

Editorial

The International Classification of Impairments, Disabilities, and Handicaps: A Mental Health Perspective

The International Classification of Impairments, Disabilities, and Handicaps (the ICIDH) was developed in the 1970s as an extension of the World Health Organization's International Classification of Diseases (ICD). It was developed principally to meet the criticisms of ICD users who thought that the ICD (a) did not sufficiently cover the impact of a given disease on an individual and the society in which he or she lived, and (b) was unable to describe the heterogeneity of the clinical expression of a disorder and the disorder's variable evolution in different individuals and societies. The ICIDH was first published by the World Health Organization (WHO) in 1980 and is currently undergoing its first major revision. In this revision process, psychiatry is being given an important place in response to complaints of users that the ICIDH presently has limited application in the mental health field. In a brief discussion here, I would like to describe the role of the ICIDH in relation to mental health—and to psychogeriatrics in particular—drawing on a number of debates in which I have been involved over the past few years.

First, it should be pointed out that the principal role of the ICIDH has been to extend the concept of disease from the traditional medical model of

etiology → pathology → manifestation

that forms the basis of ICD to a disease-process model in which disease is conceptualized as an interactive process between organ, individual, and environment. The medical or ICD model does not cover either the reasons for which individuals make contact with a health system or their ability to function in their society. Taking into account these shortcomings in the ICD, the ICIDH model extends the concept of illness to the following model:

disease → impairment → disability → handicap

The ICIDH is a classification system divided into three sections: impairment, disability, and handicap. In each section, the situation of the individual can be categorized through a hierarchical classification system, as in the ICD. Several ICIDH notations may thus be attached to a single individual. Another person

might be classified in terms of one part of the classification system only. The disability section, for example, has been used on its own to classify disabled people in national health surveys.

Impairment is defined in the ICIDH as “any loss or abnormality of psychological, physiological, or anatomical structure or function” (World Health Organization, 1980, p. 27). The ICIDH’s author, Phillip Woods, has characterized impairment as the “exterioration of a health problem” (personal communication). This notion is easily understood in the case of a physical disease in which an impairment generally can be visualized (e.g., loss of an eye). In the context of mental health, impairments refer more commonly to abstract constructs such as self-awareness, which must be described in terms of a deviation from a predetermined norm. This fundamental difference has led to a demand on the part of some ICIDH users for a separate impairment section for physical and mental disorders.

Disability is defined by the ICIDH as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (WHO, 1980, p. 28). Whereas impairment concerns parts of the body, disability concerns compound or integrated activities (e.g., a bathing disability or feeding disability). Attempts to include mental disabilities in the classification have led to the inclusion of some rather awkward items, such as a “dropping lighted matches on the carpet disability.”

The ICIDH defines *handicap* as a “disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual” (WHO, 1980, p. 29). A handicap is relative to other people and therefore is highly dependent on social values and environmental factors. Due to difficulties in establishing cross-cultural criteria, it is the concept that has perhaps been least used in relation to physical disorders, but it is obviously of paramount importance in mental health, as many mental disorders are defined and diagnosed in terms of social adjustment.

The ICIDH has many potential uses in the field of mental health. Apart from its very obvious contribution to standardizing research terminology, it may also provide an important point of reference in both clinical management and health planning. A few examples of possible applications of this classification are described here for readers unfamiliar with its content.

Describing the Consequences of Disease in a Clinical Context

It is a well-known fact in psychiatry that a single disorder may engender extremely different patient profiles in terms of both clinical presentation and dependency. This is particularly so in elderly populations with a high frequency of associated pathology and social isolation. A standardized description of a disorder’s impact on the patient’s everyday life, based on ICIDH concepts, may prove a more sensitive indicator of clinical change than symptoms and signs. Adding an ICIDH code to an ICD classification in the patient’s notes can also

indicate the most urgent adjustment problems faced by the individual, which then may become target points for therapy.

Assessing the Impact of Healthcare Policies and Specific Therapeutic Programs

The ICIDH can be used as the basis of evaluation studies. In this context it is often found to be a more sensitive indicator of change than a diagnostic table because the mechanism by which a therapeutic program has had its effect in a given cohort can be more clearly understood by the differentiation of biological, psychosocial, and environmental factors.

Estimating Staff Requirements

Institutional staffing requirements are commonly based on numbers of patients and types of disorders, without reference to disability levels. Because healthcare strategies in Western countries generally aim to maintain elderly persons in the community for as long as possible, there is an increasing tendency for institutions to accept persons with more severe symptoms or multiple pathologies. A failure to take such changes in admission criteria into account may result in understaffing, deteriorating standards of care, or even patient abuse. The ICIDH provides a standardized method of identifying and classifying changing disability levels in order to better determine staffing requirements.

Determining Social Security Allowances and Compensation Claims

Government and private benefits for the disabled elderly are usually determined by diagnosis and income. In providing an internationally acceptable standardized classification of the consequences of illness, the ICIDH has had an increasingly important role in determining sickness benefits.

The application of the ICIDH in the field of mental health has, however, been problematic. Examining the ICIDH immediately makes evident a number of reasons for this.

1. The ICIDH model postulates a causal relationship between impairment, disability, and handicap. In the area of mental health, in particular, the relationship may be two-way (e.g., depression → social isolation → depression). Additionally, the three concepts may not necessarily proceed one from the other in the causal chain suggested by the model. For instance, a person formerly suffering from a mental disorder may continue to be handicapped by stigma, although the disorder is no longer present.
2. The ICIDH is very much focused on organs and organ systems. Interestingly enough, all organs of the body except the brain are included in the impairment section. Although there is increasing evidence of underlying neurobiological abnormalities in many psychiatric illnesses, specific biological indicators are rare. However, the inclusion of the brain in the

- impairment section would not only permit the organic aspects of psychiatric illness to be documented, but would be more consistent with the structure of the classification with regard to physical illnesses.
3. Mental and cognitive impairments are presently insufficiently represented, overlapping, and inconsistent. For example, difficulty in language comprehension is classified as an impairment, whereas difficulty in understanding speech is considered a disability. Many of these difficulties arise because, in the case of mental illness, both the disease and the impairment are defined in terms of their associated disabilities, so there is considerable overlap between the concepts. One solution to this problem is to include the brain and central nervous system in the impairment section and transfer cognitive impairments to the disability section. (This, however, is unacceptable to “mental scientists” who uphold the notion that mental events may exist independently of biological systems.) Another possible approach is to restructure the impairment section to include highly specific information-processing functions and to reserve disabilities for more general functions, such as activities of daily living and independent activities of daily living.
 4. Disability in mental health is likely to be closely related to the social values and tolerance of a given social group. For example, the ICIDH concept of *parental role disability* is exceptionally difficult to define in mental health terms because the dysfunction is likely to be one of inappropriate affect rather than a performance difficulty such as the inability to bathe a baby. Obviously, one needs to distinguish culturally determined aggregate activities, which are culturally highly variable, from instinctive or biologically determined human nurturing behaviors. The former are perhaps best thought of as handicaps, and the latter as disabilities.
 5. A number of shortcomings relating to the application of the ICIDH in all areas of health, but of particular importance in mental health, are also evident. For example, there is no allowance for fluctuating performance in ratings of severity; communication disability does not stipulate that the communication should be appropriate; and there is no provision for the inclusion of the consequences of treatment rather than of the disease itself. It is hoped that these and a number of other problems will be corrected in the revision of the classification system.

CONCLUSIONS

The overall impression that one has on using the ICIDH in its present form is that psychiatry is really a secondary application. The classification system has been compiled by a rheumatologist, Phillip Wood, and it is in this area that it clearly works best. Whenever I have attended presentations on the subject of

the ICIDH, the examples cited to illustrate its use have almost always cited rheumatoid arthritis. Examples from mental health cannot be applied with such ease. If we look, for example, at the section on cognitive disability, we find the categories of IQ, thinking, and memory classified under *intellectual impairment*, with learning disability classified separately under *language impairments*, and disabilities involving psychomotor function, behavior, attention, and volition all on the same level in yet another section, entitled *other psychological impairments*. Cognitive psychologists have clearly had little involvement in the conceptual organization of the classification.

Psychiatrists and other mental health professionals have until recently shown relatively little interest in the classification system and were not involved to a very great extent in its initial development. This was apparently due more to apathy on the part of mental health professionals at the time than to lack of interest on the part of the classification system's author. However, the relative disinterest of mental health workers is to some extent understandable. Careful consideration of the wider-reaching consequences of disease has caused many branches of medicine, such as rheumatology and cardiology, to see disease in an entirely new perspective in which severity is not defined by risk of mortality but rather in terms of its consequences for an individual's quality of life. In psychiatry, such ideas are not revolutionary. Most psychiatric illnesses are defined in the first place by their impact on behavior and social functioning (disabilities and handicaps). For psychiatrists and psychologists, the ICD already contains references to disability and handicap.

The WHO hopes that, by better adapting the ICIDH to current theoretical models of cognition and psychiatric illness, the classification system will be used more widely in the field of mental health. This will in turn lead to increasing standardization of terminology regarding the social consequences of mental disorders, facilitating cross-cultural studies. The utility of this classification system rests finally, of course, on the willingness of clinicians, health planners, and persons advocating the needs of the mentally disabled to apply it in their everyday work and to communicate both achievements and frustrations to the mental health division of the WHO to be taken into account in the revision process.

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REFERENCE

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