

## The role of functional disability in psychiatric classification

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### Abstract

*Psychiatric functioning and disability have historically been considered separate from the broader disability field and have been measured differently than other medical conditions.*

*This paper provides an overview of the current concepts and international advances in the classification of psychiatric disability and explores the controversies and goals within the proposed systems.*

*It highlights key aspects of the role of disability and functioning in major psychiatric classification systems (including ICD-10/ICF, DSM-IV) and international programmes such as the Institutional Program for Psychiatry for the Person (IPPP) of the World Psychiatric Association. It stresses key studies on the impact of psychiatric illness in the overall functioning of individuals. Narrative review of studies providing details of key aspects of controversial issues is presented throughout the article.*

*ADL (Activities of Daily Living) and ICF (International Classification of Functioning) are two different models of disability which have different implications for the assessment of mental disorders. Within ICF, 'environmental' and 'personal' disabilities have been defined. In mental health, disability and functioning are part of two separate and theoretically complementary classification systems: the diagnostic system and its consequences on functioning and activity. Thus, a mental disorder may be determined by the level of dysfunction, particularly in DSM.*

*Although no system currently available properly captures the complexity*

\* Received: 26 February 2010, Revised: 20 May 2010, Accepted: 24 May 2010.

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*of the assessment of disability and functioning, the ICD-10 approach is conceptually more advanced than DSM-IV. Functional disability has significant implications in the holistic classification of mental disorders, particularly in the development of the World Psychiatric Association's IPPP programme.*

**Keywords:** Mental disability, Classification, Functioning, Quality of life.

## 1. Introduction

There is a lack of international consensus on the definition of health-related functioning and disability; which is regarded as an “elusive” concept in Medicine (Leonardi, Bickenbach, Ustun, Kostanjsek, & Chatterji, 2006). However functioning and disability are domains of a key health construct to understand the relationship between the individual and the disease, where social support plays an effect modifier role (Prince, Patel, Saxena, Maselko, Phillips, & Rahman, 2007). Functional Status Indicators (FSI) provide as robust a prediction of health events as do complex comorbidity indices (Mayo, Nadeau, Levesque, Miller, Poissant, & Tamblyn, 2005), and the predictive power of disability exceeds that of clinical diagnosis in many chronic conditions. There is also a complex relationship between the construct of functioning/ disability and the construct of autonomy/dependency.

Paradoxically, modern psychiatry has paid little attention to functioning and disability relative to other medical disciplines. On the other hand, psychiatric disability has historically been considered separate from the broader disability field and it has been measured differently than in other medical conditions (Sanderson & Andrews, 2002). Recent studies using common measures have shown the impact of psychiatric disability compared to other causes of persistent functional impairment (Sanderson *et al.*, 2002; Alptekin, Erkok, Gogus, Kultur, Mete, Uçok *et al.*, 2005). Mental disorders are a significant cause of disability and related global burden of disease. A 2005 report from the World Health Organization (WHO) on projection of the burden of disease showed that 31.7% of all years lived with disability are attributed to neuropsychiatric conditions, the four major contributors in this group being unipolar depression, alcohol abuse, schizophrenia, and bipolar depression (Mathers & Loncar, 2006). There is also a relationship between disability and use of resources; it is important to set up case-mix an other group of patients relevant to health planning (Boot, Hall & Andrews, 1997; Ruggieri, Leese, Thornicroft, Bisoffi, & Tansella, 2000). Compared to people with a physical disability, those with a mental disability require a different set of services to allow them to participate in the community and conduct their activities of daily living (Williams & Doessel, 2001).

Recent research underlines the complex interaction between mental health and disability; for example, depression is an important factor in the development and progression of disability in chronic medical conditions, while disability may influence the onset and continuance of depression (Kim, Stewart, Glozier, Prince, Yang, Shin *et al.*, 2007; Moussavi, Chatterji, Verdes, Tandon, Patel, & Ustun, 2007).

The aims of this review paper are: 1) to provide an update on the current concepts of functional impairment and disability, as well as their implications in psychiatry; 2) to review the role of functioning and disability in the main psychiatric classification systems (DSM and WHO family of classifi-

cation systems), and 3) to establish a relation between this construct and person-centred approaches in mental health and intellectual disabilities.

## 2. Methods

This review is part of the work carried out by the World Psychiatric Association (WPA) in its Institutional Program for Psychiatry for the Person (IPPP) working group to develop a person-centred approach in psychiatric diagnosis. We use an iterative process and round sessions to highlight key aspects of the major psychiatric classification systems in the area of disability such as ICD-10 (WHO, 2007), DSM-IV (APA, 2000), GLAP (Latin American Guide of Psychiatric Diagnosis - Guía Latinoamericana de Diagnóstico Psiquiátrico, APAL, 2004) and some other international efforts as well as the ICF system. The contributions made by experts in four meetings organised by the WPA-IPPP working group in 2006, 2007 and 2008 have been taken into consideration. This review stresses key studies on the impact of psychiatric illness in the overall functioning of individuals. Narrative review of studies providing detail of controversial aspects is discussed through out the article on the following key issues: 1) Conceptual framework and models of health functioning and functional disability; 2) The role of functional disability in psychiatric classification; 3) Disability in the international classification systems of mental disorders and its cultural adaptations; 4) The role of functional disability in person-centred approaches in psychiatry.

## 3. Health-related functional disability: conceptual framework and models

Two partially related but distinct models of disability coexist in Medicine; they provide divergent assessments of this construct in the mental health area. One is based on the 'Activities of Daily Living' (ADL) and it was originated in the US right after World War II to measure functioning in cancer patients and in physical rehabilitation (Karnofsky & Burchenal, 1949). The other is based on a broader concept of functional impairment. It originated at the International Classification of Impairments, Disabilities and Handicaps (ICIDH) in 1980, which gave forward to the current International Classification of Functioning, Disability and Health (ICF) (WHO, 2001).

### 3.1 *The 'Activities of Daily Living' approach to disability (ADL)*

In the 1960s, Katz (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963) and

Lawton and Brody (1969) distinguished two major groups of ADL: “basic” activities related to self-care such as eating and grooming (BADL), and “instrumental” activities such as cooking and handling money (IADL). This approach was used to develop the Katz ADL index (Katz, 1983) and the Barthel index (Barthel & Mahoney, 1965), which is still a standard rating scale to measure disability in geriatrics and other medical disciplines as well as the standard comparator to assess the psychometrics of related instruments (Dijkstra, Tiesinga, Plantinga, Veltman, & Dassen, 2005). In spite of its inconsistencies, the distinction between BADL and IADL is still deeply grounded in the medical assessment of disability (i.e. Freedman, Martin, Schoeni, & Cornman, 2008). In physical conditions ADL and ICF models may produce convergent results; whilst significant differences appear in mental disorders. In severe mental illness, high social support may be needed even when there is hardly any impairment in “basic” ADL.

The concept of ‘dependency’ or ‘care dependency’ derived from the ADL model in the early 1990s and it has provided an international framework for evaluation and care to frail population across the lifespan. For example: Japan (Takei, Takahashi, & Nakatani, 2008); Mexico (Dorantes-Mendoza, Avila-Funes, Mejía-Arango, & Gutiérrez-Robledo, 2007), the US (Freedman *et al.*, 2008), or the European Union. In 1998, the European Council made a recommendation to European Union member states to develop care for dependent population (persons with severe disability and need of support from a third person) based on the ADL approach. However, this approach has shown problems for international comparability (European Commission, 2003) and for the development of eligibility criteria which include severe mental illness. It is important to note that the term “dependency” is not mentioned in ICF.

Furthermore, severe impairment of functioning and high need of support in psychiatric disorders may not be mediated by ADL, but directly caused by symptoms and behavioural problems (i.e. monitoring due to suicidal thoughts or non-adherence related to lack of insight).

### 3.2 The WHO ‘Environmental’ approach to ‘functional disability’

Experience derived from the 1980 WHO International Classification of Impairment, Disability and Handicap (ICIDH), shifted the relationship of health and functioning from the consequences of a disease or condition to the result of complex interactions among the individual, the environment and the disease or condition. The new International Classification of Functioning, Disabilities and Health (ICF) (WHO, 2001) was designed taking into consideration this biopsychosocial/integrative approach (Stucki & Cieza, 2004). This system comprises three main components: body functions and structures, activities and participation, and environmental factors.

The ‘environmental factors’ make up the physical, social and attitudinal environment in which people live and conduct their lives. They are external

to persons and can have a positive or negative influence on the individual's performance as a member of society, on the individual's capacity to execute actions or tasks, or on the individual's body function or structure. These factors are organized in the classification to focus on two different levels:

(a) Individual – in the immediate environment of the person, including settings such as home, workplace and school. Included at this level are the physical and material features of the environment that an individual comes face to face with, as well as direct contact with others such as family, acquaintances, peers and strangers.

(b) Societal – formal and informal social structures, services and overarching approaches or systems in the community or society that have an impact on individuals (organizations and services related to the work environment, community activities, government agencies, communication and transportation services, and informal social networks).

The ICF contextual factor section includes a fourth component called 'personal factors' (WHO, 2001). It comprises individual characteristics such as age, sex, social class, life experiences, etc, which are not included in ICF. ICF argues that it has not classified them due to the large cultural variance associated with these factors.

As it is well known, the WHO definition of disability is based on the codification of deficits, limitation of activities and restriction of participation (WHO, 2001). A group of expert have developed an operational definition based on the ICF model. According to the MHADIE group (Measuring Health And Disability In Europe), "disability is a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors" (Leonardi *et al.*, 2006).

Here disability is linked to global functioning while in the ADL model it was linked to impairment in a reduced set of activities of daily living. In ICF, "functioning" is defined as a generic term which includes body functions and structures, activities and participation. It indicates the positive aspects of the interaction between the individual (with a health condition) and its context factors (*personal and environmental factors*).

Although ICF is accepted internationally as a groundbreaking and comprehensive system, several criticisms have been posed. Critics refer mainly to 1) Overall usability of the system, 2) Distinction between activity and participation, 3) Distinction between capacity and performance, 4) Need of additional qualifiers (volition and self-efficacy).

### *Overall usability / feasibility and related instruments*

The applicability of the ICF in routine clinical practice is also a major debating point among experts. A series of initiatives have been put forward to improve the usability of ICF. A version has been developed for children

and adolescents (ICF-CY). The Mini-ICF-P is a short observer rating instrument for the assessment of disabilities, especially with regard to occupational functioning. It provides a short assessment of the following dimensions (1) adherence to rules and regulations, (2) structuring of time and day, (3) flexibility, (4) competency, (5) endurance, (6) assertiveness, (7) contact with others, (8) public exposure, (9) intimacy, (10) non-work activities, (11) self maintenance, (12) mobility (Linden & Baron, 2005).

A ICF check-list and ICF Core sets are also available for an increasing number of diseases. Core sets are subgroups of ICF items selected to capture those aspects of functioning that are most likely to be affected by specific disorders. Within a given disorder, both Brief and Comprehensive Core Sets can be established to serve specific purposes. About a dozen chronic conditions, including depression (Cieza, Chatterji, Andersen, Cantista, Herceg, Melvin, 2004) and bipolar disorders (Vieta, Cieza, Stucki, Chatterji, Nieto, Sánchez-Moreno *et al.*, 2007), have been categorized using the principles of ICF. There are also efforts to develop a generic ICF core set. Its proponents argue that although the specific core sets are useful for describing particular conditions, the generic set will be valuable to compare across health conditions, serving as a common language based on the principle of etiologic neutrality (Cieza, Geyh, Chatterji, Kostanjsek, Ustün, & Stucki, 2006).

Others propose that addressing facilitators and barriers may help experts to guide priorities for interventions. Linking interventions to aspects of participation valued by the patient/client seem to make a very real difference in promoting engagement in processes like goals and goal setting (Siegert, McPherson, & Taylor, 2004).

### *Distinction between activity and participation*

WHO declares that it is difficult to distinguish activity from participation and uses the same “d” code for both. It says that these domains can be used either together or separate. This choice produces a critical taxonomic problem in any classification system, and it may reflect tension between experts in the field, and family and user organizations during the development process of the ICF.

### *Distinction between capacity/performance*

WHO also admits that the capacity/performance distinction may be hard to formulate in practice. The on-going MHADIE study may provide useful information on this issue.

### *Additional qualifiers to ICF*

Nonderfelt (2006) argues that the ICF manual includes too much in health and at the same time, some of its contents lie outside the proper domain of health. He proposes the incorporation of an “opportunity qualifier” and emphasises that when assessing the holistic health of a person in a par-

ticular situation, what should be determined is normally not the actual ‘performance’ of a specific action but the ‘ability’ to perform this action in the situation in question. In this case *will* is playing a role in the whole process.

Others proposed that *opportunity* ‘per se’ is not enough and that including other qualifiers from existing assessment tools could be beneficial for a more comprehensive evaluation. For example, the Quality of Life Profile (QLP) incorporates a number of qualifiers for each of its questions including *importance* and *satisfaction*, with a qualifier for each domain of *opportunity* and *control*. This adds a very valuable depth to understanding an individual’s health and function that would be missing if considering *opportunity* as the only qualifier (McPherson, 2006).

De Kleijn-Vrankrijker (2006) posits the need of a *will qualifier* and to find out how to apply it to the capacity and performance qualifiers. In some of the classes in ICF, the term “purposeful” is used which implies some will in the meaning of the force that is driving a person to do or not to do something.

#### 4. Disability in the classification systems of mental disorders

The relationship between the disorder per-se and its consequences remain unsolved in psychiatric nosology. Mental health is the only area of diagnosis in which disability/impairment are not just consequences of disease (coded as ICF) but a key diagnostic domain (coded in ICD-10). For example, Mental Retardation/Intellectual disability is a single entity or condition, which is classified at the same time in both systems (Salvador-Carulla & Bertelli, 2008). Functional impairment is not only regarded as a consequence of a disorder but also a key criterion for providing a standard diagnostic coding in depression. Therefore, disability and functioning are at the same time part of two separate and theoretically complementary classification systems: the diagnostic system and its consequences on functioning and activity. This overlapping of criteria in current classification systems has not been addressed properly.

##### 4.1 Role of functioning/disability in DSM

In DSM the classification of disorders is provided in Axis I and II, whilst their consequences are measured as a global activity index in Axis V. However, a major overlapping exists across both coding domains, as impairment of activity/functioning has been incorporated as a main diagnostic criterion in all major psychiatric disorders. For example, the ‘B’ criterion for schizophrenia states: “For a significant portion of time one or major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset”. This criterion implies an associa-



tion between axis I and axis V which is based on the Global Assessment of Functioning (GAF) (Goldman, Skodol, & Lave, 1992). Another example is the 'C' criterion for major depressive disorder: 'The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning'. This criterion shows that a decrease in GAF scores should be expected for patients with major depressive disorder. For axis II, a relation to GAF scores can be expected as well. The 'C' criterion for personality disorder in DSM-IV-TR (2) focuses on an 'enduring pattern' that 'leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning' (Lehman, Alexopoulos, Goldman, Jeste, & Üstün, 2002; Tungstrom, Soderberg, & Armelius, 2005).

Axis V represents the GAF scale in which the clinicians judge patients' overall levels of functioning during a particular time. Functioning is considered a composite of three major areas: social functioning, occupational functioning, and psychological functioning. The GAF scale, based on a continuum mental health and mental illness, is a 100-point scale, 100 representing the highest level in all areas. Results of research in the areas of validity and clinical use of DSM components are some of the reasons for the local and international efforts to improve this system. The work on how and where to implement the necessary upgrades and corrections of this model in several of its structural aspects including the domains of disability and functioning began several years ago and has cumulated a significant literature including a special section in *Psychiatric Services* (Goldman, 2005). The combination of symptoms and functioning in the same scale makes the measuring of functional impairment itself inaccurate (Kupfer, First, & Regier, 2002). A separate assessment of functioning was suggested and the DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS) was developed to overcome this problem although its overall reliability for functional assessment provided poor results in several studies (Roy-Byrne, Dagadakis, Unutzer, & Ries, 1996; Janca, 2001).

By requiring the presence of impairment before a psychiatric diagnosis can be made, the possibility of intervening early in the disease will be jeopardized. However, the dilemma is that given the limited resources and the need for equity regarding who gains access to services, the threshold for a specific condition to be considered a mental disorder should ultimately be determined by the level of dysfunction. An expanded assessment of functioning/activities has been suggested in DSM-V (First & Westen, 2007).

#### *4.2 Role of functioning/disability in ICD-10 (Mental and Behavioral Disorders)*

The weight of the functioning/disability domain in psychiatric diagnosis is lower in ICD-10 (WHO, 2007a) than in DSM, as it is mainly used for subclassification of disorders according to severity. For example, distinction between mild depressive episode (F32.0) and moderate depressive episode

(F32.1) depends on the ‘difficulty in continuing with ordinary activities’. Recent international studies provide evidence that even when using minimum criteria set in ICD-10 to make a diagnosis of depressive episode, those who met the criteria had disability comparable to other chronic conditions. When depression is comorbid with physical illnesses it makes the disability significantly worse (Moussavi *et al.*, 2007).

The International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders recommended against having functional impairment/ disability as part of the inclusion criteria for any specific disorder, as it is generally relatively non-specific with respect to diagnosis. The Advisory Group also suggested to provide definitions of functional impairment and disability that are consistent with the International Classification of Functioning, Disability and Health (ICF) and refer readers to the ICF for additional information on the classification of functional status. The Advisory Group recommended that any material deemed necessary about functional impairment and functional thresholds be included as part of the material generated for specific disorders or broader groups of disorders and that such material make use of the ICF framework. The group also recognized that the construct of disability is culturally embedded and it should be considered as a part of any formulation (WHO, 2007b).

To be used alongside ICD-10 classification of mental disorders, the evaluation of disability has been adapted from ICF in several ways. First, an axis on functional disability was included at the Multiaxial Presentation of the ICD-10 for use in adult psychiatry. This Axis II of ICD was conceptualized in accordance with the principles of the International Classification of Impairments, Disabilities and Handicaps (ICIDH) and it served to rate disabilities in relation to the tasks and roles expected from the individual in his/her socio-cultural setting. This axis covers specific areas of functioning clustered in four main categories: Personal Care, Occupation, Family and household, and Functioning in a broader Social Context. These four categories contain subcategories adding to 14 areas of functioning. Originally, these areas were measured using the WHO Short Disability Assessment Schedule which showed modest reliability results (Janca, Kastrup, Katschnig, López-Ibor, Mezzich, & Sartorius, 1996a; Janca, Kastrup, Katschnig, López-Ibor, Mezzich, & Sartorius 1996b; Janca Ahern, & Rock, 2001).

Second, a new and expanded version of the WHO Disability Assessment Schedule (WHODAS-II) was developed to assess disability in any medical condition, worldwide, including mental health disorders following the ICF approach (Kim *et al.*, 2005). MHADIE study is collecting data on disability across different conditions. When completed we may obtain a better understanding of the relationship of mental disorders and disability, and the differences in ADL domains between mental disorders and other medical diseases (Nieto-Moreno, Gimeno Blanco, Adan, Garcia-Olmos, Valle, Chatterji *et al.*, 2006).

Third, ICF core sets for psychiatric disorders are being developed. For example, the Brief ICF Core Set for depression included a total of 31 categories out from an initial set of 323; with 9 on body functions, 12 on activities and participation and 10 on environmental factors. A core set for bipolar disorders has also been developed (Vieta *et al.*, 2007).

#### *4.3 Cultural adaptations: Disability in IGDA, GLADP and CCMD*

The International Guidelines for Diagnostic Assessment (IGDA) (IGDA Workgroup, 2003) and its Latin-American version: ‘Guía Latinoamericana de Diagnóstico Psiquiátrico’ (GLADP) (Berganza, Mezzich, & Jorge, 2002), both contain adaptations of the concepts established in Axis II of ICD-10. Section 6 of IGDA comprises items concerning functioning, social context, cultural framework and quality of life. These guidelines involve a new comprehensive diagnostic model that articulates a standardized multi-axial evaluation with a personalized idiographic one. The corresponding recommendations concerning the conceptualization and formulation of a comprehensive diagnostic statement are the matter of Sections 7 and 8. Section 7 focuses on the standardized multi-axial formulation, involving clinical disorders, disabilities, contextual factors, and, as a new axis, quality of life (Berganza *et al.*, 2002). During the last years this approach has been expanded to other areas of medicine and it has incorporated the construct functioning/disability as one of the main components of the “Person Centered Diagnosis” model (Saloum & Mezzich, 2010; Salvador-Carulla & Gasca, 2010).

GLADP contemplates in its axis II, areas and degree of disability in four different categories (personal care, occupational functioning, family functioning and social functioning in general). Disability can be a consequence of medical or mental illness, the affected areas and degrees are to be coded in this axis, while its causes are coded in axis I (APAL, 2004). This axis corresponds to axis II of ICD-10 and axis V of DSM-IV. Studies to measure the validity of IGDA are taking place in several countries of Latin America.

The Chinese Classification of Mental Disorders, 3<sup>rd</sup> revision (CCMD-3) is an ethnomedical classification grounded in symptomatology and etiology (Chen, 2002). It incorporates impairment of functioning in the diagnosis of several culture-bound disorders, following an approach closer to DSM than to ICD.

#### *4.4 The role of disability/functioning in person-centered approaches*

##### *Classification of the American Association of Intellectual and Developmental Disabilities*

Within mental health, the field of Intellectual Disabilities has developed a long-standing experience in the use of the “positive appraisal” model. In 1992, the classification system developed by the American Association of Intellectual and Developmental Disabilities (AAIDD; formerly called

AAMR for ‘Mental Retardation’) released a classification system which provided specific dimension to assess the “adaptive behaviour” in Intellectual Disabilities -Dimension II: Adaptive behaviour (Conceptual, social and practical skills) - (AAMR, 2002). The 11<sup>th</sup> edition of the AAIDD classification follows the same model (AAIDD, 2010). It includes 3 domains, 16 types, and 26 skills. The AAIDD/AAMR classification also provides a system to evaluate the level or intensity of support needs and the planning process to implement these supports. Although this classification system implied a major conceptual advance, its usability and feasibility has been relatively low for routine practice and administration purposes.

### *Institutional Program for Psychiatry for the Person (IPPP)*

The World Psychiatric Association (WPA) has developed the IPPP Program and a related Person-centred Integrative Diagnosis (PID). This WPA taskforce is working to provide a new framework to ascertain the role and the weight of disability and functioning in the psychiatric evaluation process (Mezzich, 2007). For the construction of PID the WPA group is paying close attention to the following key points: First, the informational domains to include, of course illnesses, but perhaps also disabilities, health related problems and positive aspects of health. Second, the descriptive tools to be employed, such as categorizations (classical and probabilistic), dimensions, and narratives. Third, the evaluators, including patients, clinicians, scientific experts, family, caregivers and pertinent community figures. Contributions to consider in the development of PID Functioning and Disability component come from many areas of intense growth: the “recovery movement”, i.e. a model of care based on improving the coping and inner resources of the individual working together with other patients and other stakeholders (Anthony, 1993; Slade, 2009, 2010); the rehabilitation field; the integration of health and social services movement; and the flourishing of quality of life and protective factors as key elements in comprehensive diagnosis.

IPPP emphasizes the public health component of a psychiatry for the person. A number of papers have provided evidence of the relationship between disability and use of resources. Therefore, disability and functioning are relevant to set up case-mix and other groups of patients relevant to health planning (Boot *et al.*, 1997, Ruggeri *et al.*, 2000). Compared to people with a physical disability, those with a mental disability require a different set of services to allow them to participate in the community and conduct their activities of daily living (Williams *et al.*, 2001). Again, the role of disability in case-mix development shows peculiarities in mental health that are not seen in other medical conditions.

The IPPP model also underlines the value of positive functioning and resilience in the assessment of mental health. Concepts such as adaptive functioning and adaptive behaviour, autonomy, capacity, skills, abilities should be revised an adapted to mental health.

## 5. Discussion

### *Functional disability and related concepts*

The concept of health is dynamic, complex and closely linked to functioning. Many environmental and personal factors influence health and functioning. To date there has been very little debate on the differences between the ADL and the ICF approaches to health-related functioning and disability; given their consequences in the assessment and care of severe mental illnesses. Even more surprising is the little interest shown by psychiatry in the operational conceptualisation of psychiatric disability and its implications for psychiatric diagnosis.

Health-related disabilities may be conceptualised by two different systems: ADL disability (based on ADL approach) and functional or contextual disability (based on the WHO approach). Functional disability may be further divided into ‘environmental disability’ and ‘personal disability’, although only functional environmental disability is classified and coded at the ICF.

The conceptual background of the WHO-ICF approach has a broader perspective and it allows a better description of the functional impairment related to mental disorders. Following the logic of WHO terminology, ‘health-related environmental functioning’ may be defined as the capacity of an individual to live independently in the community with little or no help from others (high autonomy); while health-related disability may be defined as a persistent impairment of environmental functioning.

To date, no classification has been provided of functional or contextual personal disability. Three provisional categories or dimensions have been suggested in this area: Scene-setting personal factors, potentially modifiable personal factors and social relationships (Badley, 2006).

The concept of ‘dependency’ or ‘care dependency’ is based on the ADL model, and it is not mentioned in the ICF. Tentatively a definition of dependency may be derived from the WHO concept of Autonomy at the Ottawa Charter and the related glossary of terms (WHO, 1998). Within this context ‘functional environmental dependency’ may be regarded as a meta-construct related to the interaction between disability, needs and support, and their implications in designing care planning and management. This definition is important to rehabilitation professionals and planners who address and resolve the instances in which people with disabilities are being prevented from engaging in a major area of life as the result of external barriers, ineffective services and supports. (Scherer, Mc Anney, & Sax, 2006).

Contrary to the rest of medical conditions, severe disability with high special needs (dependency) may not be mediated by ADL in many mental illnesses. Hence, the medical models of disability, which are based on ADL, may not fit the particularities of mental health. However, the validity of the ADL model in comparison to ICF should be explored further as some ex-

amples of the usability of the ADL approach to the assessment of dependency in psychiatric disorders have been provided (Takei *et al.*, 2008).

Three main concerns on the usability and content validity of the ICF approach relate to its feasibility, the ability/capacity distinction and the volition domain.

1. The development of new assessment tools such as the WHODAS-II, the ICF core sets and, in the future, a generic ICF set, are major steps towards improving the feasibility of ICF in routine practice.

2. The delineation between ability and capacity needs further development. Being able to do something not always result in action, patients may have the capacity but fail to perform.

3. ICF includes “lack of will” as a personal factor to cover the above type of situation. In other instances, if the patient has the capacity but external factors such as discriminatory practices prevent the performance, then, ICF includes “environmental factor” to cover for this type of situation.

The domain volition has created important debate. Philosophical theories, psychological approaches and social ideologies have taken a deep and often controversial look into the terms *volition*, *will power*, *free will* or just *will*. Even the approach of philosophers such as Nietzsche or Schopenhauer, just to name a couple, have been interpreted in multiple different ways. In the realms of our countries and current social global disparities, we continue to question how free is this *will*?, how much is determined by outside factors, like social constrains, moral rules, community expectations, and the law? Furthermore, to what extend the unconscious mind plays a role in the final step of will, that is its ‘action?’ Therefore, the simplistic approach to will and the attempts to standardize possible outcomes or behaviours has to be looked out very carefully and on a personal-environmental symbiotic manner if we want a more real and perhaps useful model.

A key factor in the process of health promotion and prevention of health conditions is *health behaviour change* and providers play a major role in it. When we talk of opportunity qualifiers, as if just *will* is the main aspect of the individual not to perform, we can inadvertently place burden and blame on the patient. Health behaviour change, as explained by some experts, takes place in stages: contemplation, intention to change, planning and action (Prochaska & Di Clemente, 1983). A major variable in this process is *health-related self-efficacy*, a variable that is not included in ICF. Clearly, health care providers can play a major role by tailoring their interventions to the level of the individual’s readiness for change in health and functioning. In this way patients feel supported and not blamed. Based on the above lines by Nieuwenhuijsen (2006), he proposes a *readiness for change qualifier*, which applies not only to the patients but also to their family members, health care providers, policy makers, employers, co-workers, etc.

### *Functional disability and psychiatric diagnosis*

The standardization of proper diagnosis of disability in psychiatry is further complicated by intrinsic factors of mental conditions such as: stigmatization, sub threshold psychiatric symptoms, medication side effect, and psychological trauma. The authors believe that the person-centred approach, which tailors specific needs and goals of the individual in a multidiscipline context and involves family, social networks and resources, represents a step forward in the assessment of disability in psychiatry. The idiographic component of IPPP, including its narrative section, could prove very helpful in this effort. Manuals, guides, and classification systems may be cornerstone to the process of quality care, but they might not be the panacea for every patient or clinical setting.

Given the mounting literature comparing ICD-10 and DSM-IV classification systems, it is surprising the lack of comments on the different approaches to the functional disability domain provided by the two systems. The vast involvement of functioning in the diagnosis of psychiatric disorders in DSM may reflect construct validity problems in this classification system, both in the diagnostic axes (I and II) and in the functioning axis (V). Apart from overlapping with clinical symptoms, axis V does not provide an adequate assessment of function/activity consequences of psychiatric disorders (Roy-Byrne *et al.*, 1996; Kupfer *et al.*, 2002); and the assessment of functioning in this classification system should be completely changed (Lehman *et al.*, 2002; First *et al.*, 2007).

ICD-10 is not affected to the same extent than DSM by the overlapping of symptoms and consequences of disorders. However examples of use of activity/functioning as a key classifier of mental disorders and 'vice versa' have been provided (i.e. mild versus moderate depression). The development of a complementary classification system of environmental functioning within the WHO family of classifications and its related taxonomy is a major improvement and it has significant implications in the holistic classification of mental disorders. Curiously enough, this fact has not been highlighted when analysing the usability of ICD-10 in psychiatry (Janca *et al.*, 2001, First *et al.*, 2007). A series of related tools such as the Mini-ICF-P (Linden *et al.*, 2005) and the ICF core sets for severe mental disorders such as bipolar disorders (Vieta *et al.*, 2007), may improve the assessment of disability and functioning in this population group. An ICF core set for severe mental disorders in general may also be needed in the near future.

The concepts of functioning, contextual disability and functional disability could be additionally framed as complex adaptive systems, based on the Complexity Theory. This model has been previously used to conceptualise healthcare (McDaniel & Driebe, 2001), nursing (Chaffee & McNeill, 2007) or psychiatric symptoms (Sel, 1997).

## 6. Conclusion

Disability is very relevant for classification and grouping in health management and planning using case-mix. The experience gained using the adaptive functioning approach in other areas such as Intellectual disabilities may help the application of that model in psychiatric diagnosis. From a conceptual perspective, the WHO family of classifications (ICD-10/ICF) provides a more advanced assessment of disability and functioning than DSM.

Within the philosophy of IPPP, the patient's input is of utmost need for the design of the comprehensive diagnostic model. However, disability has not been fully included in the classification system. How to properly frame, measure and interpret data related to functioning and disability may be a fundamental challenge to a successful IPPP development. The group on disability and functioning of PID understands the challenges posed by the current trends and needs in psychiatric diagnosis and more specifically in the areas of functioning and disability. Nevertheless, with harmonious cooperation from our colleagues and all pertinent clinical sources we look forward to contribute to the development of the best possible model of psychiatric diagnosis by taking into consideration the perspectives of patients, family and society in order to enhance clinical care and health promotion. The person-centred approach promoted by WPA may provide a significant contribution to the operational definition of 'Personal Functioning'.

## Acknowledgements

*We acknowledge the World Psychiatric Association (WPA) in its Institutional Program for Psychiatry for the Person (IPPP) working group. Particularly we thank other experts who contribute to the disability working subgroup: Professors M. Linden, A. Soghoian and R. Williams, as well as Prof. J. E. Mezzich, for his comments.*

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