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Intellectual and developmental disabilities: Definitions, diagnostic limitations, and cross-system classification

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Abstract
Intellectual and Developmental Disabilities (IDDs) represents a broad, cross-disciplinary construct applied in literature across healthcare, education, and social policy to describe lifelong neurodevelopmental conditions, which emerge during the developmental period. However, the absence of IDD as a formal diagnostic category within major nosological systems has contributed to conceptual ambiguity, inconsistent assessment practices, and challenges in interdisciplinary communication. The authors of this paper critically examine the conceptual foundations of IDD, distinguishing the umbrella term from the core diagnosis of intellectual disability (ID) and related developmental conditions such as Global Developmental Delay (GDD) and specific developmental disorders (SDDs). Drawing on contemporary diagnostic frameworks, the authors evaluate the limitations of the Diagnostic Statistical Manual-5th Edition-Text Revision (DSM-5-TR) in identifying psychiatric comorbidities in individuals with IDDs and highlights the role of the Diagnostic Manual-Intellectual Disability-2nd Edition (DM-ID-2), as a necessary diagnostic companion. The Cognition-Conation-Affect-Sensation (CCAS) model is introduced as an integrative lens for understanding the multidimensional functioning of individuals with IDDs beyond deficit-based interpretations. A comparative analysis of DSM-5-TR and the International Classification of Diseases-11th Revision (ICD-11) classifications further clarifies areas of alignment and divergence in the conceptualization of ID, GDD, and developmental delays (DDs). Overall, the authors argue that conceptual clarity, developmentally informed diagnostics, and systems-sensitive frameworks are essential for accurate diagnosis, effective intervention planning, and equitable support across clinical and educational settings.

Keywords: CCAS model; Diagnostic classification; Global developmental delay; Intellectual disability; Neurodevelopmental disorders

Introduction

Teachers often find intellectual and developmental disabilities (IDDs) confusing because IDD does not present as a single, uniform condition and its impact on learning, behavior, and communication varies widely across students. Unlike specific learning disabilities (SLDs), IDD affects global intellectual functioning and adaptive skills. However, these limitations can be masked by strengths in routine tasks, social imitation, or rote learning, leading teachers to over- or under-estimate a student's actual abilities.

Classroom behaviors associated with IDD (e.g., inattention, emotional outbursts, withdrawal, or rigidity) are frequently misinterpreted as willful misconduct, poor motivation, or even psychiatric problems, rather than expressions of unmet cognitive, sensory, or communication needs. Moreover, confusion is also further compounded by overlapping diagnoses (e.g., autism spectrum disorder [ASD], ADHD, receptive and expressive language disorders), inconsistent terminology across medical as well as educational systems, and psychoeducational assessment reports that emphasize IQ scores without clearly translating them into practical instructional implications (see also Chia & Wong, 2014) [8]. As a result, teachers in both regular schools and special schools may struggle to distinguish between "can't do" versus "won't do," to set realistic expectations, and to design instruction that balances academic goals with adaptive, functional, and socio-emotional development (Chia & Wong, 2014) [8].

What is 'Intellectual and Developmental Disabilities' (IDD)?

'Intellectual and Developmental Disorders' (more commonly phrased as 'Intellectual and Developmental Disabilities,' IDDs) is not a single disorder, but an umbrella term that refers to a cluster of lifelong conditions characterized by significant limitations in intellectual functioning and/or adaptive behavior, with onset during the developmental period (generally before 18 years of age; however, this age has been raised to 22 years old: "Intellectual disability is a condition characterized by significant limitations in both intellectual functioning and adaptive behavior that originates before the age of 22" [AAIDD, 2026, para. 1]). The American Association on Intellectual and Developmental Disabilities (AAIDD) defines *Intellectual Disability* (ID) as a disability marked by significant limitations in both intellectual functioning (e.g., reasoning, learning, problem solving) and adaptive behavior (i.e., conceptual, social, and practical skills), originating "during the developmental period, which is defined as before the age of 22. Intellectual disability is one of several conditions known collectively as developmental disabilities" (AAIDD, 2026 [2], para. 6). The condition of IDD is best understood within the context of socio-cultural and environmental factors as well as the need for individualized supports (AAIDD, 2021). Within this framework, ID is one specific diagnostic condition, whereas developmental disabilities (DDs) include a broader range of neurodevelopmental conditions such as ASD, cerebral

palsy, and certain genetic syndromes (e.g., Russell-Silver Syndrome and Smith-Magenis Syndrome); thus, IDD refers to a category of conditions, not two separate diagnoses (Schalock *et al*., 2021) [19].

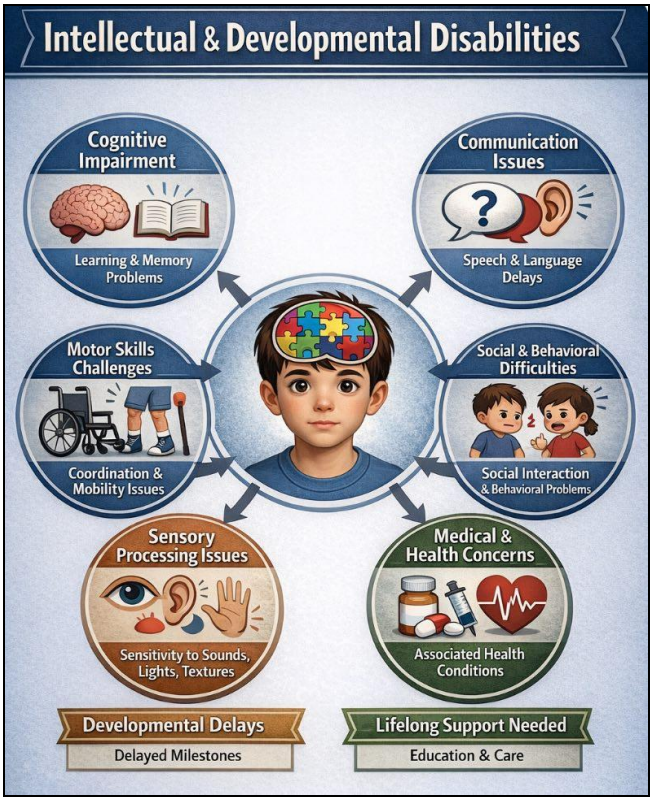

Fig 1: Traits of IDD

Based on Fig 1 as shown above, IDD can be best understood as a multidimensional neurodevelopmental condition characterized by significant limitations in intellectual functioning and adaptive behavior, and whose onset occurs during the developmental period. The common challenging problems experienced by individuals with IDD are cognitive impairments, including difficulties in learning, reasoning, memory, and problem-solving, which affect academic achievement and everyday decision-making (American Psychiatric Association [APA], 2022) [4]. Moreover, communication difficulties, e.g., delayed speech, limited receptive and/or expressive language abilities, and challenges in pragmatic communication, frequently co-occur and further influence social participation and learning outcomes (Schalock *et al*., 2021) [19]. In addition, psychomotor skill challenges, including poor coordination, balance, or fine and gross motor control, may also restrict mobility and independence, while sensory processing differences can result in heightened or reduced sensitivity to environmental stimuli such as sound, light, or texture (Miller *et al*., 2017) [15]. Fig 1 also highlights socio-emotional and behavioral difficulties that may be manifested as inevitable challenges in social reciprocity, emotional regulation, or adaptive behavior. These socio-emotional behavioral problems are often shaped by environmental demands and support quality rather than intrinsic deficits alone (APA, 2022). More importantly, not forgetting that the condition IDD is frequently associated with medical and health comorbidities, including epilepsy (e.g., Temporal Lobe Epilepsy, a common type, that can lead to auditory or visual hallucinations during the seizure), genetic syndromes (e.g., Smith-Magenis Syndrome and Russell-Silver Syndrome), and chronic health conditions (e.g., congenital heart defects are associated with Down Syndrome and Kabuki Syndrome), necessitating coordinated, interdisciplinary care (Schalock *et al*., 2021) [19]. Collectively, these interrelated domains contribute to developmental delays (DDs) and underscore the need for lifelong, individualized supports across educational, healthcare, and community contexts to optimize functioning, participation, and quality of life.

Understanding IDD from the Perspective of the CCAS Model

Chia and Kee's (2013) [6] trans-multiple abilities meta-theory conceptualizes the process of learning as the dynamic integration of cognition, conation, affect, and sensation (CCAS), which together function as interlinked mental-behavioral potentials guiding how individuals acquire, transform, and apply knowledge across developmental stages. From the perspective of the CCAS model (Chia & Lim, 2017) [7], IDD is better understood as patterns of variation and challenge across these interconnected domains. Individuals with IDD may, therefore, exhibit a constellation of cognitive (intellectual/neurological), conative (behavioral/volitional), affective (socio-emotional), and sensory (perceptuo-sensorimotor) characteristics, rather than deficits confined to a single domain (see Fig 1). Importantly, the CCAS framework emphasizes that these domains are mutually influential and should be interpreted within a developmental, environmental, and supports-based context, aligning with contemporary understandings of IDD that move beyond isolated impairments toward holistic functioning (AAIDD, 2021; Schalock *et al*., 2021) [19].

From a cognitive (intellectual/neurological) perspective, IDD is characterized by significant limitations in intellectual functioning, including difficulties with reasoning, abstract thinking, problem solving, planning, judgment, academic learning, and learning from experience (APA, 2022). These limitations reflect atypical neurodevelopment rather than neurodegenerative processes and are evident during the general childhood period. Cognitive processing may be slower, working memory capacity reduced, and generalization of learned skills across contexts more difficult. Importantly, contemporary diagnostic frameworks emphasize that intellectual functioning must be interpreted alongside adaptive functioning and within cultural and linguistic contexts, rather than relying solely on standardized intelligence testing (AAIDD, 2021; APA, 2022).

Conative (behavioral/volitional) symptoms in IDD involve challenges related to goal-directed behavior, self-regulation, and adaptive skill execution. Individuals may demonstrate difficulties with initiating tasks, sustaining effort, planning sequences of actions, and adjusting behavior in response to feedback or changing demands (Schalock *et al*., 2021) [19]. Behavioral manifestations may include dependence on external prompts, limited problem-solving strategies, and reduced persistence when faced with complex or novel tasks. In some cases, challenging behaviors (e.g., aggression, self-injury, or noncompliance) emerge, often as expressions of unmet needs, communication difficulties, or

environmental mismatch rather than as intrinsic features of IDD itself (Fletcher *et al*., 2007 [11]; APA, 2022).

In the affective (socio-emotional) domain, individuals with IDD may experience delays or differences in emotional development, social understanding, and interpersonal functioning. Common characteristics include difficulties with emotion recognition and regulation, limited perspective-taking, and challenges interpreting social cues or social norms (APA, 2022). These socio-emotional vulnerabilities can contribute to increased risk for anxiety, mood disorders, and social withdrawal, particularly when individuals encounter repeated experiences of failure, exclusion, or stigma (Schalock & Luckasson, 2004) [18]. Nevertheless, emotional experiences themselves are not diminished; rather, expression and regulation may differ depending on cognitive level, communication skills, and available supports (AAIDD, 2021).

Sensory (perceptuo-sensorimotor) symptoms in IDD may include delays or impairments in gross and fine motor coordination, balance, and motor planning, as well as atypical sensory processing (WHO, 2019). Individuals may exhibit hypersensitivity or hyposensitivity to sensory stimuli such as sound, touch, light, or movement, which can affect attention, emotional regulation, and participation in daily activities. Sensorimotor challenges may further impact adaptive functioning, including self-care, mobility, and vocational skills, particularly when co-occurring neurological or genetic conditions are present (APA, 2022). These sensory features underscore the importance of interdisciplinary assessment and individualized environmental accommodations.

Taken together, the CCAS features of IDD reflect a complex pattern of neurodevelopmental differences rather than a single deficit. Contemporary models emphasize that functioning in each domain is shaped by the interaction between individual abilities and the quality of supports provided, reinforcing the need for holistic, person-centered assessment and intervention (AAIDD, 2021; Schalock *et al*., 2021) [19].

The Historical Development of IDD

The concept now referred to as *Intellectual and Developmental Disabilities* (IDDs) has undergone substantial evolution over the past century, reflecting shifts in scientific understanding, professional practice, and social values. In the early and mid-20th century, the dominant label was *Mental Retardation* (MR), a term widely used in medical, psychological, and educational contexts to describe individuals with significant cognitive limitations (Chia & Wong, 2014 [8]; Scheerenberger, 1983) [20]. Early definitions emphasized intellectual deficits measured primarily through IQ assessment, often divorced from considerations of adaptive functioning or environmental context. During this period, individuals labeled with mental retardation (MR) were frequently institutionalized, and the term itself became closely associated with stigma, social exclusion, and deficit-based thinking (Trent, 2017) [21].

By the 1950s and 1960s, growing advocacy movements led by families, disability rights organizations, and professionals began challenging both the institutional model and the narrow cognitive focus of the diagnosis. This era saw increasing recognition of the role of social environment, education, and supports in shaping outcomes for individuals with cognitive disabilities (Schalock *et al*., 2021) [19]. In response, professional organizations such as the American Association on Mental Retardation (AAMR) gradually revised their definitions to include adaptive behavior alongside intellectual functioning, signaling a conceptual shift away from intelligence alone as the defining feature of the condition (Luckasson *et al*., 1992) [14].

A major turning point occurred in the late 20th and early 21st centuries, when person-first language and civil rights perspectives gained prominence. The term *mental retardation* (MR) became widely criticized for its pejorative connotations and misuse in popular culture, contributing to further marginalization of affected individuals (Schalock & Luckasson, 2004) [18]. In 2007, the AAMR officially changed its name to the American Association on Intellectual and Developmental Disabilities (AAIDD), replacing *Mental Retardation* (MR) with *Intellectual Disability* (ID), and emphasizing a supports-based model that considers functioning within cultural, social, and environmental contexts (AAIDD, 2021). This shift was mirrored in diagnostic systems, with the DSM-5 replacing *Mental Retardation* with *Intellectual Disability (Intellectual Developmental Disorder)* and prioritizing adaptive functioning over IQ scores in determining severity (APA, 2013, 2022).

Table 1 below provides a summary to narrate the historical development of IDD from early terminology to contemporary conceptualizations, highlighting key shifts in definitions, diagnostic criteria, and underlying theoretical perspectives that have shaped current understanding and practice.

Table 1: Historical Development of the Concept of IDD

Historical Period	Dominant Terminology	Key Conceptual Features	Influential Developments / Sources
Late 19 th-Early 20th Century	Idiocy, Imbecility, Feeble-mindedness	Moral and medical deficit models; intelligence viewed as fixed; heavy reliance on early IQ testing; widespread institutionalization	Early psychiatric classification systems; eugenics movement; Binet intelligence testing
Early–Mid 20th Century (1920s–1950s)	Mental Retardation	Emphasis on cognitive deficits measured by IQ; limited attention to adaptive functioning; segregation and custodial care common	Early DSM editions; educational classification systems (Scheerenberger, 1983; Trent, 2017) [20, 21]
Mid 20th Century (1950s–1970s)	Mental Retardation	Growing recognition of social and environmental influences; emergence of special education and deinstitutionalization movements	Parent advocacy; normalization principle; community-based services
Late 20th Century (1980s–1990s)	Mental Retardation (revised definitions)	Inclusion of adaptive behavior alongside intellectual functioning; shift toward functional assessment	AAMR definition revisions (e.g., 1992) [14]; supports-oriented framework (Luckasson *et al*., 1992) [14]
Early 21st Century	Intellectual Disability	Person-first language; adaptive functioning	AAMR → AAIDD name change (2007);

(2000s)		prioritized over IQ; reduced emphasis on deficit-only models	Schalock & Luckasson (2004) [18]
DSM-5 Era (2013-present)	Intellectual Disability (Intellectual Developmental Disorder)	Neurodevelopmental framework; severity based on adaptive functioning; childhood onset emphasized	DSM-5 and DSM-5-TR (APA, 2013, 2022)
Contemporary Usage	Intellectual and Developmental Disabilities (IDD)	Umbrella term encompassing intellectual disability and related lifelong neurodevelopmental conditions; social-ecological and rights-based models	AAIDD (2021); ICD-11 (WHO, 2019); disability rights and inclusion frameworks

Concurrently, the broader term *Intellectual and Developmental Disabilities* (IDDs) emerged as an umbrella concept encompassing ID alongside other lifelong neurodevelopmental conditions, such as ASD and cerebral palsy. This terminology reflects a more inclusive and lifespan-oriented understanding of disability, aligning with international frameworks such as the World Health Organization's *International Classification of Diseases* (ICD-11; also see Lemay *et al*., 2011) and the social-ecological model of disability (World Health Organization [WHO], 2019) [22]. Over time, the evolution from *Mental Retardation* (MR) to *Intellectual Disability* (ID) and ultimately to *IDD* represents not merely a change in terminology, but a fundamental reconceptualization of disability: one that centers dignity, functional supports, and participation rather than deficit and segregation. This shift underscores a growing emphasis on person-centered approaches, rights-based policies, and inclusive practices that recognize the interaction between individual capacities and environmental contexts in shaping outcomes across the lifespan.

Why DSM-5 is not adequate as a Diagnostic Framework for IDD

Scholarly sources (e.g., APA, 2013; Fletcher *et al*., 2016 [10]; Schalock, Luckasson, & Tassé, 2021) [19] describing the Diagnostic Manual-Intellectual Disability-2nd Edition (DM-ID-2; Fletcher, Barnhill, & Cooper, 2017) [9] and its context indicate that DM-ID-2 relies on the DSM-5 conceptualization of intellectual disability or ID (often termed *Intellectual Developmental Disorder* or IDD within DSM-5), which emphasizes childhood onset, global cognitive impairment, and limitations in adaptive functioning (a definition carried forward from DSM-5 that DM-ID-2 is designed to accompany). DM-ID-2 is explicitly structured to apply and expand DSM-5 criteria for Intellectual Disability (often reframed as *Intellectual Developmental Disorder* or IDD) to individuals with co-occurring psychiatric conditions, and its introduction makes clear that ID is already established as a starting point for diagnosis in the manual's framework. In other words, DM-ID-2 assumes the DSM-5 definition of ID as the foundational conceptual definition and then focuses on adaptations of psychiatric diagnostic criteria for this population.

According to first edition of DM-ID, Fletcher, Loschen, Stavrakaki, and First ((2007) [11] outlined the critical need for a diagnostic framework tailored to individuals with intellectual/developmental disabilities (IDDs) who might also have psychiatric disorders. In the second edition of DM-ID-2, Fletcher, Barnhill and Cooper (2017) [9] have explained that although mental health problems are common in people with IDD, traditional diagnostic nosological systems, such as the DSM-5 (APA, 2013) or DSM-5-TR (APA, 2022) [3, 4], for instance, frequently fail to identify co-occurring mental disorders accurately, particularly for those with limited expressive and receptive language or severe cognitive impairments, leading to either underdiagnosis or misdiagnosis, and consequently inadequate treatment (Fletcher, Barnhill, & Cooper, 2017) [9]. Prevalence studies demonstrate higher rates of psychiatric disorders among individuals with IDD compared to the general population, with rates varying widely depending on diagnostic systems used and methodological factors, underscoring the limitations of generic criteria when applied to this population (Fletcher, Barnhill, & Cooper, 2017) [9]. Fletcher, Barnhill and Cooper (2017) [9] have traced the historical challenges in psychiatric classification and noted that while the DSM criteria are designed to be universal, they rely heavily on self-report and observable symptoms that may not manifest typically in people with IDD; hence, the DSM criteria are further complicating the diagnosis of IDD (Fletcher, Barnhill, & Cooper, 2017) [9]. The DM-ID-2 was developed as a DSM-5 companion to adapt criteria and guide clinicians through alternative methods of eliciting necessary diagnostic information, differentiating challenging behaviors from psychiatric symptoms, and improving diagnostic accuracy through expert consensus and evidence-based considerations (Fletcher, Barnhill, & Cooper, 2017) [9]. Finally, the emphasis that accurate diagnosis is very crucial for effective planning of an intervention program, and that the DM-ID-2 provides comprehensive support for teachers, therapists and clinicians working with dually diagnosed individuals.

How GDD is related to IDD and Agnosia

Global Developmental Delay (GDD) is a provisional diagnosis used in young children, typically under 5 years of age, who show significant delays across multiple developmental domains when reliable standardized assessment of intellectual functioning is not yet feasible (APA, 2022) [13]. IDD is diagnosed later, when persistent deficits in intellectual and adaptive functioning can be formally measured, and many children initially identified with GDD are subsequently diagnosed with IDD as developmental demands increase and cognitive profiles stabilize (APA, 2022; WHO, 2019).

GDD is closely related to IDD but is conceptually and diagnostically distinct. GDD is used only in young children, typically under the age of 5 years, when standardized assessment of intellectual functioning is unreliable. It is defined as a significant delay in two or more developmental domains (e.g., cognitive, language, motor, social, or adaptive functioning) and is considered a temporary or provisional diagnosis, not a lifelong condition in itself (DSM-5-TR; APA, 2022). More importantly, some children

with GDD later meet criteria for ID, while others may catch up developmentally or receive more specific neurodevelopmental diagnoses. Other types of developmental delays (DDs), e.g., isolated speech delay, motor delay, or social-communication delay, may occur independently and do not automatically imply IDD, unless delays are pervasive, persistent, and associated with broader adaptive and intellectual impairments (WHO, 2019; APA, 2022) [13]. In short, GDD and other DDs are developmental descriptors, whereas IDD represents a diagnostic category encompassing enduring neurodevelopmental conditions.

GDD and agnosia are related at the level of higher-order neurocognitive processing but represent conceptually distinct conditions. GDD is a neurodevelopmental diagnosis applied to young children who exhibit significant delays in two or more developmental domains, reflecting diffuse and immature brain development rather than focal cortical dysfunction (APA, 2022; WHO, 2019). Agnosia, in contrast, refers to a specific impairment in the recognition or interpretation of sensory information despite intact primary sensory function and is classically associated with dysfunction in association cortices, such as the occipito-temporal or parietal regions (Gazzaniga & Mangun, 2014 [12]; Poeppel, Mangun, & Gazzaniga, 2020) [16]. In children with GDD, agnosia-like manifestations (e.g., difficulty recognizing objects, faces, or sounds) may happen as a result of underdeveloped sensory-cognitive integration networks, even though these difficulties do not always meet the strict neuropsychological criteria for agnosia, which require relatively preserved overall cognition (Bishop & Rutter, 2008) [5]. Consequently, agnosia is rarely diagnosed as an isolated condition in early childhood, and perceptual recognition deficits are instead conceptualized as part of the broader developmental profile seen in GDD, highlighting a developmental-functional relationship rather than a direct diagnostic equivalence.

Mapping IDD, GDD, and Developmental Delays: DSM-5-TR vs ICD-11

Table 2 below shows a clear mapping of Intellectual and Developmental Disabilities (IDDs), Global Developmental Delay (GDD), and specific developmental delays (SDDs) across DSM-5-TR and ICD-11. In addition, a short interpretive explanation is provided to help with clinical, educational, or policy use.

Table 2: Mapping of IDD, GDD and SDDs across DSM-5-TR and ICD-11

Concept	DSM-5-TR (APA, 2022)	ICD-11 (WHO, 2019)	Key Notes
Intellectual and Developmental Disabilities (IDDs)	Not a formal diagnostic category. Used as an umbrella term in policy and practice. Core diagnosis is Intellectual Disability (Intellectual Developmental Disorder) under Neurodevelopmental Disorders.	Not a formal diagnostic category. Functions as an umbrella term. Core diagnosis is Disorders of Intellectual Development.	IDD is a conceptual grouping, not a diagnosis, in both systems.
Intellectual Disability (ID) / Intellectual Developmental Disorder (IDD)	Intellectual Disability (Intellectual Developmental Disorder): deficits in intellectual functions and adaptive functioning, onset during developmental period. Severity based on adaptive functioning.	Disorders of Intellectual Development: significant limitations in intellectual functioning and adaptive behavior, originating during the developmental period. Severity similarly based on adaptive functioning.	High alignment between systems; ICD-11 uses plural "disorders" to reflect heterogeneity.
Global Developmental Delay (GDD)	Global Developmental Delay: diagnosis for children under 5 years with significant delay in two or more developmental domains when reliable IQ testing is not possible.	Developmental delay, unspecified or Global developmental delay (coded within developmental disorders): used for young children with pervasive delays across domains.	GDD is provisional in both systems and may later resolve or evolve into ID or another diagnosis.
Specific Developmental Delays / Disorders (SDDs)	Diagnosed as specific Neurodevelopmental Disorders, e.g.: – Language Disorder – Specific Learning Disorder – Developmental Coordination Disorder	Diagnosed as Specific Developmental Disorders, e.g.: – Developmental speech or language disorders – Developmental learning disorder – Developmental motor coordination disorder	Specific delays do not equal ID unless global and accompanied by adaptive impairment.
Autism Spectrum Disorder (ASD)	Separate diagnosis under Neurodevelopmental Disorders; may co-occur with ID.	Separate diagnosis; may co-occur with Disorders of Intellectual Development.	ASD is part of IDD umbrella conceptually, but distinct diagnostically.

Conclusion

This paper has demonstrated that IDDs should be understood not as a discrete diagnosis, but as a conceptual and functional umbrella encompassing ID and related lifelong neurodevelopmental conditions. Across both DSM-5-TR and ICD-11, ID remains the core diagnostic entity, with strong concordance in criteria emphasizing adaptive functioning and developmental onset. GDD occupies a distinct, provisional role in early childhood, while SDDs are differentiated by their domain-specific nature and do not, in isolation, constitute IDD. These distinctions are critical, as conflation of terminology can lead to diagnostic inaccuracy, inappropriate expectations, and misaligned interventions.

The analysis further underscores the limitations of DSM-5-TR when applied to individuals with IDD, particularly in the identification of co-occurring psychiatric conditions. In this context, the DM-ID-2 emerges as an essential companion framework that translates and adapts psychiatric diagnostic criteria to the cognitive, communicative, and behavioral realities of this population. Beyond diagnostic systems, the CCAS model offers a theoretically grounded, holistic perspective that reframes IDD as a pattern of interaction across cognitive, conative, affective, and sensory domains,

shaped by environmental demands and the quality of supports provided.

Taken together, these insights reinforce the need for an integrated, developmentally sensitive, and supports-oriented approach to IDD that bridges clinical, educational, and policy contexts. Conceptual precision, interdisciplinary alignment, and person-centered frameworks are not merely academic concerns. In fact, they constitute the foundation to ethical practice, effective intervention, and the promotion of dignity, participation, and quality of life for individuals with IDD across the lifespan.

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