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Masturbation

Adapted from
Chapter 9: Introduction to Sexuality Education for Individuals Who Are Deaf-Blind and Significantly Developmentally Delayed

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This is perhaps one of the most controversial topics related to sexuality education. Because this topic provokes strong feelings tied to both cultural and religious values and beliefs, it is a very difficult topic for most parents and educators to address. A range of beliefs and values about masturbation exists among parents and educators. Most people's beliefs and values can be captured in one of the four statements below:

- Masturbation is a normal healthy behavior that occurs in all human beings as they develop sexually, and it should not be stopped.
- Masturbation is an acceptable behavior if it is done in private.
- Masturbation is a shameful behavior that, if practiced, must be kept private.
- Masturbation is a sinful or shameful behavior that must be stopped. It is unlikely that these varied perspectives will find a common moral ground. However, no matter what beliefs or values exist about masturbation, there is generally agreement about society's rules related to it.
- Masturbation is unacceptable in public places.
- Masturbating in public is a deviant behavior that violates certain laws.
- A person who masturbates in public is unwelcome and avoided.
- A person who masturbates in public invites advances from sexual predators.

Regardless of personal beliefs and because standards exist in society, it is in the best interest of children to address masturbation as a part of sexuality education.

THE DEAF-BLIND CHILD'S ISSUES

The child experiences masturbation as just another type of bodily sensation. The world of the child who is deaf-blind with significant developmental delays is very different from that of a typical child. Depending on the degree of the vision and hearing loss, he or she is likely to be

extremely focused within the body. Life is a series of sensations largely bound in smell, touch, and taste. The entire body is the sense organ used to explore the world. The deaf-blind child often does not have the social inhibitions that a typical peer has about seeking out a particular sensation. To the deaf-blind child, masturbation more than likely is just another interesting and enjoyable bodily sensation.

The child does not incidentally learn society's rules about public and private behaviors. As has been noted again and again in this book, incidentally learning about what is or is not an acceptable public behavior is almost impossible if one is deaf-blind and has developmental disabilities. Most of society's rules related to masturbation were never formally taught; they were learned incidentally.

The child may not be capable of understanding others' beliefs and values about masturbation. The child may also lack basic concepts that would allow him or her to understand the values and beliefs of his family or others. The child's language, communication and experience are likely to be limited. The child may learn to control an impulse to masturbate for a time, but he or she may never really understand the moral values that guide others to participate in or refrain from this behavior.

A child may utilize masturbation strategies or tools that are harmful or dangerous. A child with deaf-blindness and developmental delays is sometimes very creative with the strategies and tools they use in masturbation. Occasionally a child or young adult may select devices that are dangerous and his or her health and safety may be at risk because of this behavior. An example of this is the young man who tried to use a hair dryer as a masturbation tool.

Some individuals may utilize a more passive and unaware peer in their masturbation. Occasionally, an individual with sensory and cognitive disabilities will seek out another more passive peer to utilize as a tool for masturbation. He or she is not seeking out a relationship with the individual, nor is he or she particularly sexually attracted to that individual. Rather, he treats the individual much like an object. The more passive individual may actually be a willing but unaware partner in this act of coupling. However, the notion of a romantic encounter is not part of this interaction.

The partner may be of a different sex or of the same sex. The deciding factor often is based more on proximity and passivity than on anything else. When one partner, in his attempt to masturbate, couples with an unwilling partner or someone who resists or is unable to give consent, it can be considered sexual abuse. Would the aggressor who was deaf-blind with developmental delays be successfully convicted of rape or abuse if these couplings occurred? Possibly not. Could the coupling result in unwanted pregnancy, the spread of sexually transmitted disease, injury, or trauma? It could happen. Might the deaf-blind individual be subjected to institutionalization or other extreme consequences as a result of this behavior? It has happened. Could a family or program be held liable for the individual's actions? It is certainly possible. But the bottom line is that no matter what the legal or health consequences are, parents do not want to see their child hurt another individual intentionally or unintentionally. Unnecessary

PARENT AND STAFF ISSUES

Masturbation may seem easier to ignore than to address.

There are a number of reasons why family and professionals may choose to ignore a child who is masturbating. Both parents and professionals are often too embarrassed to discuss it. Sometimes this event heralds the arrival of a whole new set of issues related to adulthood for the child's parents. They would rather not face the fact that their little boy or girl is becoming an adult. Another reason that parents and professionals choose to ignore masturbation is fear about why the behavior is occurring. They may be aware that one of the indicators for sexual abuse in a typical child is the exhibition of sexually inappropriate behaviors. Perhaps the main reason why parents and professionals ignore masturbation is that they do not know what to do.

Family members and/or staff may not agree that the behavior is occurring.

Many children with deaf-blindness and significant developmental delays are fixated on bodily sensations because of the other sensory losses. They may engage in a variety of creative patterns of self-stimulation. They use objects and people equally as tools to experience new and interesting types of sensations. For this reason, it is sometimes difficult to tell for sure when a child is masturbating. Some people cannot believe that a young child would masturbate. A perfect example of this is a child who started straddling a swing and who would become combative when staff tried to get her off the swing, even after a long period of time. Some of the staff thought that she was masturbating. Others, thinking she was too young to masturbate, felt it might be some other type of self-stimulation. Still others thought she was just being creative about swinging.

Family members and staff cannot reach agreement on how to address the behavior.

Even when family members and staff are in agreement that masturbation is occurring, they may have very different ideas about how to address it. There are such intense personal values and beliefs tied to this topic. Sometimes it can be difficult to agree on what to do.

Masturbation is frequently not addressed in typical sexuality education policies or instruction.

In a typical sexuality education curriculum, there is usually not much instruction provided about masturbation. Some curriculums specifically designed for people with developmental disabilities offer a bit more information. It is unusual to find a school policy that addresses this issue for the general population. The reality is, as a society, this is a topic that most people feel very uncomfortable discussing, let alone addressing. This is especially true when it relates to children and young adults.

Families look to professionals for help in addressing this issue.

The family of a deaf-blind child may expect educational or medical professionals to help them address masturbation when it occurs with their child. Unfortunately, the professionals may not have any better idea what to do than the parents. This can leave the family feeling completely without support or a way to proceed.

Educational staff and other professionals may not feel prepared to address the issue.

Sometimes the professionals think the parents should be responsible for guiding their child about this issue. This is especially true when the professionals do not have the answers either.

The professionals may have had no training in college about sexuality education issues, and they are even less likely to have had training related to masturbation. Even at an in-service level, little training is provided to help teachers work with the child on this issue in the school setting.

An additional obstacle to addressing masturbation in children with deaf-blindness and developmental delays, is the attitude on the part of education and rehabilitation professionals that providing this instruction is not part of their job. It truly may not be what they envisioned a teacher in a classroom or a rehabilitation setting doing. However, there are extreme social consequences for children or young adults with deaf-blindness who masturbate in public. For that reason alone, it is a critical area of social skills development that must be addressed.

Guidelines for Instruction and Intervention

Take Responsibility

Personal values should not determine if masturbation issues are addressed. Rather, the child's need to succeed in society must be our motivation. As has been stated previously, many deaf-blind children in this group will experience normal puberty. Some will masturbate in public places including the home, the school, and community environments. If you ignore the behavior, then you are teaching the child that it is okay to masturbate whenever and wherever he or she feels inclined. This conduct puts him or her at serious risk in public. It may also cause him or her to lose employment, it may impact adult living arrangements, and limit inclusion in a variety of community activities. You must take responsibility to address the behavior when it occurs. The child cannot afford for you to look the other way or deny that it is happening.

Follow Procedures

It is important to have a process in place for addressing any aspect of sexuality education because staff and family members need to understand their roles and responsibilities in that process. It is especially important for parents to be heavily involved in the development and implementation of instructional and intervention strategies to address masturbation. Since there may be some increased risk of accusations of sexual abuse in dealing with a child who is masturbating, it is critical for staff and family to follow established procedures and keep a team approach when addressing incidents and concerns. They should have in-service training available that clarifies policies and values. All intervention should be well documented, understood, and agreed upon by the full team and school administrators for the protection of the child, the staff, and the family. No member of the educational team should try any type of intervention to address masturbation that has not been routed through the team and addressed in written policy and instructional guidelines.

Address the Perceived Relationship Between Masturbation and Sexual Abuse

Frequently there is a perception that masturbation is an indicator of sexual abuse. Although there should always be reasonable concern about sexual abuse, it must be acknowledged that many deaf-blind children 72 http://www.tr.wou.edu/dblink Sexuality Education with significant developmental delays discover masturbation on their own. These children may appear to masturbate more frequently than other children who are their age. There are other reasons likely for the behavior than sexual abuse. Most of these children are generally less private about the behavior. Often they have much more downtime without other sources of sensory stimulation. It is also not uncommon for these individuals to develop unusual methods of masturbating, again

in part because they lack many of the inhibitions of their typical peers. As discussed later in Chapter 9, increased or unusual masturbation alone is not always a clear indicator of sexual abuse.

Analyze and Define the Behavior

When designing intervention, there are three things you must do before determining what will work in addressing the behavior with the child.

1. Describe the behavior so there is a common understanding of when to intervene. Until everyone who is working with the child shares a common understanding of the exact behavior, it will be difficult to intervene. The educational team must be precise in describing the behaviors they are targeting for intervention. As mentioned earlier, it is important to be in agreement about what the child is doing when he or she masturbates.
2. Rule out medical conditions that may cause genital discomfort. A child with deaf-blindness is subject to the same diseases and conditions as any other person. Sometimes itching or discomfort from conditions like yeast infections may occur as a result of antibiotic use. There may be an allergic reaction to detergents or fabric softeners. Urinary tract infections may also cause the child to rub or scratch at the genital area. Make sure there is no medical problem contributing to the behavior.
3. Note settings, level of activity, objects, positions, or clothing that may trigger the behavior. It is not uncommon for a deaf-blind child to participate in masturbation if he or she has nothing else to do and is left alone for long periods of time. Sometimes a child might participate in masturbation only when wearing clothes that are very loose or perhaps very tight. Sitting or lying in a particular position, certain settings, or the presence of a particular object may be associated with the behavior. Listing the triggers for the child related to masturbation is critical to developing effective intervention.

Use Effective Intervention and Support Strategies

Increase supervision and activity levels for the child.

One important strategy to use in addressing masturbation is to increase the level of supervision and the level of the child's activity. To be effective with any intervention strategies, you must first be able to redirect the child before he or she is fully engaged in the masturbation behavior. Once he or she has begun to masturbate, intervening becomes much more difficult. As mentioned earlier, masturbation often occurs because the child is left alone with little to keep him or her occupied outside his or her body. Making sure the child's day is well structured, well supervised, and full of interesting activities and interactions is one of the best ways to reduce an interest in masturbating.

Dress the child in complicated clothing.

A very simple strategy for reducing masturbation behavior is to dress the child in complicated clothing that makes touching erogenous areas of the body more difficult. Consider the benefit of clothing that makes access to the body more difficult such as pants that zip and are belted, shirts that button and tuck, and so forth. Sweat suits and similar clothing may be more comfortable and easier to get in and out of, but they may also make it easier for the child to masturbate.

Address the triggers for masturbation proactively.

If the child straddles a swing to masturbate, insist that he or she sit another way in the swing. This may even mean using a different type of swing that disallows the straddling position. If the child associates a mat in the gym with this activity, make sure he or she waits for his or her turn on a bench or in a chair. Whatever triggers the behavior, make sure you have a plan to avoid that trigger if possible or, if not, at least address the trigger proactively.

Develop strategies for times when the child may have to be alone.

Sometimes deaf-blind children will masturbate when they go into the toilet or if they are left alone for long periods of time. While the restroom may appear to be an acceptable place for this behavior, consider what would happen if he or she did this in a public toilet, especially as an adult. A simple intervention is to have the child hold the toilet paper roll while using the toilet. It keeps the hands occupied and may be a reminder to keep the child focused on toileting. If the child has to be left alone at other times (e.g., while you are trying to get dinner ready) make sure that a variety of engaging toys or activities are available that can keep him or her occupied and busy.

Teach concepts to help the child learn to control the behavior.

Provide a symbol for masturbation that communicates when and where masturbation may occur. If you are going to be successful in redirecting the behavior, you will need to let the child know that the desired behavior must wait. Having a symbol to use in a calendar system or to offer the child as you take him or her to her room is important. It might be an object symbol such as a vibrator, a small pillow from the bedroom, or something else the child associates with masturbation. Some of these children may be able to learn a sign that can be used to cue them such as “private” or “wait bed.” Learning concepts of time such as “wait,” “night,” and “later” are important. Other concepts like “bed” and “home” help the child know where masturbation will be allowed. Whatever your child’s communication system, you must have some way to tell the child what is expected.

Be clear with the child about when and where masturbation is appropriate.

When the child starts to masturbate at school, get the symbol for masturbation and talk about when and where this activity should take place. In some settings the strategy might be to redirect the child to a designated area within the school such as a restroom or a private screened area, and allow him or her a period of privacy. But it should be considered whether a typical child would be allowed to participate in this behavior during school time and also what would happen when the child is older and in other public settings. Will he or she be allowed downtime from work to go to the restroom to masturbate?

For these reasons, this behavior might be better restricted to home and the privacy of the child’s bedroom. This will mean a bit more work for the staff at school in terms of redirecting the child and keeping him or her busy. Still, ideally the child’s school day should be filled with interesting activities so that he or she does not have time to engage in this behavior or any other self-stimulation.

Keeping a child from masturbating inappropriately will also mean additional work for the family. Instructional support or training for the family may need to be offered in the home. It also means that later on there may be additional work for caregivers in rehabilitation settings.

One other note about directing the child or young adult to an appropriate place to masturbate is that group homes and other institutional settings need to have a clear policy about what is an appropriate setting. It is unrealistic to try to eliminate this behavior. If an individual shares a bedroom, that may not be a good location. Perhaps a bathroom with a door lock or an occupied sign might be better. For many individuals with deaf-blindness and significant developmental disabilities, this is their primary way of releasing sexual tension. They must be provided a private and safe place when they need it.

Accept that it will take time to consistently intervene.

It is not uncommon to hear the lament from teachers and parents alike, that they spend half their day redirecting one child. This may be true, and it may seem unrealistic to give one child so much individual time. However, this may be the most important lesson the child ever learns in terms of integration into the community and of his or her personal safety. It is worth the time that it takes to help the child with deaf-blindness learn the appropriate time and place for masturbating. If it takes an inordinate amount of time to intervene for a particular child, there may need to be one-on-one support provided throughout his or her day. The family may need to have help in developing activities that can be utilized during necessary downtimes at home. Additionally, there may need to be more supervision provided until the child learns that he or she must go to the privacy of the bedroom (or other location) to masturbate.

Develop Behavior Plans When Necessary

For some children, masturbation in public places may have already become an ingrained behavior. When this occurs, it may help to develop a behavior plan that includes strategies that are both proactive (how to head the behavior off before it occurs) and reactive (how to respond to the behavior once it has occurred). It should clearly describe what the child is doing so everyone is in agreement about the behavior that should be addressed. Triggers for this behavior should be noted so that family and staff can be alert to a possible incident and be prepared to intervene by redirecting or removing the trigger. Methods of diverting or redirecting should be consistent between home and school in order to effectively address the problem behavior. Having a good behavior plan allows everyone to remain calm while intervening and it reduces the power of the problem behavior.

Accept That Intervention Can Shape the Behavior but Probably Not Extinguish It

It is a reality that some children will masturbate. Based on the experience of teachers and parents and on research, it should be regarded as a natural behavior that the child typically discovers on his or her own. However, in the wrong time or place, it can have very serious consequences.

This behavior should not be punished. It is our belief that the goal should not be extinguishing the behavior. Punishing the child with deaf-blindness and developmental delays for masturbating is unfair. The child does not know he or she has done anything wrong. Clearly physical punishment is not an option in school settings. Besides that, punishing the behavior typically only serves to escalate the behavior or to provoke a more aggressive behavior. Time out also is ineffective. It simply provides the child an additional opportunity to be alone with nothing to do.

It is important to emphasize that the only way to appropriately address masturbation is to redirect the child to a private place through proactive intervention. If either the family or other

members of the educational team oppose this approach to addressing masturbation issues, the ability of the educational team to address the problem is blocked.

Educators and Professionals Should Respect the Family's Desires

If the family's goal is to eliminate masturbation, a program needs to be respectful of their feelings, but also straightforward about its position. Listen to what the family is saying and validate their beliefs and values. Explain that your program doesn't know how to eliminate masturbation from the child's behavior, but you can work to help control that behavior during school hours. If the family wants the behavior to be punished, remind them that school/agency policy regarding punishment prevents you from supporting their wishes. Also be sure to share with them information about the occurrence of masturbation in children with and without developmental disabilities. It may also be helpful to connect them with other parents who have been successful in addressing masturbation with their children or who at least are willing to share concerns in a supportive atmosphere.

Take Precautions to Prevent Masturbation from Becoming Abusive to Others

While masturbation may not be an indicator of abuse in children with deaf-blindness and significant developmental delays, these individuals may be at increased risk for both abusing others and being abused by those who would use them as partners in their own masturbation strategies. Be alert to the possibility of these situations, especially in settings where several individuals are left alone for long periods of time and in proximity. Take steps to prevent opportunities for abuse.

Make Sure No One Crosses a Line into Sexual Behavior with the Child

Sometimes, if not carefully thought out, interventions can be inappropriate. Some people may even consider the intervention to be participating in a sexual act or sexually abusing the child. Educators must complete training annually on reporting requirements related to sexual abuse and what constitutes sexual abuse. There is a fine line that should never be crossed. For example, giving a young man a sexually explicit magazine to replace a graphic he has incorporated on his own into his masturbation strategies would be considered abuse based on the strict definition of the term. Even keeping the bedroom door open or staying in the room to supervise the masturbating child might be considered crossing a line.

However, there may be times when supervising a child is necessary if his or her behaviors involve the risk of injury. The best protection lies in clear policy and guidelines, team planning, and communication between school and home. School policy should provide clear guidance about intervention. Staff must have in-service instruction about steps to reduce the risk of inadvertently engaging in what would be considered sexual behavior with a child or young adult.

Parents should also protect themselves from accusations of abuse. Probably one of the most effective forms of protection for both parents and educational staff related to accusations of sexual abuse is participating in an educational team process. Working with others to identify and discuss issues and to document intervention keeps everything out in the open. If someone calls an action into question, the team should be able to provide a clear explanation for what happened and why. You may want to read the following articles to guide you if you suspect someone has abused your son or daughter:

- A Guide on Responding to Suspected Abuse of People with Developmental Disabilities – by Dr. Baladerian
- People with Intellectual Disabilities and Sexual Violence

Make Sure Staff Respects the Child's Dignity and Keeps Matters Confidential

Masturbation should not be a source of humor or gossip for anyone working with the child. The behaviors should be discussed in a professional manner that always respects the dignity of the child. Information should be kept confidential and not shared with those outside the child's team any more than is absolutely necessary.

Conclusion

Masturbation is a difficult issue for most parents and professionals who work with children who are deaf-blind and have additional disabilities. There is a natural tendency to want to ignore or avoid dealing with this behavior. However, given the harsh response of society to people who break the rules about public masturbation, it is critical that masturbation not be ignored. The school and family must work together to formulate effective programming and intervention strategies to address a child's masturbation behaviors. They must provide the intensive individual intervention that may initially be required to redirect this behavior to a more appropriate expression. The child's future integration into society as well as his or her personal safety is at risk if this is not done.

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