Correspondence

Sexual offending and improvement in autistic characteristics after acquired brain injury: a case report
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There have been some small studies that suggest a link between autism spectrum disorders and criminal offending either through cognitive deficits [1] or circumscribed interests [2]. Only a handful of case reports exist about sexual offending in individuals with autistic disorder or Asperger’s syndrome. In contrast, there is a more substantial body of literature that links sexual offending to intellectual disability [3] or acquired brain injury [4]. Of greater interest is that there are even fewer reports about recovery from autistic disorder with or without specific treatment [5]. A case is reported here about improvement in certain autistic characteristics in a boy previously diagnosed with autism, after an acquired brain injury, and the unusual coexistence of sexual offending.

The patient is the eldest of two children and was born via emergency Caesarean section because of pre-labour rupture of membranes. His parents described him as being an easy child in the first year, and achieved milestones of head lifting, turning over and walking at appropriate times. Between the ages of two and five, he was not able to communicate using speech, pointing or gesturing. He cried and screamed when his needs were not met. Also, he did not play or interact with other children, and did not engage in imaginary or imitative play. He did not play with toys as they were meant to be played and was only interested in spinning the wheels of vehicle toys. He was then diagnosed with autistic spectrum disorder between the ages of four and five. He learnt to talk at the age of five but only managed short phrases and would not spontaneously initiate conversation with another person. He still did not interact with other children even though he was at a childcare centre. A circumscribed interest in vehicles and their wheels continued and he had stereotyped movements of banging doors and other furniture. He attended special needs schools where he was assessed to have mild intellectual disability with an IQ of 65.

At about the age of 14 in the year 2000, he suffered a severe traumatic brain injury (left extradural haematoma and right temporal contusion) requiring emergency surgery. His Glasgow Coma Scale dropped to 7 and his left pupil was dilated. He underwent emergency craniectomy and clot evacuation from which he recovered well physically. Less than 2 years later, his parents reported that he became chatty and sociable, more spontaneous to converse and more verbose. However, he would only talk about one same topic with one person, and this topic would differ from person to person.

Of note, his parents report that the patient does not appear to understand what constitutes moral or socially appropriate behaviour both before and after the brain injury. For example, he does not understand why there is priority seating for the elderly and pregnant women on vehicles of public transportation, and would even compete with them to take to priority seating. He would feel pleased with himself if he succeeded in doing so. He understands that he will be punished for wrongdoing but does not appreciate why the act is punishable.

He is independent in activities of daily living and is able to use public transportation on his own. He once worked as a trolley-retriever at Changi Airport for 1 year. Just prior to the index offence, he was working for an aunt who runs a business from her home office.

The patient first presented to a psychiatrist in 2006 when his parents sought help for his behavioural problems. His parents reported that he began to exhibit inappropriate behaviour towards young girls when he was 11 years old (prior to the brain injury), which seemed to be a result of an abnormal restricted interest in girls and their private parts. At that time, he was arrested for following a girl home from school. Another time, he was carrying a young girl while in church and was seen by the girl’s parents to try to pull down her underwear. In the year 2004, there were four occasions when he peeped at young girls in the toilet and twice he was caught and warned by the police.

He re-offended a few months later but the police did not press charges. An attending psychiatrist at that time assessed him to have ‘mild mental retardation, voyeurism and little knowledge about sex’.

In 2007 his parents came across a report in the newspapers about a man who had been identified on CCTV to have allegedly outraged the modesty of a young girl, and being wanted by the police. They identified him in...
the picture in the report and decided to surrender him to the police. He was arrested and remanded and found to be of sound mind, fit to plead, and at high risk of re-offending. He was sentenced to 2 years probation and his parents placed him in a halfway house. He was also put on the sex offenders’ programme to undergo psychological treatment.

He completed his probation in June 2010 and was discharged home from the halfway house. During his stay there, he did not display any inappropriate behaviour towards any of the all-male staff or the all-male fellow residents.

After his probation, his parents made every effort to supervise him closely and engaged all possible resources to do so. For example, colleagues at his aunt’s office would search for him if he was not seen for half an hour, and would remind him of his remand experience to keep him out of mischief. The patient also called his parents frequently to update them on his whereabouts and his plans. He was also given a heavy daily involvement in church and fellow church members helped to look out for him.

In December 2010, the patient took half a day’s leave from work and went to a playground at a shopping mall. He had bought sweets earlier and used them to invite two young girls to follow him to a male toilet, where he said he helped one of them to remove her underwear so she could pass urine and helped her clean her private area with toilet paper. For that offence, he was remanded for psychiatric evaluation where the authors encountered him.

The patient says he does not know what sex is. He says he does not know how babies are made and does not know the function of his sexual organ. He experiences wet dreams but says he does not know why, and he denies masturbating and cross-dressing. He says he has never experienced an erection. He denies watching pornography and there was no report of sexual abuse in the past.

He admits to feeling excited at the sight of children, particularly young girls, but not in the form of sexual excitement, but rather, in the form of fun. He has thoughts and urges to peep at children in the toilet and sometimes would act upon these urges when he ‘gets out of control’. When he acts on the urges, he denies getting sexually aroused, but claims to feel guilty and embarrassed.

The interaction between autism and traumatic brain injury is so far unclear. It is interesting how in this case, compression to the left frontal, parietal and temporal regions by an extradural haematoma may have resulted in the sequelae of increased verbosity and social interaction.

This is not unlike the brain injury sequelae in non-autistic individuals. However, in this patient’s case, his circumscribed interest and persistent preoccupation with young girls persisted even after the brain injury. This may shed some light on the neuroanatomical correlates of the characteristic features of autism, or even possible mechanisms through which improvement in social interaction can occur.

This case is also a description of an unusual mental preoccupation in an autistic person. By definition, the preoccupation is with parts of objects, but in this patient’s case he was abnormally preoccupied with the private parts of young girls. It is hypothesized that this got worse after the brain injury, resulting in the escalation of the patient’s offences from peeping to touching, as a result of disinhibition known to occur in frontal lobe injury.

This patient’s behaviour does not seem to be congruent with the random, impulsive, sexually inappropriate behaviours that are related to intellectual disability. From his most recent offence, there was a significant degree of planning prior to the act, which suggests that mental preoccupation was present.

Another point that is difficult to discuss in this case, is the interaction of the onset of puberty and its physical, psychological and emotional changes. The degree of sexual content that is involved in this patient’s behaviours is not clear as he is unable to express it precisely. Hence, it would be extremely difficult to diagnose a disorder of sexual deviancy.

This case raises challenging aetiological, diagnostic and management issues.

References


