Chapter 10
Cognitive Behavioural Therapy for Sexual Offenders With Autism Spectrum Disorders: A Case Study

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EXECUTIVE SUMMARY

The vast majority of individuals with autism do not commit sexual offenses. While there has been some suggestion of a tendency towards anti-social or offending behaviors, a propensity for breaking the law by those with a diagnosis of autism spectrum disorder has not been found in the research literature. However, the small number of individuals with autism spectrum disorder who do commit crimes appear to cover the full spectrum of offenses committed by offenders without autism spectrum disorder, including sexual offences, arson, violence, theft, terrorism, and manslaughter, although large scale studies suggest they tend to commit proportionately fewer property, driving, and drug offences. The purpose of this case study is to present the use of cognitive behavior therapy to therapeutically address the problem sexual behaviors of a young man with ASD.

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INTRODUCTION

The vast majority of individuals with autism spectrum disorder (ASD) do not commit criminal offenses. While there has been some suggestion of a tendency towards anti-social or offending behaviors (Howlin, 2004; Silva et al., 2004), a propensity for breaking the law by those with a diagnosis of ASD has not been found in the research literature. For example, Hippler et al. (2009) found no increased rate of criminal conviction among an Asperger's cohort of patients in comparison to the general population, and a systematic review by King and Murphy (2014) concluded that individuals with ASD are not disproportionately over-represented in the criminal justice system.

However, the small number of individuals with ASD who do commit crimes appear to cover the full spectrum of offenses committed by offenders without ASD, including sexual offenses (Griffin-Shelley, 2010), arson (Radley & Shaherbano, 2011), violence (Baron-Cohen, 1988), theft (Chen et al., 2003), terrorism (Faccini, 2010) and manslaughter (Murphy, 2010), although large scale studies suggest they tend to commit proportionately fewer property, driving, and drug offenses (King & Murphy, 2014).

Questions are often raised regarding the possible role that a diagnosis of ASD might play in the development or manifestation of offending behaviors, for instance in relation to a "special interests" or social naivety (Barry-Walsh & Mullen, 2003; Dein & Woodbury Smith, 2010; Howlin, 1997). In particular, there has been much discussion regarding the potential for the features of ASD to leave an individual vulnerable to committing a sexual offense due to low empathy, social communication and interaction difficulties, cognitive inflexibility, and special interests/obsessions that are sexual or deviant in nature (Griffin-Shelley, 2010; Higgs & Carter, 2015; Sutton et al., 2012). The purpose of this chapter is to present a case study on using cognitive behavioral therapy to address problematic sexual behaviors for a young man with ASD.

LITERATURE REVIEW

It has also been suggested that ASD symptomatology might potentially impact the achievement of positive outcomes following treatment for difficulties thought to underlie offending, including sexual offending (Melvin et al., 2017). Poor treatment outcomes for individuals with ASD who sexually offend have been identified in a number of case studies (Chan & Saluja, 2011; Kohen et al., 1998; Milton et al., 2002). Additionally, men with an ASD diagnosis who had completed the SOTSEC-ID program (an adapted sexual offender treatment programme for individuals with

intellectual and developmental disabilities) were reported to display higher rates of recidivism than men without ASD (Heaton & Murphy, 2013; Murphy et al., 2007; SOTSEC-ID, 2010), however it is possible this was a consequence of the type of sexual offense men with ASD committed (predominantly non-contact offenses, which tend to have higher rates of recidivism).

Current best practice for the treatment of adult sexual offenders utilises cognitive behavioral therapy (CBT) approaches, despite some inconsistencies in outcomes (Duggan & Dennis, 2014; Losel & Schmucker, 2005; Marshall et al., 2003; Mews et al., 2017). Programs are typically modular, delivered in a group setting, and contain components addressing sex and relationships education, learning the cognitive model, addressing and challenging pro-criminal attitudes and distorted thought patterns ("cognitive distortions"), increasing victim empathy and developing a relapse prevention plan. Traditional offending behavior CBT programs were founded upon Bonta and Andrews' Risk Need Responsivity model (RNR) (Andrews, Bonta & Hoge, 1990; Andrews & Botna, 2003, 2010), which assesses treatment needs framed around an individual's level of risk of re-offending based upon: (i) the potential harm that an individual poses to society through re-offending (*risk*), (ii) their dynamic risk factors or criminogenic needs (*need*), and (iii) their engagement or accessibility to treatment (*responsivity*). Responsivity includes not simply looking at individualised factors such as the offender's motivation to change, but also availability or delivery of the programs. The RNR approach has many strengths and is still a predominant consideration in formulating treatment needs, however its emphasis on individual risk, disregarding contextual or social factors, and use of *avoidance* goals has raised criticisms.

Alternative CBT programs for treatment have utilized a strengths-based paradigm. The Good Lives Model (GLM), a CBT strengths-based treatment approach (Ward & Brown 2004; Ward & Marshall, 2004), proposes that focusing on risk alone is not sufficient to reduce recidivism. In addition to risk reduction, Ward and colleagues argued that treatment should aim to improve the individual's quality of life and/or their ability to lead a more fulfilling life – "the good life." The GLM hypothesises that offenders have attempted to attain primary "goods" (relationships, sense of acceptance, achieving mastery, autonomy, etc.) through maladaptive strategies and/or have insufficient means to achieve a good life (Ward, Mann and Gannon, 2007). Treatment using the GLM model seeks to address these insufficiencies and promote attainment of pro-social goals, equipping offenders with the skills and abilities to live a "good life" in addition to managing risk (Ward, Mann and Gannon, 2007).

Regardless of whether the RNR or GLM models are used as a basis for CBT for individuals with ASD, there have been questions about whether the cognitive and behavioral profile associated with ASD renders CBT unsuitable. For example, whether social communication and interaction difficulties may result in difficulties

in creating a therapeutic relationship; if impairments in emotional intelligence and differences in information processing affect ability to learn the cognitive model and identify links between thoughts, emotions and behavior; and lastly whether executive functioning difficulties, including central coherence and procedural learning, may create difficulties in identifying and evaluating automatic thoughts (Anderson & Morris, 2006). Despite these proposed challenges, recommendations and adaptations to CBT have been suggested to meet the needs of individuals with ASD (Attwood, 2003; Gaus, 2007).

Most of the literature regarding the use of CBT for individuals with a diagnosis of ASD has focused on children and adolescents (Betty et al., 2018; Evans et al., 2018; Wood et al., 2009), however research exploring the use of CBT with adults has demonstrated utility and small- or medium-effect sizes in treating mental health issues such as anxiety and depression (Lang et al., 2009; and Weston et al., 2016), as has the use of CBT in the treatment of offenders with ASD, including sexual offenders (Kelbrick & Radley, 2013; Melvin et al., 2019)

METHODOLOGY

Participant[1]

Referral

At age 19 years, John (not his real name) was referred by his consultant psychiatrist to the psychology service, in the community team for adults with intellectual disabilities in his locality. There had been a number of incidents of concern relating to sexual behavior and the referral suggested the need for a thorough assessment, given that he was new to the team, and the investigation of possible treatment for his sexual difficulties.

Childhood

John had been born with congenital dislocation of the hips and a problem with his feet, which necessitated a number of hospitalizations and some operations in childhood (he still wears special shoes and walks with a slightly unusual gait). He grew up within a caring family (with his mother, father, and sister). Initially, as a child, John attended a mainstream school but he transferred to a school for students with physical handicaps at 11 years, because he was finding mainstream school difficult. He had missed many months of schooling between the ages of 8 and 14 years, due to hospitalizations and this may have contributed to his difficulties at

school. It is likely though that he had some difficulty keeping up with the school work anyhow, given his cognitive functioning (see below). John remained at school until he was 17 years old and gained a CSE in art, as well as a city and guilds certificate in math. He then attended a (distant) college for 18 months, returning home to live with his parents in the summer of 1987.

Social Life and Interests

John lived with his mother and father in the family home until he was 40 – he now lives in his own flat with support from a social care organization. His sister left home to live independently in her 20s. John has been described as "profoundly lonely," although by his own account, he does have two male friends, with whom he goes to the pub about once or twice a month. However, John's main interests are a little unusual (e.g. he is a *Star Trek* fan), so that some of his pursuits are similarly unusual (e.g. he attends *Star Trek* conventions in a nearby city). He says he has also developed "quite a few friends" at a weekly ASD lunch club he attends and is a keen follower of Manchester United and Charlton Athletic Football Clubs. He has had one serious girlfriend called S. and still regrets the fact that they parted (not by his choice) when he was about 25 years old. He said this led to "lots of drinking spells and silly behavior – such as chatting to a child."

Employment

After leaving college, John began on a Youth Training Scheme. Since then he has had a variety of part-time jobs, including in supermarkets, in a factory, in a plastic molds company, in a print works, and in a hardware store, where he has worked for 16 years. He very much values his jobs and says that he is reliable and works hard. Before his current job, he often did overtime that he did not really want and worried constantly that he would be sacked. He does not report any positive relationships with colleagues in previous jobs – rather he reports considerable degrees of harassment and bullying, including pejorative name-calling. John did occasionally have periods without work and was sometimes made redundant or sacked. For example, he was sacked from his job in a supermarket because of an obscene letter to a female secretary (see below for details).

Psychiatry Referral

John was referred to psychiatry at aged 18 years because of a four-year history of abnormal sexual behavior (see below). The GP's letter said that he was a "rather awkward boy with poor social skills." She also thought he was depressed and John

then began a course of anti-depressants. His psychiatrist thought he might have a psychotic disorder and prescribed neuroleptic medication but this had no beneficial effect on John or his sexual difficulties. He was then referred to clinical psychology.

Sexual Difficulties

From the age of 15years, John engaged in obscene phone calls to neighbors, aunts, and to strangers (while masturbating). Eventually his mother locked the phone and this helped to decrease his calls. He also exposed himself late at night in the street, had been known to have smeared his body with margarine while naked in the garden, shoplifted female underwear for masturbation (and had taken his mother's and sister's underwear for the same purpose), and made obscene suggestions to his sister.

At 18 years, John was questioned by the police about notes he was writing to his neighbours which included sexually explicit language. No charges were brought but he was referred to psychiatry (see above). In the same year, John wrote an obscene letter to the secretary at his workplace. He was subsequently taken to court, convicted and fined.

The following year, John approached two girls in the street and asked them to masturbate him. He was arrested and later convicted. He received a probation order and while on probation, John said that he exposed himself to his probation officer. No further charges were brought.

At 25 years, John rang his girlfriend's mother and sister and made obscene suggestions (including asking if they would like to be featured in a pornographic magazine). This resulted in the termination of his relationship with his girlfriend but again no charges were brought.

Psychology Input

At 19 years, John was assessed on the WAIS-R when he was first referred to clinical psychology in the community intellectual disabilities team, and his Full Scale IQ was in the mild intellectual disabilities range. He was also assessed on the ADOS and ADI, and subsequently diagnosed with autistic spectrum disorder.

By then, John had tried many forms of treatment in mainstream mental health services: he and his family had had family therapy but with "limited success"; he had received anti-depressants and neuroleptic medication, again with little success. He had been considered for psychotherapy in mainstream mental health services but was considered not to be suitable.

In the community intellectual disabilities team, John was considered for possible inclusion in the men's group, a treatment group for men with mild or borderline disabilities and/or ASD who had committed sexual offenses. When he was referred,

the first group was already full, so he was seen initially individually for support. He was then considered for the next group. Prior to the group all of the men were assessed for cognitive skills and sexual knowledge.

RESULTS

Pre-Group Assessment Results

Sexual Attitudes and Knowledge (SAKS)

This scale, developed by Heighway & Webster (2007), assesses basic sexual knowledge (including body part names) and socio-sexual attitudes (for example, attitudes to gay sex, masturbation, consent issues, and public behavior). The scale involves the service user looking at a series of pictures of social and sexual scenes and answering questions about them. John's scores are shown in Table 1.

John's responses suggested that his superficial social skills were adequate and he knew the names of most body parts. He also knew how people became pregnant, what masturbation was, what safe sex was, and he had no prejudices about homosexual relationships. However, he was not very good at spotting some abusive situations; for instance, he thought that a sexual relationship between an employee and her boss was acceptable. He was able to identify some abusive situations though (for example, a bus driver approaching a young boy on the bus and an abusive phone call to a woman).

Victim Empathy Scale – Adapted

This scale consists of 30 questions, probing whether the interviewee understands the victim's point of view, in relation to his offenses (Beckett & Fisher, 1994). Each question consists of a statement (such as, "Do you think the victim enjoyed what happened?"), to which the interviewee has to rate his level of agreement on a four-point scale (from "yes, very much," to "yes, mostly," to "no, not much," to "no not at all."). There is a pictorial aid to the rating scale, to assist interviewees.

John's score on this scale before the group is shown in Table 1. On the whole, he did not consider that his victims enjoyed what happened, considered him sexy, or wanted it to happen again. However, he did feel they could have stopped it happening, were not harmed much by what happened and would have quickly got over it. He summed this up by saying, "I can't believe what happened but there you go."

Questionnaire on Attitudes Consistent with Sexual Offending (QACSO)

This questionnaire consists of seven sections, each with a series of questions (Broxholme & Lindsay, 2003). The sections tap the interviewee's attitudes to women and rape; to voyeurism; to exhibitionism; to dating; to homosexual assault; to paedophilia and to stalking and sexual harassment. Each question is scored 0 (correct), 1 ("don't know") or 2 ("incorrect").

John's scores before the treatment group are shown in Table 1. He had relatively few inappropriate attitudes to rape, dating, homosexual assault or stalking. However, he had some inappropriate attitudes to paedophilia (especially in relation to age of consent) and many inappropriate attitudes to voyeurism and exhibitionism (all three of which he had engaged in).

Group Treatment

John joined the year long men's group for cognitive-behavior therapy (using the SOTSEC-ID model, see SOTSEC-ID, 2010). The group met once a week for two hours and was designed for men with intellectual disabilities and/or ASD. The topics covered by the men's group are shown in the Table 2. The techniques employed in the men's group were broadly cognitive-behavioral and very like those employed in

Table 1. Pre- and post-group assessment results

	Pre-Group (John's Score/Max Score)	**Post-Group (John's Score/Max Score)**
Sexual Attitude and Knowledge Scale (SAKS)		
Understanding relationships	2 / 6	6 / 6
Social interaction	3 / 3	3 / 3
Sexual awareness	27 / 32	32 / 32
Assertiveness	5.5 / 10	10 / 10
Victim Empathy*	22 / 84	10 / 84
QACSO*		
Rape & attitudes to women	12 / 52	13 / 52
Voyeurism	19 / 26	11 / 26
Exhibitionism	16 / 26	5 / 26
Dating	2 / 20	3/ 20
Homosexual assault	6 / 24	4 / 24
Paedophilia	14 / 36	4 / 36
Stalking & sexual harassment	6 / 32	6 / 32
Total	75 / 216	46 / 216

* Lower scores indicate progress

Table 2. Modules in the men's group (SOTSEC-ID)

Modules	Content
Module 1	Getting started: Group purpose and group rules; "good lives" and how to get them)
Module 2	Sex education (including body part names; social rules for undressing and touching; social and sexual relationships; consent and what is legal, illegal and risky in sexual behavior)
Module 3	The cognitive model (understanding and coping with feelings; thoughts and how they influence feelings; thoughts, feelings and behavior and consequences for behavior; descriptions by the men of their illegal sexual behavior)
Module 4	Victim empathy (their experiences of being victims themselves; how other people feel when they are victims; how their own victims felt; how hard it is to talk about illegal sexual behaviors and how to cope with this
Module 5	The 4 stage model of sexual offending (thinking "not OK" sexual thoughts; making excuses like denial, minimization, victim blaming; planning it; doing it)
Module 6	Relapse prevention and "keeping safe" plans.

similar treatment groups for men without disabilities, who have committed sexual offenses, though with some adaptations to take account of the men's cognitive difficulties.

John's attendance at the group was excellent and he would always inform the group facilitators in advance if he was unable to attend particular sessions. These absences were typically restricted to planned family holidays or other planned appointments. He was occasionally late for sessions due to work commitments but this did not significantly affect his participation or contribution to the group work. He appeared very self-motivated to attend the groups and his parents supported him by collecting him from the sessions by car. He said about the group, "I didn't mind it really – staying out of trouble and not been picked up by the police again".

John enjoyed the social side of the Men's Group and would seek to engage other participants and group facilitators in discussions about his hobbies (e.g. Star Trek, football, motor racing, pop music and video films) prior to the group starting and during the tea break. He appeared to understand the content of the group sessions and made valid contributions to the early group discussions when establishing the group's ground rules. His communication and social skills were relatively good and he was supportive to other participants when they became confused or had difficulties comprehending the issues being discussed. Invariably, he was one of the first men to respond to open questions from facilitators and typically, his contributions were honest, valid and appropriate (e.g. he offered other men appropriate alternatives / coping strategies for their offending behavior, such as not walking too closely behind women when walking along the pavement).

At the beginning of each session, the men were asked how their week had been (since the previous session). John would readily volunteer both the good and bad things that had happened during the previous week. Invariably, the good things would consist of his favourite football team (Manchester United) winning, watching motor racing with his friends, going out to the pub with his two friends, seeing a good film and visiting/seeing his sister and her pet rabbit. The bad things would often concern difficulties he had experienced at work (e.g. reprimands from managers for errors and disputes with colleagues) and his ongoing search for alternative employment. During some sessions he became visibly upset when talking about these issues and would elaborate on them for extended periods of time. He said he "drank a bit, maybe gambled a bit, too." It was clear that he found the group process supportive for coping with these issues.

Occasionally, he would discuss more personal issues in confidence with group facilitators, including those occasions when he felt vulnerable to re-offending, when he would make reference to his visits to local "massage parlours." He was probably seeking some validation for this activity as an appropriate coping strategy for his offending behavior and, while facilitators would not actively encourage such activity, they reminded John that it was not illegal and therefore was preferable to some of his previous sexual activities.

More positively, he would report appropriate interactions with female colleagues at his evening classes. He would imply that he did find particular women physically attractive, but he described his thoughts and conversations with them in terms of platonic friendship, even if his longer-term expectations may have indicated that he was seeking a sexual relationship with them. Although this evidence was anecdotal, self-reported and uncorroborated, it did seem that John was displaying some internal control over his offending behavior (in that he did not make obscene suggestions or phone calls to the young women he met in evening classes).

John's concentration and comprehension of the content of the sessions in the men's Group was typically excellent, although there were occasions when he was clearly displaying some fatigue as a result of the demands his job placed on him. He would volunteer to read extracts from resources to the group and was the second participant in the group to volunteer to discuss his offense in front of the group, when the majority of participants required a great deal of encouragement to do so. He was also able to demonstrate, with help from other group participants and group facilitators, a clear understanding of how his offending behavior had occurred, in terms of an ABC model (e.g. **a**ntecedent – feeling lonely and depressed; **b**ehavior – obscene phone calls; **c**onsequences – distress for the victim and arrest by the police for himself). Finally, with support from the group facilitators, John was able to make a plan for how to prevent himself re-offending.

RESULTS

Post-Treatment Assessment Results

John's scores at the end of the treatment group are shown in Table 1.

Sexual Attitude and Knowledge Scale

John achieved 100% performance in his responses to this assessment following the group treatment. Where there were significant deficits in his knowledge before the men's group (e.g. understanding relationships and assertiveness), improvements in his performance resulted in him reaching the ceiling for this assessment.

Victim Empathy Scale

John's scores after the end of the treatment group suggest that his victim empathy had improved. He was now clear that his victims found their experiences frightening and unpleasant, that they would have been harmed by them and not forgotten them, but he still thought his victims could have stopped events happening.

QACSO

John showed clear improvements in his attitudes to exhibitionism and paedophilia, with some improvement in his attitudes to voyeurism. He recalled, "I walked out into the street once [naked] – I don't know why."

After the Men's Group

John attended a follow-up meeting of the men's group and he was very pleased to come to the meeting to explain what had happened to him since the last group. He had left his job, where he had been unhappy, soon after the end of the men's group and had tried a number of different jobs since then, with the help of an employment officer. Most recently he had joined a double-glazing company, was completing an NVQ with them and said he was very happy there. Otherwise his life was continuing much as before: he was still living with his parents and still attended maths evening classes. He still did not have a girlfriend though he continued to wish he had.

About one month after the follow-up meeting John re-offended. His account of it was that he was sitting at home one Sunday, with nothing to do, and with his parents out. He telephoned his workplace on impulse and, when the female secretary's voice came on the phone (it was a recorded message), he left an obscene message (about

the size of her breasts). He said that he went to work the following Monday and he did not seem to expect that anything unusual would happen. However, his voice had been recognised on the answering machine and his phone number had been recorded as well. He was subsequently interviewed by the manager, confessed to what he had done and was asked to resign, which he did. The police were informed and telephoned him at home but they decided not to proceed.

John was now extremely sorry about what he had done, though his remorse seemed to be largely about the effect it has had on his own life. He had some one-to-one psychology sessions to revise some of the work done in the men's group and began to keep a diary. In addition, as an interim measure, with John's agreement, his parents set the home phone not to take outgoing calls when they were out as that seemed to be the time when John was most likely to re-offend.

Treatment Following Re-Offending

Following his re-offense, John was asked to repeat the men's group treatment which he did, with a similar presentation and high levels of engagement. During this time John underwent a number of positive changes in his life. He was able to move into his own flat in the community, supported by his own care team. He also acquired another job in a hardware store where he has now been for some years and has successfully integrated himself into the staff team. He said, "Most of the bosses were OK but I didn't like the changes in shift patterns. But I've had good ones for the last few years."

Subsequent to the second treatment group, John has regularly attended a monthly maintenance group, the "keeping safe" group. This group is focused upon "checking in" with men who have completed a full treatment programme, following their progress and monitoring any risk. The men report in the group how their month has been and talk about any incidents or situations which have occurred. The group is primarily concerned with situations where a sexual risk which has been present or been managed, however it can also include support in relation to non-sexual risks, depending on what is going on for the group member at the time. The group will then recap the relevant parts of the SOTSEC-ID treatment program in order to support the individual in need of help. In addition to the check in, each member also gives an indication of where they are on "the slippery slope" (with 100 being as far from re-offending as possible, and 0 reflecting planning/having committed an offense). John is a valued member of this group and has established positive relationships with the other members and supports them, drawing on his own experiences.

In addition to attendance at the keeping safe group, John continued with one-to-one psychology sessions. These sessions initially focused on John's sexual risk but as this reduced over the years, the sessions have continued to provide support and, when necessary, focus upon other John's other mental health needs, e.g. gambling habits.

Since attending the second treatment group, John has become a spokesperson for offenders with intellectual disabilities and ASD spectrum disorders. He has occasional work for a national organisation and co-delivers speeches, engages in public involvement and acts as a representative for his particular client group. "I did some training with police and prison officers, too." He has also taken part in a number of research projects focusing on ASD, offending, intellectual disabilities and treatment.

John has not re-offended for many years, after completing his second treatment group. Group facilitators have commented on his positive engagement and his continued commitment to managing his risk. "It's got to be nearly 25 years" [since offending]. He is reported to show increased insight into his risk and has requested safeguards to be put on his PC (i.e. to block pornography websites). His motivations for desistance to offending continue to be those relating to negative consequences for himself such as the loss of his job or having to "start all over again."

Although John has not re-offended there are some aspects to his behavior which are still a concern to his team. John seeks sexual activity and has previously made use of telephone sex lines. Due to the expense this incurred John calls self-help lines such as The Samaritans and will masturbate during the conversation if a lady has answered the call (if a man answers he will hang up and call again). This behavior has been on-going and despite facilitators "coming at it from different angles," in the keeping safe group and his individual psychology sessions, John continues to believe this is a not an illegal behavior and causes no harm to the victim as he "makes sure she doesn't know."

The positive aspects of John's life such as his independence, his job, his relationships, and social standing within the keeping safe group, along with his role as a representative for men with intellectual disabilities and/or ASD, and his engagement in research, are considered protective factors against re-offending for John, as they guard against feelings of loneliness or depression, which are an antecedent to his offending behaviors. "Support from (his care staff) helps a lot, too." Many of his clinical team are of the opinion that a romantic/sexual relationship would be an additional protective factor for John, however he has displayed extreme reluctance to seek a new relationship following the hurt and distress he experienced previously.

DISCUSSION

John's case demonstrates the positive outcomes that can be achieved from the use of cognitive behavioral therapy for autistic sexual offenders. The adapted version of the sex offender treatment programme enabled John, as a man with mild intellectual disabilities and a diagnosis of ASD, to benefit from such treatment as he is likely to have struggled in a non-adapted group due to its social and cognitive demands. John's expressive and receptive verbal abilities enabled his engagement in the group, and his active seeking for social interaction and motivation to desist from offending are likely to have facilitated positive outcomes from the treatment. Furthermore, it is felt the repetition of the group assisted his retention of the material and continued attendance at the maintenance groups allows his understanding of the potential risks of re-offending that remain in the present (and not relegated to the past) and at the forefront of John's mind.

Although there were some improvements in empathy and understanding his victim's distress, John continues to display some attitudes which place him at risk of re-offending sexually due to a relative lack of victim empathy, e.g. viewing masturbating while calling self-help lines as not harmful as the victim "doesn't know." As identified, this distortion appears difficult to change, and John's difficulties with empathy and cognitive inflexibility may be a consequence of, or exacerbated by his diagnosis of ASD, as suggested in the existing literature (e.g. Dein & Woodbury Smith, 2010). However, they may also be a protective mechanism against any feelings of shame John may have about his sexual behaviors. Alternatively, they may simply reflect anti-social traits in his personality. At this time, the extent to which empathic difficulties in autistic sexual offenders are a consequence of their diagnosis or are akin to empathy deficits in non-autistic sexual offenders is unknown.

Focusing on the negative consequences for John if he were to re-offend may be key in maintaining his desistance from offending. Although this appears to be using an *avoidance* goal approach (and this strategy appears across the literature regarding sexual offenders with ASD e.g. Higgs and Carter, 2015, and Melvin et al., 2016, 2019), the improvements in John's quality of life and subsequent mental health have meant John is leading "the good life"; he has attained "primary goods" (like a job, a purpose in life, some social life, an independent flat) that facilitate the continued management of his risk, e.g. concern over losing his job if he re-offends. As such, John's case illustrates the benefits of using programs incorporating principles of the Good Lives Model (Ward, Mann and Gannon, 2007) and strengths-based approaches for the treatment of sexual offenders, including for those with a diagnosis of ASD. The social goods John has achieved act as protective factors to his risk of re-offending, which perhaps could be strengthened further if he was able to develop a happy and fulfilling romantic and sexual relationship,

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ENDNOTE

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