

# International Classification of Functioning, Disability and Health: An Introduction for Rehabilitation Psychologists

David B. Peterson  
Illinois Institute of Technology

The International Classification of Functioning, Disability and Health (ICF) represents a new way for rehabilitation psychologists and other health care providers to classify health and functioning. The ICF classifies functioning and disability through the constructs of Body Functions and Structures and Activities and Participation and addresses contextual influences through Environmental and Personal Factors. The ICF and its companion classification, the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, provide a complementary, broad, and meaningful picture of the health of an individual or of entire populations. Research and clinical implementation efforts suggest that the ICF is a useful and meaningful public health tool. The development of the ICF and its universe and scope of application are reviewed. Critical concepts are defined, the structure of the ICF is illustrated, and clinical–research utility are featured in light of the ethical considerations for responsible use by rehabilitation psychologists.

The International Classification of Functioning, Disability and Health (ICF; World Health Organization [WHO], 2001) was endorsed by the 54th World Health Assembly for international use on May 22, 2001. Given its focus on health, disability, and functioning, the ICF is an important and relevant development in rehabilitation psychology practice. This article orients rehabilitation psychologists to the ICF so they can apply it to research and practice. The structure of the ICF is described, and important concepts are defined. Reviewed are related research, clinical applications, and ethical considerations associated with the use of the ICF in rehabilitation psychology and general clinical practice.

The ICF is intended to be used with its companion classification, the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10; WHO, 1992). There is some overlap between the ICF and the ICD-10 in that they both classify impairments in various body systems. However, the ICD-10 provides an etiological classification of health conditions (e.g., diseases, disorders, injuries), whereas the ICF offers a framework for conceptualizing functioning and disability associated with health conditions. Disease may manifest itself differently in two individuals, and similar functioning does not necessarily imply

similar health conditions. Thus, together the ICD-10 and the ICF yield a complementary, broad, and meaningful picture of the health of an individual or of entire populations. Health outcomes data gleaned from the ICF can be used in tandem with ICD-10 mortality data to monitor the health of international populations, allowing a much broader picture of public health to emerge than either alone could permit. For a comprehensive review of other health status measures, the reader is referred to Stucki, Ewert, and Cieza (2003).

## Overview of the ICF

The WHO followed several principles in developing the ICF. The classification needed to contain a culturally meaningful order of categories that relied on consensus from potential stakeholders, including people with disabilities; professionals in health care service delivery; insurance, social security, and other entitlement programs; labor, education, economics, and social policy development; and allied corporate entities. The different languages in the international community had to be respected, and the ICF had to be attractive to its users and subsequently to management and policymakers so they would support using the ICF. Finally, the ICF needed to have continuity with and complement classification systems already in place (WHO, 2001).

The chapters that comprise the ICF may appear numerous at first blush, perhaps even unwieldy. However, on achieving familiarity with the basic structure of the ICF, one can search purposefully for information related to health and functioning in different domains. Using the ICF is similar to using an encyclopedia, as it is not necessary or practical to read either cover to cover; rather, one engages in a guided search for specific information. An alphabetical index is available in the hard-copy version of the ICF. To facilitate quick and easy classification, the WHO developed an online version of the ICF that is searchable through the ICF Browser (WHO, 2001), as well as a CD-ROM electronic media version that is also searchable on any personal or laptop computer

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I was a U.S. participant, among participants from 65 countries, in the revision process for the International Classification of Impairments, Disabilities and Handicaps, now the International Classification of Functioning, Disability and Health (ICF). I also participated in the alpha drafting team for the American Psychological Association–World Health Organization *Procedural Manual and Guide for a Standardized Application of the ICF: A Manual for Health Professionals*. Further information on the ICF can be found on the Internet at [www.who.int/classification/icf](http://www.who.int/classification/icf).

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Correspondence concerning this article should be addressed to David B. Peterson, PhD, Institute of Psychology, Illinois Institute of Technology, 3101 South Dearborn Street, 252 Life Sciences Building, Chicago, IL 60616-3793. E-mail: [peterson@iit.edu](mailto:peterson@iit.edu)

with a CD-ROM drive. Other computer-based adjuncts to the ICF will likely be developed to facilitate its use.

*Defining Concepts*

The ICF is based on an integration of the medical and social models of disability, addressing the biological, individual, and societal perspectives of health in a biopsychosocial approach. From a disability rights activist perspective, the ICF’s interactive model complements the social model (disability being an interaction among impairment, functioning, and environment) and can be used to describe how environmental factors are key to understanding disability and how advocacy occurs through social change (Hurst, 2003). The ICF defines health in terms of the universe of well-being, composed of health domains of well-being, or those areas of functioning that are a focus of health care professionals (e.g., seeing, hearing, speaking, walking), and other domains of well-being that are not typically a focus of health care systems (e.g., education, employment, social interactions).

It is important to note that the following terms used in the ICF are capitalized to distinguish them from their lay use (Threats & Worrall, 2004). *Health* refers to components of health (e.g., seeing, remembering, learning) and health-related components of well-being (e.g., labor, education, transportation). *Functioning* is an inclusive term covering all body functions, activities, and participation in society.

Etiology of dysfunction is not the focus of the ICF; that is the province of the ICD-10. *Impairments* do not necessarily imply the presence of a disorder or disease but “represent a deviation from certain generally accepted population standards” of functioning (WHO, 2001, p. 12). Impairments are manifestations of dysfunction in the body structures or functions, differentiated from the underlying pathology itself. Determination of impairment is made by “those qualified to judge physical and mental functioning according to these standards” (WHO, 2001, p. 12). *Disability*, then, refers to any impairments, activity limitations, or participation restrictions or to “the outcome or result of a complex rela-

tionship between an individual’s health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives” (WHO, 2001, p. 17). Both functioning and disability are conceptualized within the dynamic interaction between health conditions and contextual factors.

The model of functioning and disability proposed in the ICF classification suggests dynamic and reciprocal relations among the various components that comprise the classification within the context of environmental and personal factors. Figure 1 is a heuristic depiction of the components and interactions that can be used to describe the relation between disability and functioning, or the conceptual framework of the ICF. The WHO (2001) admitted that this model is likely incomplete and only one of many possible.

*Domains* within the ICF are practical and meaningful sets of related physiological functions (including psychological functioning), anatomical structures, actions, tasks, or areas of life, described from the body, individual, and societal perspectives, which make up the different chapters and blocks within each component of the ICF. Categories within the domains contain the classes and subclasses related to the actual units of classification and are recorded by selecting an appropriate category code or codes. Essential attributes of the domains (e.g., qualities, properties, relationships) are defined by inclusions and exclusions, making the codes mutually exclusive. The classes and subclasses reflect the various levels of the hierarchical order of the ICF, with more basic levels encompassing all aspects of more detailed levels.

*Universe and Scope of the ICF*

The ICF addresses functioning that is primarily a focus of health care systems but encourages flexibility in its application to different conceptualizations of health and health-related elements. The ICF does not classify people, as many diagnostic systems do; rather, it describes the situation of the person being evaluated within an array of health or health-related domains. In addition, the person’s situation is classified within the context of Environmental and Personal Factors. Although the ICF classifies all aspects of

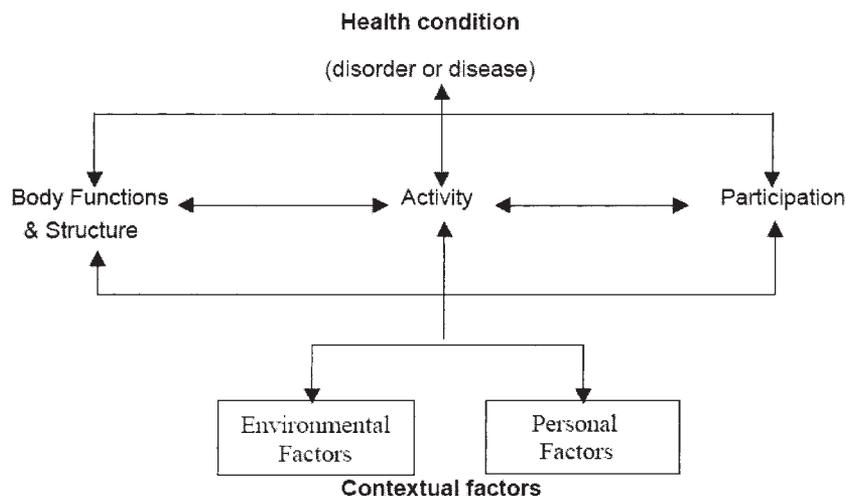


Figure 1. Interaction between components of the International Classification of Functioning, Disability and Health. From *International Classification of Functioning, Disability and Health* (p. 18), by the World Health Organization, 2001, Geneva, Switzerland: Author. Copyright 2001 by the World Health Organization. Reprinted with permission.

human health and some health-related components of well-being, it does not currently classify circumstances determined by socio-economic factors, such as race, gender, religion, or culture, that may limit full participation in society for reasons that are not health related. However, the conceptual framework uses a Personal Factors component to highlight the need to consider complex social circumstances that presently defy classification in practice and research (see Ueda & Okawa, 2003).

The ICF was designed to classify not only limitations in functioning but also positive experiences for all body functions, activities, and participation in the environment. Examples of positive experiences include communicating, tending to personal hygiene, working, and studying. In summary, the ICF portrays health as a dynamic interaction between an individual's functioning and disability within a given context.

### Structure of the ICF

As reflected in the underlying conceptual framework of the ICF (see Figure 1), the core structure of the ICF consists of two parts—(a) Functioning and Disability and (b) Contextual Factors—each of which has two components. Within Functioning and Disability, the Body component consists of two classifications, Body Functions and Body Structures. Chapters within these two classifications are parallel and organized according to body systems. The Activities and Participation component of Functioning and Disability covers domains of functioning from both an individual and societal perspective. Components of functioning can be expressed either as nonproblematic functioning or as a disability (i.e., impairment, activity limitation, or participation restriction).

The first part of the ICF is qualified through four separate but related constructs. Body Functions and Structures are interpreted

through changes in physiological systems or anatomical structures, and Activities and Participation is interpreted through Capacity and Performance. These constructs are defined through the use of qualifiers, elaborated on later.

The second part of the ICF classification (Contextual Factors) has two components. The first is Environmental Factors, or factors in the physical, social, or attitudinal world, ranging from the immediate to more general environment. Environmental Factors are qualified as either facilitating or hindering functioning. The second component is Personal Factors, which, as mentioned earlier, is not currently classified.

The categories of function for a given domain begin at a more general level and expand to levels of greater detail to enhance classificatory precision. The one-level classification (illustrated in Table 1) of the ICF expands on the core structure: (a) The Body Functions component contains eight chapters that address “physiological functions of body systems (including psychological functions)” (WHO, 2001, p. 12); (b) the Body Structures component (eight chapters) parallels the Body Functions component, dealing with “anatomical parts of the body such as organs, limbs, and their components” (WHO, 2001, p. 12); (c) the Activities and Participation component (nine chapters) addresses “the execution of a task or action by an individual” and “involvement in a life situation” (WHO, 2001, p. 14), respectively; and (d) the Environmental Factors component contains five chapters focusing on “the physical, social, and attitudinal environment in which people live and conduct their lives” (WHO, 2001, p. 171), organized from the immediate to more general environment.

The two-level classification lists specific chapter headings and the first branching level of the ICF. Alphanumeric codes begin with a letter (*b* for Body Functions, *s* for Body Structures, *d* for

Table 1  
*International Classification of Functioning, Disability and Health (ICF): One-Level Classification*

Chapter	Body Functions <sup>a</sup>	Body Structures <sup>b</sup>	Activities and Participation <sup>c</sup>	Environmental Factors <sup>d</sup>
1	Mental functions	Structures of the nervous system	Learning and applying knowledge	Products and technology
2	Sensory functions and pain	The eye, ear, and related structures	General tasks and demands	Natural environment and human-made changes to environment
3	Voice and speech functions	Structures involved in voice and speech	Communication	Support and relationships
4	Functions of the cardiovascular, haematological, immunological, and respiratory systems	Structures of the cardiovascular, immunological, and respiratory systems	Mobility	Attitudes
5	Functions of the digestive, metabolic, and endocrine systems	Structures related to the digestive, metabolic, and endocrine systems	Self-care	Services, systems, and policies
6	Genitourinary and reproductive functions	Structures related to the genitourinary and reproductive systems	Domestic life	
7	Neuromusculoskeletal and movement-related functions	Structures related to movement	Interpersonal interactions and relationships	
8	Functions of the skin and related structures	Skin and related structures	Major life areas	
9			Community, social, and civic life	

Note. Chapter descriptions are broken down by ICF components.

<sup>a</sup> Consists of eight chapters; the code letter is *b*. <sup>b</sup> Consists of eight chapters; the code letter is *s*. <sup>c</sup> Consists of nine chapters; the code letter is *d*. <sup>d</sup> Consists of five chapters; the code letter is *e*.

Activities and Participation, and *e* for Environmental Factors) and then a three-digit numeric classification that indicates the chapter and specific categories within. For example, the classification associated with the psychological function of attention is found in the first chapter of Body Functions (code begins with *b*) under the Specific Mental Function section, Attention Functions, or alphanumeric code b140.

Finally, the detailed classification with definitions lists all categories within the ICF along with their definitions, inclusions, and exclusions, providing greater levels of detail using four- and five-digit numeric codes. The level of classification implemented depends on the clinical needs presented. Considering attention functions again, examples of level of detail include Sustaining Attention (b1400), Shifting Attention (b1401), Dividing Attention (b1402), and Sharing Attention (b1403). Code groups also offer an "Other Specified" and "Unspecified Code" for functions not detailed in the current classification.

Within components, as units of classification become more detailed, there is the assumption that more detailed units share the attributes of the lesser detailed units that subsume them. For example, Dividing Attention (b1402) shares the attributes of the higher level of classification, Attention Functions (b140). More than one category may be used to classify specific functioning as a situation warrants.

In summary, the ICF has two parts, each with two components. Each component within the ICF consists of various domains composed of the categories that make up the actual units of classification, representing the health and health-related state of an individual, all of which can be qualified in both positive and negative terms. The aforementioned units of classification are qualified with numeric codes that specify the magnitude or extent of disability or function in a given category and the extent to which an environmental factor is a facilitator or a barrier (more thoroughly reviewed later). The first qualifier for Environmental Factors and Body Functions and Structures and the qualifiers for Performance and Capacity all describe the extent of problems for a given code using the same generic qualifier scale, with slight modifications depending on the component (see Table 2).

There are two versions of the ICF: The full version provides all four levels of classification detail, and the short version provides two levels of classification. Table 3 contains an overview of the concepts discussed thus far.

Table 2  
*Generic Qualifiers*

Code	Extent	Qualitative descriptors	Percentages
bxxx.0	No problem	None, absent, negligible	0–4
bxxx.1	Mild problem	Slight, low	5–24
bxxx.2	Moderate problem	Medium, fair	25–49
bxxx.3	Severe problem	High, extreme	50–95
bxxx.4	Complete problem	Total	96–100
bxxx.8	Not specified		
bxxx.9	Not applicable		

*Note.* Qualitative descriptors refer to impairment, limitation, restriction, and/or barrier. Percentages are to be calibrated in different domains with reference to relevant population standards as percentiles. "bxxx" stands for a given International Classification of Functioning, Disability and Health classification code that precedes the qualifier.

## Evolution of the ICF

A detailed summary of the development of the International Classification of Impairments, Disabilities and Handicaps (ICIDH; WHO, 1980), and the revision process leading to the publication of the ICF, can be found in Annex 7 of the ICF (WHO, 2001, pp. 246–249). Two special issues of *Disability and Rehabilitation* (Volume 17 in 1995 and Volume 25 in 2003) were dedicated to reviewing the development and application of the ICIDH and subsequent ICF, to which readers may refer for detailed accounts of the ICF's development (see Üstün, Chaterji, Bickenbach, Kas-tanjsek, & Schnieder, 2003).

Between 1993 and 2000, the ICIDH developed through international participation in a systematic revision process and extensive field testing. Health professionals from many disciplines, researchers, members of government, and, most importantly, people with disabilities contributed to the revision process. Revisions over time were designed to reflect changes in disability policy development and reforms of health care systems internationally. Translation and linguistic evaluation involved the translation of the Beta-2 draft of the ICIDH (ICIDH-2; WHO, 1999) into 15 languages (6 were in the short-form only). Since then, over 12 other language translations have been in process.

### *Revision and Field Testing*

The ICF in its current iteration was developed through a process of international consensus building, including 652 individuals from 18 countries over a 7-year period. The ICIDH-2 was field tested for cross-cultural applicability in over 50 countries at various centers, nongovernmental and intergovernmental organizations affiliated with the United Nations, and among more than 1,800 scientists, clinicians, persons with disabilities, and other experts (WHO, 2001). Feasibility and reliability of case evaluations were tested during the beta-2 field trials of the ICIDH-2 involving 24 countries, 1,884 case evaluations, and 3,216 evaluations of case summaries. The field trials showed that the ICIDH-2 was a useful and meaningful public health tool but suggested that training was needed in its implementation, particularly in the application of its conceptual framework.

As a member of the WHO's Mental Health Task Force, the American Psychological Association (APA) became involved in the revision of the ICIDH-2 in 1995. The APA's Practice Directorate has worked closely with the WHO since then, and a number of Division 22 members have been very active in the Practice Directorate's efforts to further the development of the ICIDH-2 (Daw, 2002). Field trial activity subsequent to the publication of the ICF is reviewed in an article by Reed et al. (2005).

### *Research Utility*

The ICF was created to serve several important purposes, the most revolutionary of which was "to establish a common language for describing health and health related states in order to improve communication between different users, such as health care workers, researchers, policymakers, and the public, including people with disabilities" (WHO, 2001, p. 5). The ICF provides the basis for a systematic coding scheme for global health information systems. Data from these information systems can be used to identify facilitators of and barriers to the full participation in

Table 3  
*Overview of the International Classification of Functioning, Disability and Health (ICF)*

Structural element	Part 1: Functioning and Disability		Part 2: Contextual Factors	
	Body Functions and Structures	Activities and Participation	Environmental Factors	Personal Factors
Domains	Body Functions (including psychological functioning)	Life areas (tasks, actions)	External influences on functioning and disability	Internal influences on functioning and disability
Constructs	Body Structures Change in body function (physiological) Change in body structure (anatomical)	Capacity: Executing tasks in a standard environment ("can do") Performance: Executing tasks in the current environment ("does do")	Facilitating or hindering impact of features of the physical, social, and attitudinal world	Impact of attributes of the person
Positive aspect	Functioning Functional and structural integrity Activities Participation		Facilitators	Not classified in the ICF
Negative aspect	Disability Impairment Activity limitation Participation restriction		Barriers-hindrances	Not classified in the ICF

*Note.* Units of classification are situations, not people. The ICF consists of a dynamic interaction between two parts (Parts 1 and 2 in the table). Each part has two components (as listed in the table). Domains contain the categories or units of classification for the ICF. Constructs are defined through the use of qualifiers that modify the extent or magnitude of function or disability.

society of people with disabilities. Subsequent research may permit comparison of data across countries, health care disciplines, services, and time, contributing to an international database of scientific knowledge of health and health-related states, stimulating research on the consequences of health conditions.

Since the trial version was published in 1980, the ICF (ICIDH) has been used as a(n)

1. statistical tool for population studies and in systems of information management;
2. research tool to measure outcomes, environmental factors, and quality of life;
3. clinical tool in treatment planning, vocational assessment, and rehabilitation outcome evaluation;
4. social policy tool for social security planning, compensation systems development, and policy design and implementation; and
5. educational tool in curriculum design and to raise awareness and take social action (WHO, 2001, p. 5).

For an update of recent research developments since the publication of the ICF, see Bruyère, Van Looy, and Peterson's (2005) review.

### *Clinical Utility*

Advances in medical technology have resulted in tremendous progress in the treatment of acute medical conditions, and people are living longer with chronic health conditions, thus increasing the cost of medical care over the average person's lifetime (Peterson & Aguiar, 2004; Tarvydas, Peterson, & Michaelson, 2005). In response to increased costs, the managed-care industry has forced

health professionals to extend their accountability to third-party payers beyond traditional diagnostic procedures and labels, the focus of traditional classification systems that do not precisely describe functioning, disability, and states of health. The ICF has the potential to fill this classificatory gap in the health professional armament of classifications, and some believe it is only a matter of time before detailed functional assessment is required in most, if not all, managed-care contexts. Jerome Bickenbach, professor and Queen's Research Chair at Queen's University in Ontario, Canada (an internationally recognized expert on the nature of disability and disability policy who was involved in the development of the ICF), suggested recently,

There are strong indications in many parts of the world, including the United States, that functional information will soon be required of clinicians by payers . . . in part because of a realization that functional status information is a far better predictor of health-system usage than diagnostic information. (as cited in Holloway, 2004, p. 32)

Diagnoses are necessary but not sufficient guides in providing contemporary health care. A review of health care literature suggests that diagnoses alone do not predict well service needs (National Advisory Mental Health Council, 1993), length of hospitalization (McCrone & Phelan, 1994), level of care needed (Burns, 1991), outcome of hospitalization (Rabinowitz, Modai, & Inbar-Saban, 1994), receipt of disability benefits (Basset, Chase, Folstein, & Regier, 1998; Massel, Liberman, Mintz, & Jacobs, 1990; Segal & Choi, 1991), work performance (Gatchel, Polatin, Mayer, & Garcy, 1994; Massel et al., 1990), or social integration (Ormel, Oldehinkel, Brillman, & vanden Brink, 1993). Diagnostic information enhanced by descriptions of function may better predict health service utilization (Bassett & Folstein, 1991; Hoepfer et al., 1980; Ormel et al., 1993; Regier, Barker, Manderscheid, & Burns, 1985; Von Korff, Ormel, Katon, & Lin, 1992), improvement of functioning after hospitalization (Rabinowitz et al., 1994), return to work (Hlatky et al., 1986), work performance (Massel et al., 1990),

and recovery of social integration (Tate, Lulham, Broe, Stretles, & Pfaff, 1989). The ICF can be used to construct a useful profile of an individual's functioning, disability, and health, which the literature suggests may enhance health care service provision.

For example, consider an individual with a diagnosis of post-traumatic stress disorder (PTSD). According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (American Psychiatric Association, 2000), this person may experience a number (17) of characteristic symptoms, ranging from difficulty falling asleep to a visceral reexperiencing of the trauma-inducing event. The functional implications of these symptoms may be quite different, and neither may be true of someone with the diagnosis. Possible combinations of the 15 other diagnostic criteria of PTSD highlight that diagnostic information alone is of limited value without clear descriptions of functional impact of such a diagnosis. The ICF provides health care systems with a common language to enhance diagnostic information with standard descriptions of health and health-related states and has the potential to revolutionize the way stakeholders in health care delivery systems think about and classify health (Stucki et al., 2003). See Reed et al. (2005) for further discussion of the potential impact of the ICF on health care service delivery.

### Using the ICF

This section provides a thumbnail sketch for using the ICF in clinical practice but should be supplemented with a thorough review of the document itself (WHO, 2001, Annexes 2 and 3, specifically) and participation in available training provided by local health and research entities using the ICF. The clinical implementation manual in process, soon to be released, provides the first how-to guide for use of the ICF in North America (see Reed et al., 2005).

### Body Functions, Structures, and Impairments

The Body Functions and Structures component is composed of two classifications concerning physiological functions of body systems (including psychological functions) and anatomical parts of the body (e.g., organs, limbs, and their components), respectively, classified in separate but parallel chapters (see Table 1). For example, within Body Functions, hearing functions has a corollary within Body Structures of ear and related structures. Both classifications are arranged according to the same body system taxonomy and can be interpreted in terms of changes in physiological systems or in anatomical structures. The criteria for impairment are the same for Body Functions and Structures and are classified according to (a) loss or lack, (b) reduction, (c) addition or excess, and (d) deviation.

Once identified, an impairment is further defined in terms of severity through the use of various qualifiers, depending on the component of focus. Codes have no meaning without their qualifiers, which are one or more numbers after a decimal point (or separator) that follows a multilevel code, denoting a magnitude or level of health for that code. The Body Functions component uses a qualifier that addresses severity through values ranging from 0 (meaning no impairment) to 4 (with 1 through 4 indicating mild, moderate, severe, and complete impairment, respectively; WHO, 2001, p. 47). The Body Structures component uses the same severity qualifier as a first qualifier and then a second qualifier to

indicate the nature of the change in a body structure: 0 = no change in structure, 1 = total absence, 2 = partial absence, 3 = additional part, 4 = aberrant dimensions, 5 = discontinuity, 6 = deviating position, and 7 = qualitative changes in structure, including accumulation of fluid (WHO, 2001, p. 105). The third qualifier indicates location of impairment as follows: 0 = more than one region, 1 = right, 2 = left, 3 = both sides, 4 = front, 5 = back, 6 = proximal, and 7 = distal. All three qualifiers have a not specified (8) and not applicable (9) qualifier as appropriate.

### Activities and Participation

The second component under Functioning and Disability, Activities and Participation, presents a list of nine domains that covers a wide range of aspects of functioning from both individual and societal perspectives (see Table 1). It is important to note that the Body Functions and Structures component is intended to be used along with the Activities and Participation component. An *activity* is defined as the execution of a task or action by an individual, such as sitting, copying, calculating, or driving. *Participation* is involvement in a life situation. The domains in the Activities and Participation component can be used to describe either or both activity or participation.

Activity limitations and participation restrictions "are assessed against a generally accepted population standard" (WHO, 2001, p. 15) for someone without a similar health condition. The ICF proposes four possible conceptualizations of the relation between Activities and Participation. Although a single list of domains, in one possible conceptualization, the user can code each category as either an activity or participation issue, resulting in two mutually exclusive lists; Australia has adopted this method in their clinical implementation manual (available at [http://www.aihw.gov.au/disability/icf\\_ug/icf\\_ug-ug\\_s1.html](http://www.aihw.gov.au/disability/icf_ug/icf_ug-ug_s1.html)). Alternatively, one can use the domains for both activity and participation as totally overlapping issues or as a unified list, which is how the U.S. version of a clinical implementation manual in progress is proceeding (see Reed et al., 2005; Threats & Worrall, 2004). Two other alternatives suggest compromises between separate and overlapping lists; the reader is referred to Annex 3 of the ICF for greater detail. Domains within the Activities and Participation component are qualified through the constructs of Capacity and Performance.

### Capacity and Performance Qualifiers

The domains of the Activities and Participation component are operationalized through the use of qualifiers Capacity and Performance. The Capacity qualifier "describes an individual's ability to execute a task or an action," or, more specifically, "the highest probable level of functioning that a person may reach in a given domain at a given moment" (i.e., what a person can do; WHO, 2001, p. 15). One needs to apply the Capacity qualifier in the context of a "uniform or standard environment, and thus reflect the environmentally adjusted ability of the individual" (WHO, 2001, p. 15). To make international comparisons, such environments have to be defined similarly across countries; this presents unique standardization challenges, which are being addressed in the development of the clinical implementation manual (see Reed et al., 2005; Threats & Worrall, 2004).

The Performance qualifier describes "what a person does in his or her current environment" (WHO, 2001, p. 15). Another way to

describe this qualifier is “involvement in a life situation” or “the lived experience” of a person in the environment (i.e., what a person does do; WHO, 2001, p. 15). The difference between Capacity and Performance could be used to consider what interventions might be applied to the environment to maximize an individual’s ability and function and increase opportunity for full participation in his or her environment.

The Performance and Capacity qualifiers are rated from 0 to 4, as with the first qualifier of Body Functions and Structures but substituting the term *difficulty* for *impairment*. Performance and Capacity can be considered both with and without assistive devices or personal assistance, forming four qualifiers (Performance with and without assistance and Capacity with and without assistance).

### Contextual Factors

Environmental Factors (the physical, social, and attitudinal worlds) are considered as they influence (facilitate or hinder) all components of functioning and disability at the Body Functions and Structures levels, as well as the Activities and Participation levels. Environmental Factors are organized in three levels, the individual level (e.g., support network), the services level (e.g., vocational rehabilitation), and cultural–legal systems level (e.g., worldviews, laws). The individual level has the most immediate environmental influence, for example, one’s home, workplace, or school. The services and systems level addresses the more general environmental influences, such as formal and informal social structures and service delivery systems. Table 1 includes the five chapters that comprise Environmental Factors.

Evaluation of the Environmental Factors provides opportunity for exploration into determinants and risk factors of health conditions as they exist in the environment. There are three suggested coding conventions for the Environmental Factors. They can be coded independent of other components in the ICF, coded for every component, or coded for each of the Performance and Capacity qualifiers under Activities and Participation. The factors are qualified with respect to the extent to which they are facilitators or barriers. Similar to the first qualifier for the other components, the scale ranges from 0 to 4 (or no to complete), substituting *barrier* or *facilitator* for *impairment* or *difficulty*. Facilitators, a positive environmental support, are noted with a plus sign; barriers plainly follow the decimal point.

Personal Factors may include gender, race, age, fitness, religion, lifestyle, habits, upbringing, coping styles, social background, education, profession, past and current experience, overall behavior pattern and character style, individual psychological assets, and other health conditions, all of which can affect health and functioning. Although Personal Factors are a consideration within the contextual factors, they are not coded specifically in the ICF for reasons already presented. However, they are important to consider within the overall model because they can influence the outcome of an intervention.

### Ethical Implications

Eleven basic guidelines were established in Annex 6 of the ICF to reduce the risk of disrespectful or harmful use of the newly revised classification system. From the outset, WHO coordinators of the revision efforts made sure to include people with disabilities and their advocacy organizations in all phases of the revision

process, which led to important changes in the content and structure of the ICF. The provisions detailed in the ethical guidelines (WHO, 2001, pp. 244–245) address three critical areas: respect and confidentiality, clinical use of the ICF, and social use of ICF information.

Karen Strohm Kitchener’s (2000, p. 21) “Foundational Principles for Thinking Well” can further inform ethical use of the ICF. The five concepts of nonmaleficence, beneficence, autonomy, fidelity, and justice have been integral to the development of numerous ethical codes in psychology-related professions. These principles were derived from the “common morality” in biomedical ethics (Beauchamp & Childress, 1994, p. 102). According to Kitchener (2000, pp. 23–31), *nonmaleficence* means not causing others harm, including avoiding actions that risk harming others. *Beneficence* means doing good or benefiting others, including balancing the potential consequences of an action, both beneficial and harmful. *Autonomy* addresses freedom of action and choice, promoting autonomous action that is reciprocal in nature. *Fidelity* connotes faithful, loyal, honest, and trustworthy behavior. Finally, *justice* deals with issues of fairness, crossing individual, interpersonal, organizational, and societal spheres of existence. The reader is encouraged to review the 11 guidelines and see how clearly they complement the intent of Kitchener’s five principles.

The foundational principles provide aspirational guidance to health care professionals, fostering good judgment when applying the ICF to practice: treating all people respectfully and treating classification data confidentially, using the ICF in a collaborative and facilitative spirit, and ethically managing information gleaned from the ICF that is subsequently disseminated to society. The foundational principles may also inform the development of future standards guiding the ethical use of the ICF. Threats and Worrall (2004) summed it up nicely when they posited that the ICF is not something to be done to someone but rather something to be done with them.

### Conclusion

The aim of this article was to increase the awareness of rehabilitation psychologists regarding the developmental context of the ICF, its structure, key concepts, and potential utility in the hope that they will embrace it and apply it to clinical research and practice. The underlying conceptual framework of the ICF is informed by core principles and paradigms of practice of rehabilitation psychologists, including the dignity and worth of all people, inclusion of people with disabilities in society to the fullest extent possible, consideration of not only functional limitations but also an individual’s health and functioning, and the need for advocacy to maximize their independence (Frank & Elliott, 2000; Riggall & Maki, 2004; Scherer et al., 2004). The ICF has the potential to contribute to rehabilitation psychology research, program evaluation, clinical intervention, and social policy development in significant and useful ways if it is carefully, ethically, and systematically implemented in the same collaborative and international spirit in which it was conceived.

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