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Developing a Philosophy of Masturbation Training for Persons with Severe or Profound Mental Retardation

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Although very little research has been conducted on the subject of orgasm dysfunction and persons with severe or profound mental retardation, it is generally accepted that there are individuals who experience difficulty masturbating to orgasm. For persons without mental retardation who have this problem, masturbation training is frequently utilized as a form of treatment. However, though it appears reasonable that a similar treatment could prove useful for persons with severe or profound mental retardation, training programs are usually not available. To justify the use of masturbation training as a treatment for orgasm dysfunction, a philosophical or systematic means of examining its basic concepts could help to generate future discussion and investigation of the topic. Accordingly, a philosophy of masturbation training is presented.

KEY WORDS: masturbation; profound and severe mental retardation; orgasmic dysfunction.

"No other form of sexual activity has been more frequently discussed, no other practice more roundly condemned and more universally practiced than masturbation" (1). There could not possibly be a statement that more accurately describes the historical treatment afforded masturbation. This is unquestionably the case as it applies to persons with mental retardation and is particularly so for persons with severe or profound mental retardation. Masturbation is the most prevalent form of sexual expression for these individuals, yet this behavior is usually frowned upon and at times results in punishment by the caregivers who work with them (2,3,4,5,6). This is especially upsetting in light of the fact that the freedom to express sexuality only serves to enhance one's overall adjustment and that masturbatory expression is now considered to be both thera-

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peutic and important for the overall growth and development of an individual (7,8,9,10,11,12).

Unfortunately, the negative and repressive attitudes of caregivers toward masturbation appear to have spawned a general reluctance within the profession of service provision to address reactively, much less proactively, any issue related to masturbation and persons with severe or profound mental retardation (2). For example, it is generally recognized that there are persons with severe or profound mental retardation who experience difficulty masturbating to orgasm (13,2,14,15). They will attempt to masturbate but are unable to achieve orgasm or are able to achieve it only sporadically. For persons without mental retardation the problem of orgasmic dysfunction is most always treated with the use of a masturbation training program, oftentimes proving quite successful as individuals learn how to obtain orgasm (16,10,11). However, similar treatment programs for individuals with severe or profound mental retardation are usually not available (2).

To date, only one study on masturbation training that pertains to people with severe or profound mental retardation has been conducted (14). It is easy to appreciate the reasons why this potential treatment strategy has not been evaluated for use with people with severe or profound mental retardation to the degree that it has for use with others. It is relatively likely that this treatment strategy would necessitate a restrictive type of training procedure, such as hand-over-hand assistance to learn a more effective masturbatory technique. The ethical, moral, and legal controversies which surround such a practice are many and coupled with the profession's general reluctance to address masturbatory issues, they have precluded any in-depth research on the subject. Consequently, a form of professional inertia has evolved that has left the consumer who has an orgasmic problem in limbo. A potentially viable treatment program exists to deal with this problem but there are apparently precious few professionals willing to explore its usefulness.

THE PURPOSE

My purpose for conducting this study is to establish a philosophy of masturbation training as it would apply to persons with severe or profound mental retardation. This is a systematic means of examining the basic concepts or ideas about masturbation training and the hypothetical assessment of its potential importance in people's lives. This philosophy suggests why persons with severe or profound mental retardation who experience orgasm dysfunction should have available to them masturbation training as a form of intervention, and hopefully, will provide a foundation for future discussion and investigation of the topic.

THE METHOD

Philosophical research is unique. It is not identified as a research design or method in many references related to research methodology and when it is, it usually receives only scant attention (17). However, philosophical research is most appropriate for the "initial inquiry into broad problems to examine basic purposes, generate new ideas, or illuminate additional options that may be compatible with the basic purposes and ideals of an institution, agency, or group" (17). It is an excellent preliminary to exact scientific knowledge and is a useful methodology for clarifying or formulating values, or for ascertaining what reasons are good reasons for change and whether such change is appropriate (18). It allows a profession's practitioners to analyze the basic concepts and principles of a proposed action prior to committing considerable time, resources, and effort (17). As such, it is a practical research design for the initial study of masturbation training.

Research goals of philosophical research are usually general, the procedures open, and the scope of inquiry unrestrained by disciplinary bounds (19). Although most philosophical research remains neutral in its outcomes, it does not need to be. There is considerable room for a prescriptive course of action as an end result to philosophical inquiry.

The two philosophical methods I employ are extensive argument and conceptual analysis. I utilize empirical evidence from the literature as well as my own personal beliefs and experiences to argue the need to provide masturbation training to orgasmically dysfunctional persons with severe or profound mental retardation. The empirical evidence composes part of the data of this study. My own beliefs and experiences compose the other. Russell talks about undeniable data, that being the sort of thing that no one is going to challenge or refute (20). He says, "You always have to start any kind of argument from something which appears to be true, if it appears to you to be true there is no more to be done". Edwards discusses two types of data: those impressions or perceptions which appear to a normal observer under standard conditions and those which appear to a normal observer under special conditions (21). Both my beliefs and impressions are invaluable elements of the results of this study.

This data pool of extensive arguments are analyzed conceptually, "a process which makes the most plausible generalizations from particular instances of a phenomenon . . . or counter examples in generalizations" (22). Conceptual analysis, also known as the method of examples and contrasts allows me to analyze and clarify the important distinctions that are inherent in a particular concept (22). Specifically, I will utilize generic and conditions analysis. Generic analysis will help me to determine the necessary conceptual features of masturbation training and why it should be considered a viable treatment, and condi-

tions analysis serves to identify the appropriate context for the use of masturbation training.

MASTURBATION TRAINING AS TREATMENT

I suspect that masturbation has long been privately thought to have the capability of producing both powerful and frequent orgasms. However, not until the pioneering work of Masters and Johnson was there any scholarly research that addressed the physiologic and biogenic realities of the sexual response (11). A considerable body of literature had already been accumulated that suggested masturbation provides numerous psychic benefits (i.e. relief from anxiety, reduction of tension) (23,24,25). Now came the discovery that masturbation does indeed result in more consistent and intense orgasms and the possibility that it could one day prove therapeutic in the treatment of orgasm dysfunction.

Following the work of Masters and Johnson, masturbation was determined to provide a number of healthful benefits that could assist in the overall growth and development of an individual (i.e. sharpens the body image, heightens one's sense of reciprocity, aids in the socialization of the sexual drive) (9, 26,27). Considerable research on masturbation as a possible therapeutic treatment that could help to resolve orgasmic problems continued to mount as well (28,16,29,10). Today masturbation training is a common intervention that often results in the successful treatment of both female and male orgasmic dysfunction.

Masturbation training usually entails specific masturbatory exercises designed to teach a person how to focus upon and attend to bodily sensations and feelings of arousal. The major goal of masturbation training is to assist the individual in identifying a masturbatory process to become orgasmic but it can also be used to eliminate one's fear of arousal and fear during self-stimulation (30). The person is encouraged to explore and identify areas of the body and genitals that produce pleasure and arousal when touched and caressed. Obvious erogenous zones such as the clitoris, head of the penis, labia, and underside of the penis are highlighted during the masturbatory exercises. Stimulation of non-genital areas such as the nape of the neck, nipples, ears, abdomen, etc. may also warrant consideration and attention. Various touching, rubbing, and stroking techniques are identified and the person is encouraged to explore varieties of pressure, speed, and friction in stimulating the genitals. The person is instructed to practice what is learned and is often offered specific masturbatory homework exercises to perform on his or her own.

ORGASMIC AND RELATED PROBLEMS OF PEOPLE WITH SEVERE OR PROFOUND MENTAL RETARDATION

Frequently, I have met persons with severe or profound mental retardation who have experienced difficulty masturbating to orgasm. Unfortunately, due to the lack of research on the subject, there is no way to tell just how pervasive this problem is. An exhaustive review of the literature yields a total of seven references that pertain to masturbatory problems, but only one deals with orgasmic dysfunction (14). Five of them address public masturbation and one deals with hurtful or dangerous masturbation (31,32,33,34,35,36). However, because very little information exists on the subject of orgasm dysfunction should by no means be construed to suggest that few people experience the problem.

There are probably many factors that conspire to work against any in-depth investigation of this phenomenon. Certainly, negative attitudes toward masturbation and the controversial nature of the topic are two of them. A lack of comfort with sexual issues, fear of legal liability, and an adherence to the age-old myth that to address sexual matters will only lead to an increase in sexual acting out are probably others. Additionally, I am quite sure that the belief by many that the more mentally retarded one is the less interest one has in sex has contributed as well. The lack of human sexuality experts in the human service profession is probably another. It seems likely that this lack of expertise frightens many professionals away from any direct involvement in the sexual matters of persons with severe or profound mental retardation. It may also preclude the accurate assessment and evaluation of sexual problems, thereby allowing many problem situations to go undetected.

This last point is particularly intriguing. Frequently, I have met persons whose public display of masturbation is a secondary problem not a primary one. That is, their public display of masturbation is part of the much larger problem of not being able to orgasm effectively or efficiently. Unfortunately as well, many functional analyses that address public masturbation do not include the direct and unobtrusive observation of an individual's private masturbatory behavior. Because of this oversight there is no way to tell whether or not the person's public masturbation is the result of an unsatisfactory and frustrating private masturbatory experience that has simply carried over into a public domain. It seems reasonable to suggest that should an individual have difficulty reaching orgasm in private that the need to search for that outcome could be so great that the behavior could carry over into public places. Consequently, it is likely many orgasmic problems masquerade behind the mask of public masturbation. The social and political pressures to quell such an offensive display of behavior as public masturbation tend to be so great that the need to halt the behavior clearly becomes the overiding concern of the caregiver. The tendency

is to jump to conclusions and not to analyze thoroughly the origins of problematic masturbatory behavior. As such, any investigation into a person's orgasmic capability often goes unattended and neglected.

The difficulty or inability of some individuals with severe or profound mental retardation to produce a masturbatory orgasm should be expected. Masturbation is a learned behavior and is not something that just happens. All people need to learn the different types of touch, grip, speed, friction, and pressure that will enable them to ultimately develop a personalized masturbatory technique, as well as, be able to come to terms with the cultural context in which masturbation is perceived (i.e. religious, societal, and familial influences). Accordingly, one must be very concerned with the influence that a profound or severe cognitive deficit has on one's ability to learn how to masturbate effectively and without fear or guilt of wrongdoing.

If masturbation for persons without mental retardation begins as random touching of the genitals in infancy, let us assume that it begins this way as well for persons with severe or profound mental retardation (11). An indiscriminate touch of the genitals initiates an associated response to the stimulus and the first impression to genital touch is made. However, the developing child with severe or profound mental retardation in all probability does not have at his or her disposal the same capabilities for the successful negotiation of the masturbatory tasks that a child without mental retardation has. The various sources of learning about masturbation are generally not applicable to the child and young adolescent with severe or profound mental retardation that are available to those without mental retardation (i.e. reading books, talking with and observing friends and peers). Consequently, if left to his or her own devices, trial and error becomes the primary method by which the individual will learn how to masturbate. Unfortunately, a severe or profound cognitive deficit could very well reduce dramatically the chances for quality learning and enhance the risk that errors in the act of masturbation will occur. Without assistance, the person with severe or profound mental retardation would be hard-pressed to acquire an appropriate and effective means for the accomplishment of the masturbatory task, the result of which could impede the attainment of orgasm.

Like Craft and Craft and Johnson, I too have met many individuals who spend an inordinate length of time trying to reach orgasm, often at the expense of other daily activities (13,37,14,8). I have met others still who have inflicted considerable harm and damage to their genitals from the force of rubbing or pulling on them, or by some similar means (e.g. striking the genitals). For some, there is an apparent and concomitant frustration and anxiety that comes from their inability to finish what they have started. It seems that there are persons who have developed through their masturbatory attempts enough of an appreciation for the stimulation of their genitals to continue with those attempts even at the expense of potential harm or an unsatisfactory outcome.

Regardless of the true incidence of orgasmic dysfunction, the question remains about what should be done for those who experience this problem. Sadly, the different options available to the caregiver are limited at best. He or she can either ignore the masturbatory problem, try to eliminate altogether the masturbatory behavior, or try to restructure the behavior so that it produces a desired effect. To ignore a person's orgasmic dysfunction would seem to violate many of the recent legislative enactments and guiding principles that were designed to enhance the quality of life and health of people with mental retardation. After all, if people without mental retardation who experience orgasm dysfunction are able to seek treatment, and if that treatment usually entails masturbation training, does it not follow that those with severe or profound mental retardation should be allowed similar opportunities as well? Moreover, is the caregiver legally and morally delinquent should he choose not to provide that opportunity?

Similarly, it would seem that any attempt to eliminate masturbatory behavior without objective and reasonable cause would also be a violation of one's constitutional and personal right to privacy. If the behavior is done for the purpose of obtaining sexual gratification, is done in private, and is voluntarily chosen as a personal activity to engage in, is it ever morally correct for a third party to decide to extinguish it? It does not appear reasonable that one person's desire for private masturbatory experiences should ever be the object of another's discrimination and wrath. Masturbatory expression can always be rejected for personal reasons (e.g. religious beliefs), it should not however be subjected at any time to the direct oppression that one is capable of inflicting on another.

Consequently, the only appropriate alternative for dealing with orgasmic dysfunction among persons with severe or profound mental retardation is to assist them in learning how to become orgasmic. We know, for example, that a person should be afforded the "care and treatment that is suited to his or her needs" and should "be provided educational techniques which assist in overcoming his or her response deficiencies and promote meaningful behavior growth" (38). Were these statements meant to include all things other than orgasmic dysfunction and masturbatory inadequacy? It seems reasonable to suggest that if a person has difficulties in this regard that some effort should be made to correct them.

MASTURBATION TRAINING FOR PERSONS WITH SEVERE OR PROFOUND MENTAL RETARDATION

It should come as little surprise that there may be those who view masturbation training for persons with severe or profound mental retardation as controversial. I can imagine that for some the thought of helping another person

learn the mechanics of masturbation is overwhelming, particularly if the training requires the professional caregiver to use restrictive hand-over-hand prompting to help the person learn an effective masturbatory style and technique. Yet, if this is the only method by which the person is capable of learning new tasks, is it not logical to suggest that this is the most probable method for learning how to masturbate successfully?

It seems quite possible that a professionally trained instructor will need to place his hand on the person's hand and guide him to hold and stroke his penis or, for a female, to assist her to touch and rub her clitoris. Tasks such as touching the genitals, holding and stroking them, and proper manipulation may have to be taught. The instructor would assist the person by actively leading him or her through a variety of different masturbatory actions. The objective should be to present the person with alternative ways to masturbate until he finds one to his liking. Once this is accomplished, the instructor helps the individual practice this new method of masturbation by providing direct physical assistance to him or her. This "hands-on" approach may be the only possible teaching method to help the individual learn how to successfully masturbate. As such, if all other less restrictive alternative interventions have been ruled out, then hand-over-hand should be the preferred instructional method.

Masturbation training that utilizes a hand-over-hand prompt would likely involve some form of task analytic instruction whereby the masturbatory act is taught in a step-by-step fashion. Persons generally respond well to this form of teaching so it seems reasonable to suggest that many would do likewise with masturbation training (39,40,41,14,2). Within the context of the least restrictive principle, the person is taught how to identify his or her own particular sexual response pattern. That is, the person is led or guided through each of the different components of masturbation, including holding and manipulating the genitals by using different motions and a rhythm and rate that gradually builds as the person becomes more and more sexually aroused. In this way, masturbation acts as "a helpful preliminary in learning the individual patterning and timing of stimulus and response of the lust dynamism" (25).

The person begins to learn how to regulate his own sexual responses and consequently, may come to understand that he is capable of effectuating changes in his life. It may be possible for him to learn that he can purposely alter the way he feels simply by touching and manipulating his genitals. This should assist him in learning the broader concept that if he creates some action an associated and reciprocal reaction will occur. As the person becomes capable of experiencing an orgasm, he or she may learn that this new way of masturbating far exceeds the old in both efficiency and satisfaction. In short, the person not only learns the mechanics of masturbation, but the subtle variations of genital manipulation that are necessary to trigger orgasm.

All training should take place in the person's bedroom during a time of the

day or evening that is conducive for the person to masturbate. It is important to remember that as part of masturbation training the person not only learns about masturbation but about the appropriate time and place that the behavior is to be engaged in. Accordingly, training sessions should be conducted in the same location and at approximately the same time each day.

Should "hands-on" masturbation training be employed, it seems necessary that the instructor should make every effort to reduce his level of prompting and to distance himself from the individual as much as possible during each training session. The instructor can accomplish this by refraining from over-prompting, by instituting time delays between prompts and using a least-prompts approach, by not presenting an affect that could be misinterpreted as affectionate, by backing away from the individual after the delivery of each prompt and encouraging independence, and by conducting the training in a very matter-of-fact manner.

Of course, there may be some persons who will not need hand-over-hand assistance to learn. In all likelihood there are some individuals who can learn how to masturbate with the use of some less restrictive technique, one other than direct physical assistance. Perhaps the use of a masturbation education video or role-playing opportunities using life-like genital models would be more appropriate for them. Regardless of the specific technique that is employed to help the person learn how to become orgasmic, it seems likely that considerable practice will be needed. Generally, not until orgasm has been achieved does a person have the particular reference points that can be utilized to obtain future and subsequent orgasms. That is, most people do not necessarily know what to expect of their masturbatory behavior or of orgasm until after they have experienced a climax. Only after considerable trial and error is one able to determine the masturbatory style that is most effective and efficient for him or her. Therefore, extensive practice and replay of different masturbatory techniques will likely be needed.

An appropriate time of day or evening should be selected for daily training, and practice sessions should take place in the individual's bedroom. After a 30- or 40-minute session where the person receives training by using a model or watching a video, he can be encouraged to practice the new techniques privately by himself. Should he or she choose not to practice at that particular time it should be respected. It can be expected however, that on any number of occasions the person will voluntarily practice his or her masturbation. This being the case, the instructor should expect to have to unobtrusively observe the person masturbating. The reason being that the instructor needs to know how well the person masturbates as he practices in private so that he is better prepared to assist him during their training sessions together. The individual does not have the capability of functionally communicating anything about his practice experiences to the instructor. Therefore, it appears necessary that the in-

structor would have to observe the practice sessions in order to assess if progress is being made. If revisions are necessary, the instructor would convey them to the individual at the next training session and the person would then be encouraged to practice his or her revised masturbatory technique. This process should probably continue until such time that the person either experiences a successful masturbatory orgasm or a decision is made that the training has been unsuccessful and should cease.

DISCUSSION

There are certain considerations that should be made prior to any authorization of masturbation training. A complete physical examination should be conducted to determine whether there is a physiologic or biogenic cause to the orgasmic dysfunction. Tumors, infections, altered hormonal levels, and diabetes are examples of some of the circumstances that could affect sexual functioning. These types of anomalies should be ruled out before any treatment is rendered. If applicable, certain medications can affect sexual functioning and therefore, should be evaluated to determine if they are a contributing factor in the possible cause of the orgasmic dysfunction.

The involvement of a human rights committee would seem crucial. Any third-party decision pertaining to masturbation training should be made with due care and deliberation, and as objectively as possible. Substituted consent to provide masturbation training should be promulgated by a human rights committee when the person in need of training is under the jurisdiction of a provider agency. It could be argued as well, in far more space than is allotted here, that this committee should also have at the least, an equal voice in any decision that is made when an individual's legal guardian is involved. Whereas most substituted consent decisions are taken to require some evidence about what the person with incompetence would want or what is perceived to be in an individual's best interests, it may be such that a group of third parties has a better chance of rendering an objective decision than is a parent or family member (42), particularly when the issue concerns an emotionally charged and controversial topic such as masturbation.

The training program would need to be carefully monitored by the appointed interdisciplinary professional team to ensure that the individual is receiving the very best care and treatment possible. The training procedure should be evaluated on a continual and on-going basis so that any necessary adjustments in the training design can be made in a timely fashion. Just as important is the need to establish some mechanism that protects the individual from any abuse from the instructor and at the same time protects the instructor from any erroneous allegations of abuse. Turnbull and Guess suggest in their discussion

of aversive procedures as possible therapies, that an asymmetrical power relation exists between the professional and the person with mental incompetence (43). They worry that the potential exists for the professional to misuse his position of power so that he becomes abusive to the program participant. They express concern as well that the instructor could be vulnerable to what is known as "procedural decay". That is, should an instructor abuse his relationship with the individual, he increases his chances that he will at some point act abusive towards other persons with mental retardation. Put into context with masturbation training, their argument would follow that the instructor could be encouraged by previous successes with the training procedure to over utilize it or to use it inappropriately on other people.

These concerns can be minimized however, by the use of an independent observer or witness who would be assigned to unobtrusively observe the training from outside the individual's bedroom and by the diligent monitoring of a human rights committee that must provide approval for any masturbation training to occur. Obtaining guardian consent prior to the start of any training would provide an additional level of protection.

Some consideration should be given as to whether the instructor should be the same or opposite gender as the person to be trained. Generally, it appears as though male staff assist males and female staff assist females in privacy related tasks such as toileting or bathing. It seems reasonable that the same should be suggested for masturbation training. However, if it could be determined that the individual has an established sexual orientation it may be appropriate to select an instructor who is the opposite gender of the trainee's orientation or preference. As I have met very few individuals with profound mental retardation who have developed a sexual orientation, I would think that this would be more of a concern for those persons with severe mental retardation.

Masturbation training also has implications that relate specifically to the broader concept of masturbatory choice-making. The opportunity for choice-making, the guarantee of choice as Haywood labels it, can have numerous positive influences on one's sense of personal autonomy (44). The inherent power that comes with the opportunity to make choices should enhance one's personal sense of control over things in life. By offering masturbation as a choice to persons who have never before attempted to masturbate could help them obtain some control over their sexual desires and responses. Masturbatory choice could be taught in a similar fashion and format as masturbation training. As such, the masturbatory act is demonstrated using the least restrictive level of prompting that is necessary for the individual to gain an appreciation for the consequences of the choice. Once orgasm is achieved, the person then has the requisite reference points from which he is able to make his choice whether or not to masturbate again.

Masturbation may also prove useful when utilized as a functionally equiv-

alent alternative behavior to self-injurious behavior, assuming that one's self-injury is not the result of some biomedical dysfunction. Whether one's self-injury stems from a hyperaroused or hypoaroused internal state, does it not appear possible that masturbation could be used to minimize these feelings of high or low arousal? Individuals who have a high degree of internal agitation and discomfort may find that the sudden release of tension that results from an orgasm could provide the relief they so desperately are searching for. Similarly, those who have a diminished state of arousal could find that the intense excitement that is derived from genital stimulation and orgasm could be enough to possibly satisfy them sufficiently so that they do not continue to self-injure.

CONCLUSION

Research on the topics of masturbation and masturbation training as they pertain to persons with severe or profound mental retardation is woefully inadequate. It is my hope and expectation that my comments here will spur some interest among others to investigate these matters. At the least, perhaps I have caused some persons to question the potential value of masturbation, particularly as it applies to one's quality of life and health. I can only hope that as these questions are answered that a clear understanding of the role of masturbation in individuals' lives will emerge.

If service providers and advocates are as committed to persons as they say they are, and if they want to see individuals live a life as complete as is possible, then they must be willing to acknowledge that this includes a life of sexual expression and opportunity as well. They need to analyze carefully and completely the risks and benefits associated with masturbation training and should approach their findings with an open mind and willingness to do what is right.

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