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## THE ROLE OF SOCIAL PARTICIPATION IN THE FORMATION OF IDENTITY IN YOUNG PEOPLE WITH MILD INTELLECTUAL DISABILITY AND IN INTELLECTUAL NORM: A COMPARATIVE STUDY

The article presents the results of a study on the role of social participation (Reinders) in shaping the identity (Luyckx et al.) of people with mild intellectual disability in late adolescence and emerging adulthood compared to those in intellectual norm ( $N = 127$ ). Three waves of measurement were carried out at semi-annual intervals, using the Dimensions of Identity Development Scale (DIDS/PL-1) and the Social Participation Questionnaire (SPQ-S). In all the waves people with intellectual disability had a higher level of the moratorium orientation, and at Wave 3 they had a higher level of the transitive orientation. Differences in the levels of identity dimensions were observed in only one wave and only in the case of exploration in depth. The type of social participation has proved to be a factor differentiating the levels of identity dimensions, especially commitment making and identification with commitment, the highest level of which was observed in people with integration and assimilation types. The study responds to the need, expressed in the literature, to focus on specific groups in identity development studies.

**Keywords:** identity; intellectual disability; social participation.

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Personal identity is what people reveal about themselves while answering the question “Who am I and where am I going?” (Oleś, 2008). It is one of the most frequently studied theoretical constructs in social sciences (Brubaker & Cooper, 2000). The multiplicity of psychological definitions and approaches to identity has resulted in numerous empirical studies, but the question concerning the nature of identity and the most effective methods of examining it remains unanswered (Pilarska, 2016). At present, we are facing a fragmentation of knowledge about identity rather than a comprehensive approach to it. Thirteen years ago, cross-sectional studies predominated over longitudinal ones (Schwartz, 2005). Although to this day the number of longitudinal studies on identity development has increased considerably, several of the recommendations from Schwartz’s article have still not been sufficiently implemented. This refers, for instance, to the practice of empirical studies ignoring people who are in some way unusual, such as members of social minorities, the disabled, or the sick. One of such ignored groups are people with intellectual disability (ID). In addition, there is a lack of systematic knowledge about the significance of various social factors in the process of identity formation.

The dual-cycle model of identity formation (Luyckx, Goossens, & Soenens, 2006) allows for representing identity as a process. The model analyzes five dimensions of identity, and the process of identity formation takes place in two cycles – commitment-formation and commitment-evaluation. The commitment-formation cycle consists of two dimensions of identity – *exploration in breadth* (EB) and *commitment making* (CM). EB is defined as searching for alternatives in regard to one’s own values, goals, and beliefs. CM is understood as making choices that are important to the development of identity. The next step in identity development is the commitment-evaluation cycle. What takes place during this cycle is the evaluation of the commitment, which is referred to as *exploration in depth* (ED), followed by *identification with commitment* (IC); as a result, the conviction appears that the choices made are suitable for the individual. The fifth dimension, which may co-occur in either of the two cycles and which is called *ruminative exploration* (RE), refers to concerns, fears, and doubts about the search for one’s own identity (Luyckx et al., 2008). It is associated with rumination which involves constantly recurring doubts as to the quality of one’s own actions as well as a tendency to dwell on negative experiences and to focus on negative emotions felt at a given moment.

The dual cycle model of identity formation arose as a result of empirical research on the development of identity in contemporary youth and young adults in developed countries. The results unequivocally indicated that James Marcia’s

simple model which presented the process of identity development as a transition from intensive exploration (the equivalent of EB) to making commitments presented the essence of this process in the 1960s (when the model was created), but it does not reflect the characteristics of the contemporary process of personal identity formation, which is more prolonged and characterized by making “trial” commitments. A distinguishing feature of this model is considering the possibility of returning from each stage of development again to EB, for example, when the choices made do not meet personal standards. At the same time, this model is related to the “form” of identity rather than to its “content” – which means that it refers to whether and to what extent an individual carries out exploration in breadth rather than to the decisions this individual makes concerning the content of his or her future (e.g., the choice of education or profession).

The formed identity is treated as a subjective indicator of adulthood, or as a prerequisite for the psychological transition to adulthood. Among nondisabled people, a new developmental phenomenon has been observed – the phase of emerging adulthood (which begins the period of early adulthood) (Arnett, 2007) and deferral (postponement) of adulthood (Brzezińska, Kaczan, Piotrowski, & Rękosiewicz, 2011) – i.e., increasingly late emergence of objective and subjective indicators of adulthood (in successive generations identity formation is shifting in time – Liberska, 2007). From early adolescence to early adulthood EB and ED decrease while CM increases (e.g., Brzezińska & Piotrowski, 2009); however, it is difficult to pinpoint a specific developmental period in which the most dynamic changes occur (cf. Kroger, Martinussen, & Marcia, 2010; Luyckx, Schwartz, Goossens, Soenens, & Beyers, 2008; Meeus, van de Schoot, Keijsers, Schwartz, & Branje, 2010), because the process of identity formation differs across individuals. The psychology of human development has not yet answered the question whether the same phenomena occur in young people with ID.

Identity is formed through the impact of both individual and environmental factors. The former, empirically documented, include temperament and personality traits, while in the latter category one can find young people’s educational paths, professional experience, and parenting styles (which include allowing the separation and individuation of the child). The theory of personal identity development (e.g., Slugoski, Marcia, & Koopman, 1984) indicates that the necessary condition for its formation is the appearance of Piaget’s formal operational stage (see Piaget, 1972). The results of empirical research do not fully confirm these assumptions. Achievement and moratorium, two most mature identity statuses, both with a high exploration level, were associated with the ability to perform formal operations (e.g., Rowe & Marcia, 1980; Slugoski et al., 1984). These

results have not been replicated in other studies (e.g., Berzonsky, Weiner, & Raphael, 1975; Cauble, 1976; Leiper, 1981). Hypothetically, a low level of intelligence can play a particularly important role in the development of identity. It can have a direct influence as a biological feature, for example by hindering the understanding of the consequences of one's own actions, or the process of planning one's future. Impaired executive functions in people with ID can result in problems with creating as well as maintaining and supervising their own action plan. The level of intelligence also indirectly affects the development of identity, triggering some social processes – as when, for example, a child's ID makes their parents forbid them independent exploration. A study of adolescents with mild ID (Levy-Schiff, Kedem, & Sevillea, 1990, as cited in Evans, 1998) showed a significant diversity of identity profiles in the examined subjects. The results of the individuals with ID differed from the results of the nondisabled. The researchers explain this diversity not only by the level of cognitive functioning, but also by social adaptation.

The level of intellectual functioning of individuals with ID deviates from the norm. At the same time, to some extent, they function socially in a similar way to the nondisabled. As adults, they take on some of the social roles typical of their peers in intellectual norm. According to the ICF model (WHO, 2001), ID is a mental condition which consists of functional and structural damage to the body, limitations of activity, and restrictions of social participation. Each of these elements has an impact on general development, potentially including the development of identity. It is therefore worth examining identity development in people with ID not only in relation to age and level of intelligence, but also in relation to social factors, which are potentially significant in this process. One of these potential factors is social participation – a sociopsychological concept defined by Heinz Reinders et al. (Reinders, 2006; Reinders, Bergs-Winkels, Butz, & Claßen, 2001). The authors assume that the participation of young people in social life (social participation) is expressed in two dimensions (or life orientations) – *transitive orientation* (TO) and *moratorium orientation* (MO). TO refers to undertaking activities oriented to the future, to subsequent developmental tasks, and to preparation for taking on adult roles. MO refers to coping with the tasks of everyday life and to making use of readily available opportunities. However, these two orientations are not mutually exclusive. On the basis of their intensity, the authors of the theory distinguished four *types of social participation* – integration type (high TO and MO), assimilation type (high TO, low MO), marginalization type (low TO and MO), and segregation type (low TO, high MO). The types with high TO co-occur with parents' openness to the adolescent child's

need to become independent, the adolescent student's sense of subjectivity in contact with teachers, and the child's self-confidence as well as faith in their own abilities (Mianowska, 2008). In the types with high MO, a sense of peers' closeness and of belonging to a peer group can be noticed.

It seems that the assimilation and integration types are best suited for the process of entering adulthood. The assimilation type is associated with low RE and high levels of the other four dimensions of identity development (Rękosiewicz, 2013b) as well as with being capable of regulating emotions (Jankowski & Rękosiewicz, 2013). The assimilation and integration types are linked with increased levels of CM and IC. Students with the integration type show a low level of pessimism (Reinders, 2006). The dominance of TO over MO, which can be understood as an indicator of transition to adulthood, cannot be observed until emerging adulthood (Rękosiewicz, 2014).

Studies involving people with a variety of ability restrictions have shown that those who feel limited because of their disability more often tend to live a day-to-day existence, in contrast to people who are not faced with such restrictions (such individuals try to plan their future) (Jowell, 2007). In studies of people with physical disabilities in early, middle, and late adulthood, it has been observed that, out of all the examined age groups, young adults are the least focused on the present and the most highly focused on the future (Brzezińska, Kaczan, & Rycielska, 2010). In other studies (Piotrowski, 2010), lower social activity of disabled people was observed. Self-activity is of great importance for building life plans. For example, it has been shown that the possibility of taking up paid work and of sustaining an independent livelihood significantly affect plans for the future and self-esteem in people with ID (Nowak, 2014). Due to the fact that people with ID have restricted access not only to the so-called free-market jobs, but also to workplaces specially dedicated to them, it can be assumed that being aware of these restrictions will be associated with a reduced level of TO in this area. The social situation of people with ID can create conditions for remaining too long in the period prior to adulthood (which manifests itself in lower levels of TO, EB, and ED and a higher level of MO in comparison with their nondisabled peers), since for them social opportunities of undertaking typically adult roles are limited. For the same reason, it seems that a decrease in MO and an increase in TO, CM, and IC will take place more slowly or to a smaller degree than in the case of their nondisabled peers.

The aim of the present study was to answer the question of whether people with mild ID really differ in terms of life orientation and types of social participation from people in intellectual norm, as well as whether and how these dis-

similarities translate into differences in the development of their personal identity. Three hypotheses were put forward:

1. Individuals with ID are characterized by higher MO and lower TO than those who are nondisabled and, as a consequence, they are more likely to represent the segregation type rather than assimilation, marginalization, or integration types.

2. Due to different types of social participation, individuals with ID display lower levels of EB, ED, CM, and IC, and a higher level of RE than their nondisabled peers.

3. With the passage of time, MO decreases in intensity, while there is an increase in TO as well as in CM and IC, and these changes are more significant in the nondisabled than in individuals with ID.

## METHODS

### Participants

The study participants – people with mild ID and in intellectual norm – were in their late adolescence (16-17 years of age at Wave 1) or emerging adulthood (20-21 years at Wave 1). The sample consisted of 143 participants in the first wave, 132 in the second wave, and 127 in the third. The analysis focused only on those participants who took part in all three waves ( $N = 127$ ). On the basis of two criterion variables – developmental period and the level of intellectual functioning – four study groups were distinguished (Table 1).

Table 1  
*Sample Characteristics*

Variable	Group A	Group B	Group C	Group D
	Adolescence, ID	Emerging adulthood, ID	Adolescence, ND	Emerging adulthood, ND
	$n = 36$	$n = 31$	$n = 30$	$n = 30$
Age (at Wave 1)	$M = 16.36$ ( $SD = 0.49$ )	$M = 20.42$ ( $SD = 0.50$ )	$M = 16.23$ ( $SD = 0.43$ )	$M = 20.43$ ( $SD = 0.50$ )
Female	$n = 15$ (41.7%)	$n = 12$ (38.7%)	$n = 19$ (63.3%)	$n = 21$ (70.0%)

Note. ID – intellectual disability, ND – nondisabled.

The participants attended one of four types of schools: high school or vocational school (group C), special vocational school (groups A and B – all the participants with ID), or a university (group D). All participants with ID lived with their families in villages or small towns; however, while at school (from Monday to Friday), they lived in boarding houses. The subjects from groups C and D came from villages, small towns, or big cities, but they went to school in a big city.

### Measures

Three waves were carried out at six-month intervals. In all the examined groups, we applied the same version of the measures and the same procedure, which facilitated a further comparison of the results across groups that differed in the level of intellectual functioning. Beforehand, the measures were adapted to the needs and capabilities of people with mild ID (Rękosiewicz, 2013a, 2015).

**Dimensions of Identity Development Scale – a modified version (DIDS/PL-1).** The scale is based on the dual-cycle model of identity formation by Luyckx et al. (2008). The modified version of the DIDS/PL-1 used in the study was simplified in content when compared to the Polish version of the DIDS/PL (Brzezińska & Piotrowski, 2010).

Like the original version, the modified one consists of 25 items in the form of affirmative statements (Rękosiewicz, 2015). These items are grouped into five scales (with five items in each scale) corresponding to the five dimensions of identity development. Answers were prepared in the Likert scale format. In the modified version, the original number of six response options was reduced to four: 1 – *no*, 2 – *probably not*, 3 – *probably yes*, 4 – *yes*. Example items were as follows: EB: *I think about what I might do in the future*; ED: *I have asked other people what they think about my plans*; CM: *I already know what I want to do in my life*; IC: *What I have planned suits me*; RE: *Sometimes I'm worried about my future*. During the study, each item of the questionnaire was read out by the researcher, and the examined individual was to select one of the four answers after deciding to what extent a given item reflected their view. The answer sheet was placed in front of the subject. After the answer was given, the researcher put it in the answer sheet. The result of DIDS/PL-1 is the average score for each of the five scales.

In consecutive waves, reliability measured as Cronbach's  $\alpha$  for each scale was as follows:

– Individuals with ID: EB: .71, .73, .73; ED: .76, .68, .74; RE: .70, .74, .74; CM: .76, .87, .81; IC: .83, .90, .80.

– Individuals in intellectual norm: EB: .74, .76, .76; ED: .69, .77, .67; RE: .72, .67, .66; CM: .91, .89, .90; IC: .89, .91, .91.

**Social Participation Questionnaire (SPQ-S1, SPQ-S2).** The structure of the Social Participation Questionnaire (SPQ) was based on the theoretical framework of social participation types by Merkens, Bergs-Winkels, as well as Reinders and Butz (Reinders et al., 2001). The questionnaire was developed by Brzezińska, Hejmanowski, and Rękosiewicz (for a detailed description of the tool, see Rękosiewicz, 2013a) in two versions: SPQ-1: for respondents aged 13-17 and SPQ-2: for respondents aged 18-30, as well as in the basic (SPQ) and short (SPQ-S) versions.

The short version (SPQ-S1 for subjects in late adolescence and SPQ-S2 for those in emerging adulthood) consists of 20 items in the form of affirmative statements, which make up two scales: TO and MO (10 items in each of the scales). The responses were prepared in the Likert scale format. Each statement had five answer options assigned to it: 1 – *no*, 2 – *probably not*, 3 – *hard to say*, 4 – *probably yes*, 5 – *yes*. Example items were as follows: MO – *If possible, I avoid responsibilities and spend my time in an enjoyable way*; TO – *In my mind, I'm planning my future education*. For the purposes of the study the research procedure was modified – the traditional “paper-and-pencil” format was abandoned. Each item in the questionnaire was read out by the researcher and the subject had to choose one of the five answers after deciding to what extent a given item described the analyzed person. The answer sheet was placed in front of the subject. After the answer was given the researcher marked it on the answer sheet. The result of SPQ is the average point score obtained on each of the two scales. The next step in the analysis is the allocation of the subject to one of the four social participation types on the basis of the results from both scales.

Reliability, measured as Cronbach's  $\alpha$ , was as follows:

– Individuals with ID: MO in SPQ-S 1: .70, .66, .77; MO in SPQ-S 2: .80, .82, .87; TO in SPQ-S 1: .67, .84, .67; TO in SPQ-S 2: .85, .91, .81.

– Individuals in intellectual norm: MO in SPQ-S 1: .68, .72, .69; MO in SPQ-S 2: .80, .79, .73; TO in SPQ-S 1: .80, .83, .83; TO in SPQ-S 2: .83, .91, .82.



## RESULTS

**Dimensions and types of social participation**

Multivariate analysis of variance with group as a factor and dimensions of social participation as dependent variables together with Tukey's HSD *post hoc* test revealed differences between the groups regarding MO in all waves and with reference regarding TO at Wave 3 (Table 2). On average, at Waves 1 and 2 nondisabled subjects in both age groups manifested a higher level of MO than subjects with ID in the period of adolescence. At Wave 3 there was a clearly observable difference between adolescents and emerging adults with ID, with the latter group having a lower MO. At Wave 3 subjects with ID in emerging adulthood did not differ from nondisabled subjects in terms of MO. While at Waves 1 and 2 there were no observable differences in the level of TO, at Wave 3 the nondisabled subjects in emerging adulthood had lower TO than the subjects with ID.

Table 2

*Univariate ANOVAs and Post-Hoc Comparisons Based Upon Tukey HSD Tests for the Four Groups at Waves 1, 2, and 3*

	Group A Adulthood, ID <i>M (SD)</i>	Group B Emerging adulthood, ID <i>M (SD)</i>	Group C Adolescence, ND <i>M (SD)</i>	Group D Emerging adulthood, ND <i>M (SD)</i>	<i>F (η<sup>2</sup>)</i>
MO 1	3.86 <sup>b</sup> (0.70)	3.60 <sup>a,b</sup> (0.91)	3.33 <sup>a</sup> (0.55)	3.14 <sup>a</sup> (0.66)	6.27 (.13) <i>p</i> < .001
MO 2	3.90 <sup>c</sup> (0.70)	3.55 <sup>b,c</sup> (0.91)	3.26 <sup>a,b</sup> (0.59)	3.06 <sup>a</sup> (0.65)	8.46 (.17) <i>p</i> < .001
MO 3	3.87 <sup>b</sup> (0.79)	3.35 <sup>a</sup> (1.02)	3.29 <sup>a</sup> (0.50)	3.00 <sup>a</sup> (0.63)	7.42 (.15) <i>p</i> < .001
TO 1	4.26 (0.53)	4.31 (0.75)	4.02 (0.63)	3.97 (0.63)	2.28 (.05) <i>p</i> = .08
TO 2	4.31 (0.75)	4.19 (0.94)	4.26 (0.56)	4.00 (0.67)	1.05 (.03) <i>p</i> = .38
TO 3	4.43 <sup>b</sup> (0.47)	4.38 <sup>b</sup> (0.60)	4.13 <sup>a,b</sup> (0.58)	3.94 <sup>a</sup> (0.58)	5.33 (.12) <i>p</i> < .01

*Note.* The number next to the variable indicates the wave number. Different indexes next to the mean values indicate significant differences between the groups. ID – intellectual disability, ND – nondisabled, MO – moratorium orientation, TO – transitive orientation.

In order to verify whether the subjects with ID differed from the nondisabled subjects in terms of social participation types, we performed *k*-means clustering on the whole sample, separately for each wave. Wave 1 revealed four clusters corresponding to four social participation types: integration – with relatively high levels of MO and TO ( $n = 27$ , 21.3%), segregation – with high MO and low TO ( $n = 2$ , 1.6%), assimilation – with low MO and high TO ( $n = 48$ , 37.8%), and marginalization – with moderate MO and low TO ( $n = 50$ , 39.4%). There was a minor difference in the frequency of occurrence of each type in the four groups [ $\chi^2(9, n = 127) = 22.04, p < .01, V = 0.24$ ], and a mild difference between the two groups that varied in the level of intellectual functioning [ $\chi^2(3, n = 127) = 18.97, p < .001, V = 0.39$ ]. Out of all the individuals with ID, the largest group were people with integration (35.8%) and assimilation (34.3%) types.

At Wave 2, the following types were distinguished: integration – high MO and TO ( $n = 44$ , 34.6%), segregation – moderate MO and very low TO ( $n = 14$ , 11.0%), assimilation – low MO and high TO ( $n = 31$ , 24.4%), and marginalization – moderate MO and TO ( $n = 38$ , 29.9%). With regard to the frequency of the types in all four groups, the difference was mild [ $\chi^2(9, n = 127) = 27.05, p < .001, V = 0.27$ ], whereas between groups that were dissimilar in terms of intellectual functioning there was a moderate difference [ $\chi^2(3, n = 127) = 20.08, p < .001, V = 0.40$ ]. Forty-five percent of nondisabled individuals were of the marginalization type (the largest group among the nondisabled), compared to only 16.4% of the subjects with ID of the same type. The integration type could more often be found in people with ID (50.7% *vs.* 16.7% among individuals in intellectual norm), and this type of social participation was most often found in individuals with ID.

In the last wave, cluster analysis revealed the following results: integration – high MO and TO ( $n = 27$ , 21.3%), segregation – moderate MO and low TO ( $n = 18$ , 14.2%), assimilation – low MO and high TO ( $n = 49$ , 38.6%), and marginalization – low levels of both dimensions ( $n = 33$ , 26.0%). There were moderate differences in the frequency of particular types in the four groups [ $\chi^2(9, n = 127) = 35.38, p < .001, V = 0.31$ ] and regarding the occurrence of types in groups differing in the level of intellectual functioning [ $\chi^2(3, n = 127) = 22.95, p < .001, V = 0.43$ ]. Individuals with ID were most often of the integration (37.3%) or assimilation (34.3%) types.

**The type of social participation  
as a factor differentiating the levels of identity dimensions**

Multivariate analysis of variance with group (A, B, C, D) as a factor and dimensions of social participation as dependent variables together with Tukey's HSD *post hoc* tests revealed a difference between the groups only at Wave 2 and only in the case of ED ( $F = 3.92, p < .01, \eta^2 = .09$ ). Individuals with ID in emerging adulthood were characterized by a higher level of ED ( $M = 3.22, SD = 0.61$ ) in comparison with their non-disabled peers ( $M = 2.71, SD = 0.70$ ).

Table 3

*Univariate ANOVAs and Post-Hoc Comparisons Based Upon Tukey HSD Tests for the Four Types of Social Participation at Waves 1, 2, and 3*

	Integration <i>M (SD)</i>	Segregation <i>M (SD)</i>	Assimilation <i>M (SD)</i>	Marginalization <i>M (SD)</i>	<i>F</i> ( $\eta^2$ )
EB 1	3.57 (0.46)	3.50 (0.42)	3.27 (0.71)	3.07 (0.69)	3.50 (.08) $p < .05$
EB 2	3.47 <sup>b</sup> (0.67)	2.70 <sup>a</sup> (0.77)	3.25 <sup>b</sup> (0.71)	3.26 <sup>b</sup> (0.44)	5.26 (.11) $p < .01$
EB 3	3.51 (0.69)	3.24 (0.73)	3.28 (0.60)	3.31 (0.55)	0.99 (.02) $p = .40$
ED 1	3.27 (0.61)	2.90 (1.27)	3.19 (0.66)	2.92 (0.71)	2.11 (.05) $p = .10$
ED 2	3.26 <sup>b</sup> (0.60)	2.69 <sup>a</sup> (0.83)	3.09 <sup>a, b</sup> (0.76)	2.96 <sup>a, b</sup> (0.58)	3.16 (.07) $p < .05$
ED 3	3.33 (0.84)	3.08 (0.61)	3.18 (0.59)	3.00 (0.63)	1.31 (.03) $p = .27$
RE 1	3.04 (0.63)	3.50 (0.71)	2.79 (0.80)	2.55 (0.71)	3.41 (.08) $p < .05$
RE 2	2.75 (0.83)	2.47 (0.69)	2.30 (0.84)	2.60 (0.60)	2.20 (.05) $p = .09$
RE 3	2.95 <sup>c</sup> (0.88)	2.89 <sup>b, c</sup> (0.68)	2.39 <sup>a</sup> (0.71)	2.44 <sup>a, b</sup> (0.54)	5.19 (.11) $p < .01$
CM 1	3.17 <sup>b</sup> (0.73)	1.40 <sup>a</sup> (0.57)	2.90 <sup>b</sup> (0.81)	2.74 <sup>b</sup> (0.91)	3.65 (.08) $p < .05$
CM 2	3.29 <sup>c</sup> (0.82)	2.16 <sup>a</sup> (0.97)	3.23 <sup>b, c</sup> (0.84)	2.66 <sup>a, b</sup> (0.84)	9.04 (.18) $p < .001$
CM 3	3.37 <sup>b</sup> (0.73)	2.63 <sup>a</sup> (1.12)	3.25 <sup>b</sup> (0.72)	2.92 <sup>a, b</sup> (0.75)	4.27 (.09) $p < .01$
IC 1	3.55 <sup>b</sup> (0.54)	1.90 <sup>a</sup> (0.14)	3.56 <sup>b</sup> (0.54)	3.20 <sup>b</sup> (0.75)	7.03 (.15) $p < .001$
IC 2	3.57 <sup>b, c</sup> (0.54)	2.53 <sup>a</sup> (1.05)	3.66 <sup>c</sup> (0.37)	3.12 <sup>b</sup> (0.73)	13.48 (.25) $p < .001$
IC 3	3.79 <sup>c</sup> (0.34)	3.07 <sup>a</sup> (1.04)	3.65 <sup>b, c</sup> (0.43)	3.25 <sup>a, b</sup> (0.58)	8.63 (.17) $p < .001$

*Note.* The number next to the variable indicates the wave number. Different indexes next to the mean values indicate significant differences between the groups. ID – intellectual disability, ND – nondisabled, EB – exploration in breadth, ED – exploration in depth, RE – ruminative exploration, CM – commitment making, IC – identification with commitment.

Multivariate analysis of variance with participation type as a factor and dimensions of identity as dependent variables revealed a significant main effect [Wilks's  $\lambda = .62$ ,  $F(15, 328.91) = 4.09$ ,  $p < .001$ ,  $\eta^2 = .15$ ]. Tukey's HSD *post hoc* tests showed differences between subjects with specific social participation types with regard to CM and IC at all waves, with regard to EB at Waves 1 and 2, as well as with regard to ED at Wave 2 and RE at Wave 3 (Table 3). At Wave 1, subjects with the segregation type had a lower level of CM and IC than subjects with the other types. At Wave 2 individuals with this type of social participation had a significantly lower level of EB and IC than subjects with the remaining types; the same individuals had a lower level of ED than those with the integration type. At Wave 2, subjects with the integration type had a higher level of CM than those with the segregation and assimilation types. Only at Waves 3 did RE differentiate the groups – subjects with the integration type had the highest level of RE, which made them differ significantly in this respect from the subjects with the assimilation and marginalization types. Subjects with the segregation type had the lowest levels of CM and IC, which made them significantly different from individuals with integration and assimilation types.

### **Developmental changes in the levels of identity dimensions and the dimensions of social participation**

A developmental change in identity dimensions occurred only in group A (adolescence, ID). Firstly, Tukey's HSD *post hoc* test revealed a significant difference in CM between Waves 2 ( $M = 2.97$ ) and 3 ( $M = 3.33$ ) [ $F(2, 70) = 4.13$ ,  $p < .05$ ,  $\eta^2 = .11$ ]. The second change was observed in the case of IC. The analysis showed a significant main effect [ $F(2, 70) = 4.15$ ,  $p < .05$ ,  $\eta^2 = .11$ ]. Tukey's HSD *post hoc* test pointed to a significant difference in IC between Waves 2 ( $M = 3.38$ ) and 3 ( $M = 3.63$ ). Within the other dimensions of identity and social participation no significant changes took place in any of the examined groups.

### **DISCUSSION**

The aim of the study was to acquire knowledge in the as yet under-researched field concerning social conditions in the process of personal identity formation in individuals with ID. The study was based on the assumption that people with ID differ from their nondisabled peers in terms of dimensions and types of social participation, and that these differences translate into differences

in the levels of identity development dimensions. Another hypothesis was that, in comparison to people with ID, nondisabled individuals show a greater decrease in the level of MO, an increase in the level of TO, as well as an increase in the levels of CM and IC.

The results of the study are not fully consistent with the first hypothesis. While subjects with ID had lower MO than their nondisabled peers, their TO level did not differ (or their scores were even higher). This result should be treated as a positive, pro-development phenomenon. It can be assumed that, in their social environment, people with ID were influenced by factors which encouraged them to plan their own future and prepare for it. All the subjects came from small towns and attended special vocational schools. Thus, at least in relation to the vocational area, they might have been supported in decisions concerning further educational and vocational paths, which might have led to the high level of TO.

A high TO level in individuals with ID corresponded with a particularly frequent occurrence of integration and assimilation types. It has already been shown that these types are associated with an increased level of CM and IC (Rękosiewicz, 2013b), and the present study yielded the same results (on the whole sample). The type of social participation has proved to be a factor that differentiates the levels of most of the dimensions of identity development. The effect size was the greatest in the case of IC. In each wave, the social participation type differentiated the levels of CM and IC. Of all the types, the most prominent one was the segregation type, with the lowest CM and IC. As a result, TO turned out to be a factor which supports both making commitments and developing the sense that one's choices are good. It seems that TO is more important for the development of identity than MO, and the former can be treated as a factor which supports identity development.

With regard to the dimensions of identity development, the analyses did not reveal significant differences between subjects with ID and nondisabled individuals of the same age. Therefore, the second hypothesis has not been confirmed. Individuals with ID turned out to be more strongly oriented towards moratorium than the nondisabled ones. Strong transitive orientation in individuals with ID, as those in intellectual norm, could be to some extent responsible for the lack of significant differences between these two groups in the dimensions of identity development. The relation of TO to CM and IC is of particular importance in this context. Planning the future and focusing on learning what is needed in adulthood provides the basis for making important life decisions and, conse-

quently, for making the best personal choices. Therefore, TO orientates one towards adulthood, which is underlined in theoretical studies (Reinders, 2006).

The results of the study confirm the difficulty in indicating a particular age or stage of development in which changes in identity take place. The only changes consistent with the third hypothesis have been observed among adolescents with ID. In this group, there was an increase in CM and IC between Waves 2 and 3. This result reflects the phenomenon observed in other studies, consisting in an increase (or decrease) of CM in time, accompanied by an increase (or decrease) of IC (Luyckx, Goossens, & Soenens, 2006). As in other studies (e.g., Luyckx, Schwartz, Goossens, Soenens, & Beyers, 2008), some fluctuations of IC were observed – its level decreased from Wave 1 to Wave 2 and then increased in Wave 3. Such fluctuations are interpreted as an indicator of the emergence of the commitment-evaluation cycle.

On the basis of the results, the conclusion might be that there is a considerable similarity of identity in people with ID and in intellectual norm. However, such conclusions should be drawn with caution for several reasons. Firstly, the study had a limited scope because of the small sample size. Due to difficulties in gathering a specific group (people with mild ID aged 16-17 or 20-21, without physical disability) and the decreasing number of subjects at each subsequent wave, the final sample was small. At the same time, the aim was to maintain the homogeneity of the group – all subjects with ID attended special vocational schools, were not physically disabled, and were considered by their teachers as not posing any major educational problems. Secondly, all the schools attended by the subjects while the study was in progress offered them considerable psychological and vocational support. It ought to be borne in mind that not all people with ID are provided with such support. Thirdly, the participants in the study were only people with mild ID, so the conclusions refer only to this specific group. It seems that the more severe the degree of ID, the more significant differences could be observed. Hypothetically, differences would be caused by a weaker ability to reflect upon oneself and plan the future as well as more limited social experiences which are a significant factor in the development of people with ID (Hodapp, Burack, & Zigler, 1995).

In addition, it is possible that the differences relate to the content of identity which has not been studied so far. This seems to be the most important direction for further research which could tell us more about the nature of identity of people with ID. Such studies would help to answer the question of whether a given dimension of identity development is understood in the same way by people with ID and by the nondisabled. An example item from DIDS/PL-1:

*I already know what I want to do in my life*, can be understood in different ways, also by nondisabled individuals. It would be interesting to investigate whether content differences are hidden in each dimension, and if so, what these differences are between nondisabled individuals and those with ID. *Disability identity* is a topic addressed increasingly often by researchers (Forber-Pratt, Lyew, Mueller, & Samples, 2017). The concept is defined in various ways, but, in the most general terms, it aims to answer the question: “Do I perceive myself as a person with a disability and how do I understand my disability?” Disability identity reflects the perception of oneself (with one’s own disability) as well as of one’s own organism and possibilities of interaction with the social and physical environment (Bogart, Rottenstein, Lund, & Bouchard, 2017). Personal identity discussed in this article is understood more broadly, as a way of perceiving oneself not only through the prism of one’s own disability but also through the prism of one’s own resources and weaknesses unrelated to disability. At the same time, one’s own limitations of ability seem to be a significant, if not the key, element in forming one’s own identity and making plans for the future.

This study is a response to the recommendations concerning research on identity development voiced by Schwartz (2005) – it is a longitudinal study which focuses on individuals with ID in late adolescence. Apart from its unquestionable strengths, the study has important limitations: small sample size, the selection of nondisabled subjects limited to those from specific education groups, and the inclusion of individuals with diverse ID etiology in the sample. Further research should also examine the dependence of identity development on the level of intelligence, not only on ID level. It would also be interesting to empirically test the relationship between personal identity and disability identity in people with ID.

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