

International Encyclopedia of Rehabilitation

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Intellectual Disability

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Defining Intellectual Disability

Intellectual disability is a disability characterized by limitations in intellectual functioning and resulting in the need for extraordinary supports for the person to participate in activities involved with typical human functioning (Wehmeyer, Buntinx, Lachapelle, Luckasson, Schalock, Verdugo, et al., 2008). Because how this disability is understood has changed quite dramatically in the past two decades, it is worth examining intellectual disability in the context of how disability in general is understood. This treatment will, necessarily, be broad in scope, focusing on understanding the construct underlying intellectual disability.

Intellectual disability is a type of *disability*. Within the World Health Organization's (WHO) *International Classification of Functioning, Disability, and Health* (ICF) (World Health Organization, 2001), the term 'disability' is an umbrella term for limitations in human functioning, where *human functioning* refers, simply, to all the life activities in which one would typically engage. Limitations in functioning are labeled a 'disability.' Disability can result from any problem in one or more of three dimensions of human functioning: body structures and functions, personal activities, participation.

Briefly, as per ICF, *body structures* are anatomical parts of the body; *body functions* are the physiological and psychological functions of body systems. Problems in body functions and structures are called *impairments*. *Personal Activities* are the execution of tasks or actions by an individual. Activities refer to skills and abilities of the individual that allow that person to adapt to the demands and expectations of the environment. Problems in this dimension are referred to as *activity limitations*. *Participation* is defined as 'involvement in a life situation.' Participation is related to the functioning of the individual in society. It refers to roles and interactions in the areas of home living, work, education, leisure, spiritual, and cultural activities. Problems an individual may experience in involvement in life situations are called *participation restrictions*.

Intellectual disability, then, is a disability in which impairments to the brain (e.g., body functions and structures) result in activity limitations and participation restrictions. Specifically, though, brain impairments associated with intellectual disability result in limitations in intellectual functioning. Intellectual functioning is a type of human functioning, and is defined in the American Association on Mental Retardation (now American Association on Intellectual and Developmental Disabilities, or AAIDD) 2002 *Manual on Definition, Classification, and Support Systems in Mental Retardation* (Luckasson, Borthwick-Duffy, Buntinx, Coulter, Craig, Reeve et al., 2002) as referring to a general mental ability that includes reasoning, planning, problem solving, abstract thinking, comprehending complex ideas, learning quickly, and learning from experience (p. 51).

Parenthetically, the term ‘mental retardation,’ which is the term that has been used in parts of the world, has increasingly become stigmatizing and rejected by advocates and others. Recently, members of the current AAIDD Committee on Terminology and Classification proposed that the *term* “intellectual disability” was preferable to describe the state of functioning historically referred to by the term “mental retardation.” While suggesting that the term intellectual disability “covers the same population of individuals who were diagnosed previously with mental retardation in number, kind, level, type and duration of the disability and the need of people with this disability for individualized services and supports” (p. 116), Schalock and colleagues also recognized that the term “intellectual disability” more effectively “reflects the changed construct of disability proposed by AAIDD and the WHO” (Schalock, Luckasson, Shogren, Borthwick-Duffy, Bradley, Buntix et al., 2007, p. 120). This change in terminology essentially brings the U.S. in alignment with much of the rest of the world, where the term intellectual disability has been adopted and used for longer periods of time.

The definition of mental retardation/intellectual disability introduced in the 2002 manual, which Schalock et al. (2007) suggested will “remain in effect for now and in the foreseeable future,” defines intellectual disability as:

...characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18 (p. 3).

Intellectual disability is one of a set of disabilities that can result from impairment to the Central Nervous System that manifest in limitations to general cognitive functioning. This set of disabilities is increasingly referred to by the more generic term *Cognitive Disabilities*. Cognition is the mental *process* of knowing, which includes aspects such as awareness, perception, reasoning, and judgment. Other cognitive disabilities include Traumatic Brain Injury, Learning Disability, and dementia associated with Alzheimer’s disease. Intellectual disability is set apart from other cognitive disabilities by factors such as scope of impairment (e.g., global) and age of onset (e.g., prior to age 18). Because intellectual disability must be manifested in the developmental period (e.g., prior to age 18), it is also a *Developmental Disability*. Developmental Disability is a non-diagnostic category that refers to people with both cognitive and physical disabilities whose disability (a) originates in childhood (the developmental period from birth to 18); (b) constitutes a significant challenge to typical functioning; and (c) is expected to continue indefinitely (Thompson & Wehmeyer, 2008).

The range and type of brain impairments that can result in impaired intellectual functioning are many and varied, as are the causes or etiology of those impairments. The 10th Edition of *Mental Retardation: Definition, Classification, and Systems of Supports* (Luckasson et al., 2002) addressed issues pertaining to the etiology and prevention of intellectual disability and provided a useful inventory of etiology and type of neural impairment (to which readers are referred for greater detail). Briefly, though, etiology is defined as “a multifactorial construct composed of four categories of risk factors (biomedical, social, behavioral, and educational) that interact across time, including across the life of the individual and across generations from parent to child” (Luckasson et al., 2002, p. 123). By utilizing this approach to etiology, practitioners can describe contributing risk factors that influence functioning and subsequently identify strategies

and preventative measures to reduce those risk factors. Biomedical factors are those related to innate biological processes such as maternal health and genetic disorders. Social factors include familial and social interactions and variables such as lack of access to health care and parental neglect. Behavioral risk factors include behaviors that may have contributed to limited functioning, such as parental drug use and/or abandonment. Finally, educational factors identify accessibility to educational experiences that support adaptive skills such as inadequate family support and/or special education. By identifying the etiology, preventative supports may be aligned to assuage the impact of intellectual disability.

There are three overarching types of prevention: primary, secondary and tertiary. Primary prevention is the prevention of a situation that may directly result in the development of mental retardation (e.g. maternal drug use). Secondary prevention “involves actions to prevent an existing condition from resulting in mental retardation” (Luckasson et al., 2002, p. 137). Finally tertiary prevention includes measures taken to reduce the impairment resulting from secondary prevention and/or etiological factors. The etiology of the intellectual disability may be unimportant or may be critical knowledge when it comes to intervention, but certainly knowledge about etiology is important to support people with and without disability to achieve more positive health outcomes, including improved intellectual functioning.

The AAIDD 2002 manual proposed that intellectual disability is evidenced by a poor ‘fit’ between a person’s capacities and the context in which the person must function. Capacity is the ability to perform a task; in this case a mental, cognitive, or intellectual task. Because intellectual disability manifests as limitations in intellectual functioning evidenced by a poor fit between a person’s capacity and the context, the ‘disability’ is not seen as residing within the person, but instead as a ‘function’ of the fit between the person’s capacities and the activity and participation expectations of the context. This does not imply that by ensuring, through environmental supports or through instruction, a better fit between the person’s capacity and the context, an underlying body function impairment (e.g., brain impairment) is in any way fixed. It simply recognizes that intellectual disability is not defined by the brain impairment in and of itself, but instead by the person’s functioning (e.g., the fit between the person’s capacity and the context).

Further, as noted, one feature of intellectual disability that distinguishes it from other cognitive disabilities is its global nature. Intellectual disability refers to limitations to intellectual functioning manifesting in activity limitations and participation restrictions *across all life activity and human functioning domains*.

In summary, then, intellectual disability refers to a disability manifesting as limitations in intellectual functioning (reasoning, planning, solving problems, thinking abstractly, comprehending complex ideas, learning quickly, and learning from experience) related to activity limitations, associated with participation restrictions and resulting from brain impairments or specific etiological factors.

The person-context engagement model suggests that successful human functioning results from the engagement between capacity—emphasizing personal strengths—and the context, emphasizing supports defined as strategies, resources and activities that enhance human functioning. This model presumes that limitations in personal strengths can be at least partially

offset by supports, and that poor functioning may result from of lack of supports or limited opportunities for participation.

From Deficits to Human Abilities

Historically, intellectual disability was defined primarily as a function of performance deficits. The “intelligence” construct is one that continues to be subject to considerable debate, and while diagnosis and classification of intellectual disability continues to require a linkage to ‘intelligence,’ as discussed subsequently, an adoption of a functional model, such as that illustrated by the AAIDD and WHO models discussed previously, requires a focus on examining the fit between a person’s capacities and the context in which that person lives, learns, works or plays. It is instructive, then, to consider at least one model of intelligence, that forwarded by Carroll (1999), which approaches issues relevant to understanding the functional limitations of people with intellectual disability from a strengths or abilities-based perspective.

Carroll (1999) conducted a comprehensive survey and analysis of correlational and factor-analytic research on cognitive abilities so as to “present an up-to-date review and critique of the extant literature on the identification, characteristics, and interpretations of cognitive abilities” (p. 73) by. Carroll provides, essentially, a taxonomy of the cognitive abilities that might be impacted by impairments to brain functioning. Carroll’s analysis identified eight primary or first-order factors of cognitive ability, referred to as primary domains of human cognitive ability: (1) Language; (2) Reasoning; (3) Memory and Learning; (4) Visual Perception; (5) Auditory Reception; (6) Idea Production; (7) Cognitive Speed; and, (8) Knowledge and Achievement.

Within each of these primary human cognitive ability domains there is a voluminous literature, even within the narrower scope of those studies that pertain primarily to people with intellectual disability. As such, our intent is not to provide a comprehensive literature review within each domain, but instead to capture some sense of the nature of cognitive abilities in each domain so as to illustrate the ways in which brain impairments typically impact the intellectual functioning of people with intellectual disability.

Language ability and auditory reception

Perhaps the broadest first-order domain presented by Carroll is that of language ability. Factors identified within this domain included language development factors, verbal or printed language comprehension, lexical knowledge factors, reading comprehension, decoding, and speed factors, cloze ability factors, spelling ability factors, phonetic coding factors, grammatical sensitivity factors, foreign language aptitude and proficiency factors, communication ability factors, listening ability factors, oral production factors, oral language style factors, and writing ability factors. By and large, this domain references the cognitive processes and cognitive tasks that pertain to the use of language that result in outcomes such as reading and writing as well as verbal comprehension. According to Carroll, “the communication ability factors relate to more general skills in communication, often involving listening and speech production, with or without involvement reading and writing” (p. 177). Such skills include verbal and gestural imitation skills, interactive communication skills, and the more straightforward issues of speech and language production.

Auditory reception factors identified by Carroll refer to abilities “that depends mainly on the characteristics of the auditory stimulus itself and the individual’s capacity to apprehend, recognize, discriminate, or even ignore those characteristics, independent of the individual’s knowledge of structures in language or in music... that determine the overall pattern of an extended auditory signal” (p. 364). First order factors in this domain included hearing and speech threshold factors, speech sound discrimination factors, factors in perceiving music and musical sounds, absolute pitch ability factors, and sound localization factors. The hearing and speech threshold factor included general sound discrimination tasks, pitch/timbre discrimination, sound intensity/duration discrimination, hearing threshold, sound localization, speech sound discrimination, musical sound discrimination and judgment, auditory tracking and binaural sound localization.

The limitations in intellectual functioning characteristic of people with intellectual disability introduce obvious restrictions to the full expression of language ability for this population. Abbeduto (1991) noted that skills such as verbal comprehension, reading comprehension and speed, and others in this domain are primary factors measured in traditional intelligence tests, performance on which diagnosis and classification of this disability has been based. There is an extensive literature documenting impairments in language ability as a characteristic of people with intellectual disability (see Abbeduto, 2003). Although many people with intellectual disability have concomitant auditory and hearing impairments, there is no particular association with intellectual disability and auditory reception factors. Obviously, global neural impairments will impact many domains other than cognitive domains, such as sensory domains. Some people with intellectual disability will have considerable problems with factors within the auditory reception domain, including problems with sound localization or discrimination. In other cases, though, the global neural ‘impairment’ results in quite the opposite effect. People with Williams syndrome, for example, typically have cognitive impairments resulting in intellectual disability, and yet a disproportionate percentage of the population of people with Williams syndrome have “perfect pitch:” that is, the ability to identify, name, and produce musical pitches perfectly and, by and large, without training. So, one must be cautious in overgeneralizing effects of brain impairment across all areas of functioning.

Reasoning and idea production

Carroll (1999) noted that the factors in the Reasoning domain are those that “are considered to be at or near the core of what is ordinarily meant by intelligence” (p. 196). As such, these are particularly relevant to intellectual disability. Carroll collapsed reasoning variables into three first-order factors, each with multiple subtypes. The first-order factors were sequential reasoning factors, inductive factors, and quantitative factors. Sequential reasoning factors included items that emphasized “the ability to reason and draw conclusions from given conditions or premises” (p. 234). These included items pertaining to deductive reasoning, logical reasoning, symbol manipulation, verbal reasoning, verbal analogies and syllogisms, match problems, sentence completion, and false premises. Inductive factors, those that require a person to inspect a class of stimulus materials and infer a common characteristic, including items pertaining to concept formation, verbal classification, figure matching, pattern reasoning, spatial reasoning, rule induction, and similarities. Third, quantitative reasoning factors were those requiring reasoning based on mathematical properties and relations, including critical evaluation, arithmetic reasoning and problem solving, math aptitude, and number series, classification and operations.

Carroll also proposed a fourth factor, which he calls Piagetian reasoning factors because they contained reasoning tasks devised and studied by Piaget and his collaborators. These include operativity, conservation, and representational, metarepresentational, and meta-cognitive skills.

An additional first order factor, Idea Production, is similar to the Reasoning domain. Carroll's idea production cognitive ability domain refers, quite simply, to abilities for individuals to produce ideas and communicate them in linguistic or by other means. These refer to fluency and creativity factors, in general. First order factors in this area include ideational fluency, naming facility (naming common concepts), associational fluency (producing words/concept that are associated), expressional fluency, word fluency, sensitivity to problems, originality/creativity, figural fluency (producing original drawings or sketches), and figural flexibility (solving figurative problems).

Since intellectual disability is defined by significantly subaverage intellectual functioning and because many of the reasoning factors are part of what is operationalized and measured as "intelligence", it stands to reason that people with intellectual disability have, as a characteristic, impairments in reasoning and idea production factors.

Memory and learning

The first order factors in this taxonomy include memory span factors, associative memory factors, free recall memory factors, meaningful memory factors, visual memory factors, and learning abilities factors. Memory span factors involve digit, visual presentation, and figure span tasks, and memory for sentences tasks. Meaningful memory is also referred to as 'memory for ideas' (Carroll, p. 277), and includes issues such as remembering ideas presented in content, either through written, visual, or auditory presentation modes, as well as memory pertaining to social interactions. Visual memory factors involve memory for pictures, geometric designs, relations, and map memory. Learning abilities factors include areas such as information retention and recoupment, error production, recalling learned information, and learning rate factors. In addition, Carroll's factor analyses yielded some factors which fell under a first order factor titled simply 'other,' including factors of memory for events, verbal discrimination memory, and clustering ability.

Again, limitations in memory and learning functions are characteristic of many people with intellectual disability although, again, one must be cautious in generalizing this to all people with intellectual disability, as the literature documents numerous examples of people with intellectual disability who display memory abilities that exceed those found in the general population.

Visual perception

Carroll identified the following first order factors in this domain: Visualization factors, spatial relations factors, closure speed factors (e.g., the ability to combine disparate visual stimuli into a meaningful whole), closure flexibility factors (ability to manipulate, visually, multiple objects or configurations, such as hidden figure tasks), serial perceptual integration factors (integrating sequential images), a spatial scanning factor (speed in exploring a visual field), perceptual speed factors (speed of finding desired images or stimuli), imagery factors (ability to image or visualize performance or action sequence), length estimation factors, perception of illusion factors, and perceptual alternations factors. These factors relate to the abilities in "searching the visual field,

apprehending the forms, shapes, and positions of objects as visually perceived, [and] forming mental representations” (p. 304). Unlike the auditory reception domain, visual perception factors do interact with other areas of cognitive impairment to impact functioning for people with intellectual disability.

Cognitive speed

Issues of cognitive speed abilities are particularly relevant to people with intellectual disability. First order factors unique to this domain include rate-of-test-taking factors, reaction time factors, and number ability or numerical facility. Carroll identifies many of the factors in the domains of Reasoning, Language Ability, and Idea Production as also loading on the Cognitive Speed factor, and historically the lack of speed in handling cognitive processes has been the defining feature of the disability. The long-used term ‘mental retardation’ means, literally, mental slowness.

Knowledge and achievement

The final cognitive ability domain identified by Carroll is that of knowledge and achievement. This ability domain includes first-order factors identified as general school achievement, verbal information and knowledge, information and knowledge in mathematics and science, technical and mechanical knowledge, and knowledge of behavioral content (personal-social interaction knowledge). To some degree, previous domains (reasoning, cognitive speed, memory and learning, directly impact knowledge and achievement for people with intellectual disability, but these factors represent the areas in which performance is often assessed to determine intellectual disability.

The Carroll factor-analytic taxonomy provides a more comprehensive way to present the scope of potential functional limitations imposed by a cognitive impairment. It would be incomplete, though, to conclude this section without emphasizing that intellectual disability is no longer understood simply as the limitations in the types of cognitive abilities listed in this section, but instead as the fit between the person’s capacities in these areas, and the context in which he or she must function. The literature is robust with evidence that through habilitative and rehabilitative efforts, education, technology, and supports, people with intellectual disability can improve their human functioning [see Wehmeyer, Smith, Palmer, Davies, & Stock (2004), for example, for a discussion of the role of technology to provide support in these areas of cognitive abilities.]

Diagnosing and Classifying Intellectual Disability

The AAIDD definition reflects three essential definitional elements of intellectual disability that have been used over time and across borders and which are used to diagnose and classify people within, typically, service provision systems. These three elements are: (a) significant limitations in intellectual functioning, (b) behavioral restrictions in adapting to ecological demands, and (c) identification/diagnosis prior to age 18 (Luckasson et al., 2002). Although an increasingly contentious issue, the commonly accepted means of determining limitations in intellectual functioning continues to be through the administration of intelligence tests, which yield an intelligence quotient or IQ score. Keeping in mind particular assessment strengths and weaknesses and standard error of measurement, diagnosis of intellectual disability is based on individual IQ scores that fall approximately two standard deviations below the mean of the participating population (Luckasson et al., 2002).

As has been the case for almost half a century, however, the diagnosis of an intellectual disability cannot be made solely based upon an IQ score. The second element in diagnosis and classification involves limitations in adaptive behavior. Adaptive behavior “is the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives” (Luckasson, 2002, p. 14). Adaptive behavior refers to an individual’s ability to respond and cope with daily environmental demands. Similar to intellectual functioning, significant limitations in adaptive behavior are defined as scores on standardized measures of at least two standard deviations below the mean overall, or on any one of the three types of adaptive behavior (conceptual, social, or practical) on a standardized assessment tool. Third, in terms of diagnosis, definitions of intellectual disability maintain a developmental perspective. Intellectual disability is considered a developmental disability, discussed previously, because of its onset during the developmental period (before 18), and can only be diagnosed if the limitations in human functioning manifest during the developmental period. The three defining elements, significant limitations in intellectual functioning, behavioral restrictions in adapting to ecological demands, and identification/diagnosis prior to age 18, must be present for a diagnosis to occur.

A significant change to issues pertaining to the classification of intellectual disability has emerged over the past several years. Traditionally, classification systems revolved, primarily, around the range of IQ scores achieved by people who met the criteria of an IQ score two or more standard deviations below the mean. The most common such classification scheme involved grouping people based on IQ into one of four subgroups: mild (IQ from 70 to 55), moderate (IQ from 55 to 40), severe (IQ from 40 to 25) and profound (IQ below 25). These classification systems often varied, though, according to the system in which people were being assessed and classified. For example, a parallel classification system within schools was educable, trainable, severe, and profound. In the 2002 AAIDD classification manual (Luckasson et al., 2002) suggested four levels of supports intensities (intermittent, limited, extensive, pervasive), but did not intend those four to form a classification system in the way that the four levels of mental retardation (mild, moderate, severe, profound) had done. At this point in time, although traditional classification systems are generally still in use, there is not consensus as to the best way to classify people within this population or, alternatively, whether that is useful or necessary.

Intellectual Disability and Rehabilitation

The AAIDD and ICF functional models of intellectual disability emphasize the role of supports in bridging the gap between the capacity of people with intellectual disability and the performance expectations in the environments in which they live, learn, work and play. Luckasson et al. (2002) defined supports as “resources and strategies that aim to promote the development, education, interests, and personal well-being of a person and that enhance individual functioning” (Luckasson et al., 2002, p. 151). Among the most important types of supports are those that focus on education, rehabilitation, or habilitation. It is certainly beyond the scope of this article to go into any depth on these strategies, and readers should review articles on such strategies in other sections of the encyclopedia. Impairments to any of the aforementioned areas of cognitive abilities may impact a person’s performance in a range of activities and in a variety of ways. Nevertheless, a nearly fifty-year old literature base pertaining to education and rehabilitation has shown that people with intellectual disability can improve

their cognitive functioning and learn skills and abilities that enhance their functioning in virtually any domain, from employment to academics.

Conclusions

It is not possible to capture all of the aspects of the state of functioning referred to as intellectual disability, the strengths and support needs of people with intellectual disability, or the experience of living with an intellectual disability in this chapter. We have attempted, instead, to provide an introduction to how intellectual disability is understood and defined in the context of models like the ICF; what types of cognitive abilities might be impacted by brain impairment resulting in intellectual disability; the potential for enhanced capacity given such impairment; and how the disability is diagnosed and classified.

In concluding, it is worth returning to the 2002 AAIDD definition and classification manual, which identified five assumptions to consider when applying the definition:

1. Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.
2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.
3. Within an individual, limitations often coexist with strengths.
4. An important purpose of describing limitations is to develop a profile of needed supports.
5. With appropriate personalized supports over a sustained period, the life functioning of the person with intellectual disability generally will improve. (Luckasson, 2002, p. 93).

These assumptions are there because the authors of the manual did not want the manual interpreted outside of the beliefs underlying each of these assumptions, and it is relevant to close with a brief recitation of what these assumptions mean when attempting to understand intellectual disability.

First, the fact that “limitations in present functioning considered within the context of community environments” emphasizes that criterion by which a person's functioning is compared must be observed within typical community environments such as home and school among same-age peers from similar linguistic or cultural backgrounds. Perhaps the most ‘disabling’ aspect of past models of services for people with intellectual disability is that they were conceptualized outside the context of typical human functioning and typical human lives. People with intellectual disability have, for most of the past two centuries, been segregated from their communities and sentenced to lives in institutions that became warehouses; provided opportunities to work only in congregate, poor paying work settings; and educated in separate and unequal school situations. These trends have reversed, from the focus on community-based living supports; supported, customized, and self-employment models to promote real jobs for real pay; education in the general education classroom with a focus on access to the general education curriculum as well as functional life skills, and so forth.

Second, the assumption concerning valid assessments needing to consider cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors speaks to the fact that people from economically disadvantaged and marginalized communities, including people from minority ethnic or racial groups, immigrant groups, and others, are disproportionately likely to be identified as having an intellectual disability. This is in part due to the circumstances of their lives and the opportunities, or lack thereof, available to them, but is also a function of the fact that the ways in which we determine intellectual disability and the tools used to do so do not adequately account for the vast diversity among people as a function of cultural, linguistic, ethnic, and economic factors.

Third, the assumption that limitations often coexist with strengths simply acknowledges the fact that for far too many years the only characteristics recognized with regard to people with intellectual disability were their limitations. As the self-advocacy movement has reminded us, however, people with intellectual disability are ‘people first’ and all people have both strengths and areas of needed support. The ICF and AAIDD models of intellectual disability require that we move from deficit understandings of the past, to ways of thinking about intellectual disability that considers strengths, support needs, and the context.

The fourth assumption addressing the profile of needed support, simply points out that the determination of intellectual disability should naturally lead to the identification of needed supports, not just the identification of limitations. In other words, diagnosis is only relevant if it leads to supports to improve the lives of the person being diagnosed. The stigma associated with the label of intellectual disability is not as great as that associated with older terms, including mental retardation, but it is still significant enough that practitioners must weigh the benefit of diagnosis and labeling with the very real negatives, and proceed with diagnosis only if the positives clearly outweigh the negatives.

Finally, the fifth assumption concerning the positive outcomes of people who received personalized supports over a sustained period of time, emphasizes both the significant impact such personalized supports can have on the functioning of people with intellectual disability, but also on the fact that people with intellectual disability can, with adequate supports, live lives of quality and contribute to society by their presence and productivity. To the degree that this is not reality now is simply an indictment of the system of supports in place for people with intellectual disability, and not an indictment of the people themselves. The provision of such supports through traditional and innovative rehabilitation strategies should ensure that people with ID achieve better quality of lives.

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