Choice in the diet of people with learning difficulties

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Many adults with learning disabilities experience difficulties communicating food preferences because they may have little opportunity to do so. This article discusses how health care professionals can enable people with learning difficulties to exercise choice about food and how those choices can be recognised.

Choice is often restricted for people with learning difficulties. Food choice is an integral part of our life - it is often an unconscious process that is taken for granted. However, people with intellectual difficulties are often prevented from making choices about food because they do not have the means to do so. Jenkinson (1993) summarised these difficulties in three broad categories:

- Environmental factors, such as constraints arising from group living, service structures and resource limitations. For example, when the environment is not structured to promote choice or when insufficient effort has been made to make people with learning disabilities aware that a choice is available. Routine often plays an integral part, reducing opportunities for people to make choices. A denial of choice underlies the clients’ inability to respond to stimuli, resulting in them becoming increasingly passive and unable to acquire the skills that lead to independence.

- Staff behaviour, such as overruling choices. It has been shown that carers sometimes overrule a client’s initial choices if they think the choice was based on inadequate experience of an option.

- Service-user difficulties, such as limited experience of making choices and failure to master the relevant skills.

Reduced intellectual capacity need not lead to an inability to make choices. People with severe and profound developmental disabilities can express preferences (Lancioni et al, 1996). The difficulty lies in obtaining their views, as using interview techniques is not always appropriate (Longley and Collins, 1994).

Choosing what to eat is one of the most basic life choices and as such has been included in the Essence of Care project (Department of Health, 2001). Essence of Care has been designed to improve quality, empowerment and choice and nine fundamental aspects of care have been identified, including food and nutrition, to ensure a person-centred approach is applied. This approach is aimed at minimising the historical view that people with learning difficulties are incapable of taking responsibility for their own lives, or being involved in the decisions made about them.

**Method**

This study on the food choices and satisfaction of people with a learning disability was a joint project in two residential units for people with severe intellectual difficulties within the Nottinghamshire areas of Mansfield and Newark.

The total sample size was 10, with four from one unit and six from the other. After a full explanation of the study, the managers of each unit gave ethical consent allowing a series of observations to be conducted during mealtimes over a two-month period. All the participants were observed at least eight times over a series of lunch or dinner times. The following measures were used to collect data:

- Time sampling, as used by Longley and Collins (1994), conducted by researchers in a 20-minute observation of clients’ behaviour while eating.
- Questionnaire, completed by staff members after each meal, which looked at the key areas of

<table>
<thead>
<tr>
<th>TABLE 1. Key areas of behaviour observed in the 10 participants</th>
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<tr>
<td>Client pushes food around</td>
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<tr>
<td>Client throws food</td>
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<tr>
<td>Client grabs other people’s food</td>
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<tr>
<td>Client requires prompts to eat slower</td>
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<tr>
<td>Staff give verbal prompts to encourage eating</td>
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<tr>
<td>Staff give physical prompts to encourage eating</td>
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<tr>
<td>Client looks away a lot/distressed while eating</td>
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<td>Client is excitable during meal time – clapping/banging</td>
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Staff and researchers decided on behaviours that best presented the clients’ most frequently observed positive behaviours, such as excitable behaviours and grabbing others’ food, and their negative behaviours, such as pushing food away, and requiring physical prompts to eat.

During each observation the frequency of these behaviours was noted and taken as a representation of clients’ satisfaction with the food. The observations were categorised into positive and negative behaviours. The frequency of these behaviours was correlated to show the relationship between individual clients and their communication satisfaction with meal choice. Staff responses were given after each meal alongside the clients’ observations to check the inter-observer reliability and gain the most accurate picture of the clients’ food satisfaction.

Results

The findings showed that the majority of clients had the ability to communicate that they were satisfied with their food choices. Through observing the clients’ behaviour and categorising such behaviours into positive and negative, it became apparent that they could communicate particular preferences. Positive behaviours were displayed in an average of 63 per cent of observations, indicating that it is possible for clients to communicate food choice. For example, in the case study below, it can be clearly seen that sandwiches and crisps was the preferred meal choice, with Robert Smith displaying frequent positive behaviours throughout the observation.

A case example

Mr Smith is a 43-year-old man who lives in a residential home for people with severe intellectual difficulties. He ate all his food throughout the observations, showing that overall he was satisfied with his meal choice. When he enjoyed a meal choice he clapped his hands and made excited vocalisations but when anxious or upset would push his food around, display facial discontent and require staff prompts to eat. These responses were used to create a list of Mr Smith’s food preferences (Fig 1).

Discussion

Clients benefited significantly when they were given the opportunity to make choices and carers made time to identify other foods and drinks that they liked. Familiar objects were used as objects of reference to aid their communication.

Making choices involves staff facilitating new experiences for clients. This means that stereotypes, which formal and informal carers may have about people with learning difficulties, need to be exposed and challenged.

It can be difficult to assimilate systematic opportunities for making choices into daily routines. This may interrupt routines and involve a shift in the power relationship between carer and client. Specifically, the carer is trying to determine the client’s choice rather than making it for them.

Despite these challenges, it has been demonstrated that the provision of systematic choice-making opportunities by carers is an attainable goal when appropriate training and support are provided (Parsons and Reid, 1990). Staff should be encouraged to see this as developing positive therapeutic relationships, and must consider what needs to change in the environment to facilitate choice-making.

For example, staff could look at the ways choices can be incorporated efficiently into a routine. Breakfast is a useful meal in which this can be done by offering different cereals or choices of hot or cold milk (Jackson and Jackson, 1998). Involving clients in shopping trips would enable them to indicate preferred choices. Alternatively, this could be achieved by using symbols, pictures or other communication tools before a meal is cooked.

Body movements, facial expressions and gestures can all be expressions of preference in people with severe communication difficulties. People with poor communication skills can experience difficulty in seeking help when confronted with complex choices, therefore, clients should be presented with options on as many occasions as possible, even if they originally decline (Rawlings, 1995). By making the clients aware that there is always a choice available, their willingness to participate in making choices in the future is increased.

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REFERENCES

