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1. Introduction

The purpose of this chapter is to provide a brief overview of Autism Spectrum Disorders (ASD) and sexuality, as there is a paucity of this information in the literature. Specific attention is given to sexuality involving the self, others, and interpersonal relationships. Problematic sexual behaviors, legal concerns, and sexual abuse (including victimization and perpetration) are also discussed. Finally, intervention strategies for ASD children, adults, and families are addressed. The overall aim of this chapter is to highlight major themes regarding Autism Spectrum Disorders and sexuality while contributing to the existing literature.

2. Autism overview

Autism Spectrum Disorders, as currently defined by the Diagnostic and Statistical Manual (DSM-IV-TR) criteria, include the diagnoses of Autistic Disorder, Asperger’s Disorder and Pervasive Developmental Disorder NOS. The three major diagnostic categories include the following: 1) language impairment, 2) social impairment, and 3) repetitive behaviors/restricted interests, with the impairments present prior to the age of three. Autism has been conceptualized under this diagnostic rubric as a spectrum of disorders with symptoms ranging from severe to minimally impaired [1]. With the advent of the DSM-5, only two major criteria will be included: 1) social communication impairment, and 2) repetitive behaviors/restricted interests.
The DSM-5 envisions autism as a unitary diagnosis with multiple levels of symptom severity impairing the ability to function [2]. The DSM-5 will use a system of three modifiers to signify level of severity: Level 1 is characterized for patients requiring support as they display difficulty initiating social situations and demonstrate atypical social responses. Rituals and repetitive behaviors cause significant interference for these individuals. They also resist redirection and attempts to be interrupted when involved in restricted interests or repetitive behaviors. Level 2 is characterized for patients “requiring substantial support,” as they have marked deficits in verbal and nonverbal social communication skills, which are apparent even with supports in place. They demonstrate limited ability to initiate social interaction and have a reduced or abnormal response to social overtures from others. Repetitive behaviors and restricted interests are obvious enough to be noticed by a casual observer. These patients become distressed or frustrated when they are interrupted or redirected. Level 3 is characterized for patients requiring very substantial support, as they have severe deficits in verbal and nonverbal social communication skills. Repetitive behaviors or rituals markedly interfere with functioning in all spheres. They demonstrate marked distress when routines are interrupted, and they are very difficult to redirect [2].

Proposed changes to the DSM-5 diagnostic criteria include the creation of a single broad autism spectrum disorder (ASD) diagnosis that encompasses current specific DSM-IV-TR diagnoses. Further, the proposed DSM-5 criteria reflect the tension between considering core symptoms from a dimensional perspective (i.e., symptoms are distributed in the population and patients are distinguished from unaffected persons by the severity of their symptoms), as opposed to the presence of discrete symptoms reflecting categorical distinctions between affected and unaffected persons [3]. A dimensional approach suggests that the core symptoms are quantitative traits which vary along a continuum and reflect the expression of, and interactions between, commonly occurring genetic variations and effects of environmental factors, whereas categorical approaches favor models attributing risk of illness to large effects of single genes, especially genes involved in brain development or maintenance of synaptic architecture [3]. In fact, the DSM-5 diagnostic criteria may be best represented by an empirically-derived hybrid model that merges the dimensional and categorical aspects of symptoms of autism (i.e., there are threshold values for numbers and severity of symptoms that define a categorical diagnosis of an ASD). From a biological perspective, although symptoms may be viewed along a continuum, the diagnosis of autism implies the altered, albeit subtle, architecture of the brain. The two core symptom domains of DSM-5, whose severity can vary along a continuum, were validated independently and include 1) impaired social communication and interaction (SCI), and 2) restricted, repetitive behavior (RRB) [3,4]. There is still work left to be done with respect to determining the number of criteria that must be satisfied in order to assign an ASD diagnosis. The DSM-5 criteria are clearly being shown as superior to the DSM-IV-TR criteria in terms of specificity. However, a balance must be struck between reducing “false positives,” which maximizes specificity, and assuring that criteria are sufficiently sensitive to capture ASD-affected persons that would benefit from intervention and services. This is an especially big concern among caregivers of persons that would have previously received a diagnosis of Asperger’s disorder and for children and adolescents with poor historical information about early-life symptoms (e.g.,
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Public intervention strategies should primarily focus on educating the community about the behaviors and traits common to persons with Autism Spectrum Disorders. Education has been shown to foster tolerance and understanding. In addition to this, education tends to spawn advocacy, thereby facilitating the needed changes in existing policies and law. In particular, advocates of those with ASD have the greatest opportunity to teach others about this population by modeling how best to support persons with ASD in the community.

Particular attention should be given to law enforcement, judicial systems and other populations that traditionally have minimal contact with individuals with ASD. Educational efforts should include a discussion of basic symptomatology, behavioral interventions and treatments. Efforts should also be made to dispel myths, misconceptions and assumptions about those with ASD. In addition, education should include information about potential risks to this population and the available programs and systems that are in place to provide protection for the ASD population.

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Public intervention strategies should primarily focus on educating the community about the behaviors and traits common to persons with Autism Spectrum Disorders. Education has been shown to foster tolerance and understanding. In addition to this, education tends to spawn advocacy, thereby facilitating the needed changes in existing policies and law. In particular, advocates of those with ASD have the greatest opportunity to teach others about this population by modeling how best to support persons with ASD in the community.

Particular attention should be given to law enforcement, judicial systems and other populations that traditionally have minimal contact with individuals with ASD. Educational efforts should include a discussion of basic symptomatology, behavioral interventions and treatments. Efforts should also be made to dispel myths, misconceptions and assumptions about those with ASD. In addition, education should include information about potential risks to this population and the available programs and systems that are in place to provide protection for the ASD population.

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Particular attention should be given to law enforcement, judicial systems and other populations that traditionally have minimal contact with individuals with ASD [7]. Educational efforts should include a discussion of basic symptomatology, behavioral interventions and treatments. Efforts should also be made to dispel myths, misconceptions and assumptions about those with ASD [58]. In addition, education should include information about potential risks to this population and the available programs and systems that are in place to provide protection for the ASD population [44].

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In summary, our literature review and ample experiences of the families in our clinical practice show that, while every person has the innate basis for developing sexuality in a multitude of expressions and experiences, individuals with disabilities (and especially individuals with an Autism Spectrum Disorder) most often require additional education and help to become able to express their sexuality in a socially appropriate way. While most neurotypically developing peers form intimate relationships beginning in adolescence and into adulthood, along a variety of experiences from dating to partnering in committed relationships, many individuals with an Autism Spectrum Disorder remain living with their family of origin into their adulthood and have significant difficulty navigating the social expectations surrounding relationships. Their difficulty may pertain to recognizing their own needs and wants, as well as to recognizing their partner’s wishes coupled with more inexperience than their peers in this arena. Individuals with ASD and their parents and caregivers frequently identify this difficulty when directly asked about it. Sexuality education in a supportive format that includes the individual’s family and their particular values and background will be most effective. Interventions need to be individualized with a long-range goal that matches the cognitive, social, and emotional developmental level of the person with ASD. As the prevalence of persons with ASD increases in our society, we are more than ever called to support their ability to mature into adults capable of functioning in all areas of life, including sexuality and intimacy.
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