Cambridge Quarterly of Healthcare Ethics (2026), 35: 1, 40–47
doi:10.1017/S0963180125000088

CAMBRIDGE UNIVERSITY PRESS

RESEARCH ARTICLE

Suffering and Intellectual (Dis)Ability*

Ryan H. Nelson

Abbott Northwestern Hospital, Minneapolis, MN USA and University of Minnesota, Center for Bioethics, Minneapolis, MN, USA
Email: ryan.nelson2@allina.com

Abstract

This essay argues that what distinguishes a negatively valenced phenomenal experience from suffering is an ability to make meaning of the experience. In this sense, intellectual ability influences the extent and nature of suffering. But this connection is not a straightforward one, since intellectual ability cuts both ways. On the one hand, those with higher levels of intellectual functioning are better able to make meaning of negative experiences, thereby reducing their suffering. On the other, intellectual ability can influence the depth and breadth of one's negative experiences, thereby increasing suffering. This means that we cannot make any assumptions about a person's susceptibility to suffering based on their level of intellectual functioning alone.

Keywords: disability; experience; intellectual disability; Suffering

Introduction

When it comes to non-human animals, Jeremy Bentham famously writes, "the question is not, Can they reason? nor, Can they talk? but, Can they suffer?"[1] For Bentham, it is the capacity for suffering, rather than intellectual ability, that grounds moral status. This view represents a welcomed expansion of the moral community. Yet it also suggests that the capacity for suffering operates independently of intellectual ability, which ignores the interesting and complex relationship between them. My proposal here is that intellectual ability influences both what one experiences and how they understands these experiences. Experience and understanding in turn determine the nature and extent of one's suffering. There is indeed a connection between suffering and intellect—just not a straightforward one.

One way of better understanding this connection is to look at suffering in the context of intellectual *dis*ability (ID), which is where much of the following discussion dwells. But, given the focus of so much disability scholarship, it is important to note at the outset what I will *not* be doing.

First, I will not be addressing the question of whether ID is itself a source of suffering. A central question in the philosophy of disability concerns the relationship between disability and well-being, with some arguing that disability necessarily makes someone worse off[2] and others arguing that it is an inherently neutral characteristic that makes one worse only as a result of unjust social arrangements.[3] Relatedly, some claim that to be disabled is to suffer, irrespective of how else their life goes.[4,5] Critics reject this view as an "ableist conflation" that perpetuates attitudes and practices disadvantageous to disabled people.[6] These are crucial questions, but not ones to be pursued here. Instead, I remain neutral on the issue of whether ID is a source of suffering *per se*, while arguing that intellectual ability influences one's capacity for suffering in important ways.

Also not addressed will be the issue of whether, as a matter of fact, individuals with ID tend to suffer more or less than those with typical intellectual ability. It is important to acknowledge that ID may render

*The online version of this article has been updated since original publication. A notice detailing the change has also been published.

© The Author(s), 2025. Published by Cambridge University Press. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (http://creativecommons.org/licenses/by/4.0), which permits unrestricted re-use, distribution and reproduction, provided the original article is properly cited.

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

an individual more susceptible to certain forms of harm, including physical abuse,[7] sexual abuse,[8] and other criminal victimization.[9] This is to say nothing of the maltreatment people with ID have often experienced throughout history, from inhumane institutionalization[10] to forced sterilization.[11] ID may also involve more endogenous forms of harm, such as the self-injurious behaviors seen in those with Lesch–Nyhan syndrome, for example.[12] It is clear that suffering has played a large role in the story of ID. At the same time, there is evidence that at least some people with ID have extremely high levels of happiness and self-esteem,[13] complicating the picture. Sorting out these empirical matters is certainly an interesting and important task, but again not one that will be taken on in this article. Rather the aim is to provide a broad overview of the philosophical discourse on suffering and explore conceptually how suffering and ID interact. I conclude that intellectual ability has the potential to reduce and amplify suffering in distinct ways. It follows that we cannot make any assumptions about a person's susceptibility to suffering based on their level of intellectual functioning alone.

Theories of Suffering

Brent Kious helpfully sorts philosophical theories of suffering into three categories: *flourishing-based* theories, *value-based* theories, and *feeling-based* theories.[14] He describes flourishing-based theories as "objective," since they hold that "suffering occurs independent of any feeling, distress, or subjective evaluation of one's circumstances, and depends only on whether their life is going well or poorly in some objective sense." One such view comes from Stan van Hooft,[15] who understands suffering as "the frustration of the tendency towards fulfillment of [some] aspect of our being."[16] Drawing on Aristotle's characterization of the soul, van Hooft posits that human functioning occurs at the biological, appetitive, deliberative, and contemplative levels. Suffering results from the hindrance of any such functioning. Importantly, this means that one can suffer without awareness that one is suffering, or awareness of anything at all. A patient in a minimally conscious state, for example, can be said to suffer insofar as her condition interferes with her ability to function as (say) a contemplative creature who seeks a sense of meaningfulness.

Thinking about suffering in objective terms arguably has its advantages. Tyler Tate and Robert Pearlman note that a flourishing-based account better captures intuitions in certain cases: a child in an abusive relationship who knows no different; an addict eager to continue abusing drugs; a billionaire driven by greed to neglect his family.[17] These people are suffering, the authors think, even if each would deny it. One concern about such views, however, is that they are in tension with pluralistic ideas about human good. If the standards for flourishing are established irrespective of any individual's aims or abilities, then there appears to be little room for diversity or variation. Responsive to this concern, Tate offers a revised account, according to which a person suffers when she is prevented from flourishing in a way that is available to her in her particular circumstances.[18] So, while suffering and its inverse, flourishing, are determined according to an objective set of conditions, Tate maintains that "what is necessary to prevent suffering and actualize flourishing will always differ from patient to patient."[19] The minimally conscious patient can be said to suffer, therefore, only if she fails to flourish in ways *available to her*, such as when she is not kept comfortable or treated with dignity.

As we have seen, flourishing-based theories have no subjective experiential requirement for suffering —one may suffer without experiencing pain, distress, or other negatively valanced state. For feeling-based theories, however, subjective experience plays a central role. Jamie Mayerfeld offers a utilitarian-friendly sensation-based view according to which "to suffer is to feel bad."[20] Seeking a parsimonious and inclusive account, he proposes a one-dimensional continuum of feeling with happiness (or enjoyment) on one end and suffering (or a disagreeable overall feeling) on the other. This suggests that suffering differs from other "feelings" not in kind but by the degree of its disagreeableness.

Tate objects that Mayerfeld's view "flouts ordinary language" by conceiving of suffering as a mere feeling and "stretches the concept beyond intelligibility" by applying it to everything from the experience of torture to a child's experience of having a meltdown as a result of a missed nap.[21] Another issue with feeling-based views is their apparent inability to make sense of experiences that simultaneously involve

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

both disagreeableness and enjoyment. Consider the experiences of a deep-tissue massage, watching a scary movie, running a marathon, or fasting for a religious holiday. All involve some form of disagreeableness—pain, fear, exhaustion, hunger. Yet people seek them out for their perceived benefits, meaningfulness, or (paradoxically) pleasure. This being so, we might think it strange to describe such experiences as involving suffering.

Value-based theories accommodate this complexity by proposing that subjective experiential states are necessary, but not sufficient, for suffering. Prominent among such views is Eric Cassell's, which holds that suffering is a "state of severe distress associated with events that threaten in intactness of a person."[22] Unlike flourishing-based theories, Cassell's view requires some degree of awareness on the part of the sufferer, at least enough for them to experience an emotional state plausibly regarded as distress. And unlike feeling-based theories, distress alone is not enough. It must be in response to some perceived threat to one's "wholeness," "self-identity," "integrity," or "continued existence";[23] it must stem from an "impending destruction of the person" or "threat of disintegration."[24] Michael Brady's theory brings Cassell's general idea down to earth. Suffering, he states, is "unpleasantness that we mind," where 'unpleasantness' is a negative affective experience (physical or mental) and to 'mind' something is to have an occurrent desire that the negative affective experience not be occurring.[25]

These theories capture the intuition that suffering cannot be reduced to pain, distress, or disagreeable feeling alone. But they risk being overly exclusive by requiring attributes or capacities that only cognitively typical adult human beings seem to possess. If suffering requires something like the ability to perceive threats to the self or form occurrent desires about one's experiences, then suffering would seem unavailable to (say) human infants or non-human animals. Insofar as we think such beings do possess a capacity for suffering, we should seek a theory that is more inclusive of them.

My proposal below tweaks the value-based theories of Cassell and Brady with this aim in mind. Although I am unable to provide a full defense of it here, I will present a sketch of the view before proceeding to the next section, in the hope that the discussion of suffering in the context of intellectual (dis)ability will contain some insights irrespective of whether one endorses my rough account of suffering.

On my view, suffering comprises two elements:

(1) a negatively valanced phenomenal experience

and

(2) an inability to make meaning of the experience

A negatively valanced phenomenal experience is a first-order response to a stimulus indicating that the stimulus is somehow distressing, unpleasant, or disfavored. 'Making meaning' refers to a second-order process of situating a first-order negative experience in a context that allows for a reevaluation of the negative aspects of the experience that renders them either less bad or not bad at all. There are two ways in which one can fail to make meaning of an experience. The first is to lack the developmental or intellectual capacity to do so (as might be the case, for example, when a young child is unable to understand that the pain of being vaccinated is accompanied by significant health benefits). The second is to possess the relevant capacity yet have an experience of which there is no meaning to be made (as might be the case, for example, when the individual is the victim of a random act of violence).

Unlike other values-based theories, which specify abilities required to render an experience suffering, this account proposes that suffering results from an *in*ability—namely, an inability to make meaning of a negative experience. This offers a more straightforward explanation as to how beings with limited capacities can be said to suffer since negative experiences are rendered instances of suffering as a matter of default. Consider the experience of being submerged in freezing water. Any value-based account can explain why this experience does not amount to suffering for those who seek it out, such as the Polar Plungers seen every winter morning standing neck-deep in the icy lake near my house. The Plungers do not mind the pain of the icy water (see Brady[26]) or view it as a threat to their integrity (see Cassell[27]); to

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

the contrary, they revel in the discomfort and extoll the activity's benefits. But only my view can explain why, for example, submerging an infant in freezing water would cause the infant to suffer: the infant cannot make meaning of the negative elements of the experience.

Of course, this account will not satisfy those who think that subjective evaluations of experience are irrelevant to determinations of suffering, or those who maintain that (say) childbirth involves suffering rather than "mere" pain. It also risks being interpreted as a "grin and bear it" cliché, imploring those who suffer simply to "look on the bright side." This is not at all what is intended. Instead, I ask whether someone experiencing a negative experience can understand it in a way that makes the experience worthwhile. There is much more that could be said here; but, assuming the view has been well-enough described, we proceed to a discussion of the relationship between suffering and intellectual (dis)ability.

Intellectual Disability

Licia Carlson identifies a cruel irony in the way those with ID are thought to suffer, which she refers to as the "double negation of worth."[28]

> On the one hand, persons with intellectual disabilities, by virtue of their condition, are assumed to be doomed to a life of suffering, and therefore their lives are not worth living. On the other hand, because some individuals are assumed to be so impaired that they *cannot* suffer, their lives are considered to have less value.[29]

This analysis lays bare the complex relationship between ID and suffering, as well as the ways it might be misconstrued. What is the right way to think about this relationship? How can we avoid the twin traps of pity and dismissal, while at the same time acknowledging the very real challenges those with ID face? To begin, let us get clear on what ID is.

There is a long and sordid history of attempting to classify and diagnose those seen as having deficits in intelligence. From 'feeblemindedness' to 'mental retardation,' diagnostic criteria and preferred terminology have changed. The current term of art is 'intellectual disability,' which the American Association on Intellectual and Developmental Disabilities (AAIDD) defines as "a condition characterized by significant limitations in both intellectual functioning and adaptive behavior that originates before the age of 22."

This definition reflects the tripartite conception of ID seen in DSM-5[30] and ICD-11,[31] both of whose descriptions reference intellectual functioning, adaptive functioning, and timing of onset. Intellectual functioning—which comprises mental abilities including reasoning, planning, problem-solving, and abstract thinking—is assessed with standardized intelligence testing. Those scoring two standard deviations below the mean (typically an IQ of ≤70) are considered to have a significant deficit in this domain.

Standardized testing is also used to assess adaptive functioning, which involves practical skills such as those related to communication and activities of daily living. DSM-5 and ICD-11 do not specify a precise age of onset requirement but note that deficits must occur during the developmental period (i.e., infancy, childhood, or adolescence). Common causes of ID include fetal alcohol syndrome, Down syndrome, and Fragile X syndrome—though in many cases its etiology is unknown. An estimated 1% of the population has ID.[32,33]

ID is frequently differentiated by severity. In DSM-IV,[34] for example, severity is determined by IQ, from *mild* to *moderate* to *severe* to *profound.* DSM-5 preserves these categories, but instead makes designations according to adaptive skills, ranging from "can live independently with minimal levels of support" to "requires 24-hour care." Of course, there remains heterogeneity among those diagnosed at a given level of ID, and nosology inevitably involves some degree of arbitrariness. However, the idea behind sorting by severity is to make the diagnosis of ID more predictive and useful for providing social support and intervention.

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

What does this tell us about someone's capacity for suffering? Recall Carlson's idea: some see people with ID as suffering hopelessly, while others see them as not capable of suffering at all. If ID leaves one more susceptible to suffering, then it is plausible to think that, the more severe an individual's ID, the more likely they are to suffer. This would suggest that intellectual functioning is inversely proportional to suffering: less intellectual ability, more suffering; more intellectual ability; less suffering. Alternatively, we might think that intellectual functioning is directly proportional to suffering, with higher levels of intellectual functioning leaving one more susceptible to suffering. While neither of these polar positions is plausible, considering them together does reveal something important about how intellectual ability interacts with suffering: it cuts both ways.

According to the account of suffering sketched in the previous section, suffering results when an individual has a negatively valanced phenomenal experience and is unable to make sense of the experience in a way that renders it worthwhile. This process of meaning-making plausibly involves non- or quasi-intellectual capacities, such as disposition and emotional resonance with others. Yet it also involves intellectual capacities, such as contextual understanding and means-end reasoning. With intellectual ability in mind, let us consider the ways in which those with higher levels of intellectual functioning may experience less suffering.

Compare two cases of open-heart surgery, one involving an infant and the other an intellectually typical adult. We can stipulate the facts of the cases such that the brute first-order negatively valanced phenomenal experience—call it 'pain'—are identical for both the infant and the adult. But the adult's ability to make meaning of the experience, to understand that the pain is necessary to receive the greater benefit of improved health, diminishes his suffering. It may be that this diminution is great enough that his experience is best described as "pain without suffering"; or perhaps he still suffers, but to a lesser extent. Either way, his level of intellectual functioning results in less suffering than that of the infant who experiences equivalent pain. The infant's limited intellectual functioning leaves her unable to appreciate the benefits of the surgery, to foresee the harm that would befall her if she never had it, and to understand that the pain she is feeling will subside over time. This is one reason that the distress of infants is so heartbreaking to witness.

The same can be said of individuals whose ID interferes with their ability to make meaning of negative experiences. This ability comes in degrees, which means that someone with a more severe ID will generally be less able to make meaning than someone with a less severe ID. In this sense, ID can leave the person more susceptible to suffering. Note, however, that it does not follow that those with ID *in fact* suffer more, since this depends upon what experiences they end up having.

A related, and more straightforward way, that ID has the potential to increase suffering is by limiting adaptive skills that can aid in navigating, or altogether avoiding negative experiences. Consider the experience of loneliness. Those ID has impaired their social skills might find it more difficult to form relationships with others than those with stronger social skills. Again, this is not meant to be an empirical prediction or a causal claim, since loneliness plausibly has more to do with social environment than ability.

So far, we have seen how intellectual ability can reduce suffering (and how ID can increase it). Yet it is also the case that suffering may *increase* along with intellectual ability. While intellect improves an individual's capacity for making meaning of negative experiences, it may also expand the range and depth of their negative experiences. For example, an intellectually typical adult may experience dread when considering some future occurrence (perhaps leading to *anticipatory* suffering) or experience shame when remembering some past debacle (perhaps leading to *retrospective* suffering) or experience fear when realizing that a negative experience portends additional suffering, as when a pain is recognized as a recurrence of cancer (perhaps leading to *compounding* suffering). We can likewise imagine *existential* suffering caused by reflection on the troubling state of the person's self, or country, or planet; and *proxy* suffering caused by witnessing suffering in another. Not so for an infant. And perhaps less so with some people with ID.

Higher intellectual functioning may also result in a broader range of interests whose frustration generates suffering. To use van Hooft's language, it is often easier to satisfy the biological and appetitive aspects of our nature than the deliberative and contemplative aspects. If someone's level of intellectual

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

functioning is such that they have fewer deliberative or contemplative interests, then their interests are more likely to be satisfied (all else equal with respect to social context).

Note, however, that the pitfalls of higher intellectual functioning can affect those with ID as well. Those with less severe ID may find that their interests and ambitions outstrip some of their adaptive abilities and social supports. As Carlson notes, "many individuals with mild intellectual disabilities indicate that the dynamics of social exclusion, marginalization, and inability to lead a 'normal life' contribute significantly to the suffering they experience."[35]

The idea that intellectual function can contribute to suffering is supported by data from those with acquired—as opposed to congenital—intellectual impairments. In patients with neurodegenerative diseases, for example, depression is more common in the early stages than the later.[36] So, too, with patients diagnosed with schizophrenia, who more commonly die by suicide in the earliest stages of the illness.[37] Other factors—such as adaptive preferences—may explain these data. But it is plausible to suppose that there is something about the presence of higher intellectual functioning in these patients that makes them more prone to suffering.

Beyond the possibility of broadening one's range of interests, higher levels of intellectual functioning can increase the *depth* of a negative experience. Imagine an intellectually typical adult experiencing physical abuse at the hands of a family member. The experience involves physical pain. But there are many other ways in which the experience is distressing. It may involve feelings of betrayal, anger, and unsafety; it may trigger self-loathing and mistrust; it may result in lifelong trauma that impacts future relationships and mental health. At least part of what will determine how they experience the abuse is their level of intellectual functioning.

This feature of intellectual functioning acts as the inverse of meaning-making. In the heart surgery example, the adult patient's intellect lessens his suffering by placing the pain he experiences in a context that makes it worthwhile. In the abuse example, intellect has the opposite effect. Not only is the victim unable to make meaning of the experience; her understanding of the context of the experience deepens the extent to which it is distressing. Intellectual ability, then, has an amplifying effect in both directions: it allows us to make meaning of negative experiences, thereby reducing the associated suffering; and it adds depth to the distress of negative experiences, thereby increasing the associated suffering.

Intellectual functioning, then, does not contribute to suffering either proportionally or inversely proportionally. So we cannot conclude from the fact that someone has ID, or from its severity, that they are more susceptible to suffering than those without ID, or those with less severe ID. Those with ID are susceptible to suffering insofar as they are less able to make meaning of their negatively valanced phenomenal experiences and less equipped with adaptive skills to avoid such experiences. Those with typical intellectual functioning, by contrast, are susceptible to suffering insofar as they have a broader range of interests to be frustrated and the tendency to frame negative experiences in a way that deepens their negativity.

Conclusion

The result of this analysis, I believe, is that individuals with *marginal* intellectual functioning are most susceptible to the suffering of all, *ceteris paribus*. Imagine someone with enough intellectual functioning to have a wide range of interests, yet lacking in meaning-making abilities and adaptive skills. Such a person is vulnerable in both directions. While what counts as "marginal" intellectual functioning is open to interpretation, and may vary by context, the point again is that there is no neat relationship between the level of intellectual functioning and susceptibility to suffering.

If I may end on an autobiographical note, the above has led me to reflect upon a remark that my mother made about my brother—who has Cornelia de Lange syndrome, autism, and ID—that I previously found puzzling: "I am so grateful that he is not higher functioning." Why would that not be a good thing?, I used to think. I now see what she meant. My brother's intellectual functioning, in the context of his robust social support network, is such that his interests can be satisfied more easily than if his ambitions outstripped his abilities.

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

So we see that both of Carlson's aforementioned targets are mistaken. It is not the case that those with ID are destined to a life of suffering; and it is not the case that suffering is altogether unavailable to them. Instead, the relationship between intellectual functioning and suffering is complex and multifaceted. What is clear is that ID influences how one understands their experiences. This, in turn, influences the extent and nature of their suffering.

Notes

1. Bentham J. *An Introduction to the Principles of Morals and Legislation*. London, England: W. Pickering; 1789.
2. McMahan J. Causing disabled people to exist and causing people to be disabled. *Ethics* 2005;**116**(1):77–99.
3. Barnes E. Disability, minority, and difference. *Journal of Applied Philosophy* 2009;**26**(4):337–55.
4. Harris J. Clones, *Genes and Immortality*. New York, NY: Oxford University Press; 1998.
5. Mitchell D, Snyder S. The eugenic Atlantic: Race, disability, and the making of an international eugenic science, 1800–1945. *Disability & Society* 2003;**18**(7):843–64.
6. Reynolds JM. *The Life Worth Living: Disability, Pain, and Morality*. Minneapolis, MD: University of Minnesota Press; 2022.
7. Fogden BC, Thomas SD, Daffern M, Ogloff JR. Crime and victimisation in people with intellectual disability: A case linkage study. *BMC Psychiatry* 2016;**16**:1–9.
8. Tomsa R, Gutu S, Cojocaru D, Gutiérrez-Bermejo B, Flores N, Jenaro C. Prevalence of sexual abuse in adults with intellectual disability: Systematic review and meta-analysis. *International Journal of Environmental Research and Public Health* 2021;**18**(4):1980.
9. Fisher MH, Baird JV, Currey AD, Hodapp RM. Victimisation and social vulnerability of adults with intellectual disability: A review of research extending beyond Wilson and Brewer. *Australian Psychologist* 2016;**51**(2):114–27.
10. Braddock DL, Parish SL. An institutional history of disability. In: Albrech G, Seelman K, Bury M, eds. *Handbook of Disability Studies*. Thousand Oaks, CA: SAGE Publications; 2001:11–68.
11. Rowlands S, Amy J-J. Sterilization of those with intellectual disability: Evolution from non-consensual interventions to strict safeguards. *Journal of Intellectual Disabilities* 2019;**23**(2):233–49.
12. Torres R, Puig J. Lesch–Nyhan syndrome. *Drugs of the Future* 2010;**35**(5):421–7.
13. Skotko BG, Levine SP, Goldstein R. Self-perceptions from people with Down syndrome. *American Journal of Medical Genetics Part A* 2011;**155**(10):2360–9.
14. Kious BM. Three kinds of suffering and their relative moral significance. *Bioethics* 2022;**36**(6):621–7.
15. Van Hooft S. Suffering and the goals of medicine. *Medicine, Health Care and Philosophy* 1998;**1**(2):125–31.
16. See note 15, Van Hooft 1998:127.
17. Tate T, Pearlman R. What we mean when we talk about suffering—and why Eric Cassell should not have the last word. *Perspectives in Biology and Medicine* 2019;**62**(1):95–110.
18. Tate T. What we talk about when we talk about pediatric suffering. In: Tate T, ed. *Philosophical Investigations into the Essence of Pediatric Suffering*. Dordrecht, NL: Springer; 2022:7–27.
19. See note 21, Tate 2020:158.
20. Mayerfeld J. *Suffering and Moral Responsibility*. New York, NY: Oxford University Press; 1999.
21. Tate T. What we talk about when we talk about pediatric suffering. *Theoretical Medicine and Bioethics* 2020;**41**(4):143–63.
22. Cassell EJ. The nature of suffering and the goals of medicine. *New England Journal of Medicine* 1982;**306**(11):639–45.
23. Cassell EJ. Recognizing suffering. Hastings Center Report 1991;**21**(3):24–31.
24. See note 21, Cassell 1982:640.
25. Brady MS. *Suffering and Virtue*. New York, NY: Oxford University Press; 2018.
26. See note 25, Brady 2018.

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press

27. See note 22, Cassell 1982.
28. Carlson L. *The Faces of Intellectual Disability: Philosophical Reflections*. Bloomington, IN: Indiana University Press; 2009:184.
29. See note 28, Carlson 2009:184.
30. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. 5th ed. Washington, DC: American Psychiatric Association; 2013.
31. World Health Organization. *International Statistical Classification of Diseases and Related Health Problems, 11th Revision (ICD-11)*; 2019.
32. Maulik PK, Mascarenhas MN, Mathers CD, Dua T, Saxena S. Prevalence of intellectual disability: A meta-analysis of population-based studies. *Research in Developmental Disabilities* 2011;**32**(2):419–36.
33. McKenzie K, Milton M, Smith G, Ouellette-Kuntz H. Systematic review of the prevalence and incidence of intellectual disabilities: Current trends and issues. *Current Developmental Disorders Reports* 2016;**3**:104–15.
34. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*. 4th ed. Washington, DC: American Psychiatric Association; 2000.
35. See note 28, Carlson 2009:169.
36. Liu M, Xie X, Xie J, Tian S, Du X, Feng H, et al. Early-onset Alzheimer's disease with depression as the first symptom: A case report with literature review. *Frontiers in Psychiatry* 2023;**14**:1192562.
37. Ventriglio A, Gentile A, Bonfitto I, Stella E, Mari M, Steardo L, et al. Suicide in the early stage of schizophrenia. *Frontiers in Psychiatry* 2016;**7**:116.

Cite this article: Nelson RH (2026). Suffering and Intellectual (Dis)Ability. *Cambridge Quarterly of Healthcare Ethics* 35: 40–47, doi:10.1017/S0963180125000088

https://doi.org/10.1017/S0963180125000088 Published online by Cambridge University Press