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Michael L. Wehmeyer
Nirbhay N. Singh *Editors*

Handbook of Positive Psychology in Intellectual and Developmental Disabilities

Translating Research into Practice

Springer

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For all those who seek the strengths in others

Karrie A. Shogren

For Shane

Michael L. Wehmeyer

For my brother Bramah for his amazing contributions to cardiology

Nirbhay N. Singh

Preface

This handbook examines the growing movement toward applying principals of positive psychology to research and practice across the field of intellectual and developmental disabilities. The handbook explores how this movement is being spurred by several factors, from changing perceptions of disability that emphasize strengths and supports to promote involvement in typical environments to the growth in applications in positive psychology in general. Contributions to this unique volume focus on the applications of positive psychology across such fields as mental health, education, and medicine that provide services and supports to people with intellectual and developmental disabilities and their families. The handbook describes how the emphasis is shifting to one of positive psychology, focusing on harnessing each person's strengths and abilities to enhance each individual's quality of life. It explores ways in which practitioners can focus on what a person is capable of achieving, thereby leading to more effective approaches to supports.

The handbook begins with an introductory section, with chapters providing overviews of positive psychology, strength-based approaches in the intellectual disability field, the supports paradigm and emerging strength-based approaches to assessment. These chapters set the stage for the second section of the book which focuses on applications of positive psychology in the intellectual and developmental disability field. Chapters highlight existing and emerging research and practices directions in positive psychology and intellectual and developmental disabilities, including self-determination, mindfulness, positive behavior supports, supports planning, quality of life, social well-being, decision-making, physical well-being, character strengths, adaptive behavior, problem-solving, goal setting, supported decision-making, assistive technology, motivation, community living, career design, supported and customized employment, retirement and again.

Lawrence, KS, USA	Karrie A. Shogren
Lawrence, KS, USA	Michael L. Wehmeyer
Augusta, GA, USA	Nirbhay N. Singh

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Part I

Introduction

Introduction to Positive Psychology

1

Karrie A. Shogren, Michael L. Wehmeyer
and Nirbhay N. Singh

Introduction

The goal of this handbook is to examine the growing movement toward applying principles of positive psychology to research and practice in the field of intellectual and developmental disabilities. The handbook explores how this movement is being spurred by several factors, including the emergence of new models of understanding disability that are shifting the focus to building on personal strengths (Chap. 2) as well as the emerging supports paradigm that focuses on assessing support needs and building strengths-based systems of supports that promote involvement in community environments (see Chap. 4). Other chapters focus on the application of practices linked to positive psychology across such diverse fields as mental health, education, and medicine that provide services and supports to people with intellectual and developmental disabilities and their families. All of the chapters in the handbook describe how the emphasis on the intellectual disability field is shifting to one aligned with positive psychology, focusing on harnessing each person's strengths and abilities to enhance each person's quality of life. We hope these chapters will serve as a resource for researchers, clinicians/practitioners, graduate students, educators, and others involved in supporting people with intellectual disability through research, policy, and practice to focus on what a person is capable of achieving, thereby leading to more effective approaches to providing supports and enhancing outcomes.

The editors of this handbook believe that to understand the current context and emerging application of positive psychology to the intellectual and developmental disability field, a brief history of deficit-based models in the disability and psychology field is necessary, as that background provides a context for understanding the emergence of positive psychology and strengths-based approaches and how the application of positive psychology practices, such as those discussed in this handbook, provides a means for the future of supports and services to be strengths-based and aligned with the values, interests, and preferences of people with intellectual and developmental disabilities. Thus, this chapter will provide a brief history of deficit-based approaches in the psychology and disability field to provide a context for the emergence of positive psychological approaches, then discuss critical factors in the emergence of positive psychology, key terms and constructs in positive psychology, and the alignment of

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positive psychology with emerging models the intellectual and development disability field, setting the stage for further elaboration of these models in the chapters that follow.

Deficit-Based Models in Psychology and Disability

The fields of psychology and intellectual and developmental disabilities share a common history—a history dominated by a focus on deficits and limitations. In the disability field, disability has historically been viewed through a medical lens with a focus on identifying the presence of disability and attempting to cure or remediate its characteristics (Wehmeyer, 2013b; Wehmeyer et al., 2008). As we will show in this handbook, there are strengths-based approaches that have emerged from medicine and related health professions for people with intellectual and developmental disabilities (e.g., mindfulness, see Chap. 6; exercise, sport, and physical well-being, see Chap. 12); however, throughout much of modern history, the focus was on identifying pathology rather than on building strengths and supports (Wehmeyer et al., 2008). This is reflected in the diagnostic systems used historically and currently for intellectual and developmental disabilities, as well as the terminology used over time. As Wehmeyer et al. (2008) wrote about the assumptions that undergirded the diagnostic term "mental retardation," which preceded intellectual disability, as well as the terms that preceded "mental retardation" (e.g., mental deficiency, mental subnormality):

> The first such assumption was that the disability resided within the person. To have mental retardation was to be defective. The loci of that defect was the mind. The term *mental*, which is common to all of these terms, means of or pertaining to the mind. The nature of the defect of the mind (mental deficiency) was inferior mental performance (mental subnormality) characterized by mental slowness (mental retardation)… It is a disability determined by indicators of performance linked to limitations in human functioning (p. 312).

The process of diagnosing intellectual disability continues to be rooted in these ideas, as diagnostic criteria involve identifying significant limitations in intellectual functioning and adaptive behavior (Schalock et al., 2010). Similarly, developmental disabilities are defined by mental or physical impairments that lead to substantial functional limitations in major life activities ("Developmental Disabilities Assistance and Bill of Rights Act of 2000"). While the support model (see Chap. 3) asserts that the purpose of diagnosis is to establish the need for supports and to initiate a systematic process of assessing support needs and planning for supports linked to personally valued outcomes (Schalock et al., 2010, 2012), historically, disability diagnosis and classification was viewed as an end. Diagnosis was used to place people with intellectual disability into programs, and throughout history, such programs were characterized by segregation and unequal treatment. Driven largely by the dominance of IQ testing, which emerged in the fields of psychology and disability in the early 1900s, diagnosis and classification based on IQ dictated the options available with differing programs. The underlying premise of segregation was that because of the deficits experienced by people with intellectual and developmental disabilities, they needed separate and specialized settings for remediation that would enable them to, after addressing the deficits, be reintegrated into society. As such, programs were created, particularly in the education system, based primarily on level of intellectual functioning. Such programs, however, did not consider support needs or strengths and preferences of people with intellectual disability. And, the educative focus of segregated settings, particularly institutions for people with intellectual disability, was quickly lost, with segregated settings becoming places of custodial care, characterized by neglectful and even abusive treatment of people with intellectual disability, principally because they were not viewed as fully human given their "deficits."

The psychology field has also been characterized as a deficit-oriented history, shaped by the focus that emerged in the twentieth century of classifying and remediating mental illness, in large part because of needs of veterans returning from World War II and the establishment of the

Veterans Administration and the National Institute of Mental Health, which provided funding for research and treatment of mental illness. As such, psychology essentially adopted a disease model of human functioning (Linley, Joseph, Harrington, & Wood, 2006), building classification and treatment systems for mental illness, rather than for mental health. This combined with the emphasis within psychology on operant psychology and abnormal development during this time led to, as Seligman (1998) described it:

> Human beings were seen as passive foci: Stimuli came on and elicited "responses," or external "reinforcements" weakened or strengthened "responses," or conflicts from childhood pushed the human being around. Viewing the human being as essentially passive, psychologists treated mental illness within a theoretical framework of repairing damaged habits, damaged drives, damaged childhoods and damaged brains" (p. 2).

Emergence of Positive Psychology

Subsequent chapters will more fully describe emerging models in the intellectual and developmental disability field that provide an alternative to the historic, deficit-based models of disability. Briefly, however, emerging models of disability are strengths-based and focus on person–environment fit; they shift to understanding disability not as a characteristic of a person, but as a function of the interaction between personal characteristics and environmental demands. They assume that each person, including each person with and without disabilities, has a unique profile of strengths and limitations that influence their functioning across different environments.

When thinking about disability, the reference environment should be typical community environments, not segregated environments, and the purpose of developing a profile of personal strengths and limitations, including disability characteristics, is to identify the individualized supports needed by the person to be successful in the environments that the person wants to access. Thus, the person's preferences, interests, and values should guide the identification of relevant community environments, and supports should be identified that promote success in those environments, building on strengths and based on an understanding of support needs. Critical to this perspective is the inherent value of the person and their values, preferences, and strengths both in identifying environmental demands and in planning for supports to address those demands. Further, supports do not just involve changing the person (e.g., teaching new skills), but supports also involve changing the environment to make it more accessible (e.g., cognitively accessible materials). As such, these models are closely linked to positive psychology, with its emphasis on positive traits, values, and institutions, described next.

Martin Seligman, during his tenure as president of the American Psychological Association, the largest professional organization in psychology, is credited with calling attention to the need for a "reoriented science" of psychology that "emphasizes the understanding and building of the most positive qualities of an individual" (Seligman, 1999, p. 559). He elaborated that "psychology has moved too far away from its original roots, which were to make the lives of all people more fulfilling and productive, and too much toward the important, but not all-important, area of curing mental illness" (Seligman, 1999, p. 559). And, since Seligman first introduced the term "positive psychology" in 1999, significant and organized attention has been devoted to the science of positive psychology (Yen, 2010).

For example, in 2000, a special issue of *American Psychologist* was published and Seligman and Csikszentmihalyi (2000) defined positive psychology in an introductory article. They characterized positive psychology as focusing on three "pillars": (a) valued subjective experience, (b) positive individual traits, and (c) civic values and the institutions that support them. Articles were included in the special issue on positive experiences: subjective well-being (Diener, 2000), optimal experience (Massimini & Della Fave, 2000), optimism (Peterson, 2000), and happiness (Myers, 2000); and on positive traits: self-determination (Ryan & Deci, 2000), wisdom (Baltes & Staudinger, 2000), mature defenses (Vaillant, 2000), and exceptional performance (Lubinski & Benbow, 2000; Simonton, 2000). Hart and Sasso (2011), in a review of the literature since 2000, found that more than 20,000 articles had been published in the area of positive psychology, with a steady growth since the early 2000s and the publication of the Seligman and Csikszentmihalyi special issue. A journal, *The Journal of Positive Psychology*, was established in 2006 to "provide an interdisciplinary and international forum for the science and application of positive psychology."

In addition to a new journal and peer-reviewed articles, there have been a number of scholarly books published that describe the science of positive psychology. *The Oxford Handbook of Positive Psychology* (Snyder & Lopez, 2002), now in its second edition (Lopez & Snyder, 2009), defines positive psychology and constructs included within its parameters. Specialized handbooks have been published, considering the role of positive psychology in disability (Wehmeyer, 2013a), work (Linley, Harrington, & Garcea, 2009), and education (Gilman, Huebner, & Furlong, 2009). Texts have been published on methods in positive psychology (Ong & van Dulmen, 2006) and assessment in positive psychology (Lopez & Snyder, 2003). Classification systems aligned with positive psychology have also been developed. For example, *Character Strengths and Virtues: A Handbook and Classification* (Peterson & Seligman, 2004) was published as a definition and classification system for strengths and virtues, much like the *Diagnostic and Statistical Manual* defines and classifies mental disorders. The VIA (formerly Values in Action) classification system identified in this text has been used to create character strengths assessments that can be used by children and adults to identify and attempt to capitalize on their character strengths in multiple domains of life (Park & Peterson, 2006) (see Chap. 13) Undergraduate textbooks in positive psychology have been published (Baumgardner, 2008; Peterson, 2006; Snyder, Lopez, & Pedrotti, 2010), and courses are offered at universities all over the USA and Europe (Yen, 2010).

Key Terms and Constructs

Anytime a new field emerges and experiences such quick growth, there are going to be ongoing discussions and debates about its parameters. For example, researchers have found that multiple definitions of positive psychology have been introduced in the field, and there are multiple frameworks for the constructs that fall within its parameters. For example, Hart and Sasso (2011), in their review of the literature, found that although Seligman and Csikszentmihalyi (2000) described three pillars, only the first two pillars—valued subjective experiences and positive individual traits—were well represented in the literature. Limited research and definitional consistency had emerged around civic values and institutions. Further, they identified another area in the field not included in Seligman and Cziksszentmihalyi's framework—resiliency under conditions of adversity.

Interestingly, this area of research may have emerged in response to early critiques of the field of positive psychology. Early critiques suggested positive psychology was ignoring the negative in life and adopting a hedonistic view of happiness that was not based in reality (VanNuys, 2010a, b). Positive psychology researchers have argued, however, that positive psychology does not ignore the negative, but instead focuses both on identifying and understanding the positive aspects of life, as well as using this understanding to address and navigate barriers that are encountered in life. For example, Diener (2009) wrote: "positive psychologists do not ignore the negative in life. However, they maintain that often one form of solution to problems, and in some cases the most effective one, is to build on the positive rather than directly work on the problem" (p. 10).

Overall, however, the umbrella of positive psychology is broad and expanding. Seligman and Czikszentmihalyi (2000) included 15 constructs representing the field. When the 2nd Edition of The Handbook of Positive Psychology (Lopez & Snyder, 2009) was published, it included 65 chapters, on topics ranging from emotional intelligence (Salovey, Mayer, Caruso, & Yoo, 2009) and creativity (Simonton, 2009), to love (Hendrick & Hendrick, 2009) and humility (Tangney, 2009), to happiness and positive growth after physical disability (Dunn, Uswatte, & Elliott, 2009). The handbook also included interdisciplinary efforts in the field, such as the role of neuropsychology in understanding positive affect (Isen, 2009) and the role of the heart in generating and sustaining positive emotions (McCraty & Rees, 2009).

Alignment with the Disability Field

As mentioned previously, there has been a significant increase in research in positive psychology, generally, and when looking at research in the intellectual and developmental disability field specifically, there has been a growing focus on positive psychology and strengths-based approaches and constructs as well. A review of research published in leading journals in the intellectual and developmental disability field through the mid-2000s found that older articles were much less likely to adopt a strengths perspective articles than more recently published articles (Shogren, Lopez, Wehmeyer, Little, & Pressgrove, 2006). For example, from 1975 to 1984, only 22% of articles adopted a strengths perspective; however, by 1995–2004, 50% of articles did. When specifically looking at constructs directly associated with positive psychology (such as happiness and subjective well-being), only 9% of articles from 1975 to 1984 focused on a positive psychology construct, from 1985 to 1995, 15% of articles, and from 1995 to 2004, 24% of articles.

Chapters have also been in general positive psychology texts on the role of positive psychology in understanding disability (Wehmeyer & Shogren, 2014), and disability researchers have analyzed the degree to which positive psychology aligns with and advances research in various domains in the disability field, including rehabilitation (Dunn & Dougherty, 2005; Ehde, 2010), mental health (Baker & Blumberg, 2011), quality of life (Schalock, 2004), family supports (Blacher, Baker, & Berkovits, 2013), and supporting students with autism spectrum disorders (Groden, Kantor, Woodard, & Lipsitt, 2011; Zager, 2013). Researchers have also systematically analyzed the measurement and application of constructs from positive psychology studied in the general population with people with intellectual and developmental disabilities, including character strengths (Niemiec, Shogren, & Wehmeyer, in press; Shogren, Wehmeyer, Forber-Pratt, & Palmer, 2015), subjective well-being, and hope (Shogren et al., 2006).

Overall, this body of work suggests a growing focus on strengths-based approaches and positive psychology in the intellectual and developmental disability field, highlighting the need for this handbook and a comprehensive review of applications of positive psychology and strengths-based approaches in the intellectual and developmental disability field. In the following chapters, we provide the most recent information on the growing application of positive psychology to the intellectual and developmental disability field, with the goal of providing a resource that will enable the implementation of strengths-based approaches that will harness each person's strengths and abilities to enhance each person's quality of life.

Overview of Handbook of Positive Psychology in Intellectual and Developmental Disabilities

The remaining chapters in this introductory section continue the discussion pertaining to positive psychology, strengths-based approaches to disability, and intellectual and developmental disabilities. Chapter 2 examines strengths-based models of disability that emphasize the fit between personal capacity and the demands of the environment and supports that enable people with intellectual and developmental disabilities to function successfully in typical contexts. Chapter 3 examines in greater detail the support and support needs constructs in promoting successful functioning. Chapter 4 introduces assessments and assessment practices that can enable the design of practices to apply principles of positive psychology, determine the efficacy of supports to promote personal strengths, and evaluate personal growth and outcomes.

The next section introduces various applications of positive psychology in the field of intellectual and developmental disabilities. Chapter 5 introduces the self-determination construct, examines its application to intellectual and developmental disabilities, and provides an overview of practices to promote self-determination and self-direction. Chapter 6 provides a review of mindfulness-based approaches to the care and treatment of individuals with intellectual and developmental disabilities. Chapter 7 describes approaches to system-wide efforts to promote positive behavioral outcomes within schools, juvenile justice systems, and other systems supporting people with intellectual and developmental disabilities. Chapter 8 examines traditional Individual Support Plans and an emerging alternative plan that is based on mindful engagement and aligned with positive psychology. Chapter 9 reviews the literature pertaining to quality of life and people with intellectual and developmental disabilities and provides a framework for quality of life as an organizing structure for intellectual and developmental disabilities services and supports. Chapter 10 examines the knowledge base pertaining to building friendships and social networks for people with intellectual and developmental disabilities and examines practices in school and other environments to promote friendship building, improve social inclusion, and enhance social capital. Chapter 11 discusses what is known pertaining to problem-solving and decision-making and people with intellectual and developmental disabilities, as well as reviewing programs and practices that promote positive outcomes for this population. Chapter 12 explores what is known about exercise, sport, and physical fitness and well-being for people with intellectual and developmental disabilities and provides an overview of practices to promote positive outcomes. Chapter 13 examines the application of character strengths assessment and interventions to the lives of people with intellectual and developmental disabilities, with a focus on the use of the VIA Strengths survey.

Chapter 14 describes the measurement of adaptive behavior and ways to promote positive adaptive behavior and autonomous functioning in people with intellectual and developmental disabilities. Chapter 15 discusses the hope construct, its measurement, and ways to intervene to promote hope and pathways thinking for people with intellectual and developmental disabilities.

Chapter 16 examines goal setting, focusing on interventions that have been shown to promote self-regulated problem-solving leading to setting and attaining goals in education, employment, health, and other domains for people with intellectual and developmental disabilities. Chapter 17 explores how, increasingly, a strengths-based approach to disability is driving attention away from the use of plenary guardianship and toward models of supported decision-making that enable people with intellectual and developmental disabilities to participate in decisions that impact the quality of their lives. Chapter 18 reviews evidence-based approaches to using assistive technologies for enhancing preferred skills of individuals who have complex physical and medical issues and increasing their quality of life through self-determination and choice. Chapter 19 examines the role of motivation in achieving positive outcomes, with a focus on Self-Determination Theory's structure of intrinsic, autonomous motivation and ways to enhance intrinsic motivation in school, sport, and other settings. Chapter 20 examines the skills that can be enhanced to support individuals with intellectual and developmental disabilities to enable their physical and social integration in community settings. Issues such as participation in community activities, safety skills, and immersion in the community will be covered.

Chapter 21 examines the changing landscape in career decision-making, moving from models of career development that emphasize stages of development to a focus on career design in which individuals are active participants in actions leading to future employment opportunities. Chapter 22 discusses positive approaches to employment for people with intellectual and developmental disabilities, beginning with supported employment and including self-employment and customized employment models. Chapter 23 explores emerging practices in Australia supporting people with intellectual and developmental disabilities to retire to a life of preferences and choices. And, finally (for this section), Chap. 24 examines positive approaches to supporting people with intellectual and developmental disabilities as they age at home and in their communities.

Overall, the chapters provide direction for research and practice that applies positive psychology approaches to the intellectual and developmental field and creates pathways for new conceptualizations in research and practice.

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Strengths-Based Approaches to Intellectual and Developmental Disabilities

2

Michael L. Wehmeyer, Karrie A. Shogren,
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Introduction

The opening chapter introduced the growing field of positive psychology and provided a context within which to understand and apply strengths-based approaches to intellectual and developmental disabilities. This chapter, in turn, examines historical understandings of disability, how those impacted understandings of intellectual disability, and how changing understandings of disability are leading to strengths-based conceptualizations of intellectual disability and focusing the field on promoting the health and well-being of people with intellectual and developmental disabilities. Chapter 3 will examine the supports paradigm in intellectual and developmental disabilities, as derived from strengths-based approaches to disability, and examine the role of supports in promoting successful functioning in typical environments.

Different and Pathological

Shogren, Wehmeyer, and Singh (2017) briefly recounted historical understandings of intellectual disability, but it is worth exploring in a bit more depth how what we now call intellectual disability has been understood across time. There has, of course, always been people with neurological impairments who have had difficulty functioning in society (Wehmeyer, 2013). The risk factors that result in or cause intellectual disability—biomedical, psychosocial, behavioral, and educational (Schalock, 2013)—have, by and large, always existed. For the vast majority of time across history, however, people with cognitive impairments were simply indistinguishable from the poorest and least advantaged members of society (Wickham, 2013). Keeping in mind that intelligence, as a construct, is a relatively modern convention, the earliest depictions of people with intellectual impairments in the Middle Ages and into the early modern era were of people who were viewed, primarily, as simply different from or apart from the rest of society. The term *idiot* is one of the oldest terms applied to categorize and describe people with cognitive impairments. It derives from the Greek word *idios*, which meant uniquely one's own, private, or peculiar; and the Latin *idiota*, meaning an outsider (Wehmeyer, 2013, p 29). By the time the term began to be applied to people with

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cognitive impairments (twelfth century in France, referring to an uneducated or ignorant person; fourteenth century in England, meaning someone incapable of ordinary reasoning), the generalized sense of peculiar and outside the norm had morphed into a sense of someone who was constitutionally different from other people by reason of their (perceived) lack of capacity to reason or think and, thus, function typically.

This sense of differentness took on a medical patina as the field of intellectual disability emerged, beginning in the nineteenth century. In the late 1700s and early 1800s, pioneers in the field of psychiatry in England and France had begun to differentiate—categorically and diagnostically—between people with mental illness and people whose cognitive impairments were global and long term, and by the mid-nineteenth century, institutions had been established to habilitate and provide for people with intellectual impairments. The term idiot was initially used to delineate the entire class of people with cognitive impairments, eventually, though, becoming a term that was used in classification systems to describe people with the most extensive levels of impairment. Feebleminded became the preferred overarching term, with such categories as idiot, imbecile, and moron used to delineate subcategories. The institutions were called hospitals because they were run by physicians and organized in the same ways—architecturally and process-wise—in which hospitals to treat the sick were organized.

Logically and inevitably, intellectual disability (and disability, in general) was conceptualized by these medical professionals as if it was a disease. Diseases are pathologies, by definition. A person has a disease, and that disease results in symptoms and signs. Feeblemindedness (and, later, mental deficiency and mental retardation) was construed as a type of pathology, as internal to the person and resulting in aberrant or atypical functioning. The field of intelligence testing grew in the early twentieth century, and as psychologists wrested control of the discipline from medical practitioners, the terms they used reflected, increasingly, conceptualizations of defective mental processes from mental deficiency (defective mind) to mental subnormality (subnormal mind) to mental retardation (slow mental functioning).

So, as late as the 1970s, the sole conceptualizations of what we now refer to as intellectual disability reflected the dual characteristics of differentness and defect. Attitudes about people with intellectual impairments changed—from the eugenics era and its stigmatizing characterizations of people with intellectual disability as menaces to society and responsible for many of societies social ills to the post-World War II era and its characterizations of people with intellectual impairments as victims of their pathology but worthy of pity and charity (Smith & Wehmeyer, 2012; Wehmeyer, 2013). Yet, what did not change was the understanding of intellectual disability as an internalized, pathological state and the perception of people with intellectual disability as different and peculiar.

Beyond the Medical Model

When it was established in 1948 as the public health branch of the United Nations, the World Health Organization (WHO) took on, as part of its mission, the classification of diseases. What existed at that time were a series of lists of diseases, causes of mortality, and classifications for morbidity statistics. The WHO took those lists and structured them into what was referred to as the *International Classification of Diseases, Injuries, and Causes of Death*, or, just ICD. There were minor revisions to the ICD in 1955 and 1965 and major revisions in 1979 (ICD-9) and 1994 (ICD-10). Specifically, the ICD is a taxonomy of diseases and disorders. It is a diagnostic tool used for epidemiological, health management, and clinical purposes. Diseases are defined as pathological processes manifesting in characteristic signs and symptoms and impacting health. According to the WHO-International Union of Psychological Science survey of practicing psychologists, 70% of clinicians in the world use the ICD-10 in their day-to-day clinical work. Within the ICD-10, mental retardation was included as a disorder, as it had been in every prior version and as would be expected if it was considered a disease (World Health Organization, 1999).

Over the decades during which the ICD developed, however, there was a paradigm shift in medicine, from a system that primarily engaged acute illness to one that focused on management of chronic conditions. For the first half of the twentieth century, the healthcare system was a configured to respond to acute illnesses, most notably infectious disease like tuberculosis, polio, smallpox, and so forth. Hospitals were settings where diseases were diagnosed, patients were isolated, and most care was palliative (Goldsmith, 1990). Goldsmith (1990) noted:

> An acute illness was a crisis brought on by an external agent that threw the body into violent, life threatening disequilibrium. With luck, the threat would pass, but the health care system's primary function was to comfort the patient until death occurred (p. 13).

One by one, however, vaccines and advances in medical care turned the tide against these illnesses, and life expectancy increased dramatically. The life expectancy for a female in the USA in 1948, when the WHO was established, was 69.9 years. For a male, it was 64.6 years. At the end of the century, that had risen to 79.5 years for females, 73.8 for males. Although it is true that deadly infectious diseases still exist, the change in the medical system as a result of the successes of the previous decades was an increased focus on managing chronic conditions for longer life and on preventing disease.

By the time the ICD-9 was published in 1979, there was as much interest in issues of managing chronic conditions as in diagnosing acute illnesses, and, in 1980, the WHO introduced the *International Classification of Impairments, Disabilities and Handicaps* (ICIDH), which was proposed to provide a system for classifying the *consequences* of disease (instead of diseases themselves) and of their implications for the lives of people living with chronic conditions, including disability.

Essentially, the ICIDH proposed different perspectives or planes of experience for looking at human functioning and for describing the consequences of diseases on typical functioning. Within this perspective, human functioning referred to all life activities of a person. The ICIDH perspectives for describing the impact of a health condition or pathology on human functioning were: (a) the exteriorization of a pathology in body anatomy and functions (e.g., as pertaining to intellectual disability, central nervous system and intelligence), (b) objectified pathology as expressed in the person's activities (e.g., adaptive behavior skills), and (c) the social consequences of pathology (e.g., participation in social life domains) (World Health Organization, 1980, p. 30).

Essentially, the ICIDH recognized that besides the impact of health condition factors (pathology), contextual factors (environmental or personal factors) are of pivotal importance for understanding human functioning, and that limitations in human functioning are not necessarily linear or causal consequences of a pathology, but are a function of multiple interactive processes where each factor can influence each dimension of functioning and each other factor either directly or indirectly.

The changes in understanding intellectual disability introduced by the WHO and the ICIDH in 1980 began to appear in the definitional and diagnostic procedures used by the field. The 9th Edition of the *Definition, Classification, and Systems of Supports* manual published by the American Association on Mental Retardation (Luckasson et al., 1992) stated:

> Mental retardation is not something you have, like blue eyes or a bad heart. Nor is it something you are, like being short or thin. It is not a medical disorder, although it may be coded in a medical classification of diseases… Nor is it a mental disorder, although it may be coded in a classification of psychiatric disorders… Mental retardation refers to a particular state of functioning that begins in childhood and in which limitations in intelligence coexist with related limitations in adaptive skills.

> As a statement about functioning, it describes the "fit" between the capabilities of the individual and the structure and expectations of the individual's personal and social environment" (p. 9).

Primarily due to political reasons, the term "mental retardation" was still used in this definition and in the name of the association, but this edition marked a stark difference in how the term was defined. Intellectual disability is not something one has or something one is. It is not something that is a medical disease or a mental disorder. It is a state of functioning existing when there is a lack of fit between the person's capacities and the demands of the environment.

The prior edition of the manual, issued by the then-still-named American Association on Mental Deficiency (Grossman et al., 1983) also aligned with the prevailing WHO conceptualization, ICD-9, but did not adopt the framework proposed by the ICIDH, and there is no mention of capacities, capabilities, or strengths of people with cognitive impairments to be found. The 1992 edition, which embraced (though does not explicitly cite) the ICIDH, is peppered with references to the person's capacities, most notably in three assumptions listed as part of the definition of "mental retardation":

- The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individualized needs for supports;
- Specific adaptive limitations often coexist with strengths in other adaptive skills or other personal capabilities; and
- With appropriate supports over a sustained period, the life functioning of the person with mental retardation will generally improve (p. 1).

So, this shift in how disability was understood marked the first step toward strengths-based approaches to intellectual disability and introduced conversations about personal capacities and capabilities, support needs and supports, and functioning in typical contexts and environments.

Human Functioning

In 2001, the WHO published its successor to the ICIDH, titled the *International Classification of Functioning, Disability, and Health* (ICF; WHO, 2001). The ICF "provides a standard language and framework for the description of health and health-related states (WHO, 2002, p. 2). The ICF:

> … is WHO's framework for health and disability … it is the conceptual basis for the definition, measurement and policy formulations for health and disability… it is named as it is because of its stress is (sic) on health and functioning, rather than on disability. Previously, disability began where health ended; once you were disabled, you where (sic) in a separate category. We want to get away from this kind of thinking. WE want to make ICF a tool for measuring functioning in society, no matter what the reason for one's impairments. This is a radical shift. From emphasizing people's disabilities, we now focus on their level of health. (pp. 2–3).

Within ICF, functioning is an umbrella term for all life activities of an individual and encompasses body structures (anatomical parts of the body) and functions (physiological and psychological functions of body systems), personal activities (the execution of tasks or actions), and participation (involvement in a life situation) areas. Problems or limitations in functioning (that is, all life activities of a person) are referred to as disability. Disability can result from any problem in one or more of the three dimensions of human functioning; problems in body structures and functions are referred to as impairments; problems in personal activities are referred to as activity limitations; problems in participation are referred to as participation restrictions. The ICF situates these impairments, activity limitations, and participation restrictions within the interactions between health conditions, environmental factors, and personal factors (WHO, 2002).

The ICF model has been referred to as a social model (as contrasted with a medical model), a social-ecological model (emphasizing the relationship between personal and environmental factors), a biopsychosocial model (emphasizing the interaction of biological, psychological, and social factors), and a person–environment fit model (emphasizing that disability lies in the gap between personal capacity and the demands of the environment). Though all such descriptors have utility, it is the latter that most clearly provides a path toward strengths-based approaches to intellectual disability. Within ICF, disability is seen only as the lack of fit between a person's strengths, capacities, abilities, and capabilities and the demand of the environment in which that person must function.

The 2002 edition (10th) of the (still) American Association on Mental Retardation's Definition, Classification, and Systems of Supports manual (Luckasson et al., 2002) explicitly stated that edition's alignment with the ICF and person–environment fit models of disability, including adding "context" as a fifth dimension of the theoretical model presented. The assumptions presented as part of the definition were even more forthcoming about the importance of a strengths-based approach, stating that:

- Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.
- Within an individual, limitations often coexist with strengths.
- An important purpose of describing limitations is to develop a profile of needed supports.
- With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation will generally improve (p. 1).

In the most recent Definition, Classification, and Systems of Supports manual issued by the now-named American Association on Intellectual and Developmental Disabilities (AAIDD) in 2010 (Schalock et al., 2010), the term defined was (finally) changed to intellectual disability and the manual reaffirmed the assumptions to the definition (above); defined support needs; and added chapters on context, supports, and community-based support systems.

Strengths-Based Approaches to Disability

Of course, medical, psychological, and other conceptualizations of disability are not the only factors that have provide impetus for changing how supports are provided to people with intellectual and developmental disabilities. Although how the construct we now refer to as intellectual disability was understood did not change until the later decades of the twentieth century, there were dramatic changes in society in post-WWII that, in turn, directly influenced policy and practice. Starting in the 1950s, parents began to advocate for options for their sons and daughters with intellectual and developmental disabilities other than the institutions that had dominated the service system during the first half of the century. Federal legislation in the 1960s emphasized community-based services. The civil rights movement in America influenced people with disabilities and their advocates to take on the mantle of civil liberty and equal rights. Eventually, legislation addressing discrimination and equal access emerged, including federal acts pertaining to equal access to education, protections for people with developmental disabilities and, ultimately, the Americans with Disabilities Act of 1990 (Wehmeyer, 2013).

Federal protections and investments in community-based supports led to a decline in institutions. The institution census (number of people with intellectual and developmental disabilities living in state-run institutions) peaked in 1967 at 194,650 people. The census fell below 100,000 the first time in 1988 and, as of 2005, was down to 40,532 people residing in these state-run institutions. Simultaneously, the number of smaller, community-based residential settings rose. In 1977, the number of people with intellectual and developmental disabilities living in state-funded or private community-based residences with six or fewer people totaled 20,400. By 1992, that number had risen to 119,675 and, by 2005, was slightly less than 300,000 people. An additional 50,000 people lived in slightly larger community residences supporting 7–15 people (Prouty, Smith, & Lakin, 2006).

The increased presence of people with disabilities in their communities, including the opportunity for children with disabilities to attend schools, resulted in greater opportunities for employment and school and community inclusion, which led to innovations in efforts to promote community-based outcomes, like supported employment. In fact, if one considers the basics of supported employment, which emerged in the late 1970s to mid-1980s, it is a model for how person–environment fit understandings of disability impact supports provisions. At its core, supported employment begins with a person's strengths and interests, considers the demands of the context (work site, job, etc.), and implements actions that improve personal capacity and modify the demands of the environment. In essence, the field began to move toward practices driven by person–environment fit models of disability before such models were widely promulgated.

This text takes the unequivocal position that historical pathology-based models of disability have run their course and are no longer relevant, although it must be noted that they are still far too prevalent in society. The success of people with disabilities in all aspects of life as a result of civil protections and equal opportunities has made pathology-based understandings of disabilities irrelevant or inaccurate. It is well past time to begin to consider intellectual and developmental disabilities within a strengths-based focus. The chapters in the next sections of this text do so within the lenses of positive psychology and a supports model.

Examining the literature in the field of intellectual and developmental disabilities suggests that the trends are toward these strengths-based approaches. Shogren, Wehmeyer, Buchanon, and Lopez (2006) conducted a content analysis of 30 years of the literature in the field of intellectual disability to examine the degree to which research emphasized the strengths and capacities of people with intellectual disability and the degree to which the literature base included constructs associated with positive psychology. Shogren, Wehmeyer, and colleagues found a gradual progression of the implementation of constructs found in positive psychology across decades (beginning in 1975 through 2004), with only slightly more than 27% of articles that studied some aspect of human functioning identifying positive constructs from 1975 to 1984, slightly more than 44% from 1985 to 1994, and 63% from 1995 to 2004. From among all of these constructs, examinations of personal control, problem-solving, goal setting, and self-determination constituted the largest percentage of positive constructs studied (15% of the 27% total from 1975 to 1984, 19% of 44% total from 1985 to 1994, and almost 30% of the 63% total from 1995 to 2004).

The chapters in this text reflect topics that provide applications of positive psychology and strengths-based practices to the field of intellectual disability as they lead to a new paradigm for disability supports. Some such topics (self-determination, positive behavior supports, quality of life, supported and customized employment) are well established practices in the field. Other topics (problem-solving and decision making, goal setting and attainment) are topics that are discussed, but may have had limited applications in the field. Still other topics have had very little coverage in the field (mindfulness, character strengths, hope). And, one must note, if one examines the topics that are listed in typical texts pertaining to positive psychology, there are many topics that are simply still absent from the discussion in the field of intellectual and developmental disabilities (optimism, creativity, curiosity, compassion, spirituality, etc.).

For example, one of the most widely studied constructs in positive psychology is well-being and all its facets. Happiness and life satisfaction are recognized as the pillars of emotional well-being (e.g., subjective well-being, happiness, psychological well-being, social well-being). Diener, Lucas, and Oishi (2002) defined subjective well-being as a person's "cognitive and affective evaluations of his or her life with emotional reactions and cognitive judgements of fulfillment" (p. 63). Keyes and Lopez (2002) elaborated on in this concept by dividing subjective well-being concept into two groups: emotional well-being, which includes satisfaction or happiness; and positive