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BALANCING THE RIGHT TO HABILITATION WITH THE RIGHT TO PERSONAL LIBERTIES: THE RIGHTS OF PEOPLE WITH DEVELOPMENTAL DISABILITIES TO EAT TOO MANY DOUGHNUTS AND TAKE A NAP

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In the pursuit of efficient habilitation, many service providers exercise a great deal of control over the lives of clients with developmental disabilities. For example, service providers often choose the client's habilitative goals, determine the daily schedule, and regulate access to preferred activities. This paper examines the advantages and disadvantages of allowing clients to exercise personal liberties, such as the right to choose and refuse daily activities. On one hand, poor choices on the part of the client could hinder habilitation. On the other hand, moral and legal issues arise when the client's right to choice is abridged. Recommendations are offered to protect both the right to habilitation and the freedom to choose.

DESCRIPTORS: developmentally disabled, ethics, client rights, choice behavior, mentally retarded

In the pursuit of efficient habilitation, many service providers exercise a great deal of control over the lives of clients with developmental disabilities (Guess, Benson, & Siegel-Causey, 1985; Kishi, Teelucksingh, Zollers, Park-Lee, & Meyer, 1988; Turnbull & Turnbull, 1985). Service providers often choose the client's habilitative goals, choose their work or day treatment setting, impose inflexible daily activity schedules, and regulate access to preferred activities. The choices made by the service provider may indeed promote habilitation, but these choices may not reflect the client's preferences. The purpose of this paper is to discuss the relation between the right to habilitation and the client's right to personal liberties. The following questions will be addressed: What does the "right to habilitation" mean for people with developmental disabilities? What are personal liberties? What are the advantages and disadvantages of allowing citizens with developmental disabilities to exercise their personal liberties? How might service providers better protect both the right to habilitation and the freedom to choose?

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THE RIGHT TO HABILITATION

Habilitation involves teaching the skills needed to live as independently as possible (Favell, Favell, Riddle, & Risley, 1984). A long history of inadequate services for people with developmental disabilities has been the impetus for numerous class action suits and legislative reforms guaranteeing these citizens a general right to habilitation. In the most well known of the class action suits, *Wyatt v. Stickney* (1971, 1972, 1975), an Alabama court (and subsequently the Fifth Circuit Federal Court) determined that citizens with mental retardation have a "right to receive such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society" (*Wyatt v. Stickney,* 1975, p. 397). On the basis of this ruling, the court set minimum standards that included individualized habilitation plans, a humane physical environment, and assurance of enough qualified staff to administer adequate treatment (*Wyatt v. Stickney,* 1975, p. 395). Despite the Wyatt court's determined efforts to upgrade the standards for treatment, a constitutional right to habilitation has not yet been established. In fact, in a recent Supreme Court case, *Youngberg v. Romeo* (1982), the Court guaranteed only as much habilitation as needed to ensure freedom from undue restraint.

Since 1976, federal and state legislatures have taken a much stronger position than the courts in securing the right to habilitation. Federal legislation includes the Developmental Disabilities Assistance and Bill of Rights Act (1979), the Rehabilitation Act of 1973, The Education for All Handicapped Children Act of 1975, the Medicare Catastrophic Coverage Act of 1988 (Strauss, 1988), amendments to the Social Security Act including the new Standards for Payment for Skilled Nursing and Intermediate Care Facility Services (1988), and the proposed Medicaid Home and Community Quality Services Act of 1987 (not yet enacted as of May, 1989).

Not only has legislation mandated habilitation, but most laws make funding contingent on compliance with specific habilitative standards that emphasize the teaching of independent living skills as well as the provision of a safe and attractive living environment (Developmental Disabilities Assistance and Bill of Rights Act, 1979; The Educational for All Handicapped Children Act of 1975; The Rehabilitation Act of 1973; Standards for Payment for Skilled Nursing and Intermediate Care Facility Services, 1988). Proposed positive effects of contingent funding include higher quality habilitation programs. Possible unexpected effects, however, may be the compromise of clients' personal liberties.

Personal Liberties: The Right to Choose and Refuse

In a legal context, personal liberties include freedom of speech, freedom of religion, and other rights guaranteed by the Constitution. It may be argued, however, that personal liberties are even more basic than those detailed in the Constitution. Supreme Court Justice William O. Douglas discussed the "right to be let alone," including "the privilege of an individual to plan his own affairs, . . . to shape his own life as he thinks best, do what he pleases, go where he pleases . . . freedom from bodily restraint or compulsion, freedom to walk, stroll, or loaf" (citations omitted) (*Doe v. Bolton,* 1973). This legal conceptualization of personal liberty implies that people should have a variety of available options and be free from coercion when choosing between options.

From a behavior-analytic perspective, options in life are valued, but choice is anything but free (Skinner, 1971). Choice is, presumably, a function of historical and existing reinforcement and punishment contingencies. Many of these contingencies are not readily apparent, making choice difficult to analyze and predict. How people make choices has been investigated in research on concurrent schedules of reinforcement (Catania, 1979) and has been described (with varying degrees of accuracy) with equations such as the matching law (Herrnstein, 1970; McDowell, 1988) and with theories such as maximization and melioration (see Mazur, 1986). Because choice is difficult to analyze, some researchers have defined choice by the more apparent stimulus and contigency conditions. For example, Brigham (1979) defined choice as

> the opportunity to make an uncoerced selection from two or more alternative events, consequences, or responses. By uncoerced, we mean that there are no programmed implicit or explicit consequences for selecting one alternative over the others except for the characteristics of the alternatives themselves. (p. 132)

The terms *choice* and *choosing* used in this paper correspond closely to the term *uncoerced selection* as used by Brigham.

Even though behavior analysts may argue that choice is not free, many also recognize that perceived choice is extremely valued by many people. World history and current events are filled with examples of people striving to live "free." Further, the illusion of freedom and choice seems to play an important role in the individual's successful functioning (Lefcourt, 1973; Taylor & Brown, 1988).

Not only do people strive for freedom in a broad sense, they also enjoy making simple choices, such as whether to engage in unproductive, though harmless, activities, like watching sitcoms on television, eating too many doughnuts, taking the

afternoon off from work, or taking a nap before dinner. People typically decide for themselves when to take a shower, what to eat, and with whom to spend their time. These choices are cherished by most people, including those with developmental disabilities. At issue is whether service providers actually allow clients with developmental disabilities these liberties and whether it is in the clients' best interests (i.e., interests that lead to an independent, normal lifestyle most efficiently) to exercise these liberties.

The Present Status: Compromising Liberties to Achieve Habilitation

Personal liberties can be compromised in many ways by service providers striving to meet standards for habilitation, be cost effective, and satisfy parents, board members, school administrators, neighbors, and other consumers. Some of the ways in which personal liberties may be compromised are as follows.

1. Clients may have little or no input in decisions regarding their priority treatment goals or on the procedures used to teach them (Guess & Siegel-Causey, 1985). As a consequence, clients may not be motivated to achieve particular goals. They may resist particular teaching procedures. Staff may interpret this resistance as a failure in teaching technology when it could merely be an expression of preference (Guess & Siegel-Causey, 1985; Houghton, Bronicki, & Guess, 1987).

2. Teachers or residential staff may teach behaviors with no regard for the client's preference or past learning in the area. For example, staff members may teach horseshoes and jogging because they prefer those leisure activities as opposed to determining and respecting the leisure preferences of the client. Or, staff may teach wetting the toothbrush before applying toothpaste, even though the client may be accustomed to doing it in the reverse order. Parents, guardians, or advocates who are legally responsible for making decisions for clients deemed incapacitated may make decisions based on their own interests of time, money, protectiveness, and preference, instead of the client's preferences (Turnbull, Turnbull, Bronicki, Summers, & Roeder-Gordon, 1989).

3. Choice making is not often taught. Shevin and Klein (1984) assert that "our profession has focused on choice-making as a permissible activity, rather than as a teaching target" (p. 60). Many people require teaching to help them discover their own preferences and learn to make responsible choices. Unfortunately, we have given little attention to the development of curricula for teaching students to discriminate their preferences and make choices to obtain them (however, see Hazel, Deshler, Turnbull, & Osborne, 1988). Further, perhaps due to lack of choice-making curricula, professional teacher training does not often include methods on how to instruct clients in choice making.

4. Opportunities for choice are not often given (Guess et al., 1985; Kishi et al., 1988; Knowlton, Turnbull, Backus, & Turnbull, 1988). The pressure to meet regulatory standards may cause some service providers to put too much emphasis on quantity and scheduling of habilitative activities. In fact, many service agencies, such as Intermediate Care Facilities for the Mentally Retarded, are required to implement hour-by-hour daily schedules (Standards for Payment for Skilled Nursing and Intermediate Care Facility Services, 1988). Inflexible scheduling often precludes opportunities for choice. For instance, clients may not be allowed to choose the order or timing of activities. They may be discouraged from taking breaks or from choosing activities that are not scheduled. Staff may pick out clients' clothes. A dietitian may plan clients' meals. Leisure materials may be locked in a cabinet until scheduled leisure times.

Additionally, the pressure to please funding agencies, parents, and other consumers may compel direct care staff and teachers to "put on a show" when visitors arrive. This is often done with little sensitivity to the clients' preferences at the time.

It is clear that personal liberties can be easily denied. At issue is whether it is in the client's best interest to be allowed to exercise choice (Griffith & Coval, 1984). Is it in the best interests of a client with significant independent living skill deficits to

be allowed to skip a teaching session, choose a hobby over an academic habilitation goal, refuse to go on a shopping trip, or eat too many doughnuts and take a nap? Arguments supporting each side of the issue are discussed below.

Arguments Opposing the Right to Choice

The strongest argument against the right to choice is that many people with developmental disabilities may make bad choices (Guess et al., 1985). For instance, some may have no leisure skills in their repertoire and, therefore, may engage in stereotypy, napping, or self-injury during free time. Other clients with limited skill repertoires may choose a skill that they have not mastered. For instance, they may make an incomplete lunch or attempt to to take a bus to work without knowing how. Although other members of society enjoy the right to choose an incomplete lunch, or engage in other unproductive, even unsafe, activities, they typically have a vast repertoire of learned skills and behaviors and are presumably aware of most of the consequences of their behavior. Further, they are occasionally compelled to work, cook, or study in order to meet the contingencies required to sustain their lives. The argument follows that people who do not have a repertoire of skills, and who do not understand the consequences of their behavior, require intensive teaching in these areas before being allowed to choose. Until that time, caring, responsible parents, advocates, or teachers should aid the client in deciding what activities can be refused and what types of choices he or she is capable of making (Shuman, 1975). Society has chosen to treat minors in a similar manner because of their presumed inability to make competent decisions due to age.

Another argument against giving clients the right to choose is that allowing this freedom may hinder their acquisition of critical independent living skills (Knowlton et al., 1988). For instance, if a client is allowed to choose to be dressed by staff each morning, then that client is not learning how to dress independently. If a client chooses to learn a hobby rather than a vocational task, this may hinder future opportunities for employment. Federal, state, and local funding agencies have a compelling interest in teaching independent living skills to people with developmental disabilities because they are dependents who require considerable public financial support (Griffith & Coval, 1984). The argument follows that abridging personal liberties in order to teach independent living skills is an appropriate tradeoff (Griffith & Coval, 1984; American Bar Association, 1975). Some argue further that clients have an obligation to try to achieve the goals set in the interdisciplinary planning process (IPP) (Gardner & Chapman, 1985; VanBiervliet & Sheldon-Wildgen, 1981). VanBiervliet and Sheldon-Wildgen contended: "If the client fails to fulfill this responsibility [to attempt to achieve IPP goals] and the program has tried less drastic means of resolving the situation and has failed, the client can be asked to leave the program" (p. 132).

Arguments in Favor of the Right to Choice

A compelling argument in favor of allowing clients the right to choose is that legislation guarantees it. People with developmental disabilities are guaranteed the same basic rights as other citizens of the same country and same age (Declaration of Rights of Mentally Retarded Persons, 1972; Developmental Disabilities Assistance and Bill of Rights Act, 1979). In fact, the recently enacted Standards for Payment for Skilled Nursing and Intermediate Care Facility Services (1988) not only assert that clients have the right to make choices, but require that staff provide opportunities for choice (p. 20500). Everyone has the right and ability to make choices on some level. Even a person with profound mental retardation can choose what to eat for a snack or which chair is most comfortable. People should be allowed to exercise as much choice as their abilities allow, whether it involves expressing a simple preference or weighing the advantages and disadvantages of several options during complex decision making.

A second argument is that the ability of a client to exercise choice may prepare him or her to live in the community where individuals are expected to make decisions and choices (Knowlton et al., 1988; Perske, 1972; Turnbull et al., 1989; Veach, 1977; Wolfensberger, 1972). Because most clients

are striving towards a more normalized lifestyle, learning to live as other community members do is an important goal.

Findings from experimental research with a number of different subject populations provide additional support for personal liberties. Researchers have found that individuals frequently prefer situations in which they have choice and that choice rarely proves detrimental to the individual and may, in fact, be beneficial. Below, we briefly review some of this research and note a number of pertinent research issues (see also Harchik, Sherman, & Sheldon, 1989).

Effects of Choice on Preference

In studies that examined preference for choice, subjects were concurrently presented with two situations that were equivalent, except that choice was made available in only one of the situations. Individuals most frequently chose the situation in which choice was made available. For example, children chose to participate in tasks in which they had a choice of reinforcers more often than when the experimenter chose the same reinforcers for them (Brigham, 1979; Brigham & Sherman, 1973; Brigham & Stoerzinger, 1976). Adolescents with developmental disabilities who engaged in stereotypic rocking more frequently chose a chair in which they could rock themselves over a chair rocked by the researchers at the same rate (Buyer, Berkson, Winnega, & Morton, 1987). Rats and pigeons also preferred situations in which choice was available (Catania & Sagvolden, 1980; Voss & Homize, 1970), suggesting that the effects of choice are not limited to humans.

Effects of Choice on Participation

Individuals appear to participate more in activities when opportunities for choice are available. Adolescents participated in group decision making more often when they determined consequences for their peers than when their teaching parents determined the consequences (Fixsen, Phillips, & Wolf, 1973); women who chose their own exercises had better attendance at a fitness club than other women who were assigned the same exercises (Thompson & Wankel, 1980); undergraduates who chose whether to participate and what their reward would be, participated in a puzzle game during free time more often than others who had not been given either choice (Zuckerman, Porac, Lathin, Smith, & Deci, 1978); and when office workers chose lottery tickets, they were less likely to sell or exchange their tickets before the drawing, even for tickets with better odds (Langer, 1975).

Effects of Choice on Task Performance

Opportunities to make choices in a situation may improve performance. For example, children who were given a choice of treatments for recalling or recognizing words or losing weight performed somewhat better than other children who received that same treatment but had not chosen it (Berk, 1976; Mendonca & Brehm, 1983). Similar effects were found with undergraduates who chose treatments for improving reading and study habits or for reducing fear of snakes (Champlin & Karoly, 1975; Devine & Fernald, 1973; Kanfer & Grimm, 1978), with children who were allowed to choose art materials (Amabile & Gitomer, 1984), and with undergraduates and older adults who could control the termination or duration of shocks or noise (Glass, Singer, & Friedman, 1969; Reim, Glass, & Singer, 1971). In a series of laboratory analogue studies, undergraduates who chose the words used in a paired-word learning task responded faster, learned the words faster, and learned more word pairs than others who did not choose (e.g., Perlmuter & Monty, 1973; Perlmuter, Scharff, Karsh, & Monty, 1980). Conversely, however, Dyer, Dunlap, and Winterling (1989) and Newhard (1984) found the academic performance of children with severe disabilities to be the same whether or not they chose the task, materials, or reinforcers.

Finally, students have chosen their own consequences for performance on tasks. In some studies, student performance subsequently improved (Dickerson & Creedon, 1981; Lovitt & Curtiss, 1969). In other studies, choice of consequences did not change the students' performance (Brigham & Sherman, 1973; Brigham & Stoerzinger, 1976; Felixbrod & O'Leary, 1973; Glynn, 1970).

Effects of Choice on Problem Behavior

Problem behaviors appear to be exhibited less frequently when an individual has opportunities for choice. Autistic children exhibited fewer problem behaviors (e.g., aggression, self-injury) when they had a choice of tasks, materials, and reinforcers than when the therapist made these choices (Dyer et al., 1989), and they demonstrated less social avoidance (e.g., looking and moving away) when they were engaged in activities that they preferred (Koegel, Dyer, & Bell, 1987). Students with severe developmental disabilities demonstrated less aberrant behavior and greater compliance when they could control the pace of instructions during vocational tasks (Dobbins, 1988). High school and college students demonstrated less noncompliance in completing tasks when they had opportunities for choice in the situation (Heilman & Toffler, 1976; Wright & Strong, 1982).

Effects of Choice on Responses to Aversive Stimuli

Subjects who could control an aspect of an aversive situation (e.g., choice of the termination, duration, or presentation of shock, noise, or written tests) reported less discomfort and had less extreme autonomic responding than subjects who received the same stimulus but had no control over it (Corah & Boffa, 1970; DeGood, 1975; Geer, Davison, & Gatchel, 1970; Geer & Maisel, 1972; Stotland & Blumenthal, 1964). Further, rats presented with escapable and avoidable shocks developed fewer gastric ulcers than those who received the same amount of shock that was inescapable and unavoidable (Weiss, 1971); infant boys who had opportunities to control the action of a mechanical toy were less likely to cry than other boys who did not have these opportunities (Gunnar-Vongnechten, 1978); and patients given a choice of two medical treatments were less likely to be depressed or anxious than patients assigned a treatment (Morris & Royle, 1988).

Research Issues

A number of issues should be considered in attempting to analyze the generality and applicability of the research findings on choice. First, some methodological issues deserve consideration. Few of the studies used within-subject analyses with repeated measurement of the dependent variables; most employed between-subject group designs (e.g., Amabile & Gitomer, 1984). This makes it difficult to determine the responses of individual subjects and the effects of the variables over time. Also, many studies used statistical procedures to analyze data. Although statistical significance was often obtained, inspection of the mean performance data presented for each group sometimes did not indicate strong clinical effects (e.g., Berk, 1976). Further, some of the studies were conducted in analogue or laboratory situations and, thus, if choice did appear to have an effect, it is not clear whether the same effects would have occurred in more naturally occurring situations (e.g., Zuckerman et al., 1978). Finally, undergraduates were the subjects in a number of studies, and generality to other populations cannot be assured (e.g., Perlmuter et al., 1980). Recently, however, researchers have begun to examine choice with single-subject designs under more naturally occurring conditions (e.g., Dyer et al., 1989; Kosiewicz, Hallahan, and Lloyd, 1981; Parsons, Reid, Bumgarner, & Reynolds, 1988).

Another issue relates to the interaction between making a choice and receiving a preferred outcome; that is, the effects of choosing per se may be confounded by obtaining preferred outcomes. A few studies have examined this issue. The benefits in task performance associated with being assigned a preferred outcome were similar to those associated with choosing a preferred outcome (Kosiewicz et al., 1981; Parsons et al., 1988); however, choice of outcome was preferred by subjects over assignment of singular outcomes (Brigham & Sherman, 1973).

Finally, in most of the studies, subject perception of whether or not they made choices was rarely assessed. As Langer (1983) noted, the perception of the individual, not the experimenter, may be most relevant. Many people with developmental disabilities may not perceive choice that is available and, moreover, many may not be skilled in making choices. Therefore, these people may require teach-

ing to learn how to exercise choice to obtain what they desire.

In summary, this research indicates that individuals frequently prefer situations in which they have choice. It also seems that choice may have benefits for the individual, especially in increasing participation and reducing problem behaviors. More research, however, will be needed to determine the conditions under which choice may have the most benefit for people with developmental disabilities.

Protecting Both the Right to Habilitation and the Right to Choice

Habilitation and the right to choose need not be thought of as conflicting goals. Although extra time and teaching are needed to help clients learn to make choices, this liberty may facilitate habilitation by increasing client satisfaction with habilitative goals and procedures, thereby increasing client willingness to participate. Thus, choice making should be integrated into the habilitation process. This does not mean that service providers should sit back and allow clients to "do their own thing," because clients may make a number of bad choices that would hinder habilitation. Rather, service providers should challenge themselves to work harder at teaching and providing opportunities for choice within the context of habilitation. This integration of choice into the habilitation process may be worth the extra time and effort. The following are some possible ways to accomplish this integration:

1. Service providers should emphasize teaching independent living skills and other functional behaviors that are preferred by the client. This will equip clients with a repertoire of appropriate, as well as preferred, behaviors from which to make choices.

2. Clients should have input in decisions about what skills they will learn and how they will be taught (Guess et al., 1985; Guess & Siegel-Causey, 1985; Turnbull et al., 1989; Turnbull & Turnbull, 1985). The preferences of clients with severe and profound disabilities can be assessed through observation and analysis of their responses to various skills, teaching procedures, and other stimuli (see preference assessment procedures in Caldwell, Taylor, & Bloom, 1986; Green et al., 1988; Mithaug & Hanawalt, 1978; Pace, Ivancic, Edwards, Iwata, & Page, 1985; Wacker, Berg, Wiggins, Muldoon, & Cavanaugh, 1985). For example, Pace et al. (1985) and Green et al. (1988) determined stimuli preferred by persons with severe and profound retardation by assessing each client's approach to and avoidance of each target stimulus.

Preference scales or checklists are also available to aid service providers in determining client choices (see Becker & Ferguson, 1969; Goode & Gaddy, 1976; Helmstetter, Murphy-Herd, Roberts, & Guess, 1984; Kishi et al., 1988; Turnbull et al., 1989). These assessments can be conducted by interviewing the client or by interviewing those who know the client well. These reports of client preferences can then be validated through use.

The crux of the issue is that interdisciplinary teams (educational or residential) should not make decisions about the client's future without client input (Bennett, 1981). Rather, client preferences, whether stated by the client or determined from observational data, should be considered highly. Further, once the residential or educational plan is implemented, service providers and teachers should continue to observe, evaluate, and talk to the client, being open to changes that reflect client preferences.

3. Clients should be taught how to choose (Brown et al., 1980; Guess & Siegel-Causey, 1985; Shevin & Klein, 1984; Turnbull & Turnbull, 1985). It should be part of their learning curriculum and "subject to task analysis, planning, implementation, and evaluation" (Shevin & Klein, 1984, p. 160). Unfortunately, only a few tested curricula are available for teaching choice. For example, Hazel at al. (1988) developed and tested a curriculum to teach skills (including decision making, negotiation and communication) to adolescents with mild mental retardation. Their findings showed that the adolescents used these skills to obtain some of their preferences.

A number of other materials may be useful in teaching clients to make choices. First, Wuerch and Voeltz (1982) developed a leisure skills training program for persons with severe disabilities that includes suggestions for teaching choice making.

Henning and Dalrymple (1986) presented a program for teaching a youth with autism to choose leisure materials. Guess and Helmstetter (1986), in their instructional curriculum for persons with severe disabilities, described teaching choice making in natural situations.

Other researchers and educators offer suggestions (as opposed to complete teaching curricula) about what to teach in order to prepare clients for making choices. For example, Shevin and Klein (1984) recommended teaching concepts like "choose, now, later, I want, and I do not want, etc." Guess, Sailor, and Baer (1976) described procedures to teach functional use of "yes" and "no." Reese (1986) showed that some clients learned to make complex decisions by listing options, discussing advantages and disadvantages of each option, and choosing the best option.

To ensure that clients are taught to make choices, teachers and other service providers should be well trained in this area and should be accountable for teaching and providing opportunities for choice. This means that institutions should address the need for teacher and residential staff training so that staff and teachers will be well prepared to encourage and teach choice making. Finally, educating teachers and staff about client's rights may decrease the likelihood of teachers or staff allowing competing interests (e.g., saving time and effort) to preclude the client's right to choice.

4. Clients at every functioning level should be given opportunities to make choices in their residential and work settings, within and between scheduled activities. Some clients might only be able to make simple choices initially (e.g., what dessert to eat, when to go to bed). Other clients might learn to make more complicated decisions (e.g., how to spend a workshop paycheck, how to handle a problem with another client). Staff members must be motivated to provide these opportunities for choice. Supervisors can enhance staff motivation by setting up contingencies for these activities (e.g., a program of observation, feedback, and reward). Also, activity schedules should be set up to allow time for choice.

Client refusals, bad choices, and off-task behavior should signal staff to examine the situation and to determine whether allowing more choice or teaching more choices would be of benefit (Griffith & Coval, 1984; Guess & Siegel-Causey, 1985; Shevin & Klein, 1984). For instance, instead of immediately correcting a client who does not want to take her bath because she is watching her favorite television show, staff should evaluate whether it is reasonable to change the time of the bath. If a reasonable preference cannot be honored at a particular time, staff should plan when and how it could be honored in the future. If a client repeatedly refuses to engage in habilitation activities after reasonable choices have been given, then an objective interdisciplinary review committee should consider whether that choice should be abridged.

Conclusion

All people have the right to eat too many doughnuts and take a nap. But along with rights come responsibilities. Teaching clients how to exercise their freedoms responsibly should be an integral part of the habilitation process. While learning, clients should be encouraged to make as many choices as their abilities allow, as long as these choices are not detrimental to the client or to others.

Although this paper has emphasized the vulnerability of people with developmental disabilities to rights abridgments, it is important to consider other populations that may be similarly vulnerable, such as children, research participants, and patients receiving medical care or therapy. These people may not be aware of their rights or may give up rights unwittingly in order to obtain desired treatment. Thus, clinicians, researchers, and other professionals must be vigilant in protecting the rights of all people to direct their lives as independently as possible.

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