

DSM-5 and the Assessment of Functioning: The World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) has dropped the multiaxial diagnostic system and moved to a dimensional system of diagnostic classification. This change means that there is no longer a separate Axis V or specific diagnostic category for assessment of functioning. In addition, the Global Assessment of Functioning Scale (GAF), the previously endorsed numerical rating scale used for assessment of functioning and reported on Axis V, has been eliminated. In its place, DSM-5 offers psychiatrists a new tool for assessment of global functioning and impairment, the World Health Organization Disability Assessment Schedule 2 (WHODAS 2.0). Any single global assessment of functioning rating scale inevitably has limitations. Nevertheless, the GAF has been widely used in clinical and research settings and has been adopted as meaningful by psychiatric, legal, administrative, and insurance systems and institutions. The changes in DSM-5 in regard to the conceptual and practical assessment of functioning and impairment raise many questions. In this article, I review the implications for forensic psychiatric evaluations of the changes in the recommended assessment of functioning in DSM-5.

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The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),¹ published in May 2013, is the first major conceptual revision of standard psychiatric classification since the 1980 publication of DSM-III.² One of the most significant changes introduced by DSM-5 is the conversion from a categorical diagnostic classification scheme with a multiaxial system, first adopted in DSM-III, to a dimensional, nonaxial system of diagnostic classification. Psychiatric and medical disorders (formerly Axes I, II, and III) are now listed together, along with dimensional assessments of severity. Separate notations for important psychosocial and contextual factors (formerly documented on Axis IV) and assessment of functioning (formerly documented on Axis V) are to be considered and added as appropriate.

Thus, DSM-5 does not contain a separate or specific diagnostic category for assessment of functioning. In addition, the Global Assessment of Function-

ing (GAF) Scale (Ref. 3, pp 32–4), the previously endorsed numerical rating scale used for assessment of functioning and reported on Axis V, has been dropped. In Section III, “Emerging Measures and Models,” DSM-5 recommends that psychiatrists consider a new tool for assessment of global functioning and impairment, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0).⁴

Although lamentations about changes in the new edition of DSM abound, expressions of grief over the decision to jettison the GAF are notably absent. Nevertheless, the removal of the multiaxial coding system and the loss of Axis V, the place-marker for a specific and separate assessment of functioning, have implications for general and forensic psychiatry, as well as consumers of forensic psychiatric disability evaluations. I will explore some of the questions that this structural and methodological change raises.

The GAF: What DSM-5 Is Giving Up and Why

First introduced in 1980 for use in DSM-III, the GAF in its final version³ is a clinician-rated instrument intended to measure symptom severity or psy-

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chological, social, and occupational functioning during a specified period, on a continuum from mental health (score 100) to mental illness (score 0).^{3,5} Clinicians were directed to a certain range of scores if either symptom severity or level of functioning fell within that range. When symptom severity and level of functioning were discordant, clinicians were directed to use the rating that reflected the lower of the two levels. The GAF scale specifically excluded impairment in functioning due to physical or environmental limitations.

The GAF can be reliable, valid, and sensitive to change over time.⁵⁻⁷ Nevertheless, its limitations have been widely acknowledged. A rater's training and performance are fundamental to the GAF's reliability, and appropriate training improves both reliability and validity.⁵⁻⁹ In addition, the validity of assigned GAF scores often correlates more highly with the severity of symptoms than with levels of impairment, particularly when severity of symptoms and degree of functional impairment are not congruent.^{6,7,9} The GAF's conflation of symptom severity, including dangerousness to self or others, and functional impairment into a single global assessment score decreases the construct validity of the GAF and is one of its major disadvantages.⁵⁻⁷

Despite these limitations, the GAF is the most commonly used clinician rating scale of global psychiatric disability in the United States.⁷ As the Vice Chair of the DSM Task Force and the Task Force's Research Director acknowledged, "There is no arguing that the GAF has been widely used clinically and in research and has been emulated by several other measures."¹⁰ The GAF is frequently used to assess treatment outcomes or degree of improvement or deterioration over time, demonstrate efficacy of treatment interventions, assess level of need for intervention, and evaluate disability or impairment.⁷ It is used by many insurance and governmental agencies¹ and is typically and frequently used in determinations of medical necessity for treatment by many payers and in decisions regarding eligibility for short- and long-term disability compensation.¹¹

Nevertheless, the DSM-5 Task Force decided that the GAF was not an adequate instrument for assessment of psychiatric functional impairment. DSM-5 explains that the GAF was excluded for several reasons, among which were its lack of conceptual clarity (i.e., including symptoms, suicide risk, and disabilities in its descriptors) and questionable psychomet-

rics in routine practice.¹ The American Psychiatric Association (APA) stated it was "concerned about evidence that the GAF requires specific training for proper use, and that good reliability and prediction of outcomes in routine clinical practice may depend on such training."¹¹ As a result of these and other concerns, leaders of the task force opined, "the use of Axis V global measures of 'functioning' for our patients is outdated and was properly abandoned by the DSM-5 Task Force" (Ref. 10, p 64).

The WHODAS 2.0: An Introduction

The DSM-5 Disability Study Group recommended WHODAS 2.0 as the best current measure of disability for routine clinical use and recommended its inclusion in DSM-5.¹¹ WHODAS 2.0 is based on and reflects concepts that underlie the World Health Organization's Family of International Classifications,¹² in particular, the International Classification of Diseases (ICD),¹³ currently in its 10th edition, and the International Classification of Functioning, Disability, and Health (ICF).¹⁴

WHO makes a conceptual distinction between medical and psychiatric disorders and the disabilities resulting from such disorders.^{13,14} Diagnoses of both physical and mental disorders are listed in the ICD; definitions of impairment and disability and their assessments in relation to illness are found in the ICF. WHO's separation of disease classification and functioning separates functional impairment or disability from its medical or psychiatric cause. WHO has conceptualized limitations in activities and behaviors and restrictions on participation in life and society as representing a final common pathway through which all disorders, medical or psychiatric, result in disability.¹⁴

In WHO's classification frameworks, disorders result in specific impairments in function. The term disability encompasses impairments, activity limitations, and participation restrictions, and denotes "the negative aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal context" (Ref. 4, p 79). The ICF's process for the assessment of disability requires examination of social factors related to a person's functioning, including personal circumstances (such as age, education, and motivation) and environmental circumstances (such as physical environment, accommodations, and available support).^{4,14} The WHODAS 2.0 training man-

ual provides a table to facilitate understanding of the relationship between these concepts (Ref. 4, p 11).

The conceptual definitions of illness and disability are a major difference between the ICD and DSM-5. Unlike DSM-5, in WHO's conceptual framework, the overlap between an illness and related distress, functional impairment, and disability can be significant, partial, or nonexistent. Therefore, none of these related aspects of psychiatric disorders are included in the ICD's diagnostic criteria of a disorder. In addition, two individuals can have the same disorder and the same functional impairments, but different degrees of disability, depending on personal and environmental factors. Therefore, although related to illness, neither impairment nor disability is considered an inherent feature of any medical or psychiatric diagnosis and should be assessed separately.

WHODAS 2.0 is based on and reflects this model of disease, in which the assessment of impairment and disability is separate from diagnostic considerations; can reflect any medical illness, psychiatric illness, or comorbid condition; and does not imply the etiology of impairments.^{4,15,16} Just as the ICF does not distinguish between the impact of medical and psychiatric illnesses, WHODAS 2.0 is designed to be applicable to all health conditions, including diseases, illnesses, injuries, mental or emotional problems, and problems with alcohol or drugs. It does not attempt to assign etiology or apportion impairment or disability to any particular disorder.

WHODAS 2.0 is a patient self-report assessment tool that evaluates the patient's ability to perform activities in six domains of functioning over the previous 30 days, and uses these to calculate a score representing global disability. These domains are:

- Understanding and communicating
- Getting around (mobility)
- Self-care
- Getting along with people (social and interpersonal functioning)
- Life activities (home, academic, and occupational functioning)
- Participation in society (participation in family, social, and community activities)

All domains were developed from a comprehensive set of ICF items and made to correspond directly with ICF's limitations on activity and restrictions on

participation dimensions, which are applicable to any health condition.

WHODAS 2.0 comes in 36- and 12-item questionnaires, each of which is available in self-administered, proxy-administered, and rater-administered versions. The proxy-administered versions are intended for use by a third party, such as a relative or caregiver, in the event that the patient is unable to complete the questionnaire. All versions of the WHODAS 2.0 are available in print and online.⁴ Proper use of the assessment requires interviewer training with the WHODAS 2.0 training manual, which is also available in print and online.⁴

The print edition of DSM-5 contains only the self-administered version of the 36-item WHODAS 2.0 (Ref. 1, pp 747–8). The APA's DSM-5 website provides electronic copies of this print version and of the 36-item proxy-administered version.¹⁷ Although the versions provided by the APA and DSM-5 are not rater administered, DSM-5 advises that "if the clinician determines that the score on an item should be different based on the clinical interview and other information available, he or she may indicate a corrected score in the raw item score box" (Ref. 1, pp 745–6).

WHODAS 2.0 has two scoring options: simple and complex.^{4,18} Simple scoring is a hand-scoring method that does not involve weighting individual items or converting to a standardized scale. DSM-5 indicates that simple scoring "may be the method of choice in busy clinical settings or in paper-and-pencil interview situations" (Ref. 1, p 745). However, no normative or comparative values are available for this method of scoring. The complex scoring method is based on item-response theory and requires use of a computer program, which is available from WHO.⁴ Normative values for the WHODAS 2.0 are based on this scoring method.

WHODAS 2.0 offers several advantages as an instrument for the assessment of functioning. Multiple studies have found WHODAS 2.0 to be reliable, responsive to change, and applicable across geographic regions. As a standardized cross-cultural measurement of health status, it has been demonstrated to have robust psychometric properties across a wide variety of psychiatric and physical disorders without regard to etiology.^{4,7,15–17,19} WHODAS 2.0 provides a summary measure of functioning and disability in all six domain categories and globally. It has demonstrated good face validity, including rep-

licability across countries, population groups, diagnostic groups, ages, and genders. It has also demonstrated reliability and validity in discriminating variations in profiles of disability across subgroups of the general population, among people with physical disorders and among those with mental health problems or addictions.

As with any metric, WHODAS 2.0 has certain limitations. For example, like the GAF, it may not be reliable in detecting decremental decreases in functional abilities among individuals with high premorbid baseline functioning.⁷ Also, the simple scoring method yields a number that is no more meaningful than a GAF score, as there are no normative values or comparative studies that indicate the meaning or interpretation of a specific hand-scored value for individual domains or for global functioning. In addition, WHODAS 2.0 is a self-report instrument with no internal indices to assess validity of responses.

DSM-5, ICD, and Models of Disability: An Imperfect Fit

The DSM-5 Task Force explicitly intended to bring psychiatric diagnosis into greater alignment with other medical disciplines and with the ICD system.^{1,11,20} The APA has indicated that DSM-5 and ICD should be thought of as companion publications.¹¹ However, the attempt to make DSM-5 and ICD diagnostic criteria for mental disorders congruent is incomplete and problematic in regard to models of psychiatric impairment and disability.

DSM-5 continues the practice introduced in DSM-III² of requiring a criterion of distress or disability to establish a diagnostic threshold for most psychiatric disorders.^{1,21} It states that mental disorders “are usually associated with significant distress or disability in social, occupational, or other important activities” (Ref. 1, p 19). This requirement has been operationalized by the use of a generic criterion, usually worded as “the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Ref. 1, p 20), found in each of the criteria sets of most of the diagnoses.

Unfortunately, DSM-5 also continues the tradition of using the terms impairment and disability in an “ill-defined and confusing” manner (Ref. 21, p 158). As all forensic fellows know, psychiatric symptoms and disorders can cause functional impairment, whereas disability is usually an administratively or

legally determined status, the definition of which differs, depending on the context of the determination.^{22,23} When DSM-5 uses the term disability, as in its conceptual definition of a mental disorder, the context usually indicates that impairment is actually meant.

One argument for maintaining the distress-or-disability criterion in DSM-5 was the need “to identify individuals who need treatment but whose symptoms may not cause them emotional distress” (Ref. 24, p 1761). DSM-5 also states that “the absence of clear biological markers or clinically useful measurements of severity for many disorders” creates a continuing need for inclusion of this threshold criterion (Ref. 1, p 20). Leaders of the DSM-5 Task Force noted that, absent these and other more specific criteria for the diagnosis of psychiatric disorders, the criterion of “activity limitations will retain its usefulness in determining clinical significance for clinical policy and reimbursement purposes” (Ref. 21, p 159).

In contrast, the diagnostic guidelines and criteria contained in the mental disorders section of ICD, unlike those in DSM-5, do not contain a requirement for clinically significant distress or impairment in functioning. As two of the DSM-5 Task Force leaders acknowledged, “The goal of harmonization between DSM-5 and ICD-11 will be made easier if DSM-5 makes an attempt to harmonize its approach to its specification of disability as well as its symptom criteria” (Ref. 21, p 158). As per these authors, “Separating symptoms from disability would need to occur at two levels: the symptom criteria and the clinical significance criterion” (Ref. 21, p 159).

Certainly, there is room for debate regarding the validity of any psychiatric diagnostic classification system that includes or does not include functioning and impairment as a diagnostic criterion. Nevertheless, a model of illness that includes impairment as a threshold criterion in its definition of psychiatric disorders does not map easily onto a model that separates disorders and related impairments and disability. The tension created by the difference between DSM-5’s definition of mental disorders, which includes impairment, and ICD’s definition, which does not, reflects a broader conflict between conceptual models of disability. DSM-5 continues to demonstrate the influence of the traditional medical model of disability on psychiatric diagnosis. In contrast, WHO’s classification systems reflect the inte-

gration of the newer and increasingly more popular social model of disability.^{16,19,22,25,26}

Thus, DSM-5 has created problems in regard to the evaluation of psychiatric impairment and disability that the inclusion of WHODAS 2.0 in Section III does not address. For example, will functional impairment still be routinely assessed in psychiatric evaluations? Although impairment is still a diagnostic criterion for most disorders, DSM-5 no longer provides an endorsed rating scale or method for consistent or systematic evaluation or the Axis V place-marker to emphasize the importance of the assessment of functioning in psychiatric diagnosis. (Although not required to make a psychiatric diagnosis, the use of the full five-axis system to facilitate comprehensive and systematic evaluation, including level of functioning, is recommended (Ref. 3, p 27) and routinely taught in U.S. psychiatry residency programs.)

Moreover, the APA does not actually recommend the standard use of WHODAS 2.0 for the assessment of functioning. WHODAS 2.0 is provided in the DSM-5 section on “Emerging Measures and Models,” a section reserved for items that require “further study” and “are not sufficiently established for routine clinical use” (Ref. 1, p xliii). Although items like WHODAS 2.0 provided in Section III may be clinically useful, they are not generally accepted in the mental health professions, require further research to establish their validity in routine use, and are not part of an official DSM-5 diagnosis of a mental disorder and cannot be used as such.

WHODAS 2.0 and New Learning: More Than Just the Numbers

As desirable as increased congruity with the ICD, the ICF, and a social model of disability may be, the WHODAS 2.0 cannot merely be substituted for the GAF for use in the evaluation of impairment. Effective use of WHODAS 2.0, even if it should become the standard and a required part of psychiatric diagnostic assessment, necessitates an understanding of the concepts of disease and disability on which the instrument is based.

If the APA ultimately wants to adopt the WHODAS 2.0 as the standard measure of impairment, the APA and psychiatric training programs will have to undertake active teaching of WHO’s “detailed and complex framework for describing disability” (Ref. 21, p 157), as well as the underlying

social model of disability. The ICF system “is virtually totally unfamiliar to United States psychiatrists, and the problems in disseminating an unfamiliar classification and terminology to a new audience must be considered and addressed” (Ref. 21, p 158). In fact, an examination of the application of the ICF in the field of psychiatry in the United States over a 10-year period, beginning in 2001 when the ICF was first launched, identified only 13 studies concerning the ICF and mental disorders. Of these, only seven focused on the implementation of the ICF in clinical psychiatric practice. The ICF’s “complex structure” was one of the reasons suggested for this finding.²⁷

WHODAS 2.0: Forensic Implications

Aside from these larger conceptual concerns and the unfamiliarity of the ICF and WHODAS 2.0, exclusion of the GAF and the tentative inclusion of WHODAS 2.0 create additional problems for forensic psychiatrists. Disability evaluations are frequently requested by private insurers in cases where psychiatric disability is claimed. Workers’ compensation cases often present complicated psychiatric, medical, and disability problems that are referred for forensic evaluation. Civil litigation cases, where claims of damage include psychiatric disability, are routinely referred for forensic psychiatric evaluation. All these forensic evaluations, as well as others in which disability or functioning may be at issue, such as fitness-for-duty evaluations, request or require a GAF score. Therefore, the exclusion of the GAF Scale from DSM-5 and the tentative suggestion for the use of WHODAS 2.0 have practical implications for forensic psychiatric evaluations.

WHODAS 2.0 and Differentiating Causes of Disability

The GAF was specific to symptom severity or impairment caused by psychiatric symptoms. DSM-IV-TR emphasized: “The GAF Scale is to be rated with respect only to psychological, social, and occupational functioning. The instructions specify, ‘Do not include impairment in functioning due to physical (or environmental) limitations’” (Ref. 3, p 32). In contrast, WHODAS 2.0 “has been designed to assess the limitations on activity and restrictions on participation experienced by an individual, irrespective of medical diagnosis” (Ref. 4, p 11) and requires consideration of environmental factors. Whereas the GAF Scale confounds psychiatric symptoms and

functioning but excludes environmental context, WHODAS 2.0 confounds medical and psychiatric impairment and does not exclude environmental context.

In clinical practice, it can be difficult to distinguish whether a physical or psychiatric disorder is the primary source of functional impairment, and doing so may not always be critical. However, in forensic assessments, clinicians are typically asked to make a specific determination of functional impairments and at times, even disability, due to psychiatric illness. For example, insurance policies and workers' compensation insurance may provide disability benefits for an impairment or disability due to medical illness but not for one due to psychiatric illness. In such cases, the cause of the impairment is the ultimate question and the reason for the evaluation.

Regardless of personal opinions regarding the Cartesian dichotomy between medical and psychiatric disorders, forensic psychiatrists are often asked to discriminate between medical and psychiatric disorders in such cases. A GAF score, which is limited to the assessment of psychiatric impairment or symptoms, can potentially assist in conveying this information. A WHODAS 2.0 score, even if computer generated, would not assist forensic clinicians or the consumers of forensic reports in determining causation of an impairment or disability. In addition, it is unlikely that any arguments that turn on a WHODAS 2.0 rating, an instrument that is not the standard of care at this time, would stand up to a *Daubert* challenge.

WHODAS 2.0: Self-Report Functional Impairment Assessments

WHODAS 2.0 is one of the self-report instruments referred to as patient-reported outcome measures (PROMs). It was designed to record and measure patients' views of their experiences of impairment and disability. PROMs are questionnaires used for the objective measurement of subjective constructs, such as an individual's experiences in relation to health and quality of life. In recent years, clinical research has increasingly relied on and used patient-reported outcomes as measures of changes in health status and treatment efficacy.²⁸

DSM-5 includes, for the first time, patient self-report measures of symptom severity and impairment. Leaders of the DSM-5 Task Force were aware of the trend toward increased use of PROMs, refer-

encing "a health care climate that increasingly emphasizes patient-reported outcomes" in discussing the decision to exclude the GAF.¹⁰ DSM-5 states, "A dimensional approach depending primarily on an individual's subjective reports of symptom experiences along with the clinician's interpretation is consistent with current diagnostic practice" (Ref. 1, p 733).

Nevertheless, the fact that WHODAS 2.0 is a self-report instrument lacking internal indices of validity creates difficulties for forensic psychiatrists. As with such self-report assessments, patients who cannot or will not provide valid information will produce invalid data on WHODAS 2.0, and WHODAS 2.0 does not provide clinicians with a method of determining the validity of the evaluatee's self report. An individual's assessment of his degree of impaired functioning "may not accord with the appraisal of medical and professional experts,"¹⁹ under the best of circumstances. However, among the categories of patients who may not provide valid data on WHODAS 2.0 are "persons who may not be motivated to provide accurate information" (Ref. 7, p 175).

Forensic psychiatrists are trained to be sensitive to and routinely consider the possibility of malingering in legal or administrative evaluations. Malingering, in the context of disability or workers' compensation and particularly in the form of symptom exaggeration, is not uncommon.²⁹ Self-report instruments are typically not considered objective evidence of illness or impairment in forensic evaluations because, among other limitations, they lack indices that allow assessment of the validity of self-report. Thus, despite DSM-5's inclusion of the 36-item self-report WHODAS 2.0 for the assessment of psychiatric disability, this instrument is not likely to be more useful in forensic psychiatric evaluations than other self-report instruments.

Forensic Psychiatry and Consumers of Psychiatric Disability Evaluations: What Now?

Controversy aside, it is undoubtedly too soon to tell how systems within which and for whom forensic psychiatrists provide psychiatric disability evaluations will react to the changes in DSM-5's assessment of psychiatric impairment. Leaders of the DSM-5 Task Force have acknowledged, "The introduction of patient-reported symptom assessments as part of the DSM would represent a major change in psychi-

atric practice, with implications for patient care, mental health policy, and health care funding” (Ref. 30, p 198).

So far, there is no indication that systems are using or even planning to use WHODAS 2.0 instead of the GAF. For example, the federal government’s Centers for Medicare and Medicaid Services have stated that “it is still perfectly permissible” to use DSM-IV for activities such as quality assessment and medical review.³¹ Government agencies, businesses, and other institutions may come to the same conclusion as forensic psychiatry: namely, that a self-report assessment instrument that has no measure of its validity is not ideal for use in legal, insurance, or administrative claims of disability. This conclusion may be reached even more quickly when it becomes evident that WHODAS 2.0 does not distinguish between impairment due to physical or psychiatric symptoms.

What instrument then should forensic psychiatrists use? The psychometrics of the clinician-rated versions of WHODAS 2.0 do not appear to have been studied, and so no data are available on the validity and reliability of the use of these clinician-rated versions. A clinician-rated proxy version of an earlier version of WHODAS 2.0 was developed, but there is no indication that its reliability or validity have been assessed either.⁷ It has been suggested the clinician-rated GAF, the clinician-rated version of WHODAS, or some other objective measure of impairment and functioning could be used in conjunction with the WHODAS 2.0 to improve its validity and reliability.^{7,19} However, the psychometrics of using combination methods of assessment have not been examined.

These suggestions only serve to underscore the problem that confronts forensic psychiatrists with the arrival of DSM-5. That WHODAS 2.0 is not useful for forensic evaluations of psychiatric impairment or disability is likely to encourage the increasing use of nonstandardized and non-evidence-based approaches to the assessment of psychiatric functional impairment. Forensic clinicians may choose a rating scale that is familiar and suits their practice needs but lacks an acceptable evidence base, like the suggested use of combination methods of assessment, resulting in an increase in idiosyncratic methods of assessment of psychiatric impairment and disability.

In addition, government, administrative, or legal systems requesting psychiatric disability evaluations

may ask psychiatrists to use a rating scale that best suits the specific system’s needs. A case in point is the American Medical Association’s Guides to the Evaluation of Permanent Impairment, Sixth Edition,³² the most widely used reference for evaluating permanent impairment for purposes of disability determinations in state and federal workers’ compensation cases. This edition of the Guides proposes utilization of a new, unvalidated, and non-evidence-based rating system for psychiatric impairment. Although its use has not been widely adopted, it is nevertheless an example of an idiosyncratic and unsupported methodology devised specifically to meet a system’s need to assign a numerical score that reflects impairment due to psychiatric symptoms.

Alternatively, legal and administrative systems may continue to require the use of the familiar GAF ratings. As several psychiatrists stated in a recent review of the DMS-5 changes, “It will take a while for third-party payers to cease demanding the multiaxial system.”³³ However, the GAF has the highest reliability and validity when raters are trained in its use. If the GAF is no longer endorsed by the APA or included in DSM-5, will psychiatrists still be trained in its use? If not, the validity and reliability of the GAF, already limited as discussed herein, will be further compromised.

One of the more frequent complaints regarding the GAF, and perhaps one of the reasons that its exclusion from the DSM-5 was not mourned, is that it could be easily compromised. Lower or higher scores could be assigned depending on the rater’s ultimate goal, such as meeting criteria for insurance reimbursement or supporting arguments involving disability claims. One attorney has stated:

The GAF was often misused in expert testimony in employment lawsuits, as a mental health expert would testify that before being fired the employee had a GAF of 90 (blissfully happy) and after being fired his GAF plummeted to somewhere around 40 (barely functioning). Most experts just assigned a GAF score arbitrarily. DSM-5 eliminates the GAF, so this sort of testimony will no longer be possible [Ref. 34].

The intentional misuse or distortion of any psychiatric impairment or disability numerical rating system to prove a legal argument or claim is unethical and represents an abuse of psychiatry. However, this problem is not limited to the use of the GAF Scale. Those motivated to do so can manipulate any type of numerical rating scale. As DSM-5 (Ref. 1, p 25) and previous DSM editions have emphasized, when the

DSM is used for forensic purposes, the imperfect fit between legal issues and clinical diagnoses creates a risk that the information contained in the DSM will be misused or misunderstood.

Attorneys, courts, bureaucratic, administrative, and legal systems are likely to continue to request or require some standardized numerical rating system to communicate psychiatric assessment of impaired functioning and disability. The APA has acknowledged, "For those who relied on the use of a GAF number, there will clearly be a transitional period from the GAF to the use of separate assessments of severity and disability."¹¹ The APA has advised clinicians to continue using DSM-IV-TR diagnoses and codes "when required by a specific company."¹¹ Presumably, this advice would apply to requests by specific agencies or companies requesting that evaluations of psychiatric disability continue to use the GAF as well.

At the time of submission of this article, details regarding the transition from DSM-IV-TR to DSM-5 for government and insurance systems and agencies were still developing. The APA had indicated that it expected to recommend officially that government agencies and private insurers transition from DSM-IV to DSM-5 by December 31, 2013.¹¹ As of April 24, 2014, the date of final review of this article, no official recommendation had been made. The use of the GAF is likely to be requested or required in psychiatric disability evaluations for some time to come.

Psychiatric evaluations of impairment and disability have generally benefitted from the standardization of practice provided by the multiaxial assessment methodology that included routine assessment of functioning and use of the GAF. Given the problems associated with forensic use of WHODAS 2.0 and the possibility of the proliferation of idiosyncratic methods for evaluations of psychiatric impairment and disability, psychiatric residency programs and forensic fellowships are well advised to continue training young clinicians in the use of the GAF despite its exclusion from DSM-5.

Conclusion

In these relatively early days after the publication of DSM-5, few of the questions related to the changes in the assessment of psychiatric disability have clear answers. No single number can convey enough information to address adequately all the dif-

ferent domains of function that may be affected by psychiatric disorders.¹¹ Devising any system to rate psychiatric impairment is a complex and perhaps impossible task. Nevertheless, the changes in diagnostic processes and methodology in DSM-5 are not likely to make the assessment of psychiatric impairment and disability more straightforward or less challenging.

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