Clinical Practice Guideline: **Behavioral Health Awareness**

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INTRODUCTION

It is estimated that each year in the United States, that approximately more than one in five adults has a mental health condition (NIMH, 2021). Although the majority of these individuals are able to attend to their daily functions with minimal impairment, it is important for health care practitioners of all backgrounds and specialties to be able to recognize when a patient might be experiencing unmanaged behavioral health symptoms and provide direct assistance or referral as appropriate to their training and scope.

This Clinical Practice Guideline (CPG) uses the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) to provide descriptions of behavioral health disorders. These descriptions have been assembled as a guideline to assist the health care practitioner with recognition of the symptoms associated with specific behavioral health disorders. Hence, this CPG is designed to assist the health care practitioner in identifying when behavioral health issues might be present in order to provide patients with information and referrals for behavioral health support.

Patients reporting or displaying possible symptoms of behavioral health disorders should be referred to their health plan and/or primary care physician. This CPG is not designed to assist with the diagnosis of mental health conditions and is informational only.

This guide includes the following behavioral health disorders:

- Attention-Deficit/Hyperactivity Disorder
- Schizophrenia
- Bipolar Disorder
- Major Depressive Disorder
- Panic Disorder
- Generalized Anxiety Disorder
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Eating Disorders
- Substance Use Disorders

Generalized Anxiety Disorder (Table 1)

The primary symptom of generalized anxiety disorder, commonly referred to as "anxiety", is pervasive, uncontrollable worry (APA, 2013). Patients with generalized anxiety disorder exhibit global worry about many different things in their life, rather than a specific phobia or particular preoccupation with a specific issue such as illness. Patients with generalized anxiety disorder may have many questions about their treatment and prognosis, including "what if" questions regarding circumstances that have yet to occur. Patients with generalized anxiety disorder may also seem "stressed out", inattentive, or annoyed at times during visits (APA, 2013). Patient's excessive questioning can be perceived as a lack of trust in their practitioners, or "second-guessing" the treatment provider. Practitioners should try to be patient and not take the patient's demeanor or questions to be a problem specifically directed at them, as the practitioner, or their treatment plan. Practitioners should explain procedures, test results, and the recovery process to alleviate concerns as much as possible. If excessive worry is interfering with the treatment plan, it may be necessary to refer the patient to a behavioral health specialist for additional support.

Referral Example: "I know you have been really worried about your recovery, but it seems to me that there might be something more going on. Would you be willing to talk to your primary care doctor therapist, or other health care provider about your high levels of stress and worry?"

Attention-Deficit/Hyperactivity Disorder (ADHD) (Table 2)

There are 2 primary clusters of symptoms for ADHD: difficulty paying attention, and difficulty controlling their impulses and activity level. Patients with ADHD may struggle to pay attention to instructions, sticking with tasks, and keeping track of objects and information. They may talk a lot, interrupt, and struggle to observe social conventions including sitting still and waiting (APA, 2013). Often, patients with hyperactive/impulsive ADHD do not realize that their behavior is disruptive to others. Pointing out the behavior and requesting that the patient refrain is a good option, but it is important for the practitioners to be aware that the patient may repeat the behavior inadvertently again and again, requiring multiple attempts at redirection. A useful technique to ensure that a patient with ADHD understands and is retaining recommendations is for the practitioner to have the patient repeat what the practitioner has told them. If possible, the practitioner should supply the patient with reference material appropriate to the clinical encounter in order to reinforce the clinical recommendations for the office visit.

Referral Example: "You've told me that you sometimes have trouble keeping track of our appointments, forget my instructions, and lose things often. Would it be okay with you if I reached out to your primary care physician to see if we can get you some additional support?"

Bipolar Disorder (Table 3)

Bipolar disorder is characterized by mood states that alternate between depression and mania. Patients who have been diagnosed with bipolar disorder usually spend more time in the depressive state (weeks or months) and only a few days to a week at a time in a manic state (APA, 2013). Because depression is addressed elsewhere in this document, this section on bipolar disorder will focus on manic symptoms. A patient may report feeling really good, be noticeably more talkative than usual, and have trouble staying on topic. Patients who are in a manic state sometimes engage in impulsive or risky behaviors with little regard for the potential consequences (APA, 2013). This may include disregarding treatment recommendations as overly conservative or arduous. When a patient is manic, they are often overly optimistic and your concerns, as a practitioner, will likely not seem problematic to them. Encouraging patients who are in a manic state to check in with their healthcare provider is best practice but also may be challenging. As such, it may be helpful for the practitioner to contact the patient's behavioral health care team on the patient's behalf. If a practitioner observes acute symptoms or has concerns about the patient's immediate safety, they should call 911.

Example: "You seem like you're not quite yourself right now. I'm going to give your behavioral healthcare team a call, just to make sure we're all on the same page regarding your treatment plan."

Major Depressive Disorder (Table 4)

Because depression is so common, the United States Preventive Services Task Force (USPSTF) recommends primary health care practitioners screen all adults for major depressive disorder. There are a number of screening tools available to assess symptoms of depression, including the Patient Health Questionnaire (PHQ) in various forms, the Hospital Anxiety and Depression Scales in adults, the Geriatric Depression Scale in older adults, and the Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women (USPSTF, 2016). Although it is likely that patients will be screened by their primary care team, it is important for all health care practitioners to be aware of symptoms of depression.

Major depressive disorder, commonly referred to as "depression", is characterized by either of two main symptoms: depressed mood, or loss of interest or pleasure in activities. Patients with depression may appear down, sad, or hopeless with low energy levels. The patient may have lost or gained weight, consistently appear fatigued, or have trouble focusing during appointments (APA, 2013). A formerly compliant and well-functioning patient may struggle to make appointments or follow aftercare instructions. A depressed patient may also report difficulty feeling motivated or that following their treatment plan feels overwhelming. The practitioner may notice negative self-talk and/or a pessimistic view of their future including treatment prognosis. Simplifying a treatment plan into smaller steps

and expressing optimism about treatment outcomes may help patients dealing with depression better adhere to treatment and aftercare recommendations.

Example: "You seem unusually down lately and have shared that you are having trouble staying motivated to follow our treatment plan. I'm worried about you and think that you should share how you are feeling with your primary care team. Will you agree to schedule an appointment before I see you next?"

It is vitally important to be aware of the potential for suicide with a depressed patient. A suicidal patient might present with one or more of the following verbal statements:

- "I am ready to end it all."
- "Everyone would be better off without me." or "I want out."
- "I just want to go to sleep and never wake up."
- "I am thinking of taking all of my sleeping pills."
- "What's the point of living (or existing)?"

Or the following more indirect indications:

- Expressing strong feelings of hopelessness or being trapped
- An unusual preoccupation with death or dying
- Acting recklessly, as if they have a death wish (e.g., speeding through red lights)
- Calling or visiting people to say goodbye
- Getting affairs in order (giving away prized possessions, tying up loose ends)
- A sudden switch from being extremely depressed to acting calm and happy

There are some questions that the health care practitioner may ask if concerned that there is a suicide risk:

1. Are you having thoughts of killing yourself?
2. Do you have a plan for how you would end your life?
3. Do you have what you need to carry out this plan? (They will typically ask about access to guns or pills.)
4. Have you thought of a specific time when you intend to take your own life?

If the patient answers affirmatively to any of the above questions, they should be evaluated by an appropriate mental health professional promptly. If a patient endorses thoughts of suicide with a plan and intent, or if the practitioner has concerns about a patient's ability to keep themselves safe, the practitioner should call 911.

Eating Disorders (Table 5)

There are typically three types of eating disorders that the practitioner may encounter: anorexia nervosa, bulimia nervosa, or binge eating disorders. Anorexia nervosa is characterized by a distorted body image, a pathological fear of gaining weight, and severe dieting that leads to excessive weight loss. Bulimia nervosa involves frequent episodes of

binge eating, followed by inappropriate compensatory behaviors, such as vomiting or excessive exercise, to avoid weight gain. Binge eating disorder is characterized by recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances and is marked with feelings of lack of control. A patient who engages in binge eating may have feelings of guilt, embarrassment, or disgust and may binge eat alone to hide the behavior (APA, 2013).

Patients with eating disorders may talk about feeling fat or ashamed of their bodies. It is important to note that only anorexia nervosa is associated with abnormally low body weight but all eating disorders have significant health risks. Patients with eating disorders may struggle to follow treatment plans with a dietary component or have a particular fear of treatment resulting in weight gain (e.g., having to eat with a specific medication, medications that may cause weight gain, or treatment plans requiring the patient to refrain from physical activity such as exercise.) Due to distorted body image, patients who have eating disorders often do not think their behavior is unreasonable and, therefore, can be difficult to convince to engage in treatment. A referral to a specialty mental healthcare provider for assessment and treatment is recommended. If the patient has acute symptoms or is medically at-risk, call 911.

Example: "I've noticed that you are really concerned about your weight, and you've shared with me some pretty severe habits. I think it's time for you to talk to someone about what you're going through, and I'd like to refer you to a behavioral healthcare provider."

Obsessive-Compulsive Disorder (OCD) (Table 6)

The primary symptoms of Obsessive-Compulsive Disorder (OCD) are intrusive and unwanted thoughts, urges, or images, resulting in distress that prompts the individual to neutralize these intrusive experiences with a compensatory behavior. A practitioner may observe rigid and repetitive behaviors such as hand washing, ordering, or "checking" in an individual with OCD. These behaviors are compulsions which are difficult for the patient to control (APA, 2013). In popular culture, OCD is often confused with Obsessive-Compulsive Personality Disorder (OCPD), which is a preoccupation with orderliness, perfectionism, and control. OCD is characterized by distress and anxiety, while OCPD is characterized by rigidity and lack of flexibility (APA, 2013). Patients with OCD may struggle to adjust their schedules to incorporate treatment-related routines, or excessively perform recovery-related tasks in a potentially self-harming manner. Practitioners should consult with the treating behavioral healthcare provider regarding the best way to support patients with OCD (or OCDP) in their practice.

Example: "I've noticed that you seem anxious and get stuck in certain patterns. That seems like an inconvenient way to live. I'm wondering if you'd be willing to get some support from a behavioral healthcare practitioner."

Panic Disorder (Table 7)

Panic disorder is the result of panic attacks, or abrupt surges in fear during which multiple physiological symptoms occur. A patient may begin trembling, sweating, or become short of breath. They may report heart palpitations, chest pain, feeling light-headed, or nauseated. When an individual has their first panic attack, they often think there is something medically wrong with them, rather than recognizing that they are experiencing psychological symptoms. Many individuals end up in the emergency room worried they have had a heart attack or stroke. Clinical judgment is needed to determine whether a patient's symptoms constitute a medical emergency or can be managed in-clinic.

Providing verbal reassurance to the patient exhibiting signs and symptoms of panic disorder that he/she is not in imminent danger and speaking in a soothing/calm/soft voice is often very effective. Encouraging the person to breath slowly and into their stomach or abdomen can ease the immediate symptoms of panic. Breathing into a paper bag can sometimes reduce the light-headedness and fingertip tingling sensation from hyperventilation. If a window is available, opening it enough for fresh air to circulate can also help. If the patient reports feeling light-headed or faint, then having them sit quietly or even lie down on the floor can help prevent them from falling and/or striking their head.

If the panic attack does not subside, it may be necessary to call for psychiatric assistance and/or 911. If the patient is able to regain focus, the assessment of the health issue for which they have come to see the practitioner can be continued; the practitioner should discuss the patient's current behavior and offer resources/referrals as appropriate.

Example: "It looks like you just had a panic attack. I'd like you to reach out to your primary care team so that they can follow-up with you. Can you do that before our next appointment?"

Post-Traumatic Stress Disorder (PTSD) (Table 8)

Post-Traumatic Stress Disorder (PTSD) is a mental health condition resulting from exposure to a traumatic event characterized by intrusive memories, nightmares, or flashbacks; avoidance of reminders of the trauma; negative impact on mood and beliefs; and increased physiological arousal and reactivity (APA, 2013). Many people who experience trauma never develop PTSD, however, due to the prevalence of adverse childhood events, it is advisable to follow trauma-informed healthcare provision (Aces Aware, 2021). Per SAMHSA (2014), a trauma-informed approach seeks to avoid re-traumatization of trauma survivors through providing physical and psychological safety, transparency, collaboration and shared decision-making, and empowerment. The health care practitioner should recognize the signs and symptoms possibly indicating PTSD and, to the extent possible, avoid activating potential triggers during the treatment encounter.

Patients with PTSD may exhibit fear around common treatment practices such as closing the treatment room door, being alone with the provider, or being touched during a routine examination. Talking patients through treatment procedures and asking permission before initiating physical contact may help patients feel safe and remain calm. In addition, offering to have an associate of the same gender as the patient in the room may be helpful to some people.

Although rare, a patient may experience a PTSD associated flashback during an office visit. The flashback may be triggered by the patient's own thoughts and feelings or words, objects, or situations that are reminders of the event. The health care practitioner should be aware that during flashbacks the patient is truly reliving a past traumatic experience as though it were occurring in the present. Furthermore, the patient may not be aware of the practitioner's presence or current surroundings. If a PTSD associated flashback occurs putting either the patient or others at risk of harm, the health care practitioner needs to call for immediate assistance and/or 911 emergency services. If the flashback is mild and brief enough, complete treatment visit and refer to appropriate behavioral health resources.

Example: "It looks like you were somewhere else for a bit there. Flashbacks are often a symptom related to an experience of trauma. I want to make sure you have appropriate support as you work through this. Do you feel comfortable reaching out to a behavioral healthcare provider or would you like me to send them a referral for you?"

Schizophrenia (Table 9)

Schizophrenia's hallmark symptoms include delusions and hallucinations (psychosis), as well as disorganized speech, disorganized behavior, and diminished emotional expression (APA, 2013). Practitioners may observe a patient talking to themselves and giving attention to seemingly unremarkable spaces within the clinic. In addition, they may appear withdrawn and lack emotional expression, struggle to follow conversation and directions, and behave in odd ways that are inappropriate to the situation/circumstances (APA, 2013). If a patient is experiencing a psychotic episode, the practitioner should call for immediate assistance and/or 911 emergency services.

Example: "You are behaving unusually today, and it looks like you might be seeing or hearing things that I can't. I'm going to contact behavioral health services so we can get you some support."

Substance Use Disorders (Table 10)

Substance use disorders cover a wide array of substances with vastly different effects, but all have similarities regarding problematic use, tolerance, and withdrawal symptoms (APA, 2013). According to the DSM-5 (2013), the most commonly misused substances are caffeine, nicotine, alcohol, and cannabis, but substance use trends vary requiring the practitioner to remain up to date on current trends in their area.

If the health care practitioner suspects active substance misuse, it is important to determine what substance is being used, the amount, and when/how it was used. Every healthcare treatment facility should have their own policy regarding protocols for handling intoxicated patients. In an outpatient setting, depending on the type of substance, the subsequent behavior, and current or potential withdrawal symptoms, there may be a need for immediate assistance and/or 911 emergency services.

For patients who are suspected of substance misuse but not actively intoxicated, the practitioner may gently inquire about and express concern over the amount of substance a patient is using. A practitioner should then offer referral to substance use or behavioral healthcare services as appropriate.

Example: “From what you’ve told me, it sounds like you are drinking quite a lot. I’m concerned about your health and would like to offer you a referral to treatment services. What do you think?”

The tables in this guideline are not exhaustive but represent some of the information helpful in recognizing behavioral health issues that the health care practitioner may encounter when working with patients.

Table 1: Generalized Anxiety Disorder

Industry Standard Diagnostic Criteria	Industry Standard Behavioral Criteria	Self-Reported Awareness Triggers
Generalized, persistent anxiety is characterized by excessive anxiety and worry that is difficult to control, manifested in symptoms from at least 3 of the 6 categories. The anxiety must be about a number of events or activities (such as work or school performance). Symptoms must have persisted for more days than not over at least a 6-month period and not be attributable to another medical condition (e.g., hyperthyroidism, caffeine excess/intoxication, medications, drug abuse, and/or coronary heart disease (CHD), or another psychiatric disturbance such as clinical depression or schizophrenia.	1. Restlessness or feeling keyed up or on edge	1. I worry all the time; I feel like something bad is about to happen; it seems I have a feeling of dread/fear/worry all the time; I just can't stop worrying; I keep thinking about what might happen over and over again all day/night long; I pace back and forth a lot.
	2. Being easily fatigued	2. I get tired so easily; the smallest things just sap my energy.
	3. Difficulty concentrating or mind going blank	3. I just can't concentrate; I drive for long distances and I am not aware how I even got to where I am; I feel distracted by _____ all the time; my spouse/boss/friend tells me that I seem "on edge" or anxious; I often feel impatient in grocery store lines/with my spouse/children/employer; I feel angry and agitated a lot of the day.
	4. Irritability	4. Everything bothers me so much; I get pissed off easily and find it hard to be around others for too long; everything takes forever.
	5. Muscle tension	5. I'm so tense all the time. My stomach feels like it's tied up in knots; I always have a headache, or something always hurts when there's no reason for it to hurt.
	6. Sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)	6. It takes me forever to fall asleep, my mind is always on; I wake up a lot at night, sometimes because of bad dreams or nightmares; I wake up earlier than I'd like but I just can't get to sleep; everything has to be just right for me to sleep, and even then, that doesn't always help.

Table 2. Attention Deficit Hyperactivity Disorder (ADHD)		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
There are two major diagnostic dimensions to ADHD with diagnostic sub-indicators indicating inattentive type, hyperactive/impulsive type, or a combined presentation. Overall, the symptoms of inattention and impulsivity result in impairment at home, in social, school and/or occupational functioning. At least 5 sub-indicators are necessary within each diagnostic category dimension applicability and several symptoms must be present in 2 or more settings and several inattentive or hyperactive-impulsive symptoms had to have been present before age 12	1. Inattention: a) Failure to follow through on tasks and instructions; b) Often does not seem to listen when spoken to directly; c) Easily distracted; d) Makes careless mistakes/lacks attention to detail; e) Difficulty sustaining attention; f) Exhibits poor organization; g) Avoids/dislikes tasks requiring sustained mental effort; h) Loses things necessary for tasks/activities; i) Is forgetful in daily activities.	1. My attention just wanders/I just can't seem to pay attention; I get bored really easily; no matter how hard I try, I just can't concentrate; so what if I don't finish what I start; I just don't like working on anything for very long; I like to have lots of different things going on all at the same time; my desk/house/workstation is always disorganized; my mind just wanders when I try to listen; I just can't seem to make good use of my time; my work just gets away from me; at the end of the day, I just don't seem to get much done.
	2. Hyperactivity/impulsivity (at least 5 of the following): a) Experiences restlessness; b) Excessively taps hands or feet, squirms in seat; c) Leaves seat when remaining seated is expected; d) Has difficulty engaging in quiet, leisurely activities; e) Is always "on the go" or acts as if "driven by a motor" that cannot turn off; f) Talks excessively; g) blurts out answers; h) Has difficulty waiting their turn; i) interrupts or intrudes on others.	1. I just did it; who cares what happens to me; I feel jumpy all the time; I fidget a lot; I am always drumming my fingers; tapping my feet feels good; I sleep very restlessly and get up feeling tired; my mind seems to be on overdrive; there are just too many thoughts at once on my mind; I feel like I have a motor that I can't turn off; I am constantly on the go and in motion, even when I am tired or would like to slow down or stop

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Table 3. Bipolar Disorder		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
Bipolar disorders are characterized by vast changes in presentation from depression on one side of the spectrum to mania or irritability on the other. There are two different types of bipolar disorder with the main distinction being the level of mania. Diagnostic criteria for the manic or irritable mood in bipolar I must last for at least 1 week (or any length if hospitalized and be present for most of the day, nearly every day (while diagnostic criteria for bipolar II (hypomania) must last at least 4 consecutive days, during which at least 3 symptoms have persisted (or 4 if mood is only irritable) and don't lead to major problems in daily functioning the way that bipolar I does	1. Marked increase in goal-directed activity either socially, at work, sexually, or just physically restless.	1. I just can't seem to sit still; I feel restless all the time; feels like I have ants crawling under my skin; I am flying high; having the best social/sexual/work time I have ever had.
	2. More talkative than usual or feels pressure to keep talking.	2. It seems like I just can't stop talking; my words just feel like they are being pushed out of my mouth; all my words run together; I can't seem to talk fast enough to keep up with my thinking.
	3. Flights of ideas or subjective feeling that thoughts are racing.	3. My mind is just racing; I can't concentrate on any one thing/thought for very long; my mind is just buzzing.
	4. Inflated self-esteem or grandiosity that may border on delusional.	4. No one knows how talented/smart/ athletic that I am; I feel like I could conquer the world; I feel unstoppable; nothing can get in my way now; there's no end to what I can do; sometimes I feel superior to everyone around me.
	5. Decreased need for sleep.	5. I don't need much sleep at all; I can stay awake all night long; I just don't feel tired; so who needs sleep; there is too much to do to waste time sleeping.
	6. Distractibility with the attention drawn too easily to unimportant or irrelevant, usually external stimuli.	6. I am very distracted by every little detail; I cannot see the forest for the trees; every detail jumps out at me; I am afraid that I will miss something/anything; my mental motor is always running at high speed; my constant worry is details, details, and more details.
	7. Excessive involvement in activities that have a high potential for painful consequences such as shopping sprees,	7. I know this is bad for me, but it feels so good/exciting; I just can't seem to stop myself; it may be risky but what a high; nothing is going to happen to me; nothing can stop me now; I can't believe

Table 3. Bipolar Disorder		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
NOTE: True bipolar disorders have a number of complex sub-classifications and diagnostic criteria; the symptoms are indicative but not definitive.	promiscuous sexual activities, foolish business practices or investments, gambling, and/or reckless driving.	that I bought so much/drank so much/did that sexually; driving fast is such a high and I know I can handle the car at any speed.

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Table 4. Clinical Depression		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
To meet diagnostic criteria for major depressive disorder, one must experience five or more symptoms during the same 2-week period and at least one of the symptoms should be either depressed mood or loss of interest or pleasure. A major caveat is that the "differential diagnosis" or less formal assessment is very complex in terms of an	1. Fatigue or loss of energy nearly every day.	1. I have no energy; I tire very easily; feel tired all the time; feel sleepy during the day; cannot pay attention since I feel drowsy.
	2. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.	2. I feel worthless; no one understands me; I can't seem to do anything right; I feel so guilty about everything even though I know I shouldn't; I am not as smart/talented/successful/ charming as my friends/co-workers/colleagues; not appreciated by others; no one ever tells me I am good at anything; I am a failure.
	3. Decreased ability to think or concentrate, or indecisiveness, nearly every day.	3. Can't seem to concentrate; can't remember what I have read; I drive for long distances and am not even aware of the distance or time; my brain is in a fog; I feel a cloud in my mind; not as sharp as I used to be; I am forgetting more and more details/appointments; my thoughts get scrambled/mixed up.

Table 4. Clinical Depression		
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underlying medical condition and/or complex mix of depression with other psychological disorders: • Symptoms of depression and many medical disorders can be similar or even identical • First presentations of some medical conditions can be depression • Relationship between depression and a diagnosed medical condition can be a "chicken-egg" issue • Side effects of many medications induce symptoms of and/or overt depression; Individuals on a help/coaching/self- care line are in a context where assessing such complexities is simply not	4. Loss of interest in or enjoyment of pleasurable activities.	4. I do not go out much at all; I used to enjoy "X" but not anymore; I have no interest in sex; eating is more of a chore than an enjoyment; I can't stand being around my children/spouse/friends; getting high on "X" is all I want to do; I feel like I don't have any friends anymore.
	5. A slowing down of thought and a reduction of physical movement or its opposite, restlessness or psychomotor agitation (observable by others, not merely subjective feelings of restlessness or being slowed down).	5. Everything seems to move in slow motion; I feel like I am moving underwater; talking about "X" does no good at all; no one listens to me; no matter what I do, I cannot seem to get ahead/feel better/have any impact; no matter what changes I try to make, they do no good; I feel trapped.
	6. Feeling depressed mood or appearing this way to others (e.g., appearing tearful or about to cry) or irritable mood	6. Things are never going to change; tomorrow is going to be even worse than today; if you think you have it bad, just imagine what I am going through; so who cares; no matter what I do nothing changes; it is all because of "X" (person or event in the past); it wasn't my fault; they never gave me any opportunity to explain/make things right/have a second chance; there is no way out; suddenly I just feel like crying; even little setbacks are too much and I start to cry; poor "X" (person/event); inability to talk about a problem without crying.
	7. Recurrent thoughts of death or suicide.	7. What's the use in living; I hope I don't wake up or wish I wasn't here; I don't even look when I cross the street; sometimes I just want to end it all; dying beats the hell out of living like this; I just can't take anymore;

Table 4. Clinical Depression		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
possible, advisable, ethical, or legal.		I am driving too fast, but I don't care; I don't even think about the dangers of sky diving/drinking and driving/random sex/taking new drugs
	8. Significant weight loss when not dieting or weight gain or decrease or increase in appetite nearly every day.	8. I don't feel like eating and just don't have an appetite anymore; nothing tastes good; I'm not trying to lose weight; I feel like I eat my feelings; ice cream makes me feel better.
	9. Difficulty sleeping or sleeping too long nearly every day.	9. I can't fall asleep even though I'm tired; I keep waking up throughout the night; I wake up earlier than I'd like and can't get back to sleep; I sleep all day yet I'm still tired.

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Table 5. Eating Disorders		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
Eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Some individuals report eating-related symptoms	1. Anorexia nervosa is characterized restrictive intake relative to requirements leading to a significantly low body weight.	1. - Weight that is less than minimally normal for age, sex, developmental trajectory, and physical health. - Intense fear of becoming fat or persistent behavior that interferes with weight gain despite significantly low weight. - Disturbance in the way one's body weight or shape is experienced, undue influence of body weight on self-evaluation, or lack of recognition of seriousness of current low body weight.

Table 5. Eating Disorders		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
including craving and compulsion.		
	2. Bulimia nervosa involves recurrent episodes of binge eating (occurring with a frequency of at least once a week for 3 months) followed by inappropriate compensatory behaviors to avoid weight gain, and self-evaluation that is unduly influenced by body shape and weight.	2. - Eating an amount of food that is definitely larger than what most individuals would eat in a similar period under similar circumstances - A sense of lack of control over what or how one is eating during this period - Inappropriate compensatory behaviors including self-induced vomiting, misuse of laxatives or diuretics, fasting, or excessive exercise
	3. Binge eating disorder is characterized by recurring episodes of eating significantly more food in a short period of time than	3. Binge-eating episodes are characterized by at least 3 of the following: - Eating much more rapidly than normal - Eating until uncomfortably full - Eating large amounts of food when not feeling physically hungry - Eating alone because of feeling embarrassed by how much one is eating

Table 5. Eating Disorders		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
	most people would eat under similar circumstances. It is marked with feelings of lack of control over what one is eating and marked distress. This behavior occurs, on average, at least once a week over three months.	- Feeling disgusted with oneself, depressed, or very guilty afterward

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Table 6. Obsessive Compulsive Disorder (OCD)		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
This disorder is characterized by either obsessions or compulsions, although both may be present. The obsessions are defined as recurrent and persistent thoughts, images, or urges which are	1. Obsessions – These are recurrent, persistent ideas, thoughts, images, or urges that are experienced as not voluntary or within conscious control of the individual. These seem to be thoughts that invade consciousness and are experienced as senseless or repugnant. Attempts (often futile) are made to ignore or suppress them.	1. These thoughts just flood into my mind; I try to stop these thoughts but I just have no control over them; my mind will just not turn off; sometimes my thoughts are really negative but I can't seem to change/stop/ignore them; even though I know I should not be thinking these things, I do and can't seem to stop; sometimes I go over and over the same idea/thought/word/past occurrence/future plan over and over again; my thoughts

Table 6. Obsessive Compulsive Disorder (OCD)		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
intrusive and unwanted , and cause marked anxiety or stress. Compulsions consist of repetitive behaviors or mental acts that the person is driven to perform in response to an obsession, or according to rules which must be applied rigidly, and are not realistically connected with what they are trying to neutralize or prevent. These obsessions and/or compulsions are a significant source of distress to the individual and/or interfere with social/work/school/role functioning.		are just exhausting to me; there seems to be too many words just rattling around in my brain
	2. Compulsions – Repetitive and seemingly purposeful behavior that are performed according to certain rules or in a stereotyped, rigid fashion. The behavior is not an end in itself but is designed to produce or prevent some future event or situation. However, either the activity is not connected in a realistic way with what it is designed to produce or prevent, or it may be clearly excessive. The act is performed with a sense of subjective compulsion at least initially. The individual generally recognizes the senselessness of the behavior and does not derive pleasure from carrying out the activity although it provides a temporary release of tension.	2. Every time I leave the house I check the locks/water/refrigerator/ burglar alarm many times to be sure everything is OK; if I just wash my hands/clean the floors/do the dishes/finish the laundry, then I know the day will go right for me; even though I know it is crazy, I _____ over and over again; after I do this so many times I am exhausted and satisfied that all is well for a while, then I get a really uneasy feeling and I start all over again; checking my mailbox _____ number of times a day will insure that I am not missing a bill/lottery ticket/personal letter/invitation; doing _____ over and over again is just exhausting, but I can't seem to help myself.

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Table 7. Panic Disorder		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
Panic attacks come on suddenly, repeatedly, and often without warning. They are manifested by discrete periods of apprehension or terror. At least one of the panic attacks must be followed by a month or more of persistent concern about the implications of the attack or a significant change in behavior related to the attack(s). At least four of the symptoms appear during each attack.	1. Palpitations (irregular heartbeats) 2. Chest pain or discomfort 3. Feeling of choking 4. Sensations of shortness of breath or smothering 5. Dizziness, vertigo, light-headed, faint or unsteady feelings 6. Paresthesias (numbness or tingling sensations) 7. Feelings of unreality or depersonalization (feeling detached from oneself) 8. Chills and/or hot flashes 9. Sweating 10. Trembling or shaking 11. Abdominal distress or nausea 12. Fear of dying 13. Fear of losing control or going crazy	1. Sometimes I feel short of breath; can't seem to catch my breath; my breathing is labored; 2. My heart seems to squirm in my chest; I can feel my heart skipping a beat; 3. There is a feeling of pressure in my chest/heart/stomach; my chest feels tight; 4. Sometimes I feel like I am choking; at times I feel like I am being smothered and can't get enough air; 5. Suddenly I feel dizzy/the room spins around; I can't get my balance; I feel lightheaded, and I feel like I am going to faint; there are times when I feel like I am falling or about to fall down for no reason; 6. My hands/feet feel like there are pins and needles; there is an uncomfortable tingling in my hands/fingers/feet; 7. Sometimes I feel like I am living in a movie; I can't believe what is happening/what I am saying/what I am doing; I feel like I'm having an out-of-body experience. 8. My body goes from hot to cold/cold to hot; suddenly I am freezing cold/feeling very hot and sweating; 9. Even when I am not exercising, I break out in a sweat; sometimes I have a cold, clammy sweat where I feel chilly, but I am sweating (Note: Can occur during sleep); 10. My hands tremble so much that I can't hold a book still; for no reason I start to feel a trembling in my hands/feet/fingers;

Table 7. Panic Disorder		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
		11. My stomach is killing me; I have major cramps; my stomach feels like it's in knots; 12. I feel like I'm going to die; I'm dying so I need to go to the hospital right away 13. There are times when I really feel like I am going crazy; I just do not understand what is going on/what I am saying/what I am doing.

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Table 8. Post-Traumatic Stress Disorder (PTSD)		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
The essential feature of PTSD is the development of characteristic symptoms following exposure to one or more traumatic events. PTSD symptoms vary from person to person but there are 5 major diagnostic categories and sub-indicators that an individual must display some symptoms from in order to meet diagnostic criteria.	1. The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): o Direct exposure o Witnessing the trauma o Learning that a relative or close friend was exposed to a trauma o Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)	1. I thought I was going to die when _____ happened; I had so many broken bones after the car accident; I was there on 9/11; _____ told me everything that happened to him/her and it was really scary and it really bothered me; working as an EMT, I've seen a lot of things but some of them really stick with you
	2. Re-experiencing of the trauma as evidenced by at least one of the following: a) Unwanted upsetting memories; b) Distressing dreams or	2. It is just like I am back at/in _____; all of a sudden I feel just like I did when _____ happened; it seems like it is happening all over

Table 8. Post-Traumatic Stress Disorder (PTSD)		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
	nightmares of the event; c) Flashbacks; d) Emotional distress after exposure to internal or external reminders of the trauma; e) Physiological reactivity after exposure to internal or external traumatic cues.	again; I just can't seem to get it out of my mind; I keep going over and over what happened; I just can't seem to stop it from happening; suddenly I just feel overwhelmed by _____; it is just like I am there again; I'm having nightmares about _____.
	3. Negative alterations in cognitions and mood as shown by at least two of the following: a) Markedly diminished interest in activities; b) Feeling isolated or detached from others; c) Negative affect; d) Inability to recall key features of the trauma; e) Overly negative thoughts and assumptions about oneself or the world; f) Exaggerated blame of self, others or the world ; g) Difficulty experiencing positive affect.	3. I just don't feel connected to anyone/anything; my friends/family have no idea what I am going through; better to feel nothing than that terrible feeling of _____; I have lost all interest in _____; I just don't feel much of anything anymore; I feel dead inside; everything around me looks like it is in black and white; I can't even remember everything that happened; I should have never let this happen to me.
	4. Avoidance of trauma-related stimuli after the trauma, in the following way(s) (shown by at least one of the following): o Trauma-related thoughts or feelings o Trauma-related external reminders	4. I'd rather not think about it as it gets me too upset; I can't go by _____/see _____ or do _____ since it's too triggering.

Table 8. Post-Traumatic Stress Disorder (PTSD)		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
	5. Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s): o Irritability or aggression o Risky or self-destructive behavior o Hypervigilance o Heightened startle reaction o Difficulty concentrating o Difficulty sleeping	5. Since it happened, I'm just mad all the time; So what if I [engage in a risky behavior]? Life's short and you never know when it's your time; I need to sit with my back to the wall or near the exit in case I need to run out of here; I'm a really light sleeper and worry about every little noise; I'm hyper-aware of my surroundings; it's hard to focus since my mind always goes back to what happened.

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Table 9. Schizophrenia Disorder		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
Diagnostic symptoms include at least 2 during a phase of the illness, lasting at least one month, (or less if successfully treated), and at least one of these symptoms must include: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms	1. Bizarre delusions with no possible basis in fact.	1. No one knows that I have superpowers; I am the secret head of the CIA/a secret agent; I am actually from another planet/ dimension/time; my television/radio/iPod/ computer transmits coded messages to me.
	2. Hallucinations (may be auditory, visual, or tactile)	2. Voice(s) are telling me to _____; sometimes the voice tells me to _____; I can hear conversations between people in my head; it seems like my mind is a radio receiver; these voices always are arguing; the voices tell me what I can do (or not do); the voices are always making fun of me/berating me/telling me to do strange things like _____; these voices get so loud that other people can hear them; I see things all the time (and having conversations with people

Table 9. Schizophrenia Disorder		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
(i.e. diminished emotional expression or avolition). Continuous signs of the disturbance must predominate for a period of at least six months. Overall, there is a marked deterioration from a previous level of functioning in areas such as work, social relations, and/or self-care.		others can't see); there are bugs crawling all over my skin; there's a device embedded into my body, I can feel it.
	3. Negative symptoms, such as diminished emotional expression or avolition	3. I just don't feel anything anymore; my voice/thoughts/body just feels like it is dead.
	4. Grossly disorganized or catatonic behavior	4. My body just goes rigid, and I can't move; I feel so stiff; I want to walk but I can't seem to take a step
	5. Disorganized speech (loose associations, tangentiality, incoherence)	5. Question: Why do people believe in God? "This is a good question. People worship something. Primitive people worshipped airplanes when they first saw them. Science and technology are what this age is about. It is hard to say what started it. Perhaps the industrial revolution, then people have more time to think and study you see. A university degree is certainly an advantage these days. Life is hard."

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Table 10. Substance Use Disorders		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
The essential feature of substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms	A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period: (1) Tolerance, as defined by either of the following:	A. Inability to cut down, reduce, or stop the use.

Table 10. Substance Use Disorders		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
indicating that the individual continues using the substance despite significant substance-related problems. Pathological behaviors include broad categories of impaired control, social impairment, risky use, and pharmacological criteria. The DSM-5 notes specific diagnostic features for alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives/hypnotics/anxiolytics, stimulants, and tobacco. Substances are not considered "abuse" when there is non-pathological, recreational use of a substance and/or episodes of use without a pattern of pathological use.	a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect**, or** b. Markedly diminished effect with continued use of the same amount of the substance (2) Withdrawal, as manifested by either of the following: a. The characteristic withdrawal syndrome for the substance**, or** b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms (3) The substance is often taken in larger amounts or over a longer period than was intended (4) There is a persistent desire or unsuccessful efforts to cut down or control substance use (5) A great deal of time is spent on activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects (6) Craving or a strong desire or urge to use (7) Failure to fulfill major role obligations at work, home or school	B. Use of a substance every day for at least one month. C. Impairment of social or occupational functioning (e.g., fights, loss of a job, loss of friends, absence from work, legal difficulties, arrest(s) due to possession and/or sale of an illegal substance). D. Use throughout the day (e.g., at work).

Table 10. Substance Use Disorders		
Industry Standard Diagnostic Criteria	**Industry Standard Behavioral Criteria**	**Self-Reported Awareness Triggers**
	(8) Continued use despite having persistent or recurrent social or interpersonal problems caused by use (9) Important social, occupational, or recreational activities are given up or reduced because of substance use (10) Use in situations where it is physically hazardous (11) Continued use despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)	

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