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# Reasonable Paternalism and the Limits of Sexual Freedom: a response to Greenspan and Leicester and Cooke

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**ABSTRACT** *This response argues that Greenspan's comment is basically incoherent, and that the position taken by Leicester and Cooke has unacceptable practical consequences. Greenspan admits that many people with 'mental retardation' lack adult decision-making capacities, but at the same time assumes that they have these very capacities in assigning them freedom rights. Leicester and Cooke consistently argue that people with 'mental retardation' do have adult reasoning powers and therefore should be given freedom rights. But this position has the rather disquieting implication that both the practice of treating 'mental retardation' as an exempting condition and the practice of giving them important special welfare rights seem to lose their justification.*

In a response that should be brief it is impossible to discuss all the objections raised in the comments of Greenspan and Leicester and Cooke. We shall focus on what we see as the central subject under discussion: should people with "mental retardation" have the freedom to lead their own sex lives as they see fit or is some form of specified paternalistic supervision morally justified? Before going into that question, however, we would like to address, very briefly, two unrelated matters.

The first is that we had some difficulties with isolating relevant and substantial arguments in Greenspan's overly indignant and sometimes quite insinuating response. Not only is he often misrepresenting our claims (we are not defending the view that "people with mental retardation are, essentially, perpetual children", nor do we acknowledge that our policy would work only in settings where there is "daily, if not constant, supervision"—just to mention two examples); he is also trying to convince the reader by playing the man instead of the ball (no wonder, they do not have "real friendships ... with people with mental retardation", and they are coming from a country that is "lagging behind other western nations"—not to mention other arguments *ad hominem*). And, what is worse, he is disparaging our view by associating it with expressions and practices that evoke strong negative feelings but actually have nothing to do with the claims we make (care professionals will become "sexual

police officers”, people with mental retardation are regarded as “a subspecies of human beings”, there are historical links with “eugenic practices”, and so on). If we put all this in parentheses, as we should do in a philosophical or scientific discourse, what is left are a few arguments that are relevant but flawed and even incoherent, as we shall argue below.

The second, very different, issue we would like to touch upon concerns terminology. The question of which term is the proper one for referring to the group of people we want to discuss, and also the related question of how the status of the corresponding concept should be interpreted, are important and complicated. Here we simply want to make the following observations. By far the greatest number of subscribers to the *Journal of Moral Education* is located in North America. In that part of the world the term “people with mental retardation” is the common and prevailing one, as may be deduced from the name of the largest and most important US organisation for researchers and care professionals (*American Association on Mental Retardation*), as well as from the titles of the periodicals published by the organisation, which are among the most respected and influential in the field (*American Journal of Mental Retardation* and *Mental Retardation*).

According to Leicester and Cooke, the term “intellectual disabilities” has been adopted internationally. Greenspan points out that the AAMR has already initiated the process of jettisoning the term “mental retardation”, probably in favour of “intellectual disabilities”. But a brief look at the website of the AAMR ([www.aamr.org](http://www.aamr.org)) is enough to ascertain that the term “mental retardation” is still the standard one and is used without any perceivable reservation. In the recent report of the *ad hoc* Committee on Terminology and Classification of the AAMR, many issues are discussed but not the use of the term “mental retardation”. Without further ado it is stated simply that the 2002 proposed system retains the term “mental retardation” (webpage last updated 17 October 2001). Moreover, introducing the term “intellectual disabilities” would be difficult to reconcile with central elements of the AAMR definition of “mental retardation”. For many years, and in our view rightly so, the AAMR has emphasised that intellectual limitations are not enough for a diagnosis of mental retardation. As well as significantly sub-average intellectual functioning, the existence of limitations in adaptive skills in two or more skill areas that are central to successful life functioning (such as self-care, home living, community use and work) is also regarded as a necessary condition. This central characteristic is not reflected in the term “intellectual disabilities”.

The combination of the fact that by far the largest group of *JME* subscribers is domiciled in North America, and the fact that “mental retardation” is the standard term in that part of the world, has been for us an important reason for using it in our article. An additional reason has been that alternative expressions, such as “learning disabilities” and “learning difficulties” are not only, and often not at all, associated with people with mental retardation. In the United Kingdom the term “learning disabilities” is nowadays used widely to refer to people with mental retardation, although it is striking that in last year’s volume of the *British Journal of Developmental Disabilities* the term “mental retardation” is still used frequently,

including in the titles of articles. But even in the United Kingdom the term also covers quite different groups, as may be deduced from the last year's special issue of the *Journal of Moral Education* (30:3, 2001). In the United States and many other countries, including the Netherlands, the term "learning disabilities" is not used to refer to the class of people with mental retardation at all. For example, the *ad hoc* Committee on Terminology and Classification of the AAMR considers those diagnosed with learning disabilities and developmental disabilities as "other populations".

Let us move on to the more substantial differences between our views and those of Greenspan and Leicester and Cooke. Their principal objection to our point of view is that it morally legitimates paternalistic interventions into the lives of people with mental retardation. To them any form of paternalism towards (chronological) adults with mental retardation, including any form of paternalism with regard to their sex life, is morally wrong if not morally despicable. Correspondingly, they see our views as a threat to the freedom rights of people with mental retardation, or at any rate to their right of self-determination in the sexual sphere.

Our opponents are right in stating that the view we defended implies some form of paternalism towards people with mental retardation, and therefore also some restrictions of their freedom to arrange their sex life according to their own preferences. We argued that applying the liberal principle of mutual consent to sexual interactions between people with mental retardation has unacceptable consequences. According to this moral principle, anything sexual goes as long as it is done with the valid consent of the people involved. Valid consent roughly means consent that is not coerced but freely given, that is not the result of deceit but based on relevant and adequate information, and that is given by people with deliberative capacities that are typical of adults, in the status meaning of that term. In our view, people with mental retardation who are able to participate in sexual interactions are often lacking the powers of practical reasoning required for valid consent. On the basis of the principle of mutual consent, such forms of sex should therefore be considered morally impermissible. We believe, however, that many forms of sexual interaction between people with mental retardation are morally legitimate and often indeed morally desirable. Because we could not accept the implication of the principle of mutual consent indicated, we tried to articulate a principle that is even more liberal, in the sense of morally allowing particular forms of sex that do not meet the criterion of valid consent. This principle mentions several conditions of morally permissible sex between people with mental retardation who lack the deliberative capacities required for valid consent. The most important are that the sex is wanted or preferred by the people themselves and that caregivers who meet particular criteria have given their additional consent. The first condition, the fact that the people involved do desire the sexual interaction, is not enough for making the sex morally permissible. Because the people do not have the required adult capacities of practical reasoning, their preference cannot be regarded as a form of valid consent and should therefore be complemented with the consent of adult carers.

The moral principle we defended does indeed imply some form of limited paternalism. According to the second condition, care providers should not give their

consent if, after due reflection, they have good reasons to assume that the sexual interaction will be detrimental to the interests or long-term welfare of the people with mental retardation. In that process of reflection the preferences of the persons with mental retardation will obviously weigh heavily, but a conflict between these preferences and the considered judgement of the caregiver cannot be excluded. In such cases, we argued, the carer's judgement should be given moral priority.

This specified form of paternalism implies that people with mental retardation who are not capable of giving valid consent cannot be assigned the freedom right to arrange their sex life according to their own preferences. Freedom rights or rights of self-determination are often contrasted with so-called welfare rights. A welfare right is one which entails a positive duty, that is, a duty of others to *do* certain things, in this case the duty to provide or maintain certain benefits. But a freedom right merely entails a negative duty, that is, a duty of others *not* to do certain things, in this case the duty not to interfere with or render impossible the action or practice to which the person is being said to have a right. Because we believe that interference of carers is morally legitimate under the specified circumstances, we reject the view that they have such a negative duty with respect to the sex life of people with mental retardation who lack adult reasoning abilities. Contrary to what is suggested by Greenspan, we do not deny that such people have welfare rights in the domain of sexuality. Our firm conviction is that they do have a welfare right that entails the positive duty of care providers to give them the support they need if they want to have sex that is in their best interests. For the very reason that they should be denied a sexual right of self-determination, they have a welfare right that entails the positive duty of caregivers to help them in determining which form of sex would serve those interests.

Obviously an important assumption of our argument is that there are people with mental retardation who are capable of entering into sexual interactions without having the capacities required for giving valid consent. In our original article we made the claim that people who are moderately mentally retarded, and also people with mild mental retardation in relatively complex situations, do actually meet these criteria; but we admitted that the line between people with mental retardation who meet the criteria and those who do not is vague and could be drawn differently. Leicester and Cooke, however, deny that such a line can be drawn at all, as they contend that people described as having mild or moderate mental retardation can and do give valid consent. Perfectly consistent with this view, they believe that these people should be ascribed the right to arrange their sex life according to their own choices. What is striking is that Greenspan takes the position that people with mental retardation should have the right of self-determination in matters of sexuality, *without* rejecting the view that many of them are unable to give their valid consent. With regard to people with mild and moderate mental retardation, he claims that in almost any field of practical functioning "one will find a significant minority, sometimes a sizable minority, who clearly fall in the normal adult range in terms of both outcome success and decision processes used". This claim, which is based on the results of empirical research, implies logically that a substantial majority of people with mild or moderate mental retardation do *not* have adult

decision-making capacities. Perhaps he draws the line somewhat differently than we did, but he, too, acknowledges that a substantial group of people who are diagnosed as mildly or moderately mentally retarded lacks the capacities for giving valid consent. Why, then, give the members of this group the right to sexual freedom? Contrary to claiming a welfare right, which presupposes only that the right-holder has certain interests that can be protected or promoted, claiming a freedom right presupposes that the right-holder has the mental equipment for exercising that right. This equipment consists precisely of the capacities of practical rationality involved in having the status of an adult. So Greenspan claims, on the basis of empirical research, that many people with mental retardation do *not* have the adult decision-making capacities, while at the same time presupposing that they *have* these very capacities in assigning them the right of sexual self-determination. This position is, of course, incoherent.

According to Greenspan, “a major problem with the paternalistic approach to sex is that it denies people with mental retardation the opportunity to make, and learn from, their mistakes”; but this observation is unwarranted, at least with respect to the form of paternalism we defended. The moral principle we proposed prescribes that the caregiver should consider carefully whether or not being involved in some form of sexual interaction will serve the best interests or long-term welfare of the people concerned. Why could not the caregiver come to the conclusion that some form of wanted sex does meet this criterion, even though the carer knows that having the sex will turn out to be a somewhat dramatic experience for the participants? Indeed, the reason why the caregiver is consenting may be precisely that such a learning experience will serve their long-term welfare. Moreover, we should not confuse the freedom or opportunity of people to make and learn from their mistakes with their *right* to freedom. Any justification of giving people freedom rights seems to exclude paternalistic considerations, but it is hard to conceive how giving people the freedom to make their own mistakes and to learn from them could be justified but from paternalistic reasons. Consequently, giving people with mental retardation this kind of freedom and at the same time rejecting any form of paternalism towards them, is an incoherent position.

Unlike Greenspan, Leicester and Cooke defend the view that people with mild and moderate mental retardation do have the capacities required for giving valid consent; but is their view tenable? Leicester and Cooke argue that our claims are based on an empirical mistake, but they do not support this point of criticism by presenting any results of empirical research. The empirical research Greenspan refers to seems to corroborate our view rather than theirs. Moreover, with regard to “the most vulnerable adults in our society”, they argue in favour of an “assumption of freedom within a framework of protection”. We have difficulties in determining how such a framework might be maintained without any paternalistic supervision of caregivers. But our main objection to their position is that it implies ways of dealing with people with mental retardation that are, in our view, morally unacceptable.

To begin with, in claiming that people with mild or moderate mental retardation should be assigned the right of self-determination because they do have the adult powers of practical reasoning, one commits oneself to the view that they are

fully responsible for what they do. Holding someone fully accountable presupposes that the person is seen as having the capacities of practical rationality that are constitutive of adulthood. So if one makes the claim that people with mild or moderate mental retardation do in fact possess these capacities, one is no longer in the position to present their mental condition as an exempting condition. We have great difficulty in accepting this implication of Leicester's and Cooke's view, as may be illustrated by a dramatic example. Two pages of the website of the AAMR are directed against the death penalty of people with mental retardation. According to the AAMR, "the death penalty is disproportionate to the level of culpability possible for people with mental retardation". More generally, the claim is made that "mental retardation should always be considered to be a mitigating circumstance in selecting an appropriate punishment for a serious offence". The reason for taking these views is that "mental retardation is a substantially disabling condition which may affect an individual's ability to appreciate and understand fully the consequences of actions". In other words, because people with mental retardation "have poor understanding of cause/effect and of the consequences of their actions", they cannot be held fully responsible for what they do.

Another implication of giving people with mental retardation equal rights to self-determination seems to be that many forms of desirable support will lose their justification. It is generally seen as justified that people with mental retardation have welfare rights which entail positive duties of others, including the government, to ensure that they receive the necessary support. One of the major reasons for giving them such special rights is that their powers of practical reasoning are impaired. For example, the AAMR explicitly connects forms of support and services to particular limitations in adaptive skills related to the areas mentioned above. These adaptive skill limitations, which can all be regarded as limitations in practical rationality, function as justifying reasons for giving them the required support. However, the claim that people with mental retardation should be given *special* welfare rights is difficult to combine with the claim that they should have *equal* freedom rights. For part of the justificatory basis for giving them the welfare rights indicated is the fact that they lack the capacities required for giving them freedom rights.

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