Disability and mental illness are different entities and should be assessed separately

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The acceptance of the conceptual position presented by Üstün and Kennedy is of great importance for psychiatry and for medicine as a whole. Disability – whether defined as a functional impairment in terms of the DSM-IV or as a limitation of an individual's activities as is done in the International Classification of Functioning, Disability and Health (ICF) (1) – must be assessed separately and not as a part of the individual's mental illness. It would be wrong to make the diagnosis dependent on the presence or absence of disability. Disability is produced by mental disorder, but it also depends on simultaneously present comorbid diseases or impairments. The latter is becoming a consideration of growing importance. A significant proportion of people with mental illness also suffer from physical illnesses and it is therefore difficult if not impossible to assess to what an extent the disability is caused by the mental disorder and to what extent it is produced by the comorbid conditions.

Disability must refer to the person who suffers from a disease (or diseases), lives in a particular setting, receives a particular treatment and has personality traits that define the way in which he or she will live with a disease. Assets that a person with a disease might have – be it an artistic gift or access to wealth – will also affect the occurrence and severity of disability. The realization that the disability is linked to the person and not to the disease is of significance in developing rehabilitation services, in assessing the levels of support that society will offer to the disabled person and in determining what treatment can be offered if a disease occurs.

Psychopathological findings define diagnosis but must be complemented by other assessments if they are to help in the estimation of "caseness" relevant to the provision of services or the estimation of needs for them. "Caseness" will be defined taking into account the psychopathological findings, the disability and the distress that the individual presents and relates to his or her medical/psychiatric condition. Persons with a particular psychiatric diagnosis can become "cases" for the mental health services when their disability is more pronounced (e.g., because of changes of the environment) or when their distress is enhanced (e.g., by learning about the prognosis of their condition).

In clinical work and for research purposes, the assessment of the presence of a *disorder*, of *disability* and of *distress* must be accompanied by an estimate of their *severity*. The severity of the disease is usually assessed with reference to the numbers and the frequency of occurrence of symptoms, the severity of disability by the type and number of activities in which the individual cannot take part, and the severity of distress on the basis of analogy with states that the distressed individual and the diagnostician both know and have experienced. Severity can be measured as a dimension or as a feature that divides into several operationally defined categories. The same is true for disability and for distress, but not for the psychopathological symptoms, which must have features that make them recognizable as being qualitatively different from normal functioning.

Severity of distress and severity of disability are usually correlated with the severity of the clinical syndrome, but this is not always the case. Distress might be linked to the vision of the future rather than to the level of disability or the severity of the clinical condition. The possibility that a black wart might be a melanoma will cause great distress although there are no limitations of activity and no certainty that the wart contains cells that are malignant or that it will be growing rapidly. The severity of disability might be linked to the severity of the clinical picture, but this is also not so for most of the time a person has a disease – with the exception of the most severe states of the disorder, for example in profound dementia or in a coma. People with a variety of psychopathological symptoms are often living in their community, with little or no limitation of their activity.

The usefulness of the framework presented above for research purposes depends on the possibility of measuring syndromes, disability, distress and their severity in reliable and valid ways. The development of instruments that will help researchers to do this is clearly a major challenge for the ICD and the DSM committees. The usefulness of the same framework for clinical practice will depend on making the need for these measurements explicit and on training practitioners in making the necessary assessments.

Practitioners have used the four dimensions mentioned above in dealing with people who came to ask for their help ever since medicine has been invented. A study of the way in which clinicians are operating may give precious information about their methods of assessment, which, when combined with results of research using valid and reliable assessment instruments, might allow the creation of training programmes that will make the classification of diseases accepted and used as a basis for research and for practice.

Reference

1. World Health Organization. International classification of functioning, disability and health (ICF). Geneva: World Health Organization, 2001.