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Client Masturbation During Counseling

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For mental health counselors practicing in the correctional setting, responding to client masturbation during counseling is a familiar occurrence. Masturbation within the correctional setting is pervasive and may be a release of sexual tension during long periods of limited sexual outlet (Aldridge, 1982) or nonsexual acting-out of dominance, control, and power (Darke, 1990). While client masturbation during counseling is

pervasive in correctional institutions, client masturbation can occur in any counseling setting and may be unexpected by counselors who are not trained and/or are inexperienced in dealing with such client behavior. This may mean that a large number of clinicians ignore or shun client masturbatory behaviors during counseling. Kucharski and Groves (1976) have noted that when clients act out sexually "...staff often becomes paralyzed, as if to interact with the [client]... in the obvious, corrective way would be to become involved in the sexual behavior itself" (p. 216). Addressing the issue of client masturbation during counseling may be helpful to all mental health professionals in all settings. This article (1) defines masturbation and explores related clinical issues, (2) suggests clinical responses to client masturbation during counseling, and (3) discusses client masturbation relevant to counselor education and research.

Masturbation: Definition and Clinical Issues

Masturbation may be defined as stimulating one's genitals, not necessarily

to orgasm, for the purpose of gaining sexual pleasure (Fenichel, 1954; Mish, 1996). Generally, this is carried out in private, and may often involve fantasies that would not be acted out in real life (Fenichel, 1954). Although historically masturbation was socially prohibited as a physically and psychologically destructive behavior, today it is more widely accepted as a normal and enjoyable part of human sexuality (Hillman, 1975).

While certain clinical issues associated with client masturbation during counseling are unique to the client and counselor, three clinical issues seem worthy of general discussion: Client motivation, counselor reaction, and the effect on the counseling process/relationship.

It may be helpful to understand the motivation for client masturbatory behavior. Motivational considerations might include the here-and-now experience of the client, whether the masturbatory behavior is a result of sexual arousal, whether sexual arousal is the result of session content or session process, or whether the masturbatory behavior is an attempt to

intimidate, manipulate, or be aggressive.

It may also be helpful for clinicians to understand their reactions to client masturbatory behavior. Reactionary considerations might include assessing feelings of threat, shock, disgust, fear, and/or arousal; whether the obvious was ignored or denied; whether the clinician refused to see the client after the masturbatory incident or refused to discuss it. Clinicians might also consider seeking consultation or therapy to discuss these issues.

Finally, it may be helpful to understand client motivation for, and clinician reaction to, client masturbation as relevant to the counseling process. Counseling process considerations might include the strength of the therapeutic relationship, the willingness of the client and counselor to openly discuss and resolve what has happened, and whether any agreement has been reached regarding future masturbatory behavior.

Consider the following client masturbation case and related clinical issues as they might occur in a correctional institution. Incarcerated individuals

often express antisocial tendencies through sexual aggression in a way that is opportunistic and impulsive (Seto & Barbaree, 1997). The motivation can be nonsexual and the acting out can be viewed as a tool of dominance (Arlow, 1986; Darke, 1990). Coen (1981) suggests individuals who extensively act out in a sexual manner serve their own central defense, not sexual arousal, through masturbation. Their masturbatory behavior is not an act of sexual pleasure, but aggressive posturing.

In addition, the prison environment deprives inmates of personal freedom, personal security, sexual experiences, access to services, physical movement, sensory experience, privacy, and primary relationships contributing to "deviant" sexual behavior (French, 1992). Frustrated by personal loss of freedom, and social and sensory deprivation, inmates may resort to masturbation for stimulation, intimidation, and manipulation.

Counselor reaction to client masturbation may include shock, disgust, fear, denial, and/or anger. Counselors may be tempted to either avoid clinical

rounds or ignore inmate masturbation: A coup for inmates who may then initiate litigation for deprivation of mental health services, or continue to taunt the counselor who endures the continuing masturbation having no plan for effectively addressing the behavior. The impact of all this is detrimental to the counseling process. The clinical relationship lacks collaboration and authenticity, and until these problems with the counseling process are addressed constructive ends are unlikely. Mental health clinicians in all settings face the same or similar issues in dealing with client masturbation during counseling.

Clinical Responses to Client Masturbation During Counseling

The following specific considerations can be helpful to counselors when their clients masturbate during counseling. If the client is masturbating, the counselor may visually recognize this by looking at the masturbatory behavior and then looking at the client's face (the implicit message to the client is “I see you are doing this and I am not so intimidated or shocked

that I will ignore you"). The counselor might then say to the client "I see that you are masturbating" or "I am not certain what you are doing" or "I am distracted by your movement and I would like to understand what is happening." The client may then stop masturbating and discussion of what has been happening for the client (and the counselor) can begin. Discussing the client sexual behavior to understand it as part of the client will help affect a constructive approach (Kucharski & Groves, 1976). [Note that this does not relieve clinicians of the responsibility of addressing their own issues with their own therapists regarding sexual behaviors, countertransference, boundaries, enmeshment, etc.]

If the client continues to masturbate, the counselor may then say "It seems you do not wish to talk about what is going on for you" or "I am distracted when you are masturbating. Let us end this session and talk again when you are not masturbating." At this point the counselor can stand to end the session and escort the client out of the office.

The wording of such responses can be integral to a constructive outcome and is worthy, therefore, of significant forethought and review by the counselor. Take into consideration who you are as a counselor, and your particular theoretical orientation to counseling. Avoid expressing shock, fear, or any critical reactions to the masturbatory behavior. Whether the client stops masturbating and the session continues, or whether the client continues and the session ends, addressing the client masturbatory behavior is crucial. Future sessions may include open discussion of what was happening for the client while masturbating (including feelings, thoughts, and physical reactions), the affects on the counseling process for both client and counselor, and an agreement about future masturbatory behavior during counseling sessions.

Research, Education Programs, and Client Masturbation

The research literature is dated and reflects a current disinterest in masturbation as a clinical issue. Some literature addresses masturbation

from a sexual satisfaction perspective. Some of the literature debates the pros and cons of lone sexual satisfaction and argues whether masturbation "should" be tolerated. Masturbation as a clinical issue for counselors is addressed only in relation to telephone counseling, wherein counselors are advised to discontinue the call (Lester, 1973). Hillman pointed out that "Man is evidently uncomfortable about masturbation. Our own supposedly enlightened attitudes...express guilt; for it is usually the view in psychological literature that masturbation is either substitutive or regressive behaviour..." (1975, p. 111). It may be added that, as a clinical issue, masturbation is virtually denied.

With little discussion in the literature, it follows that client masturbation issues are not generally discussed in counselor training programs. One research study found a lack of sexual awareness training in counseling programs, and the necessity for such training with regard to masturbation, sensuality, homosexuality, and heterosexuality (Landis, Miller, & Wettstone, 1975). The same research study initiated an intensive weekend-

seminar training program, designed to assist counselors in recognizing their own sexual feelings and attitudes. Upon completion of the training, 24 of the 25 counselors and graduate student participants evaluated the program positively.

Along with sexual awareness training, counselor training programs may be helpful in relieving counselor distress over the intrapsychic conflicts which may arise in the course of experiencing masturbation during counseling (Kucharski & Groves, 1976). Individual and group supervision can offer opportunities for discussing counselor reactions to client masturbatory behavior. Consultation with colleagues and individual counseling can provide additional opportunity for self-exploration. Furthermore, training programs can encourage counselors to deevlop responses to client masturbation that may constructively manage client masturbatory behaviors during counseling.

Conclusion

Client masturbation can occur in any counseling setting and can be problematic for counselors who have had little/no training or clinical experience with clients who masturbate. There is a paucity of literature and little training on the occurrence and management of client masturbation during counseling. It is suggested that: (1) counselors seek sexual awareness training, (2) counselor training programs offer opportunities for the discussion and exploration of counselor reactions to client masturbation, and (3) counselors explore possible clinical responses to client masturbation during counseling.

References

Aldridge, R. G. (1982). *Sexuality in confinement*. Rockville, MD: American Correctional Association.

Arlow, J. A. (1986). Discussion on identification of the perversions. *International journal of psychoanalysis, 2,* 245 - 250.

Coen, S. J. (1981). Sexualization as a predominant mode of defense. *Journal of the American Psychoanalytic Association, 29*, 893-920.

Darke, J. L. (1990). Sexual aggression: Achieving power through humiliation. In W. L. Marshall, D. R. Laws, & H. E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender* (pp. 55 -72). New York: Plenum.

Fenichel, O. (1954). On masturbation. In H. Fenichel & D. Rapaport (Eds.), *The collected papers of Otto Fenichel* (pp. 81 - 88). New York: W. W. Norton.

French, L. (1992). Characteristics of sexuality within correctional environments. *Corrective and social psychiatry, 38*, 5 - 8.

Hillman, J. (1975). *Loose ends*. Zurich: Spring Publications.

Kucharski, A. & Groves, J. E. (1976). The so-called inappropriate psychiatric consultation request on a medical or surgical ward.

International journal of psychiatry in medicine, 7, 209 - 220.

Landis, C. E., Miller, H. R., & Wettstone, R. P. (1975). Sexual awareness training for counselors. *Teaching of Psychology, 2(1),* 33 - 36.

Lester, D. (1973). Telephone counseling and the masturbator: A dilemma. *Clinical social work journal, 4,* 257 - 260.

Mish, F. C. (Ed.). (1996). *Merriam Webster's collegiate dictionary (10th ed.).* Springfield, MA: Merriam-Webster.

Seto, M. C., & Barbaree, H. E. (1997). Sexual aggression as antisocial behavior: A developmental model. In D. M. Stoff, J. Breiling, & J. D. Masur (Eds.), *Handbook of antisocial behavior* (pp. 305 -313). New York: Wiley.

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