DSM Wrapper Manual — Clean Guide

Clean Edition v0.1

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1 DSM Wrapper Manual

This manual is published in two clean artifacts: a **Clean Guide** (reading-first) and a **Clean Reference** (lookup-first). The title page indicates which one you are reading.

1.1 Start Here

1.2 When to Use Which

- Clean Guide: orientation, workflow, Atlas, and exemplar prototypes.
- Clean Reference: full Atlas, domains, prototypes, and lookup detail.

2 DSM Wrapper Manual — Clean Guide

Reading-first guide to the framework. Use the Clean Reference for full domain and prototype catalogs.

2.1 Start Here

- Core Workflow: Identify to Monitor
- Universal Intake Set
- Documentation Templates (overview)
- How Clinicians Actually Use This

2.2 Quick Paths

- New evaluation: Clinician Workflow → Universal Intake Set → Documentation Templates
- Safety-first: Risk Modifiers → Rule-Out Summary
- Follow-up: Documentation Templates → Documentation Examples

2.3 Guide Contents

2.4 Prototype Clusters Included

- Predominant Mood and Drive
- Predominant Threat
- Predominant Trauma and Stress
- Predominant Compulsivity
- Predominant Psychosis
- Predominant Neurodevelopmental
- Predominant Somatic and Interoceptive
- Predominant Eating and Feeding
- Substance-Related
- Personality Pattern Prototypes

3 Purpose, Scope, and Limits

This chapter orients you to what the framework is for and where it stops. Most useful when setting scope with yourself or others.

Purpose. Provide a DSM-compatible clinical reasoning companion for assessment, formulation, and documentation. Use patient-near phenomenology and dimensional ratings to reduce diagnostic noise.

3.1 Scope

- In: core workflow, universal intake, risk modifiers, Atlas entries, domain summary, prototype exemplars, rule-out summary, documentation template overview, glossary, failure modes, and label deferral.
- Out: treatment guidelines, full prototype catalogs, measurement prompts, billing policy, or definitive etiologic models.

Intended Audience. Clinicians in psychiatry, psychology, primary care, and integrated care; Trainees and supervisors who need a consistent documentation and teaching frame; Systems focused on quality, measurement-based care, and continuity.

Compatibility and Outputs. Compatible with DSM and ICD codes; codes are outputs, not the entry point. Outputs: domain ratings, prototype tags when useful, formulation summary, and risk/trajectory notes.

Guardrails

- Not a replacement for DSM or ICD.
- Not a substitute for clinical judgment, local policy, or legal requirements.
- Not a treatment manual or prescribing guide.
- Not a definitive model of cause or mechanism.

3.2 Safety and Ethics Commitments

- Record uncertainty and competing explanations when present.
- Prefer least-harmful labeling and avoid stigmatizing language.
- Center context, development, and culture in formulation.

4 Core Workflow: Identify to Monitor

This is the six-step loop for moving from presenting experience to monitoring without forcing a label.

> Quick scan
>
> Identify → Describe → Quantify → Contextualize → Decide → Monitor.

4.1 Steps (one line each)

- Identify: Clarify the presenting problem in patient language and screen for safety or rule-out-first concerns.
- Describe: Use Atlas entries to capture phenomenology and boundary markers.
- Quantify: Rate relevant domains (0-4) and time-course; optional measures (see Reference) when needed.
- Contextualize: Add developmental, cultural, and situational context; note contributors and protective factors.
- Decide: Assign provisional prototypes when useful; add specifiers that change risk or management; record confidence and competing explanations.
- Monitor: Choose a small set of signals and set a reassessment interval.

4.2 Use Patterns

- Fast path (1-2 minutes): Identify + safety screen; 1-2 domain ratings; optional prototype; brief summary line.
- Standard path (5-10 minutes): Identify + describe + quantify + context; add specifiers; use 5-minute template.
- Comprehensive: Full domain profile and formulation; rule-out compendium as needed; monitoring plan; comprehensive note.

Outputs: presenting problem line; domain ratings + prototype tags; specifiers (course, contributors, risk, context); formulation summary and monitoring plan.

Guardrails

Scope: descriptive workflow, not diagnostic criteria or treatment guidance.

5 Universal Intake Set

This chapter defines the minimum intake set that prevents safety and medical misses. Most useful at first contact or when restarting care.

Purpose. Create a minimum, repeatable intake set for every patient. Catch safety, medical, and substance issues early. Normalize cross-cutting context so it is not lost under time pressure.

5.1 Minimum Intake Set (every patient, every time)

- Safety: suicide/self-harm, violence risk, self-neglect, exploitation risk.
- Medical/neurologic red flags: acute confusion, head injury, seizures, infection signs.
- Substance/medication review: intoxication, withdrawal, recent changes, iatrogenic effects.
- Sleep/circadian: insomnia, hypersomnia, circadian shift, nightmares.
- Pain/fatigue: severity, duration, functional impact.
- Function: work/school, relationships, self-care.
- Trauma/stress exposure: recent threats, ongoing safety concerns.
- Social determinants: housing, food security, legal issues, access to care.
- Supports and strengths: relationships, coping skills, protective factors.

Red flags

- Acute confusional state or rapidly fluctuating cognition. [E0/U3]
- Severe intoxication, withdrawal, or medication reaction. [E0/U3]
- Imminent self-harm or harm to others. [E0/U3]
- Inability to care for basic needs without support. [E0/U3]

Documentation Output. Presenting problem line. Safety screen outcome. Rule-out triggers noted. Context and supports snapshot.

6 Documentation Templates (Overview)

Purpose. Provide consistent, time-scaled note structures that map to the core workflow. Keep documentation aligned with domains, specifiers, and formulation without overreach.

Full templates live in the Clean Reference and the repo; this section summarizes them for orientation.

6.1 Template Set

- 1-Minute Note: minimal structure for quick capture and continuity.
- 5-Minute Note: standard visit note with brief formulation and monitoring.
- Comprehensive Note: full assessment and formulation for complex cases.
- Recording Format: compact diagnostic line for handoffs or summaries.

6.2 When to Use Which

- 1-Minute Note: follow-up visits, stable presentations, time-constrained settings.
- 5-Minute Note: new evaluations or significant changes.
- Comprehensive Note: initial workups, complex presentations, medico-legal contexts.

6.3 Required vs Optional Fields

- Required: presenting problem, safety screen, domain ratings, specifiers, brief summary line.
- Optional: prototype tags, differential list, monitoring plan, uncertainty notes.

6.4 Local Requirements

- Templates are meant to be adapted to local policy, billing, and legal needs.
- Add institutional sections as needed, but keep the core workflow intact.

7 How Clinicians Actually Use This

Purpose. Capture real-world usage patterns without prescribing a workflow. Normalize partial use and context-dependent adoption.

7.1 Common Usage Patterns (examples)

- "I use this for messy first evals when the DSM label feels premature."
- "I use domains only for follow-ups to track change."
- "I use prototypes mostly for handoffs, billing, or service access."
- "I use the rule-out compendium when something feels off."
- "I use the intake set to avoid missing safety or medical issues."
- "I use the recording format line for fast documentation."

7.2 Entry Points in Practice

- Initial evaluation: Clinician workflow → Universal intake → Domains → Provisional prototype.
- Follow-up: Domains + specifiers + monitoring.
- High-stakes settings: Rule-out compendium + risk modifiers + documentation template.
- Primary care: Intake set + 1-minute note + rule-outs as needed.

7.3 Partial Use is Expected

- You can use the Atlas without using prototypes.
- You can use domains without assigning labels.
- You can use specifiers to document uncertainty or contributors without changing the diagnosis.

8 Risk Modifiers

Purpose. Document risk in a consistent, defensible way. Separate baseline risk from dynamic drivers.

8.1 Core Risk Domains

- Suicide or self-harm.
- Violence toward others.
- Self-neglect or inability to care for self.
- Exploitation or victimization vulnerability.

8.2 Risk Tiers

- Low: no current intent or imminent risk indicators.
- Moderate: risk factors present; monitoring required.
- High: active intent, plan, or acute instability.

8.3 Dynamic Drivers

- Recent losses, intoxication, acute stress, access to means, escalation cues. [E0/U2]

8.4 Protective Factors

- Supports, reasons for living, engagement with care, stable housing.

Documentation Output. Risk tier and primary drivers. Protective factors noted. Safety actions or escalation triggers recorded.

9 Rule-Out Compendium (Summary)

High-level overview of rule-out categories. Full detail appears in the Clean Reference.

- Delirium and Acute Confusional States → acute onset with fluctuating attention.
- Substance Intoxication and Withdrawal → sudden change with recent use or cessation.
- Medication and Iatrogenic Psychiatric Syndromes → symptoms follow med start or dose change.
- Endocrine and Metabolic Mimics → systemic symptoms or unexplained physiologic shifts.
- Seizure, Autoimmune, Infectious, and Neurodegenerative Mimics → neurologic signs, seizures, or progressive decline.
- Sleep Disorders Masquerading as Psychiatric Illness → prominent sleep disruption or daytime sleepiness.
- Pain and Fatigue Syndromes with Bidirectional Causality → chronic pain/fatigue driving mood or function.

10 Affect and Mood Experiences

This chapter starts the Atlas: patient-near descriptions of experience before labeling. Most useful when clarifying phenomenology.

10.1 Summary

- Shifts in emotional tone, intensity, or range that shape how a person feels, thinks, and functions.

10.2 Patient-Language Phrases

- "I feel empty or numb."
- "Nothing feels enjoyable anymore."
- "My mood swings fast."
- "I feel unusually energized and wired."

10.3 Core Features

- Sadness, emptiness, or anhedonia.
- Irritability or emotional lability.
- Elevated or expansive mood with increased drive.
- Emotional numbing or shutdown.

10.4 Boundary Markers

- What it is: sustained or recurrent mood states that affect function.
- What it is not: brief, proportional reactions to clear events.

10.5 Quick Structure

- **Variants / Spectrum**
  - Low mood with loss of interest.
  - Irritable or mixed mood states.

  - Elevated mood with increased energy and reduced sleep.
  - Emotional flattening or detachment.
- **Severity (0-4)**
  - 0: Typical mood range and reactivity.
  - 1: Mild shifts, limited impact.
  - 2: Moderate, persistent, impacts function.
  - 3: Severe, marked impairment or risk.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Episodic mood changes.
  - Chronic low mood or blunted affect.
  - Cyclic or seasonal shifts.
- **Functional impact**
  - Work/school: reduced performance or overactivity.
  - Relationships: withdrawal, conflict, or instability.
  - Self-care: disrupted routine, sleep, or appetite.
- **Developmental expression**
  - Childhood: irritability or withdrawal.
  - Adolescence: mood lability, risk-taking, sleep shifts.
  - Late life: somatic focus, grief overlap.
- **Cultural/context notes**
  - Mood expression varies by culture and context.
  - Grief and loss processes can mimic low mood.

11 Anxiety, Threat, and Bodily Alarm

11.1 Summary

- Heightened threat anticipation with bodily alarm and avoidance that feels out of proportion or hard to control.

11.2 Patient-Language Phrases

- "I feel on edge all the time."
- "My heart races and I can't catch my breath."
- "I keep thinking something bad will happen."
- "I avoid places because I might panic."

11.3 Core Features

- Persistent sense of threat or danger.
- Bodily arousal (racing heart, tight chest, trembling).
- Avoidance or safety behaviors.

11.4 Boundary Markers

- What it is: threat-focused worry or fear that dominates attention.
- What it is not: expected stress responses to clear, time-limited threats.

11.5 Quick Structure

- **Variants / Spectrum**
  - Worry-dominant tension.
  - Panic surges with intense bodily alarm.
  - Specific fears or phobic avoidance.
  - Social or performance-related threat.
  - Health-focused threat and scanning.

- **Severity (0-4)**
  - 0: No significant threat anticipation.
  - 1: Mild, situational, manageable.
  - 2: Moderate, recurring, interferes with focus or sleep.
  - 3: Severe, frequent avoidance or panic.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Acute spikes tied to triggers.
  - Episodic panic with inter-episode worry.
  - Chronic, diffuse tension.
  - Fluctuating with stress load.
- **Functional impact**
  - Work/school: reduced concentration or avoidance.
  - Relationships: withdrawal or reassurance seeking.
  - Self-care: disrupted routines or sleep.
- **Developmental expression**
  - Early childhood: separation fears, somatic complaints.
  - School age: school refusal, performance anxiety.
  - Adolescence: social threat, panic, avoidance.
  - Late life: health or safety-focused threat.
- **Cultural/context notes**
  - May present as somatic distress or spiritual framing.
  - Threat meaning is shaped by environment and exposure.

12 Trauma-Related Experiences

12.1 Summary

- Experiences of intrusion, hyperarousal, avoidance, or shutdown tied to past or ongoing threat.

12.2 Patient-Language Phrases

- "I keep reliving it."
- "I feel on edge, like something bad is about to happen."
- "I go numb or shut down."
- "I avoid anything that reminds me of it."

12.3 Core Features

- Intrusions (memories, flashbacks, nightmares).
- Hypervigilance and exaggerated startle.
- Avoidance and emotional numbing.
- Dissociation or fragmentation under stress.

12.4 Boundary Markers

- What it is: threat-linked responses that persist beyond the event.
- What it is not: expected short-term stress reactions to acute events.

12.5 Quick Structure

- **Variants / Spectrum**
  - Intrusion-dominant (re-experiencing).
  - Hyperarousal-dominant (vigilance, irritability).
  - Dissociative/shutdown-dominant.
  - Grief-trauma overlap or moral injury.
- **Severity (0-4)**

  - 0: No trauma-linked symptoms.
  - 1: Mild, intermittent, manageable.
  - 2: Moderate, recurrent, impacts function.
  - 3: Severe, persistent, with avoidance or dissociation.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Acute post-event reactions.
  - Chronic persistence with triggers.
  - Fluctuations with stress or reminders.
- **Functional impact**
  - Work/school: concentration issues, avoidance.
  - Relationships: withdrawal, mistrust, conflict.
  - Self-care: sleep disruption, hyperarousal.
- **Developmental expression**
  - Childhood: behavioral regression, play reenactment.
  - Adolescence: risk-taking, emotional volatility, shutdown.
  - Late life: reactivation around losses or medical events.
- **Cultural/context notes**
  - Trauma meaning varies by culture and community narratives.
  - Ongoing threat changes interpretation and management.

13 Obsessions, Compulsions, and Stuckness

13.1 Summary

- Intrusive thoughts, images, or urges paired with repetitive behaviors or mental rituals that feel hard to resist.

13.2 Patient-Language Phrases

- "I can't stop thinking about it."
- "I have to check or repeat things to feel okay."
- "I get stuck on certain thoughts."
- "I do it even though I know it doesn't make sense."

13.3 Core Features

- Intrusive thoughts or urges that feel unwanted.
- Compulsions, checking, reassurance seeking, or mental rituals.
- Sense of relief followed by return of doubt or distress.

13.4 Boundary Markers

- What it is: repetitive thoughts or behaviors driven by distress or uncertainty.
- What it is not: goal-directed habits or preferences without distress.

13.5 Quick Structure

- **Variants / Spectrum**
  - Checking and reassurance loops.
  - Contamination or harm-focused fears.
  - Symmetry or "just right" compulsions.
  - Body-focused repetitive behaviors (skin, hair).
  - Health or illness-focused rumination.

- **Severity (0-4)**
  - 0: No significant intrusive thoughts or rituals.
  - 1: Mild, occasional, manageable.
  - 2: Moderate, recurring, impacts focus or time use.
  - 3: Severe, frequent, time-consuming or impairing.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Chronic with fluctuating intensity.
  - Trigger-linked spikes.
- **Functional impact**
  - Work/school: reduced focus, time lost to rituals.
  - Relationships: reassurance seeking or conflict.
  - Self-care: delays or avoidance.
- **Developmental expression**
  - Childhood: rituals or checking that intensify under stress.
  - Adolescence: increased rumination and reassurance.
  - Late life: health anxiety or checking related to safety.
- **Cultural/context notes**
  - Some rituals are culturally normative; assess distress and impairment.

14 Reality Distortion and Psychosis-Spectrum Experiences

14.1 Summary

- Experiences where perception, belief, or thought content departs from shared reality or is held with reduced insight.

14.2 Patient-Language Phrases

- "I hear voices when no one is there."
- "People are watching or sending me messages."
- "My thoughts don't feel like my own."
- "Things feel unreal or distorted."

14.3 Core Features

- Hallucinations or perceptual distortions.
- Fixed or unusual beliefs held with high conviction.
- Disorganized thought or behavior.
- Reduced ability to test reality.

14.4 Boundary Markers

- What it is: persistent or recurrent reality-distorting experiences with reduced insight.
- What it is not: culturally normative beliefs, grief-related phenomena, or transient misperceptions tied to sleep loss or substances.

14.5 Quick Structure

- **Variants / Spectrum**
  - Auditory, visual, or tactile hallucinations.

  - Delusional themes (persecution, grandiosity, reference).
  - Thought insertion, withdrawal, or broadcasting.
  - Disorganization or catatonia-like states.
  - Insight continuum from intact to minimal.
- **Severity (0-4)**
  - 0: No reality-distortion symptoms.
  - 1: Mild, intermittent, with intact insight.
  - 2: Moderate, recurring, impacts function.
  - 3: Severe, persistent, with impaired insight or safety concerns.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Acute onset.
  - Episodic with remissions.
  - Chronic persistence with exacerbations.
  - Progressive functional decline.
- **Functional impact**
  - Work/school: disorganization or reduced performance.
  - Relationships: mistrust, withdrawal, or conflict.
  - Self-care: neglected routines or safety concerns.
- **Developmental expression**
  - Adolescence: new onset with functional change.
  - Adulthood: episodic or persistent patterns.
  - Late life: new onset warrants medical workup.
- **Cultural/context notes**
  - Assess beliefs within cultural, spiritual, or community context.
  - Language and meaning may shape symptom description.

15 Attention, Executive Function, and Neurodevelopmental Experiences

15.1 Summary

- Differences in attention, organization, impulse control, or social communication that are often longstanding and context-dependent.

15.2 Patient-Language Phrases

- "I can't stay focused unless I'm really interested."
- "I lose track of time and tasks."
- "I miss social cues or feel out of sync."
- "Sounds, lights, or textures feel overwhelming."

15.3 Core Features

- Inattention, distractibility, or hyperfocus.
- Impulsivity or difficulty with planning and follow-through.
- Social communication differences or sensory sensitivity.

15.4 Boundary Markers

- What it is: persistent patterns across time and settings.
- What it is not: acute attention changes driven by mood, sleep loss, or substances.

15.5 Quick Structure

- **Variants / Spectrum**
  - Inattention-dominant presentations.
  - Hyperactivity or impulsivity-dominant presentations.
  - Social communication and sensory regulation differences.

  - Learning-related challenges.
- **Severity (0-4)**
  - 0: No significant impairment in attention or executive function.
  - 1: Mild, situational, manageable.
  - 2: Moderate, recurring, impacts function.
  - 3: Severe, persistent, with clear impairment.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Lifelong or early-onset patterns.
  - Stable with situational fluctuations.
- **Functional impact**
  - Work/school: missed deadlines, disorganization, inconsistent performance.
  - Relationships: miscommunication, conflict, or withdrawal.
  - Self-care: routine instability, forgetfulness.
- **Developmental expression**
  - Childhood: attention, behavior, or learning challenges.
  - Adolescence: academic demands reveal deficits.
  - Adulthood: organizational strain and burnout.
- **Cultural/context notes**
  - Expectations of attention and behavior vary by context.
  - Environmental mismatch can amplify impairment.

16 Emotion Regulation, Self-Concept, and Interpersonal Pain

16.1 Summary

- Intense or unstable emotions, shifting self-concept, and painful relational patterns that drive distress and functional impairment.

16.2 Patient-Language Phrases

- "My emotions feel too big to handle."
- "I don't know who I am."
- "I'm terrified people will leave."
- "I feel empty or numb."

16.3 Core Features

- Rapid emotional shifts or intense affect.
- Unstable self-image or chronic emptiness.
- Fear of abandonment and relational volatility.

16.4 Boundary Markers

- What it is: persistent patterns of regulation difficulty and relational pain.
- What it is not: situational reactions that resolve with context changes.

16.5 Quick Structure

- **Variants / Spectrum**
  - Emotion lability or explosive reactions.
  - Chronic shame or identity instability.
  - Interpersonal conflict or push-pull patterns.

  - Emotional numbing or dissociative shutdown.
- **Severity (0-4)**
  - 0: No significant regulation or interpersonal difficulties.
  - 1: Mild, situational, manageable.
  - 2: Moderate, recurring, impacts function.
  - 3: Severe, persistent, with relational instability.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Chronic with episodic spikes.
  - Trigger-linked to attachment or rejection cues.
- **Functional impact**
  - Work/school: conflict, instability, absenteeism.
  - Relationships: ruptures, withdrawal, or intense dependency.
  - Self-care: impulsive or self-damaging behaviors.
- **Developmental expression**
  - Adolescence: identity shifts, relational volatility.
  - Adulthood: chronic interpersonal instability.
  - Late life: isolation or entrenched patterns.
- **Cultural/context notes**
  - Relationship norms and identity frameworks vary by culture.
  - Ongoing adversity amplifies relational pain.

17 Somatic Distress and Interoception

17.1 Summary

- Distressing bodily sensations, pain, or fatigue with heightened attention to internal cues and uncertainty about what they mean.

17.2 Patient-Language Phrases

- "My body feels off all the time."
- "I notice every sensation and worry about it."
- "I'm exhausted no matter how much I rest."
- "The pain feels overwhelming."

17.3 Core Features

- Persistent or intense bodily discomfort.
- Heightened interoceptive focus or scanning.
- Distress or worry about symptoms.

17.4 Boundary Markers

- What it is: bodily distress with attention amplification or uncertainty intolerance.
- What it is not: clear, fully explained medical conditions without distress amplification.

17.5 Quick Structure

- **Variants / Spectrum**
  - Pain-dominant presentations.
  - Fatigue or low-energy syndromes.
  - Functional neurologic symptoms (weakness, tremor, nonepileptic events).
  - Health anxiety overlap.
- **Severity (0-4)**

  - 0: No significant somatic distress.
  - 1: Mild, intermittent, manageable.
  - 2: Moderate, persistent, impacts function.
  - 3: Severe, frequent, with significant distress or impairment.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Chronic persistence with flares.
  - Trigger-linked or stress-linked spikes.
- **Functional impact**
  - Work/school: reduced stamina or attendance.
  - Relationships: increased reassurance seeking or withdrawal.
  - Self-care: disrupted routines, healthcare overuse or avoidance.
- **Developmental expression**
  - Childhood: somatic complaints or school avoidance.
  - Adolescence: fatigue, pain, or health anxiety.
  - Late life: symptom focus with medical overlap.
- **Cultural/context notes**
  - Somatic framing of distress may be culturally normative.
  - Access to care shapes symptom interpretation.

18 Sleep, Circadian, and Arousal Regulation

18.1 Summary

- Disruptions in sleep timing, sleep quality, or arousal level that shape mood, cognition, and function.

18.2 Patient-Language Phrases

- "I can't fall asleep no matter what."
- "I wake up all night and never feel rested."
- "My sleep schedule is flipped."
- "I'm wired at night and exhausted during the day."

18.3 Core Features

- Difficulty initiating or maintaining sleep.
- Misaligned sleep timing (delayed or advanced phase).
- Hyperarousal or low arousal states.

18.4 Boundary Markers

- What it is: persistent sleep or arousal regulation problems affecting function.
- What it is not: short-term sleep loss from temporary circumstances.

18.5 Quick Structure

- **Variants / Spectrum**
  - Insomnia (initiation, maintenance, early waking).
  - Hypersomnia or excessive sleepiness.
  - Circadian rhythm delay/advance.
  - Nightmare or parasomnia patterns.
- **Severity (0-4)**

  - 0: Restorative sleep, stable timing.
  - 1: Mild disruption, limited impact.
  - 2: Moderate disruption with daytime impairment.
  - 3: Severe, persistent disruption with functional impact.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Acute, stress-related insomnia.
  - Chronic insomnia or circadian shift.
  - Fluctuating with schedule or substance use.
- **Functional impact**
  - Work/school: fatigue, concentration issues.
  - Relationships: irritability, withdrawal.
  - Self-care: reduced routine stability.
- **Developmental expression**
  - Childhood: bedtime resistance, nightmares.
  - Adolescence: delayed sleep phase.
  - Late life: early waking, fragmented sleep.
- **Cultural/context notes**
  - Shift work or caregiving roles can drive sleep disruption.
  - Cultural norms influence sleep timing and reporting.

19 Eating, Appetite, and Body Image

19.1 Summary

- Changes in appetite, eating behavior, or body image that drive distress, restriction, or loss of control.

19.2 Patient-Language Phrases

- "I'm scared of gaining weight."
- "I feel out of control when I eat."
- "Food textures make it hard to eat."
- "I avoid meals even when I'm hungry."

19.3 Core Features

- Restriction or avoidance of food.
- Binge episodes or loss of control.
- Compensatory behaviors or excessive exercise.
- Distorted body image or weight/shape concerns.

19.4 Boundary Markers

- What it is: persistent eating-related distress or dysregulation with functional impact.
- What it is not: short-term diet changes without impairment.

19.5 Quick Structure

- **Variants / Spectrum**
  - Restriction-dominant patterns.
  - Binge/purge patterns.
  - Binge without compensatory behavior.
  - Avoidant/restrictive patterns tied to sensory or fear.

- **Severity (0-4)**
  - 0: No significant eating dysregulation.
  - 1: Mild, intermittent, manageable.
  - 2: Moderate, recurring, impacts function.
  - 3: Severe, persistent, with medical or functional risk.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Episodic with stress-linked spikes.
  - Chronic patterns with fluctuating severity.
- **Functional impact**
  - Work/school: concentration loss, health impacts.
  - Relationships: secrecy, conflict around meals.
  - Self-care: nutritional compromise or medical risk.
- **Developmental expression**
  - Childhood: picky eating, sensory avoidance.
  - Adolescence: body image concerns, restriction.
  - Adulthood: chronic patterns or relapse.
- **Cultural/context notes**
  - Body ideals and food norms shape expression.
  - Food insecurity can mimic restriction.

20 Substance Use and Compulsive Reward Seeking

20.1 Summary

- Compulsive use of substances or reward-seeking behaviors despite negative consequences and loss of control.

20.2 Patient-Language Phrases

- "I keep using even when I tell myself I won't."
- "I need more to get the same effect."
- "I feel sick or anxious if I stop."
- "It's the only thing that helps me feel okay."

20.3 Core Features

- Craving or compulsive use.
- Loss of control over quantity or frequency.
- Tolerance and withdrawal patterns.
- Continued use despite harm.

20.4 Boundary Markers

- What it is: persistent, harmful use with impaired control.
- What it is not: occasional use without loss of control or harm.

20.5 Quick Structure

- **Variants / Spectrum**
  - Binge or episodic use patterns.
  - Daily or steady use patterns.

  - Polysubstance use.
  - Behavioral reward seeking (evidence-graded).
- **Severity (0-4)**
  - 0: No clinically meaningful compulsive use.
  - 1: Mild, intermittent, limited consequences.
  - 2: Moderate, recurring, with clear impairment.
  - 3: Severe, persistent, with significant harm.
  - 4: Extreme, disabling or unsafe.
- **Time-course**
  - Episodic with relapse cycles.
  - Chronic, persistent use.
  - Fluctuating with stress or access.
- **Functional impact**
  - Work/school: missed obligations, decreased performance.
  - Relationships: conflict, secrecy, isolation.
  - Self-care: health decline, risk behaviors.
- **Developmental expression**
  - Adolescence: risk-taking, peer-influenced use.
  - Adulthood: coping-related or dependence patterns.
  - Late life: medication interactions and misuse.
- **Cultural/context notes**
  - Use patterns shaped by access, norms, and legal context.
  - Stigma can distort reporting.

21 Domain Summary

This chapter lists the domain constructs and their summary definitions. Full domain entries live in the Clean Reference.

- Mood and Drive Dysregulation: A dimensional construct describing dysregulated mood tone, energy, and drive across time and context.
- Anxiety and Threat Sensitivity: A dimensional construct describing heightened detection and response to threat signals across contexts.
- Trauma and Stress Response: A dimensional construct describing persistent threat responses, intrusions, and dysregulation following adverse or traumatic events.
- Compulsivity and Perseveration: A dimensional construct describing repetitive thoughts, urges, or behaviors that are hard to inhibit and consume time or function.
- Psychosis and Reality Testing: A dimensional construct describing the degree of reality distortion and impairment in testing beliefs or perceptions.
- Cognitive Control and Executive Function: A dimensional construct describing attention regulation, planning, impulse control, and task persistence.
- Social Communication and Relatedness: A dimensional construct describing social communication style, reciprocity, and relatedness across contexts.
- Arousal, Sleep, and Circadian Regulation: A dimensional construct describing dysregulation in sleep quality, timing, or arousal that affects function and symptom expression.
- Somatic Distress and Interoception: A dimensional construct describing heightened bodily symptom distress and sensitivity to internal cues.
- Reward, Habit, and Substance-Related Compulsion: A dimensional construct describing compulsive reward seeking, habit formation, and substance-related loss of control.
- Eating and Feeding Regulation: A dimensional construct describing regulation of eating, appetite, and body-related behaviors.
- Personality Functioning (Dimensional): A dimensional construct describing stability of self-functioning and quality of interpersonal functioning.

22 How to Use Prototypes

This chapter explains when prototypes help and when they mislead. Most useful for handoffs, communication, and billing.

Purpose. Provide practical rules for when and how to apply prototype labels. Keep prototypes optional, communication-focused, and DSM-compatible.

22.1 When to Use Prototypes

- When a recognizable pattern improves communication with clinicians, patients, or systems.
- When a label improves documentation clarity or billing alignment.
- When the pattern aligns with observed domains and time-course.

22.2 When Not to Use Prototypes

- When evidence is unclear or competing explanations dominate.
- When a label would reduce nuance or increase stigma.
- When acute rule-out conditions are unresolved.

22.3 How to Assign a Prototype (short workflow)

- Start with Atlas entry to confirm phenomenology.
- Rate relevant domains (0-4) and course.
- Apply the prototype tag only if it adds value.
- Record uncertainty or provisional status if needed.

22.4 Comorbidity and Overlap

- Overlap is expected; multiple prototypes can be used sparingly.
- Prefer domain ratings to convey complexity; use prototypes for shorthand only.

Documentation Output. Prototype tag(s) + confidence (high/medium/provisional). Linked domains and key specifiers.

23 Prototype Modules: Organization and Logic

Purpose. Explain how prototype modules are grouped and navigated. Preserve a consistent, clinician-scannable structure.

23.1 Organization Logic

- Prototypes are grouped by dominant domain pattern.
- Each cluster has an overview page plus individual prototype pages.

23.2 Module Structure (standard)

- Summary and prototype features.
- Threshold guidance.
- Expected domain profile.
- Time-course and trajectory.
- Differential and red flags.
- Specifiers and measurement prompts.
- Cross-links and documentation snippet.

23.3 Navigation Rules

- Start at Atlas for phenomenology.
- Use Domains for dimensional ratings.
- Use Prototype pages only when they add communication value.

24 Predominant Mood and Drive Prototypes

24.1 Summary

- Prototypes dominated by shifts in mood tone, energy, and drive that shape function and risk.

24.2 Included Prototypes (Guide exemplars)

- Major Depressive Episode Prototype (exemplar).
- Bipolar Spectrum Episode Prototypes (exemplar).
- Full catalog appears in the Clean Reference.

24.3 How to Use This Cluster

- Start with the Atlas entry for affect and mood experiences.
- Rate the Mood and Drive Dysregulation domain.
- Apply a prototype label only when it improves communication or documentation.

24.4 Boundary Markers

- What it is: mood/drive patterns that dominate functioning or risk.
- What it is not: short-lived, proportional reactions to clear events.

24.5 Common Overlap

- Sleep and circadian disruption.
- Anxiety and threat sensitivity.
- Somatic distress or fatigue.

24.6 Major Depressive Episode Prototype (Exemplar)

24.6.1 Summary

- A pattern of sustained low mood or loss of interest with reduced drive and functional impairment.

24.6.2 Prototype Features

- Persistent low mood, emptiness, or anhedonia.
- Reduced energy, motivation, or concentration.
- Sleep or appetite disturbance.

24.6.3 Threshold Guidance

- Use when low mood/anhedonia is prominent, sustained, and impairing.

24.6.4 Expected Domain Profile

- Mood and Drive Dysregulation: moderate to high (low mood, low drive).
- Arousal, Sleep, and Circadian Regulation: mild to moderate disruption.

24.6.5 Time-Course and Trajectory

- Often episodic with variable recovery.
- May be triggered by losses or stressors.

24.6.6 Differential and Red Flags

- Bereavement or situational sadness without persistent impairment.
- Substance or medication effects.
- Medical contributors (endocrine, neurologic).
- Psychosis or catatonia signals elevated risk.

24.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

24.7 Bipolar Spectrum Episode Prototypes (Exemplar)

24.7.1 Summary

- A set of episodic patterns marked by elevated or irritable mood with increased energy, drive, or activity, often alternating with low mood periods.

24.7.2 Prototype Features

- Elevated, expansive, or irritable mood with increased activity or drive.
- Decreased need for sleep or heightened goal-directed behavior.
- Risk-taking, impulsivity, or agitation in elevated states.

24.7.3 Threshold Guidance

- Use when elevated or mixed states are distinct, recurrent, and impairing or risky.

24.7.4 Expected Domain Profile

- Mood and Drive Dysregulation: high variability or mixed elevation/low.
- Arousal, Sleep, and Circadian Regulation: notable disruption.

24.7.5 Time-Course and Trajectory

- Episodic with variable duration and recovery.
- May show cyclicity or seasonal patterns.

24.7.6 Differential and Red Flags

- Substance or medication-induced elevation.
- Sleep deprivation or circadian disruption alone.
- Psychosis during elevated states.

24.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

25 Predominant Threat Prototypes

25.1 Summary

- Prototypes dominated by threat perception, fear responses, and avoidance or safety behaviors.

25.2 Included Prototypes (Guide exemplars)

- Panic Pattern Prototype (exemplar).
- Generalized Worry Pattern Prototype (exemplar).
- Full catalog appears in the Clean Reference.

25.3 How to Use This Cluster

- Start from the Atlas entry for anxiety/threat to confirm phenomenology.
- Rate the Anxiety and Threat Sensitivity domain.
- Apply a prototype label only when it adds communication value.

25.4 Boundary Markers

- What it is: threat-dominant patterns that organize behavior and function.
- What it is not: trauma-driven hypervigilance or obsession-driven fear without threat focus.

25.5 Common Overlap

- Sleep and arousal dysregulation.
- Somatic distress and interoceptive sensitivity.

25.6 Panic Pattern Prototype (Exemplar)

25.6.1 Summary

- A pattern marked by sudden, intense surges of fear or discomfort with prominent bodily alarm and avoidance or anticipatory anxiety.

25.6.2 Prototype Features

- Abrupt panic surges with physical symptoms.
- Anticipatory worry about recurrence.
- Avoidance of places or situations associated with panic.

25.6.3 Threshold Guidance

- Use when panic surges are recurrent or drive significant avoidance or impairment.

25.6.4 Expected Domain Profile

- Anxiety and Threat Sensitivity: moderate to high.
- Arousal, Sleep, and Circadian Regulation: mild to moderate disruption.

25.6.5 Time-Course and Trajectory

- Episodic surges with inter-episode vigilance.
- May fluctuate with stress or stimulants.

25.6.6 Differential and Red Flags

- Substance intoxication or withdrawal.
- Medical contributors (cardiac, pulmonary, endocrine).
- Trauma-related hyperarousal or flashback-driven surges.

25.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

25.7 Generalized Worry Pattern Prototype (Exemplar)

25.7.1 Summary

- A pattern of persistent, diffuse worry across multiple domains with tension, restlessness, and difficulty controlling the worry.

25.7.2 Prototype Features

- Excessive worry in multiple areas (health, work, family, finances).
- Cognitive rumination and reassurance seeking.
- Physical tension, fatigue, or sleep disruption.

25.7.3 Threshold Guidance

- Use when worry is pervasive, difficult to control, and functionally impairing.

25.7.4 Expected Domain Profile

- Anxiety and Threat Sensitivity: moderate to high.
- Arousal, Sleep, and Circadian Regulation: mild to moderate disruption.

25.7.5 Time-Course and Trajectory

- Chronic baseline elevation with stress-related spikes.
- Fluctuates with life events and uncertainty.

25.7.6 Differential and Red Flags

- Mood dysregulation with agitation.
- Obsessional intrusive thoughts.
- Substance effects or withdrawal.
- Medical contributors (thyroid, cardiopulmonary).

25.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

26 Predominant Trauma and Stress Prototypes

26.1 Summary

- Prototypes dominated by trauma-linked intrusions, avoidance, hyperarousal, or dysregulated stress responses.

26.2 Included Prototypes (Guide exemplars)

- PTSD Pattern Prototype (exemplar).
- Complex Trauma Pattern Prototype (exemplar).
- Full catalog appears in the Clean Reference.

26.3 How to Use This Cluster

- Start with the Atlas entry for trauma-related experiences.
- Rate the Trauma and Stress Response domain.
- Apply a prototype label only when it improves communication or documentation.

26.4 Boundary Markers

- What it is: trauma-linked patterns that persist beyond the event or disrupt function.
- What it is not: short-term, proportional stress reactions without persistent impairment.

26.5 Common Overlap

- Anxiety and threat sensitivity.
- Sleep and arousal dysregulation.
- Emotion regulation and interpersonal pain.

26.6 PTSD Pattern Prototype (Exemplar)

26.6.1 Summary

- A pattern of trauma-linked intrusions, avoidance, and hyperarousal that persists and disrupts functioning.

26.6.2 Prototype Features

- Re-experiencing (memories, flashbacks, nightmares).
- Avoidance of reminders and emotional numbing.
- Hypervigilance, startle response, or sleep disruption.

26.6.3 Threshold Guidance

- Use when trauma-linked symptoms are persistent, recurrent, and impairing.

26.6.4 Expected Domain Profile

- Trauma and Stress Response: moderate to high.
- Anxiety and Threat Sensitivity: moderate.
- Arousal, Sleep, and Circadian Regulation: mild to moderate disruption.

26.6.5 Time-Course and Trajectory

- Often chronic with trigger-related spikes.
- May fluctuate with stress exposure.

26.6.6 Differential and Red Flags

- Acute stress reactions without persistence.
- Dissociative episodes without trauma linkage.
- Substance effects or sleep deprivation.

26.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

26.7 Complex Trauma Pattern Prototype (Exemplar)

26.7.1 Summary

- A pattern of trauma-linked dysregulation with pervasive effects on self-concept, emotion regulation, and relationships.

26.7.2 Prototype Features

- Chronic trauma history with persistent dysregulation.
- Emotional numbing or volatility.
- Relational instability, mistrust, or attachment disruptions.

26.7.3 Threshold Guidance

- Use when trauma-linked symptoms are pervasive and span multiple domains of function.

26.7.4 Expected Domain Profile

- Trauma and Stress Response: high.
- Emotion Regulation and Interpersonal Pain: moderate to high.
- Mood and Drive Dysregulation: variable.

26.7.5 Time-Course and Trajectory

- Chronic and pervasive, often with episodic worsening.

26.7.6 Differential and Red Flags

- Personality dysfunction without trauma linkage.
- Substance effects or ongoing acute crises.
- Neurodevelopmental factors affecting regulation.

26.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

27 Predominant Compulsivity Prototypes

27.1 Summary

- Prototypes dominated by intrusive thoughts, repetitive behaviors, and difficulty disengaging from loops.

27.2 Included Prototypes (Guide exemplars)

- OCD Pattern Prototype (exemplar).
- Illness Anxiety Pattern Prototype (exemplar).
- Full catalog appears in the Clean Reference.

27.3 How to Use This Cluster

- Start with the Atlas entry for obsessions/compulsions.
- Rate the Compulsivity and Perseveration domain.
- Apply a prototype label only when it improves communication or documentation.

27.4 Boundary Markers

- What it is: repetitive, distress-driven loops that consume time or function.
- What it is not: habits or preferences without distress or impairment.

27.5 Common Overlap

- Anxiety and threat sensitivity.
- Somatic distress or interoceptive sensitivity.

27.6 OCD Pattern Prototype (Exemplar)

27.6.1 Summary

- A pattern of intrusive thoughts or urges paired with repetitive rituals or mental acts aimed at reducing distress.

27.6.2 Prototype Features

- Obsessions or intrusive doubts that feel unwanted.
- Compulsions, checking, or mental rituals.
- Temporary relief followed by return of distress.

27.6.3 Threshold Guidance

- Use when obsessions/compulsions are recurrent and impairing.

27.6.4 Expected Domain Profile

- Compulsivity and Perseveration: moderate to high.
- Anxiety and Threat Sensitivity: variable, often elevated.

27.6.5 Time-Course and Trajectory

- Chronic with fluctuating intensity.
- Trigger-linked spikes.

27.6.6 Differential and Red Flags

- Psychosis with fixed delusional beliefs.
- Trauma intrusions without rituals.
- Substance effects or neurologic contributors.

27.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

27.7 Illness Anxiety Pattern Prototype (Exemplar)

27.7.1 Summary

- A pattern of persistent health-related fear with checking, reassurance seeking, or avoidance despite limited objective findings.

27.7.2 Prototype Features

- Excessive health worry or fear of serious illness.
- Reassurance seeking, checking, or avoidance of medical settings.
- Persistent doubt despite evaluations.

27.7.3 Threshold Guidance

- Use when health anxiety is persistent and impairs function or care engagement.

27.7.4 Expected Domain Profile

- Compulsivity and Perseveration: moderate.
- Somatic Distress and Interoception: variable, often elevated.
- Anxiety and Threat Sensitivity: moderate.

27.7.5 Time-Course and Trajectory

- Chronic with flare-ups during stress or symptom changes.

27.7.6 Differential and Red Flags

- Actual medical illness explaining symptoms.
- Trauma-related hypervigilance to bodily cues.
- Somatic symptom burden without health fear.

27.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

28 Predominant Psychosis Prototypes

28.1 Summary

- Prototypes dominated by reality distortion, hallucinations, and reduced insight that drive functional impairment or risk.

28.2 Included Prototypes (Guide exemplars)

- First Episode Psychosis Prototype (exemplar).
- Schizophrenia-Spectrum Prototype (exemplar).
- Full catalog appears in the Clean Reference.

28.3 How to Use This Cluster

- Start with the Atlas entry for reality distortion and psychosis-spectrum experiences.
- Rate the Psychosis and Reality Testing domain.
- Apply a prototype label only when it improves communication or documentation.

28.4 Boundary Markers

- What it is: persistent or recurrent reality distortion beyond transient causes.
- What it is not: delirium, substance-induced states, or culturally normative beliefs.

28.5 Common Overlap

- Mood and drive dysregulation.
- Cognitive control and executive function difficulties.
- Sleep and circadian disruption.

28.6 First Episode Psychosis Prototype (Exemplar)

28.6.1 Summary

- A first clear presentation of reality distortion or psychosis-spectrum symptoms with functional change or risk.

28.6.2 Prototype Features

- New onset hallucinations or unusual beliefs.
- Reduced insight or disorganized thinking.
- Noticeable functional change or behavioral disruption.

28.6.3 Threshold Guidance

- Use when psychosis-spectrum symptoms are new and clinically significant.

28.6.4 Expected Domain Profile

- Psychosis and Reality Testing: moderate to high.
- Mood and Drive Dysregulation: variable.
- Cognitive Control and Executive Function: variable.

28.6.5 Time-Course and Trajectory

- Acute or subacute onset.
- High variability early in course.

28.6.6 Differential and Red Flags

- Delirium or acute confusional states.
- Substance intoxication or withdrawal.
- Medication or iatrogenic effects.
- Seizure, autoimmune, infectious, or neurodegenerative mimics.

28.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

28.7 Schizophrenia-Spectrum Prototype (Exemplar)

28.7.1 Summary

- A persistent pattern of reality distortion with functional impairment and disorganization that is not limited to a single episode.

28.7.2 Prototype Features

- Ongoing hallucinations or delusional beliefs.
- Disorganized thought or behavior.
- Functional decline or reduced engagement.

28.7.3 Threshold Guidance

- Use when psychosis-spectrum symptoms are persistent and impairing over time.

28.7.4 Expected Domain Profile

- Psychosis and Reality Testing: moderate to high.
- Cognitive Control and Executive Function: variable, often affected.
- Social Communication and Relatedness: variable strain.

28.7.5 Time-Course and Trajectory

- Chronic persistence with episodic exacerbations.

28.7.6 Differential and Red Flags

- Mood-psychosis pattern with mood-congruent episodes.
- Substance or medication effects.
- Neurocognitive or neurologic contributors.

28.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

29 Predominant Neurodevelopmental Prototypes

29.1 Summary

- Prototypes dominated by longstanding developmental patterns in attention, executive function, or social communication.

29.2 Included Prototypes (Guide exemplars)

- ADHD Pattern Prototype (exemplar).
- Autism Pattern Prototype (exemplar).
- Full catalog appears in the Clean Reference.

29.3 How to Use This Cluster

- Start with the Atlas entry for attention/executive/neurodevelopmental experiences.
- Rate Cognitive Control and Executive Function and Social Communication domains.
- Apply a prototype label only when it improves communication or documentation.

29.4 Boundary Markers

- What it is: persistent patterns across development and settings.
- What it is not: acute attention changes due to mood, sleep, or substances.

29.5 Common Overlap

- Sleep and circadian disruption.
- Anxiety and threat sensitivity.

29.6 ADHD Pattern Prototype (Exemplar)

29.6.1 Summary

- A pattern of persistent inattention and/or hyperactivity-impulsivity across settings with functional impairment.

29.6.2 Prototype Features

- Difficulty sustaining attention or organization.
- Impulsivity, restlessness, or distractibility.
- Symptoms present across settings and over time.

29.6.3 Threshold Guidance

- Use when attention/executive difficulties are longstanding and impairing.

29.6.4 Expected Domain Profile

- Cognitive Control and Executive Function: moderate to high.
- Arousal, Sleep, and Circadian Regulation: variable.

29.6.5 Time-Course and Trajectory

- Early-onset with persistent course.
- Fluctuates with environmental demands.

29.6.6 Differential and Red Flags

- Sleep deprivation or circadian disruption.
- Mood or anxiety-driven inattention.
- Substance effects.

29.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

29.7 Autism Pattern Prototype (Exemplar)

29.7.1 Summary

- A pattern of longstanding social communication differences with restricted interests, routines, or sensory sensitivities.

29.7.2 Prototype Features

- Social reciprocity differences and pragmatic communication shifts.
- Preference for routines or predictable environments.
- Sensory sensitivities or focused interests.

29.7.3 Threshold Guidance

- Use when social communication differences and rigidity/sensory patterns are persistent and impairing or require supports.

29.7.4 Expected Domain Profile

- Social Communication and Relatedness: moderate to high.
- Cognitive Control and Executive Function: variable.

29.7.5 Time-Course and Trajectory

- Early-onset and stable over time.

29.7.6 Differential and Red Flags

- Social anxiety or trauma-related avoidance.
- Hearing or language impairments.
- Intellectual disability or learning disorder overlap.

29.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

30 Predominant Somatic and Interoceptive Prototypes

30.1 Summary

- Prototypes dominated by bodily distress, symptom focus, or functional neurologic presentations.

30.2 Included Prototypes (Guide exemplars)

- Functional Neurologic Symptom Prototype (exemplar).
- Somatic Symptom Burden Prototype (exemplar).
- Full catalog appears in the Clean Reference.

30.3 How to Use This Cluster

- Start with the Atlas entry for somatic distress and interoception.
- Rate the Somatic Distress and Interoception domain.
- Apply a prototype label only when it improves communication or documentation.

30.4 Boundary Markers

- What it is: persistent bodily distress or functional symptoms with high impact.
- What it is not: fully explained medical illness without distress amplification.

30.5 Common Overlap

- Anxiety and threat sensitivity.
- Sleep and arousal dysregulation.

30.6 Functional Neurologic Symptom Prototype (Exemplar)

30.6.1 Summary

- A pattern of neurologic symptoms (e.g., weakness, tremor, non-epileptic events) not fully explained by structural disease and linked to functional disruption.

30.6.2 Prototype Features

- Neurologic-type symptoms with inconsistent or variable findings.
- Symptoms fluctuate with attention, stress, or context.
- Significant distress or functional impairment.

30.6.3 Threshold Guidance

- Use when functional neurologic symptoms are prominent and impairing after medical evaluation.

30.6.4 Expected Domain Profile

- Somatic Distress and Interoception: moderate to high.
- Anxiety and Threat Sensitivity: variable.

30.6.5 Time-Course and Trajectory

- Fluctuating with stress or context.
- May be episodic or persistent.

30.6.6 Differential and Red Flags

- Neurologic disease requiring workup.
- Substance or medication effects.
- Seizure disorders or syncope.

30.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

30.7 Somatic Symptom Burden Prototype (Exemplar)

30.7.1 Summary

- A pattern of multiple or persistent bodily symptoms with high distress and functional impact.

30.7.2 Prototype Features

- Ongoing pain, fatigue, or multisystem symptoms.
- High symptom-related distress or preoccupation.
- Functional impairment and healthcare use.

30.7.3 Threshold Guidance

- Use when symptom burden is persistent and impairing after evaluation.

30.7.4 Expected Domain Profile

- Somatic Distress and Interoception: moderate to high.
- Anxiety and Threat Sensitivity: variable.

30.7.5 Time-Course and Trajectory

- Chronic with episodic flares.

30.7.6 Differential and Red Flags

- Medical conditions with clear etiology.
- Substance or medication effects.
- Trauma-related somatic hyperarousal.

30.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

31 Predominant Eating and Feeding Prototypes

31.1 Summary

- Prototypes dominated by eating regulation problems, body image concerns, or avoidant feeding patterns.

31.2 Included Prototypes (Guide exemplars)

- Anorexia Pattern Prototype (exemplar).
- Binge-Eating Pattern Prototype (exemplar).
- Full catalog appears in the Clean Reference.

31.3 How to Use This Cluster

- Start with the Atlas entry for eating, appetite, and body image.
- Rate the Eating and Feeding Regulation domain.
- Apply a prototype label only when it improves communication or documentation.

31.4 Boundary Markers

- What it is: persistent dysregulation of intake or body image with impairment.
- What it is not: short-term diet changes without functional impact.

31.5 Common Overlap

- Mood and drive dysregulation.
- Compulsivity and perseveration.

31.6 Anorexia Pattern Prototype (Exemplar)

31.6.1 Summary

- A pattern of restrictive eating with weight/shape concern and significant nutritional or functional risk.

31.6.2 Prototype Features

- Persistent restriction of intake.
- Fear of weight gain or distorted body image.
- Weight loss or medical compromise.

31.6.3 Threshold Guidance

- Use when restriction is sustained and associated with medical or functional risk.

31.6.4 Expected Domain Profile

- Eating and Feeding Regulation: moderate to high.
- Compulsivity and Perseveration: variable.

31.6.5 Time-Course and Trajectory

- Chronic with episodic worsening.

31.6.6 Differential and Red Flags

- Medical causes of weight loss.
- Food insecurity or limited access.
- Anxiety-driven appetite suppression.

31.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

31.7 Binge-Eating Pattern Prototype (Exemplar)

31.7.1 Summary

- A pattern of recurrent binge episodes with loss of control, without regular compensatory behaviors.

31.7.2 Prototype Features

- Binge episodes with distress or loss of control.
- Eating faster, larger amounts, or beyond comfort.
- Guilt, shame, or distress after episodes.

31.7.3 Threshold Guidance

- Use when binge episodes are recurrent and impairing.

31.7.4 Expected Domain Profile

- Eating and Feeding Regulation: moderate to high.
- Mood and Drive Dysregulation: variable.

31.7.5 Time-Course and Trajectory

- Episodic with stress-linked spikes.

31.7.6 Differential and Red Flags

- Medication or substance effects on appetite.
- Medical conditions affecting appetite.
- Bulimia pattern with compensatory behaviors.

31.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

32 Substance-Related Prototypes

32.1 Summary

- Prototypes organized by substance class with a consistent structure for communication and documentation.

32.2 Included Prototypes (Guide exemplars)

- Alcohol Pattern Prototype (exemplar).
- Opioid Pattern Prototype (exemplar).
- Full catalog appears in the Clean Reference.

32.3 How to Use This Cluster

- Start with the Atlas entry for substance use and compulsive reward seeking.
- Rate the Reward, Habit, and Substance-Related Compulsion domain.
- Apply a prototype label only when it improves communication or documentation.

32.4 Boundary Markers

- What it is: persistent, harmful use with impaired control.
- What it is not: occasional use without harm or loss of control.

32.5 Common Overlap

- Mood and drive dysregulation.
- Sleep and arousal dysregulation.

32.6 Alcohol Pattern Prototype (Exemplar)

32.6.1 Summary

- A pattern of recurrent alcohol use with impaired control, tolerance, or withdrawal and functional harm.

32.6.2 Prototype Features

- Escalating use or difficulty cutting down.
- Tolerance or withdrawal symptoms.
- Use despite consequences.

32.6.3 Threshold Guidance

- Use when alcohol use is recurrent and impairing.

32.6.4 Expected Domain Profile

- Reward, Habit, and Substance-Related Compulsion: moderate to high.
- Mood and Drive Dysregulation: variable.

32.6.5 Time-Course and Trajectory

- Episodic with relapse cycles or chronic use.

32.6.6 Differential and Red Flags

- Medical conditions mimicking withdrawal.
- Co-occurring sedative or stimulant use.

32.6.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

32.7 Opioid Pattern Prototype (Exemplar)

32.7.1 Summary

- A pattern of opioid use with impaired control, tolerance, or withdrawal and high medical risk.

32.7.2 Prototype Features

- Craving and loss of control.
- Tolerance and withdrawal.
- Use despite harm or risk.

32.7.3 Threshold Guidance

- Use when opioid use is persistent and impairing or medically risky.

32.7.4 Expected Domain Profile

- Reward, Habit, and Substance-Related Compulsion: moderate to high.
- Somatic Distress and Interoception: variable.

32.7.5 Time-Course and Trajectory

- Chronic with relapse cycles.

32.7.6 Differential and Red Flags

- Pain management contexts with iatrogenic risk.
- Co-occurring sedative use increasing overdose risk.

32.7.7 Specifiers

Specifiers: course + contributors + risk, as relevant; see Reference for full.

33 Personality Pattern Prototypes

33.1 Summary

- Optional labels for recognizable personality patterns, anchored to dimensional severity and trait qualifiers.

33.2 How to Use This Cluster

- Start with the Atlas entry for emotion regulation/self-concept/interpersonal pain.
- Rate the Personality Functioning domain.
- Use trait qualifiers rather than fixed type labels when possible.

33.3 Boundary Markers

- What it is: enduring patterns of self and interpersonal functioning.
- What it is not: acute state changes or isolated situational reactions.

33.4 Suggested Trait Qualifiers

- Negative affectivity.
- Detachment.
- Antagonism.
- Disinhibition.
- Psychoticism.

Documentation Output. Severity tier + trait qualifiers. Note uncertainty and context.

34 Documentation Examples

Optional reference material; not required for routine use.

Purpose. Show how the framework appears in actual notes. Provide examples across complexity levels and settings.

34.1 Example Types

- 1-minute follow-up note.
- 5-minute evaluation note.
- Comprehensive assessment note.
- Compact recording format line.

34.2 Selection Criteria

- Include mixed domain profiles and comorbidity realism.
- Include at least one example with diagnostic uncertainty.
- Include at least one example with high-risk modifiers.
- Include one ambiguous case with competing explanations.
- Include one example where no prototype is assigned.
- Include one primary care style example.

Documentation Output. Example notes linked to their templates. Notes labeled as illustrative only.

34.3 Examples (illustrative only)

34.3.1 1-Minute Follow-Up Note

- Presenting: “Still having panic surges in crowds.”
- Safety: suicide/self-harm none reported; violence risk low; self-care intact.
- Domains (0-4): Threat 3, Arousal/Sleep 2.
- Specifiers: episodic; contributor: caffeine; risk: low; context: work stress.
- Prototype: Panic Pattern (provisional).
- Monitoring: panic count weekly; sleep diary.
- Snippet: “Episodic panic with avoidance; Threat 3, Arousal 2; episodic course.”

34.3.2 5-Minute Evaluation Note

- Presenting: “Low mood, low energy, and early waking for 6 weeks.”
- Context: job loss and housing uncertainty.
- Atlas: affect/mood and sleep disruption.
- Domains (0-4): Mood/Drive 3, Arousal/Sleep 2, Threat 1.
- Specifiers: course episodic; contributors: sleep disruption; risk: low; context: acute stressor.
- Prototype: Major Depressive Episode (provisional).
- Uncertainty: consider grief-related response vs mood episode.
- Monitoring: brief mood scale at each visit; reassess in 4 weeks.
- Snippet: “Sustained low mood with reduced drive; Mood/Drive 3; episodic course.”

34.3.3 Comprehensive Assessment Note

- Presenting: “Intrusions, nightmares, and avoidance after assault.”
- History: prior trauma; sleep disruption; intermittent dissociation.
- Domains (0-4): Trauma/Stress 3, Threat 2, Arousal/Sleep 2, Mood/Drive 1.
- Specifiers: chronic course; contributor: ongoing safety concerns; risk: moderate (passive SI, no plan); context: ongoing threat exposure.
- Prototype: PTSD Pattern (provisional).
- Competing explanations: rule-out substance effects; rule-out sleep disorder.
- Monitoring: trauma symptom checklist monthly; sleep log.
- Snippet: “Trauma-linked intrusions with avoidance; Trauma/Stress 3; chronic course.”

34.3.4 Ambiguous Presentation (Competing Explanations)

- Presenting: “Wired, irritable, sleeping 4 hours, cannot focus.”
- Context: rotating shift work; high caffeine; recent stimulant dose increase.
- Domains (0-4): Arousal/Sleep 3, Mood/Drive 2, Cognitive Control 2, Threat 1.
- Specifiers: fluctuating course; contributors: sleep/circadian mismatch, stimulant; risk: low.
- Prototype: deferred.
- Competing explanations: medication effect vs sleep deprivation vs hypomanic shift.
- Monitoring: sleep log; review substances/meds; reassess 2-4 weeks.
- Snippet: “Arousal/Sleep 3 with cognitive control strain; prototype deferred; competing explanations noted.”

34.3.5 Dimensional-Only Note (No Prototype Assigned)

- Presenting: “Longstanding pain and fatigue, worried about what it means.”
- Context: ongoing medical evaluation; caregiver stress.
- Atlas: somatic distress and interoception.
- Domains (0-4): Somatic Distress 3, Arousal/Sleep 2, Threat 2, Mood/Drive 1.

35 Appendix A: Glossary

This appendix standardizes shorthand and terms used throughout the manual. Most useful for fast reading and consistent documentation. *Optional reference material; not required for routine use.*

Purpose. Provide a shared language for patient-facing and clinician-facing terms. Reduce ambiguity across domains, prototypes, and notes.

35.1 Core Workflow Terms

- Presenting problem: The patient-described reason for visit in their own words.
- Atlas entry: A phenomenology description used to clarify experiences before labeling.
- Domain: A dimensional construct rated 0-4.
- Prototype: Optional syndrome label used when it adds communication value.
- Specifier: Cross-cutting modifier that changes risk, course, or management.
- Front door: Entry path (clinician workflow or reference navigation).
- Recording format: Compact line summary of domains, prototypes, and specifiers.

35.2 Domain Rating Scale (0-4)

- 0: None or not present.
- 1: Mild, intermittent, manageable.
- 2: Moderate, persistent, noticeable functional impact.
- 3: Severe, frequent, significant impairment or distress.
- 4: Extreme, disabling, or unsafe.

35.3 Course and Trajectory Terms

- Acute: Short duration, days to weeks.
- Episodic: Discrete episodes with return toward baseline.
- Chronic: Persistent over months or years.
- Fluctuating: Symptoms vary but do not fully remit.
- Trajectory: Improving, stable, worsening, or stuck.
- Seasonal: Recurring at particular times of year.
- Postpartum/perinatal: Onset linked to pregnancy or postpartum period.

- Late-onset: First presentation in later life.

35.4 Documentation Shorthand

- Threat 3: Domain rating for Anxiety and Threat Sensitivity of 3.
- Mood/Drive 2-3: Domain rating range when variable or unclear.
- Prototype (provisional): Label used with low or medium confidence.
- Competing explanations: Alternative explanations explicitly documented.
- Confidence: High, medium, or provisional based on evidence.
- Rule-out first: Medical or substance explanations considered before primary labeling.
- Distress vs impairment: Subjective suffering vs functional limitation.

35.5 Core Domains (shorthand)

- Mood/Drive: sadness, anhedonia, low or high drive, irritability.
- Threat: worry, fear, panic surges, avoidance.
- Trauma/Stress: intrusions, hypervigilance, dissociation, threat-linked responses.
- Compulsivity: intrusive thoughts, rituals, checking, perseveration.
- Psychosis: hallucinations, delusions, disorganization, reality testing shifts.
- Cognitive Control: attention, planning, working memory, impulsivity.
- Social Communication: reciprocal interaction, social cognition, relatedness.
- Arousal/Sleep: insomnia, hypersomnia, circadian shift, autonomic arousal.
- Somatic Distress: pain, fatigue, bodily focus, symptom amplification.
- Reward/Habit: craving, loss of control, compulsive use.
- Eating/Feeding: restriction, bingeing, avoidance, body image distress.
- Personality Functioning: identity stability, interpersonal patterns, self-direction.

35.6 Specifiers and Modifiers

- Severity and impairment: intensity and functional impact tiers.
- Course and time pattern: acute, episodic, chronic, fluctuating, seasonal, postpartum.
- Etiologic contributors: substances, medications, medical conditions, sleep/circadian, trauma, adversity.
- Risk modifiers: suicide, violence, self-neglect, exploitation vulnerability.
- Context and culture: cultural idioms, migration, discrimination, language needs.

35.7 Risk and Safety Terms

- Passive suicide ideation: thoughts of death without plan or intent.

- Active suicide ideation: thoughts with plan, intent, or preparatory behavior.
- Self-harm: non-suicidal self-injury used to regulate distress.
- Violence risk: credible risk to others given context and access.
- Self-neglect: inability to meet basic needs due to symptoms.
- Safeguarding concern: risk to vulnerable dependents or adults.

35.8 Patient Language to Clinician Terms (examples)

- "I cannot shut off my mind." → worry or rumination.
- "Everything feels unreal." → derealization.
- "I feel outside my body." → depersonalization.
- "Heart races, cannot breathe." → panic surge or autonomic arousal.
- "I am always on edge." → hypervigilance or threat sensitivity.
- "I cannot focus or finish." → inattention or executive dysfunction.
- "No pleasure in anything." → anhedonia.
- "I check and recheck." → compulsive checking.
- "I hear voices others do not." → auditory hallucinations.
- "My body feels broken." → somatic distress.
- "I keep replaying it." → intrusive recollection or rumination.
- "I feel numb." → emotional numbing.
- "I get stuck on details." → perseveration.
- "I eat to shut it off." → binge or compulsive eating pattern.
- "I cannot sleep until dawn." → delayed sleep phase.
- "Everything is too loud." → sensory sensitivity.

35.9 Preferred Language

- Use "patterns" or "prototypes" instead of fixed "disorders" when possible.
- Use "expected overlap" instead of "comorbidity" when domains co-occur.
- Use "competing explanations" instead of "rule-out" when framing uncertainty.
- Use "provisional" when evidence is limited or evolving.

Usage. Use the glossary to standardize documentation and communication; Update terms as language norms change.

36 Appendix G: Common Failure Modes

Purpose. Reduce common misreads that lead to premature or incorrect labels. Provide quick guardrails without adding workflow. *Optional reference material; not required for routine use.*

36.1 Common Failure Modes (quick scan)

36.1.1 Panic-like symptoms vs medical or substance effects

- Look for: acute medical red flags, syncope, abnormal vitals, recent stimulant use, withdrawal.
- Guardrail: document competing explanations and use rule-out compendium as needed.

36.1.2 Trauma hyperarousal vs psychosis

- Look for: context-linked intrusions, dissociation, preserved insight vs fixed delusions or formal thought disorder.
- Guardrail: avoid hard labeling on a single encounter; note uncertainty.

36.1.3 Executive dysfunction vs mood episode

- Look for: long-standing attention problems, sleep/circadian disruption, medication effects.
- Guardrail: rate domains separately before assuming a primary mood episode.

36.1.4 Grief response vs mood episode

- Look for: loss-linked sadness, preserved positive affect, fluctuating intensity.
- Guardrail: document time-course and context; avoid premature pathologizing.

36.1.5 Neurodevelopmental traits vs personality pathology

- Look for: early-onset social communication differences, sensory sensitivity, stable trait profile.
- Guardrail: do not assign personality labels without developmental history.

36.1.6 Sleep or circadian disruption as primary driver

- Look for: delayed sleep phase, insomnia preceding mood or threat symptoms.

- Guardrail: treat sleep as a contributor before final labeling.

36.1.7 Substance or medication effects vs primary syndrome

- Look for: symptom onset after initiation or dose change, intoxication, withdrawal.
- Guardrail: label as contributor and reassess once stabilized.

36.2 Documentation Guardrails

- Use “competing explanations” and “provisional” labels when uncertain.
- Record confidence level and a planned reassessment interval.

36.3 Cross-Links

- Rule-Out Compendium
- Specifiers: Etiologic Contributors; Course and Time Pattern; Risk Modifiers

37 Appendix H: When Not to Label Yet

Purpose. Clarify when delaying a prototype label improves accuracy and safety. Reinforce uncertainty-aware documentation. *Optional reference material; not required for routine use.*

37.1 Consider Deferring Labels When

- First episode with acute onset and unclear course.
- Prominent substance or medication change, intoxication, or withdrawal.
- Medical or neurologic workup is incomplete.
- Severe sleep or circadian disruption likely drives symptoms.
- Recent major stressor or bereavement with unclear persistence.
- Insufficient longitudinal history or collateral information.
- High risk requires stabilization before classification.
- Two or more competing explanations remain plausible.

37.2 What to Do Instead

- Use domain ratings with time-course specifiers.
- Document competing explanations and confidence level.
- Use "provisional" if a label is required for access.
- Set a reassessment interval and triggers.
- Use measurement prompts to track change.

37.3 When Labeling Is Appropriate

- Time-course is established and persistent or recurrent.
- Rule-outs are addressed and contributors documented.
- Functional impact is clear and linked to the pattern.
- A prototype adds communication value for care coordination.

37.4 Documentation Snippet (1 line)

- "Prototype deferred; Domains: Threat 2, Arousal 3; competing explanations noted; reassess in 4 weeks."

37.5 Cross-Links

- Core Workflow: Identify to Monitor
- Rule-Out Compendium
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers