DSM Wrapper Manual — Clean Reference

Clean Edition v0.1

Table of contents

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

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

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 Reference

Lookup-oriented reference for the full framework. For a reading-first overview, use the Clean Guide.

2.1 Read in Order

- Volume 0 → Volume 1 → Volume 2 → Volume 3 → Volume 4 → Volume 5 → Volume 6 → Volume 7 → Volume 8 → Volume 9 Most readers use Volumes 0-4 regularly; Volume 7 as needed for rule-outs; Volumes 8-9 are reference.

2.2 Front Doors and Structure

2.3 Volume 0 — How to Use

2.4 Volume 1 — Clinical Core

2.5 Volume 2 — Atlas of Human Experience

- Affect and Mood Experiences
- Anxiety, Threat, and Bodily Alarm
- Trauma-Related Experiences
- Obsessions, Compulsions, and Stuckness
- Reality Distortion and Psychosis-Spectrum Experiences
- Attention, Executive Function, and Neurodevelopmental Experiences
- Emotion Regulation, Self-Concept, and Interpersonal Pain
- Somatic Distress and Interoception
- Sleep, Circadian, and Arousal Regulation
- Eating, Appetite, and Body Image
- Substance Use and Compulsive Reward Seeking

2.6 Volume 3 — Dimensional Domains

- Mood and Drive Dysregulation
- Anxiety and Threat Sensitivity
- Trauma and Stress Response
- Compulsivity and Perseveration
- Psychosis and Reality Testing
- Cognitive Control and Executive Function
- Social Communication and Relatedness
- Arousal, Sleep, and Circadian Regulation
- Somatic Distress and Interoception
- Reward, Habit, and Substance-Related Compulsion
- Eating and Feeding Regulation
- Personality Functioning (Dimensional)

2.7 Volume 4 — Prototype Syndromes

- How to Use Prototypes
- Prototype Modules: Organization and Logic

2.7.1 Mood and Drive Cluster

- Predominant Mood and Drive Prototypes
- Major Depressive Episode Prototype
- Bipolar Spectrum Episode Prototypes
- Persistent Depressive Pattern Prototype

2.7.2 Threat Cluster

- Predominant Threat Prototypes
- Panic Pattern Prototype
- Generalized Worry Pattern Prototype
- Social Threat Pattern Prototype
- Specific Phobia Pattern Prototype

2.7.3 Trauma and Stress Cluster

- Predominant Trauma and Stress Prototypes
- PTSD Pattern Prototype
- Complex Trauma Pattern Prototype
- Adjustment Pattern Prototype

2.7.4 Compulsivity Cluster

- Predominant Compulsivity Prototypes
- OCD Pattern Prototype
- Body-Focused Repetitive Behaviors Prototype
- Illness Anxiety Pattern Prototype

2.7.5 Psychosis Cluster

- Predominant Psychosis Prototypes
- First Episode Psychosis Prototype
- Schizophrenia-Spectrum Prototype
- Mood-Psychosis Pattern Prototype

2.7.6 Neurodevelopmental Cluster

- Predominant Neurodevelopmental Prototypes
- ADHD Pattern Prototype
- Autism Pattern Prototype
- Learning Disorder Patterns

2.7.7 Somatic and Interoceptive Cluster

- Predominant Somatic and Interoceptive Prototypes
- Functional Neurologic Symptom Prototype
- Somatic Symptom Burden Prototype

2.7.8 Eating and Feeding Cluster

- Predominant Eating and Feeding Prototypes
- Anorexia Pattern Prototype
- Bulimia Pattern Prototype
- Binge-Eating Pattern Prototype
- ARFID Pattern Prototype

2.7.9 Substance-Related Cluster

- Substance-Related Prototypes
- Alcohol Pattern Prototype
- Opioid Pattern Prototype
- Stimulant Pattern Prototype
- Cannabis Pattern Prototype
- Sedative Pattern Prototype
- Other Substance Patterns

2.7.10 Personality Pattern Cluster

- Personality Pattern Prototypes

2.8 Volume 5 — Cross-Cutting Specifiers

- Severity and Impairment
- Course and Time Pattern
- Etiologic Contributors
- Risk Modifiers
- Context and Culture

2.9 Volume 6 — Life-Stage and Setting Adaptations

- Early Childhood
- School Age
- Adolescence
- Perinatal and Postpartum
- Adulthood
- Late Life and Neurocognitive Overlap
- Emergency and Acute Care
- Primary Care Integration

- Inpatient and Forensic Considerations
- Neurodiversity-Affirming Adaptations

2.10 Volume 7 — Rule-Out Compendium

- Delirium and Acute Confusional States
- Substance Intoxication and Withdrawal
- Medication and Iatrogenic Psychiatric Syndromes
- Endocrine and Metabolic Mimics
- Seizure, Autoimmune, Infectious, and Neurodegenerative Mimics
- Sleep Disorders Masquerading as Psychiatric Illness
- Pain and Fatigue Syndromes with Bidirectional Causality

2.11 Volume 8 — Clinical Utility Add-Ons

Optional reference material; not required for routine use.

- Care Pathways Map
- Matching Interventions to Domain Patterns
- Monitoring Schedules
- Communication Tools
- Documentation Examples

2.12 Volume 9 — Appendices

Optional reference material; not required for routine use.

- Appendix A: Glossary
- Appendix G: Common Failure Modes
- Appendix H: When Not to Label Yet

3 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.

3.1 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; use brief measures when available.
- 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.

3.2 Use Patterns

- Fast path (1-2 minutes): Identify + safety screen; 1-2 domain ratings; optional prototype; one-line snippet.
- 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; measurement 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.

4 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.

4.1 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.

5 Documentation Templates

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

5.1 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.

5.2 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.

5.3 Required vs Optional Fields

- Required: presenting problem, safety screen, domain ratings, specifiers, documentation snippet.
- Optional: prototype tags, differential list, measurement plan, uncertainty notes.

5.4 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.

6 How Clinicians Actually Use This

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

6.1 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."

6.2 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.

6.3 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.

7 Front Door A: Clinician Workflow

Purpose. Provide a symptom-first entry for clinicians under time pressure. Map quickly from presenting experience to domains, specifiers, and documentation.

7.1 Entry Path (default)

- Start with presenting problem in patient language.
- Run Universal Intake Set for safety, substance/meds, and medical red flags.
- Use Atlas to clarify phenomenology and boundaries.
- Rate 1-3 most relevant domains (0-4) and note time-course.
- Add specifiers that change risk or management.
- Apply prototype tags only if useful for communication.
- Record uncertainty and competing explanations.
- Use the 1-minute or 5-minute documentation template.

7.2 When to Branch

- Acute confusion, intoxication, or rapid change → Rule-Out Compendium.
- Prominent developmental or cultural factors → Life-Stage/Context sections.
- Severe risk → Risk Modifiers and safety planning prompts.

7.3 Outputs (minimum viable)

- Presenting problem line.
- Domain ratings and time-course.
- Specifiers (course, contributors, risk, context).
- Documentation snippet.

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 Emergency and Acute Care

Focus. Prioritize safety, rapid stabilization, and rule-out-first logic.

Key Adaptations. Use fast path workflow and minimal documentation template; High attention to delirium, intoxication, withdrawal, and medical mimics; Coordinate with medical teams and collateral sources.

Assessment Emphasis. Immediate risk and capacity; Rapid time-course changes and triggers; Acute stressors and environmental safety.

Documentation Output. Safety actions and rationale noted. Rule-out actions documented explicitly.

10 Monitoring Schedules

Optional reference material; not required for routine use.

Purpose. Standardize when and what to monitor without rigid protocols.

10.1 Core Monitoring Elements

- Symptom change (brief measures).
- Functional change.
- Risk tier and dynamic drivers.
- Trajectory (improving/stable/worsening/fluctuating).

10.2 Suggested Intervals

- Acute or high risk: weekly or more frequent.
- Moderate risk or active change: every 2-4 weeks.
- Stable course: every 6-12 weeks.

10.3 Trigger-Based Reassessment

- New safety concerns.
- Medication or substance changes.
- Significant life events or losses.

Documentation Output. Monitoring schedule and trigger list. Measures chosen and next review date.

11 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.

11.1 Example Types

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

11.2 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.

11.3 Examples (illustrative only)

11.3.1 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.”

11.3.2 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.”

11.3.3 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.”

11.3.4 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.”

11.3.5 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.

12 Front Door B: Reference Navigation

Purpose. Provide a reference-first entry for readers who already know what they are looking for. Support lookup by experience, domain, prototype, specifier, or setting.

12.1 Entry Path (reference-first)

- Start with Atlas when the question is phenomenology or patient language.
- Start with Domains when the question is dimensional rating or cross-cutting patterns.
- Start with Prototypes when a DSM-style label is needed for communication.
- Start with Specifiers when the goal is risk, course, or contributor framing.
- Start with Rule-Outs when medical or substance mimics are primary concerns.
- Start with Life-Stage when developmental or setting context drives the presentation.
- Start with Appendices for scales, glossary, cultural tools, or crosswalks.

12.2 Cross-Linking Expectations

- Every entry links to related Atlas, Domain, Prototype, and Specifier pages.
- Rule-Outs and Life-Stage pages link back to relevant domains and prototypes.

13 Standard Module Page Structure

Purpose. Keep module pages scannable and consistent across sections. Make it obvious where to find definition, boundaries, differentials, and links.

13.1 Required Header Block

- Module type (Atlas / Domain / Prototype / Specifier / Rule-Out / Life-Stage).
- Short definition.
- Last updated and status (draft / reviewed / stable).

13.2 Required Sections (all module types)

- Summary (1-2 sentences).
- What it is / what it is not (boundary markers).
- Core features or key constructs.
- Time-course patterns.
- Functional impact.
- Common mimics / differential.
- Medical / substance rule-outs (if applicable).
- Developmental expression.
- Cultural / context notes.
- Cross-links to related modules.
- Documentation snippet.

13.3 Optional Sections (as needed)

- Severity anchors (0-4).
- Measurement prompts or scales.
- Risk modifiers or red flags.
- Treatment-relevant specifiers (non-prescriptive).

14 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.

14.1 Scope

- In: presenting experiences, domains, prototypes, specifiers, life-stage adaptations, rule-out compendium, measurement prompts, documentation templates.
- Out: treatment guidelines, legal standards, 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, specifiers, formulation summary, risk and trajectory notes, and a documentation snippet.

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.

14.2 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.

15 Evidence Grading Key

Purpose. Provide a consistent way to tag statements with evidence strength and clinical utility. Make uncertainty explicit and updateable.

15.1 Evidence Strength (E0-E4)

- E0: Conceptual, consensus, or theory only; no direct evidence.
- E1: Case reports or uncontrolled series.
- E2: Observational evidence with consistent associations.
- E3: Controlled or quasi-experimental evidence.
- E4: Replicated, convergent evidence across methods.

15.2 Clinical Utility (U0-U3)

- U0: Background only; no direct clinical use.
- U1: Supports assessment language or shared understanding.
- U2: Affects differential, risk stratification, or monitoring.
- U3: Directly changes management or safety decisions.

15.3 Tagging Format

- Use [E?/U?] at the end of the statement, e.g., [E2/U1].
- If unknown, use [E?] or [VERIFY] and leave for later citation work.

15.4 Current Usage

- Selective tagging is in place for safety-critical and high-risk statements.
- Broader tagging is deferred and not yet comprehensive.

15.5 Tagging Principles

- Evidence tags annotate claims, not sections or whole pages.

- Descriptive phenomenology and workflow guidance do not require tags.
- Evidence tags reflect the state of knowledge at the time of writing; absence of a tag does not imply lack of evidence.

15.6 Citation Markers

- Use [E2/U2] [REF] when a statement needs a citation and the reference list is not yet attached.
- Replace [REF] later with a citation ID or formatted reference when the bibliography is in place.

15.7 When to Tag (rule of thumb)

- Prevalence, incidence, or risk magnitude claims.
- Causal or mechanistic assertions.
- Treatment effects or expected response claims.
- Safety-critical guidance (risk, rule-outs, escalation thresholds).
- Medical or substance contributors presented as likely or common.

15.8 No Tag Needed

- Definitions and scope statements.
- Descriptive phenomenology language.
- Workflow labels and documentation conventions.

15.9 Mechanism vs Association

- Association claims can be E1-E3 depending on design.
- Mechanism claims require E3+ to avoid overstatement.
- If mechanism is speculative, tag as E0 and label as hypothesis.

15.10 Safety Sensitivity

- If a statement could change safety planning, default to tagging.
- If evidence is weak but practice-relevant, use E0/U2 and label as consensus.

15.11 Examples

- "Insomnia is associated with increased risk of mood dysregulation." [E2/U2]
- "Evidence supports measurement-based care improving outcomes in depression." [E3/U2]

- "Caffeine can amplify panic-like symptoms in sensitive individuals." [E1/U1]
- "This pattern is consistent with trauma-related intrusions." [E0/U1]

15.12 Citation Rules (for later drafting)

- Must cite: prevalence, risk magnitude, causal claims, treatment effects.
- Optional cite: definitions, descriptive phenomenology, clinician language.

16 Measurement-Based Care Toolkit

Purpose. Make symptom change and functional change visible over time. Support shared decision-making and reduce diagnostic drift.

16.1 Core Principles

- Use brief measures that can be repeated easily.
- Track both symptoms and function.
- Prefer validated instruments when available.
- Keep the minimum set small enough to sustain.

16.2 Minimum Measurement Set

- One cross-cutting symptom measure.
- One domain-specific measure aligned to the primary domain.
- One functional/impairment measure.

16.3 When to Measure

- Baseline at intake.
- Every follow-up until stable, then spaced reassessment.
- At clear changes in trajectory or treatment plan.

16.4 Recording and Review

- Record scores alongside domain ratings.
- Note trajectory (improving/stable/worsening/fluctuating).
- Link score changes to major context or treatment changes.

17 Differential Diagnosis Engine

Purpose. Provide a consistent logic for competing explanations. Reduce premature closure and diagnostic overconfidence.

17.1 Always Consider

- Delirium or acute confusional state. [E0/U2]
- Substance intoxication or withdrawal. [E0/U2]
- Medication or iatrogenic effects. [E0/U2]
- Sleep disorders masquerading as psychiatric symptoms. [E0/U2]
- Endocrine, neurologic, infectious, or inflammatory mimics when indicated. [E0/U2]

17.2 Time-Course Logic

- Acute onset → prioritize medical/substance causes. [E0/U3]
- Episodic → consider triggers, cyclicity, or episodic prototypes.
- Chronic/stable → consider developmental patterns or entrenched traits.
- Progressive decline → evaluate neurocognitive and medical causes. [E0/U2]

17.3 Context Logic

- Proportional reactions to clear stressors vs persistent dysregulation.
- Safety threats and ongoing adversity can dominate presentation.
- Cultural or spiritual frameworks may shape symptom language.

17.4 Developmental Anchoring

- Compare to age-expected behavior and milestones.
- Consider neurodevelopmental patterns when longstanding.

Red flags

- New onset psychosis or mania. [E0/U3]
- Sudden cognitive change or fluctuating attention. [E0/U3]
- New symptoms after medication changes or substance use. [E0/U3]

Documentation Output. Competing explanations listed explicitly. Confidence level (high/medium/provisional). Rule-outs pursued or deferred.

18 Case Formulation Framework

Purpose. Provide a standardized, brief formulation that fits any setting. Connect symptoms to context, contributors, and leverage points.

18.1 Core Elements

- Presenting problem (patient language).
- Domain profile (0-4 ratings).
- Trajectory (improving/stable/worsening/fluctuating).
- Risk modifiers and safety concerns.
- Uncertainty and competing explanations.

18.2 The 4 Ps

- Predisposing: vulnerabilities and long-term risk factors.
- Precipitating: recent triggers and onset drivers.
- Perpetuating: factors maintaining symptoms.
- Protective: strengths, supports, and stabilizers.

18.3 Leverage Points

- Smallest changes likely to shift trajectory.
- Barriers to change and feasibility constraints.

18.4 Formulation Outputs (short)

- 3-6 bullet lines summarizing the above.

18.5 Formulation Outputs (full)

- Narrative paragraph plus domain ratings and specifiers.

19 Affect and Mood Experiences

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

19.1 Summary

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

19.2 Patient-Language Phrases

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

19.3 Core Features

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

19.4 Boundary Markers

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

19.5 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.

19.6 Severity Anchors (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.

19.7 Time-Course Patterns

- Episodic mood changes.
- Chronic low mood or blunted affect.
- Cyclic or seasonal shifts.

19.8 Functional Impact

- Work/school: reduced performance or overactivity.
- Relationships: withdrawal, conflict, or instability.
- Self-care: disrupted routine, sleep, or appetite.

19.9 Common Mimics / Differential

- Trauma-related numbing or shutdown.
- Substance or medication effects.
- Medical contributors (endocrine, neurologic).

19.10 Medical / Substance Rule-Outs

- Stimulants, sedatives, or withdrawal states.
- Thyroid or sleep-related contributors.

19.11 Developmental Expression

- Childhood: irritability or withdrawal.
- Adolescence: mood lability, risk-taking, sleep shifts.
- Late life: somatic focus, grief overlap.

19.12 Cultural / Context Notes

- Mood expression varies by culture and context.
- Grief and loss processes can mimic low mood.

19.13 Measurement Prompts

- Brief mood measure.
- Energy, sleep, and activity tracking.

19.14 Cross-Links

- Domains: Mood and Drive Dysregulation; Arousal, Sleep, and Circadian Regulation.
- Prototypes: Major Depressive Episode; Bipolar Spectrum Episode Prototypes; Persistent Depressive Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

19.15 Documentation Snippet (1-2 lines)

- "Reports persistent low mood and anhedonia with reduced drive; Mood/Drive 3, Arousal 2; episodic course."

20 Anxiety, Threat, and Bodily Alarm

20.1 Summary

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

20.2 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."

20.3 Core Features

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

20.4 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.

20.5 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.

20.6 Severity Anchors (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.

20.7 Time-Course Patterns

- Acute spikes tied to triggers.
- Episodic panic with inter-episode worry.
- Chronic, diffuse tension.
- Fluctuating with stress load.

20.8 Functional Impact

- Work/school: reduced concentration or avoidance.
- Relationships: withdrawal or reassurance seeking.
- Self-care: disrupted routines or sleep.

20.9 Common Mimics / Differential

- Trauma-related hypervigilance.
- Obsessional intrusive fears.
- Mood dysregulation with agitation.

20.10 Medical / Substance Rule-Outs

- Stimulants or caffeine effects.
- Withdrawal states.
- Thyroid or cardiopulmonary contributors.

20.11 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.

20.12 Cultural / Context Notes

- May present as somatic distress or spiritual framing.
- Threat meaning is shaped by environment and exposure.

20.13 Measurement Prompts

- Brief anxiety measure.
- Panic frequency or trigger log.

20.14 Cross-Links

- Domains: Anxiety and Threat Sensitivity; Arousal, Sleep, and Circadian Regulation.
- Prototypes: Panic Pattern; Generalized Worry Pattern; Social Threat Pattern; Specific Phobia Pattern.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

20.15 Documentation Snippet (1-2 lines)

- "Reports persistent threat anticipation with episodic bodily alarm and avoidance; Threat 3, Arousal 2; episodic course."

21 Trauma-Related Experiences

21.1 Summary

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

21.2 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."

21.3 Core Features

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

21.4 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.

21.5 Variants / Spectrum

- Intrusion-dominant (re-experiencing).
- Hyperarousal-dominant (vigilance, irritability).
- Dissociative/shutdown-dominant.
- Grief-trauma overlap or moral injury.

21.6 Severity Anchors (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.

21.7 Time-Course Patterns

- Acute post-event reactions.
- Chronic persistence with triggers.
- Fluctuations with stress or reminders.

21.8 Functional Impact

- Work/school: concentration issues, avoidance.
- Relationships: withdrawal, mistrust, conflict.
- Self-care: sleep disruption, hyperarousal.

21.9 Common Mimics / Differential

- Anxiety threat responses without trauma linkage.
- Obsessional intrusions without trauma context.
- Mood dysregulation with agitation.

21.10 Medical / Substance Rule-Outs

- Sleep deprivation or substance effects.
- Neurologic contributors to dissociation-like states.

21.11 Developmental Expression

- Childhood: behavioral regression, play reenactment.
- Adolescence: risk-taking, emotional volatility, shutdown.
- Late life: reactivation around losses or medical events.

21.12 Cultural / Context Notes

- Trauma meaning varies by culture and community narratives.
- Ongoing threat changes interpretation and management.

21.13 Measurement Prompts

- Brief trauma symptom checklist.
- Trigger and avoidance tracking.

21.14 Cross-Links

- Domains: Trauma and Stress Response; Anxiety and Threat Sensitivity.
- Prototypes: PTSD Pattern; Complex Trauma Pattern; Adjustment Pattern.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

21.15 Documentation Snippet (1-2 lines)

- "Reports trauma-linked intrusions and avoidance with hyperarousal; Trauma/Stress 3; chronic course."

22 Obsessions, Compulsions, and Stuckness

22.1 Summary

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

22.2 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."

22.3 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.

22.4 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.

22.5 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.

22.6 Severity Anchors (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.

22.7 Time-Course Patterns

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

22.8 Functional Impact

- Work/school: reduced focus, time lost to rituals.
- Relationships: reassurance seeking or conflict.
- Self-care: delays or avoidance.

22.9 Common Mimics / Differential

- Anxiety threat responses without rituals.
- Trauma intrusions without compulsions.
- Psychosis with fixed delusional beliefs.

22.10 Medical / Substance Rule-Outs

- Stimulant effects or withdrawal.
- Neurologic contributors to repetitive behavior.

22.11 Developmental Expression

- Childhood: rituals or checking that intensify under stress.
- Adolescence: increased rumination and reassurance.
- Late life: health anxiety or checking related to safety.

22.12 Cultural / Context Notes

- Some rituals are culturally normative; assess distress and impairment.

22.13 Measurement Prompts

- Brief obsession/compulsion measure.
- Time spent on rituals or reassurance.

22.14 Cross-Links

- Domains: Compulsivity and Perseveration; Anxiety and Threat Sensitivity.
- Prototypes: OCD Pattern; Body-Focused Repetitive Behaviors; Illness Anxiety Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

22.15 Documentation Snippet (1-2 lines)

- "Intrusive doubts with checking rituals and reassurance seeking; Compulsivity 3; chronic course."

23 Reality Distortion and Psychosis-Spectrum Experiences

23.1 Summary

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

23.2 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."

23.3 Core Features

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

23.4 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.

23.5 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.

23.6 Severity Anchors (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.

23.7 Time-Course Patterns

- Acute onset.
- Episodic with remissions.
- Chronic persistence with exacerbations.
- Progressive functional decline.

23.8 Functional Impact

- Work/school: disorganization or reduced performance.
- Relationships: mistrust, withdrawal, or conflict.
- Self-care: neglected routines or safety concerns.

23.9 Common Mimics / Differential

- Trauma-related intrusions or dissociation.
- Severe mood episodes with psychotic features.
- Obsessional intrusions with intact insight.

23.10 Medical / Substance Rule-Outs

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

23.11 Developmental Expression

- Adolescence: new onset with functional change.
- Adulthood: episodic or persistent patterns.
- Late life: new onset warrants medical workup.

23.12 Cultural / Context Notes

- Assess beliefs within cultural, spiritual, or community context.
- Language and meaning may shape symptom description.

23.13 Measurement Prompts

- Brief psychosis screening questions.
- Collateral reports and timeline checks.

23.14 Cross-Links

- Domains: Psychosis and Reality Testing; Mood and Drive Dysregulation; Cognitive Control and Executive Function.
- Prototypes: First Episode Psychosis; Schizophrenia-Spectrum; Mood-Psychosis Pattern.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

23.15 Documentation Snippet (1-2 lines)

- "Reports auditory hallucinations and fixed beliefs with reduced insight; Psychosis 3; acute onset."

24 Attention, Executive Function, and Neurodevelopmental Experiences

24.1 Summary

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

24.2 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."

24.3 Core Features

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

24.4 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.

24.5 Variants / Spectrum

- Inattention-dominant presentations.
- Hyperactivity or impulsivity-dominant presentations.
- Social communication and sensory regulation differences.
- Learning-related challenges.

24.6 Severity Anchors (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.

24.7 Time-Course Patterns

- Lifelong or early-onset patterns.
- Stable with situational fluctuations.

24.8 Functional Impact

- Work/school: missed deadlines, disorganization, inconsistent performance.
- Relationships: miscommunication, conflict, or withdrawal.
- Self-care: routine instability, forgetfulness.

24.9 Common Mimics / Differential

- Mood or anxiety-driven inattention.
- Sleep deprivation or substance effects.
- Trauma-related hyperarousal.

24.10 Medical / Substance Rule-Outs

- Sleep disorders, thyroid issues, neurologic contributors.
- Stimulant or sedative effects.

24.11 Developmental Expression

- Childhood: attention, behavior, or learning challenges.
- Adolescence: academic demands reveal deficits.
- Adulthood: organizational strain and burnout.

24.12 Cultural / Context Notes

- Expectations of attention and behavior vary by context.
- Environmental mismatch can amplify impairment.

24.13 Measurement Prompts

- Brief attention/executive screening.
- Collateral reports or rating scales.

24.14 Cross-Links

- Domains: Cognitive Control and Executive Function; Social Communication and Relatedness.
- Prototypes: ADHD Pattern; Autism Pattern; Learning Disorder Patterns.
- Specifiers: Course and Time Pattern; Severity and Impairment.

24.15 Documentation Snippet (1-2 lines)

- "Longstanding attention and organization difficulties across settings; Cognitive Control 3; chronic course."

25 Emotion Regulation, Self-Concept, and Interpersonal Pain

25.1 Summary

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

25.2 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."

25.3 Core Features

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

25.4 Boundary Markers

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

25.5 Variants / Spectrum

- Emotion lability or explosive reactions.
- Chronic shame or identity instability.
- Interpersonal conflict or push-pull patterns.
- Emotional numbing or dissociative shutdown.

25.6 Severity Anchors (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.

25.7 Time-Course Patterns

- Chronic with episodic spikes.
- Trigger-linked to attachment or rejection cues.

25.8 Functional Impact

- Work/school: conflict, instability, absenteeism.
- Relationships: ruptures, withdrawal, or intense dependency.
- Self-care: impulsive or self-damaging behaviors.

25.9 Common Mimics / Differential

- Trauma-related dysregulation.
- Mood episodes with irritability.
- Substance-driven impulsivity.

25.10 Medical / Substance Rule-Outs

- Substance intoxication or withdrawal.
- Neurologic contributors to impulse control.

25.11 Developmental Expression

- Adolescence: identity shifts, relational volatility.
- Adulthood: chronic interpersonal instability.
- Late life: isolation or entrenched patterns.

25.12 Cultural / Context Notes

- Relationship norms and identity frameworks vary by culture.
- Ongoing adversity amplifies relational pain.

25.13 Measurement Prompts

- Brief emotion regulation screening.
- Relationship instability tracking.

25.14 Cross-Links

- Domains: Personality Functioning (Dimensional); Mood and Drive Dysregulation; Trauma and Stress Response.
- Prototypes: Personality Pattern Prototypes.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

25.15 Documentation Snippet (1-2 lines)

- "Reports intense emotional swings and fear of abandonment; Personality Functioning 3; chronic course."

26 Somatic Distress and Interoception

26.1 Summary

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

26.2 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."

26.3 Core Features

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

26.4 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.

26.5 Variants / Spectrum

- Pain-dominant presentations.
- Fatigue or low-energy syndromes.
- Functional neurologic symptoms (weakness, tremor, nonepileptic events).
- Health anxiety overlap.

26.6 Severity Anchors (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.

26.7 Time-Course Patterns

- Chronic persistence with flares.
- Trigger-linked or stress-linked spikes.

26.8 Functional Impact

- Work/school: reduced stamina or attendance.
- Relationships: increased reassurance seeking or withdrawal.
- Self-care: disrupted routines, healthcare overuse or avoidance.

26.9 Common Mimics / Differential

- Medical conditions with clear etiology.
- Trauma-related somatic hyperarousal.
- Anxiety-driven bodily alarm.

26.10 Medical / Substance Rule-Outs

- Endocrine, autoimmune, neurologic, or infectious contributors.
- Medication effects or withdrawal.

26.11 Developmental Expression

- Childhood: somatic complaints or school avoidance.
- Adolescence: fatigue, pain, or health anxiety.
- Late life: symptom focus with medical overlap.

26.12 Cultural / Context Notes

- Somatic framing of distress may be culturally normative.
- Access to care shapes symptom interpretation.

26.13 Measurement Prompts

- Brief somatic symptom measure.
- Pain/fatigue tracking.

26.14 Cross-Links

- Domains: Somatic Distress and Interoception; Anxiety and Threat Sensitivity.
- Prototypes: Somatic Symptom Burden; Functional Neurologic Symptom.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Severity and Impairment.

26.15 Documentation Snippet (1-2 lines)

- "Persistent bodily distress with high interoceptive focus; Somatic 3; chronic course with flares."

27 Sleep, Circadian, and Arousal Regulation

27.1 Summary

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

27.2 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."

27.3 Core Features

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

27.4 Boundary Markers

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

27.5 Variants / Spectrum

- Insomnia (initiation, maintenance, early waking).
- Hypersomnia or excessive sleepiness.
- Circadian rhythm delay/advance.
- Nightmare or parasomnia patterns.

27.6 Severity Anchors (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.

27.7 Time-Course Patterns

- Acute, stress-related insomnia.
- Chronic insomnia or circadian shift.
- Fluctuating with schedule or substance use.

27.8 Functional Impact

- Work/school: fatigue, concentration issues.
- Relationships: irritability, withdrawal.
- Self-care: reduced routine stability.

27.9 Common Mimics / Differential

- Mood or anxiety disorders driving sleep disruption.
- Substance effects or withdrawal.
- Medical conditions (sleep apnea, pain).

27.10 Medical / Substance Rule-Outs

- Sleep apnea or other sleep disorders.
- Stimulants, alcohol, or sedatives.
- Endocrine or neurologic contributors.

27.11 Developmental Expression

- Childhood: bedtime resistance, nightmares.
- Adolescence: delayed sleep phase.
- Late life: early waking, fragmented sleep.

27.12 Cultural / Context Notes

- Shift work or caregiving roles can drive sleep disruption.
- Cultural norms influence sleep timing and reporting.

27.13 Measurement Prompts

- Sleep diary or tracker.
- Brief insomnia severity questions.

27.14 Cross-Links

- Domains: Arousal, Sleep, and Circadian Regulation; Mood and Drive Dysregulation.
- Prototypes: None (see rule-outs or sleep disorders).
- Specifiers: Course and Time Pattern; Etiologic Contributors.

27.15 Documentation Snippet (1-2 lines)

- "Reports chronic insomnia with delayed sleep phase; Arousal/Sleep 3; chronic course."

28 Eating, Appetite, and Body Image

28.1 Summary

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

28.2 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."

28.3 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.

28.4 Boundary Markers

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

28.5 Variants / Spectrum

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

28.6 Severity Anchors (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.

28.7 Time-Course Patterns

- Episodic with stress-linked spikes.
- Chronic patterns with fluctuating severity.

28.8 Functional Impact

- Work/school: concentration loss, health impacts.
- Relationships: secrecy, conflict around meals.
- Self-care: nutritional compromise or medical risk.

28.9 Common Mimics / Differential

- Medical causes of weight loss or appetite change.
- Mood or anxiety-driven appetite shifts.
- Substance effects.

28.10 Medical / Substance Rule-Outs

- Endocrine, GI, or metabolic contributors.
- Medication effects or stimulant use.

28.11 Developmental Expression

- Childhood: picky eating, sensory avoidance.
- Adolescence: body image concerns, restriction.
- Adulthood: chronic patterns or relapse.

28.12 Cultural / Context Notes

- Body ideals and food norms shape expression.
- Food insecurity can mimic restriction.

28.13 Measurement Prompts

- Brief eating behavior screen.
- Weight/behavior tracking as appropriate.

28.14 Cross-Links

- Domains: Eating and Feeding Regulation; Mood and Drive Dysregulation.
- Prototypes: Anorexia Pattern; Bulimia Pattern; Binge-Eating Pattern; ARFID Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

28.15 Documentation Snippet (1-2 lines)

- "Reports restrictive eating with weight/shape concerns; Eating/Feeding 3; chronic course."

29 Substance Use and Compulsive Reward Seeking

29.1 Summary

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

29.2 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."

29.3 Core Features

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

29.4 Boundary Markers

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

29.5 Variants / Spectrum

- Binge or episodic use patterns.
- Daily or steady use patterns.
- Polysubstance use.
- Behavioral reward seeking (evidence-graded).

29.6 Severity Anchors (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.

29.7 Time-Course Patterns

- Episodic with relapse cycles.
- Chronic, persistent use.
- Fluctuating with stress or access.

29.8 Functional Impact

- Work/school: missed obligations, decreased performance.
- Relationships: conflict, secrecy, isolation.
- Self-care: health decline, risk behaviors.

29.9 Common Mimics / Differential

- Primary mood or anxiety symptoms driving use.
- Medical conditions with overlapping symptoms.

29.10 Medical / Substance Rule-Outs

- Intoxication or withdrawal states.
- Medication interactions or iatrogenic effects.

29.11 Developmental Expression

- Adolescence: risk-taking, peer-influenced use.
- Adulthood: coping-related or dependence patterns.
- Late life: medication interactions and misuse.

29.12 Cultural / Context Notes

- Use patterns shaped by access, norms, and legal context.
- Stigma can distort reporting.

29.13 Measurement Prompts

- Brief substance use screen.
- Timeline of use and consequences.

29.14 Cross-Links

- Domains: Reward, Habit, and Substance-Related Compulsion; Mood and Drive Dysregulation.
- Prototypes: Alcohol; Opioid; Stimulant; Cannabis; Sedative; Other Substances.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

29.15 Documentation Snippet (1-2 lines)

- "Reports compulsive alcohol use with craving and withdrawal; Reward/Habit 3; chronic course."

30 Mood and Drive Dysregulation

This chapter begins the dimensional domains and how to rate severity and change. Most useful for tracking patterns over time.

30.1 Summary

- A dimensional construct describing dysregulated mood tone, energy, and drive across time and context.

30.2 Core Construct

- Instability or distortion in mood and drive that affects behavior, sleep, and function.

30.3 Subdimensions

- Low mood and loss of interest.
- Elevated mood and increased drive.
- Irritability and mixed states.

30.4 Severity Anchors (0-4)

- 0: Typical mood range and energy.
- 1: Mild shifts with limited impact.
- 2: Moderate, persistent, with clear functional impact.
- 3: Severe, recurrent or sustained, with marked impairment.
- 4: Extreme, disabling or unsafe.

30.5 Time-Course Patterns

- Episodic vs chronic.
- Cyclic or seasonal patterns.
- Trigger-linked vs autonomous shifts.

30.6 Functional Impact

- Work/school: reduced productivity or impulsive overactivity.
- Relationships: withdrawal, conflict, or instability.
- Self-care: disrupted sleep, appetite, or routine.

30.7 Developmental Expression

- Childhood: irritability, withdrawal, or behavioral change.
- Adolescence: mood lability with sleep disruption.
- Late life: mood changes with cognitive or medical overlap.

30.8 Cultural / Context Notes

- Mood expression varies with cultural norms and context.
- Grief and loss can mimic mood dysregulation.

30.9 Differential and Rule-Outs

- Substance or medication effects.
- Sleep deprivation or circadian disruption.
- Trauma-related dysregulation.
- Endocrine or neurologic contributors.

30.10 Measurement Prompts

- Brief mood or depression measure.
- Sleep/energy tracking.

30.11 Treatment-Relevant Correlates (non-prescriptive)

- High drive shifts suggest monitoring risk and sleep stability.
- Chronic low mood suggests monitoring function and withdrawal.

30.12 Cross-Links

- Atlas: Affect and Mood Experiences.

- Prototypes: Major Depressive Episode; Bipolar Spectrum Episode Prototypes; Persistent Depressive Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

30.13 Documentation Snippet (1-2 lines)

- "Mood/Drive dysregulation with low mood and low energy; Mood/Drive 3; chronic course."

31 Anxiety and Threat Sensitivity

31.1 Summary

- A dimensional construct describing heightened detection and response to threat signals across contexts.

31.2 Core Construct

- Tendency to overestimate threat and sustain fear or worry responses.

31.3 Subdimensions

- Anticipatory worry and vigilance.
- Acute fear or panic responses.
- Avoidance and safety behaviors.

31.4 Severity Anchors (0-4)

- 0: No clinically meaningful threat sensitivity.
- 1: Mild, situational, manageable.
- 2: Moderate, recurring, interferes with daily functioning.
- 3: Severe, frequent, with marked avoidance or panic.
- 4: Extreme, disabling or unsafe.

31.5 Time-Course Patterns

- Acute spikes vs chronic baseline elevation.
- Cue-bound (triggered) vs free-floating.
- Episodic panic with inter-episode worry.

31.6 Functional Impact

- Work/school: concentration loss, avoidance, decreased performance.
- Relationships: withdrawal, reassurance seeking.
- Self-care: sleep disruption, reduced routine adherence.

31.7 Developmental Expression

- Childhood: separation fears, somatic complaints.
- Adolescence: social threat, panic, avoidance.
- Adulthood: generalized worry, health threat focus.
- Late life: medical and safety-related fears.

31.8 Cultural / Context Notes

- Threat appraisal depends on context and lived experience.
- Somatic framing may predominate in some settings.

31.9 Differential and Rule-Outs

- Trauma-related hypervigilance.
- Obsessive intrusive fears.
- Substance or medication effects.
- Sleep deprivation or medical contributors.

31.10 Measurement Prompts

- Brief anxiety measure.
- Avoidance or trigger tracking.

31.11 Treatment-Relevant Correlates (non-prescriptive)

- High avoidance often predicts functional restriction.
- High arousal suggests monitoring of sleep and physiology.

31.12 Cross-Links

- Atlas: Anxiety, Threat, and Bodily Alarm.

- Prototypes: Panic Pattern; Generalized Worry Pattern; Social Threat Pattern; Specific Phobia Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

31.13 Documentation Snippet (1-2 lines)

- "Threat sensitivity elevated with avoidance and panic surges; Threat domain 3, episodic course."

32 Trauma and Stress Response

32.1 Summary

- A dimensional construct describing persistent threat responses, intrusions, and dysregulation following adverse or traumatic events.

32.2 Core Construct

- Trauma-linked reactivity that persists beyond immediate threat and alters functioning.

32.3 Subdimensions

- Intrusion and re-experiencing.
- Avoidance and numbing.
- Hyperarousal and vigilance.
- Dissociation or shutdown.

32.4 Severity Anchors (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.

32.5 Time-Course Patterns

- Acute post-event response.
- Chronic persistence with triggers.
- Fluctuating with stress load or reminders.

32.6 Functional Impact

- Work/school: concentration or attendance impairment.
- Relationships: mistrust, withdrawal, conflict.
- Self-care: sleep disruption, hyperarousal.

32.7 Developmental Expression

- Childhood: regression, reenactment, externalizing behavior.
- Adolescence: risk-taking, withdrawal, dissociation.
- Late life: reactivation with losses or illness.

32.8 Cultural / Context Notes

- Trauma meaning is shaped by culture and community narratives.
- Ongoing threat changes symptom interpretation and need for safety planning.

32.9 Differential and Rule-Outs

- Anxiety threat responses without trauma linkage.
- Obsessional intrusions.
- Substance effects or withdrawal.
- Sleep disorders and medical contributors.

32.10 Measurement Prompts

- Brief trauma symptom checklist.
- Avoidance and trigger tracking.

32.11 Treatment-Relevant Correlates (non-prescriptive)

- High avoidance often predicts functional restriction.
- Ongoing threat suggests prioritizing safety stabilization.

32.12 Cross-Links

- Atlas: Trauma-Related Experiences.
- Prototypes: PTSD Pattern; Complex Trauma Pattern; Adjustment Pattern.

- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers; Context and Culture.

32.13 Documentation Snippet (1-2 lines)

- "Trauma-linked intrusions and avoidance with hyperarousal; Trauma/Stress 3; chronic course."

33 Compulsivity and Perseveration

33.1 Summary

- A dimensional construct describing repetitive thoughts, urges, or behaviors that are hard to inhibit and consume time or function.

33.2 Core Construct

- Difficulty disengaging from repetitive cognitive or behavioral loops despite distress or low utility.

33.3 Subdimensions

- Obsessional intrusions and doubt.
- Behavioral rituals or checking.
- Perseverative rumination or mental rituals.

33.4 Severity Anchors (0-4)

- 0: No clinically meaningful compulsivity.
- 1: Mild, occasional, manageable.
- 2: Moderate, recurring, interferes with focus or time use.
- 3: Severe, time-consuming or impairing.
- 4: Extreme, disabling or unsafe.

33.5 Time-Course Patterns

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

33.6 Functional Impact

- Work/school: time loss, reduced concentration.

- Relationships: reassurance seeking or conflict.
- Self-care: avoidance or ritual delays.

33.7 Developmental Expression

- Childhood: rituals or checking under stress.
- Adolescence: increased rumination or perfectionism.
- Late life: health-focused checking or safety rituals.

33.8 Cultural / Context Notes

- Differentiate culturally normative rituals from distressing compulsions.

33.9 Differential and Rule-Outs

- Anxiety threat responses without rituals.
- Trauma intrusions without compulsions.
- Psychosis with fixed beliefs.
- Substance effects or neurologic contributors.

33.10 Measurement Prompts

- Brief obsession/compulsion measure.
- Time spent on rituals or rumination.

33.11 Treatment-Relevant Correlates (non-prescriptive)

- High compulsivity often predicts avoidance and functional restriction.

33.12 Cross-Links

- Atlas: Obsessions, Compulsions, and Stuckness.
- Prototypes: OCD Pattern; Body-Focused Repetitive Behaviors; Illness Anxiety Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

33.13 Documentation Snippet (1-2 lines)

- "Compulsivity elevated with checking and rumination; Compulsivity 3; chronic course."

34 Psychosis and Reality Testing

34.1 Summary

- A dimensional construct describing the degree of reality distortion and impairment in testing beliefs or perceptions.

34.2 Core Construct

- Reduced ability to distinguish internal experiences from shared reality.

34.3 Subdimensions

- Hallucinations or perceptual distortions.
- Delusional conviction or unusual beliefs.
- Disorganization in thought or behavior.
- Insight into experiences.

34.4 Severity Anchors (0-4)

- 0: No clinically meaningful reality distortion.
- 1: Mild, intermittent, with intact insight.
- 2: Moderate, recurring, impacts function.
- 3: Severe, persistent, with reduced insight.
- 4: Extreme, disabling or unsafe.

34.5 Time-Course Patterns

- Acute onset.
- Episodic with remissions.
- Chronic persistence with exacerbations.

34.6 Functional Impact

- Work/school: disorganization or reduced performance.
- Relationships: mistrust, withdrawal, or conflict.
- Self-care: neglected routines or safety concerns.

34.7 Developmental Expression

- Adolescence/early adulthood: new onset with functional change.
- Late life: new onset warrants medical evaluation.

34.8 Cultural / Context Notes

- Evaluate beliefs within cultural or spiritual context.
- Avoid pathologizing culturally normative experiences.

34.9 Differential and Rule-Outs

- Delirium or acute confusional states.
- Substance intoxication or withdrawal.
- Medication effects.
- Trauma-related intrusions or dissociation.
- Neurologic or autoimmune contributors.

34.10 Measurement Prompts

- Brief psychosis screening items.
- Collateral history and timeline mapping.

34.11 Treatment-Relevant Correlates (non-prescriptive)

- Lower insight suggests greater need for collateral and monitoring.
- Disorganization often correlates with functional risk.

34.12 Cross-Links

- Atlas: Reality Distortion and Psychosis-Spectrum Experiences.
- Prototypes: First Episode Psychosis; Schizophrenia-Spectrum; Mood-Psychosis Pattern.

- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

34.13 Documentation Snippet (1-2 lines)

- "Psychosis domain elevated with hallucinations and reduced insight; Psychosis 3; acute onset."

35 Cognitive Control and Executive Function

35.1 Summary

- A dimensional construct describing attention regulation, planning, impulse control, and task persistence.

35.2 Core Construct

- Capacity to initiate, organize, sustain, and complete goal-directed behavior.

35.3 Subdimensions

- Attention and distractibility.
- Planning, organization, and working memory.
- Impulse control and inhibition.

35.4 Severity Anchors (0-4)

- 0: No clinically meaningful executive dysfunction.
- 1: Mild, situational, manageable.
- 2: Moderate, recurring, impacts function.
- 3: Severe, persistent, with clear impairment.
- 4: Extreme, disabling or unsafe.

35.5 Time-Course Patterns

- Early-onset and stable.
- Worsening under stress or sleep loss.

35.6 Functional Impact

- Work/school: missed deadlines, inconsistent performance.

- Relationships: forgetfulness or follow-through strain.
- Self-care: routine instability.

35.7 Developmental Expression

- Childhood: attention and behavior challenges.
- Adolescence: organizational strain with increased demands.
- Adulthood: executive overload and burnout.

35.8 Cultural / Context Notes

- Expectations for structure vary by context.
- Environmental supports can mask or reveal impairment.

35.9 Differential and Rule-Outs

- Mood or anxiety-related inattention.
- Sleep deprivation or substance effects.
- Neurologic or medical contributors.

35.10 Measurement Prompts

- Brief attention/executive screening.
- Collateral or rating scales.

35.11 Treatment-Relevant Correlates (non-prescriptive)

- Executive strain often amplifies functional impairment.

35.12 Cross-Links

- Atlas: Attention, Executive Function, and Neurodevelopmental Experiences.
- Prototypes: ADHD Pattern; Learning Disorder Patterns.
- Specifiers: Course and Time Pattern; Severity and Impairment.

35.13 Documentation Snippet (1-2 lines)

- "Executive dysfunction with distractibility and poor follow-through; Cognitive Control 3; chronic course."

36 Social Communication and Relatedness

36.1 Summary

- A dimensional construct describing social communication style, reciprocity, and relatedness across contexts.

36.2 Core Construct

- Capacity to interpret, respond to, and sustain social interaction effectively.

36.3 Subdimensions

- Social reciprocity and responsiveness.
- Nonverbal communication and pragmatic language.
- Social motivation and comfort.

36.4 Severity Anchors (0-4)

- 0: No clinically meaningful social communication difficulties.
- 1: Mild, situational, manageable.
- 2: Moderate, recurring, impacts function.
- 3: Severe, persistent, with clear impairment.
- 4: Extreme, disabling or isolating.

36.5 Time-Course Patterns

- Early-onset and stable.
- Situational variability by context.

36.6 Functional Impact

- Work/school: collaboration challenges or miscommunication.

- Relationships: misunderstandings or withdrawal.
- Self-care: isolation or reduced support use.

36.7 Developmental Expression

- Childhood: peer difficulties or pragmatic language differences.
- Adolescence: social anxiety or isolation.
- Adulthood: relational strain or masking fatigue.

36.8 Cultural / Context Notes

- Norms for communication vary across cultures.
- Social expectations influence perceived impairment.

36.9 Differential and Rule-Outs

- Social threat/anxiety driving avoidance.
- Trauma-related mistrust or withdrawal.
- Hearing or language impairments.

36.10 Measurement Prompts

- Social communication screening questions.
- Collateral reports from school/work.

36.11 Treatment-Relevant Correlates (non-prescriptive)

- Social mismatch often predicts functional strain.

36.12 Cross-Links

- Atlas: Attention, Executive Function, and Neurodevelopmental Experiences.
- Prototypes: Autism Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Context and Culture.

36.13 Documentation Snippet (1-2 lines)

- "Social communication differences with reciprocal strain; Social Relatedness 3; chronic course."

37 Arousal, Sleep, and Circadian Regulation

37.1 Summary

- A dimensional construct describing dysregulation in sleep quality, timing, or arousal that affects function and symptom expression.

37.2 Core Construct

- Difficulty achieving restorative sleep or stable circadian timing.

37.3 Subdimensions

- Insomnia or sleep fragmentation.
- Hypersomnia or excessive sleepiness.
- Circadian phase delay/advance.
- Hyperarousal or low arousal states.

37.4 Severity Anchors (0-4)

- 0: Restorative sleep, stable timing.
- 1: Mild disruption with limited impact.
- 2: Moderate disruption with daytime impairment.
- 3: Severe, persistent disruption with functional impact.
- 4: Extreme, disabling or unsafe.

37.5 Time-Course Patterns

- Acute, stress-linked insomnia.
- Chronic insomnia or circadian shift.
- Fluctuating with schedule or substance use.

37.6 Functional Impact

- Work/school: fatigue, concentration issues.
- Relationships: irritability, withdrawal.
- Self-care: reduced routine stability.

37.7 Developmental Expression

- Childhood: bedtime resistance, nightmares.
- Adolescence: delayed sleep phase.
- Late life: fragmented sleep, early waking.

37.8 Cultural / Context Notes

- Shift work or caregiving roles can drive sleep disruption.
- Cultural norms influence sleep timing and reporting.

37.9 Differential and Rule-Outs

- Mood or anxiety disorders driving sleep disruption.
- Substance effects or withdrawal.
- Sleep apnea or other primary sleep disorders.
- Medical pain or neurologic contributors.

37.10 Measurement Prompts

- Sleep diary or tracker.
- Brief insomnia severity questions.

37.11 Treatment-Relevant Correlates (non-prescriptive)

- Severe disruption often amplifies other domains.

37.12 Cross-Links

- Atlas: Sleep, Circadian, and Arousal Regulation.
- Prototypes: None (sleep disorders are rule-out first).
- Specifiers: Course and Time Pattern; Etiologic Contributors.

37.13 Documentation Snippet (1-2 lines)

- "Sleep/circadian dysregulation with chronic insomnia; Arousal/Sleep 3; chronic course."

38 Somatic Distress and Interoception

38.1 Summary

- A dimensional construct describing heightened bodily symptom distress and sensitivity to internal cues.

38.2 Core Construct

- Amplified attention to bodily sensations with distress or uncertainty about their meaning.

38.3 Subdimensions

- Pain or fatigue burden.
- Interoceptive sensitivity and scanning.
- Health-related worry or uncertainty.

38.4 Severity Anchors (0-4)

- 0: No clinically meaningful somatic distress.
- 1: Mild, intermittent, manageable.
- 2: Moderate, persistent, impacts function.
- 3: Severe, frequent, with high distress or impairment.
- 4: Extreme, disabling or unsafe.

38.5 Time-Course Patterns

- Chronic persistence with flares.
- Trigger-linked or stress-linked spikes.

38.6 Functional Impact

- Work/school: reduced stamina or attendance.

- Relationships: reassurance seeking or withdrawal.
- Self-care: healthcare overuse or avoidance.

38.7 Developmental Expression

- Childhood: somatic complaints, school avoidance.
- Adolescence: fatigue or pain prominence.
- Late life: symptom focus with medical overlap.

38.8 Cultural / Context Notes

- Somatic framing may be culturally normative.
- Medical access shapes symptom meaning.

38.9 Differential and Rule-Outs

- Medical conditions with clear etiology.
- Trauma-related hyperarousal.
- Anxiety-driven bodily alarm.
- Medication effects or withdrawal.

38.10 Measurement Prompts

- Brief somatic symptom measure.
- Pain/fatigue tracking.

38.11 Treatment-Relevant Correlates (non-prescriptive)

- High interoceptive focus often predicts reassurance seeking.

38.12 Cross-Links

- Atlas: Somatic Distress and Interoception.
- Prototypes: Somatic Symptom Burden; Functional Neurologic Symptom; Illness Anxiety Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

38.13 Documentation Snippet (1-2 lines)

- "Somatic distress elevated with persistent pain and fatigue; Somatic 3; chronic course."

39 Reward, Habit, and Substance-Related Compulsion

39.1 Summary

- A dimensional construct describing compulsive reward seeking, habit formation, and substance-related loss of control.

39.2 Core Construct

- Persistent use or reward-seeking despite harm and reduced control.

39.3 Subdimensions

- Craving and cue reactivity.
- Compulsive use or habit strength.
- Tolerance and withdrawal patterns.

39.4 Severity Anchors (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.

39.5 Time-Course Patterns

- Episodic with relapse cycles.
- Chronic, persistent use.
- Fluctuating with stress or access.

39.6 Functional Impact

- Work/school: missed obligations, decreased performance.
- Relationships: conflict, secrecy, isolation.
- Self-care: health decline, risk behaviors.

39.7 Developmental Expression

- Adolescence: risk-taking or peer-influenced use.
- Adulthood: coping-related or dependence patterns.
- Late life: medication interactions and misuse.

39.8 Cultural / Context Notes

- Legal and social context shape reporting.
- Stigma affects disclosure and engagement.

39.9 Differential and Rule-Outs

- Primary mood or anxiety driving use.
- Medical conditions with overlapping symptoms.
- Medication effects or iatrogenic contributions.

39.10 Measurement Prompts

- Brief substance use screen.
- Timeline of use and consequences.

39.11 Treatment-Relevant Correlates (non-prescriptive)

- High cue reactivity predicts relapse risk.

39.12 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Prototypes: Alcohol; Opioid; Stimulant; Cannabis; Sedative; Other Substances.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

39.13 Documentation Snippet (1-2 lines)

- "Reward/habit compulsion with loss of control and withdrawal; Reward/Habit 3; chronic course."

40 Eating and Feeding Regulation

40.1 Summary

- A dimensional construct describing regulation of eating, appetite, and body-related behaviors.

40.2 Core Construct

- Balance of intake, appetite, and body image concerns that shape eating behavior.

40.3 Subdimensions

- Restriction or avoidance.
- Binge or loss of control.
- Compensatory behaviors or excessive exercise.
- Body image or weight/shape concern.

40.4 Severity Anchors (0-4)

- 0: No clinically meaningful eating dysregulation.
- 1: Mild, intermittent, manageable.
- 2: Moderate, recurring, impacts function.
- 3: Severe, persistent, with medical or functional risk.
- 4: Extreme, disabling or unsafe.

40.5 Time-Course Patterns

- Episodic with stress-linked spikes.
- Chronic patterns with fluctuating severity.

40.6 Functional Impact

- Work/school: concentration loss, health impacts.

- Relationships: secrecy, conflict around meals.
- Self-care: nutritional compromise or medical risk.

40.7 Developmental Expression

- Childhood: avoidant or sensory-based restrictions.
- Adolescence: body image concerns, restriction or bingeing.
- Adulthood: chronic patterns or relapse.

40.8 Cultural / Context Notes

- Food norms and body ideals shape expression.
- Food insecurity can mimic restriction.

40.9 Differential and Rule-Outs

- Medical causes of weight loss or appetite change.
- Mood or anxiety-driven appetite shifts.
- Substance or medication effects.

40.10 Measurement Prompts

- Brief eating behavior screen.
- Weight or behavior tracking as appropriate.

40.11 Treatment-Relevant Correlates (non-prescriptive)

- High restriction with low insight suggests medical risk monitoring.

40.12 Cross-Links

- Atlas: Eating, Appetite, and Body Image.
- Prototypes: Anorexia Pattern; Bulimia Pattern; Binge-Eating Pattern; ARFID Pattern.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

40.13 Documentation Snippet (1-2 lines)

- "Eating dysregulation with restriction and body image concern; Eating/Feeding 3; chronic course."

41 Personality Functioning (Dimensional)

41.1 Summary

- A dimensional construct describing stability of self-functioning and quality of interpersonal functioning.

41.2 Core Construct

- Consistency of identity, self-direction, empathy, and intimacy over time.

41.3 Subdimensions

- Self: identity and self-direction.
- Interpersonal: empathy and intimacy.

41.4 Severity Anchors (0-4)

- 0: Stable self and relationships; flexible functioning.
- 1: Mild instability or relational strain.
- 2: Moderate instability with recurring impairment.
- 3: Severe instability with chronic impairment.
- 4: Extreme dysfunction with high risk or incapacity.

41.5 Time-Course Patterns

- Chronic and longstanding.
- Fluctuates with stress and relational context.

41.6 Functional Impact

- Work/school: conflict, inconsistency, instability.
- Relationships: intense, unstable, or avoidant patterns.

- Self-care: impulsive or self-damaging behavior.

41.7 Developmental Expression

- Adolescence: identity instability and relational volatility.
- Adulthood: entrenched patterns.
- Late life: isolation or rigidity.

41.8 Cultural / Context Notes

- Norms for identity and relationships vary by culture.
- Context can mask or amplify impairment.

41.9 Differential and Rule-Outs

- Trauma-related dysregulation.
- Mood episodes with interpersonal effects.
- Substance-driven impulsivity.

41.10 Measurement Prompts

- Brief personality functioning screening.
- Collateral reports when available.

41.11 Treatment-Relevant Correlates (non-prescriptive)

- Higher severity predicts broader impairment and risk.

41.12 Cross-Links

- Atlas: Emotion Regulation, Self-Concept, and Interpersonal Pain.
- Prototypes: Personality Pattern Prototypes.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers; Context and Culture.

41.13 Documentation Snippet (1-2 lines)

- "Marked instability in identity and relationships; Personality Functioning 3; chronic course."

42 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.

42.1 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.

42.2 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.

42.3 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.

42.4 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.

43 Prototype Modules: Organization and Logic

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

43.1 Organization Logic

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

43.2 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.

43.3 Navigation Rules

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

44 Predominant Mood and Drive Prototypes

44.1 Summary

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

44.2 Included Prototypes

- Major Depressive Episode Prototype.
- Bipolar Spectrum Episode Prototypes.
- Persistent Depressive Pattern Prototype.

44.3 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.

44.4 Boundary Markers

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

44.5 Common Overlap

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

44.6 Cross-Links

- Atlas: Affect and Mood Experiences.
- Domains: Mood and Drive Dysregulation; Arousal, Sleep, and Circadian Regulation.

- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

44.7 Documentation Snippet (1-2 lines)

- "Mood/drive-dominant profile with low mood and reduced drive; consider major depressive vs persistent pattern after domain rating."

45 Major Depressive Episode Prototype

45.1 Summary

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

45.2 Prototype Features

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

45.3 Threshold Guidance

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

45.4 Expected Domain Profile

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

45.5 Time-Course and Trajectory

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

45.6 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.

45.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, recurrent, seasonal).
- Contributors (sleep loss, medical conditions, substance use).
- Risk modifiers (suicide risk, self-neglect).

45.8 Measurement Prompts

- Brief mood or depression measure.
- Sleep and activity tracking.

45.9 Cross-Links

- Atlas: Affect and Mood Experiences.
- Domains: Mood and Drive Dysregulation; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

45.10 Documentation Snippet (1-2 lines)

- "Sustained low mood with loss of interest and reduced drive; Mood/Drive 3, Arousal 2; episodic course."

46 Bipolar Spectrum Episode Prototypes

46.1 Summary

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

46.2 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.

46.3 Threshold Guidance

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

46.4 Expected Domain Profile

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

46.5 Time-Course and Trajectory

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

46.6 Differential and Red Flags

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

46.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, cycling).
- Contributors (sleep loss, substances, medications).
- Risk modifiers (impulsivity, safety risk).

46.8 Measurement Prompts

- Mood and energy tracking.
- Sleep/circadian log.

46.9 Cross-Links

- Atlas: Affect and Mood Experiences.
- Domains: Mood and Drive Dysregulation; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

46.10 Documentation Snippet (1-2 lines)

- "Episodes of elevated mood and increased drive with reduced sleep; Mood/Drive 4, Arousal 3; episodic course."

47 Persistent Depressive Pattern Prototype

47.1 Summary

- A pattern of long-standing low mood or reduced interest with chronic functional strain, often less episodic than major depressive episodes.

47.2 Prototype Features

- Enduring low mood, pessimism, or low energy.
- Reduced pleasure or engagement over time.
- Symptoms feel "baseline" rather than episodic.

47.3 Threshold Guidance

- Use when low mood/low drive is persistent and functionally limiting over time.

47.4 Expected Domain Profile

- Mood and Drive Dysregulation: moderate, sustained low.
- Arousal, Sleep, and Circadian Regulation: mild to moderate disruption.

47.5 Time-Course and Trajectory

- Chronic or long-standing course with intermittent worsening.

47.6 Differential and Red Flags

- Medical contributors (endocrine, sleep disorders).
- Trauma-related numbing or loss of meaning.
- Substance use or medication effects.

47.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (sleep debt, medical conditions, adversity).
- Risk modifiers (self-neglect, demoralization).

47.8 Measurement Prompts

- Brief mood measure.
- Function and activity tracking.

47.9 Cross-Links

- Atlas: Affect and Mood Experiences.
- Domains: Mood and Drive Dysregulation; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

47.10 Documentation Snippet (1-2 lines)

- "Long-standing low mood and reduced interest; Mood/Drive 2-3; chronic course with intermittent worsening."

48 Predominant Threat Prototypes

48.1 Summary

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

48.2 Included Prototypes

- Panic Pattern Prototype.
- Generalized Worry Pattern Prototype.
- Social Threat Pattern Prototype.
- Specific Phobia Pattern Prototype.

48.3 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.

48.4 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.

48.5 Common Overlap

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

48.6 Cross-Links

- Atlas: Anxiety, Threat, and Bodily Alarm.
- Domains: Anxiety and Threat Sensitivity; Arousal, Sleep, and Circadian Regulation.

- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

48.7 Documentation Snippet (1-2 lines)

- "Threat-dominant profile with avoidance; consider panic vs generalized worry prototype after domain rating."

49 Panic Pattern Prototype

49.1 Summary

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

49.2 Prototype Features

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

49.3 Threshold Guidance

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

49.4 Expected Domain Profile

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

49.5 Time-Course and Trajectory

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

49.6 Differential and Red Flags

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

49.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, trigger-linked).
- Contributors (caffeine, sleep loss).
- Risk modifiers (acute distress or avoidance severity).

49.8 Measurement Prompts

- Panic frequency log.
- Brief anxiety measure.

49.9 Cross-Links

- Atlas: Anxiety, Threat, and Bodily Alarm.
- Domains: Anxiety and Threat Sensitivity; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

49.10 Documentation Snippet (1-2 lines)

- "Recurrent panic surges with anticipatory avoidance; Threat 3, Arousal 2; episodic course."

50 Generalized Worry Pattern Prototype

50.1 Summary

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

50.2 Prototype Features

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

50.3 Threshold Guidance

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

50.4 Expected Domain Profile

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

50.5 Time-Course and Trajectory

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

50.6 Differential and Red Flags

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

50.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (sleep debt, caffeine, ongoing stress).
- Risk modifiers (distress vs impairment mismatch).

50.8 Measurement Prompts

- Brief worry or anxiety measure.
- Sleep and tension tracking.

50.9 Cross-Links

- Atlas: Anxiety, Threat, and Bodily Alarm.
- Domains: Anxiety and Threat Sensitivity; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

50.10 Documentation Snippet (1-2 lines)

- "Diffuse, persistent worry across domains with tension and insomnia; Threat 3, Arousal 2; chronic course."

51 Social Threat Pattern Prototype

51.1 Summary

- A pattern marked by intense fear of negative evaluation, leading to avoidance or endurance with significant distress.

51.2 Prototype Features

- Fear of embarrassment or rejection in social or performance settings.
- Avoidance, safety behaviors, or prolonged anticipatory worry.
- Physical symptoms in social contexts (blushing, tremor, nausea).

51.3 Threshold Guidance

- Use when social fear drives avoidance or persistent distress in key roles.

51.4 Expected Domain Profile

- Anxiety and Threat Sensitivity: moderate to high.
- Social Communication and Relatedness: mild to moderate strain.

51.5 Time-Course and Trajectory

- Situation-bound with anticipatory anxiety.
- Often chronic without exposure to feared contexts.

51.6 Differential and Red Flags

- Autism-related social communication differences.
- Trauma-related social hypervigilance.
- Mood dysregulation with social withdrawal.

51.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (situational, chronic).
- Contributors (bullying, discrimination, performance pressure).
- Risk modifiers (avoidance severity).

51.8 Measurement Prompts

- Brief social anxiety measure.
- Avoidance tracking.

51.9 Cross-Links

- Atlas: Anxiety, Threat, and Bodily Alarm; Emotion Regulation and Interpersonal Pain.
- Domains: Anxiety and Threat Sensitivity; Social Communication and Relatedness.
- Specifiers: Course and Time Pattern; Context and Culture; Severity and Impairment.

51.10 Documentation Snippet (1-2 lines)

- "Marked fear of negative evaluation with avoidance; Threat 3, Social Relatedness 2; situational course."

52 Specific Phobia Pattern Prototype

52.1 Summary

- A pattern of intense fear linked to a specific object or situation, leading to avoidance or distress when confronted.

52.2 Prototype Features

- Fear focused on a discrete trigger (e.g., heights, needles, animals).
- Immediate anxiety or panic on exposure.
- Avoidance or endurance with marked distress.

52.3 Threshold Guidance

- Use when fear is persistent and functionally impairing.

52.4 Expected Domain Profile

- Anxiety and Threat Sensitivity: mild to moderate overall, high in specific contexts.

52.5 Time-Course and Trajectory

- Trigger-bound, often stable over time.

52.6 Differential and Red Flags

- Trauma-related cues resembling the trigger.
- Medical fears linked to health anxiety.
- Developmentally typical fears in children.

52.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (trigger-linked, stable).
- Contributors (traumatic exposure, learned fear).
- Risk modifiers (avoidance severity).

52.8 Measurement Prompts

- Trigger exposure log.
- Brief fear severity scale.

52.9 Cross-Links

- Atlas: Anxiety, Threat, and Bodily Alarm.
- Domains: Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Severity and Impairment.

52.10 Documentation Snippet (1-2 lines)

- "Intense fear of a specific trigger with avoidance; Threat 2; trigger-linked course."

53 Predominant Trauma and Stress Prototypes

53.1 Summary

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

53.2 Included Prototypes

- PTSD Pattern Prototype.
- Complex Trauma Pattern Prototype.
- Adjustment Pattern Prototype.

53.3 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.

53.4 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.

53.5 Common Overlap

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

53.6 Cross-Links

- Atlas: Trauma-Related Experiences.

- Domains: Trauma and Stress Response; Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers; Context and Culture.

53.7 Documentation Snippet (1-2 lines)

- "Trauma-dominant profile with intrusions and avoidance; consider PTSD vs complex trauma prototype after domain rating."

54 PTSD Pattern Prototype

54.1 Summary

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

54.2 Prototype Features

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

54.3 Threshold Guidance

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

54.4 Expected Domain Profile

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

54.5 Time-Course and Trajectory

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

54.6 Differential and Red Flags

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

54.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, trigger-linked).
- Contributors (ongoing threat, sleep disruption).
- Risk modifiers (self-harm risk, dissociation).

54.8 Measurement Prompts

- Brief trauma symptom checklist.
- Sleep and trigger log.

54.9 Cross-Links

- Atlas: Trauma-Related Experiences.
- Domains: Trauma and Stress Response; Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

54.10 Documentation Snippet (1-2 lines)

- "Trauma-linked intrusions with avoidance and hyperarousal; Trauma/Stress 3, Threat 2; chronic course."

55 Complex Trauma Pattern Prototype

55.1 Summary

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

55.2 Prototype Features

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

55.3 Threshold Guidance

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

55.4 Expected Domain Profile

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

55.5 Time-Course and Trajectory

- Chronic and pervasive, often with episodic worsening.

55.6 Differential and Red Flags

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

55.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (ongoing threat, developmental trauma).
- Risk modifiers (self-harm, dissociation).

55.8 Measurement Prompts

- Trauma symptom checklist with dissociation items.
- Emotion regulation tracking.

55.9 Cross-Links

- Atlas: Trauma-Related Experiences; Emotion Regulation and Interpersonal Pain.
- Domains: Trauma and Stress Response; Personality Functioning; Mood and Drive Dysregulation.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers; Context and Culture.

55.10 Documentation Snippet (1-2 lines)

- "Chronic trauma-linked dysregulation with relational instability; Trauma/Stress 4, Emotion Regulation 3; chronic course."

56 Adjustment Pattern Prototype

56.1 Summary

- A pattern of distress and functional disruption that is clearly linked to an identifiable stressor or life change.

56.2 Prototype Features

- Onset after a defined stressor.
- Emotional or behavioral symptoms out of proportion to baseline coping.
- Impairment in functioning or increased distress.

56.3 Threshold Guidance

- Use when stressor linkage is clear and symptoms are time-limited or improving.

56.4 Expected Domain Profile

- Trauma and Stress Response: mild to moderate.
- Mood and Drive Dysregulation: mild to moderate.
- Anxiety and Threat Sensitivity: variable.

56.5 Time-Course and Trajectory

- Acute onset with improvement as stressor resolves.
- May become persistent if stressor continues.

56.6 Differential and Red Flags

- Major mood episode without clear stressor linkage.
- Trauma pattern with intrusions or avoidance.
- Substance effects or medical contributors.

56.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (acute, trigger-linked).
- Contributors (ongoing adversity, resource loss).
- Risk modifiers (suicide risk in acute stress).

56.8 Measurement Prompts

- Brief distress scale.
- Function tracking during stress period.

56.9 Cross-Links

- Atlas: Trauma-Related Experiences; Affect and Mood Experiences.
- Domains: Trauma and Stress Response; Mood and Drive Dysregulation; Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Context and Culture; Risk Modifiers.

56.10 Documentation Snippet (1-2 lines)

- "Stress-linked distress with functional decline; Trauma/Stress 2, Mood/Drive 2; acute course."

57 Predominant Compulsivity Prototypes

57.1 Summary

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

57.2 Included Prototypes

- OCD Pattern Prototype.
- Body-Focused Repetitive Behaviors Prototype.
- Illness Anxiety Pattern Prototype.

57.3 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.

57.4 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.

57.5 Common Overlap

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

57.6 Cross-Links

- Atlas: Obsessions, Compulsions, and Stuckness.
- Domains: Compulsivity and Perseveration; Anxiety and Threat Sensitivity.

- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

57.7 Documentation Snippet (1-2 lines)

- "Compulsivity-dominant profile with intrusive doubts and rituals; consider OCD vs illness anxiety prototype after domain rating."

58 OCD Pattern Prototype

58.1 Summary

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

58.2 Prototype Features

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

58.3 Threshold Guidance

- Use when obsessions/compulsions are recurrent and impairing.

58.4 Expected Domain Profile

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

58.5 Time-Course and Trajectory

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

58.6 Differential and Red Flags

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

58.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (sleep loss, stress).
- Risk modifiers (time-consuming rituals, self-neglect).

58.8 Measurement Prompts

- Brief obsession/compulsion measure.
- Time spent on rituals.

58.9 Cross-Links

- Atlas: Obsessions, Compulsions, and Stuckness.
- Domains: Compulsivity and Perseveration; Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

58.10 Documentation Snippet (1-2 lines)

- "Intrusive doubts with checking and ritualizing; Compulsivity 3; chronic course."

59 Body-Focused Repetitive Behaviors Prototype

59.1 Summary

- A pattern of repetitive, hard-to-control behaviors focused on the body that provide temporary relief or tension reduction.

59.2 Prototype Features

- Repetitive behaviors (e.g., skin picking, hair pulling).
- Rising tension or urge before the behavior.
- Relief or gratification after the behavior.

59.3 Threshold Guidance

- Use when behaviors are recurrent and lead to distress, impairment, or injury.

59.4 Expected Domain Profile

- Compulsivity and Perseveration: moderate.
- Somatic Distress and Interoception: variable.

59.5 Time-Course and Trajectory

- Chronic with stress-related spikes.

59.6 Differential and Red Flags

- Dermatologic conditions driving scratching.
- Substance effects or neurologic contributors.
- Self-harm behaviors with different intent.

59.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (stress, sensory dysregulation).
- Risk modifiers (injury, infection risk).

59.8 Measurement Prompts

- Frequency and duration tracking.
- Body area impact log.

59.9 Cross-Links

- Atlas: Obsessions, Compulsions, and Stuckness; Somatic Distress and Interoception.
- Domains: Compulsivity and Perseveration; Somatic Distress and Interoception.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

59.10 Documentation Snippet (1-2 lines)

- "Repetitive skin picking with tension relief; Compulsivity 2; chronic course with stress-linked spikes."

60 Illness Anxiety Pattern Prototype

60.1 Summary

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

60.2 Prototype Features

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

60.3 Threshold Guidance

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

60.4 Expected Domain Profile

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

60.5 Time-Course and Trajectory

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

60.6 Differential and Red Flags

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

60.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (recent illness, health-related loss).
- Risk modifiers (care avoidance or overutilization).

60.8 Measurement Prompts

- Health anxiety measure.
- Checking and reassurance frequency.

60.9 Cross-Links

- Atlas: Obsessions, Compulsions, and Stuckness; Somatic Distress and Interoception.
- Domains: Compulsivity and Perseveration; Somatic Distress and Interoception; Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

60.10 Documentation Snippet (1-2 lines)

- "Persistent health fear with checking and reassurance; Compulsivity 2, Somatic 2; chronic course."

61 Predominant Psychosis Prototypes

61.1 Summary

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

61.2 Included Prototypes

- First Episode Psychosis Prototype.
- Schizophrenia-Spectrum Prototype.
- Mood-Psychosis Pattern Prototype.

61.3 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.

61.4 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.

61.5 Common Overlap

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

61.6 Cross-Links

- Atlas: Reality Distortion and Psychosis-Spectrum Experiences.

- Domains: Psychosis and Reality Testing; Mood and Drive Dysregulation; Cognitive Control and Executive Function.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

61.7 Documentation Snippet (1-2 lines)

- "Psychosis-dominant profile with hallucinations and reduced insight; consider first episode vs schizophrenia-spectrum pattern after domain rating."

62 First Episode Psychosis Prototype

62.1 Summary

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

62.2 Prototype Features

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

62.3 Threshold Guidance

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

62.4 Expected Domain Profile

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

62.5 Time-Course and Trajectory

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

62.6 Differential and Red Flags

- Delirium or acute confusional states.
- Substance intoxication or withdrawal.
- Medication or iatrogenic effects.

- Seizure, autoimmune, infectious, or neurodegenerative mimics.

62.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (acute, episodic).
- Contributors (substance use, sleep loss, medical factors).
- Risk modifiers (safety risk, self-care impairment).

62.8 Measurement Prompts

- Brief psychosis screening items.
- Collateral timeline and functional baseline.

62.9 Cross-Links

- Atlas: Reality Distortion and Psychosis-Spectrum Experiences.
- Domains: Psychosis and Reality Testing; Cognitive Control and Executive Function; Mood and Drive Dysregulation.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

62.10 Documentation Snippet (1-2 lines)

- "New onset hallucinations with reduced insight and functional change; Psychosis 3; acute course."

63 Schizophrenia-Spectrum Prototype

63.1 Summary

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

63.2 Prototype Features

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

63.3 Threshold Guidance

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

63.4 Expected Domain Profile

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

63.5 Time-Course and Trajectory

- Chronic persistence with episodic exacerbations.

63.6 Differential and Red Flags

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

63.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (sleep disruption, substances, medical factors).
- Risk modifiers (self-care impairment, safety concerns).

63.8 Measurement Prompts

- Symptom and function tracking over time.
- Collateral reports of baseline and decline.

63.9 Cross-Links

- Atlas: Reality Distortion and Psychosis-Spectrum Experiences.
- Domains: Psychosis and Reality Testing; Cognitive Control and Executive Function; Social Communication and Relatedness.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors; Risk Modifiers.

63.10 Documentation Snippet (1-2 lines)

- "Persistent hallucinations and disorganization with functional decline; Psychosis 3; chronic course."

64 Mood-Psychosis Pattern Prototype

64.1 Summary

- A pattern where psychosis-spectrum symptoms occur in the context of prominent mood or drive shifts.

64.2 Prototype Features

- Psychotic experiences temporally linked to mood elevation or depression.
- Mood and energy changes are prominent and episodic.
- Psychosis intensity tracks with mood shifts.

64.3 Threshold Guidance

- Use when psychosis is clearly tied to mood episodes and functional change.

64.4 Expected Domain Profile

- Mood and Drive Dysregulation: moderate to high.
- Psychosis and Reality Testing: mild to moderate, episodic.

64.5 Time-Course and Trajectory

- Episodic with mood-driven fluctuations.

64.6 Differential and Red Flags

- Primary psychosis with secondary mood symptoms.
- Substance-induced mood elevation or psychosis.
- Trauma-related intrusions misread as psychosis.

64.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, mood-linked).
- Contributors (sleep loss, substances, stress).
- Risk modifiers (impulsivity, safety risk during episodes).

64.8 Measurement Prompts

- Mood and energy tracking.
- Psychosis symptom tracking by episode.

64.9 Cross-Links

- Atlas: Affect and Mood Experiences; Reality Distortion and Psychosis-Spectrum Experiences.
- Domains: Mood and Drive Dysregulation; Psychosis and Reality Testing.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

64.10 Documentation Snippet (1-2 lines)

- "Psychosis emerges during mood episodes; Mood/Drive 4, Psychosis 2; episodic course."

65 Predominant Neurodevelopmental Prototypes

65.1 Summary

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

65.2 Included Prototypes

- ADHD Pattern Prototype.
- Autism Pattern Prototype.
- Learning Disorder Patterns.

65.3 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.

65.4 Boundary Markers

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

65.5 Common Overlap

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

65.6 Cross-Links

- Atlas: Attention, Executive Function, and Neurodevelopmental Experiences.
- Domains: Cognitive Control and Executive Function; Social Communication and Relatedness.

- Specifiers: Course and Time Pattern; Severity and Impairment.

65.7 Documentation Snippet (1-2 lines)

- "Neurodevelopmental profile with attention and social reciprocity differences; consider ADHD vs autism pattern after domain rating."

66 ADHD Pattern Prototype

66.1 Summary

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

66.2 Prototype Features

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

66.3 Threshold Guidance

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

66.4 Expected Domain Profile

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

66.5 Time-Course and Trajectory

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

66.6 Differential and Red Flags

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

66.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (early-onset, persistent).
- Contributors (sleep loss, stress, environment mismatch).
- Risk modifiers (impulsivity, accidents).

66.8 Measurement Prompts

- Attention rating scales.
- Collateral reports across settings.

66.9 Cross-Links

- Atlas: Attention, Executive Function, and Neurodevelopmental Experiences.
- Domains: Cognitive Control and Executive Function.
- Specifiers: Course and Time Pattern; Severity and Impairment.

66.10 Documentation Snippet (1-2 lines)

- "Longstanding inattention with organization problems across settings; Cognitive Control 3; persistent course."

67 Autism Pattern Prototype

67.1 Summary

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

67.2 Prototype Features

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

67.3 Threshold Guidance

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

67.4 Expected Domain Profile

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

67.5 Time-Course and Trajectory

- Early-onset and stable over time.

67.6 Differential and Red Flags

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

67.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (early-onset, stable).
- Contributors (environment mismatch, sensory overload).
- Risk modifiers (burnout, isolation).

67.8 Measurement Prompts

- Social communication screening questions.
- Sensory profile or collateral reports.

67.9 Cross-Links

- Atlas: Attention, Executive Function, and Neurodevelopmental Experiences.
- Domains: Social Communication and Relatedness; Cognitive Control and Executive Function.
- Specifiers: Course and Time Pattern; Severity and Impairment; Context and Culture.

67.10 Documentation Snippet (1-2 lines)

- "Longstanding social communication differences with sensory sensitivity; Social Relatedness 3; stable course."

68 Learning Disorder Patterns

68.1 Summary

- A set of patterns marked by persistent, specific academic skill difficulties despite adequate instruction and effort.

68.2 Prototype Features

- Difficulties in reading, writing, or math that are persistent.
- Performance below expected level for age or instruction.
- Functional impact in academic or training settings.

68.3 Threshold Guidance

- Use when learning difficulties are sustained and impairing across time.

68.4 Expected Domain Profile

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

68.5 Time-Course and Trajectory

- Early onset with stable or slowly improving course.

68.6 Differential and Red Flags

- Inadequate instruction or language barriers.
- Sensory impairments.
- Attention or mood-related performance issues.

68.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (early-onset, stable).
- Contributors (instruction mismatch, stress).
- Risk modifiers (academic failure, dropout risk).

68.8 Measurement Prompts

- Academic achievement testing or school reports.
- Progress tracking over time.

68.9 Cross-Links

- Atlas: Attention, Executive Function, and Neurodevelopmental Experiences.
- Domains: Cognitive Control and Executive Function.
- Specifiers: Course and Time Pattern; Severity and Impairment; Context and Culture.

68.10 Documentation Snippet (1-2 lines)

- "Persistent reading and writing difficulties despite supports; Cognitive Control 2; stable course."

69 Predominant Somatic and Interoceptive Prototypes

69.1 Summary

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

69.2 Included Prototypes

- Somatic Symptom Burden Prototype.
- Functional Neurologic Symptom Prototype.

69.3 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.

69.4 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.

69.5 Common Overlap

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

69.6 Cross-Links

- Atlas: Somatic Distress and Interoception.
- Domains: Somatic Distress and Interoception; Anxiety and Threat Sensitivity.

- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

69.7 Documentation Snippet (1-2 lines)

- "Somatic-dominant profile with high symptom focus; consider somatic burden vs functional neurologic pattern after domain rating."

70 Functional Neurologic Symptom Prototype

70.1 Summary

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

70.2 Prototype Features

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

70.3 Threshold Guidance

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

70.4 Expected Domain Profile

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

70.5 Time-Course and Trajectory

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

70.6 Differential and Red Flags

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

70.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, fluctuating).
- Contributors (stress, trauma history, medical events).
- Risk modifiers (falls, injury risk).

70.8 Measurement Prompts

- Symptom frequency and functional impact tracking.
- Activity or mobility limitations log.

70.9 Cross-Links

- Atlas: Somatic Distress and Interoception.
- Domains: Somatic Distress and Interoception; Cognitive Control and Executive Function.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

70.10 Documentation Snippet (1-2 lines)

- "Functional neurologic symptoms with fluctuating weakness; Somatic 3; episodic course."

71 Somatic Symptom Burden Prototype

71.1 Summary

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

71.2 Prototype Features

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

71.3 Threshold Guidance

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

71.4 Expected Domain Profile

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

71.5 Time-Course and Trajectory

- Chronic with episodic flares.

71.6 Differential and Red Flags

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

71.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (medical comorbidity, sleep disruption).
- Risk modifiers (functional decline, care avoidance).

71.8 Measurement Prompts

- Brief somatic symptom measure.
- Pain or fatigue tracking.

71.9 Cross-Links

- Atlas: Somatic Distress and Interoception.
- Domains: Somatic Distress and Interoception; Anxiety and Threat Sensitivity.
- Specifiers: Course and Time Pattern; Severity and Impairment; Etiologic Contributors.

71.10 Documentation Snippet (1-2 lines)

- "High somatic symptom burden with chronic pain and fatigue; Somatic 3; chronic course with flares."

72 Predominant Eating and Feeding Prototypes

72.1 Summary

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

72.2 Included Prototypes

- Anorexia Pattern Prototype.
- Bulimia Pattern Prototype.
- Binge-Eating Pattern Prototype.
- ARFID Pattern Prototype.

72.3 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.

72.4 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.

72.5 Common Overlap

- Mood and drive dysregulation.
- Compulsivity and perseveration.

72.6 Cross-Links

- Atlas: Eating, Appetite, and Body Image.

- Domains: Eating and Feeding Regulation; Mood and Drive Dysregulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

72.7 Documentation Snippet (1-2 lines)

- "Eating-dominant profile with restriction and body image concern; consider anorexia vs ARFID pattern after domain rating."

73 Anorexia Pattern Prototype

73.1 Summary

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

73.2 Prototype Features

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

73.3 Threshold Guidance

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

73.4 Expected Domain Profile

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

73.5 Time-Course and Trajectory

- Chronic with episodic worsening.

73.6 Differential and Red Flags

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

73.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, fluctuating).
- Contributors (stress, medical factors).
- Risk modifiers (malnutrition, self-neglect).

73.8 Measurement Prompts

- Weight and nutritional status tracking.
- Brief eating behavior screen.

73.9 Cross-Links

- Atlas: Eating, Appetite, and Body Image.
- Domains: Eating and Feeding Regulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

73.10 Documentation Snippet (1-2 lines)

- "Restrictive intake with weight/shape concern and low weight; Eating/Feeding 4; chronic course."

74 Bulimia Pattern Prototype

74.1 Summary

- A pattern of recurrent binge episodes with compensatory behaviors and body image concern.

74.2 Prototype Features

- Binge episodes with loss of control.
- Compensatory behaviors (vomiting, laxatives, excessive exercise).
- Body image or weight/shape preoccupation.

74.3 Threshold Guidance

- Use when binge/compensatory cycles are recurrent and impairing.

74.4 Expected Domain Profile

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

74.5 Time-Course and Trajectory

- Episodic with stress-linked spikes.

74.6 Differential and Red Flags

- Medical causes of vomiting or GI symptoms.
- Substance effects.
- Binge eating without compensation.

74.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, fluctuating).
- Contributors (stress, body image pressure).
- Risk modifiers (electrolyte risk, self-harm risk).

74.8 Measurement Prompts

- Binge frequency log.
- Compensatory behavior tracking.

74.9 Cross-Links

- Atlas: Eating, Appetite, and Body Image.
- Domains: Eating and Feeding Regulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

74.10 Documentation Snippet (1-2 lines)

- "Recurrent binge episodes with compensatory behaviors and body image concern; Eating/Feeding 3; episodic course."

75 Binge-Eating Pattern Prototype

75.1 Summary

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

75.2 Prototype Features

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

75.3 Threshold Guidance

- Use when binge episodes are recurrent and impairing.

75.4 Expected Domain Profile

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

75.5 Time-Course and Trajectory

- Episodic with stress-linked spikes.

75.6 Differential and Red Flags

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

75.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, fluctuating).
- Contributors (stress, sleep disruption).
- Risk modifiers (metabolic risk, distress).

75.8 Measurement Prompts

- Binge frequency log.
- Eating pattern tracking.

75.9 Cross-Links

- Atlas: Eating, Appetite, and Body Image.
- Domains: Eating and Feeding Regulation; Mood and Drive Dysregulation.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

75.10 Documentation Snippet (1-2 lines)

- "Recurrent binge episodes with loss of control and distress; Eating/Feeding 3; episodic course."

76 ARFID Pattern Prototype

76.1 Summary

- A pattern of restrictive or avoidant eating driven by sensory sensitivity, fear of adverse consequences, or low interest in eating, without body image concern.

76.2 Prototype Features

- Limited intake or narrow food range.
- Sensory-based avoidance or fear of choking/vomiting.
- Nutritional compromise or growth concerns.

76.3 Threshold Guidance

- Use when avoidant eating is persistent and impairing, not explained by body image concern.

76.4 Expected Domain Profile

- Eating and Feeding Regulation: moderate.
- Cognitive Control and Executive Function: variable.

76.5 Time-Course and Trajectory

- Early onset with chronic course.

76.6 Differential and Red Flags

- Medical or GI conditions affecting intake.
- Food insecurity or limited access.
- Body image-driven restriction.

76.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (early-onset, chronic).
- Contributors (sensory sensitivity, anxiety).
- Risk modifiers (nutritional risk, growth impact).

76.8 Measurement Prompts

- Dietary range and intake tracking.
- Nutritional status monitoring.

76.9 Cross-Links

- Atlas: Eating, Appetite, and Body Image.
- Domains: Eating and Feeding Regulation; Cognitive Control and Executive Function.
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

76.10 Documentation Snippet (1-2 lines)

- "Avoidant eating with sensory sensitivity and low intake; Eating/Feeding 3; chronic course."

77 Substance-Related Prototypes

77.1 Summary

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

77.2 Included Prototypes

- Alcohol Pattern Prototype.
- Opioid Pattern Prototype.
- Stimulant Pattern Prototype.
- Cannabis Pattern Prototype.
- Sedative Pattern Prototype.
- Other Substance Patterns.

77.3 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.

77.4 Boundary Markers

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

77.5 Common Overlap

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

77.6 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

77.7 Documentation Snippet (1-2 lines)

- "Substance-dominant profile with loss of control and withdrawal; consider alcohol vs stimulant pattern after domain rating."

78 Alcohol Pattern Prototype

78.1 Summary

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

78.2 Prototype Features

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

78.3 Threshold Guidance

- Use when alcohol use is recurrent and impairing.

78.4 Expected Domain Profile

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

78.5 Time-Course and Trajectory

- Episodic with relapse cycles or chronic use.

78.6 Differential and Red Flags

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

78.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, chronic).
- Contributors (stress, access, social context).
- Risk modifiers (withdrawal risk, accidents).

78.8 Measurement Prompts

- Brief alcohol use screen.
- Timeline of use and consequences.

78.9 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

78.10 Documentation Snippet (1-2 lines)

- "Recurrent alcohol use with tolerance and withdrawal; Reward/Habit 3; chronic course."

79 Opioid Pattern Prototype

79.1 Summary

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

79.2 Prototype Features

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

79.3 Threshold Guidance

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

79.4 Expected Domain Profile

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

79.5 Time-Course and Trajectory

- Chronic with relapse cycles.

79.6 Differential and Red Flags

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

79.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, episodic).
- Contributors (pain, access, trauma history).
- Risk modifiers (overdose risk, withdrawal risk).

79.8 Measurement Prompts

- Opioid use history and timeline.
- Withdrawal symptom monitoring.

79.9 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

79.10 Documentation Snippet (1-2 lines)

- "Opioid use with loss of control and withdrawal; Reward/Habit 3; chronic course."

80 Stimulant Pattern Prototype

80.1 Summary

- A pattern of stimulant use with impaired control, craving, and functional harm.

80.2 Prototype Features

- Escalating use or binge cycles.
- Sleep disruption and agitation during use.
- Crash or withdrawal symptoms.

80.3 Threshold Guidance

- Use when stimulant use is recurrent and impairing.

80.4 Expected Domain Profile

- Reward, Habit, and Substance-Related Compulsion: moderate to high.
- Arousal, Sleep, and Circadian Regulation: often disrupted.

80.5 Time-Course and Trajectory

- Episodic binges or chronic use.

80.6 Differential and Red Flags

- Primary mood elevation or anxiety without substance linkage.
- Co-occurring stimulant prescriptions.

80.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, binge-linked).
- Contributors (sleep loss, access, stress).
- Risk modifiers (psychosis risk, medical complications).

80.8 Measurement Prompts

- Stimulant use timeline.
- Sleep and crash tracking.

80.9 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

80.10 Documentation Snippet (1-2 lines)

- "Stimulant binges with sleep disruption and crashes; Reward/Habit 3; episodic course."

81 Cannabis Pattern Prototype

81.1 Summary

- A pattern of recurrent cannabis use with impaired control and functional impact.

81.2 Prototype Features

- Regular use with difficulty reducing.
- Impact on motivation, cognition, or mood.
- Use despite negative consequences.

81.3 Threshold Guidance

- Use when cannabis use is persistent and impairing.

81.4 Expected Domain Profile

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

81.5 Time-Course and Trajectory

- Chronic or episodic with periods of escalation.

81.6 Differential and Red Flags

- Primary mood or anxiety symptoms without substance linkage.
- Cannabis-induced psychosis risk in vulnerable patients.

81.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, episodic).
- Contributors (stress, access, social context).
- Risk modifiers (psychosis risk, functional decline).

81.8 Measurement Prompts

- Cannabis use frequency tracking.
- Timeline of consequences.

81.9 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

81.10 Documentation Snippet (1-2 lines)

- "Persistent cannabis use with reduced motivation; Reward/Habit 2; chronic course."

82 Sedative Pattern Prototype

82.1 Summary

- A pattern of sedative or anxiolytic use with impaired control, tolerance, or withdrawal and functional impact.

82.2 Prototype Features

- Escalating dose or prolonged use.
- Tolerance or withdrawal symptoms.
- Use despite cognitive or safety consequences.

82.3 Threshold Guidance

- Use when sedative use is persistent and impairing or risky.

82.4 Expected Domain Profile

- Reward, Habit, and Substance-Related Compulsion: moderate to high.
- Arousal, Sleep, and Circadian Regulation: disrupted.

82.5 Time-Course and Trajectory

- Chronic use with withdrawal risks on cessation.

82.6 Differential and Red Flags

- Medical causes of sedation or cognitive slowing.
- Co-occurring alcohol or opioid use.

82.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (chronic, persistent).
- Contributors (sleep problems, anxiety, access).
- Risk modifiers (withdrawal risk, falls).

82.8 Measurement Prompts

- Sedative use timeline.
- Withdrawal symptom monitoring.

82.9 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion; Arousal, Sleep, and Circadian Regulation.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

82.10 Documentation Snippet (1-2 lines)

- "Sedative use with tolerance and withdrawal risk; Reward/Habit 3; chronic course."

83 Other Substance Patterns

83.1 Summary

- Additional substance-specific patterns using the same prototype structure (e.g., hallucinogens, inhalants, dissociatives).

83.2 Prototype Features

- Substance-specific use patterns and harms.
- Loss of control or compulsive use.
- Examples include hallucinogen, inhalant, or dissociative-related patterns.

83.3 Threshold Guidance

- Use when a specific substance pattern is clinically useful for communication.

83.4 Expected Domain Profile

- Reward, Habit, and Substance-Related Compulsion: variable.

83.5 Time-Course and Trajectory

- Episodic or chronic depending on substance and context.

83.6 Differential and Red Flags

- Substance-induced psychiatric states.
- Medical complications tied to specific substances.

83.7 Specifiers (treatment-relevant, non-prescriptive)

- Course/time pattern (episodic, chronic).
- Contributors (access, stress, context).
- Risk modifiers (overdose risk, medical harm).

83.8 Measurement Prompts

- Substance-specific use timeline.
- Consequences and risk tracking.

83.9 Cross-Links

- Atlas: Substance Use and Compulsive Reward Seeking.
- Domains: Reward, Habit, and Substance-Related Compulsion.
- Specifiers: Course and Time Pattern; Etiologic Contributors; Risk Modifiers.

83.10 Documentation Snippet (1-2 lines)

- "Substance-specific pattern with loss of control; Reward/Habit 2; episodic course."

84 Personality Pattern Prototypes

84.1 Summary

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

84.2 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.

84.3 Boundary Markers

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

84.4 Suggested Trait Qualifiers

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

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

84.5 Cross-Links

- Atlas: Emotion Regulation, Self-Concept, and Interpersonal Pain.
- Domains: Personality Functioning (Dimensional).
- Specifiers: Course and Time Pattern; Severity and Impairment; Risk Modifiers.

84.6 Documentation Snippet (1-2 lines)

- “Personality functioning impairment with high negative affectivity and disinhibition; severity 3.”

85 Severity and Impairment

This chapter introduces cross-cutting specifiers that change monitoring and risk. Most useful when documenting severity or course.

Purpose. Separate symptom severity from functional impairment. Capture distress and disability without conflating them.

85.1 Core Distinctions

- Severity: intensity of symptoms within a domain.
- Impairment: impact on function (work/school, relationships, self-care).
- Distress: subjective suffering that may not match impairment.

85.2 Severity Anchors (per domain)

- 0: Absent / within typical range.
- 1: Mild; noticeable but limited impact.
- 2: Moderate; clear impact and persistent symptoms.
- 3: Severe; significant disruption and high burden.
- 4: Extreme; disabling or unsafe.

85.3 Functional Impairment Tiers

- None: functioning intact.
- Mild: some disruption, compensatory coping effective.
- Moderate: substantial disruption in one or more domains.
- Severe: unable to maintain key roles or self-care.

Documentation Output. Domain severity ratings (0-4). Functional impairment tier and primary areas affected. Distress level if it diverges from impairment.

86 Course and Time Pattern

Purpose. Capture time-course patterns that change risk, interpretation, and monitoring. Make trajectory explicit rather than implied.

86.1 Core Elements

- Onset: sudden / gradual.
- Duration: brief / persistent / recurrent.
- Pattern: acute, episodic, chronic, fluctuating.
- Remission: partial / full / none.
- Triggers: identifiable / none.

86.2 Common Course Specifiers

- Acute onset
- Episodic / recurrent
- Chronic / persistent
- Seasonal pattern
- Perinatal or postpartum onset
- Late onset
- Rapid cycling / high variability
- Trigger-linked vs autonomous

Documentation Output. Course specifier phrase. Onset and duration in plain language. Trajectory (improving / stable / worsening / fluctuating).

87 Etiologic Contributors

Purpose. Record likely contributors without asserting definitive cause. Make hypotheses explicit and evidence-graded.

87.1 Contributor Categories (non-exhaustive)

- Substance or medication effects.
- Medical or neurologic contributors.
- Sleep or circadian disruption.
- Trauma exposure or ongoing threat.
- Social adversity or deprivation.
- Neurodevelopmental vulnerability.
- Grief and loss processes.
- Iatrogenic or system-related effects.

87.2 Confidence Levels

- Suspected: plausible but unconfirmed.
- Probable: supported by history or timing.
- Confirmed: strong temporal or clinical link.

Documentation Output. Contributors listed with confidence level. Note whether contributors are ongoing or historical. Link to rule-outs pursued or deferred.

88 Context and Culture

Purpose. Ensure context and culture are integrated, not appended. Avoid pathologizing normative responses to adversity or culture.

88.1 Core Context Elements

- Housing, food security, employment, legal stressors.
- Family structure, caregiving demands, social supports.
- Access to care and barriers to follow-up.

88.2 Cultural and Meaning-Making Elements

- Idioms of distress and explanatory models.
- Migration, displacement, or refugee experiences.
- Spiritual or religious framing.
- Discrimination, minority stress, and identity safety.
- Language and interpreter needs.

Documentation Output. Brief context snapshot tied to symptoms or trajectory. Cultural framing that informs interpretation or engagement.

89 Early Childhood

This chapter begins life-stage adaptations so age and setting shape interpretation. Most useful when developmental context changes the picture.

Focus. Emphasize developmental expectations and caregiver context; Avoid pathologizing age-typical variability.

Key Adaptations. Use caregiver language and observations as primary data; Prioritize sleep, regulation, attachment, and sensory patterns; Consider developmental trauma and safety of the caregiving environment.

Assessment Emphasis. Developmental milestones and regressions; Caregiver capacity and stress; Context of daycare or preschool settings.

Documentation Output. Developmental framing with caution on labeling. Safety and caregiving context noted.

90 School Age

Focus. Anchor assessments to school, home, and peer contexts.

Key Adaptations. Integrate teacher reports and school performance when possible; Distinguish attention, learning, and anxiety-driven impairments; Consider bullying, family stress, and learning environment.

Assessment Emphasis. Functional impact at school and home; Behavior across settings (generalized vs situational); Sleep and routine stability.

Documentation Output. Multi-setting functional snapshot. Clarified context of academic and social stressors.

91 Adolescence

Focus. Emphasize identity development, autonomy, and peer context; Avoid over-pathologizing normative risk-taking.

Key Adaptations. Confidentiality and consent considerations; Distinguish mood variability from persistent impairment; Screen for substance use, trauma exposure, and self-harm risk.

Assessment Emphasis. School, peers, and family dynamics; Sleep and circadian disruption common in this stage; Online/social media stressors.

Documentation Output. Developmentally anchored formulation and risk notes. Contextual factors tied to symptoms and trajectory.

92 Perinatal and Postpartum

Focus. Integrate medical, hormonal, and psychosocial shifts; Prioritize safety for parent and infant.

Key Adaptations. Screen for mood, anxiety, and psychosis symptoms; Consider sleep deprivation and caregiving load; Coordinate with obstetric or primary care providers.

Assessment Emphasis. Onset relative to pregnancy and delivery; Support systems and caregiving resources; Risk of harm to self or infant.

Documentation Output. Perinatal timing noted clearly. Safety and support plan summarized.

93 Adulthood

Focus. Emphasize role functioning and cumulative stressors; Balance symptom reporting with functional impact.

Key Adaptations. Attend to work, caregiving, and relationship roles; Track substance use and sleep disruption as common contributors; Consider trauma history and ongoing adversity.

Assessment Emphasis. Role strain and resource constraints; Physical health comorbidities; Social supports and isolation.

Documentation Output. Role-based functional snapshot. Contextual drivers linked to trajectory.

94 Late Life and Neurocognitive Overlap

Focus. Prioritize cognitive change, medical comorbidity, and functional decline; Avoid mistaking neurocognitive disorders for primary psychiatric syndromes.

Key Adaptations. Screen for delirium and medication effects; Involve caregivers and collateral history when possible; Emphasize safety, capacity, and support needs.

Assessment Emphasis. Baseline function and rate of change; Sensory impairments that alter presentation; Social isolation and bereavement.

Documentation Output. Cognitive baseline and change described explicitly. Safety and support needs noted.

95 Primary Care Integration

Focus. Provide a minimal, usable mental health framework for primary care settings.

Key Adaptations. Use brief measures and simplified domain ratings; Emphasize functional impact and safety screening; Coordinate care pathways and referral thresholds.

Assessment Emphasis. Somatic symptom overlap and medical comorbidity; Time-limited visits and documentation constraints.

Documentation Output. Compact recording format and 1-minute note template. Clear referral or follow-up plan.

96 Inpatient and Forensic Considerations

Focus. Emphasize safety, capacity, and clear documentation in high-stakes settings.

Key Adaptations. Risk modifiers and rule-outs are prioritized; Document uncertainty and competing explanations explicitly; Coordinate with legal and institutional requirements.

Assessment Emphasis. Capacity and consent; Violence risk and vulnerability to exploitation; Collateral information and records review.

Documentation Output. Risk tier and rationale clearly stated. Decision points and justifications documented.

97 Neurodiversity-Affirming Adaptations

Focus. Reduce deficit-only framing and emphasize functioning in context; Separate distress from difference.

Key Adaptations. Use language that centers support needs and strengths; Consider sensory profiles, communication styles, and routines; Avoid pathologizing adaptive coping strategies.

Assessment Emphasis. Functional mismatch with environments, not just symptoms; Co-occurring anxiety, trauma, or sleep issues; Input from patient and caregivers on accommodations.

Documentation Output. Strengths and supports documented alongside challenges. Environment adjustments noted as part of formulation.

98 Delirium and Acute Confusional States

This chapter starts the rule-out compendium for acute, high-stakes presentations. Most useful when something feels off or time-critical.

Purpose. Prevent catastrophic misses by prioritizing acute confusional states. Flag presentations where psychiatric framing is unsafe.

98.1 Hallmark Signs

- Acute onset with fluctuating attention or awareness.
- Disorganized thinking, altered level of consciousness.
- Visual or tactile misperceptions with waxing/waning course.

98.2 High-Risk Contexts

- Older adults, hospitalized patients, recent surgery, infection, withdrawal.
- New medications or polypharmacy.

98.3 Minimum Workup (by setting)

- ED/inpatient: vitals, glucose, electrolytes, infection screen, medication review. [E0/U2]
- Outpatient: urgent referral if acute confusion or fluctuating attention. [E0/U3]

Red flags

- Any acute confusion with safety concerns or inability to care for self. [E0/U3]
- Rapidly worsening cognition or new neurologic signs. [E0/U3]

Documentation Output. "Delirium ruled out vs rule-out required." Rationale for referral or immediate workup.

99 Substance Intoxication and Withdrawal

Purpose. Ensure substance-related states are identified before primary psychiatric labels. Reduce misattribution in acute presentations.

99.1 Hallmark Signs

- Acute onset or rapid fluctuation tied to use patterns.
- Autonomic instability, tremor, agitation, sedation, or perceptual changes.
- Temporal link to recent initiation, cessation, or dose change.

99.2 High-Risk Contexts

- Polysubstance use, recent detox, medically frail patients.
- New prescriptions with psychoactive effects.

99.3 Minimum Workup (by setting)

- ED/inpatient: vitals, tox screen as appropriate, medication reconciliation. [E0/U2]
- Outpatient: structured substance/meds review and safety assessment. [E0/U2]

Red flags

- Severe withdrawal risk, delirium tremens, or unstable vitals. [E0/U3]
- Psychosis or agitation with unclear substance history. [E0/U3]

Documentation Output. "Substance/withdrawal ruled out vs rule-out required." Substances considered and temporal relationship noted.

100 Medication and Iatrogenic Psychiatric Syndromes

Purpose. Identify medication-induced symptoms before labeling primary disorders. Reduce harm from iatrogenic effects and misdiagnosis.

100.1 Hallmark Signs

- Temporal link to medication start, stop, or dose change.
- New-onset agitation, insomnia, mood elevation, or psychosis.
- Sedation, cognitive slowing, or emotional blunting after medication changes.

100.2 High-Risk Contexts

- Polypharmacy, drug interactions, medically complex patients.
- Steroids, stimulants, sedatives, anticholinergics, and certain antibiotics.

100.3 Minimum Workup (by setting)

- Medication reconciliation with timeline. [E0/U2]
- Review recent changes, adherence, and OTC/supplement use. [E0/U2]

Red flags

- Acute mania/psychosis after medication changes. [E0/U3]
- New neurologic signs or severe autonomic effects. [E0/U3]

Documentation Output. "Medication-induced contribution suspected/probable/confirmed." Medication timeline and rationale noted.

101 Endocrine and Metabolic Mimics

Purpose. Flag common endocrine and metabolic conditions that mimic psychiatric symptoms.

101.1 Hallmark Signs

- New mood, anxiety, or cognitive changes with systemic symptoms.
- Weight change, temperature intolerance, or unexplained fatigue.

101.2 High-Risk Contexts

- Thyroid disease history, diabetes, adrenal disorders.
- Older adults or medically complex patients.

101.3 Minimum Workup (by setting)

- Basic labs as appropriate (e.g., thyroid, glucose, electrolytes). [E0/U2]
- Coordinate with primary care when indicated. [E0/U2]

Red flags

- Rapid decline, severe metabolic derangements, or altered mental status. [E0/U3]

Documentation Output. "Endocrine/metabolic mimics considered." Specific tests ordered or deferred.

102 Seizure, Autoimmune, Infectious, and Neurodegenerative Mimics

Purpose. Flag neurologic or systemic conditions that can present as psychiatric syndromes.

102.1 Hallmark Signs

- New-onset psychosis, seizures, or rapidly progressive cognitive change.
- Fluctuating neurologic symptoms or focal deficits.
- Systemic signs (fever, weight loss, inflammatory markers).

102.2 High-Risk Contexts

- First-episode psychosis with neurologic signs.
- Immunocompromised patients.
- Older adults with cognitive decline.

102.3 Minimum Workup (by setting)

- Neurologic exam and vitals. [E0/U2]
- Coordinate urgent medical evaluation when indicated. [E0/U3]

Red flags

- Seizure activity, catatonia, or rapid cognitive deterioration. [E0/U3]
- Suspicion of autoimmune encephalitis or CNS infection. [E0/U3]

Documentation Output. "Neurologic/infectious mimics considered." Rationale for escalation or referral.

103 Sleep Disorders Masquerading as Psychiatric Illness

Purpose. Prevent mislabeling primary sleep disorders as psychiatric conditions.

103.1 Hallmark Signs

- Daytime fatigue, cognitive fog, irritability tied to poor sleep.
- Sleep disruption precedes mood or anxiety symptoms.
- Snoring, apnea, or abnormal movements reported by others.

103.2 High-Risk Contexts

- Shift work, irregular schedules, high caffeine use.
- Older adults, obesity, or cardiopulmonary disease.

103.3 Minimum Workup (by setting)

- Sleep history and basic sleep log. [E0/U2]
- Consider sleep medicine referral when indicated. [E0/U2]

Red flags

- Severe insomnia with safety risk or suspected sleep apnea. [E0/U3]
- Parasomnias with injury risk. [E0/U3]

Documentation Output. "Sleep disorder considered as primary or contributing." Sleep history summary and next steps.

104 Pain and Fatigue Syndromes with Bidirectional Causality

Purpose. Recognize pain and fatigue syndromes that both mimic and drive psychiatric symptoms. Avoid reducing complex presentations to primary psychiatric labels.

104.1 Hallmark Signs

- Chronic pain or fatigue predates mood/anxiety changes.
- Flare patterns tied to stress, sleep, or activity.
- Somatic distress dominates clinical presentation.

104.2 High-Risk Contexts

- Long-term pain conditions, post-infectious fatigue, fibromyalgia.
- High functional impairment with mixed symptom clusters.

104.3 Minimum Workup (by setting)

- Basic medical evaluation and review of prior workups. [E0/U2]
- Clarify bidirectional impacts on mood, sleep, and cognition.

Red flags

- Sudden worsening, neurologic red flags, or severe functional decline. [E0/U3]

Documentation Output. "Pain/fatigue contribution suspected/probable." Summary of bidirectional effects and monitoring plan.

105 Care Pathways Map

This chapter is optional reference for level-of-care navigation and monitoring. Most useful when planning escalation or referral.

Optional reference material; not required for routine use.

Purpose. Offer a lightweight pathway map without prescribing care. Clarify when to step up, step down, or refer.

105.1 Pathway Layers

- Self-management and brief supports.
- Outpatient psychotherapy or medication management.
- Intensive outpatient or partial hospitalization.
- Inpatient or emergency care.

105.2 Step-Up Triggers

- Escalating risk or safety concerns.
- Worsening trajectory despite adequate trial.
- Severe functional impairment or inability to maintain roles.

105.3 Step-Down Triggers

- Sustained improvement and stable supports.
- Symptom stability with low risk.

105.4 Referral Thresholds

- Medical or neurologic rule-outs required.
- Complex comorbidity or diagnostic uncertainty.
- Specialized services (sleep, neuropsych, addiction).

Documentation Output. Pathway level selected and rationale. Referral or escalation triggers noted.

106 Matching Interventions to Domain Patterns

Optional reference material; not required for routine use.

Purpose. Provide high-level matching logic without becoming a treatment manual. Emphasize leverage points rather than specific modalities.

106.1 Matching Logic (non-prescriptive)

- Threat-dominant patterns → prioritize safety, exposure tolerance, and arousal regulation.
- Mood/drive dysregulation → prioritize activation, routine, and stabilization of sleep.
- Trauma-dominant patterns → emphasize safety, pacing, and grounding.
- Compulsivity/perseveration → emphasize response interruption and flexibility.
- Psychosis/reality testing → prioritize safety, stabilization, and support structures.
- Cognitive control/executive → emphasize structure, scaffolding, and environmental supports.
- Somatic/interoceptive → emphasize symptom tracking and uncertainty tolerance.

Guardrails

- If rule-out workup is incomplete.
- If risk tier is high and safety is not stabilized.

Documentation Output. Domain pattern named and leverage points noted."Non-prescriptive" label included when referencing intervention alignment.

107 Communication Tools

Optional reference material; not required for routine use.

Purpose. Provide neutral, patient-respectful language for explaining formulations. Support team communication without overclaiming certainty.

107.1 Patient-Facing Language Patterns

- "Here's what we think is happening and why."
- "These experiences often travel together."
- "This is our best current explanation; we'll keep testing it."

107.2 Team-Facing Language Patterns

- Presenting problem line + domain ratings.
- Specifiers that change risk or management.
- Uncertainty and competing explanations.

107.3 Family and Caregiver Communication

- Emphasize safety, support needs, and practical observations.
- Avoid stigmatizing labels when possible.

Documentation Output. One-line formulation summary for handoff. Shared decision-making statement included when relevant.

108 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.

108.1 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.

108.2 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.

108.3 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.

108.4 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.

108.5 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.

108.6 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.

108.7 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.

108.8 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.

108.9 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.

109 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.*

109.1 Common Failure Modes (quick scan)

109.1.1 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.

109.1.2 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.

109.1.3 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.

109.1.4 Grief response vs mood episode

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

109.1.5 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.

109.1.6 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.

109.1.7 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.

109.2 Documentation Guardrails

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

109.3 Cross-Links

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

110 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.*

110.1 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.

110.2 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.

110.3 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.

110.4 Documentation Snippet (1 line)

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

110.5 Cross-Links

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