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# A Review of the Clinical Utility and Psychometric Properties of the Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP): Norms, Percentile Rankings, and Qualitative Descriptors

The Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP), developed by the HiTOP Consortium, is a 45-item self-report measure designed to provide broad screening assessment of psychopathological dimensions across six primary spectra and two secondary scales in adults (HiTOP Consortium, 2025). This technical review provides clinicians with comprehensive scoring frameworks, percentile rankings, and detailed interpretive guidelines. The document outlines the dimensional structure of the six HiTOP spectra (Internalising, Somatoform, Detachment, Thought Disorder, Disinhibition, and Antagonism) and two secondary scales (Externalising and p-Factor), the relationships of the spectra with hierarchical psychopathology models, and important considerations for transdiagnostic assessment and treatment planning. The HiTOP approach to assessment of psychopathology represents a paradigm shift from traditional categorical diagnostic approaches to dimensional assessment that captures the full spectrum of psychopathological variation observed in quantitative research.

Click to view information on the B-HiTOP

**August 2025**

## Developer & Author

The Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP) was developed by the HiTOP Consortium (HiTOP Consortium, 2025):

> HiTOP Consortium. (2025). Hierarchical Taxonomy of Psychopathology (HiTOP) B-HiTOP Overview. https://www.hitop-system.org/hitop-self-report-measures

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This document was developed by NovoPsych to review contemporary literature and to describe original scoring methodologies and to provide interpretation material, enhance normative data and provide qualitative descriptors.

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## Description

The Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP), developed by the HiTOP Consortium, is a 45-item self-report measure designed to provide broad screening assessment of dimensions that span the hierarchical structure of psychopathology in adults (HiTOP Consortium, 2025). Developed within the empirical framework of the Hierarchical Taxonomy of Psychopathology, the B-HiTOP evaluates six primary spectra and two secondary scales:

**Primary Spectra:**

1. **Internalising** - assesses symptoms related to emotional distress, anxiety, depression, and mood difficulties including worry, fearfulness, sadness, and related internalised experiences of psychological distress.
2. **Somatoform** - evaluates physical symptoms and bodily concerns that may not have clear medical explanations, including pain, heightened bodily awareness, health anxiety, and preoccupation with physical health.
3. **Detachment** - measures social withdrawal, preference for solitude, and avoidance of close relationships, reflecting reduced interest in romantic partnerships and diminished motivation for interpersonal connection.
4. **Thought Disorder** - screens for unusual perceptual experiences, reality testing difficulties, dissociative experiences, and hallucinations that may reflect psychotic-spectrum difficulties or reality distortion.
5. **Disinhibition** - assesses impulsivity, risk-taking behaviours, and difficulties with behavioural control and constraint.
6. **Antagonism** - evaluates interpersonal manipulation, callousness, entitlement, need for special treatment, desire for power and control, and difficulties with empathy and prosocial behaviour.

**Secondary Scales:**

1. **Externalising** - represents a broad factor combining aspects of disinhibited and antagonistic behaviours, reflecting a tendency toward behavioural dyscontrol.
2. **p-Factor** - measures general psychopathology that cuts across all spectra, representing global severity or symptom burden.

The B-HiTOP offers clinicians a practical, evidence-based alternative to traditional diagnostic checklists like the DSM-5. As an alternative to discrete categories, this innovative screening tool uses a dimensional approach which views symptoms as part of a spectrum rather than an all-or-nothing diagnosis. The B-HiTOP is grounded in the Hierarchical Taxonomy of Psychopathology (HiTOP) model.

The Hierarchical Taxonomy of Psychopathology (HiTOP) framework is a hierarchy of dimensional constructs derived from decades of research on the patterns of covariation among symptoms, traits, and traditional mental disorders (Kotov et al., 2017). Dimensional approaches to quantifying mental illness operate outside the confines of traditional categorical diagnoses and are gaining traction as a way to advance research on the causes and consequences of mental illness (Conway et al., 2022). Unlike traditional categorical diagnostic systems such as the DSM-5-TR, which impose arbitrary diagnostic thresholds and exclude subclinical symptomatology, HiTOP provides continuous dimensional scores that capture the full range of psychopathological variation observed in both clinical and community populations (Kotov et al., 2017). The framework addresses fundamental limitations of categorical systems, as generations of psychologists have been taught that mental disorder can be carved into discrete categories, each qualitatively different from the others and from normality, but this model is now outdated (Conway et al., 2021). Research demonstrates that a hierarchical taxonomy of psychopathology can transform mental health research by providing phenotypes that cut across traditional diagnostic boundaries (Conway et al., 2019). Additionally, empirical reorganisation of DSM-5 symptoms into data-driven hierarchical frameworks demonstrates that symptom overlap between diagnoses and heterogeneity within diagnoses can be addressed through empirically derived homogeneous constructs (Forbes et al., 2024). Research demonstrates that HiTOP offers superior clinical utility compared to traditional diagnostic systems, with clinicians rating it as significantly more useful for describing psychopathology and assessing global functioning (Hetfeld et al., 2025). Consequently, the B-HiTOP serves as an efficient screening tool that enables clinicians to

identify areas of clinical concern in the HiTOP dimensions that span traditional diagnostic boundaries and use the results to target more in-depth assessments relevant to the specific needs of the client.

The B-HiTOP employs dimensional scoring approaches where higher scores indicate greater symptom severity within each spectrum. This dimensional framework enables clinicians to capture a broad range of psychological difficulties rather than relying on arbitrary diagnostic cut-offs that may miss subclinical but clinically relevant symptoms. The measure's transdiagnostic approach allows clinicians to identify symptom patterns that span traditional diagnostic boundaries, providing a more comprehensive understanding of patient presentations and comorbidity patterns. Unlike categorical systems that force clinicians into either-or diagnostic decisions, the B-HiTOP's continuous scoring enables more nuanced clinical judgement and targeted intervention planning. For busy clinical settings, the B-HiTOP serves as an efficient broad screening tool that can quickly identify areas of concern across the full spectrum of psychopathology, allowing clinicians to direct their limited assessment time towards more detailed evaluation of the specific domains where clients show elevated symptoms.

## Psychometric Properties

Normative data for the B-HiTOP has been established through a demographically-representative cross-validation study conducted via the Prolific research platform (HiTOP Consortium, 2025). The normative sample comprised 780 adults in the USA ranging in age from 18 to 80 years (M = 44.42, SD = 14.90), with a balanced gender distribution of 48.6% male and 50.5% female participants. The sample demonstrated good demographic diversity, with 70.5% identifying as White, 10.7% as Black, 5.8% as Asian, 4.4% as Hispanic, and 7.7% as multiple races. Educational attainment varied considerably, with 33.3% holding bachelor's degrees, 13.7% having completed graduate degrees, and 22.4% reporting some college or university education.

Mental health service utilisation was substantial within the sample, with 20.3% currently receiving services, 15.9% having received services within the past two years, 26.9% having received services more than two years previously, and 36.5% reporting no history of mental health service use.

The following means and standard deviations provide reference points for clinical interpretation across the B-HiTOP spectra and secondary scales:

- Internalising (M = 1.85, SD = 0.77)
- Somatoform (M = 1.82, SD = 0.71)
- Detachment (M = 2.13, SD = 0.88)
- Thought Disorder (M = 1.26, SD = 0.46)
- Disinhibition (M = 1.65, SD = 0.60)
- Antagonism (M = 1.42, SD = 0.45)
- Externalising Secondary Scale (M = 1.54, SD = 0.49)
- General Psychopathology (p-Factor) Secondary Scale (M = 1.68, SD = 0.55)

All scales demonstrated appropriate distributional properties for clinical use, with skewness values ranging from 0.55 to 2.51 and kurtosis values from -0.72 to 7.24. The Thought Disorder spectrum showed the greatest positive skew (2.51) and kurtosis (7.24), reflecting the expected low base rate of psychotic-spectrum symptoms in the general population. Conversely, the Detachment spectrum exhibited the most normal distribution characteristics (skew = 0.55, kurtosis = -0.72), consistent with its conceptualisation as a fundamental personality dimension.

The B-HiTOP demonstrated good internal consistency across both derivation and cross-validation samples (HiTOP Consortium, 2025). Cronbach's alpha coefficients for the six primary spectra ranged from .82 to .90 in the cross-validation sample. Specifically, alpha values were: Internalising (.90), Somatoform (.88), Detachment (.86), Thought Disorder (.85), Disinhibition (.86), and Antagonism (.82). The secondary scales also demonstrated good reliability, with the Externalising scale achieving alphas of .83 and the p-Factor scale achieving .86.

Discriminant validity was supported by appropriate intercorrelations between spectra. In the cross-validation sample, correlations ranged from .13 (Detachment-Antagonism) to .73 (Internalising-Somatoform), with most correlations falling in the moderate range (.30-.60). The strongest association was observed between Internalising and Somatoform spectra (.73), consistent with theoretical expectations regarding shared distress components. The weakest correlation was between Detachment and Antagonism (.13), supporting their distinctiveness as separate spectra. These correlation patterns replicated well across samples, providing evidence for stable factor structure and discriminant validity.

Due to the over-representation of individuals with current mental health difficulties within the normative sample (20.3% currently accessing mental health services), traditional statistical cutoffs based on 1 standard deviation (approximately 85th percentile) and 1.5 standard deviations (approximately 93rd percentile) above the mean were adjusted downwards to provide more clinically meaningful interpretive thresholds. The adjusted percentile cutoffs were:

- **Normal Range**: Less than 75th percentile - Symptom levels within expected limits for the general population
- **Elevated**: ≥75th percentile but <85th percentile - Symptom levels somewhat above average but not yet in the clinically significant range
- **Clinically Significant**: ≥85th percentile - Symptom levels substantially above average, suggesting potential clinical concern

## Scoring & Interpretation

The Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP) scores consist of dimensional scores across six primary spectra and two secondary scales. Higher average scores represent higher levels of symptoms within each spectrum measured. Scores are provided for the following spectra and scales of the B-HiTOP:

**Primary Spectra:**

1. **Internalising** (Items 4, 11, 17, 19, 23, 41, 42, 43) - assesses symptoms of emotional distress, anxiety, depression, and internalised psychological difficulties.
2. **Somatoform** (Items 2, 3, 8, 14, 20, 26, 28, 31) - evaluates physical symptoms and bodily concerns that may not have clear medical explanations, including pain, heightened bodily awareness, health anxiety, and preoccupation with physical health.
3. **Detachment** (Items 22, 25, 32, 36, 38) - measures social withdrawal, preference for solitude, and avoidance of close relationships, reflecting reduced interest in romantic partnerships and diminished motivation for interpersonal connection.
4. **Thought Disorder** (Items 7, 9, 10, 34, 35, 45) - screens for unusual perceptual experiences, reality testing difficulties, dissociative experiences, and hallucinations that may reflect psychotic-spectrum difficulties or reality distortion.
5. **Disinhibition** (Items 1, 13, 15, 21, 27, 30, 33, 37, 44) - assesses impulsivity, risk-taking behaviours, and behavioural control difficulties.
6. **Antagonism** (Items 5, 6, 12, 16, 18, 24, 29, 39, 40) - evaluates interpersonal manipulation, callousness, entitlement, need for special treatment, desire for power and control, and difficulties with empathy and prosocial behaviour.

**Secondary Scales:**

1. **Externalising** (Items 5, 12, 13, 15, 16, 18, 21, 33, 39, 44) - represents a broad factor combining aspects of disinhibited and antagonistic behaviours, reflecting a tendency toward behavioural dyscontrol.
2. **p-Factor** (Items 3, 10, 11, 12, 18, 19, 21, 22, 26, 35, 36, 44) - measures general psychopathology that cuts across all spectra, representing global severity or symptom burden.

The B-HiTOP employs dimensional scoring approaches where average scores for each spectrum provide continuous measures of symptom severity. Average scores are calculated by dividing the total raw score by the number of items in each spectrum. The percentiles are based upon these dimensional average scores and are derived from community normative samples. Scores are presented as percentile ranks indicating the individual's position relative to peers in the normative sample. A percentile of 50 indicates that the symptom level is at average and expected levels, whilst a percentile of 85 indicates relatively high symptom levels compared to peers (i.e., higher than 85 percent of peers).

The B-HiTOP uses percentile-based interpretation ranges. Dimensional scores are categorised into three interpretive ranges based on normative percentiles:

- **Normal Range**: Less than 75th percentile - Symptom levels within expected limits for the general population
- **Elevated**: ≥75th percentile but <85th percentile - Symptom levels somewhat above average but not yet in the clinically significant range
- **Clinically Significant**: ≥85th percentile - Symptom levels substantially above average, suggesting potential clinical concern

These percentile-based ranges enable clinicians to interpret B-HiTOP scores within a dimensional framework that recognises the continuous nature of psychopathological experiences. Unlike traditional categorical diagnostic cutoffs, these ranges provide graduated levels of clinical concern that can guide assessment and intervention decisions.

On the first administration of the B-HiTOP, two types of plots are typically shown. The first is a stacked bar chart displaying percentile scores for all spectra and secondary scales with background shading indicating elevated and clinically significant ranges. The second is a series of horizontal bar charts showing average scores for each spectrum compared to community percentile distributions, with guidelines marking the 25th, 50th, and 75th percentiles and coloured regions indicating normal range, elevated, and clinically significant ranges.

When B-HiTOP scores are available from multiple timepoints, changes in scores can provide valuable information about the effectiveness of interventions or changes in symptoms. Although B-HiTOP does not have an established framework for interpreting change over time, we can use the established recommendation of changes of at least 0.5 standard deviations in average scores being considered clinically meaningful (the minimally important difference) (Norman et al., 2003; Turner et al., 2010). These changes are categorised as ‘significant improvement’ (≥0.5 SD reduction in average score), 'significant deterioration' (≥0.5 SD increase in average score), ‘slight improvement or deterioration’ (<0.5 SD change in average score), or ‘none’ (no change in average score). If applicable, this interpretive text outlining change in scores is displayed first within the interpretive text section.

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## Supporting Information

### *Percentile Calculations*

The percentile rankings for the B-HiTOP are from a demographically-representative cross-validation study conducted by the HiTOP Consortium (HiTOP Consortium, 2025). NovoPsych used the raw de-identified data (R. Kotov, personal communication, June 3, 2025) to create percentile rankings. The percentile rankings represent the position of a given average score relative to the distribution of scores in the normative sample.

### *Percentile Tables*

**Internalising**

| Avg. Score | Percentile |
|---|---|
| 1 | 8 |
| 1.1 | 15 |
| 1.3 | 29 |
| 1.4 | 33 |
| 1.5 | 42 |
| 1.6 | 45 |
| 1.8 | 54 |
| 1.9 | 57 |
| 2 | 64 |
| 2.1 | 66 |
| 2.3 | 72 |
| 2.4 | 74 |
| 2.5 | 79 |
| 2.6 | 80 |
| 2.8 | 84 |
| 2.9 | 85 |
| 3 | 90 |
| 3.1 | 91 |
| 3.3 | 94 |
| 3.4 | 94 |
| 3.5 | 97 |
| 3.6 | 97 |
| 3.8 | 98 |
| 3.9 | 99 |
| 4 | 99.99 |

**Somatoform**

| Avg. Score | Percentile |
|---|---|
| 1 | 6 |
| 1.1 | 11 |
| 1.3 | 25 |
| 1.4 | 31 |
| 1.5 | 42 |
| 1.6 | 46 |
| 1.8 | 55 |
| 1.9 | 58 |
| 2 | 67 |
| 2.1 | 69 |
| 2.3 | 76 |
| 2.4 | 78 |
| 2.5 | 82 |
| 2.6 | 84 |
| 2.8 | 89 |
| 2.9 | 90 |
| 3 | 92 |
| 3.1 | 93 |
| 3.3 | 94 |
| 3.4 | 95 |
| 3.5 | 97 |
| 3.6 | 97 |
| 3.8 | 98 |
| 3.9 | 99 |
| 4 | 99.99 |

**Detachment**

| Avg. Score | Percentile |
|---|---|
| 1 | 6 |
| 1.2 | 16 |
| 1.4 | 26 |
| 1.6 | 35 |
| 1.8 | 43 |
| 2 | 50 |
| 2.2 | 57 |
| 2.4 | 65 |
| 2.6 | 72 |
| 2.8 | 77 |
| 3 | 82 |
| 3.2 | 85 |
| 3.4 | 88 |
| 3.6 | 92 |
| 3.8 | 95 |
| 4 | 98 |

**Disinhibition**

| Avg. Score | Percentile |
|---|---|
| 1 | 7 |
| 1.1 | 25 |
| 1.2 | 33 |
| 1.3 | 41 |
| 1.4 | 49 |
| 1.6 | 49 |
| 1.7 | 57 |
| 1.8 | 63 |
| 1.9 | 69 |
| 2 | 77 |
| 2.1 | 82 |
| 2.2 | 84 |
| 2.3 | 86 |
| 2.4 | 89 |
| 2.6 | 89 |
| 2.7 | 92 |
| 2.8 | 93 |
| 2.9 | 96 |
| 3 | 97 |
| 3.1 | 98 |
| 3.2 | 98.2 |
| 3.3 | 98.8 |
| 3.4 | 99 |
| 3.6 | 99 |
| 3.7 | 99.2 |
| 3.8 | 99.99 |
| 3.9 | 99.99 |
| 4 | 99.99 |

**Thought Disorder**

| Avg. Score | Percentile |
|---|---|
| 1 | 29 |
| 1.2 | 58 |
| 1.3 | 79 |
| 1.5 | 81 |
| 1.7 | 83 |
| 1.8 | 91 |
| 2 | 92 |
| 2.2 | 94 |
| 2.3 | 96 |
| 2.5 | 97 |
| 2.7 | 97 |
| 2.8 | 98.6 |
| 3 | 98.8 |
| 3.2 | 99.1 |
| 3.3 | 99.2 |
| 3.5 | 99.4 |
| 3.7 | 99.99 |
| 3.8 | 99.99 |
| 4 | 99.99 |

**Antagonism**

| Avg. Score | Percentile |
|---|---|
| 1 | 10 |
| 1.1 | 37 |
| 1.2 | 51 |
| 1.3 | 61 |
| 1.4 | 70 |
| 1.6 | 70 |
| 1.7 | 75 |
| 1.8 | 81 |
| 1.9 | 85 |
| 2 | 90 |
| 2.1 | 93 |
| 2.2 | 94 |
| 2.3 | 95 |
| 2.4 | 97 |
| 2.6 | 97 |
| 2.7 | 97 |
| 2.8 | 98 |
| 2.9 | 98 |
| 3 | 98.6 |
| 3.1 | 99.1 |
| 3.2 | 99.4 |
| 3.3 | 99.99 |
| 3.4 | 99.99 |
| 3.6 | 99.99 |
| 3.7 | 99.99 |
| 3.8 | 99.99 |
| 3.9 | 99.99 |
| 4 | 99.99 |

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**Externalising**

| Avg. Score | Percentile |
|---|---|
| 1 | 6 |
| 1.1 | 18 |
| 1.2 | 29 |
| 1.3 | 39 |
| 1.4 | 48 |
| 1.5 | 57 |
| 1.6 | 65 |
| 1.7 | 71 |
| 1.8 | 76 |
| 1.9 | 81 |
| 2 | 84 |
| 2.1 | 87 |
| 2.2 | 90 |
| 2.3 | 92 |
| 2.4 | 93 |
| 2.5 | 95 |
| 2.6 | 96 |
| 2.7 | 97 |
| 2.8 | 98 |
| 2.9 | 98 |
| 3 | 99 |
| 3.1 | 99 |
| 3.2 | 99.1 |
| 3.3 | 99.2 |
| 3.4 | 99.4 |
| 3.5 | 99.99 |
| 3.6 | 99.99 |
| 3.7 | 99.99 |
| 3.8 | 99.99 |
| 3.9 | 99.99 |
| 4 | 99.99 |

**p-factor**

| Avg. Score | Percentile |
|---|---|
| 1 | 5 |
| 1.08 | 16 |
| 1.17 | 16 |
| 1.25 | 27 |
| 1.33 | 36 |
| 1.42 | 37 |
| 1.5 | 45 |
| 1.58 | 53 |
| 1.67 | 53 |
| 1.75 | 60 |
| 1.83 | 67 |
| 1.92 | 68 |
| 2 | 74 |
| 2.08 | 79 |
| 2.17 | 79 |
| 2.25 | 84 |
| 2.33 | 88 |
| 2.42 | 88 |
| 2.5 | 91 |
| 2.58 | 93 |
| 2.67 | 94 |
| 2.75 | 95 |
| 2.83 | 96 |
| 2.92 | 97 |
| 3 | 98 |
| 3.08 | 99 |
| 3.17 | 99 |
| 3.25 | 99.3 |
| 3.33 | 99.99 |
| 3.42 | 99.99 |
| 3.5 | 99.99 |
| 3.58 | 99.99 |
| 3.67 | 99.99 |
| 3.75 | 99.99 |
| 3.83 | 99.99 |
| 3.92 | 99.99 |
| 4 | 99.99 |

*Interpretive Text*

The interpretive report for the Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP) is constructed from several components that are conditionally displayed based on the individual's scores and assessment history. The report follows a structured format designed to provide clinicians with meaningful insights into the individual's psychopathological profile across six primary spectra and two secondary scales.

If this is the first administration, the report begins with:

> "The results of the Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP), as completed on [date], demonstrate [summary of current results]."

If the individual has completed the B-HiTOP previously, the report begins with a comparison of current results to previous scores (based upon the minimally important difference):

> "The current B-HiTOP results, as completed on [date], demonstrate [summary of changes from initial assessment on date]."

**Overall Summary Structure**

The interpretive text varies based on the distribution of scores across descriptor categories, which are defined as:

- Normal Range: Less than 75th percentile - Symptom levels within expected limits for the general population
- Elevated: ≥75th percentile but <85th percentile - Symptom levels somewhat above average but not yet in the clinically significant range
- Clinically Significant: ≥85th percentile - Symptom levels substantially above average, suggesting potential clinical concern

*All Scales Normal Range.* When all spectra and secondary scales fall within the normal range:

> "that all spectra and secondary scales are within the normal range."

*Mixed Results.* When some scales are elevated or clinically significant, the summary follows this pattern:

> "that [scale names] [is/are] within the clinically significant range, whilst [scale names] [is/are] within the elevated range, [and scale names] [is/are] within the normal range."

*Detailed Scale Interpretations.*The report provides detailed sections for the highest-scoring dimensions (up to 3), introducing them as:

> For 1 scale: "The highest scoring dimension (based upon percentiles) is outlined below:"
>
> For multiple scales: "The [number] highest scoring dimensions (based upon percentiles) are outlined below:"

**Primary Spectra Interpretations**

*Internalising Spectrum:*

- Elevated: "The client's responses indicate elevated levels of internalising symptoms, which encompass experiences of emotional distress, anxiety, or mood difficulties. This elevation suggests the client may be experiencing worry, sadness, guilt, or fearfulness that could be interfering with daily functioning and wellbeing."
- Clinically Significant: "The client's responses indicate clinically significant levels of internalising symptoms, which encompass persistent experiences of emotional distress, anxiety, and mood difficulties. This elevation suggests the client may be experiencing intense worry, sadness, guilt, or fearfulness that may interfere with their daily functioning and wellbeing. These symptoms often include rumination, emotional dysregulation, and heightened stress reactivity that can impact their relationships, work performance, and overall quality of life."

*Somatoform Spectrum:*

- Elevated: "The client's scores reflect elevated somatic concerns, indicating increased preoccupation with physical symptoms or bodily sensations. This pattern suggests the client may be experiencing heightened bodily awareness, multiple unexplained physical symptoms, pain in various body parts, or health-related anxiety that could be impacting their daily activities.."
- Clinically Significant: "The client's scores reflect clinically significant somatic concerns, indicating elevated preoccupation with physical symptoms and bodily sensations that cause significant distress. This pattern suggests the client may be experiencing multiple unexplained physical symptoms, persistent pain across various body parts, hypervigilance to bodily sensations, and intense health anxiety including fears of serious illness. The client may also experience frustration when others don't validate their physical concerns, and these preoccupations may impact their daily activities and mental wellbeing."

*Detachment Spectrum:*

- Elevated: "The client's responses indicate elevated levels of social detachment, characterised by preference for solitude or reduced interest in close relationships. This pattern could present as an avoidance of romantic partnerships and decreased motivation for interpersonal connection."
- Clinically Significant: "The client's responses indicate clinically significant levels of social detachment, characterised by marked avoidance of close relationships and strong preference for solitude. This pattern could present as substantial disinterest in romantic partnerships, active avoidance of interpersonal closeness, and a consistent preference for being alone over social connection. The client appears to find relationships burdensome rather than rewarding, which could significantly limit their ability to form and maintain meaningful interpersonal bonds."

*Thought Disorder Spectrum:*

- Elevated: "The client's scores suggest elevated thought disorder symptoms, including unusual perceptual experiences or reality testing difficulties. This elevation indicates the client may be experiencing difficulty distinguishing reality from imagination, dissociative experiences such as feeling outside their body, or occasional perceptual disturbances that could affect their daily life."
- Clinically Significant: "The client's scores suggest clinically significant thought disorder symptoms, including marked perceptual disturbances and reality testing difficulties. This elevation indicates the client may be experiencing hallucinations (seeing or hearing things others cannot), dissociative experiences, difficulty distinguishing reality from fantasy, and derealisation where things feel unreal. These symptoms could significantly interfere with their ability to accurately perceive and interpret their environment and maintain a stable sense of reality."

*Disinhibition Spectrum:*

- Elevated: "The client's responses reflect elevated disinhibition, characterised by increased impulsivity or difficulties with self-control. This pattern indicates potential challenges with considering consequences before acting or maintaining focus on tasks."
- Clinically Significant: "The client's responses reflect clinically significant disinhibition, characterised by marked impulsivity, risk-taking behaviours, and difficulties with self-control and planning. This pattern may indicate challenges with considering consequences before acting, maintaining focus on tasks, or regulating urges that may lead to problematic outcomes. The client may experience difficulty with organisation, time management, and following through on commitments, which could create challenges in various life domains."

*Antagonism Spectrum:*

- Elevated: "The client's scores indicate elevated antagonistic traits, suggesting emerging interpersonal difficulties characterised by manipulative behaviours, entitlement, or disregard for others' feelings. This elevation reflects tendencies toward attention-seeking, deceptiveness, and desire for control that could be creating conflict in relationships."

- Clinically Significant: "The client's scores indicate clinically significant antagonistic traits, suggesting a pattern of interpersonal difficulties characterised by manipulation, callousness, or disregard for others' feelings. This elevation reflects marked tendencies toward deceitfulness, entitlement to special treatment, need for power and control, attention-seeking behaviours, or lack of empathy that could create significant conflict in relationships. The client could potentially view others as objects to manipulate for personal gain and expects preferential treatment, potentially leading to persistent interpersonal problems and difficulty maintaining trust with others."

**Secondary Scales Interpretations**

*Externalising Secondary Scale:*

- Elevated: "The client's externalising score is elevated, indicating emerging patterns of outward-directed difficulties that combine impulsive and antagonistic behaviours. This suggests potential problems with behavioural control and interpersonal conflict."
- Clinically Significant: "The client's externalising score is clinically elevated, indicating a broad pattern of outward-directed difficulties that combine both impulsive and antagonistic behaviours. This suggests pervasive problems with behavioural control and interpersonal conflict that could manifest in ways that significantly impact their environment and relationships. The elevation reflects a general tendency toward acting out rather than internalising distress, potentially resulting in visible consequences and conflicts with others."

*General Psychopathology (p-Factor) Secondary Scale:*

- Elevated: "The client's p-factor score is elevated, indicating psychological difficulties across multiple domains. This suggests the client is beginning to experience symptoms in various areas of functioning."
- Clinically Significant: "The client's p-factor score is clinically elevated, indicating psychological difficulties that span multiple domains of mental health. This suggests the client is experiencing a broad range of symptoms across different areas of functioning, reflecting an overall elevation in psychological distress and impairment. The elevation indicates that rather than having difficulties in one specific area, the client could be experiencing widespread challenges that affect emotional, cognitive, behavioural, and interpersonal functioning."

**Item-Level Analysis**

For each elevated or clinically significant scale, the report includes specific items that were endorsed at moderate to high levels:

> "In particular, the client endorsed the following items in the [scale name] [spectrum/secondary scale]:"

Items are presented with their question numbers and text, along with response levels, formatted in italics for easy identification.

**Assessment Recommendations**

For each elevated or clinically significant scale, targeted assessment recommendations are provided:

> "To further investigate potential difficulties within the [scale name] [spectrum/secondary scale], NovoPsych recommends the following assessments:"

Recommendations are presented as numbered lists with direct links to relevant assessments, tailored to each specific spectrum or secondary scale:

***Internalising***

1. Depression Anxiety Stress Scales - Short Form (DASS-21)
2. International Trauma Questionnaire (ITQ)

3. Penn State Worry Questionnaire (PSWQ)
4. Generalised Anxiety Disorder Assessment (GAD-7)
5. Patient Health Questionnaire - Depression (PHQ-9)

***Somatoform***

1. Short Health Anxiety Inventory (SHAI)
2. Pain Self-Efficacy Questionnaire (PSEQ)
3. Fatigue Assessment Scale (FAS)
4. Tampa Scale of Kinesiophobia (TSK)
5. Tinnitus Handicap Inventory (THI)

***Detachment***

1. Maladaptive Schema Scale
2. Social Avoidance and Distress Scale (SADS)
3. Attachment Style Questionnaire - Short Form (ASQ-SF)
4. Experience in Close Relationship Scale - Short Form (ECR-S)
5. Agnew Relationship Measure - 5 (ARM-5)

***Thought Disorder***

1. Multidimensional Inventory of Dissociation - 60-item version (MID-60)
2. Mood Disorder Questionnaire (MDQ)
3. General Behaviour Inventory (GBI)
4. Automatic Thoughts Questionnaire - Believability (ATQ-B)
5. Dissociative Experiences Scale - II (DES-II)

***Disinhibition***

1. Adult ADHD Self-Report Scale (ASRS)
2. Personality Inventory for DSM-5 - Short Form (PID-5-SF)
3. Difficulties in Emotion Regulation Scale - 16 item version (DERS-16)
4. Alcohol Use Disorders Identification Test (AUDIT)
5. Problem Gambling Severity Index (PGSI)
6. Executive Skills Questionnaire - Revised (ESQ-R)
7. General Behaviour Inventory (GBI)

***Antagonism***

1. Personality Inventory for DSM-5 - Short Form (PID-5-SF)
2. Buss and Perry Aggression Questionnaire (BPAQ)
3. Empathy Quotient (EQ-40)

***Externalising***

1. Personality Inventory for DSM-5 - Short Form (PID-5-SF)
2. Buss and Perry Aggression Questionnaire (BPAQ)
3. Executive Skills Questionnaire - Revised (ESQ-R)
4. Alcohol Use Disorders Identification Test (AUDIT)
5. Problem Gambling Severity Index (PGSI)

***General Psychopathology (p-Factor)***

1. Personality Inventory for DSM-5 - Short Form (PID-5-SF)
2. Depression Anxiety Stress Scales - Short Form (DASS-21)
3. Adverse Childhood Experiences Questionnaire (ACE-Q)
4. Benevolent Childhood Experiences (BCEs) scale

**Note:** These assessments are recommended to provide more detailed evaluation of specific areas identified as elevated or clinically significant on the B-HiTOP. The PID-5-SF appears across multiple spectra / secondary scales as it provides comprehensive personality pathology assessment relevant to several domains.

## Developer

HiTOP Consortium. (2025). Hierarchical Taxonomy of Psychopathology (HiTOP) B-HiTOP Overview. https://www.hitop-system.org/hitop-self-report-measures

*Click the logo above to visit the HiTOP website for more information about the HiTOP model*

## References

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## Assessment Questions

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# Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP)

### Instructions:

Please consider whether there have been significant times during the last 12 months during which the following statements applied to you. Then please select the option that best describes how well each statement described you during that period.

| | | Not at all | A little | Moderately | A lot |
|---|---|---|---|---|---|
| 1 | I paid my bills late or missed other important deadlines. | 1 | 2 | 3 | 4 |
| 2 | Reading articles about disease made me worry about my health. | 1 | 2 | 3 | 4 |
| 3 | I was bothered by several bodily symptoms (e.g., headache, fatigue or stomach problems) for which there was no clear or sufficient medical explanation. | 1 | 2 | 3 | 4 |
| 4 | My mind was flooded with troubling images of a bad experience. | 1 | 2 | 3 | 4 |
| 5 | I found it easy to manipulate others. | 1 | 2 | 3 | 4 |
| 6 | People told me I was coldhearted. | 1 | 2 | 3 | 4 |
| 7 | I had trouble telling whether something really happened or I just imagined it. | 1 | 2 | 3 | 4 |
| 8 | I noticed small changes to how my body feels. | 1 | 2 | 3 | 4 |
| 9 | My fantasies felt very real to me. | 1 | 2 | 3 | 4 |
| 10 | I felt like I was outside of my body. | 1 | 2 | 3 | 4 |
| 11 | I was disgusted with myself. | 1 | 2 | 3 | 4 |
| 12 | I did things to get others to notice me. | 1 | 2 | 3 | 4 |
| 13 | I made decisions quickly without thinking them through. | 1 | 2 | 3 | 4 |
| 14 | I was frustrated with having to convince others I had a real illness. | 1 | 2 | 3 | 4 |
| 15 | I had trouble planning and keeping to schedules. | 1 | 2 | 3 | 4 |
| 16 | I liked attracting the attention of others. | 1 | 2 | 3 | 4 |

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| | | Not at all | A little | Moderately | A lot |
|---|---|---|---|---|---|
| 17 | Even when I was very careful, I worried whether I had done something correctly. | 1 | 2 | 3 | 4 |
| 18 | I found it easy to deceive others. | 1 | 2 | 3 | 4 |
| 19 | I felt on guard and on edge. | 1 | 2 | 3 | 4 |
| 20 | I had pains in several parts of my body. | 1 | 2 | 3 | 4 |
| 21 | I said things without thinking. | 1 | 2 | 3 | 4 |
| 22 | Romantic relationships seemed like a hassle to me. | 1 | 2 | 3 | 4 |
| 23 | My moods were intense and unpredictable. | 1 | 2 | 3 | 4 |
| 24 | I deserved special treatment. | 1 | 2 | 3 | 4 |
| 25 | When I had the chance, I chose to be alone rather than with other people. | 1 | 2 | 3 | 4 |
| 26 | I felt something was wrong with my body. | 1 | 2 | 3 | 4 |
| 27 | I bought much more than I needed. | 1 | 2 | 3 | 4 |
| 28 | I was afraid that I might suffer from a serious illness | 1 | 2 | 3 | 4 |
| 29 | Things went best when I told others what to do. | 1 | 2 | 3 | 4 |
| 30 | I was a messy person. | 1 | 2 | 3 | 4 |
| 31 | I could feel changes in my body. | 1 | 2 | 3 | 4 |
| 32 | I had no interest in romantic relationships. | 1 | 2 | 3 | 4 |
| 33 | I lost things that I needed. | 1 | 2 | 3 | 4 |
| 34 | I saw things that were not really there. | 1 | 2 | 3 | 4 |
| 35 | I heard things that no one else could hear. | 1 | 2 | 3 | 4 |
| 36 | I felt that I did not want to be in a close relationship. | 1 | 2 | 3 | 4 |

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| | | Not at all | A little | Moderately | A lot |
|---|---|---|---|---|---|
| 37 | I was never on time. | 1 | 2 | 3 | 4 |
| 38 | I was happiest when I was alone. | 1 | 2 | 3 | 4 |
| 39 | I expected to get treated better than others. | 1 | 2 | 3 | 4 |
| 40 | I liked having power. | 1 | 2 | 3 | 4 |
| 41 | I thought a lot about death. | 1 | 2 | 3 | 4 |
| 42 | I had a hard time asserting myself to others. | 1 | 2 | 3 | 4 |
| 43 | I was overwhelmed by anxiety. | 1 | 2 | 3 | 4 |
| 44 | I quit tasks that became too challenging. | 1 | 2 | 3 | 4 |
| 45 | I felt that things around me were not real. | 1 | 2 | 3 | 4 |

## Developer Reference:

HiTOP Consortium. (2025). Hierarchical Taxonomy of Psychopathology (HiTOP) B-HiTOP Overview. https://www.hitop-system.org/hitop-self-report-measures

Administer Now

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## Sample Result

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### Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP)

| | | | |
|---|---|---|---|
| *Client Name* | Generic Client | *Date administered* | 28 Aug 2025 |
| *Date of birth (age)* | 14 Dec 2015 (9) | *Time taken* | 52s |
| *Assessor* | Dr David Hegarty | | |

### Results

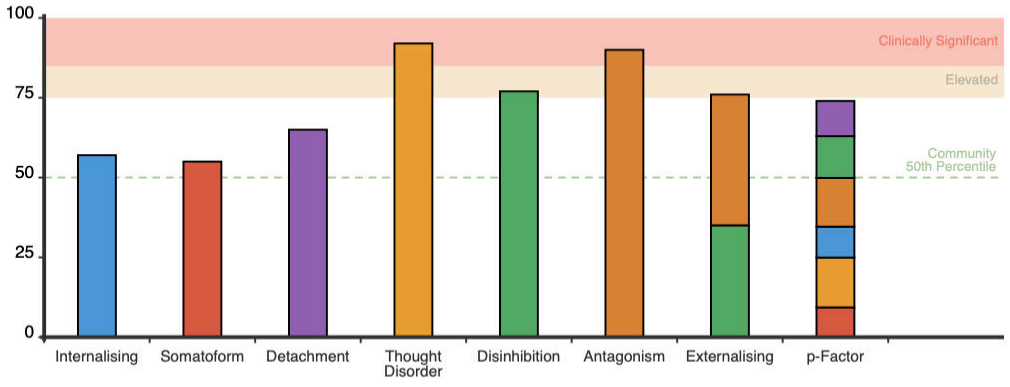
| | Average Score | Community Percentile | Descriptor |
|---|---|---|---|
| Internalising | 1.9 | 57 | Normal Range |
| Somatoform | 1.8 | 55 | Normal Range |
| Detachment | 2.4 | 65 | Normal Range |
| Thought Disorder | 2 | 92 | Clinically Significant |
| Disinhibition | 2 | 77 | Elevated |
| Antagonism | 2 | 90 | Clinically Significant |

### Secondary Scales

| | Average Score | Community Percentile | Descriptor |
|---|---|---|---|
| Externalising | 1.8 | 76 | Elevated |
| p-Factor | 2 | 74 | Normal Range |

***Note.*** *The B-HiTOP is in active research. The results from this assessment should be interpreted with consideration of the evolving literature and evidence. The ranges calculated here are based on preliminary norms that will be updated as new data are available.*

### B-HiTOP Spectra and Secondary Scale Percentiles



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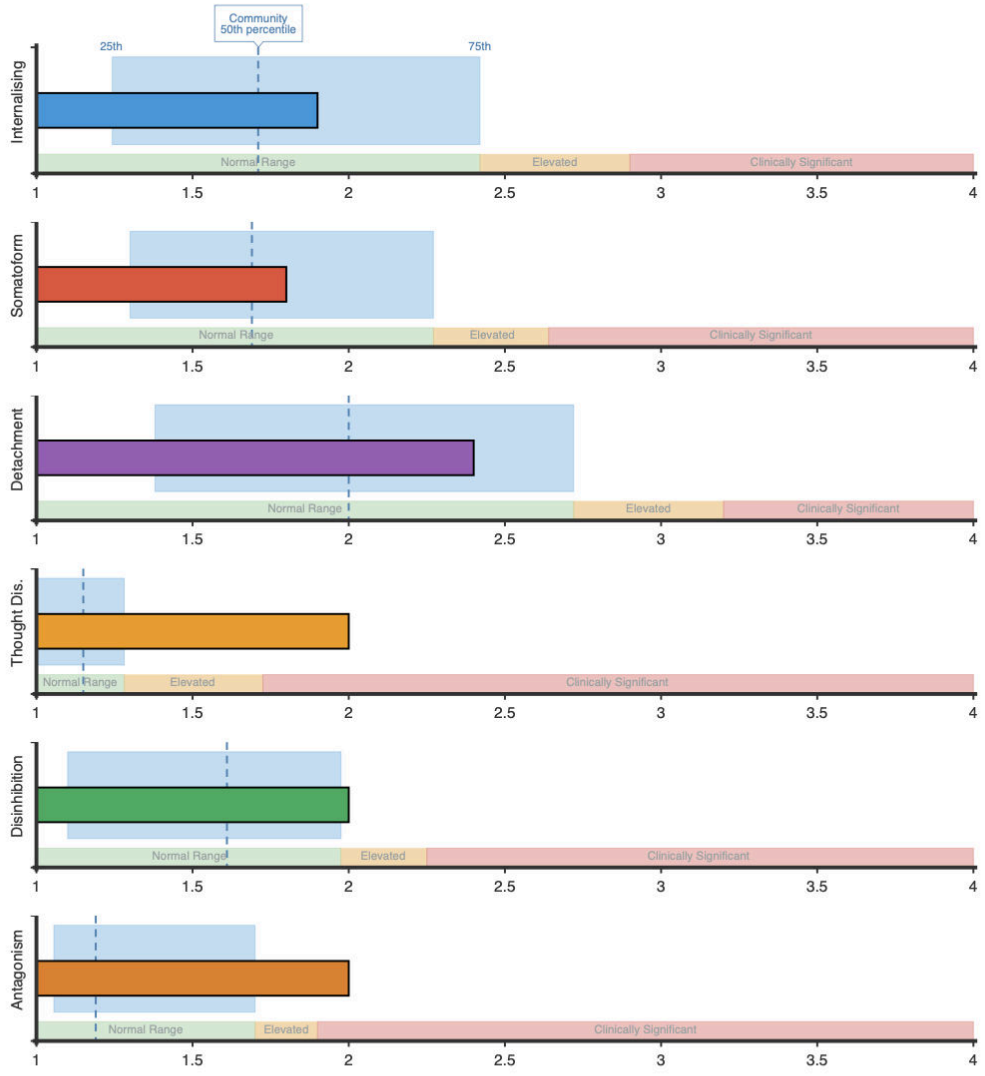
| Client Name | Generic Client |
|---|---|

**B-HiTOP Spectra Average Scores**
**Compared to Community Distributions**



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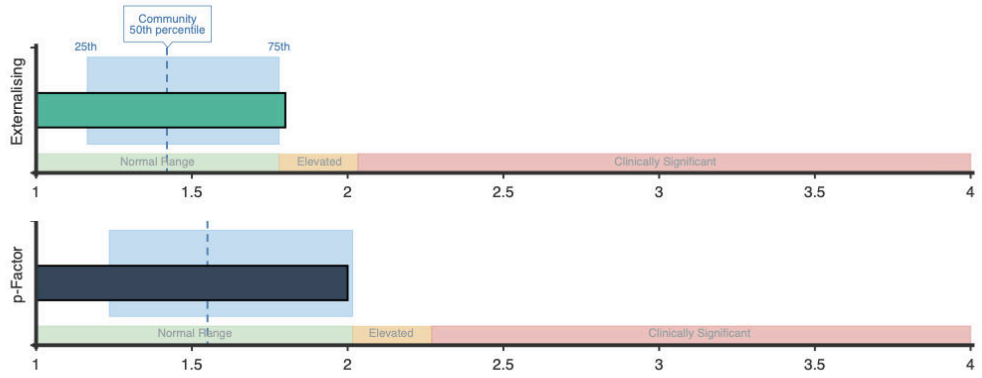
| Client Name | Generic Client |
|---|---|

**B-HiTOP Secondary Scale Average Scores Compared to Community Distributions**




## Interpretation

The results of the Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP), as completed on 28 August 2025, demonstrate that Thought Disorder and Antagonism are within the clinically significant range, Disinhibition and Externalising are within the elevated range, whilst General Psychopathology (p-Factor), Detachment, Internalising, and Somatoform are within the normal range.

The 3 highest scoring dimensions (based upon percentiles) are outlined below:

**Thought Disorder**
The client's scores suggest clinically significant thought disorder symptoms, including unusual perceptual experiences, unconventional beliefs, and difficulties with clear thinking. This elevation indicates the client may be experiencing confusion, disorganised thoughts, unusual sensory experiences, or beliefs that others find difficult to understand. These symptoms can interfere with communication, decision-making, and their ability to accurately perceive and interpret their environment. In particular, the client endorsed the following items in the Thought Disorder spectrum:
*- 9. My fantasies felt very real to me. (A lot)*
*- 10. I felt like I was outside of my body. (A little)*
*- 34. I saw things that were not really there. (A little)*
*- 45. I felt that things around me were not real. (A little)*

To further investigate potential difficulties within the Thought Disorder spectrum, NovoPsych recommends the following assessments:
1. Multidimensional Inventory of Dissociation - 60-item version (MID-60)
2. Mood Disorder Questionnaire (MDQ)
3. General Behaviour Inventory (GBI)
4. Automatic Thoughts Questionnaire - Believability (ATQ-B)
5. Dissociative Experiences Scale - II (DES-II)

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| Client Name | Generic Client |
|---|---|

**Antagonism**
The client's scores indicate clinically significant antagonistic traits, suggesting a pattern of interpersonal difficulties characterised by hostility, callousness, and disregard for others' feelings and social norms. This elevation reflects tendencies toward manipulation, deceitfulness, aggression, and lack of empathy that create significant conflict in relationships. The client may experience persistent interpersonal problems, difficulty maintaining trust with others, and a pattern of exploitative or harmful behaviours. In particular, the client endorsed the following items in the Antagonism spectrum:
- *24. I deserved special treatment. (A lot)*
- *5. I found it easy to manipulate others. (Moderately)*
- *6. People told me I was coldhearted. (Moderately)*
- *29. Things went best when I told others what to do. (A little)*

To further investigate potential difficulties within the Antagonism spectrum, NovoPsych recommends the following assessments:
1. Personality Inventory for DSM-5 - Short Form (PID-5-SF)
2. Buss and Perry Aggression Questionnaire (BPAQ)
3. Empathy Quotient (EQ-40)

**Disinhibition**
The client's responses reflect elevated disinhibition, characterised by increased impulsivity and difficulties with self-control. This pattern indicates emerging challenges with considering consequences before acting and maintaining focus on tasks. In particular, the client endorsed the following items in the Disinhibition spectrum:
- *27. I bought much more than I needed. (A lot)*
- *13. I made decisions quickly without thinking them through. (Moderately)*
- *15. I had trouble planning and keeping to schedules. (A little)*
- *33. I lost things that I needed. (A little)*

To further investigate potential difficulties within the Disinhibition spectrum, NovoPsych recommends the following assessments:
1. Adult ADHD Self-Report Scale (ASRS)
2. Personality Inventory for DSM-5 - Short Form (PID-5-SF)
3. Difficulties in Emotion Regulation Scale - 16 item version (DERS-16)
4. Alcohol Use Disorders Identification Test (AUDIT)
5. Problem Gambling Severity Index (PGSI)
6. Executive Skills Questionnaire - Revised (ESQ-R)
7. General Behaviour Inventory (GBI)

## Scoring and Interpretation Information

For comprehensive information on the B-HiTOP, see here.

{link to be added and Scoring & Interpretation section to be added here}
The Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP) scores consist of dimensional scores across six primary spectra and two secondary scales. Higher average scores represent higher levels of symptoms within each spectrum measured. Scores are provided for the following spectra and scales of the B-HiTOP:

Primary Spectra:
1. Internalising (Items 4, 11, 17, 19, 23, 41, 42, 43) - assesses symptoms of emotional distress,

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| Client Name | Generic Client |
|---|---|

anxiety, depression, and internalised psychological difficulties.
2. Somatoform (Items 2, 3, 8, 14, 20, 26, 28, 31) - evaluates physical symptoms and bodily concerns including pain, fatigue, and health preoccupation.
3. Detachment (Items 22, 25, 32, 36, 38) - measures social withdrawal, emotional numbing, anhedonia, and interpersonal disconnection.
4. Thought Disorder (Items 7, 9, 10, 34, 35, 45) - screens for unusual thoughts, perceptual disturbances, and reality distortion experiences.
5. Disinhibition (Items 1, 13, 15, 21, 27, 30, 33, 37, 44) - assesses impulsivity, risk-taking behaviours, and behavioural control difficulties.
6. Antagonism (Items 5, 6, 12, 16, 18, 24, 29, 39, 40) - evaluates interpersonal hostility, manipulation, callousness, and lack of empathy.

Secondary Scales:
1. Externalising (Items 5, 12, 13, 15, 16, 18, 21, 33, 39, 44) - represents a broad factor combining aspects of disinhibited and antagonistic behaviours, reflecting a tendency toward behavioural dyscontrol.
2. p-Factor (Items 3, 10, 11, 12, 18, 19, 21, 22, 26, 35, 36, 44) - measures general psychopathology that cuts across all spectra, representing global severity or symptom burden.

The B-HiTOP employs dimensional scoring approaches where average scores for each spectrum provide continuous measures of symptom severity. Average scores are calculated by dividing the total raw score by the number of items in each spectrum. The percentiles are based upon these dimensional average scores and are derived from community normative samples. Scores are presented as percentile ranks indicating the individual's position relative to peers in the normative sample. A percentile of 50 indicates that the symptom level is at average and expected levels, whilst a percentile of 85 indicates relatively high symptom levels compared to peers (i.e., higher than 85 percent of peers).

The B-HiTOP uses percentile-based interpretation ranges. Dimensional scores are categorised into three interpretive ranges based on normative percentiles:
- Normal Range: Less than 75th percentile - Symptom levels within expected limits for the general population
- Elevated: Greater than or equal to 75th percentile but less than 85th percentile - Symptom levels somewhat above average but not yet in the clinically significant range
- Clinically Significant: Greater than or equal to 85th percentile - Symptom levels substantially above average, suggesting potential clinical concern

These percentile-based ranges enable clinicians to interpret B-HiTOP scores within a dimensional framework that recognises the continuous nature of psychopathological experiences. Unlike traditional categorical diagnostic cutoffs, these ranges provide graduated levels of clinical concern that can guide assessment and intervention decisions.

On the first administration of the B-HiTOP, two types of plots are typically shown. The first is a stacked bar chart displaying percentile scores for all spectra and secondary scales with background shading indicating elevated and clinically significant ranges. The second is a series of horizontal bar charts showing average scores for each spectrum compared to community percentile distributions, with guidelines marking the 25th, 50th, and 75th percentiles and coloured regions indicating normal range, elevated, and clinically significant ranges.

When B-HiTOP scores are available from multiple timepoints, changes in scores can provide valuable information about the effectiveness of interventions or changes in symptoms. Although

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| Client Name | Generic Client |
|---|---|

B-HiTOP does not have an established framework for interpreting change over time, we can use the established recommendation of changes of at least 0.5 standard deviations in average scores being considered clinically meaningful (the minimally important difference) (Norman et al., 2003; Turner et al., 2010). These changes are categorised as ‘significant improvement’ (?0.5 SD reduction in average score), 'significant deterioration' (?0.5 SD increase in average score), ‘slight improvement or deterioration’ (

## Client Responses

| | | Not at all | A little | Moderately | A lot |
|---|---|---|---|---|---|
| 1 | I paid my bills late or missed other important deadlines. | **1** | 2 | 3 | 4 |
| 2 | Reading articles about disease made me worry about my health. | **1** | 2 | 3 | 4 |
| 3 | I was bothered by several bodily symptoms (e.g., headache, fatigue or stomach problems) for which there was no clear or sufficient medical explanation. | 1 | 2 | 3 | **4** |
| 4 | My mind was flooded with troubling images of a bad experience. | 1 | 2 | **3** | 4 |
| 5 | I found it easy to manipulate others. | 1 | 2 | **3** | 4 |
| 6 | People told me I was coldhearted. | 1 | 2 | **3** | 4 |
| 7 | I had trouble telling whether something really happened or I just imagined it. | **1** | 2 | 3 | 4 |
| 8 | I noticed small changes to how my body feels. | 1 | **2** | 3 | 4 |
| 9 | My fantasies felt very real to me. | 1 | 2 | 3 | **4** |
| 10 | I felt like I was outside of my body. | 1 | **2** | 3 | 4 |
| 11 | I was disgusted with myself. | 1 | 2 | **3** | 4 |
| 12 | I did things to get others to notice me. | **1** | 2 | 3 | 4 |
| 13 | I made decisions quickly without thinking them through. | 1 | 2 | **3** | 4 |
| 14 | I was frustrated with having to convince others I had a real illness. | 1 | **2** | 3 | 4 |
| 15 | I had trouble planning and keeping to schedules. | 1 | **2** | 3 | 4 |

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**Client Name** | Generic Client

## Client Responses (cont.)

| | | Not at all | A little | Moderately | A lot |
|---|---|---|---|---|---|
| 16 | I liked attracting the attention of others. | **1** | 2 | 3 | 4 |
| 17 | Even when I was very careful, I worried whether I had done something correctly. | **1** | 2 | 3 | 4 |
| 18 | I found it easy to deceive others. | **1** | 2 | 3 | 4 |
| 19 | I felt on guard and on edge. | **1** | 2 | 3 | 4 |
| 20 | I had pains in several parts of my body. | **1** | 2 | 3 | 4 |
| 21 | I said things without thinking. | **1** | 2 | 3 | 4 |
| 22 | Romantic relationships seemed like a hassle to me. | 1 | 2 | **3** | 4 |
| 23 | My moods were intense and unpredictable. | 1 | **2** | 3 | 4 |
| 24 | I deserved special treatment. | 1 | 2 | 3 | **4** |
| 25 | When I had the chance, I chose to be alone rather than with other people. | **1** | 2 | 3 | 4 |
| 26 | I felt something was wrong with my body. | **1** | 2 | 3 | 4 |
| 27 | I bought much more than I needed. | 1 | 2 | 3 | **4** |
| 28 | I was afraid that I might suffer from a serious illness | 1 | **2** | 3 | 4 |
| 29 | Things went best when I told others what to do. | 1 | **2** | 3 | 4 |
| 30 | I was a messy person. | **1** | 2 | 3 | 4 |
| 31 | I could feel changes in my body. | **1** | 2 | 3 | 4 |
| 32 | I had no interest in romantic relationships. | 1 | 2 | **3** | 4 |
| 33 | I lost things that I needed. | 1 | **2** | 3 | 4 |
| 34 | I saw things that were not really there. | 1 | **2** | 3 | 4 |

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| Client Name | Generic Client |
|---|---|

## Client Responses (cont.)

| | | Not at all | A little | Moderately | A lot |
|---|---|---|---|---|---|
| 35 | I heard things that no one else could hear. | **1** | 2 | 3 | 4 |
| 36 | I felt that I did not want to be in a close relationship. | 1 | 2 | 3 | **4** |
| 37 | I was never on time. | 1 | **2** | 3 | 4 |
| 38 | I was happiest when I was alone. | **1** | 2 | 3 | 4 |
| 39 | I expected to get treated better than others. | 1 | **2** | 3 | 4 |
| 40 | I liked having power. | **1** | 2 | 3 | 4 |
| 41 | I thought a lot about death. | 1 | **2** | 3 | 4 |
| 42 | I had a hard time asserting myself to others. | **1** | 2 | 3 | 4 |
| 43 | I was overwhelmed by anxiety. | 1 | **2** | 3 | 4 |
| 44 | I quit tasks that became too challenging. | 1 | **2** | 3 | 4 |
| 45 | I felt that things around me were not real. | 1 | **2** | 3 | 4 |