abused on more than one occasion; a male fixated on his foster mother's underwear, clean or dirty and used it for masturbation, which may have been related to a sexual attraction to her and a male who from the age of three years old had a fixation on sleeping with bras and peeping at his mother in the shower. He was later alleged to have attempted to rape his mother. Several were fixated on fantasies of rape and talked openly to peers and adults about these fantasies. In one case a fixation with watching rape scenarios had led to the random sexual attack on two female adult strangers in the street

These are behaviours and paraphilias which would be unusual in HSB practice. In this study they included hyper sexuality and paraphilias of voyeurism and bestiality. In the interviews a small number of the cases were of voyeurism with all of them in the family home and involved either watching or taking pictures of mothers, sisters and foster carers' adult children in the shower. In one case the male was searching for bestiality online as well as child abuse images.

5.16.3. The people they targeted

The similarities with the non-autistic population were that the majority of the cases (16) were by males to younger females, mostly family members or known to the male through the community, school or family network. In the one case of a male targeting two adult females who were strangers to him, he had also abused females within the family, as well as talking about fantasises about raping women. All of these would be high risk red flag factors in HSB.

The following are not differences as such, as they can occur in HSB practice, however, they would be unusual and indicative of high risk, red flag behaviours for recidivism, therefore, to have so many in one small study is surprising. However, the meaning and motivation for the behaviours was often different to their non-autistic

peers, primarily due to less understanding of appropriate boundaries, or autistic traits around age and gender blindness, but there were some who were aware and took actions to prevent themselves getting into trouble.

Adult females

In seven of the cases males targeted female adults, in most of the cases the motivation appeared to be sexual curiosity in the context of being unaware of appropriate intimate boundaries with family members or their online activity had blurred boundaries. Some took opportunities to stroke or touch breasts, genitals, legs or arms. Several were peeping through bathroom keyholes or spying on their mother/foster mother in the shower with one taking and distributing pictures of his mother online. In two cases there were sensory elements re smells and materials creating sexual arousal, where the intimate underwear of a mother and a foster mother was openly taken, whether clean or dirty and used for masturbation.

Males and Mixed Genders

Although small numbers, there was a case of male on male abuse and also cases of male abuse of both males and females. In the male on male case, unlike usual HSB practice he had not been abused himself, but he did have a chaotic, emotionally neglectful environment where he spent extensive time unsupervised online looking at pornography. In three cases the males targeted family or community members and their behaviours were repeated over time. In these cases the behaviours seemed indicative of blurred boundaries, accessibility and opportunity but also ‘gender blindness’ i.e., a lack of sexual preference for a specific gender, described in the literature review (Jack, 2012; Bejerot and Eriksson, 2014).

5.16.4. Evidence of cognitive awareness that the behaviour was not consensual and/or socially and legally acceptable

Evidence of planning and manipulation shows that there is cognitive awareness that the behaviour is not acceptable. These features were present in over half (23) of the interview cases and included strategies such as, the use of porn to groom or

‘normalise’ the sexual behaviour; calling the behaviour, a ‘game’ and ‘fun’; use of emotional pressure etc.

The use of coercion, threats, force and violence are more extreme ways of ensuring compliance and preventing the person targeted from feeling able to tell anyone. This was present in six of the interview cases and included threats; use of ropes and tape to tie up a child; discussing violent sexual fantasies of raping women and threats in the context of the individual having a history of aggressive behaviour where the person was likely to believe that they were in danger, both during the abuse but also if they told anyone.

5.17. Technology Assisted HSB (TA-HSB)

TA-HSB involves the use of the internet/social media and access to porn and sexual imagery. The interviewees, particularly those working in psychiatric and secure estate services highlighted that they were seeing increasing numbers of autism and TA-HSB cases and were beginning to gather data on this themselves.

> “...but I think it’s become such a huge part of our work that I think there’s just so many different facets. …… Yeah, I can’t give you figures but I certainly can soon because we’re starting to gather that data, so it is disproportionate definitely.” (Interviewee No.7)

In just over a third of the interview cases, the use of the internet/social media and access to porn and sexual imagery was relevant to the HSB. Some were deliberately searching for sexual imagery using terms such as ‘sex with siblings’, ‘child porn’ indicating a sexual interest in that type of material. They were accessing some extreme sites, for example going on the Dark Web child abuse chat rooms, or sites specialising in bestiality or rape, which was then feeding into fantasies of potentially wanting to try this out. Some used the material to groom others by ‘normalising’ illegal or immoral sexual activity such as sexual acts with children, or sexual acts with family members.

With regard to downloading, possessing, requesting, making, taking or sharing sexual images, all are activities which are illegal when the child or adolescent is under the age of 18 years old. Some of the requests were then used to coerce the other person into further activity, in a small number of the more extreme cases, there was incitement of another to abuse someone else online, the imagery of which was then shared to hurt or humiliate the individual concerned. This level of intent and manipulation would be of significant concern

There were three striking themes in the online behaviours in this study. Firstly, that some reflected the individual's own sexually abusive experiences, for example a female who was sexually exploited online then exploited others and a male in a highly sexualised home environment, where his sister had been abused. He had compulsively used pornography, including seeking information on 'sex with sisters' and he was involved in sending and requesting sexual images from a much younger female.

Secondly, in several of the cases the behaviours were primarily about seeking connections with others to meet the child/adolescent's emotional as well as sexual needs. This was linked to experiences of social rejection / isolation or lack of social opportunities to make those connections.

Lastly, the online world allowed some of them to have a different more successful persona from their real lives. Online they were more in control, more confident, assertive and successful. They were able to communicate more easily and confidently than when they were in direct contact with others as the medium of messaging allowed them time delays to think and edit messages and they did not have to look at the actual person.

"And this bizarre sense of belonging where they feel like they don't belong in the real world, and nobody gets me. I'm seen as a weirdo. I'm seen as a bit of a freak. And then I go online …and other people accept me…. Whatever it might be that they get some sense that it meets perhaps a sort of need around belonging, and just something that they're good at. (Interviewee No.7)

“And the communication online when it did occur, like for most of these incidences, became sexualised very quickly and there was a confidence in his presentation online which he felt he wasn’t capable of having offline.” (Interviewee No. 14)

5.18. Arson

Although this is not a sexual behaviour, arson co-occurs frequently in HSB cases and autistic individuals are over represented in the statistics for arson (Allely, 2021; ; Palermo and Bogaerts, 2017; Palermo, 2015; Enayati et al., 2008; Newman and Ghaziuddin, 2008; Mouridsen et al., 2008; Siponmaa et al., 2001). It was not surprising therefore to find one case in this study, although he also had a very traumatic background as a refugee fleeing war and had lost all his family, so behaviours such as stealing and fire setting may have been indicative of his trauma rather than a link to his autism.

> “He also had a fascination with fire…. and his foster placement nearly broke down because he set the sitting room on fire (Interviewee No. 16)

5.19. Sexual Behaviours - Context of the Sexual Behaviours

5.19.1. Individual schema

Individual schema refers to how an individual rationalises to themselves that their sexual behaviours are appropriate. It was evident in some cases that some of the autistic individuals were not aware of the social, moral or legal context of their behaviour or how it could be seen or experienced as harmful by someone else, therefore they were not overcoming internal inhibitors in the same way as a non-autistic adolescent. Some of them initially struggled with other people’s alternative perspectives when their sexual behaviours were reported. However, some were clearly aware their behaviours were not acceptable, evident by their attempts to hide their actions or to manipulate others into not telling. Examples of differences in their schema were:

Compartmentalisation

Compartmentalisation of different aspects of their lives may also be related to a previous point made about having a different persona online. The individuals may feel more in control, confident, assertive and successful. For example, a male sent and asked for sexually explicit images from a much younger female. He knew her through school but only ever contacted her online to get images and ignored her during the day at school. When being assessed he said she was his girlfriend, therefore he felt it was appropriate to ask for the images and could not see any dissonance with the fact he had no contact with her except online as he had compartmentalised his life into online and offline worlds.

Empathy and emotional disconnect

Not expressing empathy or appearing emotionally disconnected are deemed high-risk factors in HSB practice. Several of the interviewees emphasised the importance of not assuming an autistic individual lacks empathy. Instead there is a need to recognise that because of their autistic traits, there can be differences in understanding, experiencing and expressing emotions, which may mean they misread non-consensual or distress signals from the other person, or give unusual or limited emotional responses when questioned about their sexual behaviour, which can be read as lacking empathy, or cold or callous (Allely, 2021).

> "And I think the thing around the empathy is huge. So, lack of empathy is equated to callousness. And these are the least callous children you'll ever meet, particularly the boys I'm talking about, so far from callous I can't tell you, but can they empathise, no because they've just got no ability to perspective, but it's not a lack of compassion". (Interviewee No.7)

> "…I don't see how they present in court but they're quite…. their facial expressions are not- they don't give a lot away basically, and I wonder- … and it might not be the case for all the boys in custody, but are some of them getting either harsher sentences, or sentences because in court they appear to not care what they've done. Are they being mis read? Are their social difficulties meaning that when they're sat there in court staring straight ahead is it an assumption that

> they don't care. And I don't know whether that is the case but there's something for me- some of our boys are so vulnerable and I'm really shocked at them getting these long custodial sentences." (Interviewee No.7)

Age and gender blindness

In some of the cases in this study the concept of age and gender blindness was raised. Contrary to non-autistic adolescents who would usually be sexually interested in peers, some of the individuals in the study had crushes or fixations on adults, for example, a female teacher or a foster mother. If they chose younger children this would be illegal, but they may not understand those boundaries, for example:

> "…. I called it age blindness, and why are they blind to the relevance of the age, part of that is social as well of course, but I see that as different to understanding a social relationship, they literally go "well you are 7, do you fancy me?" Well, that's ok, they fancy me so we can be boyfriend and girlfriend. Oh, you are 7 and I am 14 so down the road, I will be 28 and you will be 21 and that is fine, 21-year-olds date 28 year olds and they don't see that it is inappropriate to start it at 7, so those kinds of things, so they will apply the little or few rules they have still inappropriately so it's age blindness." (Interviewee No.1)

Regarding gender, there were several cases where the individual abused both males and females, usually family members, siblings and cousins or peers and in some of these cases it was more about blurred concepts of appropriate intra-familial boundaries around attachment and affection. However, being indiscriminate about gender would be a high risk behaviour in usual HSB practice.

Consent

This is a complex concept anyway and if an autistic individual has not had sex and relationship education explained to them in a way that they can process and their main frame of reference is online sexual acts, then they may not understand what consent is or what it might sound or look like. Examples from this study about how consent was rationalised included the previous case where a male requested and

sent sexual images to a much younger girl. In his mind she had sent the pictures therefore it was consensual; he had no concept of the inappropriateness of asking such a young girl for the pictures. Another male believed if a girl was nice to him or smiled at him then she wanted to have sex with him.

5.19.2. Illegal or socially unacceptable Schema

Sexual interest in children

In a small number of cases adolescents under the age of 16 years old had stated that they had a sexual preference for children, with one of them consistently adhering to the view that children can consent and that viewing child abuse imagery was acceptable. In these cases, practitioners were cautious that these statements did not necessarily indicate paedophilic tendencies, as the male referred to in the quote below tended to try to shock in different ways.

> "He says that he thinks that children can consent, he doesn't accept that they can't. He thinks that the children that he's seen- … he says that he doesn't particularly look for images where children are in pain, so as far as he's concerned these children are happy to be doing what they're doing, and he's saying that why- it's sort of society, it's us that have got the problem. (Interviewee No.7).

Large volume of child sexual abuse images

In HSB practice, large collections of sexual images particularly including those from categories A and B[34] would be of high concern and indicative of recidivism. However, with an autistic adolescent this may be more related to autistic traits of fixations or collections than to specific sexual interests. They may collect indecent images of children but may not be sexually interested in children or may not understand that actual children are being hurt or abused (Attwood, Hénault and Dubin, 2014).

[34] Sexual abuse images are categorised into:
Category A: images involving penetrative sexual activity; sexual activity with an animal; sadism
Category B: images involving non-penetrative sexual activity
Category C: indecent images not falling into categories A or B

"…Parents will tell us that they might have started off as little children collecting things to the extreme…we had a boy collected bus tickets, and he just had hundreds of thousands, but then when we looked at how many child abuse images he had again that was in the hundreds of thousands…and it felt like for him there was something about the technology assisted HSB just offering him another opportunity to sort of collect, and we were never convinced it was necessarily entirely sexually motivated, although albeit sexual images. (Interviewee No.7)

5.19.3. Psycho-sexual complexities

Some interviewees stated that they were experiencing rising numbers on their caseloads of autistic adolescents with psycho-sexual complexities such as hyper sexual arousal where there is a much stronger sex drive potentially linked to sexually compulsive, repetitive behaviours or fixations; paraphilias or complex sexuality issues as per the example below.

"...and then separate to that is broader psycho-sexual issues as can be seen in Boy 3 case where he went from (children).. would arouse him and then he became fixated on wanting to marry his teacher…so he went from children to inappropriate adults and then he moved into straight/ homosexual/bisexual, then he revealed he was cross-dressing but did not want to be a girl. He was very, very clear, he liked his bits of male anatomy but thought he looked better when he dressed as a girl and so you have these ASD kids with complex, psycho-sexual issues." (Interviewee No 1)

The interviewees felt that some of the psycho-sexual issues such as paraphilias may be related to sensory sensitivities or interests and that the behaviours need to be understood in the context of that individual's autistic traits.

"And there might be kind of sexual dysfunction stuff that might be related to sensory stuff. I think that's probably an area that needs more attention with those on the autistic spectrum, than not, or considered as a possibility that that plays a role." (Interviewee No. 3)

> "Especially where you have a kid who's interested or the HSB is maybe involves some form of animals, not necessarily full bestiality but you know even that whole kind of interest in animals and pornography or whatever. Or the fur do you know, I think you wouldn't want to misjudge a kid nor would you want to miss something where there's a sensory issue or there's a comfort thing." (Interviewee No. 21)

There were strong statements from the interviewees about over and under reaction from professionals, both linked to a lack of knowledge and confidence about autism, creating over reactions such as thinking that the autism means the adolescent will continue to repeat the behaviours and therefore pose a risk.

> "…. and they may have hyper sexual needs but that doesn't necessarily mean it is a risk, so I think there is a lot in that domain... where people, people want to cluster "oh ASD, oh if they have ASD, they are not going to get the rules, oh they are not going to understand and they will make those mistakes again" (Interviewee No.1)

Or creating under-reactions with the focus on the autism rather than exploring the sexual behaviour with referrals more likely to be made to CAMHs rather than the criminal justice processes.

> "Why are kids being diverted to CAMHs and not in the CJS when you look at the adults who should have been picked up much earlier…. I would query why that is." (Interviewee No.14)

5.19.4. Open and direct about discussing the behaviour and fantasies

Denial and minimisation as defence mechanisms are common features in HSB practice as the adolescents are aware of the social opprobrium, reputational and legal consequences for themselves of admitting what they have done. However, autistic adolescents are less likely to lie or dissimulate if asked a direct question about their sexual behaviour. Their openness is more likely to be the acknowledgement of a straightforward fact, yes, it was them and that is what they did, rather than taking responsibility for the harm their behaviour had caused, in fact they may argue with other people's perception of their behaviour.

They may not be aware that denying, lying or not telling the whole story could be an option that may get them out of trouble or they may not be aware that they are in trouble (Dorer, 2022). For example, in this study, a male sexually abused his younger cousin and thought if adults knew, he might get grounded. He was shocked to be interviewed by the Police and end up in the criminal justice system.

> "There is something else I've noticed, as well, when kind of doing the initial assessment, tendency for those on the autistic spectrum to be more kind of open and not really worry about some of the information that they're giving out, as they perhaps don't kind of understand the connotations or maybe don't experience the sort of embarrassment or shame associated with that, because they don't understand the kind of social context or reaction to that type of behaviour". (Interviewee No. 3)

Autistic adolescents can also be very open and direct when asked about their sexual fantasies and what they are accessing online, which may include graphic, extreme elements such as kidnap, rape and violence. Normally this openness would increase the level of concern, yet conversely it can make it easier to talk more directly with the adolescent to help them have some insight into their behaviour to make changes.

5.20. Developing good practice

This section looks at the combined information from the surveys and interviews about the experiences of the practitioners in working with autistic children and adolescents with HSB. This perspective was missing from the research literature and an important part of this study was to make these views heard – to make 'tacit knowledge explicit' (Somekh, 2006). It covers the challenges they perceive they face; the gaps in the knowledge base they have identified and the good practice they have developed through their work.

5.20.1. Challenges

Problems with Diagnosis

There were two significant challenges identified with regard to autism diagnosis, firstly that for many it was difficult to get a diagnosis. There were several examples given of parents and practitioners struggling to get a diagnosis, sometimes to be able to protect an individual and to access resources, but also to ensure that the HSB was seen in the context of their autism. Secondly that in some cases having a diagnosis meant that it became the focus which led to either over or under-estimation of the risk.

> "…we also felt that it was in his interests in terms of getting future services and that, that he would have a diagnosis, because there was a concern for us that this was a very vulnerable boy" (Interviewee No. 16)

> "But I do think that if there is a diagnosis, people, professionals see the child more and not just the risk which is a bonus because often if the child doesn't have neuro developmental difficulties professionals see the risk and not the child" (Interviewee No. 6)

> "Yeah, and also, all autistic children don't have harmful sexual behaviour, so sometimes the kind of idea that he's autistic, that explains it all is just not enough is it. Is the autism even relevant at all or is it only relevant in that we need to adapt how we work with him or is autism at the centre of what's gone on, is it completely about not understanding social norms. So, for some children we formulate their harmful sexual behaviour is almost not directly caused by but very heavily linked to their autism." (Interviewee No.7)

Systemic Issues

A significant theme in the interviews was this work involved the dual disciplines of autism and HSB, with practitioners who were more experienced in one discipline often feeling less confident with the other. There was a need for more training and guidance on how to understand and adapt practice. Without this it was felt that some practitioners avoided the work or lacked proportionality in their analysis of risk.

Where inter-agency coordination was available, such as in multi-disciplinary teams, or those with access to specialists from other disciplines, it was found that combining different knowledge bases was the most effective way of influencing practice. Some of the HSB specialist services felt they had an additional pressure of trying to coordinate, educate and support other practitioners as well as do their own work, otherwise they faced battles about accessing resources and the development of a coordinated safety plan.

This was particularly evident when work and support was needed for both parents and their child, especially if different agencies were involved. This could either mean that the two agencies worked separately with no coordination of an agreed outcome or focus or key messages, or due to waiting lists, the work for parents could not happen at the same time as the work for their child.

> "… CAMHs weren't going to meet with parents, so they weren't going to do any systemic work. They suggested that parents get involved with ..(X a local agency) who work with kids or offer advice around ASD, but of course there was a massive waiting list. So, I kind of said well what's the plan B, what's going to be done in the meantime and there's just never a plan B because there's just not the services out there. So, that's a big frustration." (Interviewee No. 6)

There was a clear desire and need for supervision and consultation for workers to be able to learn in practice, and to ask questions. Those who worked in multi-agency teams really valued this access, but in other frontline services such as social work, education or youth justice, the interviewees stated they felt very alone.

> "There's just nobody out there, and it's very difficult to get CAMHS, … they do offer consultation, but you know you have to be high end to get in there. I think sometimes the impression I get from education is that they feel very alone. They try really, really hard but there's nowhere for them to go…. but I think there is a lack of training, and …a place to go to reflect and to talk about things around interventions." (Interviewee No.6).

5.20.2 Developing good practice - Gaps in the Knowledge base

In six of the interviews, the interviewees had been unable to find research and guidance on understanding autism generally and autism and HSB specifically which was the main driver for this research. As with some of the studies in the literature review (Greaves-Lord et al., 2020; Malovic et al., 2020), several interviewees identified the need for updated, evidence based structured frameworks and tools. Many of the practitioners were used to structured measurement tools such as psychometrics, which they recognised miss a lot of the autism traits particularly around sensory sensitivities. They raised the point about how could a risk assessment model be created for autism and HSB when there is so little empirical research, particularly around recidivism data.

There was also a perception that the subject is too complex to be able to create these. Consequently, the interviewees welcomed the attempt to create some practice guidance as a starting point, to empower others to feel more confident about the work they are already doing and to encourage more research.

> "…And you know it's one of those areas that people have probably, because of the challenges with it, stayed away from it and that's created problems then." (Interviewee No. 14)

> "And there is nothing that, you know, there is no framework, there is no specific guidance that allows you as the professional or assessor, to begin to rule out things and rule in things." (Interviewee No14)

> "…definitely something I've been interested in for a while. When I kind of initially sort of tried to …. pick out the psychometric scores of those that had an ASD diagnosis, compared to our other groups of young people, but we just didn't have enough in the way of numbers, at that point." (Interviewee No. 3)

> "And I think there is a massive gap there in producing something that we can stand over with any certainty to say doing this has a sufficient level of impact in improving

> the quality of outlook for that young person's life and reducing the level of recidivism." (Interviewee No.1)

The high numbers of autistic adolescents in secure units for serious sex offences was raised as another issue which needed more data and research. Is their autism relevant to their sexual offending? Are they misdiagnosed and their behaviours relate more to ADHD, which many have as a co-existing condition, or trauma, as many of them have complex abuse histories? Is it because of how they present in criminal justice settings? This needs more research.

5.20.3 Developing Good Practice - What worked well

In the vacuum created by the lack of practice guidance, it was clear that practitioners had been developing things through trial and error to find out what works. However, because these developments were all created separately and there was no forum for sharing of resources and ideas, they had nothing against which to compare their own work. One hope for the Practice Guidance was that it was a starting point of collating these experiences and providing ideas and affirmation of ongoing practice. What became clear in the study was that many of the changes made to practice due to autism, were also beneficial for work with non-autistic children and adolescents, improving practice overall.

> "… but actually, I would say my work has really now improved throughout. It's all transferable and I think the more understanding you get actually helps the more general bits that you do. You can be a bit more creative, but certainly I think once you get into it, you wouldn't have any problems." (Interviewee No. 15)

Get the individual profile first

Several of the interviewees made the point about the need to understand the individual's profile – what were their challenges and strengths, how they process information and communicate with others, their social skills etc to enable the practitioner to adapt their own practice to be able to communicate better with them.

> "Generally, if a young person presents as a non-neuro-typical, we need to understand more about that experience from their perspective, as a consequence of their own neurology and means of thinking schema and outlook etcetera … So, there is something there about how these experiences are integrally interpreted by a child with autism." (Interviewee, No.14)

Build Rapport

The interviewees felt that building rapport with the child or adolescent allowed them to begin to trust the practitioner and to be able to engage in the work in a meaningful way. This meant the practitioners adapting their resources or style to better accommodate the individual's processing. Several also mentioned that while building rapport is important , practitioners also have to be careful about not creating dependence and to help the child or adolescent to transfer their learning and skills to other situations.

> "…I think one of the challenges for me that I thought of a lot in terms of this young man is doing so much, and being so part of it, and then maybe an over reliance.….And I think that is difficult with children with learning difficulties. Because you have to work so hard to build up that relationship, it's important, but there's times when you're not there or you have to start that process of stepping back a little bit. (Interviewee No.15)

Work is slower

This was a consistent theme that the work had to go at a much slower pace as it may take an autistic child/ adolescent more time to feel comfortable and to trust the practitioner or more time to learn, retain and transfer information to other settings. They may also need more time to process questions, therefore offering alternative methods of communication is essential. It may be easier at times to write on a post-it note or write text into a phone and show it, as compared to verbal language (Hughes, 2022).

Dependent on their autistic traits, some children or adolescents needed to have information and learning repeated within sessions and to have ongoing daily

reminders to keep this fresh in their minds. The essential role of parents/carers in relation to this meant that if they were not engaged or receiving services or support themselves, the work undertaken in sessions with the child or adolescent could be less effective. This can present a problem for practitioners who work to statutory guidance on assessment timeframes, so it potentially needs to be flagged up as a strategic policy issue.

Obsessions or fixed interests

If the sexual behaviour was an obsessional or fixed interest, a practice concern had been about how could they work with the individual to get them to refocus on something else and how difficult it might be for them to make any changes, therefore what ultimately is the long term option for them? The interviewees discussed strategies they had found successful, such as being creative and adapting their practice to best engage the child or adolescent in the work by using the special interest as the medium for the HSB work and the messaging, for example, Star Wars has heroes and villains and morality tales about right and wrong, so one practitioner had used this to discuss social rules and the sexual behaviours. For some autistic individuals changing behaviours would be more difficult but for many, interventions were successful. Knowing this gave the practitioners more confidence that positive outcomes were attainable.

The function of 'stimming'

Repetitive behaviours, movements or noises – 'stimming' can be a way that an autistic person deals with sensory overload: stressful situations or happy ones. It has a regulatory function to stimulate or calm the individual (Kim, 2015). If the child or adolescent needs to move around during a session, or uses their stimming techniques, this is usually about them trying to make the situation they are in feel safer or at least more tolerable for them, potentially so they can stay in the session and engage. In usual HSB practice, these types of behaviours would be perceived as attempts to disrupt the session or to avoid answering difficult questions and the individual would not be considered motivated to engage in the assessment or the intervention, which would consequently increase the level of concern. Therefore, if

practitioners are not aware of the function of stimming, they may overestimate the level of concern.

Sensory sensitivities

This can include thinking about where the sessions are held, for example, busy offices with fluorescent lighting or strong smells such as perfume, deodorant may be distracting or overwhelming for an autistic person. Also think about what can be easily added to the sensory environment to make the autistic child or adolescent more comfortable with regard to their sensory sensitivities, for example letting them know that they can bring comfort items with them to a session can be very helpful (and shows that a clinician understands their needs) for example, a fidget toy, cuddly toy, something they might carry "for luck".

> “It can be very helpful to ask the autistic person to do an audit of the space in their first session. It may be hard for them to predict what will be challenging in an environment, and something they have not encountered before may be difficult. It can be useful to check in at the start of each session re how a sensory space is feeling so they know that it is safe to speak up if one day something is causing them difficulty” (Hughes, 2022).

Use of digital devices

Interviewees stated that removing digital devices is often an action taken once an allegation has been made, regardless of the cause or type of the sexual behaviour. They felt that while this may be appropriate in some cases, it may be extremely difficult for an autistic individual to cope with, particularly if they spend a disproportionate amount of time online. This may be due to social isolation and rejection and they may have few other options for social contact or leisure opportunities. A balance between managing the risk of the online activity and not creating additional emotional, psychological stresses for the individual child or adolescent is required, for example, this may mean supervised access online for set time periods.

Alternatively, if they are proficient and comfortable with working on digital devices, then this might be a good way to connect with them during the assessment by asking them questions or doing exercises with them on a computer. There would however need to be caution in terms of not sending mixed messages about online activity, so boundaries about how it will be used, time limits and supervision are required.

Involve and support parents

In over half of the interviews it was emphasised that parents need to be seen as key partners and engaged from the beginning as they are essential for getting a better understanding of the child/adolescent, their challenges and strengths. Parents and the network of adults around the individual are the core element in effective interventions, giving consistent, persistent messages and guidance on an ongoing basis. The specialist HSB services recognised that parents needed support as well, so all included parent sessions as part of their intervention programmes and two ran parent groups to provide them with a space for their own learning and reflection.

> "… I think an intervention in terms of one on one doing something either segued to educational work or psycho-sexual work or whatever, has its place. But unless we create the environment for change none of this work, the individual work won't take hold. …..Both family and professional systems that create that security, that sense of safety that meets the basic needs of the child, in order to ensure that they are in a place where, well in order for them to learn cognitively…" (Interviewee No. 14)
> "…. so that means we have to go slower and we have to give them more and we have to be more patient and we have to understand what the parents have been through. Because usually they've had a battle royal for years before we get to this stage and so a lot of empathy for the parents, not just for the kids, and that I think pays dividends." (Interviewee No. 22)

> "...we will just have conversations with the parents about ASD and their young person and things that might help them better to understand how this might roll out over the course of the young person's life, so for him now and in the future,.. so, we have to give them practical skills…that certainly is a common thread that we see in almost all of our ASD cases. (Interviewee No. 1)

The interviews highlighted that the most important, sensitive and in some cases controversial part of the intervention with parents/carers was around helping them understand their child's sexual development, their sexuality and their harmful sexual behaviours. Some struggled with their child's sexual development, finding it difficult to talk about sex with them and were potentially over-protective, worried that their child may be vulnerable to being exploited or to getting into trouble with the criminal justice system (Franklin, Raws and Smeaton, 2015). Some were too restrictive also reducing possibilities for healthy sexual experiences, creating confusion and potentially sexual frustration for their child.

5.21. Summary of the findings from the survey and interviews

The aim of Phase One: Development, was to collate the information previously known from the literature review with the findings from the survey and interviews to try to develop a more coherent picture of autistic children and adolescents with HSB. There were significant gaps in the research literature around the perspective of front line practitioners, autistic children and HSB and on understanding of cases with possible autistic characteristics. This is the first study to gather and analyse this information. There was also limited information on individual profiles, family backgrounds, trauma or abuse and the types of sexual behaviours. This made it more difficult to make a comparison with current HSB practice so gathering this information was an essential focus for this study to be able to develop theoretical constructs around similarities and differences for HSB practice.

Information on the practitioners' views was gathered through discussion about their cases and asking them what they felt was needed to develop good practice in this field of work. The study gave data on the cases with possible autistic characteristics with suggestions of why the numbers are rising and cautionary notes for practitioners about potential explanations other than autism. This is the first study to specifically look at autistic children and HSB and found they shared many similarities with their non-autistic peers in terms of individual profiles, family backgrounds and types of

behaviours. The differences identified were around early puberty in females and the violation of adult female carers' privacy and personal possessions.

Regarding profiles and backgrounds, this study found similarities with non-autistic peers in terms of their age and gender. There was a mixed picture in relation to their family backgrounds, with some in complex family situations similar to their non-autistic peers. However, there were no children or adolescents on child protection plans.

More were in settled home environments, whether with parents or with carers; this is also found in other practitioners' experiences and in some studies in the literature review (Bleil-Walters et al., 2013; Sullivan and Knuston, 2000). Related to this was the finding that the most significant forms of trauma and abuse that the children and adolescents experienced were not sexual which is common in HSB practice, but social trauma, emotional and neglect with a primary factor being the stress for parents trying to meet the needs of their autistic child.

Because of a practice hypothesis that autism may be significant in relation to TA-HSB, as both share characteristics of settled backgrounds and extensive time online, this study looked at the backgrounds of those who engaged in TA-HSB and found they had the more complex family backgrounds in this study, so in this respect, this study does not confirm the practice hypothesis.

Key differences were in the pathways into the HSB: having extensive, unsupervised online access to sexual imagery was more relevant than experiences of sexual abuse and violence, which would be more common in HSB practice. The factor of minimisation of the sexual behaviour, out of lack of knowledge, a desire to protect or a belief an autistic individual cannot have sexual intent, meant there were no consequences and for some their behaviours continued and escalated.

Regarding the type of sexual behaviours, the full range of behaviours on Hackett's (2010) continuum (*see Figure 4, Chapter Three*) were present and much of the methodology was the same. However, what was different was the meaning and

motivation for the behaviour for an autistic individual i.e., how they understood and rationalised their own behaviours; what needs it was meeting and what motivated them to do it. There were some types of sexual behaviour which were more directly related to specific autistic traits such as fixations, collections, sensory interests and paraphilias. A final difference was that autistic individuals were more likely to be open and direct about their sexual behaviours when asked, when usually adolescents would deny or minimise. A key practice issue raised by this study was the similarity between autistic traits and the HSB recidivism factors and this needs more exploration in future research.

The findings from the case examples in the study along with the information from the literature review was used to take the current HSB practice understanding and integrate it with knowledge about autism to demystify this aspect of HSB practice and understand what is similar and what is different to consider how to change and adapt practice. This shaped the development of the Practice Guidance, which was then peer reviewed and piloted in Phase Two: The External Review.

Chapter Six - Phase Two: External Review

6.1. Introduction

Phase Two of the study was the External Review, which incorporates Cycle 3: Development of the Practice Guidance and peer review and Cycle 4: Pilot process. The external review process was undertaken to add further trustworthiness and authenticity to the research (Spoto et al., 2023; Noble and Heale, 2019; McNiff and Whitehead, 2012; Guba and Lincoln, 1981), through data triangulation (Spoto et al., 2023; Noble and Heale, 2019; Carter et al., 2014; McNiff and Whitehead, 2012). This helped to increase the auditability and confirmability of the research (Guba and Lincoln, 1981) mitigating the risk of researcher bias, as I was the main 'research instrument', doing all the analysis, coding and interpretation.

Cycle 3 involved the creation of the Practice Guidance and then submitting it to peer review by a different group of practitioners from those who had completed the surveys and interviews. The peer review included autistic professionals and people working with the autistic community as well as HSB specialists. Once the peer review group were in agreement with the theoretical constructs and content included in the Guidance it was then submitted for further testing in Cycle 4: Pilot Process. This meant another different group of practitioners tested its usefulness in practice and to see if it supported them in developing confidence and competence in this field of work. This chapter describes the development of the Practice Guidance and the learning from the peer review and pilot processes.

6.2. Cycle Three: Development of the Practice Guidance and Peer Review

6.2.1 Introduction and creating the practice Guidance

The aim of this cycle of the research was to develop draft Practice Guidance which would then be sent out for peer review (Robson, 2002). The draft Practice Guidance was created using data from the first two research cycles – literature review and surveys and interviews, to develop theoretical constructs around the similarities and differences between the autistic and non-autistic child and adolescent populations in relation to HSB and to provide the guidance that practitioners requested. The aim of the Guidance was to try to make a complex subject more accessible for busy practitioners. The surveys and interviews had also highlighted that the Guidance needed to contain more information than simply an adaptation of the AIM3 model (Leonard and Hackett, 2019). The following is an overview of the chapters included and the rationale for their inclusion:

Chapter One – Introduction

This included the need for the Guidance and why I undertook this work and the terminology being used throughout. This was important to address neurodiversity issues and to be sensitive to the debates around identity within the autistic community itself and to clarify the HSB language being used.

Chapter Two – Understanding Autism

This provided information for practitioners who were unfamiliar with autism, about diagnostic criteria and the potential links to their harmful sexual behaviours, along with other potential additional co-existing conditions which can exacerbate the challenges an autistic individual may experience. The reason for including the diagnostic criteria which is a medical model of autism and includes deficit language was that it is currently the only way autism can be officially identified. The practitioners had indicated that they felt confused and disempowered by the diagnostic criteria, so the explanation in this chapter was to give the practitioners a

language to understand autism and communicate more confidently with professionals in other agencies.

Chapter Three – Autism and HSB

This chapter focused on the information from the research and practice knowledge bases about autism and HSB, looking at similarities and differences with the non-autistic population. It also covered those who had possible autistic characteristics but did not have a diagnosis.

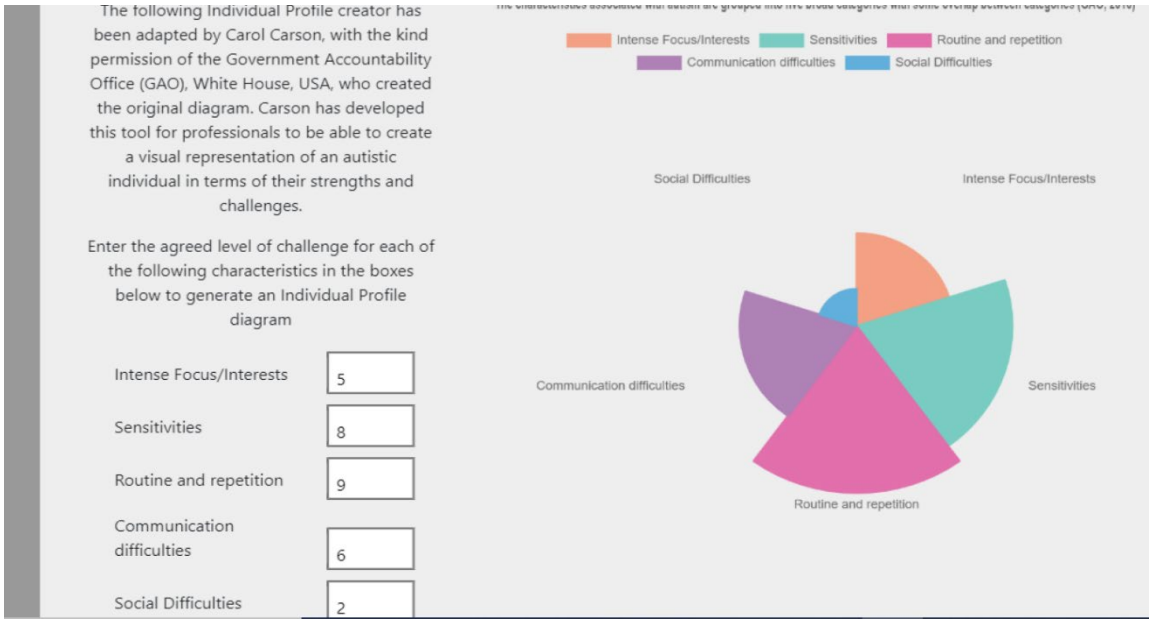
Chapter Four – Preparation

This chapter outlined aspects that need to be considered when preparing for assessments or interventions such as the potential for the behaviour to be related to attachment, trauma or speech and language issues rather than autism. It provided suggestions for preparing for sessions and thinking about possible sensory impacts for example, lighting, room size, practitioner's perfume etc. It emphasised the need to prepare sessions in advance, rehearse language to be used and to be creative in adapting content, particularly if able to appropriately include special interests.

Understanding the individual and their autism; the strengths they have and the challenges it brings to their everyday lives is essential to more accurate assessments and effective interventions. It enables better communication and helps highlight how the worker's practice needed to be adapted to enable positive engagement (Hughes, 2022). As this was a key theme throughout the Practice Guidance, to support practitioners, I created an individual profile creator *(see Figure 8)* of their strengths and challenges based on a diagram by the GAO[35] and a set of questions to discuss with the individual, their parents/carers and other relevant adults in their network. The Practice Guidance is clear that this was not intended as a diagnostic tool.

[35] GAO – Government Accountability Office of the White House, USA. They had used the diagram for a report on autistic youth, not specifically in relation to HSB

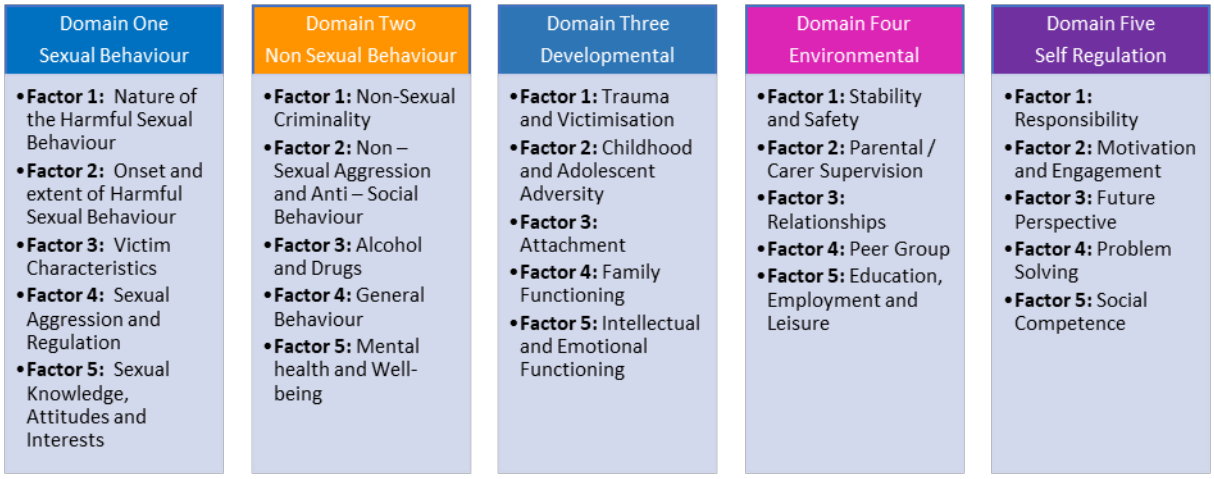
Figure 8: Individual Profile Creator adapted from GAO diagram



Chapter Five – Assessment of Adolescents

This focused on adolescents only, as the information on autistic children was so limited that I chose not to adapt the AIM Children Under 12 years old model (Carson, 2019). The information in the chapter was designed to be used in conjunction with the AIM3 model (Leonard and Hackett, 2019), so that it could be adapted for use with autistic adolescents. As there are a lot of similarities with current HSB practice, most of the information within AIM3 equally applies to autistic adolescents. I then took every Domain, Factor and Item *(see Figure 9 below)* and highlighted any differences which need to be considered when making an assessment.

Figure 9: AIM 3 Domains and Factors (See Appendix Nine for more details)



Chapter Six – Intervention

This chapter covered the information from Cycle 2 - surveys and interviews, about what the practitioners, in the absence of any guidance, had found through trial and error had worked in practice. This was to add to the research knowledge base by making 'tacit knowledge explicit' (Somekh, 2006). A striking theme from the interviewees was about developing their practice in a vacuum and not knowing what else was being developed by other people. There was nowhere for them to seek or share ideas. One of the main things they wanted from the Practice Guidance was for good practice to be collated as a starting point to affirm and inform practice.

6.2.2. The Peer Review

Getting started – pre-peer review

The peer reviewers were a mix of autistic adults, or those working with the autistic community and practitioners specialising in HSB. Involving autistic adults and community representatives in the research demonstrated qualitative research rigour as it addressed elements of fairness, ontological and educative authenticity (Lincoln

and Guba, 1985). Dr Chloe Farahar writing for the Aucademy website[36] states: "... too long there has been a precedent of non-autistic people and researchers doing the research and the talking."

Most of the peer reviewers had a limited understanding of each other's research and practice knowledge, a reflection of the state of practice at this current moment. For the HSB specialists, I put extra chapters into the Practice Guidance to support their learning and I did a pre-peer review briefing session by video link, with the autistic peer review group to give them a context of the research and practice knowledge base on adolescents with HSB and the AIM3 model (Leonard and Hackett, 2019) (a copy of which was also provided) and to enable them to ask me questions. It also allowed me to check in with them about how they were feeling about reading and discussing this type of material and to facilitate them to express any concerns they may have had before the research started.

Although I had created the pre-peer review briefing for the autistic peer review group as a solution to a logistical problem, it had the unintended benefit and powerful learning experience for me, of seeing HSB from their perspective. They raised additional features that were not present or being talked about in Phase One, in neither the research nor the interviews, for example, co-existing factors like executive functioning and alexithymia, which have on reflection such resonance for HSB practice generally as well as in relation to autistic individuals (*See Appendix Three for details*).

Neither of these conditions are generally considered in HSB practice, yet are relevant to high risk criteria, for example in relation to alexithymia - difficulties with identifying or describing emotions. HSB assessments and interventions focus a considerable amount of time on the individual's feelings, prior to, during and post the sexual abuse. The aim is to consider triggers for the abuse, what needs it was meeting for them, whether or not they had any understanding or compassion for how the other person was feeling and how they felt after they had committed the abuse.

[36] Aucademy – https://aucademy.co.uk

In usual HSB practice difficulties in discussing feelings would be of concern and may lead to the individual being considered to be lacking in empathy, cold, callous or not engaging in the work, all of which are high risk factors for HSB work. If an HSB practitioner does not have an understanding of alexithymia then HSB assessments could be over estimating risk levels and interventions may be less effective.

In relation to executive functioning i.e. how does the brain process information, this is relevant to both the individuals and their parents. High risk HSB factors include elements such as not following through on safety plans; being unable to problem solve and change behaviours in relation to triggers; being unable to generalise learning from one situation to another or being unable to be cognitively flexible. If an individual or their parents appear to not be implementing the safety plan or the learning from the interventions then this would cause concern. Again this is not something that would be screened for in usual HSB practice but could be relevant to many of the HSB cases and make a difference to the assessment and to the interventions provided. Consequently, Appendix Three is an extract from the Practice Guidance which was to help HSB practitioners understand the implications of these for sexual behaviour work.

The autistic peer reviewers also highlighted that the genetic link with autism may mean that parents are also autistic, or there may be more than one autistic child in the family. As this was an action research framework, I was able to go back and revisit the literature review for information about these factors to then update the Guidance. It was interesting that the genetic link and potential autistic parenting was not mentioned at all by the interviewers.

I also learned from them about sensitivities for the autistic community of bringing this type of subject into the open, for example in relation to concerns that when considering attachment issues, autistic parenting should not automatically be considered a problem even though it might present differently. Practitioners should consider how love and attachment can also be shown in less conventional ways and the child can still feel loved and secure. In fact they might meet their child's needs better having had the same experiences as them; this was also reflected in the

literature review (Kim, 2015) and was particularly sensitive given the recent history of autism being blamed on 'refrigerator mothers' (Rudy, 2022; Fletcher-Watson and Happé, 2019).

> "Is the negative interpretation of behaviour based on assumptions of what is 'normal'? Might parents be responding differently compared to non-autistic parents because their children have different sensory and social needs? This is a lovely opportunity to invite the clinician to rethink *their* definitions of appropriate responding" (Peer Reviewer 1)

A further sensitivity was about a developing societal view that autism is potentially a high risk factor in violent and sexual offences; there is no evidential base for this but several recent high profile cases in America and the UK have begun to shape this view. The autistic peer reviewers were concerned that acknowledging that HSB was also an issue for the autistic community, would feed into this narrative but rather than shutting down the debate, they wanted to be open about it as an issue but to ensure that what was written was not implying that autism is a key factor in HSB, without an evidence base for this assertion.

I was humbled by the fact that they had taken a risk to become involved with my research and their feedback on the Practice Guidance was essential not only for the integrity of the Guidance, to make sure it was not simply seen through the lens of HSB practice, but also for me to know that I had respected their lived experience and had gained their approval for the statements I was making.

6.2.3 First round of peer review

All of the above meant that the first draft of the Practice Guidance was revised to include this information prior to the beginning of the peer review. This revised version was then sent to the whole peer review group to go through two rounds of peer review. After the first round of feedback from the group, amendments and additions were made. The peer review information from the autistic peer reviewers was helpful and covered several different aspects that they wanted to be included to reflect a better understanding of the autistic lived experience, which were:

The language being used

I was advised that using neuro-typical as an alternative to autism, implied that autism was the exception to the 'typical' pattern of neurology, whereas autism is just one of many neuro-diverse conditions and could also co-exist with others such as ADHD. Having a neuro-diversity approach means not favouring one way of existing over another (Hughes, 2022). It was agreed to use the terminology non-autistic to be clear that I was referring to a person without autism.

Several peer reviewers noticed deficit focused language being used such as impairments, difficulties in functioning etc. which they felt was primarily driven by use of a medical model of autism. They understood why the diagnostic criteria had been used, nonetheless, they emphasised that neuro-diverse practice should be looking at how an individual experiences their world and searching for strengths as well as challenges and it should challenge others to reflect on potential changes they can make to their own practice to support and engage them better.

> "Difficult at times as autism represented as a medical model. Lots of talk of deficits and less of differences in a more positive way. The ability to form alliances with young people is crucial, so the tone needs revisited and reframed in less clinical terms." (Peer Reviewer 5)

> "Autism research has historically looked at differences that are part of autistic behaviour as an impairment, but differences can just be differences – they don't need to be value laden. When a neurodiversity framework isn't used, it's very easy to interpret or search for negatives that don't reflect experience" (Peer Reviewer 1)

The same peer reviewer elaborated further on the impact that this can have on the power dynamics in the relationship with the practitioner and the need for practitioners to consider the concept of 'double empathy' being required (Zamzow, 2021; Milton, 2012). This is described as a mismatch in communication style between both parties, but where the difficulties in communication are solely attributed to the autistic person's style of communication or interaction. It happens when practitioners do not

try to understand how the autistic child or adolescent thinks, feels and communicates and simply interpret it against their own frame of reference.

> "The therapy dynamic and process changes dramatically depending on whether a clinician walks into a room thinking "this person is likely to be poor at communicating" compared to "This person communicates differently to me" (Peer Reviewer 1)

Individual Identity

This was about whether individuals described themselves as autistic first, i.e., an autistic person, as they see autism as central to their identity in terms of how they view the world and the world views them. Others describe themselves as a person first, i.e., a person with autism, with autism being a condition that they have. (Hughes, 2022; Farahar, 2021).

Managing an unsafe world

They explained that an autistic person's experience of the world can be confusing and frightening and their 'stimming' techniques or rituals and insistence on sameness were ways of managing unsafe situations and of emotional regulation. They also make the point that they are not unique to the autistic population, non-autistic people may also have repetitive movements which perform the same function, for example, "…jiggling their foot or playing with their keys if they are anxious or chewing their pen when they are thinking..." (Peer Reviewer 1).

Anxiety and Depression

Several of the peer reviewers felt that there needed to be a stronger emphasis on the high levels of anxiety and depression in the autistic community, due to their struggle to survive in a social world which does not accommodate them, gives them little time and space to process information, along with the strain of coping or masking to try and fit in, or the pain of social isolation. More recent research highlights significant self-harm within the autistic community (Moseley et al., 2019).

Anti-depressant medication can also affect their sexual arousal and ability creating further stress.

6.2.4 Second round of peer review

These changes were then made creating a further draft of the Practice Guidance which was sent back to the members of the group who had volunteered to be involved in the second round. The second round was important as a further quality assurance check that I had properly understood and reflected the meaning of the changes they identified and had not simply selected the changes that fitted with my own perceptions of what was needed in the Guidance.

All five of the peer reviewers involved in the second stage felt that the changes had addressed the areas of practice or concerns that had been raised and respected the autistic lived experience. The Practice Guidance had therefore been fair and had ontological and educative authenticity (Lincoln and Guba, 1985).

> "(the) author has done an excellent job of presenting the research in a way that highlights potential difficulties, that is respectful to autistic people and their lived experiences, getting the balance between not saying this is more likely to lead to HSB and on the other being clear that certain aspects may lead them to experience difficulties with boundaries etc." (Peer Reviewer 8)

> "The Guidance is a huge positive step to understanding and supporting autistic young people who have shown harmful sexual behaviours. The efforts made to develop an accurate understanding of autism and the appropriate and respectful way to discuss the autistic experience is impressive" (Peer Reviewer 1)

6.2.5. Feedback from the Peer Review

As well as direct feedback onto the draft Practice Guidance, all eight peer reviewers were asked to complete a short questionnaire with broad questions designed to elicit their views on the integrity of the Guidance. The following are the questions asked and a collation of the responses.

a) What is your overall critical reflection of the Practice Guidance?

Overall, the peer reviewers reflected that it was a huge and valuable piece of work providing a good starting point for practice. They liked the clear links between the evolving evidence base re autism and HSB and the implications for practice and where the gaps in the literature remain.

> "A nice example of practice-based evidence with regard to clinical application"
> (Peer Reviewer 3)

They felt that the structure was laid out well, with a logical flow, easy to follow and understand, readable and engaging. It was felt to be a clear comprehensive, detailed, in-depth approach giving practitioners not familiar with autism or with HSB an introduction into what it might mean for them to work with an autistic child or adolescent. It provided a good balance between theory and practice and they felt the theoretical constructs were valid. It was also felt that the Guidance could be generalised to working with autism in services other than HSB.

> "Overall, I think it's a fantastic guidance document that is really useful, practical and accessible (the 3 key things in my eyes as a clinician!)"
> (Peer Reviewer 6)

The adaptation of the AIM3 model (Leonard and Hackett, 2019) was appreciated and supported practitioners to understand the differences that need to be considered. They felt that it was a good reflection of a lived experience of autism.

b) What works well and why?

The HSB peer reviewers particularly identified the level of detail backed up with research on the links between autistic traits, sexual development and HSB, which they stated helped practitioners focus, engage and learn about what they need to take into consideration in order to have more proportionate analysis and decision making.

All the peer reviewers really liked the practical sections of the Guidance such as the clarity of the information around executive functioning and the individual profile diagram and suggested questions framework. They were also positive about practice themes throughout the Guidance such as the focus on supporting parents and working with families and how to understand sensory sensitivities and responses such as stimming. It was also felt that there was a lot of transferable information and practice examples which could be applied to other autistic behaviours and services as well as non-autistic adolescents involved in HSB.

> "I said a little 'yey' for comments and explanations of how clinicians need to monitor sensory responses e.g., stimming. Guidance on practical sessions was great" (Peer Reviewer 6)

c) What does not work and why?

Several of the peer reviewers mentioned that there were gaps in understanding, as this was an emerging field of research, but that those could be reviewed and updated when that evidence becomes available. There was a query about who the Guidance was for and there was a request for more clarity for practitioners that they will have to be prepared to challenge their own current assumptions about autistic clients and adapt their own practice.

> "The author has done a good job situating the research in terms of language and the neurodiversity paradigm, I would like to see an opening paragraph explaining to practitioners that they will need to challenge their assumptions about autism and even more so their own understanding of communication and sensory profiles. What should act as a foundation for them, though, is their understanding of a model that they use with clients, which doesn't need to be adapted greatly for autistic young people" (Peer Reviewer 1)

Also raised were sections written on gender identity and gender stereotypes where it was felt that these two concepts had been conflated and needed to be separated out. It was acknowledged that this itself is an emerging area of research which is highly charged and emotive for understandable reasons.

> “Autistic people may be gender non-conforming but do not have a gender identity (trans, non-binary or otherwise) as distinct to or separate to their biological sex.” (Peer Reviewer 8)

Other comments related to it being a long document and in parts repetitive with ideas for making it even easier to navigate around by providing a contents page and suggestions of an abstract at the beginning with main points to attract the reader and summaries at the end of chapters of key points.

d) What do you think has been missed, or what would you have liked to have seen more about?

There were additional aspects of research and practice that the peer reviewers would have liked to have seen more about in the Practice Guidance. They noted that this was not a sense that the Guidance had failed, instead it was that they were already beginning to think of the future adaptions required as it gives them a solid foundation upon which to build. The additions included the need for more information and an evidence base in relation to:

- The voice of autistic adolescents - It was felt that an important next step for the guidance would be to involve autistic adolescents to get their perspective on what had been written, to add an extra dimension to the work;

> “This is such a drastically under researched area, that the author has done very well to present such comprehensive guidance. As with any research focusing on a marginalised group, it would be wonderful to hear the voices of the autistic young people who will be directly impacted by the guidance. What are their thoughts on the guidance, does the understanding presented mirror their experience, what would they change?” (Peer Reviewer 1)

- Technology assisted HSB (TA-HSB), stalking and harassment, which are all featuring more frequently now within the adolescent criminal justice system;

- Speech and language difficulties and developmental language disorder and the difficulties in picking up inference meaning, for example, someone saying, “It is cold in here!” meaning “Please shut the window!” and the other person replying “Yes, it is”;

- Trauma and what trauma informed practice means for this work, particularly developmental trauma and the trauma becoming involved with HSB professionals or the criminal justice system;

- AIM3 – more depth and examples for some of the Domains and Factors and for the graph;

- An emphasis on the need for regular peer and clinical supervision;

- More on interview techniques and supporting an autistic person to communicate as effectively as possible;

- Need more reference to schools who will be a major influence, on how schools can help and how to work with schools;

e) Is anything inaccurate – what amendments should be made?

Most of the peer reviewers felt that there were no obvious inaccuracies; the only point made was that terminology such as functioning or high functioning were not currently supported or liked by the autistic community

6.2.6. Moving on to Cycle 4: Piloting Process

After the second round of peer review and the feedback from the questionnaires, further minor revisions were made and the final draft of the Practice Guidance was ready for the next stage of the research, Cycle 4, being piloted by HSB specialist services to review how it worked in practice.

6.3. Cycle 4: Piloting the Autism and HSB Practice Guidance

6.3.1. Introduction

The peer review process had been challenging but reassuring that the peer review group had found the theoretical concepts and content of the Practice Guidance credible, enhanced understanding of this complex subject and believed it would provide a good initial framework for practice. The next step was to test the trustworthiness and authenticity (Lincoln and Guba, 1985; Guba and Lincoln, 1981) of the research further with a completely new set of practitioners, to see if the information in the Practice Guidance was able to be transferred and generalised to different practice settings and therefore was capable of being used more widely in practice (Morse, 2015; McNiff and Whitehead 2012; Somekh, 2006; Lincoln and Guba, 1985). This was the final part of the data triangulation (Noble and Heale, 2019; Carter et al., 2014). As with the peer review process, the pilot process also helped to mitigate against researcher bias.

6.3.2. Briefing Sessions

Pre- pilot briefing sessions for the pilot participants were set up, some online and some face to face. Each participant had received a copy of the Practice Guidance in advance, so they could bring any immediate comments or questions to the briefing session for clarification. The pilot group was made up of eight teams of HSB specialists who were already experienced in working with autism, so I was expecting robust challenge and questions. However, in the briefing sessions even after having simply read the Practice Guidance, they acknowledged and confirmed some aspects of the Practice Guidance had added further validity to their own understanding and were also welcoming of new knowledge, for example, a mother of two autistic sons stated:

> “The guidance is extremely comprehensive; it gives you a really good grasp on how ASD might affect the individual in terms of their HSB. In fact, even taking the HSB out of the matter it would give any practice staff a good insight into how the autistic brain functions differently…. I think that being a parent to kids on the

> spectrum I was more aware of the issues and factors that could have contributed to HSB behaviour and was taking these into account with my cases, however, to have a concrete piece of guidance is brilliant, as often I found myself challenged by peers as to why I would have scored one way or the other, particularly if it didn't fit entirely with the standard AIM assessment" (Pilot Service 3)

Even at this early briefing stage there were suggestions for further things to include, for example, it was suggested to add intimacy / frustration as a cause, that some autistic people might find intimate emotional and sexual relationships emotionally draining and not sustaining of their needs and some might feel no need for emotional intimate relationships at all, but all of whom still had sexual needs. This might be a reason that some seek sexual gratification not from relationships but online or through fetishes / paraphilias.

6.3.3. Pilot process

The pilot took place over two months and the participants were asked as a minimum requirement to use the Practice Guidance in conjunction with the AIM3 model (Leonard and Hackett, 2019) on a fictional case study. If they had time and suitable cases within the time frame, they could apply it to retrospective or current cases. Due to the ethical issue of the Practice Guidance being in draft form, the AIM3 assessment would remain the valid assessment tool and the pilot participants would reflect on what difference, if any, the Practice Guidance made to their understanding and analysis of the case. Practitioners were asked to give feedback on not only the case option they chose but also an individual questionnaire for their views on the theoretical constructs and content of the Practice Guidance and if it had made any impact on their practice.

6.3.4. Feedback from the Pilot

Most of the feedback was given in written form, but one service requested an online video meeting with me in order to give their feedback verbally, as they felt that using the Practice Guidance had had a significant impact on their practice already and wanted to share that more comprehensively with me. All eight services provided

feedback so there was a good overview of the different practice settings. There were 14 fictional case studies completed and returned from the eight services; it was the main method of the pilot participants trying out the Practice Guidance. Some did it as a team, or in pairs or on an individual basis, so some services provided more than one return. In addition, half of the services were able to use the Practice Guidance with a retrospective or current case example. There were 18 individual questionnaires returned which represents almost half of the total group of 39 who attended the briefings.

6.3.5 The fictional case study *(See Appendix Eight)*

The fictional case study of an autistic adolescent male called Sam, was a pragmatic and practical solution to the pilot participants potentially not having a current or a retrospective case that was appropriate within the pilot period, but it was also beneficial to see how using the Practice Guidance was experienced by different practitioners with different agency settings. *NB: A brief overview of how the AIM3 model works is provided in Appendix Nine to give context for the feedback*.

A comparison of case study responses *(See AppendixTen)* showed that for most of the Domains, there was a degree of consensus amongst the responses on the level of concern and areas for future intervention, apart from Domain Four (Environmental) which had a wider spread and Domain Five (Self-Regulation) where there was a division of views. Importantly in their rationale for their analysis there were clear indicators that the Practice Guidance had been influential. The following are examples from each of the Domains illustrating the pilot participants' application of the Practice Guidance to their analysis of the case study.

Domain One – Sexual Behaviour

> **"**Offence occurred within the family home, using the ASD guidance to interpret his behaviour gives a different perspective on the location and perhaps motivation of the HSB, the case study demonstrates that Sam has limited opportunities for the development of appropriate peer relationships, his GAO diagram demonstrates the greatest deficits in the areas of social difficulties and communication difficulties, he

frequently accesses pornography and this may fuel his desire to try out some of what he has seen" (Pilot Service 3)

"Victim age difference is significant however in the context of Sam's ASD and limited peers and victim access it would appear that her age is somewhat irrelevant for Sam's decision to engage in the HSB" (Pilot Service 6)

"Likewise, the third incident, there was no direct, verbal 'no' from Susan, so Sam may also, erroneously think that he did have consent, especially as he has difficulties interpreting non-verbal communication. While Sam has had education in consent, we also know that he can struggle to take learning from one context and apply it to another. We also know that due to executive function problems, he can forget what he has learned, especially when overloaded or distressed (and perhaps also when sexually aroused?)" (Pilot Service 7)

Domain Two - Non-Sexual Behaviour

"Changes to routine can cause increased issues for autistic young person – change of dad's circumstances and loss of contact with dad…. Mum and school have attempted to address earlier HSB concerns but maybe not helping Sam to make all the connections." (Pilot Service 3)

"Sam can be physically violent when frustrated. Is this a response to sensory overload or a method of control that he has learned? It is likely, therefore to either be directly or indirectly related to his autism" (Pilot Service 7)

Domain Three – Developmental

"Several concerns here because of his autism – challenges with emotional regulation, getting frustrated and not understanding. Empathy skills are low, particularly for Susan. Being out of school negatively impacts on his educational ability" (Pilot Service 6)

"Trauma from separation from father, recent trauma from Police involvement and being made to leave his home. The communication difficulties make any historic trauma more likely to have remained unresolved" (Pilot Service 7)

Domain Four – Environmental/Family

> "Very limited peer group due to Sam's ASD difficulties in a social context. Strong desire to be accepted by peers and limited understanding of contexts which he may overhear in conversations, Sam is influenced by his understanding and then tries to engage. HSB is a good example of this in action" (Pilot Service 6)

Domain Five – Self Regulation

> "Sam has very significant difficulties linked to his autism diagnosis… he seems to use 'masking' like repeating graphic sexual language he has heard online. He does find online communication much easier and this is a strength and has established a peer group around common interests. … Sam has poor general life skills and competence re intimacy and social boundaries in comparison with his peers. This is impacted by his executive functioning difficulties (memory). He is not as aware as peers of social etiquette which is an area most impacted by his autism" (Pilot Service 5).

Final comment was a summary from one participant of their experience of using the Practice Guidance with the fictional case study

> "By using this new knowledge and the information in each Domain about the differences between ASD and non-ASD children, I felt confident in analysing Sam and his particular challenges linked to HSB. This made the assessment very child focused and needs led" (Pilot Service 1)

6.3.6. Application to retrospective cases

There were four retrospective case examples used by three different services. They were asked to feedback on three questions:

Question 1: *If there was no diagnosis but you felt there was a strong possibility that they had autistic traits – what made you come to that conclusion?*

All four cases had a diagnosis of autism so this question did not apply.

Question 2: *Did your overall analysis and the graph change? (If it did, what were the parts of the assessment where the Practice Guidance impacted or changed your understanding of the autistic adolescent and appropriate interventions and why?)*

In one of the retrospective cases the overall scoring and graph came down. The pilot participant reflected that they had altered their scores as they felt they had a better understanding of the sexual behaviour in relation to the adolescent's autism by going into their world and seeing things from their perspective. They felt that this helped them to feel less concerned overall and much clearer about what the interventions would be and how they would carry them out.

In the other two retrospective cases, the scoring on Domains One to Four went up however in both cases the pilot participants reflected that this did not mean that they thought there was a higher risk of recidivism, but that there were a number of complexities related to the autism that they felt that they had understood better and would need to take into account in their interventions, for example, compartmentalisation and crossovers; collections; stating they did it, is not the same as taking responsibility; executive functioning; alexithymia and the function of 'stimming'.

Question 3: *If your overall analysis and the graph did not change, why do you think that was? (Where there any parts of the assessment where the Practice Guidance impacted or changed your understanding of the autistic adolescent and appropriate interventions?)*

In one of the retrospective cases, the scoring and the graph did not change at all, but the pilot participant reflected that they had a much better understanding of the individual's autism and the connection with their sexual behaviour.

> "I would have used the GAO picture diagram to better grasp the five key autism traits measured there and how they applied for X in his world…… The new guidance allows theory and research to link autism traits to the incident and HSB

behaviour without the hesitancy or concern of 'excusing behaviour because he is autistic'" (Pilot Service 3)

"In general, the new guidance would simply have given a better ASD overview to all parts of the assessment and better prepared me to work with and support X" (Pilot Service 3)

6.3.7. Application to current cases

There were three pilot participants who used the Practice Guidance along with undertaking a current AIM3 assessment. They were asked to address the following question:

Question: *Do you feel that using the Practice Guidance along with AIM3 made any difference to your analysis and decision making? If so, what difference did it make? If not, why not?*

Two of the current cases were with the same service and they reflected that it had made a significant difference to how they were analysing Domain One – Sexual Behaviour and had meant that they would potentially have lowered their scores. They felt that it was very supportive for the discussion process and had helped to formulate a clear intervention plan.

One of the most experienced practitioners who is also an ADOS [37] trained clinician reflected that despite having an extensive knowledge of autism, the Practice Guidance had provided them with a simple framework for explaining autism and co-existing conditions to others, particularly the visual diagram. They also said it had given them more confidence in their own analysis of HSB cases where autism was a factor, allowing them to underpin their arguments with research and practice knowledge.

[37] ADOS - (Autism Diagnostic Observation Schedule) The ADOS is a semi-structured, standardised assessment of communication, social interaction, and play or imaginative use of materials for individuals who have been referred because of possible autism (National Autistic Society website, 2023)

The final pilot participant who had used the pilot Guidance with a current case also reflected on the confidence that having the Guidance had given them in being able not only to do the assessment but also to talk with the professional system.

> "The information in the guidance allows me to speak with confidence regarding risk – the professional system is very worried about this boy and are starting to only see risk – so my knowledge of his ASD and particular challenges is crucial in allowing me to ensure he is offered the right support going forward. The guidance has also helped me to communicate how this boy's behaviour (no emotion, masking etc) does not mean that he doesn't feel but rather that he lacks the skills to communicate – this then helps move the narrative away from a child being manipulative and predatory (which we know are unhelpful terms and are not accurate in this case) (Pilot Service 1)

6.3.8. Individual Questionnaires

The individual questionnaires were completed by the pilot participants following completion of the fictional case study and/or the application of the guidance to retrospective or current cases. The feedback from the questionnaires, confirmed the views of the peer review group that the theoretical concepts and content of the Practice Guidance were valid and applicable to practice and had already had a positive impact on their practice, regardless of their previous level of understanding and experience.

Like the peer review group, they added a wish list of things they would want to see in future iterations of the Practice Guidance, but like them appreciated that this would require more research in this area of knowledge but that the Practice Guidance was a good reliable starting point. The questions in the individual questionnaire were:

Question 1: *Which aspects of the Autism and HSB Practice Guidance work or do not work and why?*

a) What works and why?

The most popular view by 16 of the respondents was that the Practice Guidance was useful alongside AIM3 to look at the similarities and differences with the non-autistic population and felt that it led to more informed analysis. A small number of others also felt that the chapters on up-to-date research/practice and on interventions were immensely helpful.

Half of the respondents felt that the explanation of autism and co-existing conditions and the impact on the individual was very helpful for practitioners with little knowledge about autism but also as an affirmation of practice for those more experienced, giving them the language and justification for their decision making. A third of the respondents felt it was well written, comprehensive and easy to follow and almost a third found the visual representation of the individual profile generator diagram very helpful.

b) What does not work and why?

There were fewer responses for this part of the question, with three main points made - that it was clunky having to use two books and they would prefer if the information was integrated into the AIM3 model; they wanted to have case exemplars to illustrate how to evaluate practice and there were concerns that having higher red zones in the AIM3 graph could create more professional anxiety if not explained well in the report.

Question 2: *What has been the impact of using the Autism and HSB Practice Guidance on your own understanding and practice?*

The majority response from 16 respondents was that it had been essential in increasing their confidence with a beneficial effect on their practice, by providing an in-depth knowledge base and understanding of the key areas of challenge and day to day presentation of autism and its impact on an individual. Nearly half of the

responses stated that it was a helpful framework highlighting when autism is and is not relevant to HSB, to provide a consistent approach to neuro-diverse clients and that it supports experienced practitioners in explaining their decision making. This structure was felt to be a good tool for supporting multi-agency working due to the clarity of the information and the visual individual profile creator. Over a fifth felt it has informed more effective case formulation, safety and treatment plans. Nearly a third of the responses stated that it had made them think differently about their own practice in terms of how they structure their interviews and deliver interventions and they found the visual individual profile creator particularly helpful in understanding the individual, avoiding a 'one size' fits all approach.

Question 3: *Are there any practice themes re working with this population of children and young people that you feel have not been covered by the Autism and HSB Practice Guidance?*

17 of the 18 respondents felt that there was little else to add and there were comments about it being very comprehensive, great resource, superb and fantastic piece of guidance! Additional areas for consideration of inclusion in the next iteration of the Practice Guidance were the need for more information on practice issues such as: TA-HSB, the impact of trauma on autistic adolescents; co-existing conditions such as personality disorders; autism and empathy/callousness and unemotionality; other neurodivergent conditions such as Pathological Demand Avoidance (PDA) or ADHD; cultural issues to be explored more, for example, Māori culture.

Additional resources were requested including the inclusion of a formulation to analyse the information and make recommendations for safety planning, risk management and interventions; case examples as a baseline of reference for how to the guidance might apply to the AIM3 scoring; more resources for the direct work.

6.4. Brief Summary of the External Review

The external review was a further stage of establishing the rigour of this research by additionally asking two different set of practitioners, through the peer review and pilot process, if they found the theoretical constructs in the Practice Guidance to be valid; if it had the correct content (Robson, 2002) and if it had applicability to practice outside of the research. Both the peer reviewers and pilot participants were sufficiently distant from my own practice and there were no relationship issues which could have impacted on their willingness to express any reservations or criticisms.

They were all interested in creating new theoretical constructs for autism and HSB and if they had felt that the constructs were weak or invalid, it was in their interests to critique the Guidance and highlight these areas for further improvement. I had constructed the feedback processes through questionnaires and case feedback to be broad enough to allow for any critiques of the Practice Guidance, but both groups felt that the theoretical constructs and the content of the Guidance had validity and would support the development of practice in this area of work. There were no criticisms, simply suggestions for more things to be added in future iterations of the Guidance, once there is a stronger research base.

Chapter Seven – Discussion Chapter

7.1. Introduction

While the majority of adolescents do not sexually harm other people, there are a small cohort who engage in HSB. As they are not a homogenous group, HSB research which began more than 30 years ago has been trying to identify what was different about these adolescents in terms of their family backgrounds, experiences of trauma and abuse, psycho-sexual development etc and what were the causal factors for their sexually harmful behaviours (Creeden, 2013; Mutale, 2003; Taylor, 2003; Kelly et al., 2002; Skuse et al., 1998).

As a primary focus of HSB practice is to reduce the risk of further harm, research has also attempted to identify factors and sub-groups of adolescents which present greater risk and likelihood of recidivism (Leonard and Hackett, 2019; Edwards et al., 2012; Pullman and Seto, 2012; Finklehor et al., 2009; Almond et al., 2006; Parks and Bard, 2006; Hanson and Morton-Bourgon, 2005; Worling and Curwen, 2000).

Autism and HSB is a relatively young field of study and as practitioners we are in the early stages of researching what is different about autistic children and adolescents with HSB. The autistic peer reviewers raised with me that this can be a sensitive research subject for some members of the autistic community who are concerned that a perception that autism is a risk factor for violent and sexual crimes is becoming more prevalent, without any empirical evidence for this, impacting on an already marginalised community. As an acknowledgement of their concerns, I would like to stress that only some autistic children and adolescents engage in HSB, but just like our original HSB research, it is this small cohort that we do need to understand, in terms of the relevance of their autism to their sexual behaviours and the likelihood of recidivism.

The need for this research came from community based front line practitioners in agencies such as education, social services, youth justice and HSB specialist services who were concerned they were working with increasing numbers of autistic clients without any guidance on how best to understand and assess their sexual behaviours and to provide effective interventions. They had been developing their own ways of working but this was in a vacuum where they were unsure of what others were doing, particularly as there were no studies in the literature review which looked specifically at the experiences of frontline practitioners. As they had raised the need for guidance, they wanted to be involved in the study and in the creation of a practice guide which met their needs.

Aims and objectives of this research

The **Aim** of this research was to contribute to the development of good practice in relation to Autism and HSB. The three objectives of this research study were:

Objective 1: To contribute to the academic research knowledge base which was limited in relation to autistic children and adolescents with HSB.

Objective 2: To look at this practice issue from the perspective of community based front line practitioners to determine what guidance they require and what constitutes good practice.

Objective 3: To develop, peer review and pilot Practice Guidance on Autism and HSB to address the immediate practice need identified by the frontline practitioners.

This chapter discusses the research findings in relation to the aim and objectives of this study. Taking each one at a time, it considers how the objectives were addressed, what the answers to the research questions were and how they link with the wider theoretical, research and practice literature. Areas for future research are also highlighted.

7.2. Objective 1: To contribute to the academic research knowledge base which was limited in relation to autistic children and adolescents with HSB.

There have been previous studies comparing the two research knowledge bases, primarily adult studies or adolescents in specialist mental health or criminal justice residential settings (Brown and Davy, 2023; Allely, 2022; Greaves-Lord et al., 2020; Allely and Creaby-Attwood, 2016). As far as I am aware my study is the first to undertake this comparison in relation to autistic children and adolescents on the caseloads of frontline practitioners. I also believe it is the only research to study two specific aspects of practice - the sexual behaviours of autistic children, and why practitioners might have high numbers of cases with possible autistic characteristics but no diagnosis.

The following information focuses on four main areas where this research has contributed to or challenged the academic research knowledge base; it includes the relevant research questions and also any implications for practice.

1. Diagnosed autism or possible autistic characteristics;

2. Autistic children and HSB;

3. Similarities and differences between non-autistic and autistic children and adolescents in relation to HSB;

4. Autism and Recidivism.

7.2.1. Diagnosed autism or possible autistic characteristics

Relevant Research Question

a) How many children and adolescents with diagnosed autism or possible autistic characteristics were on practitioners' caseloads?

This specific question was asked because prior to the research, practitioners were experiencing increasing caseload numbers of diagnosed autistic clients or those with autistic type characteristics and were unsure if this was unique to their services or was also being experienced by other practitioners. In the literature review, several studies also noted that there were numbers of individuals with possible autistic traits (Vaswani et al., 2022; Vinter and Dillon, 2020; Baarsma et al., 2016; Fernandes et al., 2016; Sutton et al., 2012) but did not analyse the reasons for this.

The surveys for this study indicated that this is a widespread practice issue, with practitioners in different agencies stating that between 20 – 55% of their HSB case work was with autistic individuals or those with possible autistic characteristics. What stood out were the Youth Justice practitioners who had only 14% of their total caseloads focused on HSB cases, but 55% of those HSB cases, were individuals diagnosed autistic or with possible autistic characteristics, making the number of autistic clients disproportionate to the proportion of autistic people within the general population.

In terms of the balance on caseloads between diagnosed and possible cases, the survey in this study showed that two thirds of the children had a diagnosis and one third had possible autistic characteristics. Regarding the adolescents, there was an almost 50/50 split with twenty cases having a diagnosis and twenty-one with possible autistic characteristics. This confirmed the practitioners' views that the numbers of possible autistic cases on their caseloads were as high as those with a diagnosis.

Hypotheses derived from the literature review and the practitioners' reflections about why there might be high numbers of possible cases are:

a) That some individuals are autistic but may have been ‘masking’ their autistic traits until their coping abilities have become overwhelmed (Vinter and Dillon, 2020; Fernandes et al., 2016);

b) Diagnostic overshadowing – clinicians reframing other conditions such as global delay as autistic type traits (Fletcher-Watson and Happé, 2019);

c) Causal overshadowing - due to increased autism awareness, practitioners not considering other possible explanations for the behaviours, such as trauma and attachment problems and misidentifying possible autism as being the causal factor;

d) The presence of a broader autism phenotype (BAP) - autistic-like traits, but not autism found in higher rates among the biological relatives of autistic people (Fletcher-Watson and Happé, 2019);

e) Pressure for resources which can be accessed only with a diagnosis.

I analysed the case data from the surveys and interviews but found no significant differences between those with a diagnosis and those with possible autistic characteristics, in relation to their profiles of age, gender identity, family backgrounds, possible trauma or abuse or the types of sexual behaviours. If the possible case numbers include not only those with undiagnosed autism but also individuals whose causal factors are not due to autism at all, but to trauma, attachment or speech and language issues then it poses two questions:

a) how can researchers and practitioners separate these out to determine the actual numbers of autistic individuals, whether or not diagnosed, particularly in relation to research questions about potential over-representation of autism in HSB services and in the youth criminal justice system?

b) if there are no differences between the diagnosed and possible groups in profiles and types of behaviours, then is the commonality between the groups

due to limitations or challenges that autistic individuals and others share, rather than autism being the relevant factor?

This needs to be explored in future research but in terms of immediate implications for practice there is a need for autism awareness training to include an understanding of the potential overlap between autistic type traits and behaviours and those caused by trauma, attachment and speech and language problems. There also needs to be processes in HSB practice for filtering cases at referral and assessment stages, with consideration given to other assessments of these presenting problems being undertaken first before autism is considered.

7.2.2. Autistic Children and HSB

Relevant Research Questions

b) What was the age, gender identity and type of sexual behaviour of those children and adolescents?

c) What was their family environment like and have they experienced any trauma, abuse or victimisation in their lives?

d) What are the similarities and differences between autistic and non-autistic children and adolescents?

There were only three studies in the literature review which provided some limited information on autistic children and HSB (Ferahkaya and Bilgiç, 2021; Fourie, Kotzé and Van der Westhuizen, 2017; Mouridsen, 1989). Because of my previous work on children and the fact practitioners were asking me about autistic children as well as adolescents, I was particularly interested in this area of the research and I believe my study is the first research study which includes autistic children as well as adolescents. There are some overlaps in the information between those two groups, for example, in terms of their family backgrounds and pathways into HSB, so those are covered in the following section on similarities and differences. This section focuses on what is known that is specific to autistic children and HSB and implications for practice.

Types of sexual behaviours

All the children targeted people known to them, through their family, neighbourhood or school, particularly school. Their understanding of their sexual behaviour, the social, moral and legal rules was more limited than their non-autistic peers due to their developmental stage, their autism or other co-existing conditions. The main sexual behaviours for the younger children (aged six to nine years old) were touching others without consent, public exposure of genitals and inappropriate and graphic sexual language and gestures, all of which would be on the inappropriate or problematic part of Hackett's (2010) continuum.

While the behaviours were similar to their non-autistic peers, from about the age of five or six years old, non-autistic children are more likely to be learning the social rules around these types of behaviours, through direct messages from and observation of their peers and adults, so these behaviours usually decline by the time they are seven to nine years old (Freud, 1905), unless they are a specific problem for that child. However autistic children may have to be overtly taught the social rules as they may not just 'pick them up' in the same way.

Most of the sexual behaviours of the older children (aged eleven and twelve years old) still fell in the problematic part of Hackett's continuum, but notably there were some with more serious sexual behaviours, falling on the abusive/ violent part of the continuum, including sexual coercion, assault and attempted rape. In HSB practice some of these cases would be considered unusual even for adolescents and would be high risk indicators of recidivism. For example, one boy had targeted his mother and in two other cases, the boys had targeted several family members of different genders over time. To have several of them in a small study of fifteen children raises questions - what part, if any, does autism play in their understanding of appropriate boundaries in family settings and the potential relevance of issues such as age and gender blindness discussed in the literature review chapter (Bejerot and Eriksson, 2014; Jack, 2012).

Sexual development

Although puberty is usually thought of as happening in adolescence, pre-pubescent stages are beginning for some children as early as ten years old, but for many puberty starts around eleven or twelve years old (Weir et al., 2021; May et al., 2017; Ray, Marks and Bray-Garretson, 2004). A most interesting feature from this study was about the potential impact of early or late onset of puberty which is not an issue often debated in HSB research and practice. Puberty can overwhelm some autistic children's coping mechanisms due to the need for additional skills to deal with new and complex issues around their sexual development and sexuality (Gadsby, 2022; Vinter and Dillon, 2020; Fernandes et al., 2016; Kim, 2015; Cridland et al., 2013; Nicols and Blakely-Smith, 2010). Feeling overwhelmed can affect their ability to absorb peer information on sexual behaviours and social and legally appropriate boundaries (Attwood and Garnett, 2018; Stokes and Kaur, 2005).

Both early and late onset of puberty can also create a dissonance between the child and their peer group which can exacerbate problems they may have already been experiencing in trying to 'fit in' with their peers (Sullivan and Caterino, 2008). This was a relevant factor in the sexual behaviours of some of the older male children aged eleven or twelve years old in this study, who were using graphic sexual language or committing sexual acts to try to impress and connect with their peer group.

In the research literature, the late developers were all male and the early developers were female (Corbett et al., 2020; Fourie, Kotzé and Van der Westhuizen, 2017; Pohl et al., 2014; Mouridsen, 1989). Although some explanations were given for why the males might be delayed, for example, naïve skills or lack of opportunities, particularly if they were in all male specialist residential or criminal justice facilities - the sites of most of the studies (Dewinter et al., 2016), there was no analysis of the females or the potential relevance of this gender divide. Early puberty onset for autistic females may be an anomaly but even in my small - scale study, I had one female child aged eight years old, something I would not normally have had in my HSB practice. As such, this is an area that would benefit from further study.

In children under 12 years old, there was no specific pathology or signs of sexual deviance that needed to be addressed. For those who were targeting family members, particularly adult female carers, there needed to be analysis of their understanding of intimate boundaries within family settings and the dynamics of their relationship with their carer, as these may both be key areas which any intervention work needs to address.

As causal factors for many of the behaviours were about the absence of having clear, specific information and guidance on appropriate boundaries or trying to ‘fit in’ with their peers, addressing their experiences of social isolation and peer bullying along with education on social skills, sex and relationships and social, moral and legal boundaries, would be more effective than HSB treatment programmes focusing on the sexual behaviour alone.

Given that the children targeted those known to them through family, community and school and some of the behaviours targeted at female adults, including school teachers, this emphasises the need for education staff to be trained and supported in understanding children with HSB generally and specifically in relation to autism so their responses are proportionate.

7.2.3. Similarities and differences between non-autistic and autistic children and adolescents in relation to HSB

Relevant Research Questions

b) What were the ages, gender identity and types of sexual behaviour of those children and adolescents?

c) What was their family environment like and have they experienced any trauma, abuse or victimisation in their lives?

d) What are the similarities and differences between autistic and non-autistic children and adolescents?

A central focus of this research was to attempt to identify any similarities and differences between autistic and non-autistic children / adolescents in relation to HSB. To do so required establishing comparable information to the assessment criteria used in HSB practice, in terms of their individual profiles; family backgrounds; trauma and abuse histories; co-existing conditions and types of sexual behaviour. However, undertaking the literature review had identified there were significant gaps in the research information around these factors.

This study was able to contribute to the research knowledge bases for both disciplines, through the analysis of the case examples in the study and the development of theoretical constructs about what might be different when assessing or working with an autistic child or adolescent and the implications for practice. This was achieved by merging the research knowledge in the fields of autism and HSB with both my own and the research participants' HSB knowledge and experience. (Strang et al., 2020). This section focuses on those similarities and differences, implications for HSB practice and what needed to be in the Practice Guidance.

Individual profile information – age, ethnicity, gender and sexuality identity

There was no significant difference regarding the individual profile information. The age range of the children and adolescents in this study was from six to seventeen years old. The peak age for displaying the HSB for the children was around eleven to twelve years old, which was comparable with their non-autistic peers. For the autistic

adolescents it was between 14 to 15 years old, similar to HSB practice where it is usually between 15 -16 years (Leonard and Hackett, 2019; Carson, 2019; Hackett, 2014; Hackett et al., 2013; Finklehor et al., 2009;Vizard et al., 2007)

Ethnicity and its relevance to HSB is poorly understood in both the autism and HSB research knowledge bases (Leonard and Hackett, 2019; Hackett et al., 2013; Mir and Okotie, 2002), yet it was a factor in a fifth of the cases in this study especially in the work with parents regarding their parenting style and understanding of their child's sexual behaviour, due to the influence of their cultural and faith beliefs. It is an area for further research in both fields of practice.

Equally, there was no significant difference regarding gender, with the majority of cases being male and only a small number of the forty-one cases being female with more female children than adolescents. The numbers of female children is similar to other studies where there were more females below the age of 12 years old than in the adolescent group, with gender socialisation being considered relevant, in that as females move past puberty they begin to internalise difficult emotions and also as females are not seen as sexually aggressive or harmful, their sexual behaviours often get reframed as their own vulnerability (Hackett, Branigan and Holmes, 2019; Ghani and Barnardos, 2016; McCartan et al., 2011; Bunting, 2007; Carson, 2006; Saradjian, 1996; Cutler and Nolen-Hoeksema, 1991).

There was one individual who identified as other. Societal views re binary concepts of gender and sexual identity are not as influential within the autistic community, and for some, both are seen as being more fluid or open to multiple different ways of being defined (Jackson-Perry, 2020; Fletcher-Watson and Happé, 2019; Cooper et al., 2018; Attwood, 2018; Jack, 2012; Bumiller, 2008). Understanding that autistic adolescents may not be as socially conditioned by prevailing male/female gender stereotypes is important as it raises challenges to current theoretical underpinnings of HSB practice based on feminism and gender theories (Jack, 2012).

Statistics show HSB to be an approximately 93-95% male crime or behaviour (Youth Justice Board, 2023; Hackett et al, 2013, Finklehor et al, 2009; Bunting, 2008; Taylor,

2003) and HSB research and practice has identified gender power issues involving misogyny, homophobia and abuse of male sexual power are common in HSB cases and that they are risk factors for the likelihood of recidivism (Leonard and Hackett, 2019; Hackett, 2014; Worling, 2002).

This is one of the areas where the intention, meaning and motivation for the behaviours can be so significantly different. If autistic adolescents are not as socially conditioned, making assumptions that they are acting sexually for the same reasons as their peers could dramatically skew an assessment and create a disproportionate analysis of risk. So how should we interpret their behaviour? A thorough understanding of their attitudes, beliefs and values re gender and identity is important to put their behaviours in context.

Family Backgrounds

This was an area of weakness in the research literature as most of the studies focused on the individuals themselves and included little analysis about their home environments and the relevance of this to their sexual behaviours. Where information was given about family background it was a mixed picture, with some studies indicating that they were as likely as other children/adolescents to have dysfunction, stresses, abuse or trauma in their backgrounds (Brenner et al., 2017; Higgs and Carter 2015; Sevlever et al., 2013; Sutton et al., 2012; Mehzabin and Stokes, 2011; Edelson, 2010; Kumagami and Matsuura 2009; Hénault, 2005; Attwood, 1998). However, these studies were primarily in mental health or criminal justice settings, therefore there was a higher likelihood of these factors being present.

Other studies concluded that they were less likely to have these factors in their backgrounds believing that the parents/ carers were more likely to be supportive of their child and potentially over protective, minimising their sexual behaviours and seeking to ensure that they did not become involved in the criminal justice system (Brenner et al., 2017; Fourie, Kotzé and Van der Westhuizen, 2017; Dewinter et al., 2016; Dekker et al., 2015; Dewinter et al., 2015; Sevlever 2014; Mehtar and Mukaddes, 2011). However, caution is needed with some of these studies as well,

as they had higher numbers of individuals with co-existing learning disabilities which could have contributed to the parents/carers' protectiveness and minimising the sexual nature of the behaviours.

In this study, there was also a mixed picture on family backgrounds. In almost a quarter of the cases the family background was not discussed. In the remaining cases, just over a third had typical HSB family background profiles of dysfunction, poor boundaries, chaotic family systems or family breakdown and discontinuity of care. Therefore those autistic children and adolescents were experiencing attachment related traumas and difficulties like their non-autistic peers.

However, theoretical perspectives on trauma informed practice and attachment theories (Skuse and Matthew, 2014; Creeden, 2013; Hughes, 2009; Perry, 2009; Crittenden, 1995) need to be used in conjunction with an understanding of that individual child or adolescent. Some may experience additional trauma or difficulties to adjust to changes in their environment or carers if they need the security of stable routines. Dependent on a person's autism, any stress or trauma may be heightened further if they are not able to understand and process the traumatic experience, or conversely it may mean that they are less affected by it if they do not understand it as traumatic.

However, in a slight majority of cases they were in settled, secure family environments, whether that was with their parents, or in care or adopted. This would be unusual for HSB practice, and there are two elements from this study which may be relevant. Firstly, in the cases which were either in care or adopted, some had come into care as they had been given up by their parents who felt unable to meet their needs. Some parents had sought help from or handed the care of their children to their relatives. Therefore, the children were in stable, settled family environments but not with their biological parents.

Secondly, another significant difference from usual HSB practice was that there were no children on child protection plans; although it was a small study, this was an unusual finding. One of the interviewees stated that in their practice experience, the

numbers of autistic children or adolescents on child protection plans was very limited. If the parents were struggling then either the families were viewed as families in need of support, or the child/adolescent was in care or living with extended family members. If the absence of the more complex family backgrounds with child protection issues is repeated in practice this may help to explain the practitioners' views that one of the main differences they experience in working with autistic children and adolescents is that they tend to live in more stable and settled environments.

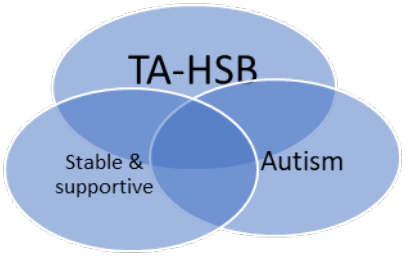
A potential stress factor for families specific to autism is the theoretical causal factor of genetics (Fletcher-Watson and Happé, 2019; Chaste and Leboyer, 2012), therefore there can be the possibility of more than one child in the family being autistic. In this study a fifth of the children had autistic siblings and in one case the mother was trying to manage the needs of two of her children who had very different autistic traits. This could increase the pressure on parents, especially as this study highlighted that following their child receiving an autism diagnosis, many parents were left with little or no guidance or support.

The autistic peer reviewers raised the possibility that some of the parents may also be autistic (Kim, 2015). I reflected on this and re-checked the interviews but the interviewees were either not identifying this in their practice or there were no autistic parents in this study. The relevance to HSB of parents also having autism was also not discussed in the academic research. The autistic peer reviewers stated that it was important to explore sensitively with the parents how their own experiences of growing up had influenced their parenting style and the boundaries and guidance they give their children. This was to ensure that any differences in parenting styles, for example regarding attachment behaviours, unconventional expressions of emotion and boundaries, should not automatically be considered as potential attachment issues. They emphasised that this is a highly sensitive issue for the autistic community, due to historical beliefs that autism was a result of 'refrigerator mothers' (Rudy, 2022; Fletcher-Watson and Happé, 2019; Kanner,1943).

Family backgrounds and TA-HSB

In the HSB research literature, many of the adolescents who engage in TA-HSB also appear to have a different profile to other HSB cases, as many of them have stable and supportive families, with no obvious abuse or trauma and they spend a disproportionate amount of their time online (Allotey and Swann, 2019; Hollis and Belton, 2017; Moulrie, 2006). There are a rising number of autistic adolescents engaging in TA-HSB on practitioners' caseloads and a practice hypothesis is that as many of the autism cases share similar backgrounds with TA-HSB cases and also spend long periods of time online, is it possible that TA-HSB includes a disproportionate number of autistic individuals and is this influencing the profiles of the TA-HSB cases?

Figure 10: TA-HSB and Autism overlap



To test this out in my study, I specifically looked at the backgrounds of the interview cases where the primary sexual activity was TA-HSB, including requesting and sending explicit sexual images, downloading, distributing and inciting abuse of others and the development of large collections of indecent images of children. Where background information was available, the majority of them included adversities and abuse, including difficult parental separations; parental drug use and domestic abuse. All the TA-HSB cases had experienced emotional abuse and neglect whether historical or current and two of them had experienced either sexual abuse or a highly sexualised environment. This study, although small, therefore does not support the hypothesis that those with stable and supportive backgrounds who are involved in TA-HSB, are disproportionately more likely to be autistic.

Trauma and abuse

Child abuse is usually described as four categories: sexual, physical, emotional and neglect. In HSB practice, sexual abuse or highly sexualised environments are frequent causal factors for HSB, however a significant difference in this study was that only three out of forty one cases in the whole study had been sexually abused; two were children and were abused by peers at school, external to the family setting. The third was an adolescent female who had been sexually abused online, but the fact that there was no abuse by adult carers or intra-familial abuse by siblings is highly unusual. Some of the adolescents lived in sexualised environments but the most relevant factor why their behaviour and the children's behaviour was sexual was extensive, unsupervised, online activity, particularly where their parents were unaware of what they were accessing.

Both the research literature and this study found that this could lead to an increased vulnerability to the addictiveness of the internet and being drawn further into more graphic images to which they may become aroused and an increased vulnerability to becoming radicalised, for example, through accessing terrorism or incel websites and chatrooms (Sparks et al., 2023; Sparks et al., 2022; Allely, 2021; Hoffman et al., 2020; Maxwell et al., 2020; Ging, 2019; Jaki et al., 2019; Al-Attar, 2017). Understanding the internet and the potential risks should therefore be a key part of prevention education, particularly if the autistic person has difficulties distinguishing between fantasy and reality, as well as being part of HSB intervention programmes. It is also a significant education issue for their parents which should be included in any work with them.

Physical abuse, usually the second most frequent factor in HSB practice (Armstrong, 2021; Creeden, 2013; Longo et al., 2013; Randall and Haskell, 2013) was also quite low in this study, being present in only a few cases and not directly relevant to why the sexual behaviour happened. It was primarily related to cultural practices re physical chastisement, parental mental health issues or parental frustration in not knowing how to understand or manage their child's autistic behaviours.

Emotional abuse and neglect were the common factors present in this study and were also mentioned as relevant factors in the research literature (Bleil-Walters et al., 2013; Sullivan and Knuston, 2000). Most of the emotional abuse and neglect was related to parental mental health, drug and alcohol misuse, which is comparable with usual HSB practice, but in a few of the cases some of this was related to the parents trying to cope with parenting their autistic child.

Some parents experienced difficulties with bonding and attachment and were being supported in their parenting by other family members, in another example a mother placed her child for adoption. The pressure of trying to meet their child's needs meant that some had lashed out and hit the child but a more common feature was allowing them long periods of unsupervised time on their devices to keep them occupied, to gain some respite. It is important for practitioners to understand the additional stress that parents of autistic children may experience and the need for guidance and support as part of any work with them.

In this study by far the most striking difference with usual HSB practice was the strong presence of social trauma, which although it can be a factor for non-autistic cases as well, the desire and need to fit in and belong, was prevalent in the autistic case studies and hugely significant to their sexual behaviours. Addressing their social trauma and giving them the education and skills they need to be able to engage with others to develop positive relationships should be the core of any intervention programme with them about their HSB.

Causal factors

As well as disrupted family backgrounds, trauma and abuse being causal factors for HSB, other factors such as co-existing conditions of learning disability, ADHD, anxiety and depression are already considered in the AIM 3 assessment model (Leonard and Hackett, 2019), but they featured more prominently in the autistic cases in this study where when present they compounded or exacerbated the autism and were in some cases more relevant to the sexual behaviours. For example, in this study, in eight of the thirteen interviews, co-existing conditions were present such as

ADHD or depression, often related to the strain of ‘masking’ and trying to fit in and they were relevant factors to the HSB.

Co-existing factors such as executive functioning and alexithymia which were raised by the autistic peer reviewers who had noted the potential connection to HSB during the pre-peer review briefing, are relevant to HSB practice generally as well as specifically to autistic clients. They can help practitioners understand why a child or adolescent or indeed their parents may have difficulties in answering questions about their emotions. This can make them seem to lack empathy, be in denial or appear cold and callous, all of which increase the level of concern in assessments. They can also affect safety planning and interventions, if the parents are struggling to implement the safety plan or the adolescent has difficulties with impulse control, remembering and transferring information from one scenario to another.

In the research literature, several studies highlighted that often the seriousness of the behaviour or why they were in the criminal justice system was not simply autism, but also co-existing conditions such as ADHD, psychiatric disorders including pathological paraphilias; anxiety and depression and that this could explain some of the gap between clinical and forensic studies (Vinter and Dillon, 2020; Yu et al., 2020; Hofvander, 2017; Palermo and Bogaerts 2017; Baarsma et al., 2016; Palermo, 2015; de la Cuesta, 2010; Burdon and Dickens, 2009; Newman and Ghaziuddin, 2008). Långström et al., (2009) noted that adults with autism and violent criminality had significantly higher levels of comorbid psychopathology diagnosis.

A key difference in causal factors highlighted by this study was about minimisation by parents/ carers and professionals of the sexual behaviours. Although denial, minimisation and shame are key theoretical perspectives and common elements in HSB practice (Taylor, 2017; Smith et al, 2014; Braithwaite, 1989; Foucault, 1978;) and there was some evidence that these were applicable to some of the cases, there was also evidence in the research literature and in this study of both parents and professionals using language which downplayed the sexual behaviour for example, reframing it as being ‘sexualised’ or ‘inappropriate’ because they were autistic (Fedoroff et al., 2015; Attwood, 2007). This is similar to responses for non-autistic

children but with the added complexity of attributing their behaviours not only to their age and development but also their autism.

In the autism research literature, this is usually described in positive terms, as being protective, ensuring the behaviour is seen in the context of the child or adolescent's, ability level and how they process information. Minimisation is understandable, when research highlights that this an area which causes parents and carers to worry about their child, fearful that they will be vulnerable to being bullied or exploited or drawn into the criminal justice system (Fedoroff et al., 2015; Attwood, 2007).

However, this study highlighted that this also meant that in some of the cases not only did the child or adolescent not 'pick up' clear information about appropriate boundaries from parents and peers but when they crossed those boundaries they did not get appropriate education and sanctions for their behaviours, so they did not learn what was and was not acceptable. Piaget's theory (1932, 1936) on cognitive and moral development involves learning by the examples set and messages reinforced by those within the child's network.

As many autistic children and adolescents are not receiving or processing messages around morality in the same way as their non-autistic peers, there is a need for those within their network to be even more explicit about morality and boundaries. The absence of the basic information compounded by a lack of education or sanctions, or obscure messaging meant for some of them that they went on to have increasingly more serious behaviours as they got older, which could have been prevented by some earlier intervention, education and redirection.

Types of sexual behaviour

"It's not the what and the how, it's the why and the who" (Carson, 2022)

I developed this theoretical concept to simplify for practitioners the main similarities and differences in types of sexual behaviours when working with autistic clients. In terms of HSB, there were similarities between non-autistic and autistic peers in what

they did and how they did it, but the significant difference was in why they did it and who they chose to target. Both the peer reviewers and pilot participants found this a helpful concept.

The What and the How: what they did and how they did it

This study found that in the main there were no significant differences in terms of the types of sexual behaviours, i.e., the full range of problematic and abusive/violent behaviours on Hackett's (2010) continuum were present. Therefore, there was no evidence for previous practice myths that autistic individuals would be less likely to be involved in sexual behaviours at the higher end of Hackett's continuum.

For the autistic children and adolescents in this study who were aware that the people they targeted were not consenting to the sexual behaviour and it was likely that their behaviour would either be considered socially unacceptable or potentially would have legal consequences, they used similar strategies of grooming, manipulation, threats, force and coercion as their non-autistic peers (Allely and Creaby-Attwood, 2016; Dewinter et al., 2015, 2016; Søndenaa et al., 2014; de Graf et al., 2012; Seto et al., 2010; t'Hart-Kerkhoff et al., 2009). Like their non-autistic peers, they primarily targeted people known to them in their family networks, at school and in the community, where they had significant access to them, over long periods of time (Hackett, 2014).

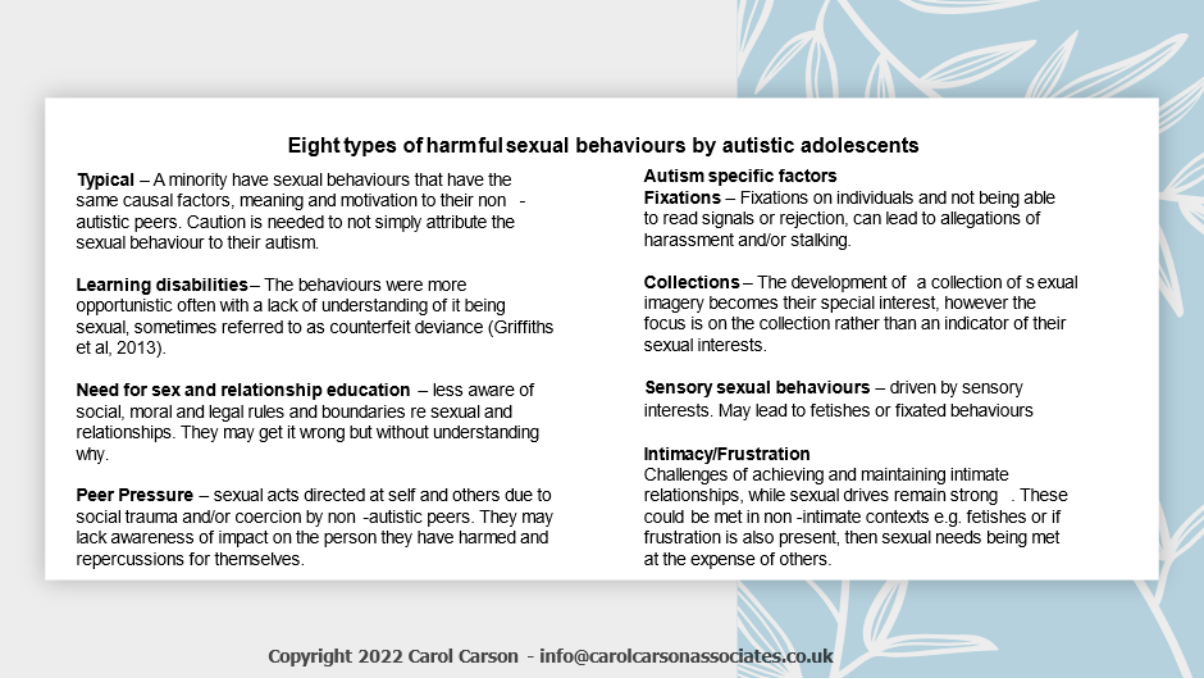
The Why: the intention, meaning and motivation for the behaviour

The study showed that the most significant difference from their non-autistic peers was with regard to the intention of the behaviour; the meaning it had for them and their motivation when engaging in HSB (Allely, 2021). While they may do the same things and in the same way, why they do it may be entirely different, therefore practitioners need to understand the individual's schema, how they rationalise to themselves that their sexual behaviours are appropriate and make sense and to take this into account when undertaking assessments and interventions. If the current HSB assessment criteria are used to determine risk of recidivism this may

significantly over-estimate the risk and using current HSB treatment programmes can at best be ineffective and at worst, traumatic for the individual.

The differences in the why they do it, varies from individual to individual but drawing from the research literature and the field work in this study, I have identified eight different factors which may be relevant to the intention or meaning of the behaviour for an autistic child or adolescent (*see figure 11).*

Figure 11: Types of autistic harmful sexual behaviours



Typical

For some, the reason for their behaviours is exactly the same as for their non-autistic peers (power, control, misogyny, reactions to their own experiences, etc.) and their autism was either not a factor or was not the most relevant factor. Caution is needed therefore in assessments not simply to assume that their autism is the reason for their sexual behaviours.

Learning disabilities

For those with co-existing learning disabilities where they did not understand concepts of private behaviours and the personal space of others, these were the types of behaviours often minimised by parents and professionals (Fedoroff et al., 2015; Attwood, 2007) in the research literature and described as ‘counterfeit deviance’ (Hingsburger et al., 1991).

Need for sex and relationship education

Findings from the research literature (Allely, 2021; Greaves-Lord et al., 2020; Vinter and Dillon, 2020; Melvin et al., 2017; Allely and Creaby-Attwood, 2016; Higgs and Carter 2015; Sevlever et al., 2013; Sutton et al., 2012; de la Cuesta, 2010) and this study showed some autistic adolescents learned little from formal sex and relationships education, particularly around appropriate boundaries because it did not suit their learning style. Unlike their peers they may not be intuitively ‘picking up on’ the nuances of the multi-layered, non-verbal communications around dating and relationships. If they are experiencing social trauma or isolation, they will have fewer opportunities to learn ‘dating etiquette’, ask questions and to practice the skills required for positive romantic and sexual connections. This in turn would make it more likely that they could experience higher levels of failure and rejection than their non-autistic peers, in this crucial area of adolescent development.

If in addition they had high levels of unsupervised online access to sexual imagery this could influence their individual schema about what was and was not appropriate and create difficulties for them in understanding other people’s perspectives when challenged about their sexual behaviours. So, for some there was no obvious conscious decision by them to ‘break the rules’, they were getting it wrong but had no idea why.

Peer pressure/ victimisation

Social trauma featured strongly for autistic children/adolescents in this research with its consequences of social isolation and rejection. The causal factors for many were about wanting to belong to their peer group, ‘to fit in’. The literature research and this

study found that this could make them vulnerable to being exploited by their peers, where they were coerced into sexual acts on themselves or others in public settings (Brenner et al., 2017; Sevlever et al., 2013; Mehzabin and Stokes, 2011; Edelson, 2010; Hénault, 2005; Attwood, 1998).

Autism specific factors

a) Fixations – if an autistic individual develops a romantic or sexual fixation on someone, then they may pursue them even if it is clear to other people that their interest is not reciprocated; this ultimately can lead to charges of harassment or stalking (Allely, 2022; Allely, 2021; Hofvander, 2017). The behaviour may be because of their fixation but also the initial romantic rejection can often be obscure or misleading, which can create difficulties for an autistic adolescent in understanding the meaning of the exchange. For example.. "I really like you but…." which the autistic adolescent may hear as, she really likes me.

b) Collections – fixed interests focused on sexual imagery or acts can lead to having large collections which may include illegal imagery of abuse of children as part of the collection rather than be an indicator of a specific sexual interest in children (Attwood, Hénault and Dubin, 2014). In HSB practice this would be a high-risk indicator of both sexual interest in children but also the likelihood of recidivism, particularly if there are images from all the defined categories[38]; therefore any assessment of an autistic individual needs to check out the meaning of the collection rather than make assumptions it is for the same reasons as a non-autistic person.

c) *Sensory sensitivities and interests*- if combined with sexual interests could lead to fetishes or paraphilias and touching of others, or use of their intimate personal clothing without consent. In HSB practice, cases with these features would be unusual and raise concern, yet within the research literature on autism and sexuality

[38] Sexual abuse images are categorised into:
Category A: images involving penetrative sexual activity; sexual activity with an animal; sadism
Category B: images involving non-penetrative sexual activity
Category C: indecent images not falling into categories A or B

discussion of paraphilias is common (Greaves-Lord et al., 2020; Visser et al., 2017; Helleman's et al., 2010; Stokes and Kaur, 2004). There is no evidence in the research knowledge and in this study of a clear crossover of paraphilic interest into HSB, with many engaging in paraphilias legally and not harming anyone, therefore the higher presence of this in autistic cases should not automatically be seen as a potential indicator of increased risk, as it would be in non-autistic cases.

d) *The challenges of maintaining intimate emotional relationships*- which can mean having to work hard to understand what the other person means and wants. The relationship can be impacted if there are sensory sensitivities relating to sexual activity which can make them unsatisfactory or unfulfilling for the autistic partner. Engaging in sexual acts in non-intimate contexts such as online or fetishes and paraphilias can be a way of getting these sexual needs met. For an adolescent the opportunities to explore these options may be more limited and if known about may create anxiety in parents and professionals.

The Who: who they harmed and why this would usually increase the level of concern

In this small study there were several cases which would have raised high risk, red flags for risk of recidivism and danger to others, based on the current HSB knowledge base (Leonard and Hackett, 2019; Pullman and Seto, 2012; Almond, et al., 2006; Worling, 2002) for example, targeting adult females; male on male abuse and indiscriminate abuse of several different people of mixed age and gender. However, the meaning and motivation for who they chose to target was different from their non-autistic peers.

Regarding the adult females who were targeted, they were mothers, foster mothers, stepmothers, grandmothers, female teachers, all in a caring role for the autistic adolescent either within the family or in their school environment. It would be unusual for a non-autistic adolescent male to target adult females, particularly those with whom they were in close contact. In my thirty year career in HSB practice, I have

only dealt with two cases where adolescent males have abused adult females who were known to them, yet in this study it featured in nearly one fifth of the cases.

However, it appeared to be about sexual curiosity or sexual interest, in the context of being unaware of appropriate intimate boundaries with family members or it was because their online activity had blurred boundaries for them. In two cases there were sensory elements re smells and materials creating sexual arousal, where the intimate underwear of a mother and of a foster mother was openly taken, whether clean or dirty and used for masturbation.

In the male on male case, the usual factor of the male having been sexually abused themselves, usually as a child by an adult male (Worling, 2002), was not present, but in this case and the mixed age and gender cases the most relevant factor for the behaviours was extensive time, unsupervised, online looking at pornography; blurred boundaries; accessibility and opportunity but also ‘gender blindness’ i.e., a lack of sexual preference for a specific gender, described in the literature review (Bejerot and Eriksson, 2014; Jack, 2012) and ‘age blindness’ as described in the interviews.

Open and direct responses

One of the most common theoretical perspectives which is evident in the majority of HSB cases is denial and minimisation due to issues of shame and fear of legal and social consequences for the individual and their family (Taylor, 2017; Smith et al., 2014; Hackett, Masson, Balfe and Phillips, 2013; Braithwaite, 1989; Foucault, 1978). However, a common feature for the HSB practitioners working with autistic clients both in this study and wider practice was that most of them gave open and direct answers when questioned about their sexual behaviours and their sexual fantasies, but as this study highlighted, they may not have understood the risk to them of being so open and the potential benefit to them of dissembling or denial (Dorer, 2022). This was another gap in the research literature which had not focused on understanding this difference.

It can mean four things in HSB practice. Firstly, admission of responsibility is often seen as a positive, meaning the adolescent is able to engage in work to change their behaviour, but with an autistic adolescent it may not have the same positive connotation; they may be saying “Yes, I did it” as a statement of fact and their individual schema may mean that they think it was appropriate and they have no reason to change their behaviour.

Secondly, if the admission of responsibility is given as a simple fact “Yes I did it ” particularly if expressed with little emotion, because of autistic traits such as the theoretical perspectives of ‘Theory of Mind’ (TOM), or alexithymia, (Holt et al., 2022; Fletcher-Watson and Happé, 2019; Scott and Baillargeon, 2017; Piaget, 1936), then it could be misconstrued as a lack of empathy, or a callous response. If the individual is in the criminal justice system, the admission of responsibility will mean they are charged and processed. If they are also perceived to have no empathy or be callous, they may get a harsher penalty (Allely, 2021), which may be relevant to the question raised by the interviewees in the secure and forensic CAMHs settings who had noted an increasing number of autistic adolescents receiving harsher sentences than their non-autistic peers would receive for the same behaviour.

Thirdly, if they say, “Yes I did it” and describe the behaviour by talking about it positively, particularly if they appear animated when discussing it, in HSB practice there is more likely to be an assumption of high risk, as there appears to be no concept of the seriousness of the behaviour, little empathy for the person they harmed and they appear to have little motivation to desist from the behaviour. This may be an over-estimation of risk and potential recidivism if the individual has not understood the seriousness of the behaviour nor the impact on the other person but if informed and educated they can express remorse and empathy and demonstrate that they will not repeat the behaviour, the level of concern would substantially reduce.

Finally, a common question asked in HSB assessments and interventions is about sexual fantasies, which adolescents usually find excruciating to answer and will often supply limited information to avoid embarrassment and further consequences. If an

autistic adolescent openly discusses their sexual fantasies in response to this question, particularly if they are animated in their description or if they are describing graphic hard core fantasies including kidnap, rape and violence because of what they watch online, some practitioners may see this as a significant indicator of risk, when it may be more related to the individual not understanding the social conventions around discussing these issues.

The difficulty for practitioners and a question often asked in practice is how can the assessors know if the fantasies would be enacted in reality? This is a difficult one to answer; there is no evidential base for adolescents, including autistic adolescents enacting these extreme fantasies in real life. For an autistic adolescent, essential questions to ask in an assessment would be about what attracts them most about the fantasy, it may be elements of power and control, when they feel powerless. What is their understanding of the fantasy in terms of their understanding of the difference with reality? What are their frames of reference for understanding sex and relationships? If their learning has all been online and they have nothing to counter-act this information, this further highlights the need for preventive sex and relationship education and safety when using the internet.

Implications for Practice

The key implication for practice is that practitioners need training and guidance on what is different if they are assessing autistic children and adolescents, so they do not simply analyse the potential risk of recidivism against current HSB factors. Instead they need to establish a detailed individual profile looking at how that autistic person, thinks, feels, relates to others and the intention, meaning and motivation for their sexual behaviour.

Both the research literature and this study highlighted the need for adapted assessment models/ tools when working with autistic clients (Greaves-Lord, 2020; Malovic et al., 2020; Hanson and Morton-Bourgon, 2005). The Practice Guidance and the individual profile tool (Carson, 2023) created as part of this research was designed to support practitioners and be a base for further development of practice.

7.2.4. Autism and Recidivism

Relevant Research Question

d) What are the similarities and differences between autistic and non-autistic children and adolescents?

This study raised three main questions in relation to autism and recidivism factors which because of the complexity of the subject, may require large scale, longitudinal studies to explore in depth.

a) Have autism and autistic traits been influential in the development of HSB risk factors and recidivism?

b) Are there disproportionate numbers of autistic adolescents in the criminal justice system?

c) Is autism relevant to the low recidivism figures for sexual offences in the criminal justice statistics?

a) Have autism and autistic traits been influential in the development of HSB risk factors and recidivism?

Understanding what would constitute a high risk factor for recidivism is at the core of HSB research as this determines which individuals are deemed to present the most risk to others and the least likely to desist from the sexual behaviour, even if intervention work is undertaken. This has led to the development of key factors which are used in HSB practice to guide assessments. These factors include profile information around backgrounds, trauma and abuse and also factors relevant to the HSB, such as presenting as cold and callous (Allely, 2021; Hofvander; 2017; Kim, 2015); not stopping when there are signs of distress; having no empathy for the person they have harmed; poor social and communication skills; social isolation;

misogyny; indiscriminate targeting regardless of age and gender; unusual sexual behaviours or paraphilias etc (Leonard and Hackett, 2019).

In addition, as those who engage in HSB are not a homogenous group, several large-scale studies and systemic literature reviews have worked on identifying sub-groups in relation to their motivation to harm and posing the greatest risk of recidivism (Pullman and Seto, 2012; Seto and Lalumière, 2010; Almond et al., 2006; Parks and Bard, 2006). There is a degree of overlap in their studies with findings of factors such as sexual preoccupation; emotional, psychological and physical impairment; behavioural problems; educational difficulties; ADHD and learning disabilities and those with difficulties in developing intimate relationships, whether friendship, romantic, or sexual and who may be socially isolated.

There are obvious similarities between autistic traits and experiences and risk and recidivism factors but are the similarities simply due to limitations or challenges that autistic individuals and others share. If it is simply about shared characteristics and challenges, then a concern raised by this study is the potential for an over-estimation of risk of recidivism, if the current factors are applied in assessments without taking into account the autistic individual's understanding, intent and motivation to engage in the behaviour and the potential for them to alter their behaviour (Allely, 2021; Vinter and Dillon, 2020; Fletcher-Watson and Happé, 2019; Fernandes et al., 2016). This may be a reason why autistic adolescents appear to be over-represented in HSB and criminal justice populations.

Or, has the HSB recidivism criteria been developed through research unknowingly based on populations which have already included non-diagnosed autistic individuals who may have been 'masking' their autism and therefore have we attributed things to trauma and attachment when possibly autistic traits are more relevant to risk and recidivism? If so, then this would necessitate repeating those studies but with autism taken into account to determine its relevance.

b) Are there disproportionate numbers of autistic adolescents in the criminal justice system?

This is definitely an area for future research as the current research literature creates a very confusing picture, with arguments that some autistic traits such as a narrow inward focus and difficulties describing inner emotional states, TOM[39], may limit their ability to interpret or perceive something as traumatic for others, while fixations, collections and sensory interests (Allely, 2021; Yu et al., 2020; Allely and Creaby-Attwood, 2016; Higgs and Carter 2015; Browning and Caulfield, 2011), can make it more likely for an autistic individual to fall foul of social conventions and the law regarding sexual behaviours. Therefore, it would seem likely that they would be over-represented.

Others argue that many autistic adolescents are diverted away from the criminal justice system to protect them so are more likely to be under-represented (Vinter and Dillon 2020; Yu et al., 2020; Kincaid and Sullivan 2019; Hofvander, 2017; Cheely et al., 2012). While this has many merits, there are also some risks - if the individual is not receiving any significant sanctions or consequences for their sexual behaviours, then they are not learning what the appropriate boundaries are and as such their behaviours may continue or even escalate, potentially leading to them being involved with the criminal justice system at a later stage. This was a factor for several of the cases in this study, who were then extremely shocked and distressed to find themselves being questioned by the police.

This area of understanding is hampered by the lack of comparable official statistics on the numbers of autistic people in the criminal justice system, but different research studies, including my study have found disproportionate numbers of autistic individuals involved with HSB in criminal justice populations (Sutton et al., 2012). In this study, for example, in the Youth Justice Service, 55% of their HSB cases had diagnosed autism or possible autistic characteristics and several of the other interviewees identified rising numbers of clients either diagnosed or with possible autistic characteristics ending up in forensic psychology services and the secure

[39] TOM – theory of mind

estate and receiving more severe and custodial sentences than their referral behaviours would necessarily warrant, compared to their non-autistic peers. If autistic adolescents are disproportionately represented in the criminal justice system, this raises questions for future research as to why:

- Does the inclusion of possible autistic cases create a perception of disproportionate numbers in HSB and criminal justice services? If they were removed would the numbers drop significantly?

- Are autistic traits relevant to HSB? If so, why are there not higher numbers involved in the criminal justice system?

- Do practitioners over-estimate risk because autistic traits and behaviours are similar to HSB recidivism criteria?

- Autistic adolescents are more likely to be open and direct when questioned about their sexual behaviours or sexual fantasies, who they targeted and why. Does this potentially lead to perceptions of the autistic individual presenting as being cold and callous about what they have done?

- Is it because of the impact on autistic individuals of being processed through the criminal justice system?

- Do societal perceptions about autism being a high-risk factor for violence and sexual offences have an influence on professional decision making?

c) Is autism relevant to the low recidivism figures for sexual offences in the criminal justice statistics?

This is a definite area for future research. If autistic individuals are over-represented in the criminal justice system, then what relevance, if any, does autism have to why the recidivism rates for adolescent sexual offences are significantly lower than for other types of offence? (Youth Justice Board, 2023).

One of the practice myths is that autistic traits such as fixations, repetitive behaviours and sensory interests make it difficult for an autistic individual to change their behaviour. As these are also behaviours which may make it more likely an autistic adolescent ends up in the criminal justice system, then the natural corollary of this belief would be that autistic adolescents pose a greater risk of recidivism (Yu et al., 2020; Baarsma et al., 2016; Howlin, 2004).

And yet, this does not seem to be evident in practice. The HSB research knowledge base shows that recidivism rates for adolescent sexual offences are significantly lower than for other types of offence, for example 6.8% for sexual against 37% for theft (Youth Justice Board, 2023); this means there is only a small sub group of adolescents whose harmful sexual behaviours are likely to be persistent and there is no evidence in the academic research nor this study that autism is over represented in this sub group.

A possible hypothesis about the relevance of autism to low recidivism rates is that if many autistic adolescents' sexual behaviours are driven by factors such as being unclear about appropriate social and legal boundaries, if they are then given a sanction for their sexual behaviours and education about these boundaries, are they more likely to adhere to the boundaries and not repeat the behaviour again? (King and Murphy, 2014). If this hypothesis has any validity then it is relevant to the concern about minimisation and lack of early sanctions for some of the cases in this study, who then ended up in specialist HSB services or secure settings.

7.3. Objective 2: To look at this practice issue from the perspective of community based front line practitioners to determine what guidance they require and what constitutes good practice.

Relevant Research Question

e) What did practitioners find were the most challenging aspects of working with autistic children and adolescents with HSB and what works in terms of assessments and interventions?

7.3.1 Challenges and gaps in the knowledge base

There were several challenges identified by the practitioners such as the need for adapted frameworks and tools to aid understanding, assessments and interventions with autistic individuals (Greaves-Lord, 2020; Mogavero and Hsu, 2019; Mehzabin and Stokes, 2011; Hellemans et al., 2010). This is what the development of the Practice Guidance sought to address, with its adaptation of the AIM3 model (Leonard and Hackett, 2019), introduction of the individual profile tool (Carson, 2023) and the collation of suggestions for interventions.

Other challenges will need further strategic discussions in agencies about necessary adaptations to current policies and practice, such as the need for training so that a wider range of professionals including their supervisors/ managers have an increased understanding of autism and HSB. The training could enable improvements in inter-agency co-ordination helping practitioners in different agencies to feel more confident in how they can contribute to good practice. This may be around preventative work, on understanding appropriate boundaries; decoding dating etiquette and skills in making connections and relationships with others. Preventative work could help some autistic individuals avoid becoming involved with statutory services because of their sexual behaviour and should be fundamental components of any HSB programme with autistic individuals.

Another challenge was in relation to intervention programmes. Practitioners identified that work with autistic children or adolescents took longer than their usual HSB cases and that parents with autistic children needed much more information and

support. Therefore they were having to develop separate, detailed programmes of work for the parents as well as the work with their child. These created the dilemma that more time was needed when many of their agencies had strict statutory time limits for assessments and interventions.

Practitioners expressed that not having enough knowledge about autism meant that they felt less confident in what they were trying to assess. They wanted more information on diagnostic criteria and the relevance of this for understanding an autistic individual's sexual behaviour. A specific knowledge gap was around the rising numbers of autistic adolescents in secure unit populations, with seemingly harsher sanctions for their sexual behaviours than their non-autistic peers might receive (Allely, 2022; Yu et al., 2020; Allely and Creaby-Attwood, 2016; Browning and Caulfield, 2011; Higgs and Carter 2015).

7.3.2 What works?

In the absence of guidance, practitioners were learning what works by trial and error, so this question was to collate their learning in one place so it could affirm and inform practice across a range of agencies. Those who worked in multi-disciplinary teams where there was a blend of autism and HSB knowledge or those who had access to colleagues with experience in the opposite discipline from their own, had quickly moved forward in being able to adapt their assessments and interventions, to feel more confident in this type of work and to meet the needs of each individual young person; they tended to be in the specialist HSB or forensic CAMHs services.

Those not in multi-disciplinary teams such as social workers and youth justice officers stated that inter-agency working was one of the major challenges to good practice. A learning point then from this research would be that the development of links between the different disciplines would be beneficial in supporting the sharing of knowledge and growth of confidence and competence across all agencies in working with autism and HSB.

Developing an individual profile of each child or adolescent in terms of their autism and what it means for them in daily life, was a key message about what works in assessments and interventions. To support this, I developed an individual profile creator tool (Carson, 2023) as part of the Practice Guidance, which provides a visual representation of the individual, allowing the practitioners to understand how to use a double empathy approach (Zamzow, 2021; Milton, 2012) to tailor the sessions in order to build rapport with the child or adolescent and to enable them to engage meaningfully in the work.

In relation to interventions, this study raised a challenge for HSB practitioners to consider adaptations to their practice to create bespoke sessions of work rather than use orthodox HSB programmes which are usually psycho-social-educative programmes based on what would be considered normative for non-autistic adolescents.

> "…it strikes me that all of what you cover in the earlier chapters provides a compelling picture that for many autistic children who present with 'HSB' what we are actually seeing are the consequences of autism, rather than any kind of pathology or sexual deviance. So, there is a real discussion to be had about what to 'treat'…. This would be a real challenge for HSB specialist services." (Peer Reviewer 7)

Using the individual profile to understand the intention, meaning and motivation for an autistic child or adolescent to engage in the sexual behaviour and the needs it was meeting can begin to put their behaviours into perspective. Understanding how they process information can support practitioners in thinking about how the work should be tailored, for example, are they a structured or kinaesthetic learner? Structured learners are better with clear rules and instructions and visual, concrete, black or white exercises. Kinaesthetic learners learn better when information is visual and linked to movement and activities such as role plays (Carson and Aujla, 2021; Ray, Marks and Bray-Garretson, 2004).

Both the literature review (Allely, 2021; Greaves-Lord et al., 2020; Vinter and Dillon, 2020; Melvin et al., 2017; Allely and Creaby-Attwood, 2016; Higgs and Carter 2015;

Sevlever et al., 2013; Sutton et al., 2012; de la Cuesta, 2010) and this study highlighted the need for a substantial part of the intervention work to be focused on core social and communication skills to support autistic children and adolescents in being able develop healthy friendships and to become more socially integrated.

A second strand of the work would be on sex and relationship education, which should cover not only appropriate social and legal boundaries and issues like consent in relation to sexual behaviours but also support for autistic adolescents with developing their skills in understanding the nuances of flirtation and 'dating etiquette'; supporting them in practising these skills through the development of scripts, role plays and scenario rehearsals. They also need the opportunity to practise, to make mistakes and to ask questions, which highlights the importance of supporting them to be able to develop friendships and to have more social opportunities.

7.4. **Objective 3.** To develop, peer review and pilot Practice Guidance on Autism and HSB to address the immediate practice need identified by the community based front line practitioners.

Relevant Research Question

f) Do the theoretical constructs and the content included in the Practice Guidance reflect the research participants' and the autistic community's views and experience and does the Practice Guidance support practitioners in developing more informed and proportionate assessments and interventions for autistic children and adolescents?

7.4.1. Development of the Practice Guidance

From my previous experience of developing practice guidance on children and HSB, I had learned that the starting point of developing practitioner confidence and competence in working with such a complex subject, was to demystify it, increase understanding and create frameworks for assessment and interventions which are then used in practice and refined. The purpose of the Practice Guidance on Autism

and HSB was to take the learning from the literature review and this research and replicate this process.

The Guidance was designed to be very practical and accessible, to support practice and to facilitate dialogue with colleagues, other agencies, parents and autistic children and adolescents. This was particularly relevant to the need identified by the interviewees for information which could be used with parents to help them to understand their child's sexual behaviour. It was shaped by using the action research methodology with cycles of hermeneutic reflection and action, which meant sometimes revisiting earlier stages of my learning when new information arose (Dick, 2000), for example when the autistic peer reviewers raised the issue of executive functioning and alexithymia. This meant that the structure of the Practice Guidance developed and changed as the research progressed.

Although the initial concept for the Guidance was envisioned solely as an adaptation of the AIM3 Model (Leonard and Hackett, 2019) to provide more informed and proportionate assessments for autistic children and adolescents (Malovic et al., 2020) it gradually expanded to include information about autistic diagnostic criteria (Lord and Jones, 2012) and the relevance to sexual development and behaviours, for those practitioners with more limited experience in working with autism.

To adapt the AIM3 model (Leonard and Hackett, 2019) for use with autistic adolescents, I applied the theoretical constructs that I had developed about the similarities to the practitioners' previous knowledge, skills and practice and the differences which required adaptations to their analysis and practice. They were developed by comparing the information from the research on autism and HSB, with knowledge of HSB from both the interviewees' and my own practice experience (Young and Cocallis, 2023; Allely, 2022; Greaves-Lord et al., 2020; Visser et al., 2017; Fernandes et al., 2016; Beddows and Brooks, 2015; Kellaher, 2015). The final chapter on interventions was based on the research participants' suggestions about what worked and their suggestions for how practice could be adapted.

A crucial additional chapter that I had not anticipated at the beginning of this research project was about the importance of developing an individual profile of the autistic child or adolescent. From the beginning of my research, a constant message I had received was the reason that no guidance had been created so far, was that it was too complex to achieve, as there are a range of autistic traits and additional co-existing factors and as each individual would have their own combination of these, how could I create guidance that fitted every possible scenario. Initially I was daunted until I realised that I could make the information accessible through combining two processes. Firstly, developing the broad theoretical constructs of similarities and differences identified through this research which were used to adapt the AIM3 model (Leonard and Hackett, 2019).

Secondly, to begin assessments with understanding the individual first, through the development of a set of questions and a tool which can create a visual, individual profile of the autistic child or adolescent, to understand what their autism means for them, in terms of their identity, their strengths and their challenges (Carson, 2023; Allely, 2021; GAO, 2016), and then looking at what relevance this has for their sexual behaviours. This made it clearer, when using the adapted AIM3 model, what was relevant to the particular individual.

Feedback from the pilot participant group was that the individual profile tool (Carson, 2023) made the frontline practitioners feel more confident in asking the diagnostic clinicians further questions about the diagnosis and in helping them think about how they could adapt their own practice to engage the child or adolescent in the assessment or intervention processes. Because of the high numbers of cases with possible autistic characteristics on practitioners' caseloads it was important the profile tool could be used for those cases as well. The same principles applied but it was stressed that this was not a diagnostic tool.

7.4.2 Reflections on the external review

The purpose of the external review was to evidence the trustworthiness and authenticity of the research, by checking if the Practice Guidance was representing

the actual phenomenon being studied (Robson, 2002), and its applicability to practice. This was done through triangulation using two further methods of peer review and piloting each with different participants and different perspectives (Noble and Heale, 2019; Morse, 2015). Using different sets of practitioners to independently review the Practice Guidance, meant that the research findings were not compromised by the peer review or pilot groups being invested in finding the Practice Guidance authentic and valid for practice.

None of these practitioners had been involved in Phase One, the development stage of the research, so were coming to the information with a fresh perspective. They had all either volunteered or been selected to be involved as they were interested in developing good practice guidance and had experience in this area of work. If they had felt that the constructs were weak or invalid, it was in their interests to critique the Guidance and highlight these areas for further improvement.

Half of the peer review group had a background in HSB academia or practice and the other half were either autistic or worked with the autistic community enabling the Guidance to be reviewed from both perspectives. The pilot group were all HSB specialist teams, who were considering if it would be helpful to them in their practice. The involvement of the autistic peer reviewers was essential in ensuring that the Practice Guidance was centred in an understanding of the autistic lived experience. Although I had created the pre-peer review briefing for the autistic peer review group as a solution to a logistical problem, it had the unintended benefit and powerful learning experience for me, of seeing HSB from their perspective.

They raised additional features that were not present or being talked about in Phase One of this research, in neither the literature review nor the interviews, such as co-existing factors like executive functioning and alexithymia, which have, on reflection, such resonance for HSB practice generally as well as in relation to autistic individuals. They also talked about the genetic link with autism which means that parents may also be autistic, or there may be more than one autistic child in the family. As this was an action research framework, I was able to go back and revisit the literature review for information about these factors to then update the Guidance.

This also emphasised to me how bringing the knowledge from two different research and practice silos, helps practitioners and researchers in each silo to find connections to their own knowledge base of which they would have otherwise been unaware (Strang et al., 2020).

Both groups felt that the Guidance had a logical structure beginning with an awareness of autism; then the research and practice knowledge base on Autism and HSB leading onto the practical elements of the individual profile generator (Carson, 2023), the adaptation of the AIM3 model (Leonard and Hackett, 2019) and then suggestions for intervention. They liked the AIM3 model (Leonard and Hackett, 2019) being the core model as it was a familiar starting point for practitioners. The autistic peer reviewers stated that they were really pleased with the practical aspects of the guidance as they felt they were useful ways of helping practitioners begin to think about how they could adapt their practice when working with autistic individuals.

Regarding the validity of the content, both groups felt that the theoretical constructs around similarities and differences when working with autistic clients and suggestions for how to adapt practice were credible and appropriate for the practice context (Guba and Lincoln, 1981). A key point repeatedly made by the pilot group was about how it provided confidence and clarity, which they felt came from having a tangible reference framework, which demystified this complex subject for both front line practitioners as well as experienced clinicians and specialists. They also felt it gave them confidence in their own analysis and decision making and a language to talk about it, which meant they could communicate more clearly with others.

The lack of negatives or criticism in both the peer review and pilot processes, I feel was because the Practice Guidance had genuinely met a need, particularly because the use of an action research framework had included the practitioners in identifying what the Guidance should contain. The depth of understanding provided about the autistic lived experience by the autistic practitioners put all the HSB research and practice knowledge into the right context. The suggestions for future additions indicated that they were envisioning the Practice Guidance as a useful starting point for the ongoing development of good practice in autism and HSB.

7.5. Limitations of this Research

As Autism and HSB is a relatively new area of research (Allely, 2019) our understanding about what constitutes good practice is still being created. As this was a small-scale study focused on the perspectives of frontline practitioners about their experience, what guidance they needed and what they had found already worked, the development of practical guidance and tools met their immediate need and can be revised and built on in the future. However, the size of the study could not offer definitive, empirically valid data (Robson, 2002) and some of the questions it has raised would require large-scale longitudinal studies to address, but in raising these questions, it has contributed to the discussion.

The experiences and views of autistic individuals were integral to this research and the development of the Practice Guidance. Initially, I had also intended to have a focus group of autistic adolescents to discuss their experiences of puberty, their sexuality, developing romantic and/or sexual relationships and what they would like practitioners to understand or to do differently when working with them, but was dissuaded by the experiences of other researchers in terms of the amount of time it would take to develop an appropriate way of seeking their views (Attwood, 2007; Greene and Hill, 2005; Punch, 2002) especially with such a controversial subject. Involving them would also raise ethical issues about the benefits for the adolescents themselves as HSB is a sensitive subject even for adults and the Practice Guidance was to be designed for practitioners to use. I was therefore concerned that involving them would be possibly tokenistic.

However, studies I read later in the literature review showed clear benefits in having autistic adolescents' self-reports on their sexual development and behaviours even though they took more time to set up, rather than relying on their parent/carer reports (Mogavero et al., 2020; Visser et al., 2017; Dewinter et al., 2016; Mehazabin and Stokes 2011; Gilmour et al., 2012). Along with it being a future area of development suggested by the autistic peer reviewers and my own developing confidence of how practice can be adapted appropriately, consideration of how to include their views will be in the next rounds of development of the Practice Guidance, post this PhD.

To address the limitations of being a sole researcher with the potential for researcher bias (Nowell et al., 2017), each phase of the research included primarily self-selected random samples of frontline practitioners demonstrating that no participant was under pressure to engage with the research and were free to be honest in their responses. However, because they had self-selected and the survey and interview processes were based on practitioner self-reports about challenges, gaps in information and what they had found worked, there was potential for them to be biased. To test and balance their views, the external review processes of peer review and piloting using separate practitioner groups were set up. They were used to check if the information derived from the survey and interview processes resonated or was discordant with their own practice experiences.

Chapter Eight: Conclusion

8.1 Developing good practice in Autism and HSB

The purpose of my PhD was to support the development of good practice in relation to autistic children and adolescents with harmful sexual behaviours (HSB). The lack of adapted guidance for this population had been identified by practitioners from a range of agencies who had highlighted that they had increasing numbers of autistic or possibly autistic individuals on their caseloads.

The three objectives of this study were to add to the academic research knowledge base, through the creation of this thesis. To listen to and report the frontline practitioners' experiences in working with autism and HSB, the challenges they faced, what they had found worked and what information they would want any guidance to cover. Finally, to produce Practice Guidance to meet the identified practice need, which then was independently peer reviewed and piloted, processes which included members of the autistic community, to test its validity in practice.

The findings of this research evidenced that all of those who engaged in each of the phases of the study, including the members from the autistic community, felt more confident and competent in this aspect of HSB practice. For some it was the learning that they took from going through their part of the process and for others the experience of using the Guidance in practice and seeing how it could enhance their understanding and their assessments and interventions with autistic children and adolescents.

8.2 Making Tacit Knowledge Explicit (Somekh, 2006)

The aim of this thesis and the Practice Guidance was to make 'tacit knowledge explicit' (Somekh, 2006) and therefore create the basis for further discussion and development. A key objective of this study was to listen to the practitioners' experience of working with autistic children and adolescents with HSB as their

perspectives had not previously been studied. Other studies have reported on adolescent populations in specialised mental health and criminal justice settings but not the views and experiences of the practitioners who work with them.

Using the information the practitioners provided in the surveys and interviews about case data and their own experience of what was similar and different to their usual HSB practice when working with autistic individuals, enabled me to create theoretical constructs which were meaningful for practice, making their ‘tacit knowledge explicit’ (Somekh, 2006). The collation and coding of the interview data also helped me to draw out and develop themes and questions for HSB practice, especially around the complexity of autism and recidivism, which have not previously been discussed in this way.

Asking for their specific experiences around challenges and what works meant that the Practice Guidance was adapted to meet their practice needs, for example providing more information about autism or how to enable better communication in assessments and interventions. This is also the first time that the practitioners’ experiences of what works had been collated and presented in one place. The practitioner voice was also essential in the external review, as only they could evaluate whether the Practice Guidance informed, supported and developed their HSB practice.

The second influential group on ‘making tacit knowledge explicit’ were the autistic professionals and those working with the autistic community, who were involved in the peer review and pilot processes. The pre-peer review briefing session with these individuals was a turning point for the development of this research and ultimately the Practice Guidance. The connections they made between the lived experience of autism and the information I was providing about HSB, were revelatory and influential for both of our practice knowledge bases. This was a perfect example of how creating a bridge between the two disciplines creates a more informed, combined perspective with the potential for agreed language and definitions. When this happens, it enhances and challenges them both (Strang et al., 2020).

For them, it opened up new ways of understanding some of the autistic individuals they were working with by adding the HSB knowledge to their thinking. They also they felt it would support them in having discussions within their community about autistic adolescents and HSB and emphasising that this work was not about demonising them but trying to get better informed and proportionate decisions and outcomes for them.

For me, learning from them about concepts such as executive functioning and alexithymia opened up questions for me about why we were not routinely considering these in HSB practice generally, as they may provide a context for why some non-autistic children, adolescents and their families struggle in assessment and intervention processes. Overlaps with regard to high levels of anxiety and depression experienced in both autistic and non-autistic adolescents involved with HSB enabled further links to be made between the two groups, as well as understanding how the effect might be compounded for autistic adolescents.

In addition to these concepts, having autism specific information on issues around genetics and autistic parenting when assessing attachments and on how stimming and some autistic traits can be a way of dealing with a world which feels unsafe and unsupportive, alongside the challenge from the autistic peer reviewers to HSB practitioners to consider double empathy (Milton, 2012) and make changes to their practice, led to significant changes in the Practice Guidance. These additions were highlighted by the practitioners in the External Review as being transformative for their practice.

8.3 Contribution to the field of knowledge

This research has made a unique and significant contribution to the academic research knowledge base by being the first study to analyse HSB practice with autistic children and adolescents, identifying similarities and differences to HSB practice with non-autistic peers. Specifically, it is the first study to consider autistic children and HSB. It has provided new theoretical constructs for practitioners to

develop their understanding with regard to what they need to consider and how they need to adapt their HSB practice.

The key theoretical construct when considering the types of sexual behaviours **'it's not the what and the how, but the why and the who'** (Carson, 2022), was felt by the peer reviewers and the pilot participants to be a very succinct but clear way of visualising what was different and what they needed to focus on in their assessments of autistic clients and they felt it had had an immediate impact on their practice.

The similarities identified were related to **what they did and how they did it**, in that they engaged in the full range of behaviours on Hackett's (2010) continuum and used similar methodologies for getting themselves into a position to be able to abuse the other person and to ensure that that person did not feel able to tell anyone. But **the why and the who**, were strikingly different. In other words the meaning, motivation and intent of an autistic child or adolescent's sexual behaviour and who they target can be significantly different, creating the danger of over-estimating risk if there is no clear understanding of the individual's schema in relation to their sexual behaviours.

Being given the individual profile creator (Carson, 2023) to help them shape their understanding of the child or adolescent was considered to be one of the most important parts of the Guidance, which immediately had an impact on practice. The feedback was that it helped to make the practitioners feel less overwhelmed as they had the language and a visual tool to help them both understand and to communicate better with parents, autistic children and adolescents and other professionals.

This is also the first study to look at the practitioners' concern about the rise of the numbers on their case loads of non-diagnosed cases which they believed had possible autistic characteristics. This raises important issues for HSB practice and research in terms of over identification of cases as possibly autistic, due to increased autism awareness and the similarities between some autistic characteristics and trauma characteristics. Concerns raised about the increase in numbers of autistic

adolescents in the criminal justice and specialist HSB services may be attributable to these possible causes.

Another area of under researched practice looked at in this research was the practitioners' view that there is a disproportionate number of autistic adolescents involved in TA-HSB. Practitioners report similarities in the backgrounds of their TA-HSB cases and their autistic cases, with more individuals being in settled, supportive environments rather than in chaotic and/or abusive environments which would be a more usual HSB profile. Both groups also have extensive time unsupervised online.

This study did not confirm that practice view, as all the cases had traditional background profiles of unsettled backgrounds, trauma and/or abuse. However, it should be noted that all of these cases were in specialist services and therefore potentially were not representative of the typical adolescents who engage in TA-HSB. This is an area which does require more research.

8.4 Implications for practice

The major implication for practice is the development of the Practice Guidance. Following the completion of this thesis, it will continue to be peer reviewed and piloted in practice and provides a starting point for future practice development.

The research has shown that rather than working with autism and HSB being a completely different or new way of working with HSB, it is fundamentally basic good practice about understanding the individual and finding ways of engaging and building rapport with them. The challenges were about how to have a better understanding of autism and specifically each individual's experience of autism, in order to adapt HSB practice to facilitate their engagement in the assessment and intervention processes. The practitioners involved in the research fed back that they found the Individual Profile tool (Carson, 2023) invaluable for this. The feedback from the peer review and pilot processes was that this had been one of the most helpful things in the Guidance.

Other implications for practice raised in the literature review, that this research would support, includes the need for more early prevention work with autistic children and adolescents. This involves the overt and tailored provision of information on puberty and sexual development, as well as how to understand and manage all the non-verbal, nuanced, multi-level communications around flirting, dating and relationships. Autistic children and adolescents may not have the same opportunities to receive and process this information as other adolescents. As well as enhancing their well-being, it could address some of the reasons why autistic individuals engage in HSB.

It also means work with their parents/carers and professionals such as education staff, about the impact of minimising the sexual behaviour. Lack of consequences and guidance can mean some children and adolescents progress to more serious behaviours and become involved in HSB services or the youth criminal justice system.

The research collates and highlights the challenges the practitioners face and the need for training and for systemic acknowledgement of the need for more time for the work; improved inter-agency cooperation; informed supervision and access to consultation from colleagues with experience in the opposite discipline to their own practice. It is hoped that this research will begin these debates on a strategic level in order to support good practice.

8.5 Implications for future research

The most significant question this research raised for HSB practice was around autism and recidivism criteria. There are some similarities between the two in terms of how an autistic person may express themselves and who they might target, for example in this small study, there were several cases where adult female carers were abused. However, there is a danger in assuming that autism traits and recidivism criteria are connected, which can lead to over-estimation of risk. This along with rising numbers of cases with possible autistic characteristics on agencies' caseloads may be relevant to the increasing numbers of autistic individuals coming into the criminal justice system and secure care settings.

Both of these need to be researched and explored further, to consider what impact the numbers of possible cases have on the data and also if the similarity is simply about trauma and autism having similar characteristics, or have autistic traits been influential in the development of HSB risk factors and recidivism? i.e. that the studies have been done on populations containing autistic individuals but without this being recognised. Hackett (2014) has said HSB practice had a 'research pile' rather than a research knowledge base as there are no real challenges by the HSB community to theoretical constructs developed through research.

Researching autism as a new aspect of HSB has raised that challenge. It brings different perspectives, with their own logic, that HSB practitioners need to understand. Just as autistic individuals challenge the prevailing norms and understanding about gender and sexuality (Jackson-Perry, 2020; Jack, 2012; Bumiller, 2008), understanding autism and HSB challenges our current HSB concepts about sexual harm, causal factors, meanings and motivations and recidivism.

Further research is also required in relation to autistic children and HSB. This small study has provided the first information on this population but more needs to be done, for example, what relevance, if any, does gender have to early or late onset of puberty in autistic children?

8.6 Next steps and final thoughts

While I began the study with a concept that if I understood the similarities and differences, then we could adapt our current HSB thinking and models to 'fit autistic individuals in', I soon realised that this knowledge had the potential to challenge our current way of thinking about HSB and the research on which it is based. This research was ultimately not about fitting autism into the HSB world but challenging both the HSB and autism worlds to reflect on what it means for each of them. The challenges or questions for HSB practitioners are how much do we need to change?

How much of our knowledge base needs to be revisited? How much room is there to embrace diverse perspectives?

Through the creation of the Practice Guidance, practitioners and researchers now have a framework based on research and practice knowledge, which has resonance for their own practice, both affirming and supporting their development. It has provided a starting point for discussion, research, challenges and further development. In the feedback from the research participants, they expressed that being involved in the research had already had an impact on their practice. Having accessible information relating to practice questions and a clear framework had facilitated them in feeling more confident in this work and beginning to positively think about future developments.

As the final part of this Thesis, I wanted to end with some observations about my own learning journey, the first person inquiry element of the action research framework. This was a steep learning curve, going from being an expert in my field of HSB to an absolute novice in understanding neurodiversity, autism and the lived experience of autism. It was an intense, challenging but incredibly enlightening process.

It made me realise that the work on autism and HSB not only has to borrow information from research about autism but to be centred within an understanding of autism to properly understand and analyse the HSB behaviours. I appreciate the guidance and support I received from the autistic peer reviewers and pilot participants and the empowering way they helped me develop my own understanding of autism and the context of the changes they felt needed to be made.

Developing good practice in autism and HSB is in its early stages and I believe that this research has contributed to the discussion and is already beginning to have an influence on practice.

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Appendices

Appendix One - Critical Narrative Review Sources

The critical narrative review was complex as there were two large research data bases one on HSB and one on Autism, with a significantly smaller research knowledge base on autistic children and adolescents with HSB. Further complications were the changes in terminology particularly around autism diagnostic criteria and categorisation. The following table provides an overview of the main databases used plus other sources of information.

Databases	**Journals**	**Other Sources**
Frontiers	Professional Journals re Health, Nursing, Social Care, Child Abuse, Education, Autism, Disability, Psychology/Psychiatry,	
Google Scholar		Websites
National Library of Medicine		
Medline		Webinars
Oxford Handbooks online		Conference papers
PsychArticles	Journal of Sexual Aggression (NOTA)	University Research Project papers
PsychInfo	NOTA News	National Autistic Society Publications
PubMed	Child Abuse Review	Middletown Autism Centre Publications
Research Gate		
Russell House Publishing		Newspaper articles
Safer Society Press		ATSA
Sage Journals		
Science Direct		
Scientific Research		
Scopus	**Government Publications**	
Social Policy and Practice	Public Health/Justice Documents	
Social Science Citation Index	NICE publications	
Springer Journals	National Crime Agency	
Taylor & Francis online		
Web of Science		
Wiley		

Search themes

HSB knowledge – to check if there had been any new developments

Children with HSB – child*; younger child*; sex* behaviour; sexualised behaviour; sexually inappropriate behaviour; hsb; HSB; harmful sexual behaviour; sexuality. For example “child* & sex* & behaviour”

Adolescents with HSB – young person/ young people; adolescent*; teenager*; sexual offending; sexuality; sexual behaviour; hsb; HSB; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidivism. For example “Adolescent* & sex* & offending”

History and theories of HSB – HSB; Harmful sex* behav*; inappropriate sex* behav*; theorie*; practice; history; review; evaluation;

Autism broad overview

History and theories of Autism – Autis*; theor*; genetic*; environment*; caus*; behaviour*

Autism Diagnosis – Autis*; diagnostic criteria; diagnos*; high functioning; asperg*; classic; neuro* diversity; typical; definition*

Autism and sexuality/ sexual development – Autis*; child*; adol*; young person; young people; teenagers; sex*; sexuality; sexual development*; hyper sexuality; paraphilia*; gender; binary; gender dysmorphia; trans*; hetro*/homo*;

Autism and co-existing conditions – Autis*; child*; adol*; young person; young people; teenagers; paraphilia*; executive function*; alexithymia; intellectual disability; learning disability; sociopath*; psychopath*;

Autism and emotional and mental health - Autis*; child*; adol*; young person; young people; teenagers; emotion*; health; resilience; depression; anxiety; mental health

Autism and HSB

Autism, adolescents, potential causal factors (trauma, abuse, attachment, family background etc) Autis*; adol*; young person; young people; teenagers; trauma*; abus*; attach*; family; background*; dynamics; discontinuity of care; child protection; residential care;

Autism and Adolescents with HSB - Autis*; adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidivism; types of behaviour. For example “Autis* & Adol* & sex* behave*”

Autism and TA-HSB - Autis*; adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidivism; techno* sex* behave*; TA-HSB;

Autism, HSB, Demographics - Autis*; child* adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidivism; types of behaviour; demographics;

Autism, adolescent HSB risk assessment - Autis*; child* adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidivism; risk assess*

Autism, adolescent HSB interventions - Autis*; child* adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidivism; intervention*

Specific gaps in the research literature

Autistic children and HSB; autism diagnosed or possible cases; autism, HSB and recidivism were areas in which an initial review of the literature had highlighted significant gaps in the literature.

NB: No matter what combination I used, I could only find one study which focused on autistic children and analysed the causes and types of their behaviour (Fourie, Kotzé and Van der Westhuizen,2017). There were several studies which talked about children but were meaning adolescents. There was also limited information on diagnosed and possible cases and on autism and recidivism with HSB. I asked the Queen's Librarian to check my search terms to see if I was missing anything, she found nothing in addition to any articles I had already identified.

Autistic children and HSB – Autis*; child*; younger child*; sex* behaviour; sexualised behaviour; sexually inappropriate behaviour; hsb; HSB; harmful sexual behaviour; sexuality.

Autism diagnosed and possible cases - Autis*; child*; younger child*; adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; possibl*; suspect*; trait*; characteristic*

Autism, HSB and recidivism - Autis*; child*; younger child*; adol*; young person; young people; teenagers; sexual offending; sexuality; sexual behaviour; hsb; harmful sexual behaviour; inappropriate sexual behaviour; sexualised behaviour; perpetrat*; recidiv*;

Appendix Two – Types of Paraphilias

Paraphilia - a condition characterized by abnormal sexual desires, typically involving extreme or dangerous activities, but not necessarily illegal.

Paedophilia – sexual interest in pre-pubescent children; grooming of children for sexual activity and sexually abusing children (Baarsma et al., 2016; Fernandes et al., 2016; Dewinter et al., 2013; Hellemans et al., 2010; Robinow, 2009; Ray, Marks and Bray-Garretsen, 2004; Murrie et al., 2002; ; Realmuto and Ruble 1999).

Voyeurism – is a crime if an individual to arouse or gratify their sexual desires or those of another, they knowingly view, photograph, or film another person in a private place without consent. (Beddow and Brook, 2015; Ray, Marks and Bray-Garretson, 2004; Milton et al., 2002; Murrie et al., 2002).

Exhibitionism involves exposing the genitals to become sexually excited or having a strong desire to be observed by other people during sexual activity (Beddow and Brook, 2015; Ray, Marks and Bray-Garretson, 2004; Milton et al., 2002; Murrie et al., 2002).

Frotteurism (sometimes called frottage) the practice of achieving sexual stimulation or orgasm by touching and rubbing against a person without the person's consent and usually in a public place (Ray, Marks and Bray-Garretson, 2004).

Zoophilia/Bestiality – zoophilia is a condition where a person has a sexual attraction to animals; bestiality is sex with animals (Kellaher 2015; Allely, 2020).

Transvestism - the practice of wearing clothes usually associated with a different gender and this may be linked to the rejection of social norms by autistic individuals (Landén and Rasmussen, 1997).

Objectophilia – being sexually aroused to inanimate objects which are imbued with genders or personalities (Hellemans et al., 2010). In Simner et al's, 2019 study, this

was found to be over 30 times higher in the autistic group than the control group and more prevalent in females than males. Robinow, 2009, felt that these abnormal object choices were wired into their sexual circuitry from a young age.

Partialism – focusing on one part of the body, not usually the genitals, for example, feet, hair, earlobes, hands. Hypotheses are that this may be related to early stages of development when more of the body is auto-erotic (Freud, 1905), or it is related to restrictive and repetitive interests (Kellaher 2015) or that it does not need interaction with another person in a relationship type situation (Kellaher, 2015; Hellemans et al., 2010; Ray Marks and Bray-Garretson, 2004; Haracopos and Pedersen 1992).

Fetishism – on self-reports this is the most common paraphilia (Visser et al., 2017; Fernandes et al., 2016; Långström and Seto 2006; Långström and Zucker, 2005) and is related to sensory interests, the use of a fetish object which evokes a sensory response during masturbation, which may involve using it to stimulate sexual organs or simply the feel and sensation of the object itself (Dozier et al., 2011). It can also be gratification derived from sensual activity with other parts of the body such as feet and is therefore linked to partialism (Kellaher, 2015).

Masochism/Sadism – this may relate to hyper or hypo sexuality. Schöttle et al., (2017) hypothesized that with hyper sexuality the drive for new forms of stimulation may lead to paraphilic interests such as masochism or sadism. In terms of hypo sexuality, the need for stronger stimulation, deeper pressure and for some autistic people a reduced experience of the sensation of pain (Kim, 2015).

Appendix Three – Executive Function and Alexithymia

Executive Function (extract from Autism and HSB Practice Guidance, Carson, 2022)

Although not part of the diagnostic criteria for autism, other factors such as problems with executive function also need to be considered as this feature is often co-exists with autism traits (Kramer and Madden 2008). The definition of executive function is the brain manager- the cognitive processes that help regulate, control and manage thoughts and actions. It includes planning, working memory, attention, problem solving, verbal reasoning, inhibition, cognitive flexibility, initiation of actions and monitoring of actions.

Any individual whether autistic or not, can have difficulties with some of these aspects of executive function more than others, for example, they can make plans but lack the ability to see it through. However, the more skills the individual has in relation to executive function can help to shape their ability to manage some of their autistic traits like theory of mind and to be able to cope in day-to-day life (Pellicano, 2012).

Practitioners also need to consider the parent or carer's executive functioning particularly if they are also on the autistic spectrum, do they have a history of not implementing plans or missing appointments? In a neuro typical adult, these would raise concerns about the parent or carer's willingness or ability to protect and support their child. If, however, they have an executive function impairment, then this needs to be considered but may mean that other adults also need to be involved with managing the safety plans.

The following information on executive function and implications for sexual behaviour work is based on work by the author Maureen Bennie and The Autism Awareness Centre (2018) with the kind permission of the author.

Cognitive Skill	Implications for sexual behaviour work
Planning The ability to forward think and choose actions to reach a goal and in which order and establish a plan of action. Those on the spectrum can have difficulty formulating plans to get through their days and to organise tasks into completable sections.	If there are deficits in planning skills • Planning and manipulation are less likely to be part of their sexual behaviours. • Having a future perspective and planning are strengths within the assessment process, so deficits in these areas will raise concerns. They may require more support or the responsibility for managing the behaviour may have to be with the adults around them
Problem solving Problem solving uses almost all the other executive functions including reasoning, attention, planning, initiation, working memory and monitoring. Dependent on which of the executive functions the individual struggles with, that is where the problem-solving chain will get broken	If there are deficits in problem solving The ability to problem solve is seen as a strength in HSB work, if the individual does not have this capacity, the focus should be on whether they can be supported to develop these skills or if the adults around them will need to take responsibility for managing the behaviour
Memory *Working memory:* the ability to remember specific short-term memories needed to execute a function or daily task, such as self-care	If there are deficits in memory • *Working memory* they may not retain the learning from the intervention requiring the work to be repetitive they may have deficits in self care which impacts on their social integration • *Impaired episodic memory:* (Lind and Bowler 2010) can mean that they have difficulty recalling their own abuse or their abuse of others particularly sequentially, therefore may give confused statements or appear defensive

Cognitive Skill	Implications for sexual behaviour work
Attention Attention is closely tied to working memory. An individual's ability to focus directly affects what they can keep in and recall from their short-term memory Individuals with autism often have a keen ability to focus but directing that focus can be challenging. If the person with autism has sensory issues, then their attention may be distracted by the sound of the lights buzzing or the smell of the other people in the room	If there are attention deficits Underlines the need to establish sensory sensitivities when setting up where sessions will be held, otherwise they may not be able to engage in the work
Reasoning This is the ability to understand and think critically about concepts presented in words, and then relay them back or integrate them successfully. Verbal reasoning can also be hindered by social meanings that are not obvious to those with autism	If there are deficits in reasoning ability Compounds difficulties with social communication and understanding Underlines the need for time to be given for them to process information
Generalisation This is the difficulty in generalising from one situation to another. Can understand one concept but not how it would link to another.	If there are deficits in generalisation • They may continue the behaviour in a different way but without intent to be devious and manipulative. This emphasises the need for very specific instructions or having very tight rules. • They may understand their own experience of abuse was traumatic but not be able to apply that to the feelings of the person they harmed.
Initiation Initiation is the ability to start an activity, plan or task. An individual may want to play a certain game, do their homework but unless the activity is initiated by someone else it does not happen. It has nothing to do with desire, or "want" – it is about lacking the function of "just doing it"	If there are deficits in initiation The individual may want to engage with the safety plan and interventions but then do not follow through with the work required. This may make it look like they are not engaging with the plans which would normally raise concern.

Cognitive Skill	Implications for sexual behaviour work
Inhibition Inhibition is impulse control; the ability to have emotional, cognitive or physical reactions that are not acted upon in the moment. An autistic person “information downloading” all the names and songs of their favourite pop groups, this would be a lack of cognitive impulse control. Emotional outbursts, hand flapping, or stimming can be emotional and physical ways that impulse control are not in place (although some stimming can be soothing and help concentration if controlled and non-harmful). Some autistic children simply cannot control their impulses sufficiently to participate in structured situations.	If there are deficits in impulse control Developing impulse control is a significant part of any intervention plan with sexual behaviours, so if the individual has significant difficulties with this, then the focus of the safety plan may need to be on the adults around them. Stimming strategies being displayed in sessions should be seen as indicators of an emotional state. This requires a good understanding of the individual’s own stimming behaviours and how they use them

Cognitive Skill	Implications for sexual behaviour work
Cognitive Flexibility Cognitive flexibility is the ability to roll with the punches and adapt to different social situations and demands, particularly in relationships. Those with autism are well known to need structure and predictability and change can be very challenging. This can also lead to rigidity of thoughts and opinions, as well as schedules and routines	If there are deficits in cognitive flexibility Cognitive flexibility is essential when managing social communications and developing relationships, especially romantic or sexual ones. Not being able to cognitively adapt may lead to social isolation and sexual needs not being able to be met in a healthy way. It could also lead to increased frustration and anger with the chance of sexual behaviours involving force and aggression
Monitoring Monitoring is a subconscious process that kicks in when a person is on auto pilot doing normal tasks. For instance, walking down the street and talking to someone at the same time. Normally only a small part of the brain is thinking about walking, so the monitoring function of the brain takes over, to stop the person bumping into things while chatting. For someone with executive function issues, if they were tired or overloaded, they would suddenly have problems with the “auto pilot” settings on basic activities, dropping or bumping into things, or simply not being able to pay attention in ways that could be hazardous like walking out onto a busy street	If there are deficits in monitoring This may be evident if the individual is getting tired or stressed in a session and they do not seem to be paying attention. This is not an indicator of disengagement with the work and should be picked up on by the practitioner

Alexithymia (extract from Autism and HSB Practice Guidance, Carson, 2022)

Alexithymia translated from the Greek, literally means ‘having no words for emotions’ and is used as a theory to describe the traits of people who have difficulty in verbalising their emotions (expressive ability) (Autistica.org.uk; Kim, 2015). Although there is a high rate of alexithymia in autistic people – autism research charity Autistica describes it as 1:5 autistic people, it is also experienced by non-autistic people, for example individuals experiencing depression.

Kim (2015) describes alexithymia as:

- difficulty identifying feelings
- difficulty distinguishing between feelings and bodily sensations related to emotional arousal
- difficulty describing feelings to others.

This does not mean a person with alexithymia has no emotions, but that they may struggle to identify what they are feeling and to talk about it, sometimes because their emotions are confused or sometimes because they are overwhelmingly intense (Kim, 2015). They may struggle to show or feel socially appropriate emotions such as happiness at a celebration (Autistica.org.uk) or they may experience emotional upset as a physical complaint, for example, feeling very physically cold if they are sad (Kim, 2015).

They also may not be able to understand or anticipate physical symptoms of anxiety such as changes in heart rate or an adrenaline rush and experience these as confusing or unnerving thereby increasing their anxiety. This may make it more difficult for them to regulate their emotions, in the way others might through anticipating and accepting levels of anxiety present in situations such as before an exam or an interview (Autistica.org.uk).

It also may affect their receptive ability with understanding the emotions of others but does not mean that they have no ability to show compassion or empathy, however, it may be harder for them to understand what emotion the other person is experiencing and how to respond to this. They also may become overwhelmed by other people’s strong emotions and not know how to manage their own emotional responses (Kim, 2015).

Relevance to sexual behaviour assessment and interventions

Puberty is a life stage with intense physical and emotional sensations; for those with alexithymia it may be very difficult to understand all these new things they are experiencing or feeling, or to be able to express themselves to others, or to ask questions. It may be frightening for them and their sexual behaviours need to be understood in the context of this struggle.

Someone with alexithymia may have great difficulty answering the question, how do you feel? Or how did you feel when…? Not being able to answer can create high levels of stress or anxiety of feelings of failure for them. Kim (2015) states that if

someone with alexithymia says they do not know how they feel, to believe them as they are not saying it to be obstructive or defensive. She also states that sometimes they may need to take time out from an emotionally charged conversation to take time to identify their feelings. They may need help to tease out what emotion they are feeling, for example, using their interests to help them navigate emotions in different settings (Hughes, 2022).

This is important when undertaking assessments re HSB as some of the initial discussions about what they have done sexually, can be emotionally challenging for any adolescent and may be even more so for someone with alexithymia. They may need time out within a session or for a session to be halted and the information revisited when they have had a chance to process it. It is also a common feature to ask about their emotional state when they engaged in the sexual behaviour and they may not be able to answer this.

There are myths that autistic individuals do not feel emotions and are incapable of empathy, which is now challenged; many can be easily emotionally overwhelmed and struggle with their emotional regulation and many when they learn how their behaviour has impacted someone else can find this distressing. Some autistic people may have more difficulties in reading other people's emotions and knowing how to respond and alexithymia may be part of that difficulty for them.

In HSB intervention work, again it is essential to understand that if someone has alexithymia, they will struggle to talk about how they feel or name their emotions. As work on feelings and emotional regulation are key components of HSB work, this does not mean that the work cannot happen. The website Autistica states that targeted work on identifying and communicating feelings or mindfulness exercises are effective ways of helping individuals to be better able to regulate their emotions, but it may take more time.

Appendix Four – Information Sheets for Phase One of the Research - Cycle 2, Surveys and Interviews

Participant Information Sheet – Survey

Autism and Harmful Sexual Behaviours (HSB): Developing good practice

My name is Carol Carson and I am a research PhD student at Queen's University Belfast. The purpose of my research is to develop and pilot Practice Guidance on Autism and HSB to meet an identified practice need. The research will combine areas of research and practice in relation to autism and harmful sexual behaviours (HSB) [Harmful sexual behaviours is the umbrella term for a range of sexual behaviours which cause concern from those which may originate from a lack of understanding of what is appropriate, to those which would be considered illegal, such as rape and sexual assault]. The research will contribute to the academic body of knowledge as well as support the development of practice in this area of work.

Ethical approval

This research has been ethically approved by the Research Ethics Committee, School of Social Sciences, Education & Social Work, Queen's University Belfast.

Your participation

Thank you for your interest in being involved with this research, the first stage is to complete a short survey, see attached link. I am interested in getting the views of practitioners, about young people they work with who have diagnosed or possible autism and there are concerns about their sexual behaviours. The survey is looking at numbers; age; gender; types of sexual behaviours and what assessment models are currently being used. This survey should take no more than 20 minutes.

If you feel that you have more in-depth information that you wish to discuss on the cases and with regard to the challenges and gaps in practice around this issue, and what works well, then the second stage is to arrange an interview. This can be done at the end of the survey by indicating your interest and providing your email address. I will then contact you to arrange a time for the interview. In terms of timing, I anticipate that most interviews will be approximately one hour. The interview with you would be on an entirely voluntary basis, you are free to withdraw consent at any time during the time of the data collection, up to the point of data anonymisation. There will be no adverse consequences for choosing to withdraw.

The participation of other colleagues

In order to reach the widest range of professionals possible, it would assist the research, if as well as completing this survey yourself you could pass this email, with the attached information sheet and electronic survey to your colleagues who you feel may be interested in becoming involved. Please make it clear to them that they do

not have to participate in the survey and there is no adverse consequence for them if they choose not to participate.

What will be done with the information from the surveys?

The information from the surveys will be collated to draw out general themes from practice, to inform the development of the Practice Guidance and to contribute to the academic research knowledge base. All information will be anonymised; this is not an evaluation of any individual or agency's practice and no reference will be made to any individual or agency.

Any information relating to the young people you have worked with will be kept anonymised but may be used to illustrate some of the themes, or to contribute to the academic research base about the types of sexual behaviours displayed. The information will also be published in the form of a Doctoral thesis as part of my PhD and a copy will be held in the library of Queen's University Belfast.

The information will be kept confidentially and securely on the Queen's University Network Server in an electronic medium and will be password protected. In line with Queen's University Policies on data retention, the data will be stored securely by Queen's University for at least 5 years after the end of the research project, after which it will be securely destroyed.

Risks and Rewards of Involvement

The reward of being involved in the research is to be part of an attempt to address a very real practice issue, which has been raised by practitioners like yourself. The information from the surveys will support the more detailed information from the interviews which will contribute to the development of the Practice Guidance and increase the professional and academic knowledge base on this subject.

The risks are minimal and relate primarily to data sharing which has been addressed through the coding, anonymising of the contributions and the collation of general themes therefore no individual or agency would be at risk of having their own practice challenged. The risks to the individual young people will be managed through anonymising the case material and I will have no access to their records.

So, what happens next?
If you are interested in being involved with this research then complete the attached survey and send it back to me at ccarson24@qub.ac.uk, if you are also interested in being interviewed, then provide your email address at the end of the survey and I will arrange a time for an interview.If you have any concerns about this survey or research then please contact my supervisor Dr Lisa Bunting at lbunting@qub.ac.uk

I look forward to hearing from you, Carol Carson, Research PhD student,Queen's University Belfast

Participant Information Sheet – Interviews

Autism and Harmful Sexual Behaviours (HSB): Developing good practice

My name is Carol Carson and I am a research PhD student at Queen's University Belfast. The purpose of my research is to develop and pilot Practice Guidance on Autism and HSB to meet an identified practice need. The research will combine areas of research and practice in relation to autism and harmful sexual behaviours (HSB) [Harmful sexual behaviours is the umbrella term for a range of sexual behaviours which cause concern from those which may originate from a lack of understanding of what is appropriate, to those which would be considered illegal, such as rape and sexual assault]. The research will contribute to the academic body of knowledge as well as support the development of practice in this area of work.

Ethical approval

This research has been ethically approved by the Research Ethics Committee, School of Social Sciences, Education & Social Work, Queen's University Belfast.

Your participation

Thank you for your interest in being involved with this research, completing the survey and registering your interest in being interviewed in more detail. In terms of time, I anticipate that most interviews will last approximately one hour and will be conducted either via a Zoom meeting or by telephone. The interview with you is on an entirely voluntary basis, you are free to withdraw consent at any time during the time of the data collection, up to the point of data anonymisation. There will be no adverse consequences for choosing to withdraw.

The interviews will go into more depth on the information raised in the surveys, on both your own responses and also the general themes emerging. I am aiming to get your perspective as a practitioner on the young people you work with, the behaviours they display; the challenges you experience in working with them, and any good practice you have developed.

What will be done with the information from the interviews?

With your permission, the interview will be audio recorded to facilitate the transcribing of the interview to ensure that I have understood what you are saying. Following transcription, the audio tape will be destroyed and the transcriptions stored securely for a minimum of 5 years at Queen's University Belfast.

The information from the interviews and surveys will be anonymised and interviews will be allocated a code, so no individual can be identified. The information will be collated to draw out general themes from practice, to inform the development of the Practice Guidance and to contribute to the academic research knowledge base. This is not an evaluation of any individual or agency's practice and no reference will be made to any individual or agency.

Any information relating to the young people you have worked with will be kept confidential and anonymised but may be used to illustrate some of the themes, or to contribute to the academic research base about the types of sexual behaviours displayed.

The information will also be published in the form of a Doctoral thesis as part of my PhD and a copy will be held in the library of Queen's University Belfast. The information will be kept confidentially and securely on the Queen's University Network Server in an electronic medium and will be password protected. In line with Queen's University Policies on data retention, the data will be stored securely by Queen's University for at least 5 years after the end of the research project, after which it will be securely destroyed.

Safeguarding

It is anticipated that the young people discussed in the interview will already be known to statutory agencies due to concerns about their sexual behaviour or allegations that they have committed a sexual offence. In some cases, the background and welfare of these young people may already be known to statutory agencies. However, if you raise with me in the interview new information re safeguarding or sexual concerns/ offences that are not already known, then you will be advised to share that information with the relevant authorities.

Risks and Rewards of Involvement

The reward of being involved in the research is to be part of an attempt to address a very real practice issue, which has been raised by practitioners like yourself. It provides an opportunity for you to talk about the challenges posed by trying to understand and manage these young people's sexual behaviour, as well as to share any good practice you may have developed to help to shape the Practice Guidance.

The risks are minimal and relate primarily to data sharing and these have been addressed through the coding, anonymising of the contributions and the collation of general themes rather than individual practice, therefore no individual or agency would be at risk of having their own practice challenged. The risks to the individual young people will be managed through anonymising the case material and I will have no access to their records.

So, what happens next?
If you are still interested in being interviewed, then please contact me at ccarson24@qub.ac.uk and I will arrange a time for an interview. If you have any concerns prior to or during the interview then please contact my supervisor Dr Lisa Bunting at lbunting@qub.ac.uk. I look forward to hearing from you
Carol Carson, Research PhD student, Queen's University Belfast

Consent Form – Interviews

I have read the attached information letter which explains what this research is about.

I understand that I am being asked for my permission to be interviewed about my experience as a practitioner working with young people with autism, either diagnosed or possible, where there are concerns about sexual behaviours, so that the researcher can develop Practice Guidance to support the development of good professional practice.

I understand that the interview will be audio-recorded and used to transcribe the interview. Only the researcher will hear the audio tape and following the transcriptions this will be destroyed. The transcriptions will be stored securely for a minimum of 5 years at Queen's University Belfast.

I understand that all the information gathered will be kept confidential and will be collated for the broad practice themes. My own practice and that of my agency will not be identified.

I understand that my involvement in the interview process is voluntary and that I am free to withdraw my consent at any time, during the time of the data collection, up to the point of data anonymisation.

I understand that this research will be published in the form of a Doctoral Thesis as part of a PhD and a copy will be held in the library at Queen's University Belfast.

I understand that the Research Ethics Committee, School of Social Sciences, Education and Social Work at Queen's University Belfast has given ethical approval for this research.

Please sign below to indicate that you agree to being interviewed by the researcher as part of this research.

Signature: Date:
(Name)

Appendix Five – Example of the Questions for electronic survey

Introduction
Thank you for agreeing to complete this survey. The research is looking developing an assessment model of young people on the autistic spectrum who are displaying sexual behaviour problems. It will be based on the practice experience of professionals who are working with these young people. This survey is seeking to understand the numbers of young people who are coming the attention of professionals, their age and gender; the types of sexual behaviour they are displaying; the risk assessment models currently used and who undertakes these assessments.

In order to reach the widest range of professionals possible, **it would assist the research if as well as completing this survey yourself, you could also pass this survey onto your colleagues** who you feel may be interested in becoming involved.

About your professional experience
1. In what professional area do you currently work with children and young people? (for example, education, social services, specialist HSB service, youth justice, psychology etc)

2. How many years have you been working with children and young people
0 -5 6 -10 11 -15 16 +

3. To what extent does your current role involve working with children and young people with concerning sexual behaviours
Occasionally A Lot Primarily

4. How may years' experience do you have in working with children and young people with concerning sexual behaviours?
0 -5 6 -10 11 -15 16 +

5. As part of your total caseload, in the past year, how many children and young people would you estimate you have worked with?

6. Of these, what number have involved concerns about harmful sexual behaviour?

About the children and young people you are working with

7. The young people you are working with may not have a clinical diagnosis of autism, but you may have concerns that they have significant autistic behavioural traits. Of the cases were there were concerns about harmful sexual behaviour how many have involved young people with diagnosed or possible autism?0

	Number
Diagnosed:	
Suspected:	

8. Please provide case details for each of the young people who were **diagnosed** as having autism. (if there are more than 5 cases, you can insert additional rows by clicking the + button at the end of the table)

Gender	Age	Briefly describe what type of sexual behaviour did the individual display, what did they do or say?	Was a sexual behaviour risk assessment undertaken?	Who completed the assessment	What sexual behaviour risk assessment model was used?

9. Please provide case details for each of the young people who were **possibly** autistic. (if there are more than 5 cases, you can insert additional rows by clicking the + button at the end of the table)

Gender	Age	Briefly describe what type of sexual behaviour did the individual display, what did they do or say?	Was a sexual behaviour risk assessment undertaken?	Who completed the assessment	What sexual behaviour risk assessment model was used?

About autism and HSB practice

10. What are the challenges for you as a practitioner in understanding and managing children and young people with diagnosed or possible autism, who display harmful sexual behaviours?

11. In your experience, what works with children and young people with diagnosed or possible autism, in relation to the development of their sexual knowledge, understanding and behaviours?

Further involvement in the research

12. Would you be interested in being interviewed to discuss your practice experience in more detail?

13. If yes, could you please enter your email address and I will be in contact

Appendix Six – Semi-Structured Interview Schedule

Introduction – thank you for agreeing to be interviewed today about your experience of working with young people on the autistic spectrum where there are concerns about their sexual behaviour. I would like to go over some of the information you gave in the survey and ask you to expand on this and to look at challenges in this work; the associated gaps in knowledge, guidance, assessments and interventions and what do you find works with these young people.

As stated in the information sheet, all the information you give me will be anonymised and kept confidential. Only the broad themes about practice will be drawn from the information and no individual or agency's practice will be highlighted. If there are anonymised case examples which may be used to enhance the professional knowledge base, then permission to use these case examples will be sought.

1. My first question is about your professional background to put your comments in the context of your profession.

a) How long have you been working / What roles have you had?
b) Where do you work now?
c) Have you experienced working with young people on the autistic spectrum where there are concerns about their sexual behaviour, only in this post, or have you also experienced it in other posts as well?

2. Referring to your survey responses, you noted that there are x individuals about whom you had concerns.

a) Can you talk me through each of these cases in more detail but anonymised.
b) If the young person was not diagnosed as being on the autistic spectrum, what made you think they had autistic characteristics but undiagnosed?

3. What were the challenges for you in understanding and managing the work with the young person?

4. How did you overcome these?

5. What do you perceive the gaps to be in the knowledge base on concerning sexual behaviours and ASD? What do we not know enough about?

6. What guidance would you want with regard to:
a) Assessments
b) Interventions

7. What works with regard to interventions with these young people re:
a) Their general understanding and social and relationship behaviours
b) Their sexual knowledge, understanding and behaviours

Appendix Seven - Information sheets for Peer Review and Pilot processes

1. Information sheet for potential Peer Review Group member from the Autistic community

Research on Autism and Harmful Sexual Behaviours (HSB)

Introduction

My name is Carol Carson I am undertaking a research PhD at Queen's University Belfast. and I am the Director of one of the leading UK/International charities supporting professionals in learning how to understand and work with children and young people who have harmful sexual behaviours (HSB), including those who commit sexual offences and who are in the criminal justice system.

Over the last few years, I have been increasingly asked by professionals about children and young people who are either diagnosed with autism or have autistic traits and harmful sexual behaviours. I have been unable to find any practice guidance which might help them. My concern is that if professionals lack awareness of what to consider when working with a child or adolescent with autism, then they may end up making uninformed and disproportionate decisions about them, which will affect that child/adolescent, their lives and their families. It is vital to get a fair balance between under and over reactions to the behaviour.

My research PhD at Queen's University Belfast is to develop good practice guidance on Autism and HSB, with regard to both assessments and interventions, in order to have more informed and proportionate outcomes for children and young people. Ethical approval from Queen's University Belfast, Social Sciences, Education & Social Work Department's School Research Ethics Committee has been granted and can be provided on request.

Practice Guidance

The practice guidance will have several parts:

Introduction – Introduction to how the guidance can be used

Understanding – This provides an overview of an understanding of autism and how individuals might function as well as information from research and practice on why children and adolescents with autism or with autistic traits might act out sexually including harming other people.

Preparation – This gives guidance to professionals on how to prepare for the work and what might be different from their usual practice

Assessment - This takes the established adolescent assessment model called AIM3 (Leonard and Hackett, 2019) and goes through each part, highlighting what professionals may need to think about differently when working with an adolescent with diagnosed or possible autism.

Intervention – This will include work with the child/ adolescent as well as with their families and will detail good practice already taking place.

Request for your involvement

I have been working with professionals who are experienced in working with HSB but I need guidance from someone from the autistic community or with experience in working with children and adolescents with autism, to make sure that what I am writing about autism is accurate and that I have not overlooked something that should have been included. Therefore, I would like to invite someone to join my Peer Review Group to provide me with this insight and guidance.

I am conscious that the subject matter of the guidance, which is frank, open and direct about all aspects of sexual behaviour, is sensitive and difficult for some people and therefore completely understand that involvement with the research will not be suitable or comfortable for everyone. I am happy to have an online meeting with any interested people to explain further what it might involve in terms of their time but also in terms of the content and there can be options to be involved in some parts of the guidance and not others.

What would it involve?

The Peer Review Group is a small group of 'critical' friends, some of whom are HSB specialists and is where I feel the autism perspective is missing. The group would peer review the first and second drafts of the Practice Guidance, which will then go onto be piloted by a group of HSB specialist services.

The peer review would identify gaps, areas lacking clarity or areas which address the need particularly well and provide a check and balance on any researcher bias. This involves reading the guidance and giving individual feedback at each stage and if necessary to be involved in a group discussion with other members of the Peer Review Group on points raised.

The timeframe for this is:

Briefing session – this will be to provide information on HSB and the AIM3 model which will be adapted to be appropriate for use with autistic adolescents

May 2022 **1st draft** – to be available by beginning of May 2022, with potentially three weeks for peer review

June 2022 **2nd draft** – following amendments made, to be available by early June 2022 with two weeks for peer review as the material will now be familiar and only an opinion on the amendments required.

I hope you find this information helpful to your decision about becoming involved with the research, but please contact me if you have any further questions or concerns.

[redacted]

Carol Carson -Director of The AIM Project, www.aimproject.org.uk
student Queen's University Belfast, ccarson24@qub.ac.uk

2. Information sheet for potential Peer Review Group member from the HSB community

Research on Autism and Harmful Sexual Behaviours

The purpose of this research PhD, at Queen's University Belfast, is to develop good practice guidance on autism and harmful sexual behaviours (HSB), both on assessments and interventions, in order to have more informed and proportionate outcomes for children and young people diagnosed or with autistic type characteristics. The need for such guidance has been raised by practitioners in frontline agencies and by specialist services in HSB, due to the ongoing rise in numbers on their caseloads of children and young people diagnosed autistic or with possible autistic type characteristics.

The Practice Guidance will have several parts covering both assessments and intervention. AIM3 (Leonard and Hackett, 2019) will be used as the core model with the autism guidance 'layered' onto the AIM3 model highlighting similarities and differences with the neurotypical population and differences required in interpretation and analysis

The research is using an action research framework to enable practitioners to be involved in the development of the good practice guidance through a series of cycles of development and reflection. This will be achieved by the establishment of a small Peer Review Group acting as 'critical friends' re the development of the guidance and through piloting the draft Practice Guidance with a Pilot Group of HSB specialist services experienced in HSB work and the use of AIM3 who would review its use in practice and its impact on their own understanding and practice.

The research will not involve any direct contact with young people or their families nor require any access to confidential information from agency files. Themes for practice will be drawn from discussions with the Peer Review Group and the Pilot group. Ethical approval from Queen's University Belfast, Social Sciences, Education & Social Work Department's School Research Ethics Committee has been granted and can be provided on request.

Request for your involvement

I would like to ask you to be involved with the Peer Review Group, which would involve peer reviewing the first and second drafts of the Practice Guidance.

The peer review would identify gaps, areas lacking clarity or areas which address the need particularly well. Also, the group would provide a check and balance on any researcher bias. This involves reading the guidance and giving individual feedback at each stage and where necessary to be involved in a group discussion with other members of the Peer Review Group on points raised.

The timeframe for this is:

May 2022 **1st draft** – to be available by beginning of May 2022, with potentially three weeks for peer review

June 2022 **2nd draft** – following amendments made, to be available by early June 2022 with two weeks for peer review as the material will now be familiar and only an opinion on the amendments required.

Confidentiality

All information from the research will be kept confidentially and securely on the Queen's University Network Server in an electronic medium and will be password protected. In line with Queen's University Policies on data retention, the data will be stored securely by Queen's University for at least 5 years after the end of the research project, after which it will be securely destroyed.

I hope you find this information helpful to your decision about becoming involved with the research, but please contact me if you have any further questions or concerns.

Carol Carson ccarson24@qub.ac.uk
Research PhD student
Queen's University Belfast

3. Information sheet for agencies on involvement in the Pilot

Research on Autism and Harmful Sexual Behaviours

Introduction

I am undertaking a research PhD at Queen's University Belfast, the purpose of which is to develop good practice guidance on autism and harmful sexual behaviours (HSB), both on assessments and interventions, in order to have more informed and proportionate outcomes for children and young people diagnosed autism or possible autistic type characteristics. The need for such guidance has been raised by practitioners in frontline agencies and by specialist services due to the ongoing rise in numbers of autistic children and young people on their caseloads.

My research is using an action research framework to enable practitioners to be involved in the development of the Practice Guidance, through a series of cycles of development and reflection. This will be achieved by the establishment of a small Peer Review Group acting as 'critical friends' re the development of the Practice Guidance and by then piloting the draft guidance with a Pilot Group of individuals and teams experienced in HSB work and in the use of AIM3 (Leonard and Hackett, 2019) (the established adolescent assessment model in the UK). The purpose of the pilot would be to review the use of the Practice Guidance in practice and its impact on the worker's own understanding and practice.

The research will not involve any direct contact with young people or their families nor require any access to confidential information from agency files and will not involve service users in clinical trials. Themes for practice will be drawn from discussions with the Peer Review Group and the Pilot Group. Ethical approval from Queen's University Belfast, Social Sciences, Education & Social Work Department's School Research Ethics Committee has been granted and a copy of the approval is provided with this request.

Request for the involvement of members of your agency/service

I would like to request involvement from members of your agency/service to be part of the Pilot Group piloting the draft Practice Guidance, due to their experience in working with autism and harmful sexual behaviours (HSB). The benefit for the team's practice are:

- They would receive a briefing on the most up to date information on autism and HSB and how to use the guidance.
- They would be embedding the learning from the briefing in the practical application of the draft Practice Guidance in the pilot phase
- They would be contributing to the development of the Practice Guidance which is a significant practice need identified both by them and by other frontline practitioners,

Timeframe and what it would entail

July to Sept 2022

- Briefing session on up to date information on autism and HSB and use of the Practice Guidance

- Piloting of the Practice Guidance by some or all of the following three options:

a) A fictional case example as the minimum requirement if there are no other cases available in the time frame
b) Retrospective application of the guidance to previous AIM3 assessments to check similarities and differences with their original understanding and decision making. The original assessment would remain as the valid assessment as the autism guidance is untested.

c) On a new case in that time period it would be used in a shadow capacity only, i.e., an AIM3 would be completed as normal and used for any decision making as the autism guidance is untested. Then the team would discuss if the autism guidance would have made any difference to their analysis or decision making.

Feedback
Feedback will be taken in the following ways

a) return of the Fictional case study analysis and outcome if used

b) Feedback through a brief questionnaire on what impact, if any, did the use of the Practice Guidance on retrospective or current cases, have on their analysis and decision making and outcomes for the assessment and intervention

c) Feedback through a brief individual questionnaire on the validity of the Practice Guidance and impact on their own understanding and practice.

Confidentiality

All information from the research will be kept confidentially and securely on the Queen's University Network Server in an electronic medium and will be password protected. In line with Queen's University Policies on data retention, the data will be stored securely by Queen's University for at least 5 years after the end of the research project, after which it will be securely destroyed.

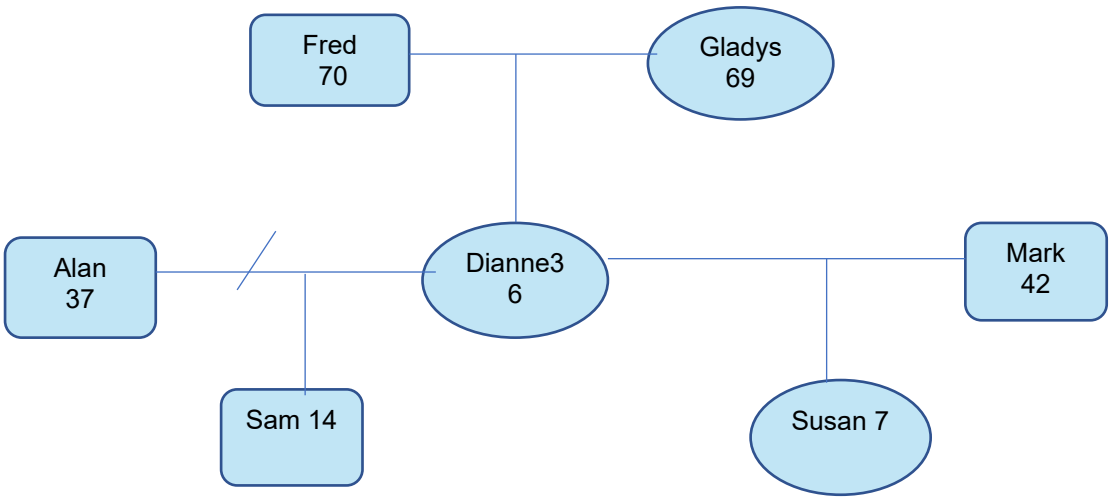
I hope you find this information helpful to your decision about your agency/service becoming involved with the research, but please contact me if you have any further questions or concerns.

Carol Carson ccarson24@qub.ac.uk
Research PhD student
Queen's University Belfast

Appendix Eight – Fictional Case Study Documents

Autism and HSB Case Study - Sam an autistic adolescent aged 14 years

Family Tree



1. Referral Information – Sexual Behaviour - (See also Pattern Mapping example attached)

Sam was referred because of a range of concerns about his sexual behaviour, with the most recent being 3 episodes of sexual assault of his younger half-sister over a four-month period, which was reported one month ago. On the 1st and 2nd occasions he came into her room at night and asked her if he could sleep with her and then asked her to touch his penis, when she said no, he then rubbed his penis against her and 'pretended' he was tickling her with it. On the final occasion he asked her permission to put his penis between her legs, there was no attempt at penetration, but he rubbed himself between her legs to the point of ejaculation. His sister did not give her permission, she was shocked and confused, so said nothing. She is said to be a bit wary of Sam as he is physically much bigger than her and over the last two years, has been verbally and physically aggressive to her, including pinching her.

She told her mother, who initially tried to manage the situation herself, by telling Sam he was wrong and not to go into his sister's bedroom at night. Susan remained scared and told her father, who reported Sam to the Police and told him to move out. Sam is now living with his maternal grandparents Fred and Gladys, who are elderly and do not know what to make of all this.
Concerns about Sam's sexual behaviour have been ongoing from Primary School, where at the age of 6 years it was recorded that he was using sexualised language. It was believed that his father watched a lot of porn and was not boundaried in what Sam was able to see. His mother asked his father to leave home and then worked with school to set boundaries for Sam and the behaviour subsided.

There are also records of concerns about Sam in Secondary School. Since he was 13 years old, intermittently he would say graphic sexual things to peers and teachers, some of which included that he wanted to rape women. His mother said he was also saying things in the street and in shops to random adults and she was becoming more worried about taking him out. Sam can be aggressive if frustrated and can physically lash out but he has never been sanctioned for this at school. The trigger for most of these seemed to be when Sam felt emotionally overloaded, either positively or negatively. The Head of Pastoral Care worked with Sam and his mother on appropriate boundaries about what to say in conversations, which seemed to work for a while, then there would be another episode.

About six months ago, there was a complaint about Sam harassing a peer aged female pupil in school. He said she was his girlfriend and kept invading her personal space, mainly trying to stroke her hair. The girl was not interested in him at all and complained that he was harassing her and making her uncomfortable. When questioned about this he was angry and told the Head of Pastoral Care that he was going to rape the girl as she was lying, that they were boyfriend and girlfriend.

With the recent allegations against his half-sister as well as harassment and the previous concerns, the Head of Pastoral Care felt that Sam's needs would be better met in a specialist setting, so he has been out of education for a month, waiting for a suitable provision. He spends most of his time online or with his grandparents.

He has been engaging with the workers in the assessment, who have noted that when describing what sexual imagery he watches, he tells them in great detail and appears to become aroused when talking about it, he does not appear aroused when talking about what he did to his half-sister.

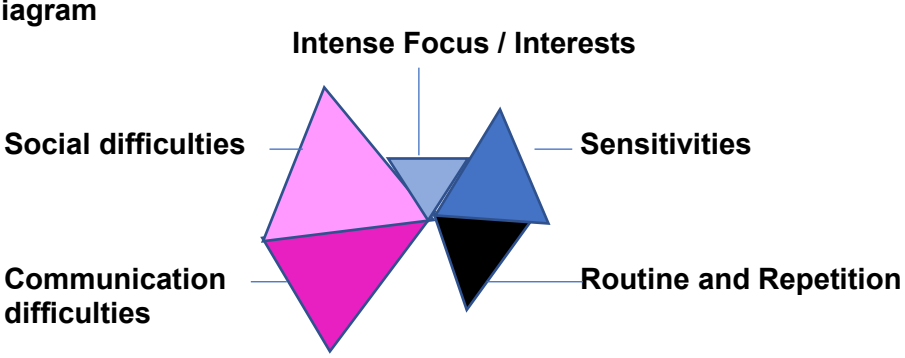
Current Safety Plan

- Sam is to live with his grandparents until at least the assessment is completed
- Sam can go and see his mother two evenings per week, when Mark, his stepfather takes Susan to visit his parents, as Susan has said she is frightened of him and does not want to see him
- An appropriate education provision to be found
- Sam's use of the internet is to be monitored by his grandparents and mother
- Sam does not have a mobile phone and should not be given one.

2. Autism Diagnosis

Sam received a diagnosis of autism when he was 5 years old, although his mother had concerns from when he was about 18 months old. He also has co-existing conditions of executive function problems, ADHD and anxiety.

GAO diagram



Communication difficulties

This is the most evident feature of Sam's autism. He has difficulties with turn taking in conversations and is not always aware of his impact on others and possible consequences for what he has said. He also has challenges with processing nonverbal communications such as body language, tone of voice, facial expressions.

Sam has above average intelligence but needs time to process information and has difficulties understanding communications which are multi-layered and potentially contradictory, such as jokes or flirtation. He also tends to take conversations literally. This makes him slow to respond to peers in conversation, or to give odd responses which they were not expecting.

Social Difficulties

Sam lacks awareness of how he appears to others in social situations. He knows he thought odd by his peers but is not clear why. He does try to engage with them at school - he has no known friends outside of school - and there is evidence of him 'masking' and trying to get involved by repeating graphic and violent sexual language he has heard online when his peer group have been talking about sex. This has led to some of the complaints at Secondary School.

He finds social communication online much easier, as people there share his interests in stamps and he can control the amount of time he spends on social interactions. He does not have good skills in distinguishing fact from fiction, so his online access to sexual imagery is of concern.

He went through puberty at 13 years old, a little later than his peers. He told his Head of Pastoral care, when asked about the allegation of harassment, that he feels that everyone else knows what to do if they fancy someone or want to have sex, but he is confused. He keeps being told he has got it wrong but he is not sure why.

After the harassment allegation, the Head of Pastoral care had asked for a specific sex and relationship education programme for him and he seemed to take on board issues of consent and checking out if the other person was interested in engaging in romantic or sexual activity with him. The episodes with his sister indicate some of this learning but not applied in an appropriate context.

Routine and repetition

This is not a particular area of difficulty for Sam, he struggles with changes but can cope if he is prepared well by adults and he has some good resilience skills that help. He has struggled with puberty and his sexual development both in understanding what was happening to his body and thoughts and also because he was a late developer and this meant he was out of sync with his peers in relation an increased interest in relationships and sexual activity. The messages he received about sexual imagery from when he was 6 years old, was that it was bad and 'dirty', yet all his peers want to talk about it.

His 'stimming' habits which help him regulate strong positive and negative emotions are mainly a low humming noise and waggling his fingers. He finds spinners helpful when he needs to concentrate.

Sensitivities

Sam finds some environments difficult to manage, particularly classrooms with florescent lights or areas with large groups of pupils, like the dining hall and assemblies. The school have worked hard to support him by arranging a timetable for him which means that he is in the newer part of the school most of the time with larger, day lit classrooms. He has pack lunches but this means that he has less opportunities to socialise with peers.

He struggles with light touches, finding they make him quite nauseous. His preference is for deep pressure touch, which has also been a feature in his sexual development, when he feels the need for pressure when masturbating. His experimentation with rubbing his penis against or between something has led to his most satisfying ejaculations.

Intense focus/ Interests

Sam does not have particular difficulties with intense focus or interests. His hobby is stamp collecting and he is very knowledgeable about the subject. He can talk at length if asked about it but he is able to talk about other things as well, or to be diverted from this subject.

Co-existing Conditions

Sam has additional difficulties with ADHD and Executive function. This affects his ability to concentrate for long periods of time and he can be forgetful of things he has already learned without being prompted. He can sometimes find it difficult to fully understand context when applying rules and transferring learning from one situation

to another and needs to have this clearly spelt out for him. He has some planning skills but his memory sometimes lets him down so his plans do not always work out which causes him and the adults around him some frustration.

He was doing well academically at school, but this had deteriorated over the last year. His Head of Year felt that the social aspects of school and peer group activities were causing him anxiety and that was affecting his learning, so he referred him to the school counsellor, who developed a good relationship with Sam. Sam talked to him about feeling depressed, anxious and socially isolated. He tried to keep up with his peers by using sexual language and was surprised when he got into trouble for this, as his perception was that all his peers talk about sex, all the time.

3. Background Details

Sam's parents, Alan and Dianne split up when he was 6 years old. There had been tensions in their relationship since Sam was 4 years old, due to Alan having an industrial accident which made it difficult for him to find other work, leaving Dianne as the family's main earner. Alan's mental health deteriorated and he was prescribed anti-depressants by his GP. He began to drink heavily and to spend most of his days watching porn on TV even though Sam was in the room; he believed Sam was too young to understand. When Sam aged 6 years began to use sexual language in school, Dianne asked Alan to leave the home.

She met Mark a few months later and quickly became pregnant with Susan. Mark then moved in with Dianne, Sam and the baby and has lived with them ever since. Mark has been a stable influence in Sam's life and he and Dianne have a good relationship. Sam appears to resent his half-sister and often shouts at her, more recently he has been pinching her when annoyed, causing problems with Mark. Mark is currently angry about the abuse of Susan and needed Sam to leave the family home. He protects Susan by taking her out when Sam visits Dianne. He was angry with Dianne for not telling him when she knew and feels she is always making excuses for Sam because of his autism. Dianne feels that he might become more involved with Sam again once he has calmed down.

Dianne struggled with Sam's diagnosis and can be a little overprotective of him, particularly since he has become an adolescent. She has been very responsive each time the school had contacted her about their concerns and tried to implement the work suggested. She was very worried after the harassment allegation that Sam would get into trouble again but she was extremely shocked to find out about Susan as she had never considered that it would happen in her family home. Her initial instincts were to support and protect Sam and hoped that setting boundaries for him would be enough but when Mark said he had to leave the family home, she agreed to protect her daughter. She felt Sam would be safe and protected by her parents, until the situation could get resolved.

Dianne and Mark both have a supportive network of parents, family and friends, but feel ashamed to tell many people at the moment, so only their parents know. They have told friends and other family members that there is a difficult relationship between Mark and Sam at the moment, so they are having some time apart.

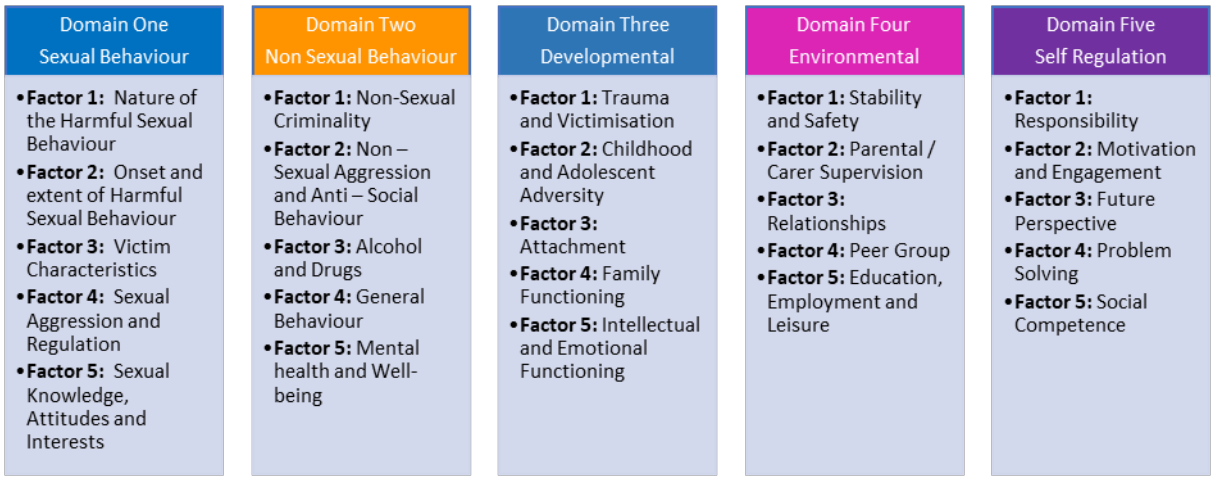
Pattern Mapping for Sam

Life Events	**Sexual Behaviours**
0 years Born to Dianne and Alan	
4 years Alan loses job, family tension, depression, watching porn with Sam present	
5 years Sam diagnosed as autistic	
6 years Parents split up and Alan leaves the family home	**6 years** Sam using sexual lang and making sexual gestures at primary school to other pupils and teachers. Behaviour reduces after work by mum and school
7 years Dianne meets Mark, pregnant with Susan. Mark moves in. Susan born. Sam not happy with the new baby in the house	
13 years Sam goes through puberty, watching online porn, including violent porn	
13- 14 years Sam shouting at Susan and has pinched her on several occasions, she is wary of him	**13 – 14 years** Intermittent incidents of graphic and violent sexual language to peers and teachers, including expressing he would like to rape women. Mum again works with school
14 years	**14 years** **March** - Allegation of harassment of peer aged female pupil. Sam given programme of work on consent and relationships **May – July** - 3 incidents with his half-sister Susan, asking permission for sexual acts but not acknowledging that she was not consenting
August - Sam moves to his maternal grandparents following the allegation about his half-sister. He is out of school, waiting for more 'suitable' provision. He misses his school, Head of Year and school counsellor	**August** – incidents with sister become known

Appendix Nine – Brief Overview of the AIM3 Model (Leonard and Hackett, 2019)

Rather than seeing risk as a one-dimensional characteristic, analysis of key issues within each of the five areas outlined below, called Domains in the model, promotes an understanding of areas of relative strength and areas of relative need across the young person's overall situation and presentation. The five Domains are inter-related and multiply influenced. AIM3 encourages practitioners to develop an overall profile of the young person across these five Domains, so that the HSB is considered, not in isolation from other elements of the young person's life, but within the context of the young person's wider development and functioning.

The Domains are broad in scope and so are further broken down into five Factors (as depicted below) that considered together, assist the assessment of the Domain as a whole.



Scoring of the AIM3 Assessment model

Each Domain has five Factors, each of which is scored. The items which support the analysis of the Factors are not individually scored but guide the practitioner to the types of information they need to gather or questions to ask in order to analyse the Factor. The purpose of the scores is to enable the development of a graph as a visual representation of the young person in their entire context, where the concerns are and what strengths are available to build upon in the interventions. It is designed to support the development of safety plans and interventions.

AIM 3 uses a consistent scoring frame for all the Factors across the model

(4) indicating a significant concern in the factor

(2) identifying some concern

(0) indicating there is no general concern within this factor/or (where appropriate to the factor concerned) that the factor represents an area of strength

The scores for each of the Factors are added to comprise an overall score for each Domain, leading to an overall profile analysis of the young person's situation which is represented by a visual graph, highlighting specific needs and strengths both within and between each of the Domains.

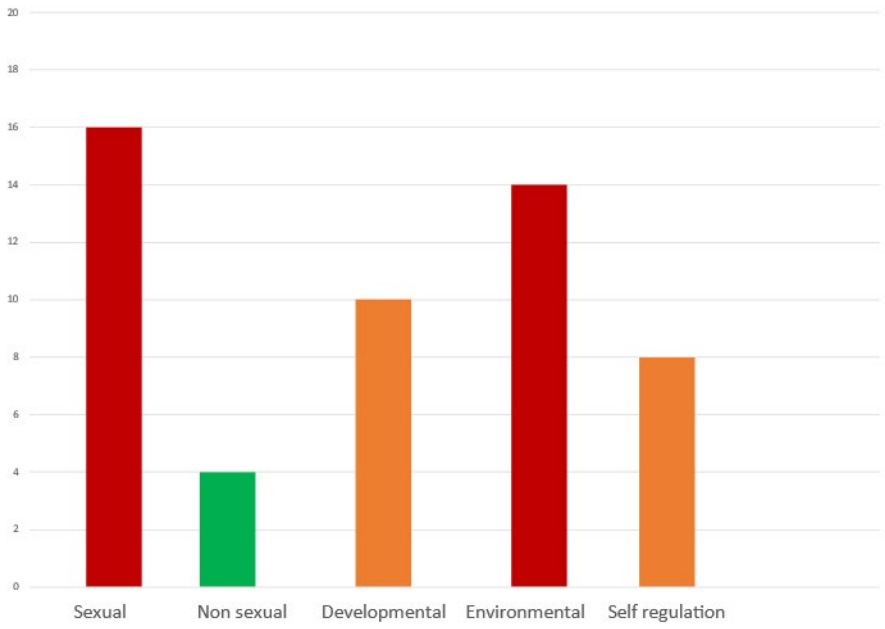
Domain can be considered against three indicative bands:

- **a 'red' band** (a score of 14-20) which may indicate an area of relative need or risk requiring specific or immediate action

- **an 'amber' band** (a score of 6-12) which may indicate work is required to lower risk and meet needs

- **a 'green' band** (a score of 0-4) which may indicate an area of relative strength in the young person's background

An example of a completed graph is given below



Appendix Ten – Comparison of Fictional Case Study Responses

NB: This was a short fictional case study, so there was likely to be some variance in the analysis, but overall apart from Domain Four, there was a strong degree of consensus. The scores for each Domain are out of 20, with each factor scored either zero, two or four – See Appendix Nine for more details. If participants are within 2 points of the composite score and have a good rationale that is acceptable; wide variance with the composite score would trigger the need for a review of the rationale.

	Composite score	Team 1	Team 2	Team 3			Team 4	Team 5		Team 6				Team 7	Team 8	Range
			Team effort	1 (J&L)	2 (EH)	3 (A)		1 (J&D)	2 (R&L)	1 (B)	2 (V)	3 (T)	4 (S)			
Domain One																
Factor 1	2	2	2	2	2	4	2	2	4	2	2	2	2	2	2	
Factor 2	2	4	2	2	2	4	2	2	2	2	2	2	2	4	4	
Factor 3	2	4	2	0	0	2	2	2	2	2	4	4	4	2	4	
Factor 4	2	2	2	2	0	2	2	2	2	2	0	2	2	2	2	
Factor 5	4	4	4	2	4	2	4	4	4	2	2	2	2	4	4	
Overall Score	12/20	12/20	12/20	8/20	8/20	14/20	12/20	12/20	14/20	10/20	12/20	12/20	12/20	14/20	16/20	7 matches, 4 in range, 3 out
Domain Two																
Factor 1	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	
Factor 2	2	4	2	2	0	2	0	0	2	2	2	0	2	2	2	
Factor 3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Factor 4	2	2	2	2	2	2	2	2	2	2	2	2	0	2	4	
Factor 5	2	2	2	2	2	2	4	2	4	2	2	2	2	4	4	
Overall Score	6/20	10/20	6/20	6/20	4/20	6/20	6/20	4/20	8/20	6/10	6/10	4/20	4/20	10/2	12/20	7 matches, 5 in range, 2 out

Domain Three															
Factor 1	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**0**	**2**	**0**	**0**	**2**	**0**	
Factor 2	**2**	**2**	**2**	**0**	**0**	**0**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	
Factor 3	**0**	**2**	**0**	**0**	**0**	**2**	**2**	**0**	**2**	**0**	**0**	**2**	**2**	**2**	**0**	
Factor 4	**0**	**2**	**2**	**0**	**2**	**0**	**0**	**2**	**2**	**0**	**0**	**2**	**0**		**2**	
Factor 5	**2**	**4**	**2**	**4**	**2**	**2**	**2**	**2**	**4**	**4**	**2**	**4**	**2**	**4**	**4**	
Overall Score	**6/20**	**12/20**	**8/20**	**6/20**	**6/20**	**6/20**	**8/20**	**8/20**	**12/20**	**6/20**	**6/20**	**10/20**	**6/20**	**10/20**	**8/20**	**6 matches 4 in range 4 out**
Domain Four															
Factor 1	**0**	**2**	**0**	**0**	**2**	**0**	**2**	**0**	**2**	**2**	**2**	**2**	**0**	**2**	**4**	
Factor 2	**2**	**2**	**2**	**0**	**2**	**0**	**2**	**0**	**2**	**0**	**0**	**0**	**2**	**2**	**4**	
Factor 3	**2**	**4**	**0**	**0**	**2**	**0**	**2**	**2**	**2**	**0**	**2**	**2**	**0**	**4**	**2**	
Factor 4	**2**	**4**	**4**	**4**	**2**	**2**	**0**	**2**	**4**	**4**	**4**	**2**	**0**	**2**	**4**	
Factor 5	**4**	**2**	**4**	**2**	**2**	**2**	**0**	**2**	**4**	**2**	**4**	**2**	**0**	**2**	**4**	
Overall Score	**10/20**	**14/20**	**10/20**	**6/20**	**10/20**	**4/20**	**6/20**	**6/20**	**14/20**	**8/20**	**12/20**	**8/20**	**2/20**	**12/20**	**18/20**	**2 matches 4 in range 8 out**
Domain Five															
Factor 1	**4**	**2**	**2**	**2**	**2**	**0**	**2**	**2**	**2**	**0**	**2**	**2**	**4**	**4**	**2**	
Factor 2	**2**	**2**	**0**	**0**	**2**	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**2**	**2**	**2**	
Factor 3	**2**	**2**	**0**	**0**	**2**	**2**	**0**	**2**		**2**	**0**	**2**	**0**		**2**	
Factor	**2**	**4**	**4**	**2**	**4**	**2**	**2**	**4**	**4**	**4**	**2**	**2**	**4**	**4**	**4**	
Factor 5	**4**	**4**	**4**	**2**	**4**	**2**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	
Overall Score	**14/20**	**14/20**	**10/20**	**6/20**	**14/20**	**6/20**	**8/20**	**14/20**	**10/20**	**10/20**	**8/20**	**10/20**	**14/20**	**14/20**	**14/20**	**6 matches 8 out**