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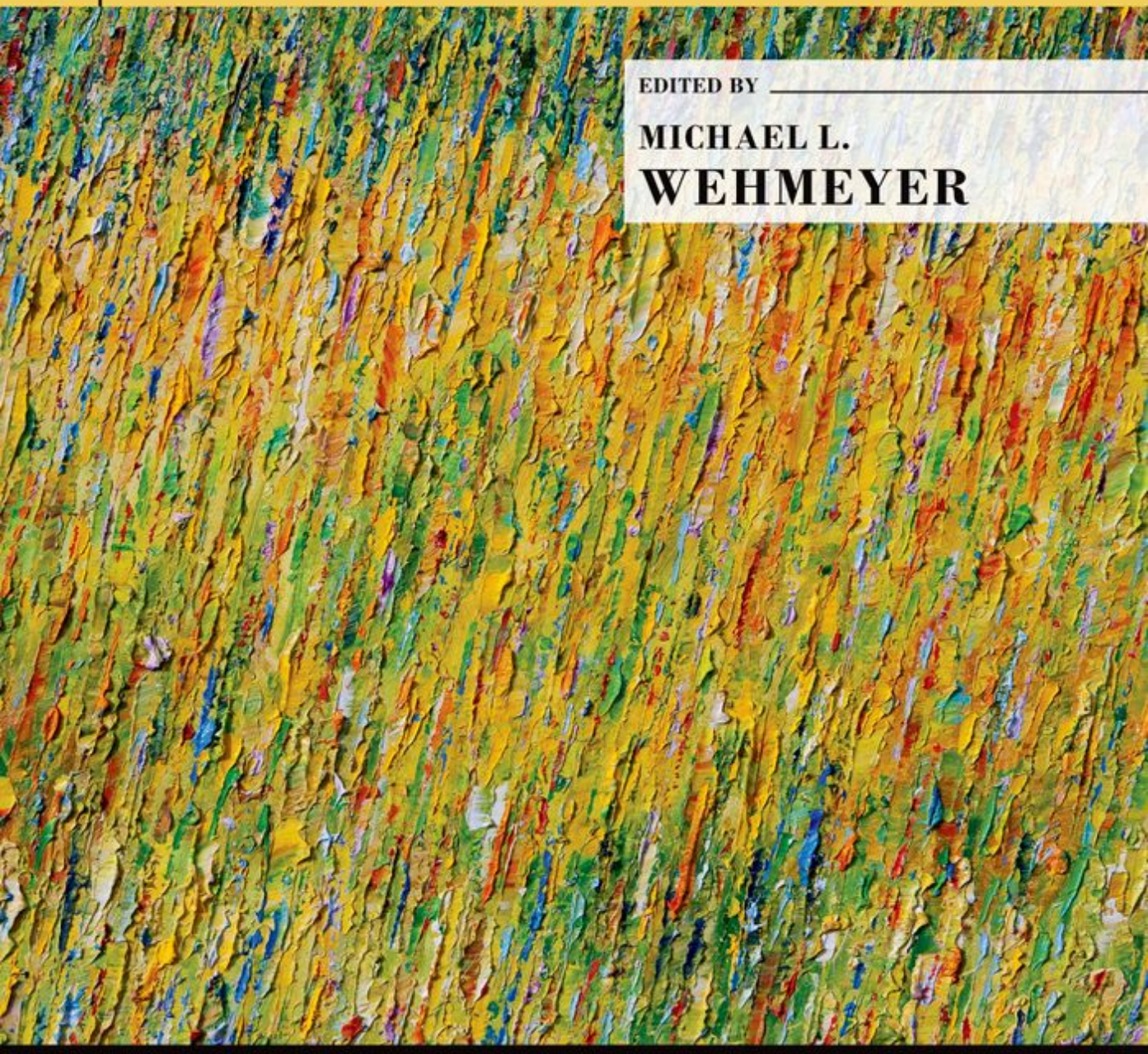

EDITED BY

MICHAEL L. WEHMEYER

The Oxford Handbook *of* POSITIVE PSYCHOLOGY *and* DISABILITY

The Oxford Handbook of Positive Psychology and Disability

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The Oxford Handbook of Positive Psychology and Disability

Edited by

Michael L. Wehmeyer

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The *Oxford Library of Psychology,* a landmark series of handbooks, is published by Oxford University Press, one of the world's oldest and most highly respected publishers, with a tradition of publishing significant books in psychology. The ambitious goal of the *Oxford Library of Psychology* is nothing less than to span a vibrant, wide-ranging field and, in so doing, to fill a clear market need.

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PART 1

Overarching Themes in Positive Psychology and Disability

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CHAPTER

1

Beyond Pathology: Positive Psychology and Disability

Michael L. Wehmeyer

Abstract

Historically, disability has not been conceptualized within the context of strengths and positive attributes. This chapter briefly recalls the history of how disability has been understood and the consequences of such understandings in the lives of people with disabilities. The chapter discusses the complexity inherent in the notion of disability and the seeming lack of homogeneity among and between people with disabilities, noting that the universal experiences of people with disabilities have been discrimination and marginalization. The potential for positive psychology to contribute to paradigmatic changes in the field with regard to how disability is understood is discussed.

Key Words: disability, people with disabilities, disability history, understanding disability

One theme repeated frequently in the chapters that comprise this volume on positive psychology and disability is the seeming incongruity between these two constructs. Put bluntly, across history, people with disabilities have not been viewed in the context of strengths and capacities. Shogren (Chapter 3) provides a historical analysis that clearly shows that, although progress has been made, the literature in the field of disability has not been strengths-focused, and the literature in the field of positive psychology has not addressed disability. So, why create a volume of the *Oxford Library of Psychology* on positive psychology and disability? Quite simply, the trends of the past decade have created an impetus to consider issues of disability through the lens of positive psychology, and it is intended that this volume provide a catalyst to accelerate that trend, both on the disability side and on the positive psychology side.

Buntinx and Shogren (Chapters 2 and 3), among other authors in this volume, articulate those changes in the way in which disability is understood that are driving a focus toward a strengths-based psychology for people with disabilities, and readers are referred to the next two chapters for a thorough treatment of how "functional" models of disability—or person-environment fit models—are shifting the understanding of disability from an interiorized pathology to an exteriorized state best characterized by the fit between personal capacity and the demands of the environment or context. What may not be as evident to those readers of this volume who do not have a history in disability is exactly how older ways of understanding disability have affected the lives of people with disability. "What is past is prologue," Antonio says in Act II of Shakespeare's *The Tempest*. With the hope that this is not the case with regard to how people with disability are treated, it is important to understand what that past looked like for many people with disability so as to avoid repeating prior mistakes.

First, though, a note on "disability" and "people with disabilities." Any discussion about disability must acknowledge that, fundamentally, there is no such thing as a unitary "disability identity." Indeed, it is difficult to generalize almost anything as applying to the group referred to as "people with disabilities" due in part to the sheer number of people in this

category and in part to the wide range of experiences associated with varying types of disability. According to census data, there are 54 million people with disabilities in the United States alone, a large and diverse group in and of itself, and, of course, there are many more millions of people with disabilities around the world. Some of these people are born with a disability, others experience injuries or are identified later in childhood or adolescence. Some disabilities are "hidden," known only to the people who have them and by those close to them, whereas others are openly discernible. Some disabilities impact cognitive development and performance; others do not. Not surprisingly, then, differences among and between people with disabilities are often as notable as differences between people with and without disabilities.

Some people with disability and some scholars in the field would question the utility of even talking about disability, sentiments that are discussed, in part, by Brueggemann (Chapter 19). And, whereas given the lack of homogeneity among "people with disabilities" makes creating a valid taxonomy under this term difficult, if not impossible, there is one universal among and between people with disabilities that, in our minds, justifies a volume on positive psychology and disability. That is, people with disabilities have experienced discrimination and marginalization as a function of their disability.

For purposes of this volume, we have drawn from literature pertaining to a variety of disabilities, with a section containing chapters that focus on specific disability populations (physical disability, cognitive and developmental disabilities, severe multiple disabilities, emotional and behavioral disabilities, and autism spectrum disorders). Although chapters in the application to disability section include literature pertaining to a wide array of disabilities, including traumatic brain injury and sensory disabilities, this volume is not intended to cover the field of rehabilitation psychology for the simple fact that findings in the area of rehabilitation and rehabilitation psychology would justify a volume unto itself. By and large, the focus of this volume is on people who have experienced lifelong disability, and does not as much concern people who have been injured later in life (spinal cord injury, traumatic brain injury, etc.). Again, to flesh out topic areas such as optimism, coping, and resilience, it was necessary to cast a broad net and include research from these rehabilitation areas. But this volume is not intended to provide a comprehensive synthesis of the literature in rehabilitation medicine, cognitive rehabilitation, and rehabilitation psychology.

Pathology and Discrimination: Disability in History

Disability has always been associated with "differentness" and, consequently, people with disabilities have, throughout time, been treated as such, sometime benignly, other times not. The Greek city-state of Sparta and Rome, for example, are frequently identified as practicing infanticide for newborns who were weak or disabled. People with intellectual impairments in the Middle Ages were portrayed as "village idiots," and people with physical disability or epilepsy were relegated to the role of beggars.

Beginning in the late 18th and through much of the 19th centuries, there emerged efforts to educate people with disabilities, almost all associated with segregating people with disabilities in institutions. Over time, these institutions lost their habilitative nature and become warehouses for isolating people with disabilities from society. Physicians and, eventually psychologists, in the early 20th century created the professional discipline of "disability services" and had the sole voice in decisions about how people were treated.

Perhaps the darkest period for people with disabilities since the Middle Ages was the first two decades of the 20th century; ironically, an era of progressivism and social reform in America. Of most importance was the emergence of the pseudoscience of eugenics and its application to social services. *Eugenics*, a term coined by the originator of the concept, Charles Darwin's half-cousin, Francis Galton, referred to the supposed study of hereditary improvement of the human race by controlled or selective breeding. By the first decade of the 20th century, the most rabid eugenicists were Americans. The agendas of men like Charles B. Davenport, Paul Popenoe, and Harry H. Laughlin focused on limiting immigration and curtailing opportunities for people who were seen as "poor genetic stock" to reproduce. Their tools were segregation and sterilization (Smith & Wehmeyer, 2012).

It was, in some ways, a "perfect storm" that resulted in gross human and civil rights violations of America's most vulnerable citizens. Contributing to the mix were the massive overcrowding of institutions; the growing sense of futility with regard to solving what seemed to some to be irresolvable social problems; the notion of science, in the form of genetics and eugenics, as providing answers to these social problems; unresolved class and racial issues festering in America since the Civil War; and the growing concern that the "unfit" were flooding the genetic stock of the population with poor

genes. People with disabilities began to be portrayed as menaces to society and blamed for social problems like prostitution, poverty, crime, alcoholism, and moral decline. Stories about "degenerate" families who propagated generations of "unfit" people reinforced these beliefs, including 1877's *The Jukes* and Vineland psychologist Henry Herbert Goddard's 1912 book, *The Kallikak Family* (Smith & Wehmeyer, 2012). The general public heard their president and Spanish-American war hero, Theodore Roosevelt, bombastically talk about "race suicide," the idea that the purported watering down of the genetic stock, caused by "unfit" people reproducing at higher rates than the so-called "fit," would eventually lead to the downfall of America. Thus, the already burgeoning institutionalized population of people with disabilities exploded in the first decade of the 1900s as a first line of defense against these dire consequences, segregation, was implemented. Institutionalization was no longer about education or habilitation, but was mainly about "protecting" society (Smith & Wehmeyer, 2012).

In 1910, Goddard translated and began to use the Binet-Simon intelligence test on inmates at the Vineland Training School. It was such a success that he then implemented it with school children in the New York City public schools. At a 1910 meeting of the American Association for the Study of the Feebleminded (the new name for the superintendents' group), Goddard suggested a classification scheme for intellectual disability that included the levels of "idiot," "imbecile," and "moron," determined by mental age scores from the Binet-Simon. The latter category, moron, which Goddard defined as people testing with a mental age between 8 and 12 years, was a new category. The term "moron" was derived by Goddard from the Greek word for fool. Soon immigrants, the poor, and, particularly, those women of child-bearing age who were viewed as morally "loose," were being classified as morons and sentenced to institutions (Trent, 1994).

Eventually, though, eugenicists saw segregation as insufficient to address the problem (as, of course, they defined it). In 1907, Indiana became the first state in the nation to legalize involuntary sterilization, providing for the "prevention of the procreation of 'confirmed criminals, idiots, imbeciles, and rapists' " (Landman, 1932, p. 55). By the late 1920s, more than half the states had laws similar to Indiana's. Propelled by the 1927 U.S. Supreme Court ruling (*Buck v. Bell*) that involuntary sterilization was constitutional, it is estimated that 50,000 people who had been labeled "feebleminded" were involuntarily sterilized. Meanwhile, under pressure from eugenicists and the general public, the U.S. Immigration Offices added "imbeciles and feeble-minded persons" to its exclusion list (Gould, 1981; Trent, 1994; Wehmeyer, 2013).

The catalyst to change came in several forms. In the economic (and population) boom of the post-World War II 1950s, a growing parents' movement rejected the notion that their children would be better off in an institution. Advances in science and medicine changed the way disability was perceived and greatly increased the lifespans of people with disabilities. Influenced by the large number of veterans disabled in World War II, who spurred an emphasis on rehabilitation and training, and by the successful development of vaccines for diseases like polio, which gave hope to greater cures for disabling conditions, the earlier stereotypes of disability were replaced with more humane (although still in many ways debilitating) stereotypes. People with disabilities were viewed as objects to be fixed, cured, rehabilitated and, at the same time, pitied. They were seen as "victims" worthy of charity, thus precipitating the emergence of the poster child as a fund raising tool (Shapiro, 1993).

A combination of the passage of federal legislation prohibiting discrimination against people with disabilities in education, employment, and access to the community, combined with a civil rights movement by people with disabilities and their allies that focused on community inclusion and equal access has, over the past four decades, encouraged us to consider issues of disability through the lens of positive psychology. The historical view of disability as pathology has run its course, although it remains far too prevalent. The success of people with disabilities in all aspects of life, aided by civil protections and equal opportunities, has made pathology-based understandings of disabilities irrelevant or inaccurate. It is well past time to begin to consider disability using a strengths-based focus, and this volume provides, it is hoped, a step in that direction.

Beyond Pathology: Disability and Positive Psychology

This volume assembles chapters by leading scholars in the fields of disability and positive psychology to provide a comprehensive synthesis of the state of the combined field of positive psychology and disability. Chapters are organized into thematic sections, beginning with three chapters (including this chapter) providing information on overarching themes in positive psychology and disability. This is

followed by a section highlighting the application of positive psychological constructs to disability. In some cases (quality of life, self-determination, adaptive behavior), a robust disability-related psychological literature is available from which to draw; in other cases (optimism, hope, problem solving), the psychological literature base is limited, but work in other disciplines is available as well as models under which to consider the construct's application to disability. In still other cases, we have turned to experts in disability outside the sphere of psychology because the psychological literature simply has not addressed certain issues pertaining to disability. Chapter 16 on forgiveness, gratitude, and spirituality, for example, is authored by a clergyman who has worked in the field of intellectual and developmental disabilities. Similarly, Chapter 19 on disability studies and disability culture is written by an expert in that field. These different perspectives are important, we believe, because no single field or discipline can adequately address the complexity of the lives of people with disabilities.

The third section addresses systemic issues in disability that impact positive psychology, again turning to disciplines beyond psychology (special education, rehabilitation sciences, family and disability policy) to address areas in which positive psychology can be applied. A fourth section highlights the knowledge base in positive psychology by disability type. There is, necessarily, much overlap in what is important to people across disability types, but equal knowledge or emphasis has not been accorded across such categories, so a disability-type section seemed justified. Finally, to challenge readers to think hard about the application of positive psychology to disability, the text closes with a thoughtful chapter by psychologist Robert Cummins on the limitations of positive psychology.

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CHAPTER

2

Understanding Disability: A Strengths-Based Approach

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Abstract

In the past 30 years, "disability" has moved from the area of pathology into the area of human functioning. New models of disability were developed, such as the International Classification of Functioning, Disability, and Health (WHO) and the conceptual framework of human functioning (AAIDD). Accordingly, the focus of professionals moved from diagnosing impairments and limitations to also assessing functional strengths and support needs and resources to enhance human functioning. At the individual level, the concept of quality of life provides a positive aid for aligning personal support goals with supports strategies in the context of individualized supports planning. At the societal level, the United Nations Convention on the Rights of Persons with Disabilities constitutes an overarching set of internationally accepted values to guiding positive disability policies. The chapter demonstrates the relationships between these concepts and models and points to parallel developments in psychology. Implications of the new strengths-based approach for professional practices are discussed.

Key Words: ICF, UN convention, quality of life, assessment, supports, ecological psychology, interdisciplinary intervention

The purpose of this chapter is to reflect on the background of a positive and strengths-based approach to disability and its implications for professional practice. It aims more at offering an overview of a number of related developments and less at in-depth descriptions of specific items and constructs; most of the concepts and constructs used in this chapter have been discussed in more depth elsewhere in this volume.

Psychology is, essentially, a discipline that studies behavior and related mental processes using scientific methodology. As such, psychology is neither positive nor negative. However, as human endeavors, both academic activities and the application of resulting evidence by professionals in practice take place within a cultural context of contemporary knowledge, values, and social axioms. So, which questions are asked, what purposes are served, and what technology is used depend not only on the state of scientific knowledge of the discipline but are also determined by social context.

This is particularly true for "disability," a phenomenon that "exists at the intersection between the particular demands of a given impairment, society's interpretation of that impairment, and the larger political and economic context" (Braddock & Parish, 2002, p. 3). And, as for the psychology of disability, context is exactly what has changed significantly in the past 50 years.

In the 20th century, the psychology of disability and mental disorder gradually moved from psychoanalysis and behaviorism to ecological and humanistic psychology. Psychoanalysis, although it may inspire the study of social attitudes toward disability, does not specifically address the understanding of disability as such. Behaviorism introduced behavior

therapy and behavior modification as powerful tools for changing individual behavior, which appeared very useful in the field of disability. The question, however, as to what behavioral changes should be made proved strongly related to environmental and personal conditions. For example, learning how to travel by bus or prepare meals would not be very useful for a person living in an institutional environment with no place to go and with food provided by the facility's central kitchen. Taking the environment into account not only offers a more complete understanding of present behavior but also offers a more realistic context for intervention in terms of opportunities and resources. Ecological psychology introduced a useful theoretical frame for both scientific study and professional practice. In the area of disability, Uri Bronfenbrenner's ecological theory on human development (Bronfenbrenner, 1979, 1999; Bronfenbrenner et al., 1994) added a fruitful perspective, but there is more to understanding disability than even ecological theory addresses. Even moving toward normalized community settings implies more than learning and applying skills and (re)arranging relations between person and environment: it also needs to take into account the perspective of the person and address his or her needs, goals, preferences, subjective experiences, and life perspectives. From the 1960s on, humanistic psychology called for a holistic approach to human existence and addressed the development of human potential in a broader, existential context. Motivation, life goals, and meaning became important "variables" in the understanding of behavior and the enhancing of human functioning (Aanstoos, Serlin, & Greening, 2000; Bugental, 1967; Sutich & Vitch, 1969). More recently, positive psychology enlarged the view because it intends to promote positive functioning in individuals, families, and communities by using psychological knowledge in a growth- and well-being–enhancing way. It focuses not only on positive human functioning and personal well-being but also on civic virtues, relationships, and even on social institutions that constitute the playing field of human existence (Peterson, 2006; Seligman & Csikszentmihalyi, 2000).

Understanding and successfully applying positive psychology in the disability field requires an extension of the perspective beyond psychology. In this chapter, this broader perspective will be described around three related developments with respect to new conceptual frames of disability, new perspectives of rights and quality of life (QOL), and new systems of supports. Then, implications for professional practice will be discussed.

Understanding Disability

The historical dynamics of defining and understanding disability have been documented in the literature (Braddock & Parish, 2002; Kanner, 1964; Stiker, 1997; Trent, 1995). From this literature, it is clear that disability has to do with impairments in physical and/or mental functions. But it is also clear that the identification of the impairment as such is hardly predictive of the functioning of the person as an individual and even less so as a member of society. In other words, how impairment interacts with a person's specific abilities and how society responds to people with an impairment is as relevant for understanding disability as is the understanding of the impairment as a functional defect. A pathological approach alone will, therefore, not lead to a full understanding of a person with a disability nor will it lead to successful interventions. Knowledge of social contexts and their responses is necessary to understand the effects of impairment on a person's functioning and to develop a professional approach to mitigating that person's impaired functioning. Hence, ecological models that take the role of behavior context and environment into account became potent factors in the development of the psychology of disability (Barker, 1965; Fuhrer, 1990; Landesman, Dossett, & Echols, 1996; Schalock & Begab, 1990). In social science, the ecological approach focuses on the congruence between people and environments. One of the features of the ecological approach is the organization of the environment into micro (face-to-face relationships), meso (settings), and macro (overarching cultural, attitudinal factors and systems) levels.

Such a complexity of perspectives, however, leads readily to Babel-like confusion in communication, a confusion that not only exists within or between different academic disciplines but also in the arena of social policy, where many different interests and stakeholders meet. So, both understanding and intervening in matters of disability benefit from models that clarify and organize the different perspectives. The need for such models grew in the last quarter of the 20th century, when it became clear that disability was not a problem of small and specific minorities; the number of persons with disabilities was increasing as a result of aging and longevity; increased social risk factors, such as becoming victim of accident; medical interventions that help patients survive with disability; and an increasing demand for equal rights, access to resources, and participation in society. It was clear that these models should be multidimensional and multidisciplinary.

World Health Organization Models of Disability

The *International Classification of Impairments, Disability and Handicap* (ICIDH, World Health Organization [WHO], 1980) was the first systematic attempt to combine different perspectives for looking at disability. The ICIDH defined three planes of experience in explaining disability as the consequences of a "disease" or pathological health condition. According to the ICIDH, a disease may manifest or express itself in:

1. Problems in body functions and/or anatomy, resulting in *impairment*
2. Related problems in the person's activities, resulting in *disability*
3. Problems in performing social roles in society, resulting in a *handicap* (WHO, 1980, p. 30)

These three perspectives coincide with the functional levels of the body, the individual, and the society. The ICIDH was a breakthrough in integrating the medical model with the psychological and social models of disability and in combining the individual perspective with the social perspective. For the first time, the ICIDH provided a conceptual model with clear definitions and an extensive classification system.

However, the ICIDH was criticized for conceptual as well as technical reasons (Fougeyrollas, 1998; Kraijer, 1993; Tarlov, 1993; WHO Collaborating Center, 1994; WHO, 1999). This criticism included:

1. The unidirectional and alleged causal nature of the disabling process, starting with a disease or health condition, leading toward impairment, which consequently leads to disability, and, finally, results in handicap.
2. The absence of the environment as a factor in the disabling process.
3. Weaknesses of application in problems of children and the elderly (the system is not sensitive to development).
4. The use of negative language ("impairment," "disability," "handicap") and hence stigmatizing effects.
5. The conception of disability as a separate phenomenon, without reference to the functioning of people without a disability. This could enhance categorization and conceptually separate persons with from persons without disabilities. Disability was seen as a class in its own and not as being on a continuum of human functioning.

This criticism, as well as feedback from the worldwide use of the ICIDH in research, provided input to a fundamental revision that started in 1993 and ended in November 2001 with the official release of the ICF; the *International Classification of Functioning, Disability, and Health* (WHO, 2001). This new conceptual model of human functioning comprises six components. The three core components of human functioning (similar to the ICIDH components worded differently) are distinguished from health conditions, and two contextual components are seen as influencing factors.

The ICF provides a multidimensional framework for the description of human functioning and disability in a more positive way. *Functioning* is used as an umbrella term for neutral or nonproblematic functional states, whereas *disability* is used as an umbrella term for problems in functioning. Disability is seen as part of human functioning and not as an independent phenomenon.

The ICF model takes into account the interacting domains of human functioning. Definitions and descriptions of these domains can be considered the grammar of a "language" that allows professionals from different disciplines to communicate in clear terms and to compile and organize information from different sources. The domains of the ICF model are defined as follows.

Body functions and structures. Body functions and structures comprise two major domains, defined as the physiological and psychological functions of body systems, respectively, such as the anatomical parts of the body (e.g., organs, limbs, and their components). *Impairments* are problems in body functions or structures, such as a significant deviation or loss. For example, in the context of intellectual disability, intellectual functions and cognitive functions are subdomains of body functions; intellectual disability would code: b117.

Activities. Activities refer to a person's execution of a task or action. Activities can be understood as referring to learned activities or skills. Difficulties a person may have in capacity and/or in the performance of activities are referred to as *activity limitations*.

Participation. Participation refers to a person's involvement in life situations. It denotes the degree of the person's involvement in the community. Problems that an individual may have in the manner or extent of involvement in life situations are called *participation restrictions*. Unlike the activity dimension, which is about individual performance and the presence of skills relevant to various aspects

of life, the participation dimension is about the actual involvement of the person in real-life social settings. Participation restrictions are about disadvantages that limit the fulfillment of social roles considered normal (depending on age, sex, culture) for the individual. The term *participation restrictions* is congruent with the earlier term *handicap* in the ICIDH. *Health conditions* are disorders and diseases as listed in the WHO International Classification of Diseases (WHO, 1994). *Environmental factors* make up the physical, social, and attitudinal environment in which people live and conduct their lives. *Personal factors* occur in the background of a particular individual's life, such as gender, race, age, fitness, lifestyle, habits, social background, education, profession, and significant life events. The same model and definitions apply to the children and youth version of the ICF published in 2007.

The AAIDD Model of Human Functioning

In the field of intellectual disability, a breakthrough was realized in 1992 through its multidimensional conceptualization by the American Association on Intellectual and Developmental Disabilities (AAIDD)—at that time acting under the name American Association on Mental Retardation (AAMR). In the 9th edition of the AAIDD "manual on definition" (Luckasson et al., 1992), a very important shift was made through the adoption of a social-ecological approach to disability that took environmental considerations fully into account (even before the ICF included them). A second innovation of the 9th edition was its positive approach to the classification and description of the person's functioning by considering not only problems and weaknesses but also the person's strengths in different dimensions of functioning. This implied looking for possibilities and opportunities during the interdisciplinary assessment process, not just for difficulties and barriers. A third innovation was shifting the center of gravity from classifying defects and limitations to the determination of needed supports. Supports are not restricted to specialized and institutionalized programs but extend to the environmental context and include generic support resources in the community. These innovations accounted for a paradigm shift in the assessment of and intervention in disabilities.

The new paradigm was further developed in the manual's 10th edition (Luckasson et al., 2002) and finalized in the 11th edition, in 2010 (Schalock et al., 2010). The present AAIDD conceptual framework of human functioning represents a positive view on disability that starts from a nonpathological concept of "human functioning" that allows identifying strengths and weaknesses in five functional dimensions. The most important addition to this model, compared with the ICF, is the central role of supports. Supports act precisely at the center of the person–environment interaction and can significantly affect the quality of a person's functioning. As a consequence, the role of professionals in disability can be redefined as facilitating the support process to enhance positive life experiences. Typical professional tasks in this process encompass the assessment of strengths and weaknesses in all dimensions of functioning and arriving at a description of the person's support needs. Next, the role of professionals is to facilitate the support process by contributing from their field's knowledge base (e.g., psychology, health and medical sciences, social work). Such a support contribution may focus either on the person (e.g., by offering specialized therapeutic or educational interventions), on the environment (e.g., by strengthening and enabling access to nonspecialized resources, such as family, friends, and informal and nonpaid supports, or to generic services, such as schools, housing services, employers, communities), or on more effectively delivering supports (Buntinx & Schalock, 2010).

Although the ICF and AAIDD models were developed independently, both stem from an ecological view of disability and their conceptualizations of dimensions are also related. In fact, both models can be translated into each other, which facilitates their use in interdisciplinary practice (Buntinx, 2006; Wehmeyer, Buntinx, Lachapelle, Luckasson, & Schalock, 2008).

The Perspective of Supports

Although a multidimensional view of human functioning would certainly help us arrive at a better understanding of disability, the question remains about how and to what end supports should be given in order to be effective. The ICF and AAIDD multidimensional frameworks of human functioning, although rooted in a positive perception of human functioning, are primarily tools for identifying problem areas in functioning. Knowing these problems, and even considering strengths, does not automatically result in supports. There are three reasons for this. First, these frameworks are professional and highly analytic constructs. The associated classifications do not exact reflect a person's experiences but are for use within professional or academic settings. Indeed, assuming that supports

should simply try to reverse the assessed limitations and weaknesses would be naïve and ineffective as a guide for real-life support actions: positive personal functioning is not the reverse of disability. Second, the identification of impairment, activity limitation, participation restriction, or contextual barriers may not correspond easily with treatment or mitigating activities. Some limitations are beyond treatment or "repair," and limitations in activities and participation resulting from these conditions would still exist despite supports. Third, these frameworks do not take subjective experiences and personal life goals into consideration, and people seldom express their goals and ambitions in life in terms of the ICF. So, the notion of "supports" calls for an orientation or perspective that goes beyond disability. Thus, the language of supports should be different from the language of limitation classification.

Two developments at the end of the 20th century answered this problem. One was the introduction of the concept of *quality of life,* and the other is the human rights approach to disability. The first resulted in concepts and instruments that would help identify personal needs for supports, formulate personal goals, and set criteria for the evaluation of supports outcomes and a person's overall well-being. Quality of life is a concept at the individual, psychological level.

The second resulted in the clarification of human rights for persons with disabilities that eventually culminated in the United Nations (UN) Convention on the Rights of Persons with Disabilities (WHO, 2006). This international rights document addresses the social-political environment of human functioning as expressed in laws, regulations, and cultural norms that govern society.

Quality of Life

According to the World Health Organization (WHO), QOL is the "individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and their relationship to salient features of their environment" (WHO, 1997, p. 1). The Quality of Life Research Unit of the University of Toronto defines it as "[t]he degree to which a person enjoys the important possibilities of his or her life" (Quality of Life Research Unit, 2012).

In the 1990s, considerable work was done in the field of disabilities and QOL by authors David Felce (1995, 1997), Roy Brown (1997), Robert Cummins (1997), Robert Schalock (1990), and Schalock et al., 2002). The construct developed into multidimensional models that identify a number of life domains to cover human existence as a whole. Within these domains, specific indicators and measurement instruments can be operationalized. An essential feature of the construct of QOL is the acknowledgment of both subjective and objective criteria for evaluation. The subjective approach refers to a person's satisfaction with a domain or indicator and their relative importance for that person in his or her life. The objective approach refers to objective norms available in society. For example, a person can be perfectly satisfied with his or her health (subjective) but can suffer from high blood pressure or other health conditions or maintain an unhealthy lifestyle (objective); or, a person may be satisfied with his or her living situation in a run-down institutional building and see no reason to move (subjective), but institutional environments and large living groups in congregate settings are not considered positive environments by contemporary professional standards (objective). Objective norms can be found in legal and professional standards. Subjective norms can be obtained by simply asking the person about his or her life experiences or by using satisfaction inventory methods.

Three commonly used QOL domain frameworks are shown in Table 2.1. The concept of QOL serves as a reference frame for identifying support needs, both subjective and objective. Subjective support needs follow from the person's personal aspirations and goals in life. Objective support needs result from a professional appraisal of the person's present functioning, taking both his or her (dis)abilities and contextual circumstances into account.

The construct of QOL adds a powerful perspective to positive support practices in disability because it introduces positive values and offers a background for formulating positive goals. Although specific indicators may be sensitive to cultural and lifespan perspectives, they involve universally perceived aspects of personal well-being (Schalock et al., 2005; Schalock, Gardner, & Bradley, 2007). Quality of life is a sensitizing notion for identifying individual support needs, assessing support outcomes, and also for guiding the development of social policies (Schalock et al., 2012).

The United Nations Convention on the Rights of Persons with Disabilities

The UN Convention on the Rights of Persons with Disabilities (henceforth, the Convention) is the culmination of a history of applying human rights to

Table 2.1 Domains of Quality of Life According to Three Major Authors

Domains of Quality of Life according to Schalock et al. (2007), World Health Organization (WHO, 1997), and the Quality of Life (QOL) Research Unit (Toronto)

Schalock	WHO	QOL Research Unit
1. Personal development	1. Physical Health	1. Physical Being
2. Self-determination	2. Psychological	2. Psychological Being
3. Interpersonal relations	3. Level of Independence	3. Spiritual Being
4. Social inclusion	4. Social Relations	4. Physical Belonging
5. Rights	5. Environment	5. Social Belonging
6. Emotional well-being	6. Spirituality/Religion/Personal beliefs	6. Community Belonging
7. Physical well-being		7. Practical Becoming
8. Material well-being		8. Leisure Becoming
		9. Growth Becoming

the situations of persons with disabilities. Although the Universal Declaration of Human Rights, adopted by the UN General Assembly on December 10, 1948, addresses all humans without exception, the need was felt to more explicitly translate these rights to the situations of persons with disabilities. This led to the Declaration on the Rights of Mentally Retarded Persons (December 20, 1971) followed by the Declaration on the Rights of Disabled Persons (December 9, 1975). The awareness that rights do not automatically lead to a better life if people lack opportunities to actually exercise those rights led to the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (December 20, 1993). This non-legally binding UN document described the conditions and target areas for community participation of persons with disabilities. Finally, the legally binding Convention was adopted (December 13, 2006), stating the terms and conditions with which states should comply to create conditions for full citizenship and participation for persons with disabilities. It is important to realize that this document was developed with significant input from persons with disabilities and their organizations. The Convention reaffirms that all people with disability must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to persons with disabilities. It identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and where protection of rights must be reinforced.

The importance of this Convention can hardly be overestimated. In terms of ecological psychology, the Convention is an instrument at the macrolevel. It represents the fundamental and universal values that states and their institutions need to observe in developing an equitable society. Professional support organizations for people with disabilities are part of society and are, in most cases, governed by national (health) policy. Therefore, people with disabilities are fully affected by the values and targets of the Convention. Thus, promoting social participation and inclusion, enhancing self-determination and development, and striving for equal opportunities for persons with disabilities cannot be considered local idealism or naïve enthusiasm on the part of organizations or individual professionals; it is simply their duty "under the law" to enhance the dignity, equality, and inclusion of their clients as equal citizens. Because the Convention represents universal values and targets, every individual professional and every organization in the field has a moral obligation to define its position against this backdrop.

Quality of Life and the Convention

It is important to realize that the fundamental values expressed in the QOL concept and in the Convention are identical. In that the conceptualization and operationalization of QOL is directed more at the level of individual supports, it is fitter for clinical use. The Convention is better fit to social-political applications at the societal level.

One can say that the Convention creates societal conditions for QOL to be effective at the individual level, but both share the same underlying values. Therefore, the QOL domains and the articles of the Convention can be aligned as shown in Table 2.2 (Schalock et al., 2012, p. 45).

Because the Convention is rooted in internationally accepted values, it is a strong binding force across sociopolitical, professional, and academic stakeholders in support processes at any level. This was emphasized at the 14th Congress of the International Association for the Scientific Study of Intellectual and Developmental Disabilities (IASSIDD) in Halifax by Klaus Lachwitz (2012), president of Inclusion International, and Michael Bach, vice-president of the Canadian Association for Community Living. In Bach's view, the scientific (and I would add as well the professionals') task is not to determine *if*, but *how*;

> Not *if* people with intellectual disabilities have a will and preference, but *how* to determine it even when its contours are occluded by our usual ways of seeing and knowing; not *if* people with even the most complex disabilities can live in the community, but *how* that is to be made possible.... Not *if* people with intellectual disabilities benefit from being supported to exercise self-determination and making their own choices,... but *how* to enable others to respect and act upon the legal power they possess. It is only with such knowledge, founded on a law, science and ethics of inclusion, that we might nurture a new relationship between the state, society and people with intellectual disabilities. (Bach, 2012)

Supports System

Supports are defined as resources and strategies that aim to promote the development, education, interests, and personal well-being of a person and enhance individual functioning (Schalock et al., 2010; et al., 2002, 2009). The AAIDD framework of human functioning moves supports to the center of the professional's involvement with persons with disabilities. This involvement should focus on the identification of support needs and the development of an individualized support plan to enhance individual functioning. The supports system addresses three items: support needs, support resources, and support strategies.

Table 2.2 Relationships Among Quality of Life (QOL) Domains and United Nations Convention Articles

QOL Domains	Exemplary QOL Indicators and Applicable UN Convention (Art. 5–30)
Personal Development	Education status, personal skills, adaptive behavior *Art. 24*
Self-determination	Choices/decisions, autonomy, personal control, personal goals *Art. 8, 9, 18, 20, 27, 29, 30*
Interpersonal Relations	Social networks, friendships, social activities, relationships *Art. 23*
Social inclusion	Community integration/participation, community roles, supports *Art. 8, 9, 18, 20, 27, 29, 30*
Rights	Human (respect, dignity, equality) legal (legal access, due process, privacy) *Art. 5, 6, 7, 10, 11, 12, 13, 15, 22*
Emotional Well-Being	Safety and security, positive experiences, contentment, lack of stress) *Art. 16, 17*
Material Well-Being	Health and nutrition status, recreation, leisure *Art. 16, 25, 26*
Material Well-Being	Financial status, employment status, housing status, possessions *Art. 28*

Support needs. Support needs are defined as a psychological construct referring to the pattern and intensity of supports that are necessary for a person to participate in activities associated with normative human functioning (Thompson et al., 2009). Normative functioning is related to the construct of QOL. Therefore, support needs are rooted in both subjective and objective needs. Objective needs can be identified in a professional assessment process using professional or social standards. For example, when a person has a severe mobility limitation due to impairment in movement related body structures and/or functions (e.g., related to cerebral palsy or paralysis), this person will need support to go shopping or to more generally move around in the community. Subjective needs are related to the life goals, preferences, ambitions, and wants of the person or his or her actual dissatisfaction in specific QOL domains or indicators. Developing supports is therefore based on an assessment of both subjective and objective needs. Professional support process models currently include both (Buntinx et al., 2010; Thompson et al., 2009). For the assessment of support needs from the professional perspective, instruments such as the Supports Intensity Scale are available (Thompson et al., 2004).

Support resources. Traditionally, support resources in the disability field are seen as professional and specialized organizations such as institutions, sheltered workshops, day activity centers, or group homes. However, the need for supports does not necessarily mean that they should be delivered in a specialized or restricted setting.

The AAIDD conceptualization of support resources starts with the personal strengths and possibilities of the person with disabilities. This person always possesses relative strengths, as assessment using ICF and AAIDD frameworks should make clear. Even in the case of very severe and multiple disabilities, a positive approach may identify relative strengths in functioning that may be relevant to enhancing the person's QOL. The person can be pictured in the middle of a set of concentric circles. Surrounding the person are the three circles of family and friends, informal supports (such as colleagues at work, co-members of a club, fellow pupils at school), and generic services that are open to the public at large (such as shops, sports and cultural facilities, health services). These three circles are natural resources that are available in the general community environment. The use of public resources supposes that these are inclusive to persons with disabilities. In states and nations that ratified the Convention, general obligations to inclusion exist. The fourth and last circle regards specialized services-based resources. These are supports provided by people and equipment that are not typically part of the person's natural environment, such as specially trained professionals like psychologists, teachers, therapists, nurses, direct support staff, or paid volunteers. These services usually are provided under some form of contract with the government and use public funding. In the past, support resources for persons with disabilities were mainly restricted to specialized services. In the case of institutions and other special or segregated facilities, this often resulted in the person being cut off from his or her natural support strengths. Family were merely "visitors" in the facility when they came to see their relative; contact with friends was hardly possible and not part of the facility's "treatment" policy. Specialized organizations offered alternatives for school, work, sports, or cultural activities, separated from the same functions and organizations in the community at large. In the last quarter of the 20th century, the tide turned, and persons with disabilities began to make more use of their natural support resources. However, to succeed, this movement supposes a change in the structures and culture of specialized services and in the attitudes of professionals. Although this might be seen by some politicians as a rationale for budget cuts, the primary reason for making use of natural resources is the common sense that people with disabilities are and want to be part of their community. Discovering, however, the support potential of a community may require facilitation, which may, in some cases, also require additional funding and professional facilitation. In addition to direct face-to-face contacts and personal assistance, supports also include the access to and use of technical aids, information and communication technology, social media, financial means, and information.

In the ecological conceptualization of disability, focusing on natural resources is closer to QOL thinking, and it is certainly closer to the implications of the Convention than is focusing on specialized services alone.

Support strategies. Strategies integrate goals with resources and support activities for an individual with disabilities in the context of an individualized support plan (ISP). Before developing an ISP, it is assumed that an assessment of functioning and support needs has been made. On the basis of the person's ambitions for the future, preferences, and wants, as well as based on information about the more objectified assessed support needs (e.g., through the use of

the Supports Intensity Scale), personal goals can be selected and prioritized. This is the first step of the ISP. Next, for each goal, relevant support activities and resources are identified. Support activities can refer to development, teaching, education, befriending, assistance, coaching, or treatment (health and behavioral) activities. Support resources refer the natural and/or service-based resources discussed in the previous section. Finally, the person's goals and related support activities are placed within a timeframe, and support agreements and responsibilities are specified.

The ISP is placed within a systematic cycle, which involves monitoring progress and evaluating outcomes. The ISP should be developed with as full involvement of the person as possible and, eventually, with the participation of significant others or advocates. The ISP takes the form of an agreement between the person with disabilities and others with respect to supports delivery (both natural and specialized). In the strengths approach, individualized supports are typically created around the person and not around a professional service or funding stream.

In the past few decades, the emphasis of professional intervention moved away from developing "programs" for persons with common characteristics such as " type of impairment," "level of functioning," or "behavior problems" and toward developing strictly individualized strategies. The voice of the person and his or her self-determination in terms of personal dreams, goals, and a say in the way these would be pursued, are key to the supports process. This changes the role of the professional from "program designer" and "expert" to "partner" in developing and delivering individualized supports.

With respect to supports strategies that make use of the person's strengths and empower natural resources, a new range of strategies and methods is being developed. *Person-centered planning* has become an umbrella term for such strategies (Claes, Van Hove, Vandevelde, Van Loon, & Schalock, 2010). Methods associated with person-centered planning strategies include Planning Alternative Tomorrows with Hope (PATH), Making Action Plans (MAPS) (O'Brien & O'Brien, 2002; O'Brien, Pearpoint, & Kahn, 2010), and Active Support (Felce et al., 2000). Examples of methods that focus on the mobilization of support strengths in natural resources include *wraparound care* (Winters & Metz, 2009) and *family group conference* (Huntsman, 2006; Kyeong-Hwa & Turnbull, 2004; Lupton, 1998).

The participation of the person with disabilities in these methods is more than a physical presence at an ISP meeting; it supposes an active involvement in the process (Carnaby, 1997; Dowling, Manthorpe, & Cowley, 2007; Wehmeyer, 2002; Williams & Robinson, 2000). Self-determination in the support process leads to dynamic partnerships among persons with disability, their natural environment, and professionals.

Looking at support strategies in an ecological context focuses on aspects of the broader macrosystems, such as social and cultural attitudes toward disability and factors that affect the availability and accessibility of services. Moreover, funding systems and regulations (e.g., social security, health care system) strongly affect the provision of supports strategies. Thus, successful support strategies in practice are not just a matter of strategies at the individual level but will also depend on facilitating strengths and weaknesses on the level of services and society. The synergetic alignment of macro, meso, and micro strategies is therefore an important condition and remains, in many cases, a challenge.

Implications for Professional Practice

In recent decades, significant developments took place to change scientific and societal views on disability. What is considered good practice in disability is affected by these developments, as discussed in the previous sections. The implications of these developments for professional practice can be summarized as follows.

Understanding disability has definitely moved from describing impairments and limitations to understanding human functioning as a whole and understanding individual needs for support. Developing and delivering supports require an individualized process, organized around the person's desired life experiences and goals and taking into account assessed support needs. The direction of the support process points to the common denominator of QOL, a perspective that people with disabilities share with all other people in society and that has been incorporated in internationally recognized rights documents. Good practice implies that person-centered strategies should be observed.

The process as a whole can be aligned along the concepts of functional strengths and weaknesses, needs, goals, and perspective. Translated into good practice for clinical professionals, these concepts can be arranged in a four-phase approach (Buntinx & Schalock, 2010). First, assessment of

a person's strengths and weaknesses in functioning along a multidimensional (i.e., interdisciplinary) path is necessary to identify relevant potentials, but also to discover relevant impairments, activity limitations, and participation restrictions together with associated health conditions (etiology) and contextual factors. It must be clear that emphasizing the importance of strengths and facilitators does by no means make diagnosis of health conditions, etiology, impairments, and limitations less important. On the contrary, failure to identify relevant pathology could result in serious health risks and ineffective supports. However, the strengths-based approach will not stop at identifying pathology, impairments, limitations, and barriers but will go beyond these to look for functional strengths. Second, assessment of a person's desired life experiences, ambitions, and wants, as well as an assessment of objectified support needs and needs intensities, is another aspect of the process. Third, the individualized supports planning process is directed toward linking personal goals with a range of related resources and action strategies. People involved in the delivery of supports should participate as closely as possible in the ISP planning process. The ISP should be monitored and evaluated in a systematic way.

Fourth, supports outcomes are evaluated in terms of QOL. The basic question here is if and how the person has benefited from support efforts and investments. From this evaluation, new support goals and strategies can be formulated.

Although this four-phase approach reflects an analytic view on disability from the professional's point of view, it does by no means imply a mechanical process. The elements as discussed in this chapter are the rational backbone of good practice that also requires communication and client-centered skills that allow for a flexible approach to real life. In the same way that a patient does not need to study functional analysis, behavior therapy, or medicine in order to participate in treatment, a person with disabilities does not need to learn the language of the ICF or ISP methodology. The professional, however, will need not to simply study the theory and methods of disability but will also need to become familiar with their application in practice, as part of his or her education.

In a strengths-based supports strategy, the person's own abilities and strengths are explicitly considered before calling in other resources. Thus, the empowerment of the person has a high priority; in addition, the strategy also emphasizes the empowerment of other nonspecialized or natural resources. For professionals in the field of disability, this means that they should not only apply their knowledge and competencies in direct face-to-face interventions with the person but also in empowering natural resources to playing a role in the overall provision of supports. For professionals who are used to dealing with persons with disability within the borders of their service or facility, this may mean a shift of focus. Instead of applying their professional skills and time in direct assistance, teaching, or treatment activities, they may need to learn how to involve and facilitate nonprofessionals to effectively support the person with disabilities (Carr et al., 2002). In these cases, the professional must undertake a mediating role in the support process. Hence, positive practice professionals and their organizations will not just need expertise with respect to impairments but also skills in communication, and with scouting and empowering environments.

Positive approaches to disability involve not only academic and clinical input. As demonstrated, part of the understanding of disability and, even more, a lot of intervention, presupposes the involvement of the community and societal environment as conditions for success. Therefore, positive practices in disability will always require a multipath approach that includes clinical, organizational, and social-political factors. The message here is that support of a person with disabilities is never a one-person affair. It will always require the involvement of a broad range of contextual stakeholders. As such, disability support is a community endeavor involving professionals and nonprofessionals alike. As argued in this chapter, tools are available to enhance a common language and concerted actions on the individual as well as the societal level. That is a positive factor. Improving these tools through research and putting them to work effectively to the benefit of people with disabilities is an academic and professional challenge. It may require not simply shifting working procedures for professional disciplines but also redesigning organizational structures, developing new disability policies and systems, and possibly changing societal attitudes as well.

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CHAPTER 3

Positive Psychology and Disability: A Historical Analysis

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Abstract

The disability and psychology fields have undergone significant changes since the latter part of the 20th century. Within psychology, positive psychology has emerged as an alternate paradigm through which to understand the complete human condition. Within disability, person-environment fit and social-ecological models have influenced conceptualizations of disability. This chapter analyzes the historical trends in psychology and disability that have led to the emergence of these paradigms, analyzes the impacts that these shifts have had on literature in each field, and explores implications for future research, policy, and practice.

Key Words: positive psychology, social-ecological, disability, supports

Substantial changes have emerged within the fields of psychology and disability in recent decades. In psychology, an alternate paradigm—positive psychology—has grown into a flourishing subfield. In the disability field, there have been major shifts in our understanding of the construct of disability, including a movement away from a deficit-based or medical model of disability to a social-ecological model of human functioning. The purpose of this chapter is to analyze the historical trends in psychology and disability that have led to the emergence of these paradigms, analyze the impacts that these shifts have had on literature in each field, and explore implications for future research, policy, and practice.

Historical Trends

Positive Psychology

In 1998, while president of the American Psychological Association, Martin Seligman stated 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). Seligman called for a "reoriented science that emphasizes the understanding and building of the most positive qualities of an individual" (Seligman, 1999, p. 559), which he called "positive psychology." Although other researchers (cf. Maslow, 1954) had called for greater attention to be paid to the positive within psychology, it was not until Seligman's call that "positive psychology" began to receive significant and organized attention from psychology scholars.

Seligman and Csikszentmihalyi (2000) elaborated, "before World War II, psychology had three distinct missions: curing mental illness, making the lives of all people more productive and fulfilling, and identifying and nurturing high talent" (p. 6) but a number of factors following the war led to the focus of psychology narrowing, with the greatest emphasis in the field placed on curing mental illness. Two highly influential factors included the founding of the Veterans Administration, which provided funding for treating mental illness, and the founding of the National Institute of Mental Health, which provided funding for researching mental illness.

These factors led to psychology adopting, in large part, a disease model of human functioning (Linley, Joseph, Harrington, & Wood, 2006). Although research that focused on making life productive and fulfilling and nurturing high talent continued, it was a minority in the field. Psychology primarily focused on the "dark side of human existence" (Snyder & McCullough, 2000, p. 151), where:

> 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. (Seligman, 1998a, p. 2)

Seligman's call for positive psychology had a substantial impact on psychology. Although research on constructs associated with positive attributes and values had existed throughout the history of psychology, never before had a positive, strengths-based model of understanding human functioning, rather than a disease model, been described and systematically integrated into research and practice in the field. And, since Seligman's presidential address, there has been, as some researchers characterize it, an "explosion" of research on positive psychology (Yen, 2010).

In 2000, in a special issue of *American Psychologist*, Seligman and Csikszentmihalyi (2000) introduced positive psychology and presented 15 articles that described constructs that fit within the positive psychology paradigm. Since that time, dozens of general and specialized (e.g., social psychology, clinical psychology, humanistic psychology, behavioral psychology, school psychology) psychology journals have published special issues or special sections on positive psychology (Linley et al., 2006). In a recent review, Hart and Sasso (2011) found that more than 20,000 articles had been published in the area of positive psychology between 1998 and 2009, with a steady growth in the number of publications since Seligman gave his presidential address in 1998. In 2006, *The Journal of Positive Psychology* published its first issue and has continued to publish theory and research in positive psychology.

As with research, a number of scholarly books have been 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, including the present text, as well as others on topics ranging from work and positive psychology (Linley, Harrington, & Garcea, 2009) to positive psychology in schools (Gilman, Huebner, & Furlong, 2009). Texts have been published on methods (Ong & van Dulmen, 2006) and assessment in positive psychology (Lopez & Snyder, 2003). Books have been published on positive psychology coaching (Biswas-Diener, 2010), flourishing (Keyes & Haidt, 2003), and authentic happiness (Seligman, 2003), just to name a few. *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. Undergraduate textbooks in positive psychology have been developed (Baumgardner, 2008; Peterson, 2006; Snyder, Lopez, & Pedrotti, 2010), and courses are offered at universities all over the United States and Europe. In fact, at Harvard, positive psychology has been identified as one of the most popular undergraduate courses (Yen, 2010). The Clifton Strengths School (http://www.strengths.org/) was established to support strengths-based education and development. Gallup polls the hope, engagement, and well-being of youth grades 5–12 across the nation (http://www.gallupstudentpoll.com/home.aspx). Research centers on positive psychology have been funded, such as the Positive Psychology Center at the University of Pennsylvania (http://www.ppc.sas.upenn.edu/). A yearly Positive Psychology Summit has been held since 1999, bringing together scholars interested in positive psychology. Multiple foundations and federal agencies, including the Annenberg Foundation, the Templeton Foundation, the Gallup Foundation, and the U.S. Department of Education, have funded grants on positive psychology research (Seligman, Park, & Peterson, 2005). Positive psychology has received significant attention in the popular media; *Time* magazine has covered positive psychology (Wallis, 2005, 2009). Researchers have presented on daytime news programs (e.g., *Good Morning America*), and multiple lay websites and blogs have emerged. Clearly, since 1998, there has been a substantial increase and interest in positive psychology research.

Definitional Framework

Positive psychologists assert that positive psychology is not meant to supplant the disease model of

human functioning but, instead, to create a new paradigmatic lens through which to view psychology (Snyder & Lopez, 2002). In early writings on positive psychology, Seligman (1998b) defined the mission of positive psychology as "to measure, understand and then build the human strengths and the civic virtues" (p. 2). People are viewed "as decision makers, with choices, preferences, and the possibility of becoming masterful, efficacious, or in malignant circumstances, helpless and hopeless" (Seligman & Csikszentmihalyi, 2000, p. 8). Seligman and Csikszentmihalyi (2000) characterized positive psychology as focusing on three "pillars": valued subjective experience, positive individual traits, and civic values and the institutions that support them.

However, as in any new field, the parameters of positive psychology are still being defined. Multiple definitions of positive psychology and the constructs included in its parameters exist (Hart & Sasso, 2011). Some definitions align with the three pillars offered by Seligman and Csikszentmihalyi (2000), others focus on a specific pillar, and still others focus on specific aspects of "the good life," such as happiness, fulfillment, and flourishing. The degree and manner in which positive psychology focuses on "problems" is also a matter of debate. Positive psychology has been criticized by researchers and the popular media alike for adopting a "Pollyanna" view, ignoring the negative issues in life (Lazarus, 2003) or focusing on "happiology" or a hedonic happiness that promotes passive, wishful thinking and coping only in those who are already living "the good life" (VanNuys, 2010a, 2010b). But, as Diener (2009) writes, "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). Diener and others assert that positive psychology does not ignore problems; it simply searches for strengths-based approaches for addressing problems. But Diener also states that "we have for too long focused almost exclusively on the negative and on problems, and that positive aspects of humans are at least equally important, if not more so" (p. 10). Thus, an emerging consensus appears to be that positive psychology focuses on the positive in life—the things that make life good—but also explores ways to approach problems that emerge in life from a positive, strengths-based perspective.

Given the multiple frameworks forwarded in the literature for positive psychology, Hart and Sasso (2011) did a content analysis of definitions of positive psychology in the published literature (identified through PsycINFO searches), in course syllabi, and in undergraduate textbooks in the United States and Canada. Despite slight differences in the themes in the definitions across the sources and across countries, there was general consistency. They identified six themes across the 53 definitions of positive psychology forwarded in the published literature from PsycINFO: (a) virtues, character strengths, positive personality traits, abilities, and talents; (b) happiness, positive emotional well-being, fulfillment, and quality of life; (c) development processes associated with growth, fulfillment, actualization of potential, and the authentic self; (d) the good life or the life worth living; (e) thriving and flourishing, and (f) resilience or adaptive functioning/behavior. The first two themes dominated the literature, found in 40% and 34% of definitions, respectively, although the remaining themes were also frequently noted, ranging from 11% to 21% of the definitions. Hart and Sasso argue that the first five themes correspond to two of the pillars of positive psychology identified by Seligman and Csikszentmihalyi (2000) in their definition of positive psychology: positive subjective experiences and positive personal traits. However, Seligman and Csikszentmihalyi's third pillar—positive institutions—was not well represented in the definitions forwarded in the literature. Instead, another theme that was not clearly defined in the original framework emerged—resiliency under conditions of adversity. Notably, although research on the other themes steadily increased since Seligman's 1998 presidential address, research on resiliency showed a very large gain in publications in the 2000s, suggesting increased attention to this body of research in recent years (Hart & Sasso, 2011). This may correspond with researchers expanding the framework of positive psychology, as suggested by Diener (2009), to include both positive constructs and positive approaches/responses to problems or challenging situations.

Clearly, the diversity of research suggests, as do Hart and Sasso (2011), that positive psychology focuses on more than "the study of 'enjoyable feelings' and 'happy thinking' in fortunate people who are privileged to live in pleasant circumstances." It also has an increasing focus on "morphing of the experience of suffering, and . . . [transforming] the conditions that give rise to this suffering" to create a "subjective sense of meaning and a purpose and a style of virtuous living marked by a quest for authenticity" (p. 91).

Included constructs and approaches. As described previously, there are emerging themes that define the

field of positive psychology; any construct or approach that focuses on "what makes life most worth living" (Snyder & Lopez, 2009, p. xxiii) and approaches this from a scientific perspective has the potential to be included in the positive psychology movement. And it is likely that the breadth and scope of included constructs will change over time. In the first special issue of *American Psychologist* (2000) devoted to positive psychology, a handful of constructs were identified that fit within the pillars of positive psychology. For example, articles were included on positive experiences: subjective well-being (Diener, 2000), optimal experience (Massimini & Delle 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). The first edition of *The Oxford Handbook of Positive Psychology* (Snyder & Lopez, 2002) included an even more diverse array of constructs that fit within the parameters of positive psychology. The second edition of the *Handbook* (Lopez & Snyder, 2009) includes 65 chapters on topics ranging from emotional intelligence (Salovey, Mayer, Caruso, & Yoo, 2009) to creativity (Simonton, 2009), love (Hendrick & Hendrick, 2009), humility (Tangney, 2009), and to happiness and positive growth after physical disability (Dunn, Uswatte, & Elliott, 2009). The *Handbook* even includes chapters on biological approaches to positive psychology, 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). Given the newness of the positive psychology field, it is likely that there will be expansion and contraction of the constructs identified as key to prompting "the good life." Key future research directions may include exploring the relationships among various positive constructs and the degree to which diverse experiences and traits are associated with positive outcomes. Other key issues may include integrating research and practice, as well as integrating diverse lines of research across disciplines and subfields that contribute to understanding the good life (Lopez, 2009).

Paradigms of Disability

Within the disability field, a deficit-based model has also dominated modern (and historical) paradigms of disability. Commonly called the *medical* or *functional limitations model*, the focus here was on an "abnormality or deficiency . . . held to be central to actions, experiences, and social identity. The underlying physical or biological defect is considered the primary causal source of an individual's enduring state of limitation in thinking and acting within the social world. An imperfection within the individual . . . results in actions or behaviors that fall significantly short of what one would want or expect" (Danforth, 2001, p. 349). The medical model of disability led to disability being viewed as a trait rather than a state of functioning (Luckasson et al., 1992), with a narrow focus on identifying, quantifying, and remediating the deficits experienced by the individual. For example, for persons with intellectual disability, the predominant focus throughout much of the 20th century was on quantifying intellectual functioning through IQ scores to identify the extent of the intellectual deficit and ascribe interventions to remediate the problem based on the level of intellectual functioning (Snell et al., 2009; Wehmeyer et al., 2008). And, if the deficit could not be remediated (or was perceived to be unremediable), people with disabilities were often placed in segregated institutions, schools, and classrooms. Several sources detail the impact of these deficit-based conceptualizations of intellectual disability in the late 19th and 20th century (Scheerenberger, 1983; Trent, 1994; Wehmeyer & Patton, 2000).

During the latter part of the 20th century, social and political movements within the disability field drew increased attention to the role of the environment in shaping the experiences of people with disabilities and began to shift conceptualizations of disability in the field. These social and political movements included the disability rights movement (Shapiro, 1993), which defined disability as a form of diversity and the barriers experienced by people with disabilities not as inherent to the individual but as a result of oppression and discrimination from a society that did not integrate and accommodate people who learned, moved, and interacted in diverse ways. The normalization (Nirje, 1969; Wolfensberger, 1972) and deinstitutionalization (Bradley, 1994) movements brought increased attention to the inherent rights of people with disabilities to live, learn, work, and play in typical environments. The self-advocacy and self-determination movements (Ward, 2005; Wehmeyer, Bersani, & Gagne, 2000) brought attention to the right of people with disabilities to be causal agents in their own lives. Principles and practices related to universal design (Connell et al., 1997) and universal design for learning (Rose & Meyer, 2002) highlighted how modifying environments to make them

more physically and cognitively accessible could significantly change the experiences of people with disabilities.

These movements brought increased attention to the range of factors that impacted the functioning of people with disabilities—especially the influence of the environment. Whereas previous conceptualizations of disability placed exclusive focus on the physical or biological difference and remediating that difference, new conceptualizations of disability emphasized the person-environment interaction and incorporated a social-ecological model of human functioning (Bronfenbrenner, 1979; Shogren et al., 2009). This model of disability acknowledges that people with disabilities experience differences in functioning that can impact their functioning in a given environment. A functional limitation is defined as "the effect of specific impairments on the performance or performance capability of the person" (Luckasson et al., 1992, p. 10). However, a disability is the "expression of such a limitation in a social context" (Luckasson, 1992, p. 10). Disability is not the same as a functional impairment nor is it a trait inherent to a person; instead, disability is a state of functioning resulting from the interaction of functional limitations and environmental demands. Further, although people with disabilities do have functional limitations, it is also important to note that this conceptualization of disability recognizes that the functional limitations are only one aspect of a person's capabilities. In defining intellectual disability, for example, a key assumption in the application of the definition is that "within an individual, limitations often coexist with strengths" (Schalock et al., 2010, p. 1).

Thus, a new framework for understanding disability has emerged that recognizes that disability is influenced by a range of factors, internal and external to the individual. A functional limitation is simply one of many internal factors that influence the functioning of people with disabilities in the multiple environments in which they live, learn, work, and play. This model, which is referred to as a *social-ecological model* (Buntinx & Schalock, 2010; Schalock et al., 2010) or a *biopsychosocial approach* (World Health Organization, 2007), emphasizes the interaction between diverse personal capabilities and environmental demands and acknowledges the multidimensional nature of human functioning. It shifts the focus from remediating a limitation to identifying "mismatches" between personal capabilities and environmental demands as a means to identify supports needed to optimize functioning in valued contexts to promote subjective personal outcomes, including quality of life (Schalock et al., 2010).

Definitional Framework

Since the latter part of the 20th century, the social-ecological model of disability has received increased attention in the disability filed. The model emphasizes the interactive effects of personal capabilities (which can include both limitations and strengths in functioning) and the demands of the environment. Essentially, disability exists when there is a mismatch between a person's capacities and the demands of the environment. This social-ecological model has been integrated into the World Health Organization's *International Classification of Impairment, Disability and Health* (ICF; World Health Organization, 1980, 2001, 2007) since the 1980s, as well as into the American Association on Intellectual and Developmental Disabilities' (AAIDD) conceptual framework of human functioning since 1992 (Luckasson et al., 2002; Luckasson et al., 1992; Schalock et al., 2010). In these frameworks, disability is viewed as a universal human experience, something that anyone can experience if there are changes in personal capabilities or environmental demands. For example, the *International Classification of Functioning, Disability and Health* (ICF; World Health Organization, n.d.) states that "disability is not something that only happens to a minority of humanity. The ICF thus 'mainstreams' the experience of disability and recognises it as a universal human experience. By shifting the focus from cause to impact it places all health conditions on an equal footing" (World Health Organization, n.d.).

By focusing on the universality of disability and the interactive role of personal capabilities and environmental demands, the social-ecological model incorporates a multidimensional approach to human functioning. For example, the AAIDD conceptual framework of human functioning (Schalock et al., 2010) includes five dimensions: intellectual abilities, adaptive behavior, health, participation, and context. The ICF framework (World Health Organization, 2007) focuses on bodily functions and structures, activities and participation, and personal and environmental factors. Other sources more fully describe and compare these models (Buntinx & Schalock, 2010; Schalock et al., 2010; World Health Organization, 2001). However, a key emphasis in each framework is that each individual has a unique profile of strengths and functional limitations across the domains of human functioning.

The social-ecological approach significantly changes the way that we approach diagnosing, classifying, and supporting people with disabilities. Rather than view disability as a defect that resides within the person and that needs to be remediated, the social-ecological model emphasizes the importance of identifying mismatches between personal capacities and environmental demands and identifying the supports needed to address these mismatches. It: "(a) exemplifies the interaction between the person and their environment; (b) focuses on the role that individualized supports can play in enhancing individual functioning; and (c) allows for the pursuit and understanding of 'disability identity' whose principles include self-worth, subjective well-being, pride, common cause, policy alternatives, and engagement in political action" (Schalock, Luckasson et al., 2007, p. 117).

From a social-ecological perspective, the ultimate goal of identifying disability is to build systems of supports that promote optimal human functioning. The purpose of diagnosis and classification is to identify needed supports to enhance human functioning (Thompson et al., 2009). These supports may be instruction to promote new skill development, environmental modifications through universal design, natural supports, technology supports, or any other resources and strategies to "promote the development, education, interests, and personal well-being of an individual and that enhance human functioning" (Schalock et al., 2010, p. 175). Unlike the medical model, the focus is not on remediating the deficit (although this might happen). Instead, the focus is on identifying the demands of the environments where the individual lives, works, learns, and plays and identifying the supports that will lead to optimal functioning in those environments.

The social-ecological model also shifts the focus from the outcome of promoting "normal" or "typical" human functioning (which was, by and large, the goal of the medical model) to promoting personally defined quality-of-life outcomes referenced to individually valued environments. Quality of life has become a key indicator of personal outcomes in the disability field (Schalock, Gardner, & Bradley, 2007). In the disability field, quality of life is defined by three factors with eight associated domains: independence (associated with the domains of personal development, self-determination); social participation (interpersonal relations, social inclusion, rights); and well-being (emotional well-being, physical well-being, material well-being) (Schalock, Bonham, & Verdugo, 2008). Consistent with the social-ecological model, quality of life is believed to be influenced by personal characteristics and environmental factors, and quality of life is assessed primarily through self-report measures of perceived well-being on indicators of each domain, although objective assessment through direct observation can also be incorporated into quality-of-life assessment, particularly for people with significant disabilities. A key aspect of assessing quality of life is to provide information on the subjective experiences of people with disabilities to provide a framework for quality improvement in supports and services (Schalock et al., 2008; Schalock et al., Verdugo, Jenaro, Wang, Wehmeyer, Xu et al., 2005).

Thus, under a social-ecological framework, the primary purpose of identifying functional limitations is to understand mismatches between personal capabilities and environmental demands so that a personalized system of support can be developed that will promote valued personal outcomes. The AAIDD (Schalock et al., 2010; Thompson et al., 2009) has developed a process for assessing, planning, monitoring, and evaluating individualized supports that begins with identifying desired life experiences and goals, moves on to assessing supports needed to achieve these desired life experiences and goals, and then developing, implementing, and evaluating a plan to make those outcomes occur. This process clarifies that the only purpose of identifying deficits or limitations experienced by an individual in a given environment is to develop a profile of needed supports to promote optimal human functioning. It also emphasizes the importance of building on strengths and capacities that an individual has to promote personally valued outcomes.

Parallel Directions

As described in the previous sections, both the disability and psychology fields have undergone significant changes in recent history. Although these changes mostly occurred independently of each other (i.e., there was limited overlap in the research and political agendas of leaders in the positive psychology and disability fields), there is conceptual overlap in the factors that contributed to the emergence of these new paradigms and the key concepts associated with each paradigm.

In both psychology and disability, until the latter part of the 20th century, a deficit model of human functioning dominated, with a narrow focus on identifying and describing problems in functioning (i.e., mental illness, functional limitations). Although some researchers studied positive

aspects of functioning, research and practice were dominated by deficit-based models. Relatedly, there was a focus on remediating problems rather than promoting optimal human functioning. This led, at times, to narrow interventions that focused simply on curing a problem rather than on promoting optimal functioning and "the good life." Finally, rarely studied were the positive aspects of life (e.g., positive traits or experiences) or the optimal growth and development for people with and without disability.

In response to these issues, and because of the limited ability to work to promote quality of life or "the good life" when starting from a focus on deficits, both fields began to shift toward a more comprehensive framework of human functioning, attempting to understand "the *complete* human condition" (Gable & Haidt, 2005, p. 109). In positive psychology, this involved infusing more of a focus on positive experiences, traits, and institutions. In the disability field, this involved acknowledging the multidimensionality of human functioning, the presence of strengths and limitations within each individual, and the influence of the environment in shaping experiences and creating support needs. Both fields also began to focus on outcome variables that did not simply target the absence of mental illness or disability, but instead emphasized positive subjective experiences, including quality of life and subjective well-being. The ultimate goal of each area was to identify positive approaches to promoting optimal functioning for all individuals.

Intersection of Positive Psychology and Disability

Clearly, the emergence of positive psychology and the social-ecological model of disability were shaped by limitations of previous paradigms in the psychology and disability fields. Clear also is that there is significant overlap in the focus of positive psychology and the social-ecological model of disability—promoting positive experiences and the good life. However, there are differences. Psychology is a much broader field. Positive psychologists describe the importance of promoting the good life for all people and often emphasize the importance of including people who do not experience mental illness. Lopez and Gallagher (2009) write, "People not suffering from a mental disorder, more than 80% of the population on a given day, are trying to make sense of the work and use available information to make a good life. Positive psychology science and practice is accessible and . . . meets the daily needs of 'normal' people" (p. 4).

The disability field, by definition, focuses on people who experience disability or are at risk for disability, including people who experience mental illness. However, divisions between "normal" and "non-normal" are increasingly rejected in the disability field. Instead, a social-ecological perspective emphasizes that disability is a part of the continuum of human experience, something that anyone can experience or be impacted by in some way (e.g., family member, friend). Further, evidence-based practices created for people with disabilities can have applicability and relevance for all people (e.g., universal design and universal design for learning). People with disabilities may need more intensive supports to achieve optimal functioning, but no matter where a person falls on the continuum, everyone needs support to achieve optimal functioning, and the most useful way to provide this support may be to focus on building on strengths and promoting positive traits and experiences. From this perspective, it becomes about identifying positive, strengths-based approaches to promote the good life for all people, including those who experience disability. However, this framework has not yet been widely acknowledged within positive psychology, with a few notable exceptions (Dunn et al., 2009; Shogren, Lopez, Wehmeyer, Little, & Pressgrove, 2006)

In summary, within positive psychology and disability, an increased emphasis has been placed on recognizing the entire range of human functioning and supporting all people by using strengths-based approaches to achieve a good life. The focus in neither field is on fixing problems (although this can happen along the way to building a good life), but instead is on creating this good life using positive, proactive approaches that build on positive traits and experiences through the creation of positive institutions.

Effect on the Literature

In the previous sections, the historical trends in psychology and disability that led to the emergence of positive psychology and the social-ecological model of disability were analyzed and parallel directions and intersections identified. In this section, the effect that these two movements have had on the literature in the psychology and disability field is analyzed.

Effect on Psychology Literature

As briefly described in the previous section, researchers have begun to quantify the effect that positive psychology has had on scholarship in psychology. Hart and Sasso (2011), in a review of the positive psychology literature, found more than

20,000 articles published since Seligman's 1998 presidential address, with a steady increase in articles over time. Other researchers have investigated the permeation of positive psychology within specific subfields of psychology. For example, Lopez et al. (2006) examined the degree to which positive psychology constructs were represented in the published literature in four main counseling psychology journals. They found substantial increases in the number of articles in the counseling psychology literature that emphasized positive constructs over time. In the 1950s, only 16% of articles focused on positive constructs; by the 1970s, this percentage had increased to 23% of articles; by the 1990s, 34% of articles; and by the 2000s, 40% of articles. The most commonly studied positive constructs included values/ethnics, self-efficacy, self-esteem, achievement, adjustment, coping, and empathy.

Schmidt and colleagues (2011) undertook a similar analysis in the subfield of health psychology and replicated the pattern of increases documented by Lopez et al. (2006). Schmidt et al. reviewed three primary health psychology journals and found that a 227% increase in the number of articles focused on constructs related to optimal human functioning between 1996–2000 and 2001–2005. The most frequently studied positive constructs included social support, coping, well-being, self-efficacy, quality of life, locus of control, positive affect, adjustment, treatment adherence, and self-esteem. Interestingly, a majority of articles (57%) that focused on positive constructs did so in populations that had some form of diagnosis (i.e., a medical disease, impairment, or disability). The remaining articles focused on promoting optimal health in individuals without diagnoses.

However, in a review in the subfield of school psychology, researchers found a slightly different pattern. Froh, Scott, Youssef, and Conte (2011) examined four guild journals in school psychology over a 50-year period. They found limited change over time in the degree to which the literature published in these journals focused on positive constructs and processes. For example, in the 1960s, 33% of articles had a positive focus; in the 1980s, 28%; in the 1990s, 25%; and in the 2000s, 27%. These numbers suggest that, unlike in the field of psychology as a whole and the subfields of counseling and health psychology, school psychology has not experienced a shift in the positive focus of the literature over the past 50 years. A quarter to a third of articles published over time in these guild journals have focused on positive constructs and processes. The most frequently positive construct/process was achievement, distantly followed by adjustment and competency. Froh et al. suggest that this may result from the historic (and continued) emphasis in school psychology on psychoeducational problems and the process of diagnosing and remediating problems.

Thus, although within the field of psychology as a whole and within two specific subfields there has been a substantial impact of positive psychology on the literature, there appears to be variation across different subfields, perhaps influenced by the characteristics of those subfields.

Positive Psychology Constructs and Processes in the Disability Literature

Given the concurrent trends in psychology and disability emphasizing a positive, strengths-based perspective to understanding human functioning and the theoretical overlap just described, it is also important to explore the degree to which positive constructs and processes have permeated the disability literature. Shogren, Wehmeyer, Pressgrove, and Lopez (2006) reviewed the application of positive psychology constructs to research in the intellectual disability subfield between 1975 and 2004. We selected five top journals in the intellectual disability field: *American Journal of Intellectual and Developmental Disabilities (AJIDD), Education and Training in Autism and Developmental Disabilities (ETADD), Intellectual Disability (ID), Research and Practice for Persons with Severe Disabilities (RPSD),* and *Research in Developmental Disabilities (RIDD).* We reviewed one randomly selected issue of each journal from 1975 to 2004 (with the exception of RIDD, which was first published in 1980, and RPSD, which was first published in 1976), resulting in a total of 144 journals and 1,124 research articles or literature reviews/program descriptions. Each article was coded across multiple dimensions (see Shogren, Wehmeyer et al. [2006] for a full description of the methods) relevant to the adoption of a strengths perspective and the inclusion of positive psychology constructs in intellectual disability research. First, each article was reviewed to determine if it focused on human capacities of people with intellectual disability (not family members, other support providers, or systems). A human capacity was defined as "the ability to perform or produce or the innate potential for growth, development, or accomplishment (American Heritage Dictionary of the English Language, 2000)" (Shogren, Wehmeyer et al., 2006, p. 340). Articles that focused on human capacities in people with intellectual disability were coded to

determine if they adopted a strengths perspective, a deficits perspective, a mixed, or a neutral perspective to understanding human capacity. A strengths perspective was defined as "locating and developing personal and social resources and adaptive tendencies so that the person can be assisted in making more effective use of them (Super, 1955, p. 5)," whereas a deficits perspective was coded when "articles focused on quantifying deficits in a given aptitude or ability and developing strategies to remediate this lack of aptitude or ability" (Shogren, Wehmeyer et al. 2006, p. 340). Articles that adopted a strengths or a mixed perspective were further coded to determine if they incorporated a construct associated with positive psychology.

Of articles that focused on a human capacity in people with intellectual disability, 35% of articles adopted a strengths perspective; however, this focus changed significantly over time, from a low of 22% of articles in 1975–1984 to a high of 50% of articles in 1995–2004. Of these articles, 15% included a construct associated with positive psychology as a primary focus over time, but, as has been found by other researchers (Lopez et al., 2006; Schmidt et al., 2011), this focus shifted over time. From 1975 to 1984, only 9% of articles focused on a positive psychology construct; from 1985 to 1995, 15% of articles had this focus; and from 1995 to 2004, 24% of articles. The most frequently cited positive psychology constructs included personal control (13% of articles), personal relationships (10%), and interpersonal skills (5%). Interestingly, happiness, one of the most frequent themes in positive psychology research and definitions, was only included in 1% of studies.

We also explored the degree to which articles focused on key dimensions of human functioning identified in the AAIDD conceptual framework of human functioning: intellectual abilities, adaptive behavior, participation, interaction and social roles, and health. Historically, articles focused on intellectual abilities were the most common, likely because of the focus on IQ testing and classification by levels of intelligence in the intellectual disability field. However, over time, the number of articles focused on the other dimensions increased significantly, suggesting more emphasis being placed on the multidimensionality of human experience for people with intellectual disability. These findings suggest that there has been a significant shift in the disability field, with more focus on a strengths-based perspective incorporating positive psychology constructs that focus on the multidimensionality of human experiences. This shift is consistent with the shift in the psychology field and the subfields of counseling psychology and health psychology toward a focus on positive constructs and processes.

Indications are that a greater emphasis continues to be placed on research focused on building on strengths and positive psychology constructs and processes in the disability field. Recently, authors have argued for the importance of positive psychology in rehabilitation psychology, a subfield of psychology that focuses on disability-related issues (Ehde, Frank, Rosenthal, & Caplan, 2010) and described how acquired disability can contribute to positive development (Dunn et al., 2009). The application of positive psychology has been explored for specific disability groups, including those that experience intellectual disability (Dykens, 2006; Shogren, Lopez et al., 2006), dual diagnoses of intellectual disability and mental illness (Baker & Blumberg, 2011), spinal cord injury (Catalano, Chan, Wilson, Chiu, & Muller, 2011; Smedema, Catalano, & Ebener, 2010), physical disability (Quale & Schanke, 2010), and stroke (Berges, Seale, & Ostir, 2011).

Inclusion of Disability Issues in the Positive Psychology Literature

It is also important, given the aforementioned intersections of positive psychology and a social-ecological model of disability, to understand the degree to which disability issues have permeated the positive psychology literature. To date, there has been no review of the infusion of disability issues in the broader field of positive psychology.

Review of The Journal of Positive Psychology. To provide initial insight into the degree to which disability issues have permeated the positive psychology literature, I reviewed abstracts of articles published in *The Journal of Positive Psychology* since its inception in 2006 (through volume 6, issue 2) to determine the extent to which articles focused on (a) the application of positive psychology constructs and processes to people with disabilities and (b) the degree to which people with disabilities were included in research on positive psychology constructs and processes relevant for all people (e.g., if people with disabilities mentioned as a subgroup or part of a sample included in research studies or reviews). Clearly, there are limitations in the interpretation of this cursory review. There are a number of specialized disability journals that researchers may gravitate to when publishing work specific to disability. Further, positive psychology research is also published in many other sources in the psychology field. Additionally, only abstracts were reviewed, so it

is possible that further discussion of subpopulations was contained in the article. However, this review provides initial insight into the inclusion of disability issues in the leading positive psychology journal.

I found a limited, but promising, focus on disability issues within *The Journal of Positive Psychology*. Of the 162 articles published in *The Journal of Positive Psychology* from 2006 to 2011 (vol. 2), six abstracts (4% of articles) explicitly mentioned people with disabilities or people with health-related issues that could be associated with disability. Of the six articles, the majority focused on specific health-related conditions that may be associated with disability (e.g., asthma, chronic illness, and cancer). For example, Peterson, Park, and Seligman (2006) explored the relationship of character strengths to recovery from illness. They analyzed the relationship between adults with physical illness and psychological disorders and found associations between a history of these conditions and character strengths including beauty, curiosity, and love of learning. They also found that when people did not "recover" from their illnesses, they had decreased life satisfaction, and these researchers concluded that recovering from illness could benefit character.

Reynolds and Lim (2007) studied how art could promote positive well-being for women living with cancer, especially when this fit with their skills, personal values, and models of managing adversity. Berg and colleagues (2007) analyzed adherence to medical treatments in children with asthma and found that hope was a significant predictor of adherence. Pavot and Diener (2008) reviewed the literature on the Satisfaction with Life Scale (Diener, Emmons, Larson, & Griffin, 1985) and explored the application of the construct of life satisfaction to multiple populations, including those experiencing significant health concerns. Weis and Ash (2009) explored the influence of hopefulness on treatment outcomes for adolescents referred to psychotherapy and found that when youth and parents were hopeful about treatment, better outcomes resulted. Finally, Shogren, Lopez, Wehmeyer, Little, and Pressgrove (2006) examined the degree to which positive psychology constructs (hope, optimism, locus of control, and self-determination) predicted life satisfaction in adolescents with and without cognitive disabilities (e.g., learning disabilities, intellectual disability). They found that the same constructs were being measured in both groups, and that hope and optimism predicted life satisfaction in youth with and without cognitive disabilities. However, there were mean level differences across youth with and without cognitive disabilities in self-determination, hope, and locus of control, but not in optimism and life satisfaction, suggesting the influence of personal capabilities and environmental demands.

These six articles demonstrate that there are researchers in the field of positive psychology who are interested in disability-related issues and who view disability issues as a part of positive psychology. Although articles that specifically mentioned disability or conditions that could be associated with disability were a minority in the field, this could be expected because of the vast range of issues encompassed within the field of positive psychology. However, it is important to note that the majority of the articles that highlighted issues related to disability published in *The Journal of Positive Psychology* focused on health-related conditions that may or may not lead to disability in different environmental contexts (e.g., cancer, asthma). Furthermore, several of the articles focused on the role of positive psychology constructs in "recovery" or "treatment" to remediate conditions (Peterson et al., 2006; Weis & Ash, 2009), rather than focusing on building a good life when living with a disability. Also of note is the fact that disability was rarely mentioned as a part of the range of the human experience in articles focused on other positive psychology constructs and processes for the general population.

Future Directions

As mentioned in the preceding sections, there have been parallels in the emergence of positive psychology and a social-ecological model in the disability field. However, with a few notable exceptions, there has been little discussion of the overlap of these two paradigms and how they might intersect to promote positive outcomes for all people, including those who experience disability. In analyzing the degree to which these paradigms have permeated research in the psychology and disability fields, it is clear that there has been a substantial impact. Furthermore, it appears that disability issues are receiving attention within the broader field of positive psychology. However, there are clearly more avenues for the mutual engagement of researchers in positive psychology and disability to promote the good life and optimal functioning for all people, including people with disabilities.

First, a vision articulated by positive psychologists is that positive psychology can "unify" psychology, creating a framework for researchers from various subfields to come together and study "the *complete* human condition" (Gable & Haidt, 2005, p. 109).

Clearly, disability issues fit within this unified mission. If positive psychologists accept disability as part of the universal human experience, then the impact of positive psychology constructs and processes for all people, including people with disabilities, can become part of this unified mission. Further, the social-ecological model and the frameworks derived from it focus on the multidimensional nature of human functioning, a perspective that would enhance the ability of positive psychology researchers to look at the multiple internal and external factors that influence optimal functioning in all people.

Second, although the disability field is moving toward a social-ecological model, with its emphasis on individualized, strengths-based interventions, there is still significant room for growth in the degree to which positive psychology constructs and processes are studied in relation to disability. Although positive constructs like quality of life (Schalock et al., 2002; Schalock, Verdugo, Jenaro, Wang, Wehmeyer, Jiancheng et al., 2005; Wang, Schalock, Verdugo, & Jenaro, 2010) and satisfaction with life (Pavot & Diener, 2008; Shogren, Lopez et al., 2006) have been researched in recent years with people with disabilities, other constructs that have received significant attention in positive psychology (e.g., happiness, flow, optimism) have not yet been extensively researched. However, researchers have started to explore ways to measure and promote happiness in people with disabilities, even in those with the most significant disabilities (Lancioni, Singh, O'Reilly, Oliva, & Basili, 2005; Lancioni et al., 2007) and have explored the application of happiness (Dykens, 2005) and hope (Lloyd & Hastings, 2009; Ogston, Mackintosh, & Myers, 2011) to parents and siblings of people with disabilities. Greater collaboration and unification of research among disability and positive psychology scholars could advance these efforts. Furthermore, given the focus on unification in positive psychology, rather than defining, assessing, and intervening to promote happiness and hope in people with disabilities and their families separately, integrating research across the range of human experience holds promise to enable an analysis of the complete human condition, for all people, not just a select few.

Third, one of the initial pillars of positive psychology introduced by Seligman and Csikszentmihalyi (2000) was *positive institutions*, which they defined as "institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic" (p. 5). Reviews of positive psychology research (Hart & Sasso, 2011), however, have suggested that less research has been devoted to building positive institutions, with more emphasis being placed on positive traits and subjective experiences. The social-ecological model, however, brings increased focus to the role of the environment and the institutions within the environment. People with (and without) disabilities interact with many "institutions" to access the supports they need to promote optimal functioning. As well, a great deal of research has occurred within the disability field on ways to shift organizations that previously used a deficit model to become ones that focus on individualized supports and services to promote valued life outcomes (Bradley, 1994; Bradley & Moseley, 2007; Shogren et al., 2009). This work could inform efforts to reform multiple institutions within our society, ranging from education to health care, to long-term supports and services to create an environment supportive of valued outcomes for all citizens. This focus may also facilitate more change in those subfields of psychology, such as school psychology, that are strongly influenced by institutions (i.e., the education system), thus promoting better outcomes for all youth served by those institutions.

A greater infusion of disability within positive psychology also has the potential to bring greater attention to the role of supports in promoting optimal functioning for all individuals. The role of supports in addressing the mismatch between personal capabilities and environmental demands for people with disabilities was discussed earlier, but it is important to emphasize that the role of supports in enhancing human functioning is not specific to disability. All of us benefit when we have supports available to address mismatches between our capabilities and environmental demands, regardless of whether these mismatches define a "disability." People with disabilities simply have a greater need for support because of their functional limitations, but there is room for increased attention to the importance of understanding person-environment fit for all people and for building strengths-based approaches to addressing the mismatches that we all experience in certain environments. This may even help address emerging criticisms of positive psychology that suggest too limited a focus on the role of contextual factors (McNulty & Fincham, 2011).

Conclusion

In conclusion, the fields of disability and psychology have undergone significant changes. Both fields have moved from a deficit-driven perspective to focus

more comprehensively on the complete human condition, including positive constructs and processes and strengths-based approaches to promoting optimal functioning and the good life. However, these changes have largely occurred in parallel, despite overlapping concepts. In fact, within positive psychology, the degree to which "adversity" or "disability" fits within its parameters has been questioned. And, within the disability field, although functional limitations are acknowledged as a defining feature of disability, more emphasis is being placed on viewing disability not as a pathology to be fixed but as a difference in functioning that is part of the continuum of human experience, something that anyone can experience with changes in personal capabilities or environmental demands. This perspective has the potential to open up a new perspective within positive psychology. Disability does not have to be viewed simply as a form of adversity or as an area within which to study resilience, but rather as one aspect of human functioning that can inform positive growth and development, particularly when strengths-based approaches aiming to build individualized supports that promote optimal human functioning are created within positive institutions and contexts.

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PART 2

Application of Positive Psychological Constructs to Disability

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CHAPTER

4

The Impact of the Quality of Life Concept on the Field of Intellectual Disability

Robert L. Schalock *and* Miguel Angel Verdugo Alonso

Abstract

This chapter focuses on five significant impacts that the quality of life (QOL) concept has had on persons with intellectual and closely related developmental disabilities (IDD). The chapter begins with a discussion of paradigms and paradigmatic shifts and explores how the current IDD paradigm has altered the conceptual and service delivery framework that mediates the interaction between a scientist or practitioner and persons with IDD. The second section describes the five significant impacts the QOL concept has had on public and organization policies and practices toward persons with IDD. The chapter concludes by asking a simple question: "Has the QOL concept really made a difference?"

Key Words: continuous quality improvement, evidence-based practices, individualized supports, quality of life, redefined organizations

Over the past three decades, a significant paradigm shift has occurred in public policies and practices regarding people with intellectual and closely related developmental disabilities (IDD), one that parallels the paradigmatic shift in psychology toward positive psychology. The concept of quality of life (QOL) has been integral to this paradigm shift, along with the development of an ecological model of disability and the provision of individualized supports. The power of the QOL concept is that it integrates these two paradigm shifts and, in the process, has become a change agent in the redefinition of organizations and systems that provide services and supports to people with IDD.

This chapter focuses primarily on five significant effects that the concept of QOL has had on people with IDD. The chapter begins with a discussion of paradigms and paradigmatic shifts and how the current IDD paradigm has altered the conceptual and service delivery framework that mediates the interaction between a scientist or practitioner and persons with IDD. The second section describes five significant impacts that the QOL concept has had on public and organization policies and practices toward persons with IDD. These five effects of the QOL concept include fostering the provision of individualized supports, furthering the development of evidence-based practices, encouraging the evaluation of personal outcomes, providing a quality framework for continuous quality improvement, and becoming a major catalyst in the redefinition of organizations and systems providing services and supports to persons with IDD. The chapter concludes by asking a simple question: "Has the QOL concept really made a difference?"

Much of the material presented in this chapter is based on the collaborative work of the two authors and their colleagues who have focused over the past three decades on the conceptualization, measurement, application, and evaluation of the QOL construct as applied to persons with IDD.

Throughout the chapter, *individual-referenced QOL* is defined as:

> A multidimensional phenomenon composed of core domains influenced by personal characteristics and environmental factors. These core domains are the same for all people, although they may vary individually in relative value and importance. The assessment of quality of life domains is based on culturally sensitive indicators.

For the interested reader, parallel developments and the application of family-related QOL can be found in Brown, Schalock, and Brown (2009), Isaacs, Clark, Correia, and Flannery (2009), and Summers et al. (2005).

The QOL Concept and the Paradigm Shift in Public Policy and Practices

A paradigm can be defined as a constellation of beliefs and techniques that reflect an approach to an issue and provide a pattern or example. The notion of a paradigm and paradigm shift was first introduced by Kuhn (1970), in reference to a conceptual scheme that mediates the interaction between the scientist and the world. More recently, the notion of a paradigm shift has been discussed in reference to revolutions in the history and philosophy of science (Weinert, 2009).

A significant paradigm shift has occurred over the past three decades in how we view and interact with persons with IDD. The three phases of this paradigm shift in public policies and practices are:

- *Phase I (1960s and 1970s)*. Doubts and difficulties (i.e., a "crisis") arose regarding the then-current paradigm, which was characterized by viewing disability as a defect in the person and segregating persons with IDD from the mainstream of life.
- *Phase II (1970s and early 1980s).* An "anomaly" occurred due to a persistent disagreement between the pre-1960s paradigm and personal observations of the lives of persons with IDD and invalid predictions regarding their potential. The anomaly was reinforced based on results of the civil rights and deinstitutionalization movements, the focus on adaptive behavior and the learning potential of persons with IDD, the beginning of the self-advocacy movement, and the successful integration of persons with IDD into more normalized inclusive education, residential, vocational, and community-based environments.
- *Phase III (mid 1980s to present).* As a result of phase II factors, there emerged in the mid-1980s a new IDD paradigm based on social and scientific developments involving the investigation of the lives and perspectives of persons with IDD. This paradigm is characterized by its emphasis and focus on an ecological (i.e., person × environment) conception of disability and the provision of individualized supports within community and inclusive environments. It is important to note that the QOL concept also emerged in the 1980s and was thus well positioned to provide an overarching principle that integrated the current (phase III) IDD paradigm and also provided a common language across key stakeholders, a vehicle to implement the paradigm shift in public policies and practices, and a basis for policy development and evaluation (Schalock, Gardner, & Bradley, 2007).

The Concept of Quality of Life, the Ecological Model of Disability, and an Individualized System of Supports

The Concept of Quality of Life

Over the past three decades, the QOL concept has evolved from a sensitizing notion to a social construct that guides program practices, outcomes evaluation, and continuous quality improvement. The issue that the concept addresses is the lives of persons and ensuring that citizens with IDD experience "the good life." To this end, the QOL concept reflects the following four principles: (a) QOL is composed of the same factors and relationships for all people, (b) QOL is experienced when a person's needs are met and when that person has the opportunity to pursue life enrichment in major life activity settings, (c) QOL has both subjective and objective components, and (d) QOL is a multidimensional construct, influenced by individual and environmental factors. These four principles are congruent with a number of postmaterialist values that are impacting people throughout the world. Chief among these values are the emergence of cultural modernization tenets related to equality, personal freedom, and self-fulfillment; an emphasis on relationships, spirituality, networking, and ecological sustainability; the power of communitarianism and social capital; and the rise of responsible individualism and taking responsibility for the design of our personal and social futures.

Over the past two decades, the authors have developed and validated cross-culturally a QOL conceptual and measurement framework that is summarized in Table 4.1. In the framework depicted in Table 4.1, indicators refer to QOL-related perceptions,

Table 4.1 Quality of Life Conceptual and Measurement Framework

Factor	Domain	Exemplary Indicators
Independence	Personal Development Self-Determination	Activities of daily living Choices, decisions, personal goals
Social Participation	Interpersonal Relations Social Inclusion Rights	Social networks, friendships Community involvement Human and legal
Well-Being	Emotional Well-Being Physical Well-Being Material Well-Being	Safety and security Health and nutrition status Financial status, employment

behaviors, and conditions that operationally define each QOL domain. Furthermore, psychometrically robust and culturally sensitive indicators are used to assess either the person's perceived well-being ("self-report") or an objective indication of the person's life experiences and circumstances ("direct observation"). More details about the development and validation of this framework can be found in Schalock, Keith, Verdugo, and Gomez (2010b), Schalock, Verdugo, Jenaro, Wang, Wehmeyer, Xu, and Lachapelle (2005), and Wang, Schalock, Verdugo, and Jenaro (2010).

Table 4.2 Relationship Between Quality of Life (QOL) Domains and United Nations (UN) Convention Articles

Domains of QOL	Indicators	UN articles	Other related articles
Personal Development	– Education status – Personal skills – Adaptive behavior	**24**	27
Self-Determination	– Choices/Decisions – Autonomy-Personal control – Personal goals	**14, 19, 21**	9, 12
Interpersonal Relations	– Social networks – Friendships – Social activities – Relationships	**23**	30
Social Inclusion	– Community integration/participation – Community roles – Supports	**8, 9, 18, 20, 27, 29, 30**	19, 21, 24
Rights	– Human (respect, dignity, equality) and legal (legal access, due process)	**5, 6, 7, 10, 11, 12,13, 15, 22**	14,16,18, 21
Emotional Well-Being	– Safety and security – Positive experiences –Contentment-Lack of stress	**16, 17**	23, 25
Physical Well-Being	– Health and nutrition status – Recreation – Leisure	**16, 25, 26**	17
Material Well-Being	– Financial status – Employment status – Housing status – Possessions	**28**	

The QOL conceptual and measurement framework presented in Table 4.1 can also be used to integrate international disability policies (Verdugo, Navas, Gomez, & Schalock, in press). For example, Table 4.2 shows the relationship among the eight QOL domains listed in Table 4.1 and corresponding articles in the United Nations Convention on the Rights of Persons with Disabilities (2006).

The application of the QOL concept emphasizes person-centered planning and individualized supports based on the principles of human potential, inclusion, equity, self-determination, and the rights of citizenship. In addition, its application enhances well-being within cultural contexts; provides a basis for a multidimensional approach to the provision of individualized services and supports; should be evidence-based and have a prominent place in education and training; and should be applied across environments, all levels of intellectual and adaptive behavior limitations, and all dimensions of human functioning (Brown et al., 2009; Claes, van Hove, van Loon, Vandevelde, & Schalock, 2010).

The Ecological Model of Disability

The basic tenet of the current ecological model of disability is that human functioning is determined by an interaction between the person's capability and the performance demands of his or her environment. As we discuss later in reference to supports, the purpose of an individualized system of supports is to reduce the discrepancy or mismatch between an individual's capability and the requirements of his or her environment.

Both the World Health Organization through its *International Classification of Function* (ICF; World Health Organization [WHO], 2001) and the American Association on Intellectual and Developmental Disabilities (AAIDD) through its conceptual framework for human functioning (Schalock et al., 2010a) stress that human functioning is determined by interactions among:

- Health condition, body functions and structures, activities, participation, and context (WHO, 2001).
- Intellectual abilities, adaptive behavior, health, participation, context, and the pattern and intensity of support provision (Schalock et al., 2010a).

In both models, context includes personal and environmental factors. Personal factors or characteristics include gender, age, race/ethnicity, motivation, lifestyles, habits, coping styles, social background, education levels, and individual psychological assets. Environmental factors include public policies, attitudes toward people with IDD, and opportunities for community living/access, employment, and inclusive education.

The QOL model summarized in Table 4.1 and the ecological model of disability just described can be compared on a number of variables, such as their conceptual basis, content, assessment focus, intended purposes, and role of the person. This comparison is found in Table 4.3 (Buntinx & Schalock, 2010). As shown clearly in these comparisons, the integrative role of the QOL concept is to provide a conceptual basis for service delivery (i.e., to enhance human functioning and personal outcomes) and a measurement framework for assessing personal, QOL-related outcomes. The different roles of the person in the two models should not be overlooked.

Table 4.3 Comparison of the Quality of Life (QOL) Concept and the Ecological Model of Disability

Primary Component	Model	
	ICF/AAIDD	**Quality of Life**
Conceptual basis	Human functioning dimensions Functional limitations	Personal well-being
Content	Components of functioning	QOL factors and domains
Assessment focus	Strengths and limitations in functioning; contextual factors	Objective status & subjective personal experiences
Intended purpose	Description, classification (ICF) diagnosis, classification, and system of supports (AAIDD)	Framework for services and supports, personal outcomes evaluation, and quality improvement
Role of person	Secondary ("object of assessment")	Primary ("participant")