

Bipolar | Psychosis | Autism | Personality Pathology | Broad-Spectrum Screening

Systematic Assessment of Psychopathology



90 Minute Webinar

Presenters:

- Dr David Hegarty
- Dr Miri Forbes
- Dr Simon Baker
- 20 Minute Panel Discussion & Q&A



Join the discussion in the chat box



Slides available on the website



Request a certificate of attendance online

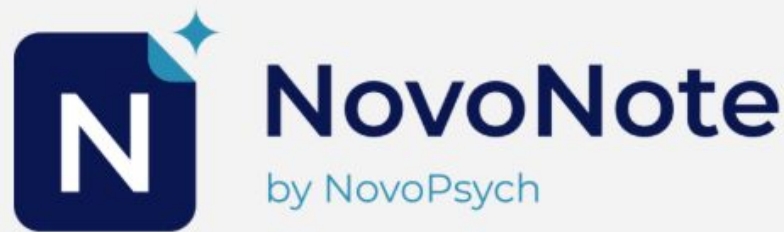
Dr Ben Buchanan



Psychometric Scales and AI Scribe for **Mental Health Practitioners** in One Platform



- ✓ Access to Over 150 Assessments
- ✓ Instant Scoring and Metrics
- ✓ Graph Symptoms Over Time



- ✓ AI-Generated Progress Notes
- ✓ One-Click Session Notes
- ✓ Secure Data Storage

Adult ADHD Self-Report Scale (ASRS)

The [Adult ADHD Self-Report Scale \(ASRS v1.1\)](#) is an 18-item self-report questionnaire designed to assess Attention Deficit Hyperactivity...

ADHD

Diagnosis

Adult ADHD Observer-Report Scale (ASRS-O)

The [Adult ADHD Observer-Report Scale \(ASRS-O\)](#) gathers informant-rated observations of adult ADHD symptoms, complementing the self-report ASRS.

ADHD

Diagnosis

Executive Skills Questionnaire – Revised (ESQ-R)

The [Executive Skills Questionnaire-Revised \(ESQ-R\)](#) is a 25-item, self-report measure of executive functioning skills, including plan and time...

ADHD

Autism

Formulation

Swanson, Nolan and Pelham Rating Scale (SNAP-IV) – 18 Item Version

The 18-item [Swanson, Nolan and Pelham Rating Scale \(SNAP-IV\)](#) assesses difficulties in attention and behavioural regulation in children and adolescents.

ADHD

Adolescent

Child

Diagnosis

UPPS-P Impulsive Behavior Scale (UPPS-P)

The [UPPS-P Impulsive Behavior Scale \(UPPS-P\)](#) is a 59 item self report scale to assess impulsive personality. The scale can be used...

ADHD

Adolescent

Formulation

Wender Utah Rating Scale – 25 item version (WURS-25)

The [Wender Utah Rating Scale - 25 item version \(WURS-25\)](#) is a 25-item self-report measure designed to retrospectively...

ADHD

Diagnosis

Formulation

ADHD Clinical Outcome Scale (ACOS-Self) – Self-Report Version

The [ADHD Clinical Outcome Scale \(ACOS\)](#) is a 15-item routine clinical outcome measure of ADHD and related mental...

ADHD

Outcome Monitoring

ADHD Clinical Outcome Scale (ACOS-Clinician) – Clinician Version

The [ADHD Clinical Outcome Scale \(ACOS-Clinician\) - Clinician Version](#) is a 15-item routine clinical outcome measure of ADHD and related mental...

ADHD

Outcome Monitoring

Strengths and Weaknesses of ADHD Symptoms and Normal Behavior Scale (SWAN)

The SWAN assesses strengths and difficulties in attention and behavioural regulation in young people between 5 and 18 ...

ADHD



Dr David Hegarty
Psychologist &
Psychometrician

Dr David Hegarty is a psychologist and psychometrician who leads NovoPsych's Psychometrics Team. His work is focussed on turning complex research literature into tools clinicians actually use.

David completed his PhD at the University of Sydney, where his research examined computerised adaptive cognitive training. His current research interests include: the psychometric properties and clinical utility of self-report and informant-report scales and dimensional models of psychopathology.



A/Prof Miri Forbes

A/Professor Miri Forbes is a leading researcher in the classification of mental disorders, with an internationally recognised track record in advancing evidence-based alternatives to traditional diagnostic frameworks: namely, the Hierarchical Taxonomy of Psychopathology.

She is currently the President of the HiTOP Society, Associate Professor at Macquarie University.



Dr Simon Baker

Dr Simon Baker is a Research Fellow at NovoPsych, where he researches and develops the psychological scales in NovoPsych's assessment library. Simon joined NovoPsych after 15 years in mental health research, spanning neuroimaging, digital mental health, prevention, implementation science, and service evaluation at Monash University, the Black Dog Institute, and Orygen.

[← Back to Assessments](#)

Search...



Multilevel Assessment of Psychoopathology (MAPsy)

The MAPsy is a 154-item self-report questionnaire that screens for the symptoms of DSM-5 disorders and shows which symptoms are elevated through two lenses: 41 disorder scales, and 127 dimensions of an empirically derived hierarchy of psychopathology. Designed as a broad initial assessment, it helps clinicians identify which areas warrant further assessment.

⌚ 20 minutes

👤 Ages 16+

✅ Formulation

 Administer Now

MAPsy
Overview

MAPsy
Constructs

MAPsy Scoring &
Interpretation

MAPsy
Psychometrics

Professional
Access

The Multilevel Assessment of Psychoopathology (MAPsy) is a 154-item self-report measure of psychopathology. It assesses symptoms of disorders described in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013) and scores them on 41 disorder scales. It also maps the client's symptoms onto an empirically derived hierarchy of psychopathology comprising nine spectra, two subspectra, 21 subfactors, and 95 symptom and syndrome clusters, based on the work of Forbes and colleagues (2025) and aligned with the Hierarchical Taxonomy of Psychopathology (HiTOP; Kotov et al., 2017). Each score is assigned a severity band, which indicates whether the client's level of psychopathology warrants clinical attention, and is reported as a percentile.

Structure of the MAPsy

Empirical Hierarchy

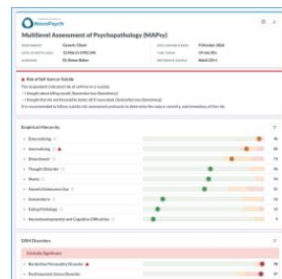
9 Spectra

DSM-5 Disorder Scales

41 Disorder scales



[Download MAPsy PDF](#)



Email us at

Psychometrics Feedback: psychometrics@novopsych.com

Other enquiries: info@novopsych.com

NovoPsych.com



Dr Simon Baker



Dr David Hegarty
Psychologist &
Psychometrician



A/Prof Miri Forbes

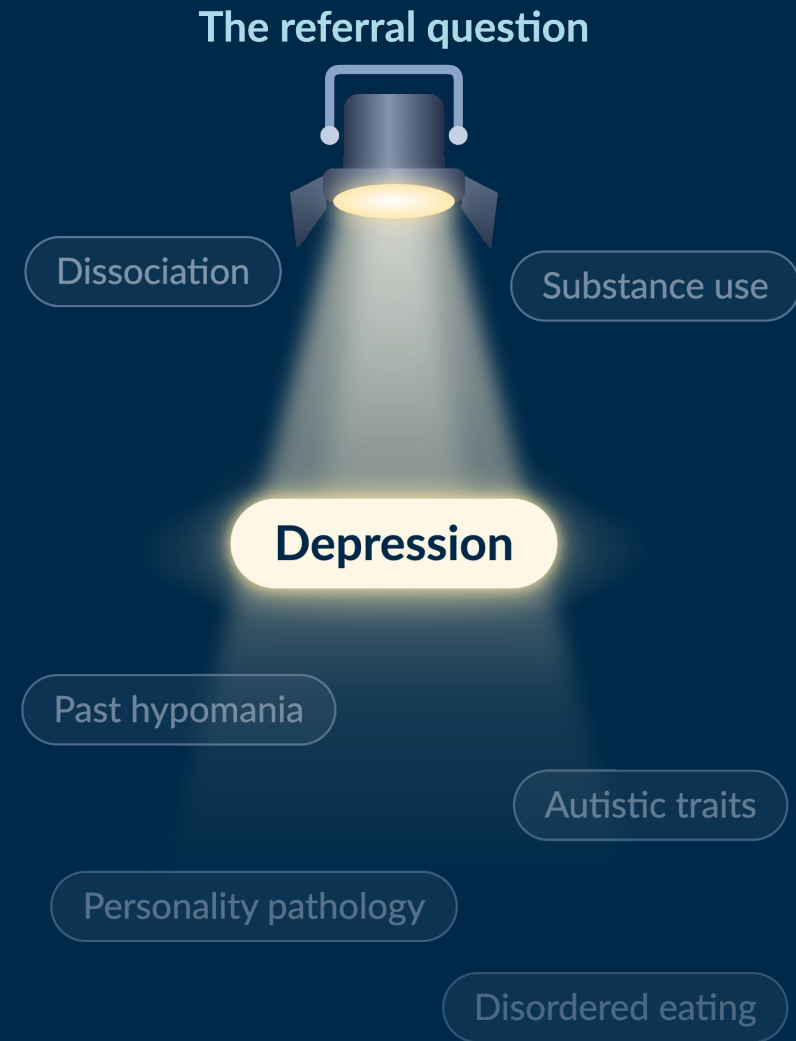
Dr Ben Buchanan



The problem in clinical practice

We miss things when we assess only what we are asked to assess

Dr David Hegarty · Psychologist | Head of Psychometrics, NovoPsych



Three referrals arrive this week



Sam, 22

they/them

REFERRAL

“Depression and social anxiety”

The GP wrote a care plan. Sam has had two courses of CBT for social anxiety.

LIKELY FIRST MEASURES

DASS-42



Mark, 42

he/him

REFERRAL

“I think I have adult ADHD”

Mark referred himself. His GP has treated him for depression on and off for ten years.

LIKELY FIRST MEASURES

ASRS

DASS-21



Jess, 27

she/her

REFERRAL

“Depression and PTSD from childhood”

The emergency department referred Jess after she took an overdose.

LIKELY FIRST MEASURES

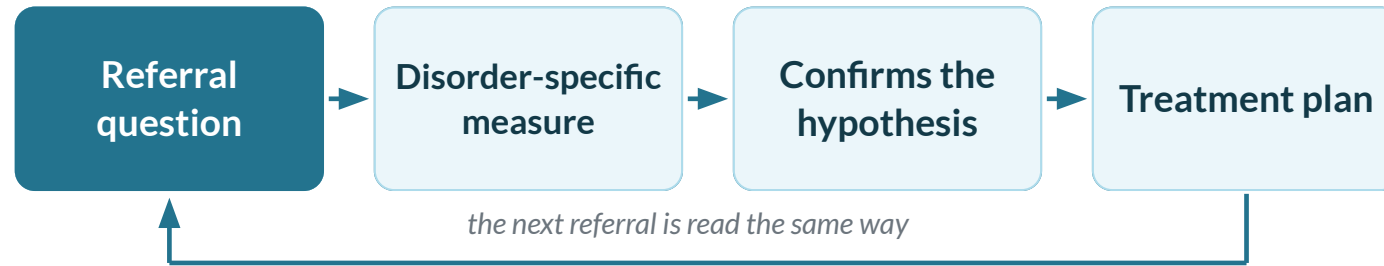
DASS-21

PCL-5

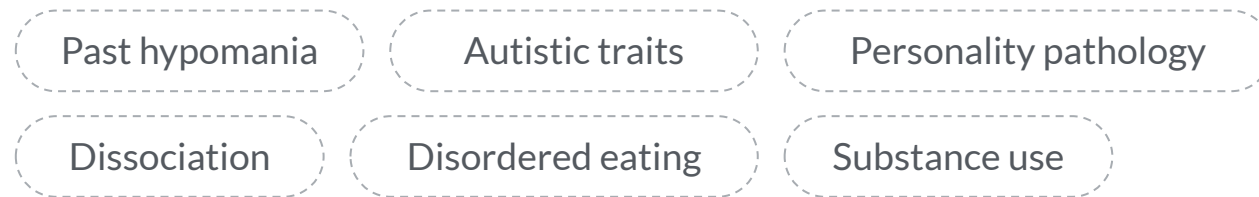
Tell us in the chat or write down which measures you would send each of them before the first session.

We tend to find what we look for

The confirmation loop



OUTSIDE THE LOOP



Every step in the loop is reasonable. The problems we never ask about stay hidden.

What the evidence says

 Clinicians record fewer co-occurring diagnoses in routine interviews than in structured interviews (Zimmerman & Mattia, 1999).

 We tend to anchor on the presenting problem and stop assessing too early. Both lead to diagnostic errors (Croskerry, 2003).

 A DASS-21 measures how depressed someone is. It has no items that ask whether they have ever been manic.

Narrow assessment can delay diagnosis by years

Years until the right diagnosis

OCD and ADHD
about 3 years

Stengler et al., 2013; Nylander et al., 2013

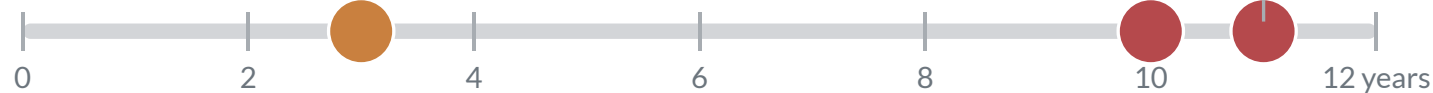
Bipolar disorder
10+ years for more than a third

Hirschfeld et al., 2003,

Autism in adults

median 11 years from first evaluation

Fusar-Poli et al., 2022



69%

of 600 people with bipolar disorder said they were first misdiagnosed. The most common wrong diagnosis was unipolar depression.

4

doctors, on average, saw each misdiagnosed person before one got it right.

*Hirschfeld et al., 2003,
as cited in Nusslock & Frank, 2011*

Three things make diagnoses easy to miss



Disorders often occur together



The US National Comorbidity Survey Replication looked at people with a disorder in the past year. Of those people, 45% met criteria for two or more.

Kessler et al., 2005



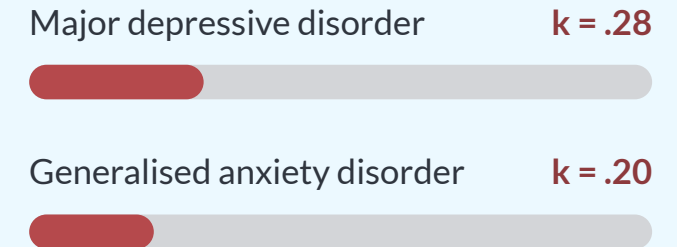
Most measures check for one disorder

- DASS-21** depression, anxiety, stress
- GAD-7** generalised anxiety
- ASRS** adult ADHD
- PCL-5** PTSD

A disorder-specific measure works when you already know what to look for. It helps you confirm a diagnosis and track change. It won't tell you what else is going on.



Diagnostic boundaries are blurry



In the DSM-5 field trials, two clinicians assessed the same patient. These kappas show how well they agreed. The authors rated .20 to .39 as questionable.

Regier et al., 2013

The same client can end up with different diagnoses

Each numbered peg is a chance event

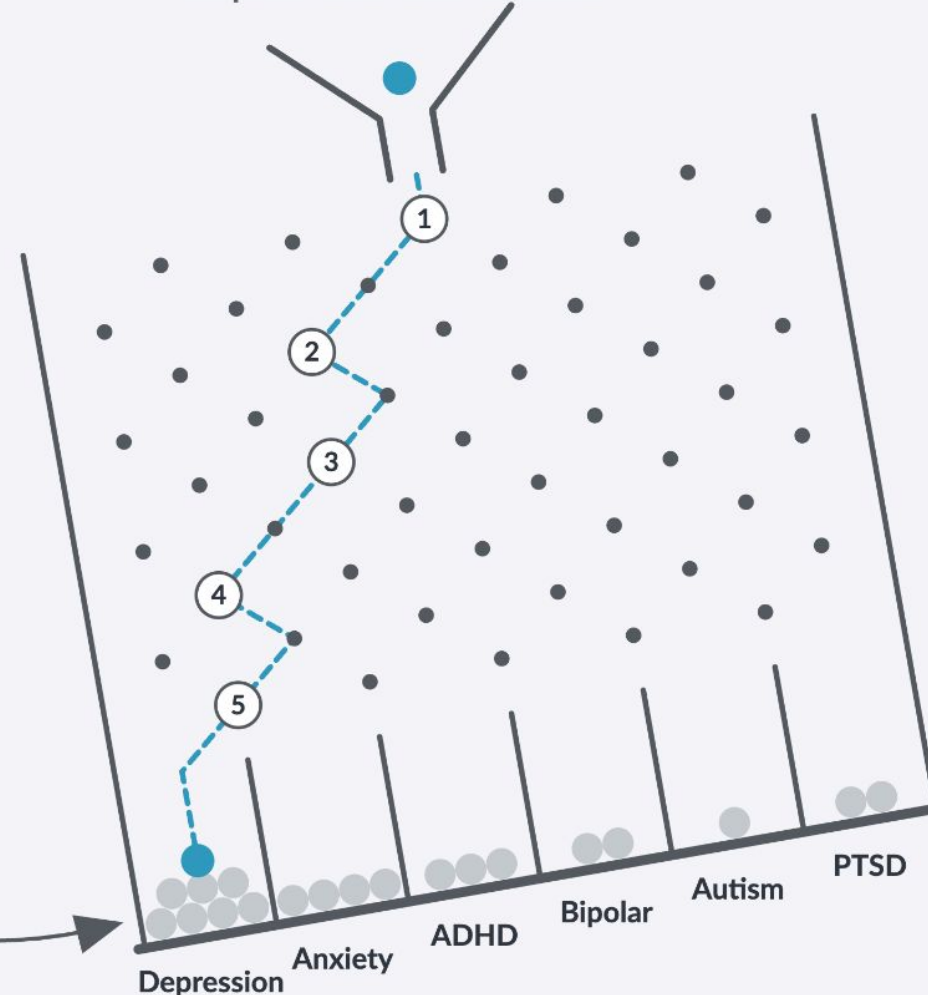
- ① Which clinician they see first
- ② What the referral letter says
- ③ Which measure gets sent
- ④ Their mood on the day
- ⑤ What they choose to mention

On the board

--- One drop, traced

The referral question
tilts the board

Drop the same client 20 times



The referral sets the direction

We choose a measure that matches the referral, and it usually confirms it.

Same client, different slots

Two clinicians assessing the same patient agreed on depression with $\kappa = .28$ (Regier et al., 2013).

One ball, one slot

Of people with a disorder in the past year, 45% met criteria for two or more (Kessler et al., 2005).

What if we could check every slot?

Start broad, then go deep

Generate
hypotheses

1 Broad assessment

Which areas cause this person the most difficulty?
B-HiTOP · MAPsy

Test
hypotheses

2 Targeted measures

Is it this disorder, and how severe is it?
MDQ · ASRS · PCL-5 · RAADS-R

3 Interview and formulation

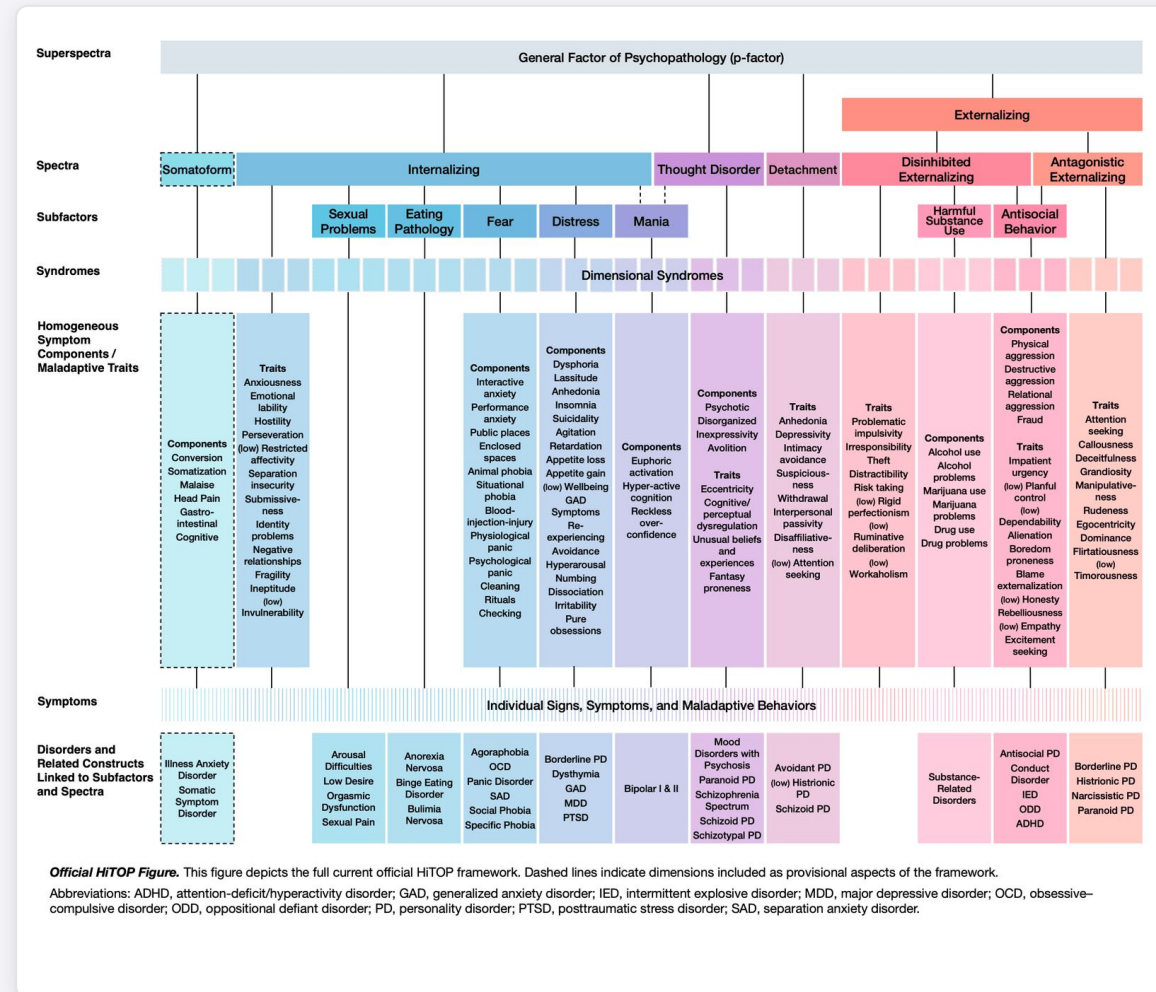
Ask about onset, course, impairment,
exclusions and context.

Q In practice

Many clinicians start at step 2. They choose a measure to match the referral question.

A scientist-practitioner generates rival hypotheses before testing any one of them.

The Hierarchical Taxonomy of Psychopathology (HiTOP)



It is dimensional

Psychopathology varies continuously. Clinicians decide where to set a threshold.



It is hierarchical

Broad spectra sit at the top. Subfactors, syndromes and specific symptoms sit below them. You can read a client's results at the level of detail you need.



It explains co-occurrence

Depression and anxiety both belong to the Internalising spectrum. We should expect them to occur together.

Figure: official HiTOP model, hitop-system.org, licensed under CC BY 4.0. Kotov et al. (2017).

The B-HiTOP gives a quick profile of the spectra

Brief Hierarchical Taxonomy of Psychopathology (B-HiTOP)

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

Example B-HiTOP results page, NovoPsych report



It has 45 items and takes about 8 minutes. It is for adults 18+.



It scores six spectra: Internalising, Somatoform, Detachment, Thought Disorder, Disinhibition and Antagonism.



It also scores two secondary scales: Externalising and the p-factor.



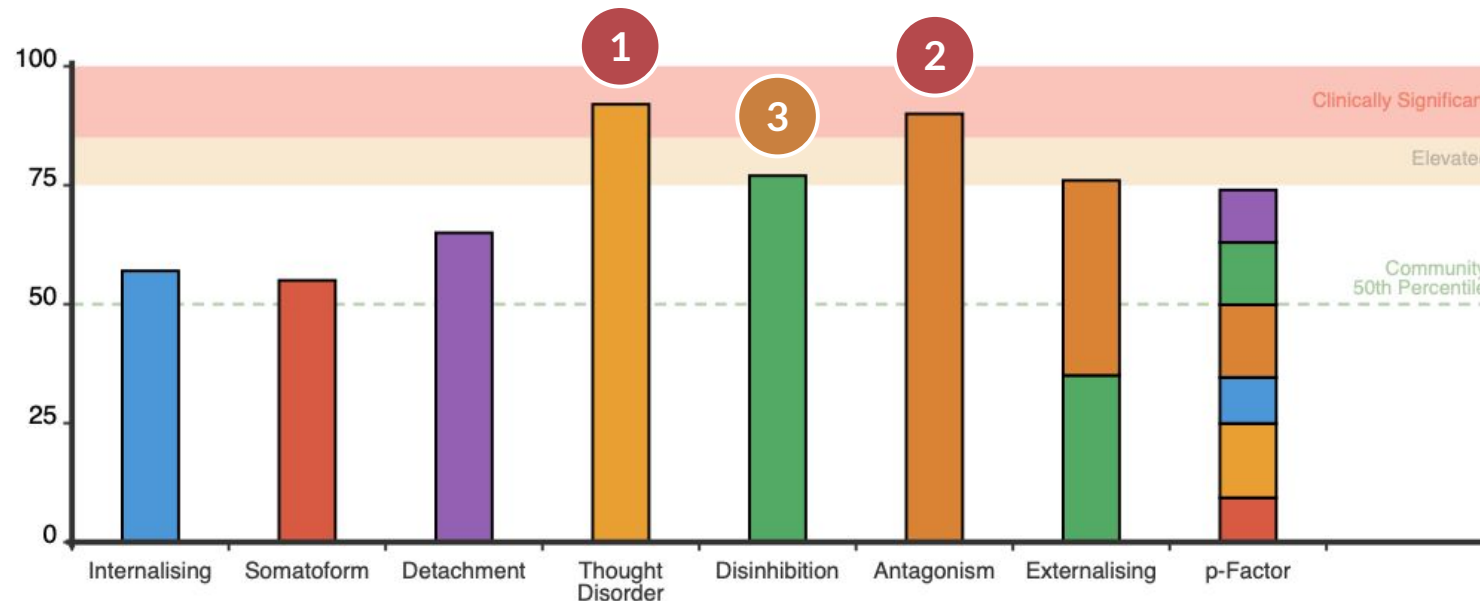
It reports community percentiles. Scores from the 75th percentile are Elevated, and scores from about the 85th are Clinically Significant.



The HiTOP Consortium developed it, and it is available on NovoPsych.

The profile shows us where to look

B-HiTOP Spectra and Secondary Scale Percentiles



Example B-HiTOP percentile profile

- 1 Thought Disorder**
92nd • Clinically Significant
- 2 Antagonism**
90th • Clinically Significant
- 3 Disinhibition**
77th • Elevated

The p-factor is at the 74th percentile. The client's overall difficulty is in the normal range.

The next question is what kind of Thought Disorder this is.

One spectrum score can mean several different things



Example items from three different B-HiTOP Thought Disorder scales (HiTOP Consortium, 2025).

One diagnosis can describe very different people

These two clients both meet criteria for major depressive disorder

	Client A	Client B
Depressed mood	☒	☒
Loss of interest or pleasure	☐	☒
Appetite or weight change	☒	☐
Sleep change	☒	☐
Psychomotor change	☒	☐
Fatigue	☒	☐
Worthlessness or guilt	☐	☒
Poor concentration	☐	☒
Thoughts of death or suicide	☐	☒

Each client has five of the nine symptoms. They share only one.

1,030

unique symptom profiles appeared among 3,703 outpatients with depression. The most common profile applied to just 1.8% of them.

*Fried & Nesse, 2015 (STAR*D)*

What do our diagnostic labels hide? And what happens when researchers rebuild the classification from the symptoms up?



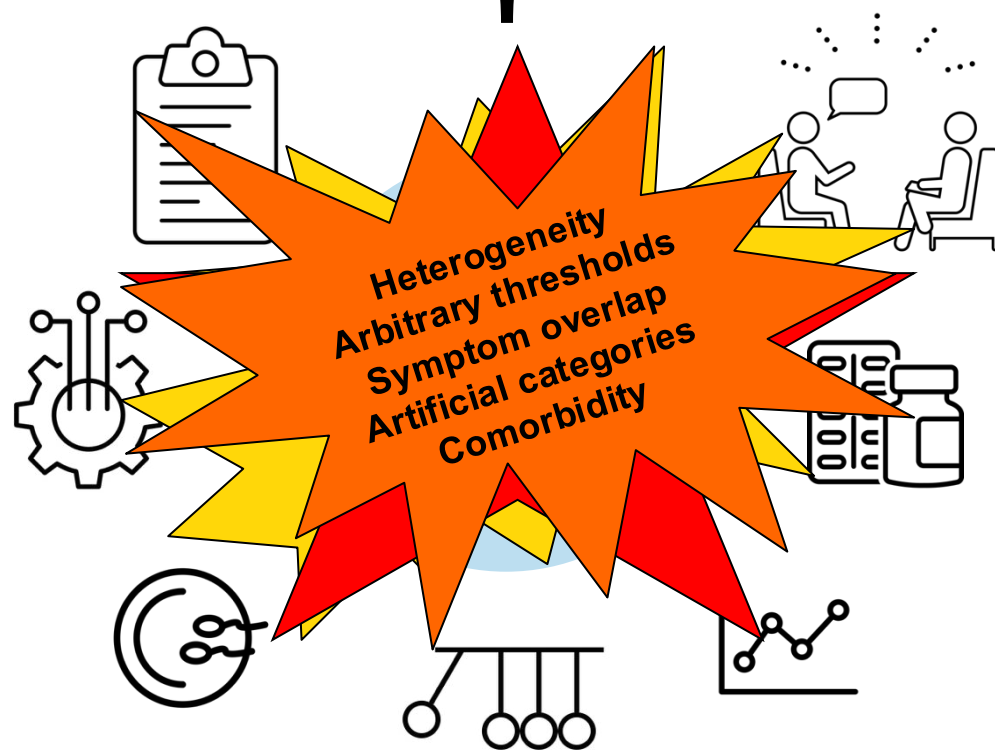
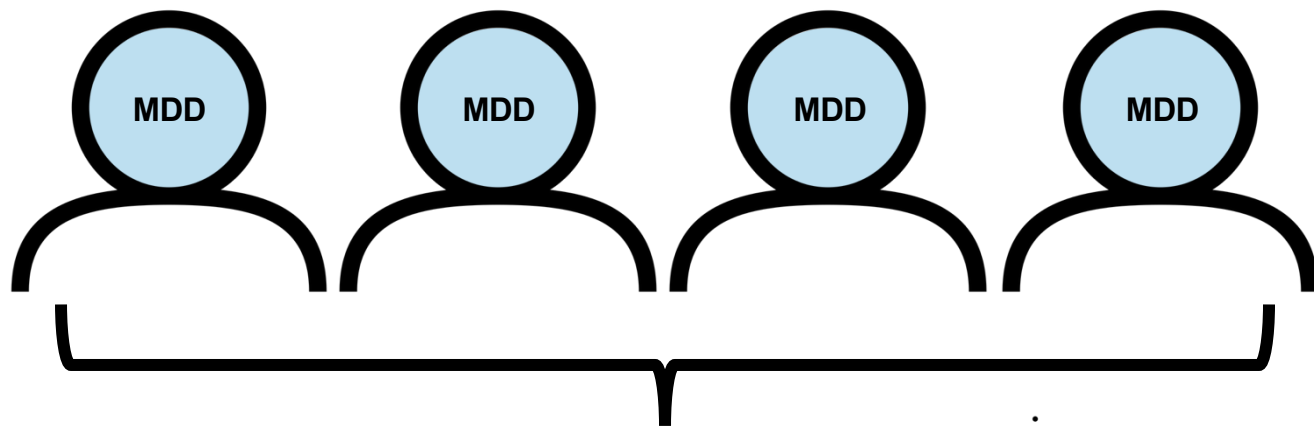
RECONSTRUCTING PSYCHOPATHOLOGY

A DATA-DRIVEN REORGANIZATION OF THE SYMPTOMS IN DSM-5

Miriam K. Forbes, Ph.D.

School of Psychological Sciences, Macquarie University

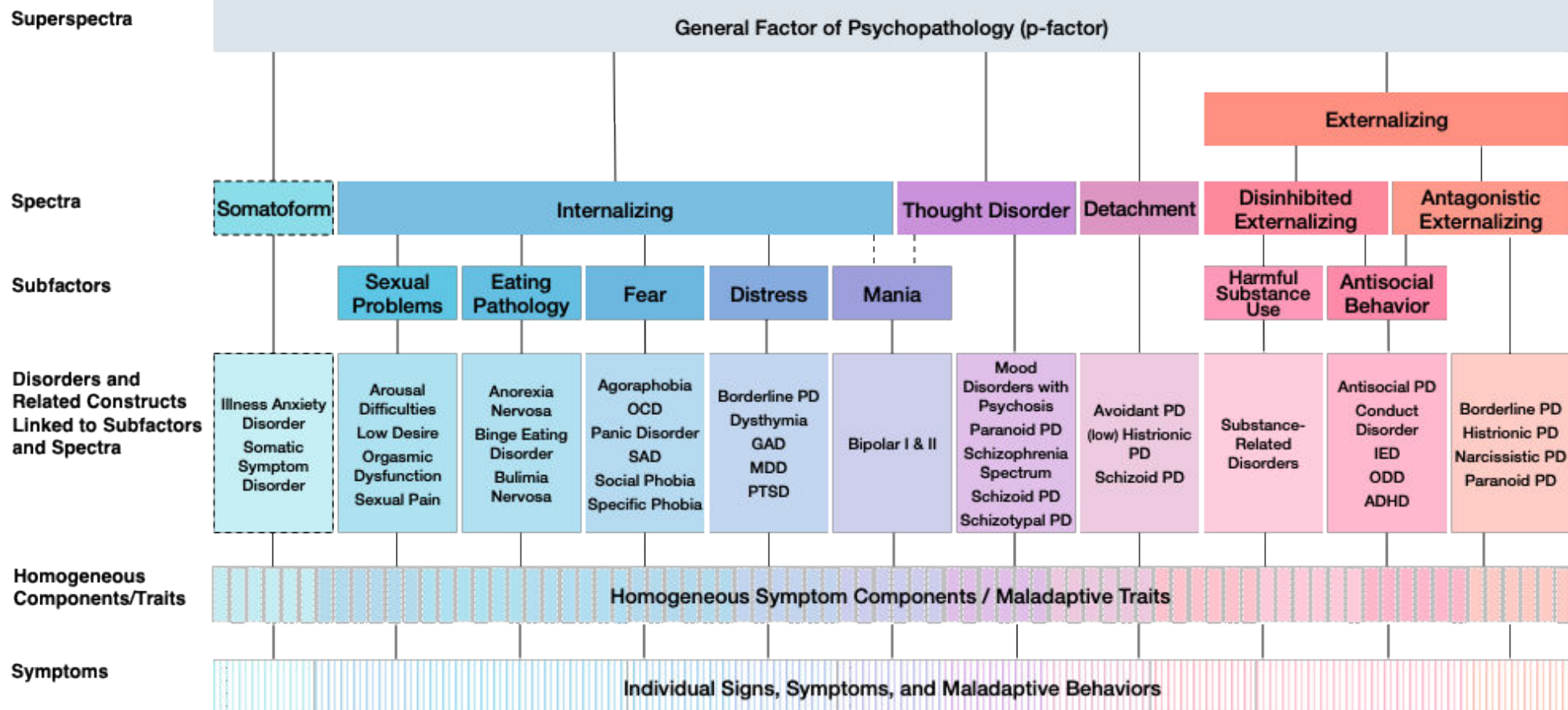


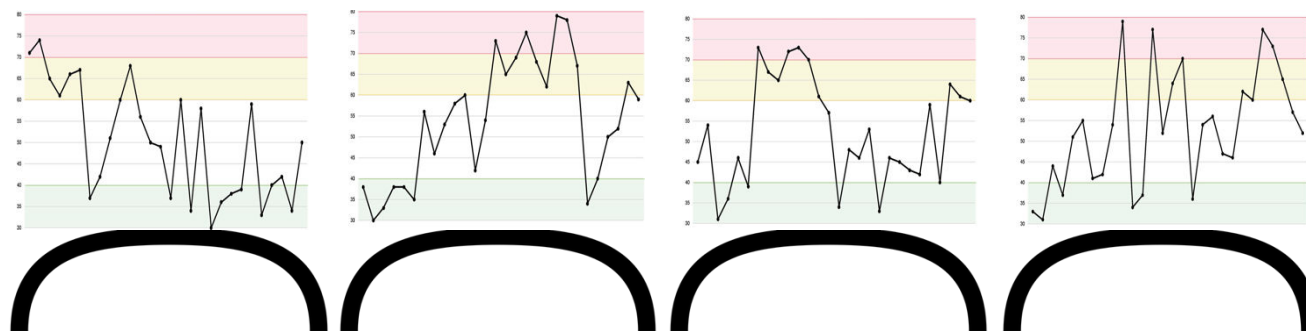
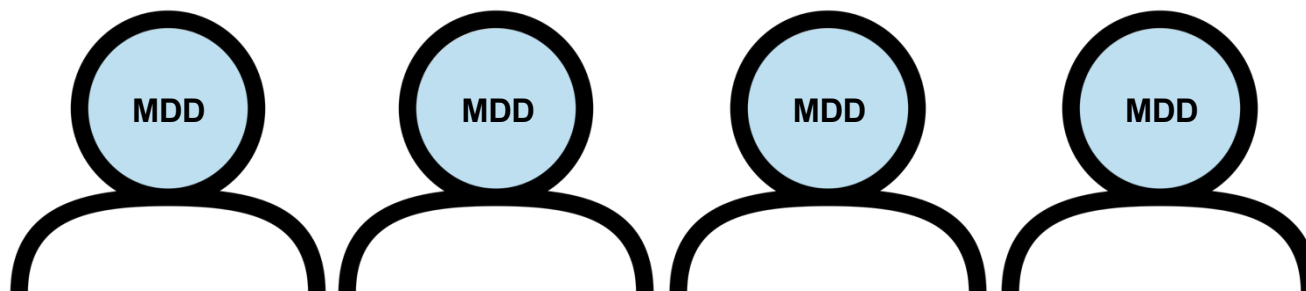
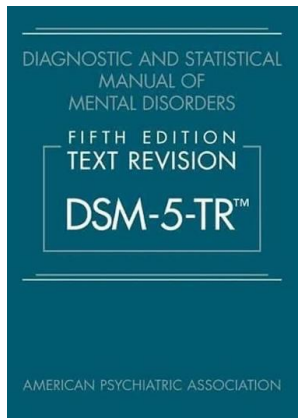




HiTOP

Hierarchical Taxonomy
of Psychopathology







HiTOP

Hierarchical Taxonomy
of Psychopathology

Superspectra

General Factor of Psychopathology (p-factor)

Spectra

Somatoform

Internalizing

Thought Disorder

Detachment

Externalizing

Disinhibited
Externalizing

Antagonistic
Externalizing

Subfactors

Sexual
Problems

Eating
Pathology

Fear

Distress

Mania

Harmful
Substance
Use

Antisocial
Behavior

Disorders and
Related Constructs
Linked to Subfactors
and Spectra

Illness Anxiety
Disorder
Somatic
Symptom
Disorder

Arousal
Difficulties
Low Desire
Orgasmic
Dysfunction
Sexual Pain

Anorexia
Nervosa
Binge Eating
Disorder
Bulimia
Nervosa

Agoraphobia
OCD
Panic Disorder
SAD
Social Phobia
Specific Phobia

Borderline PD
Dysthymia
GAD
MDD
PTSD

Bipolar I & II

Mood
Disorders with
Psychosis
Paranoid PD
Schizophrenia
Spectrum
Schizoid PD
Schizotypal PD

Avoidant PD
(low) Histrionic
PD
Schizoid PD

Substance-
Related
Disorders

Antisocial PD
Conduct
Disorder
IED
ODD
ADHD

Borderline PD
Histrionic PD
Narcissistic PD
Paranoid PD

Homogeneous
Components/Traits

Homogeneous Symptom Components / Maladaptive Traits

Symptoms

Individual Signs, Symptoms, and Maladaptive Behaviors

Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from

Order in the DSM-5	DSM-5 Chapter	DSM-5 Disorder	Constituent symptom (wording from DSM-5)
307	Ch4 - Depressive Disorders	Major Depressive Disorder	Depressed mood
308	Ch4 - Depressive Disorders	Major Depressive Disorder	Diminished interest in all, or almost all, activities
309	Ch4 - Depressive Disorders	Major Depressive Disorder	Diminished pleasure in all, or almost all, activities
310	Ch4 - Depressive Disorders	Major Depressive Disorder	Significant weight loss
311	Ch4 - Depressive Disorders	Major Depressive Disorder	Significant weight gain
312	Ch4 - Depressive Disorders	Major Depressive Disorder	Decrease in appetite
313	Ch4 - Depressive Disorders	Major Depressive Disorder	Increase in appetite
314	Ch4 - Depressive Disorders	Major Depressive Disorder	Insomnia
315	Ch4 - Depressive Disorders	Major Depressive Disorder	Hypersomnia
316	Ch4 - Depressive Disorders	Major Depressive Disorder	Psychomotor agitation
317	Ch4 - Depressive Disorders	Major Depressive Disorder	Psychomotor retardation
318	Ch4 - Depressive Disorders	Major Depressive Disorder	Fatigue or loss of energy
319	Ch4 - Depressive Disorders	Major Depressive Disorder	Feelings of worthlessness
320	Ch4 - Depressive Disorders	Major Depressive Disorder	Feelings of inappropriate or excessive guilt (which may be delusional)
321	Ch4 - Depressive Disorders	Major Depressive Disorder	Diminished ability to think or concentrate
322	Ch4 - Depressive Disorders	Major Depressive Disorder	Indecisiveness
323	Ch4 - Depressive Disorders	Major Depressive Disorder	Thoughts of death (not just fear of dying)
324	Ch4 - Depressive Disorders	Major Depressive Disorder	Suicidal ideation without a specific plan
325	Ch4 - Depressive Disorders	Major Depressive Disorder	Suicide attempt
326	Ch4 - Depressive Disorders	Major Depressive Disorder	Specific plan for committing suicide

observed by others).

1516 symptoms → 711 unique symptoms

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, a specific suicide plan; or a suicide attempt.

Developing the item pool

Rewrote symptoms into items

- First person, past tense

Readability testing

- Readability calculators-->revisions
- Two pilots with first-year psychology students-->revisions
- Used simpler terms, added DSM-5 examples
- Kept as close as possible to DSM-5 phrasing

Expert review

- 16 experts in psychopathology measurement
- Rated fit, clarity, assumptions, memory demands, bias
- Wording revised where needed, then a final pilot

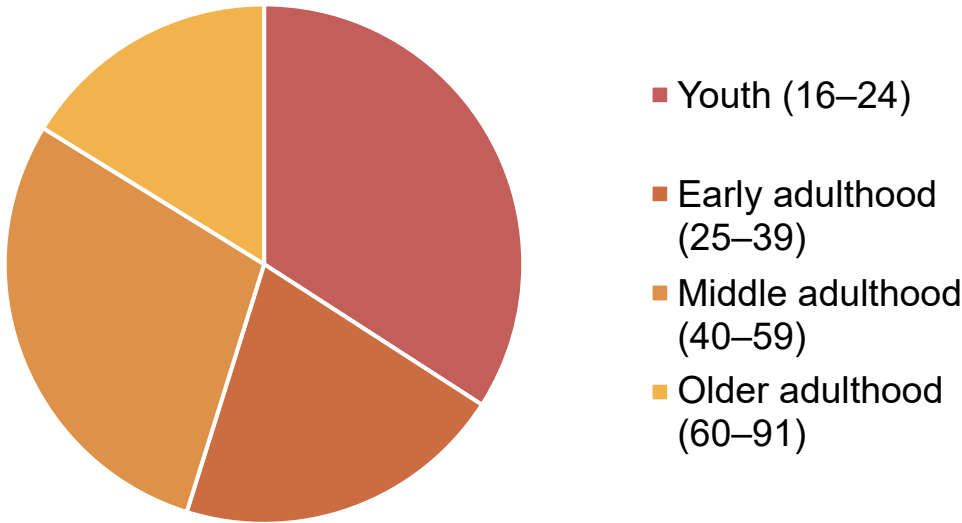
711 unique symptoms → 680 items

Developing the item pool

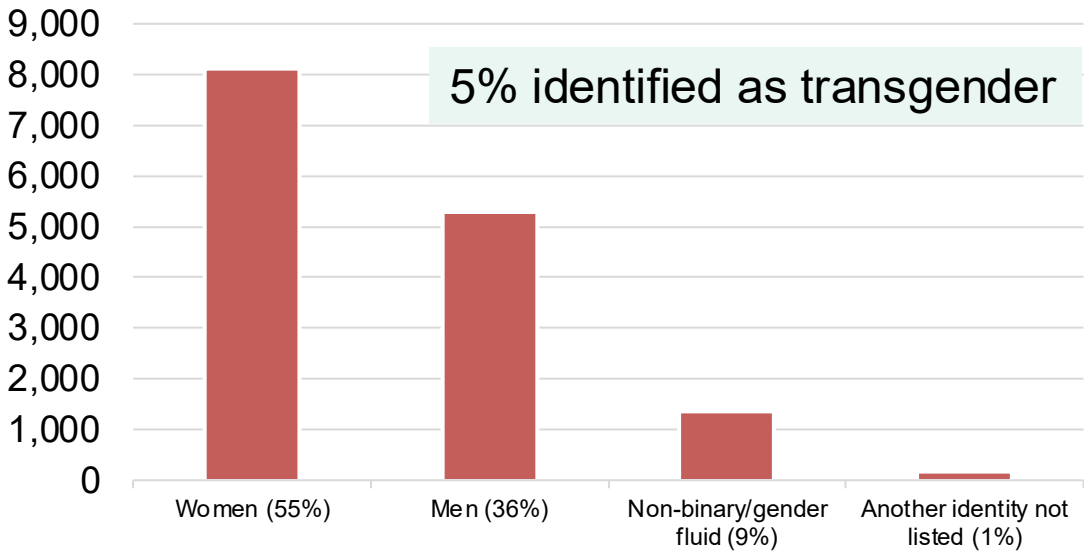
Constituent symptom (wording from DSM-5)	Survey item
Depressed mood	I felt depressed (e.g., sad, miserable, or hopeless).
Diminished interest in all, or almost all, activities	I lost interest in my usual activities (e.g., work, study, friends, hobbies).
Diminished interest in all, or almost all, activities	I lost interest in things that I usually enjoy.
Diminished pleasure in all, or almost all, activities	I experienced less pleasure from life than usual.
Significant weight loss	I lost more than a few kilograms.
Significant weight gain	I gained more than a few kilograms.
Decrease in appetite	I had a smaller appetite than usual.
Increase in appetite	I had a bigger appetite than usual.
Insomnia	I had trouble falling asleep, staying asleep, or getting back to sleep.
Hypersomnia	I had trouble staying awake during the day even after getting enough sleep (e.g., sleeping for at least 7 hours at night).
Psychomotor agitation	I moved a lot without purpose (e.g., pacing, fidgeting, wringing my hands, or pulling my clothes).
Psychomotor retardation	I felt slowed down (e.g., thinking or moving slowly).
Psychomotor retardation	Others told me I seemed slowed down (e.g., moving or talking slowly).
Fatigue or loss of energy	I was easily fatigued or felt like I had less energy than usual.
Feelings of worthlessness	I felt worthless.
Feelings of inappropriate guilt (which may be delusional)	I felt guilty when I hadn't done anything wrong.
Feelings of excessive guilt (which may be delusional)	I felt very guilty about something small.
Diminished ability to think or concentrate	I found it harder than usual to think or concentrate.
Indecisiveness	I found it difficult to make decisions.
Thoughts of death (not just fear of dying)	I thought about death.
Suicidal ideation without a specific plan	I thought about killing myself, but didn't have a specific plan to do it.
Suicide attempt	I attempted suicide.
Specific plan for committing suicide	I had a specific plan for killing myself.
Depressed mood	I felt depressed (e.g., sad, miserable, or hopeless).

Demographics in the analytic sample (n = 14,762)

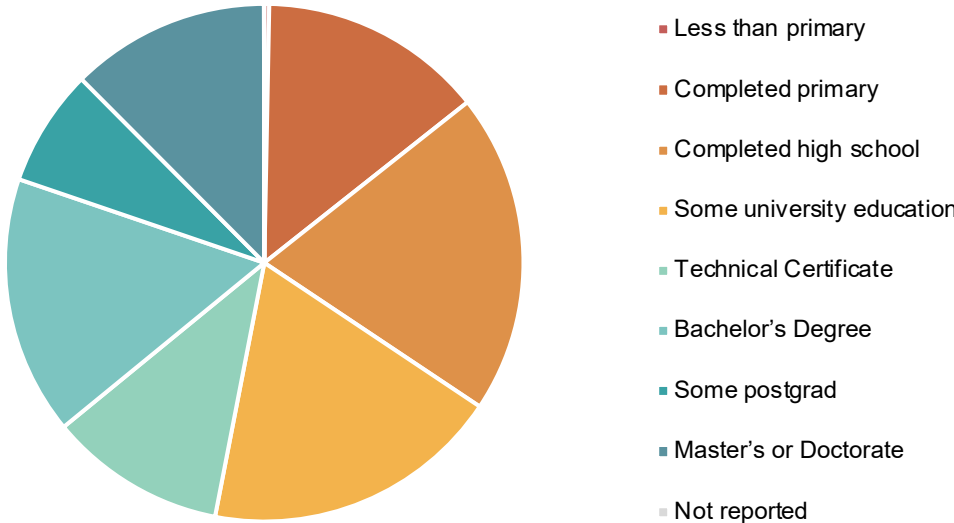
Age



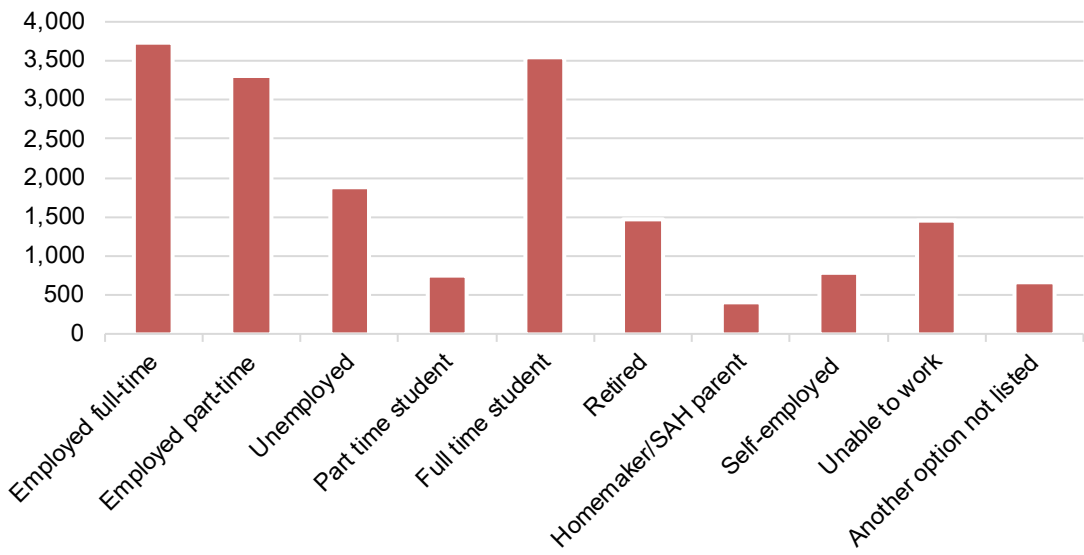
Gender



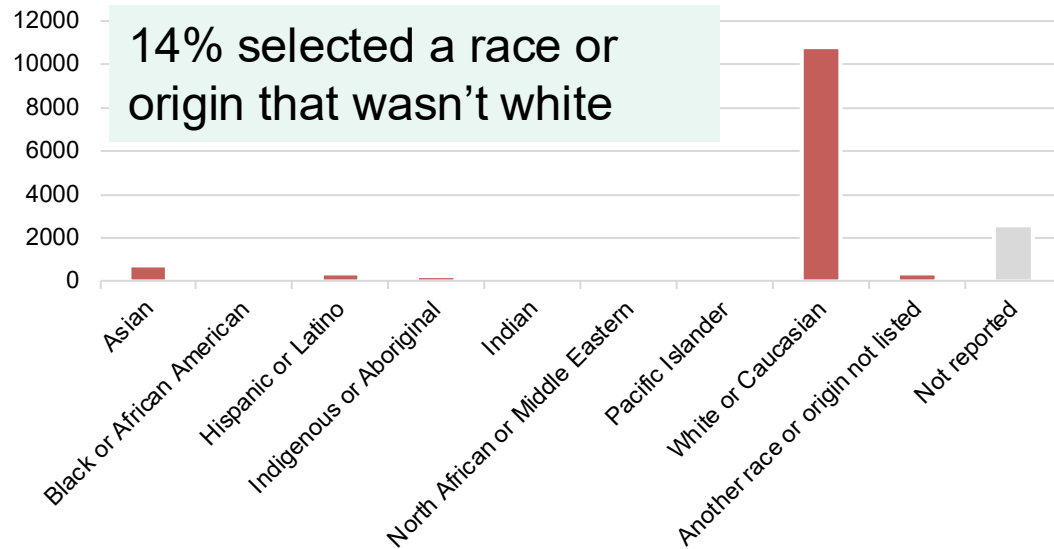
Education



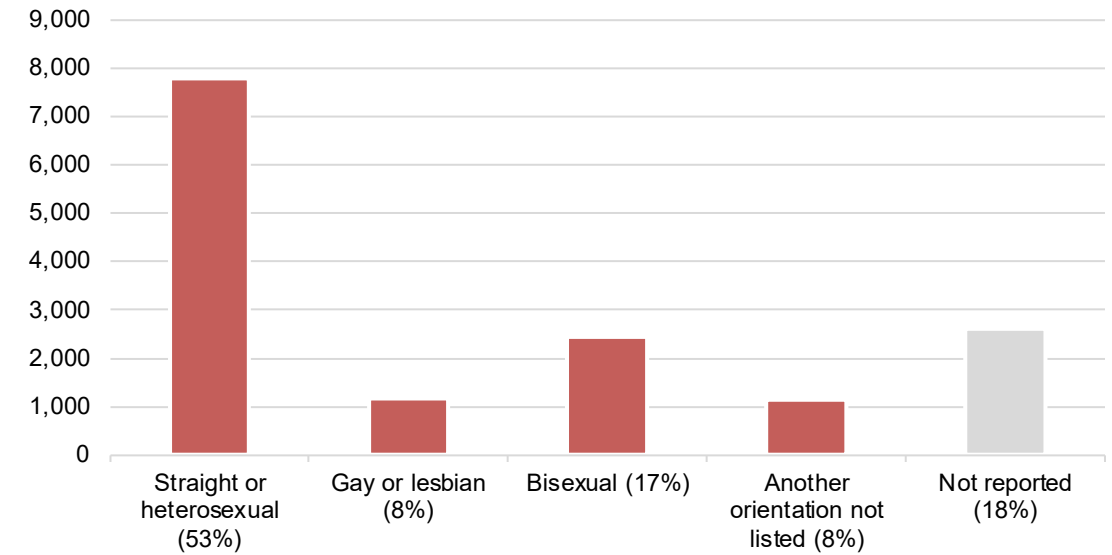
Employment Status



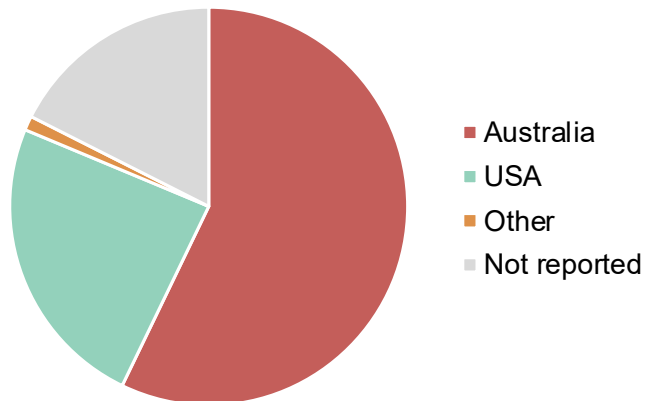
Race or Origin



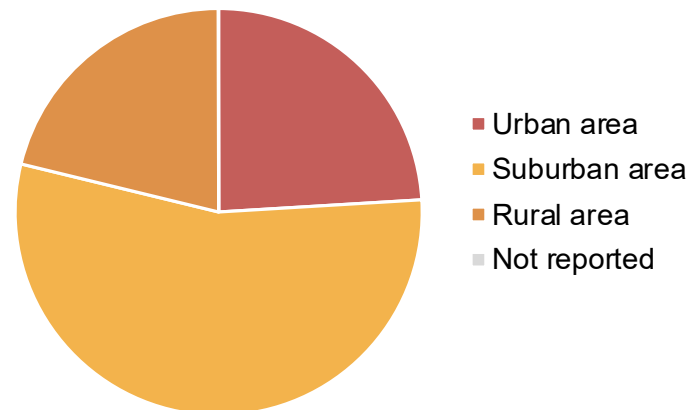
Sexual Orientation



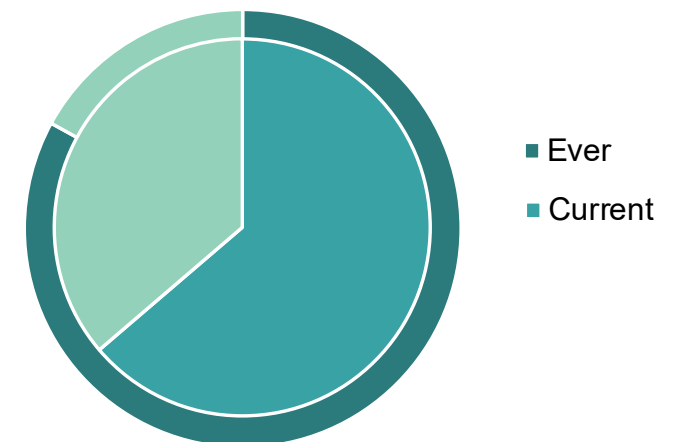
Country of Residence



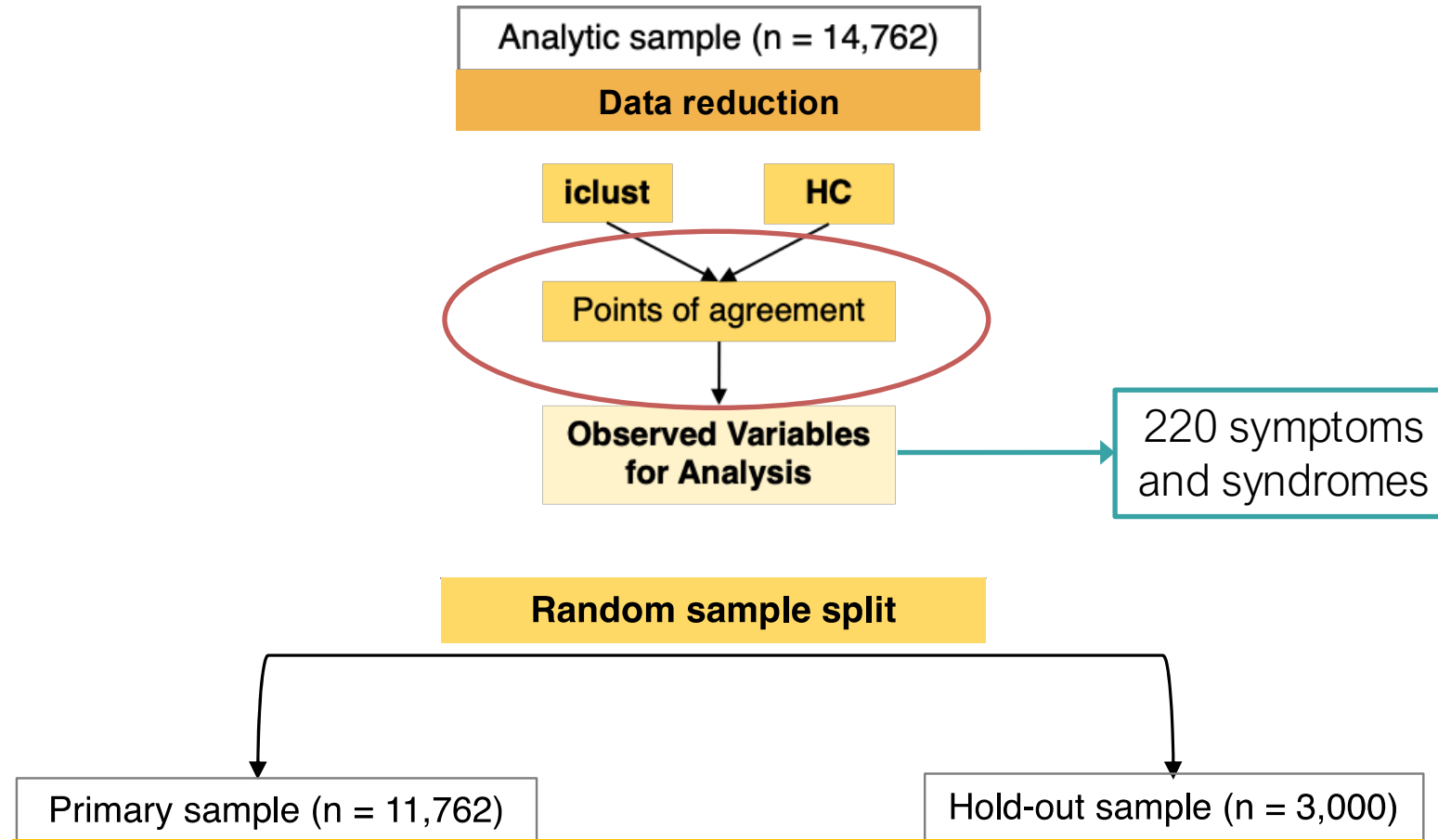
Residential Area Type



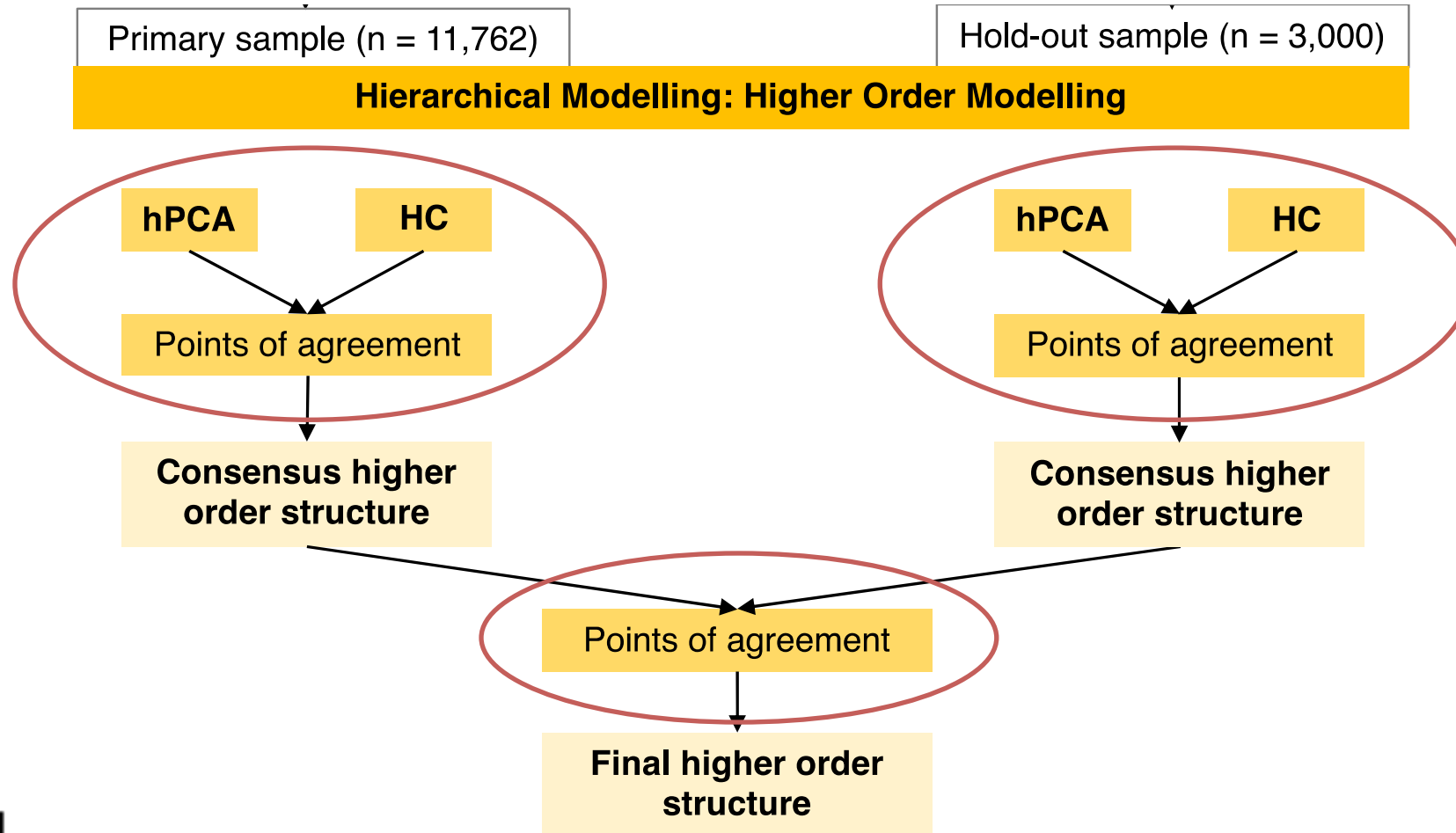
Treatment for Mental Health



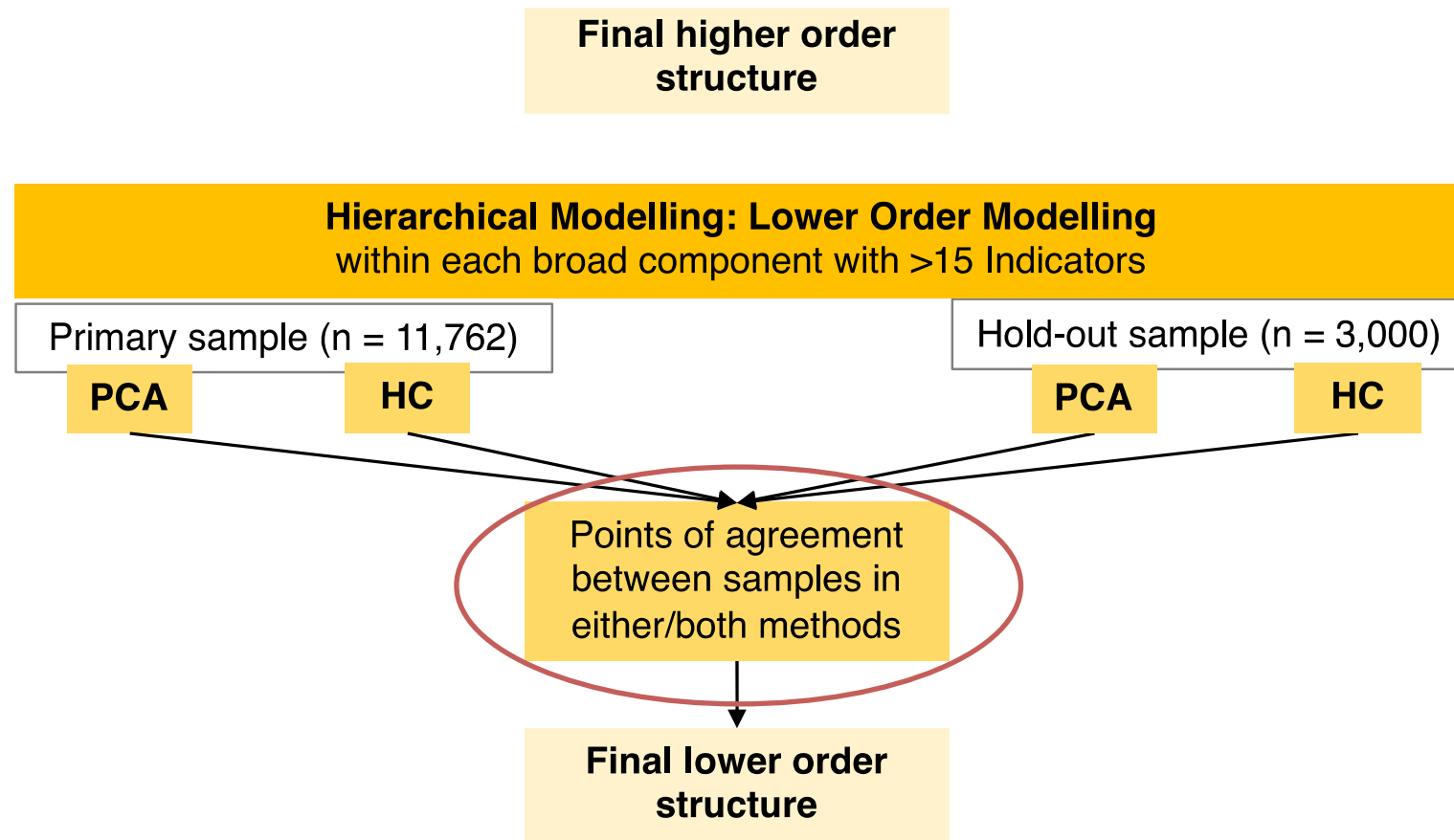
Methods



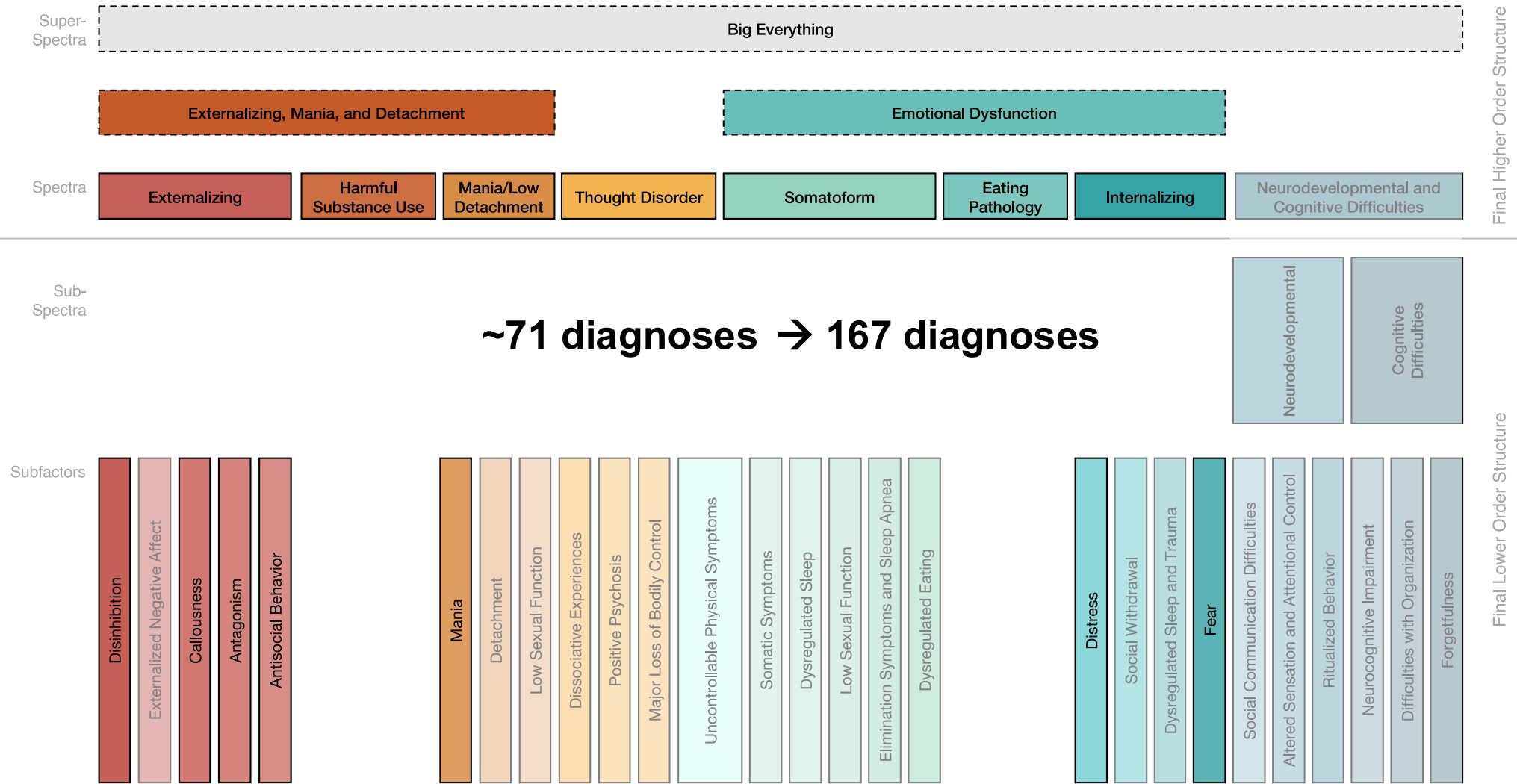
Methods



Methods



A quantitative symptom-level model



Notably Homogeneous Disorders | Notably Heterogeneous Disorders

DSM

Dimensional Model

Dimensional Model

Dimensional Model

DSM

Intermittent Explosive Disorder
Oppositional Defiant Disorder
Conduct Disorder

Externalized Negative Affect
Antisocial Behavior
Antagonism
Disinhibited Externalizing
Callousness

Externalizing

Externalized Negative Affect
Antisocial Behavior
Antagonism
Disinhibited Externalizing
Callousness

Male Hypoactive Sexual Desire Disorder
Female Sexual Interest/Arousal Disorder
Delayed Ejaculation
Erectile Disorder
Female Orgasmic Disorder
Genito-Pelvic Pain/Penetration Disorder

Mania
Low Sexual Function

Mania/
Low Detachment

Mania
Detachment

Illness Anxiety Disorder
Somatic Symptom Disorder

Somatic Symptoms
Dysregulated Sleep

Somatoform

Dissociative Experiences
Positive Psychosis
Major Loss of Body Control

Uncontrollable Physical Symptoms
Dysregulated Sleep
Dysregulated Eating

Binge-Eating Disorder
Bulimia Nervosa
Anorexia Nervosa

Eating Pathology

Unassigned

Unassigned

Agoraphobia
Separation Anxiety Disorder
Social Anxiety Disorder
Specific Phobia

Distress
Social Withdrawal
Fear

Internalizing

Distress
Social Withdrawal
Sleep Problems and Trauma
Fear

Neurodevelopmental

Ritualized Behavior
Social Communication Difficulties
Altered Sensation and
Attentional Control

Cognitive Difficulties

Forgetfulness
Neurocognitive Impairment

Neurocognitive Impairment

Neurocognitive Domains - Executive function
Neurocognitive Domains - Complex attention

Manic Episode

Schizophrenia

Major Depressive Disorder

Posttraumatic Stress Disorder

Autism Spectrum Disorder

Attention-Deficit/Hyperactivity Disorder

Neurocognitive Domains - Social cognition

DSM Disorders

Subfactors

(Sub-)Spectra

Subfactors

DSM Disorders



Contact info:



miri.forbes@mq.edu.au



@miriforbes.bsky.social

Funders:



MACQUARIE
University



Australian Government
National Health and
Medical Research Council



My brilliant co-authors!



Andrew Baillie

Phil Batterham

Alison Calear

Roman Kotov



Bob Krueger



Kristian Markon

Louise Mewton

Liz Pellicano



Matthew Roberts



Craig Rodriguez-Seijas

Matt Sunderland

David Watson

Ashley Watts



Aidan Wright



Lee Anna Clark

Building a clinical measure on Forbes et al.'s work

THE FOUNDATION

Reconstructing Psychopathology

Forbes et al. (2025)

- **DSM-5 symptoms**
Items written in the language of the DSM-5 symptoms
- **An empirical hierarchy**
The symptoms organised from narrow clusters up to broad spectra

One set of responses, read two ways

WHAT NOVOPSYCH DID

549

items in the starting pool

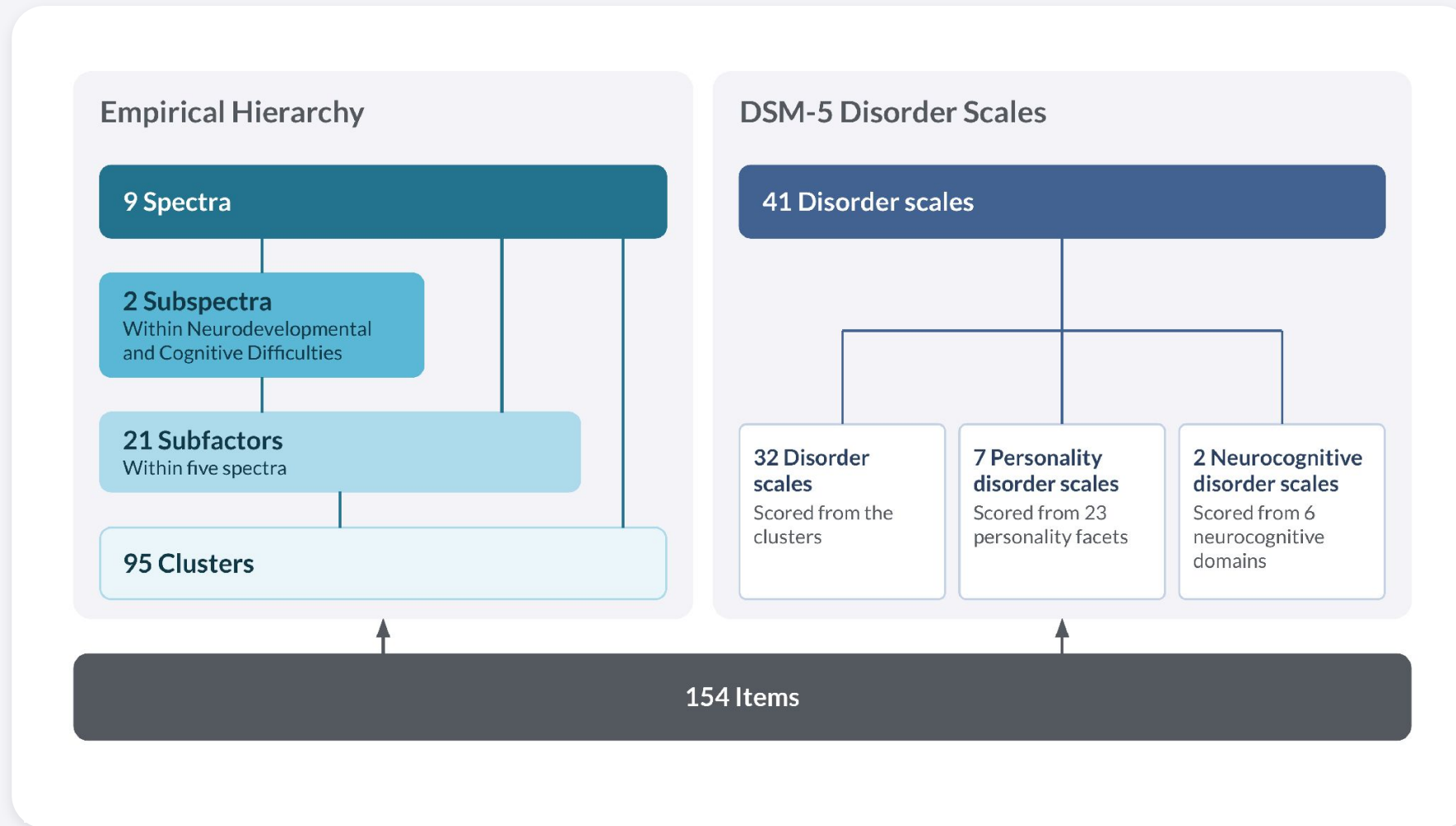


154

items in the MAPsy

- 1 **Chose the disorders**
Those most relevant to everyday clinical work
- 2 **Kept the best items**
Within each symptom cluster, the items that measure it best and read most clearly

Two lenses on the same responses



- **One measure**
Both frameworks are scored from the same 154 items
- **Side by side**
The two frameworks are shown together, not merged into one
- **Move between them**
Each disorder scale opens to the clusters, facets or domains it is scored from

What the two lenses add to clinical practice

DSM-5 DISORDER SCALES

The language we share

With colleagues, referrers and the treatment literature

EMPIRICAL HIERARCHY

The shape of the presentation

Where the weight of a client's difficulties lies, and why disorders co-occur

TOGETHER

See what's behind an elevated score

● Major Depressive Disorder • Clinically Significant

Client A

High mainly because of

- Depressed mood and anhedonia
- Guilt/shame proneness

**Sit within Distress
(Internalising)**

Client B

High mainly because of

- Insomnia
- Overeating
- General cognitive difficulties

**Sit mostly in Somatoform and
Neurocognitive Impairment**

Same score for MDD, but quite a different underlying picture.

Where the evidence stands

WHAT WE HAVE EXAMINED

- **Structure** The hierarchy is preserved in the 154 items
- **Agreement** Scores agree closely with the full 549-item pool
- **Reliability** Internal consistency is high at every level
- **Thresholds** Clinical review of every item; disorder scales anchored to population prevalence
- **Reference sample** 6,883 respondents recruited online and through community groups, not through clinics. Percentiles discriminate across the full range of severity

WHAT'S NEXT

Convergent validity

Against other established measures

Test-retest reliability

Stability when the measure is repeated

Sensitivity to change

Whether scores move as a client improves

An adaptive version

Fewer items for each client, without losing the quality of the scores

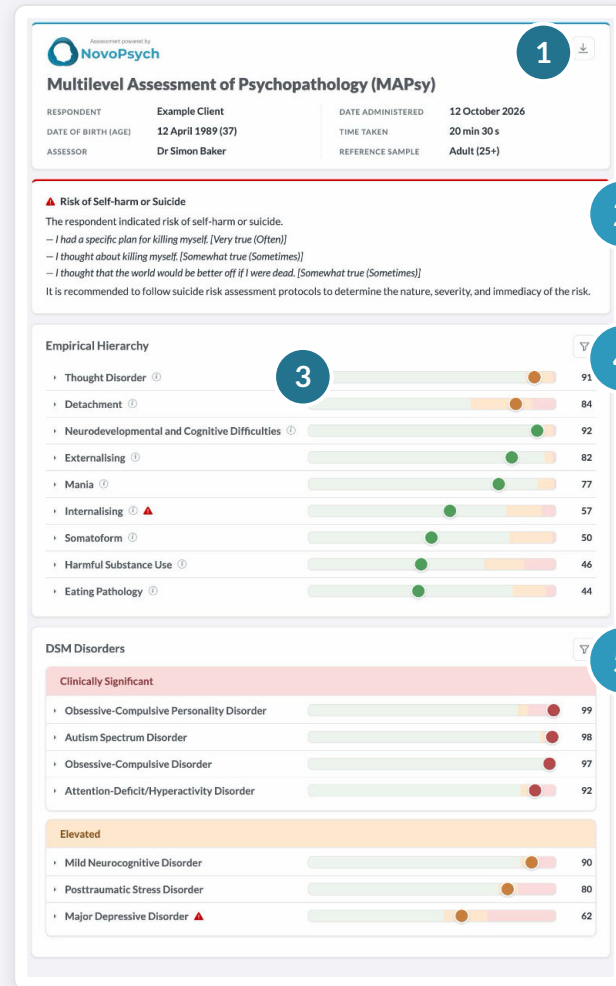
The MAPsy in practice

We look at three clients, their reports, and what to do when something flags

Dr David Hegarty



Here's how to read a MAPsy report



1 Client Details and reference sample
The report uses Youth (16–24) or Adult (25+) norms based on date of birth. You can change this in settings.

2 Risk of self-harm or suicide
This panel appears when a client endorses any of the four suicidality items. It lists each response.

3 Bars and dots
The bar shows the severity bands; the dot marks the client's percentile.

4 Empirical Hierarchy
It shows nine spectra. Each row opens down to the items and the client's responses.

5 DSM Disorders
It lists Clinically Significant scales, then Elevated ones. Open a scale to see what makes up its score.



Compare severity bands, not percentiles

Each scale has its own thresholds. A higher percentile doesn't always mean a higher band.

Here, Detachment is Elevated at the 84th percentile. Neurodevelopmental and Cognitive Difficulties is Not Elevated at the 92nd.

- Not Elevated
- Elevated
- Clinically Significant

Sam was referred for depression and social anxiety



Sam, 22

they/them • Youth reference sample

REFERRAL

The GP referred Sam for depression and social anxiety. Two courses of CBT, at school and university, didn't help much.

NOW

Sam deferred a computer science degree after failing second year and spends most days alone. Sam finds conversation “exhausting, like doing maths in real time”. The noise and lights in supermarkets are too much. Sam sleeps poorly and took an overdose seven months ago.

MUM SAYS

“Sam was always a bit different. We thought it was shyness.”

DSM Disorders

Clinically Significant

Autism Spectrum Disorder		97
Obsessive-Compulsive Personality Disorder		95
Social Anxiety Disorder (Social Phobia)		89
Mild Neurocognitive Disorder		88
Major Depressive Disorder		70

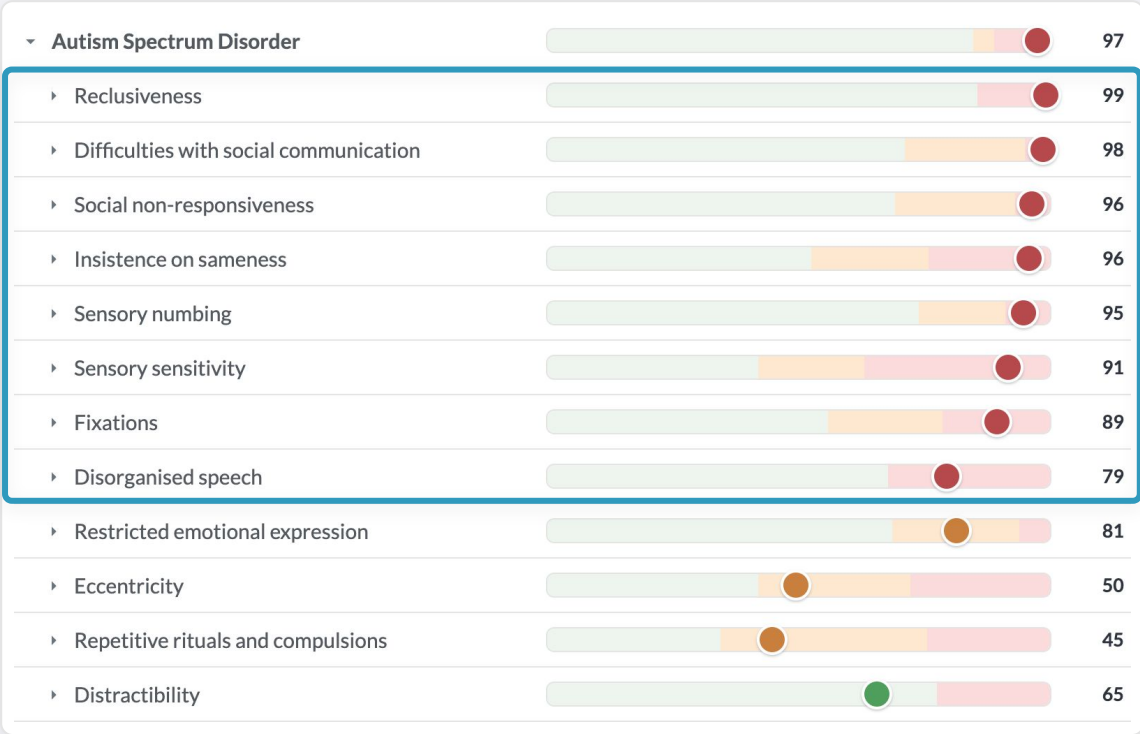
Elevated

Major Neurocognitive Disorder		88
Insomnia Disorder		62

- Detachment (88th) and Neurodevelopmental and Cognitive Difficulties (84th) are elevated.
- The Risk panel shows a suicide attempt and a plan.

Expand the scales before you interpret them

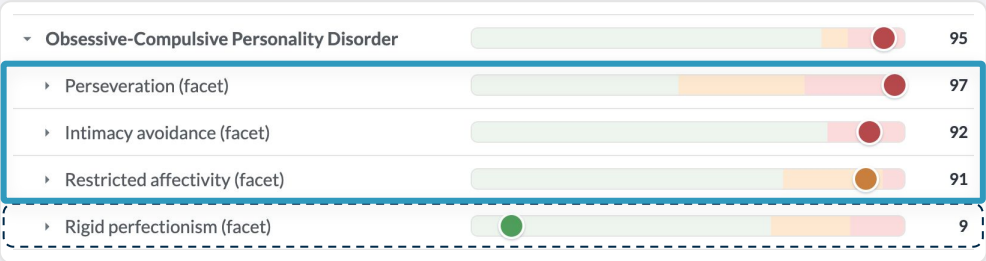
● Autism Spectrum Disorder • 97th



 Drive the high score Core features that are low

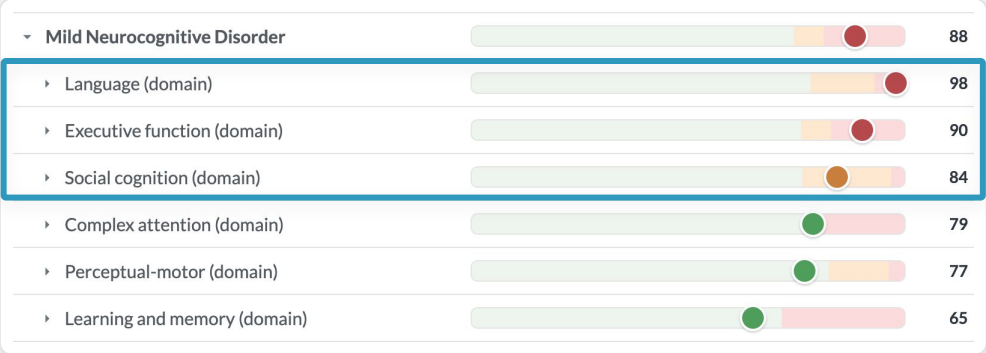
Sam scores high on both DSM-5 autism domains.

● Obsessive-Compulsive Personality Disorder • 95th



Rigid perfectionism is at the 9th percentile. The high score comes from facets that overlap with autistic traits.

● Mild Neurocognitive Disorder • 88th



These domains are high, but Sam is 22 and reports no decline. Read this as neurodevelopmental first.

Here's a plan for Sam

1 Check risk

Sam endorsed a suicide attempt and a specific plan. Complete a suicide risk assessment and a safety plan before anything else.

FROM THE REPORT

▲ Risk of Self-harm or Suicide
The respondent indicated risk of self-harm or suicide.
— I attempted suicide. [Perfectly true (Always)]
— I thought about killing myself. [Very true (Often)]
— I thought that the world would be better off if I were dead. [Very true (Often)]
— I had a specific plan for killing myself. [Somewhat true (Sometimes)]
It is recommended to follow suicide risk assessment protocols to determine the nature, severity, and immediacy of the risk.

2 Interview for what a questionnaire can't capture

- Take a developmental history, ideally with a parent. Ask about early social communication, play, routines and sensory responses.
- Ask whether Sam masks or camouflages in different settings.
- Ask whether Sam fears judgement or finds socialising too tiring.
- Check whether the cognitive difficulties are lifelong or new.

3 Choose measures

RAADS-R	autistic traits
CAT-Q	camouflaging
AQ	autism quotient
PHQ-9	depression baseline
AIS	insomnia



Formulation Build the formulation around the Detachment and Neurodevelopmental spectra. If the interview supports autism, then consider Sam for an autism diagnosis and adapt therapy to suit a neurodivergent client. The earlier CBT for social anxiety may have targeted the wrong problem.

Mark thinks he has adult ADHD



Mark, 42
he/him • Adult reference sample

REFERRAL

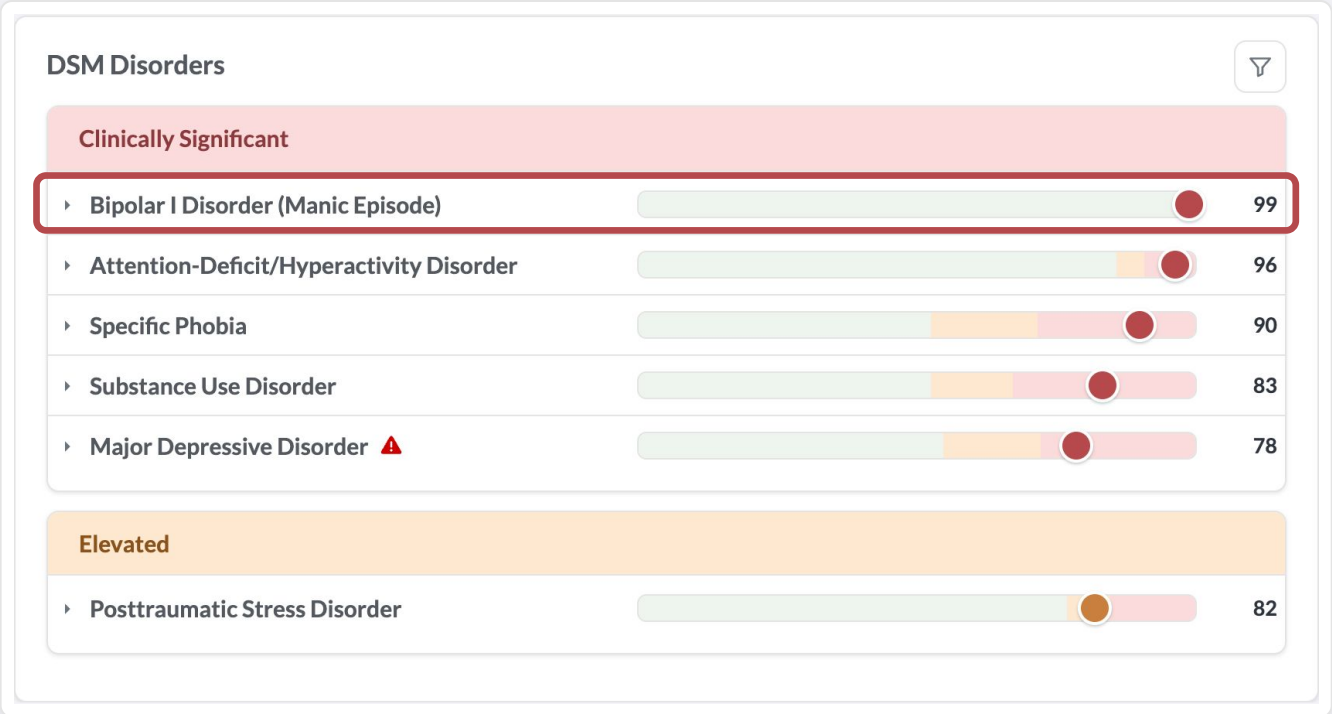
Mark referred himself for an adult ADHD assessment. “My mind races, I talk over people, and I start ten projects and finish none.”

HISTORY

His GP has treated him for depression for ten years. One antidepressant left him “wired, barely sleeping for a week”. He has spending sprees he regrets. He drinks most nights and uses cocaine at weekends. He diets, then binge eats.

HIS PARTNER SAYS

“Some months he’s the life of the party. Other months he can’t get off the couch.”



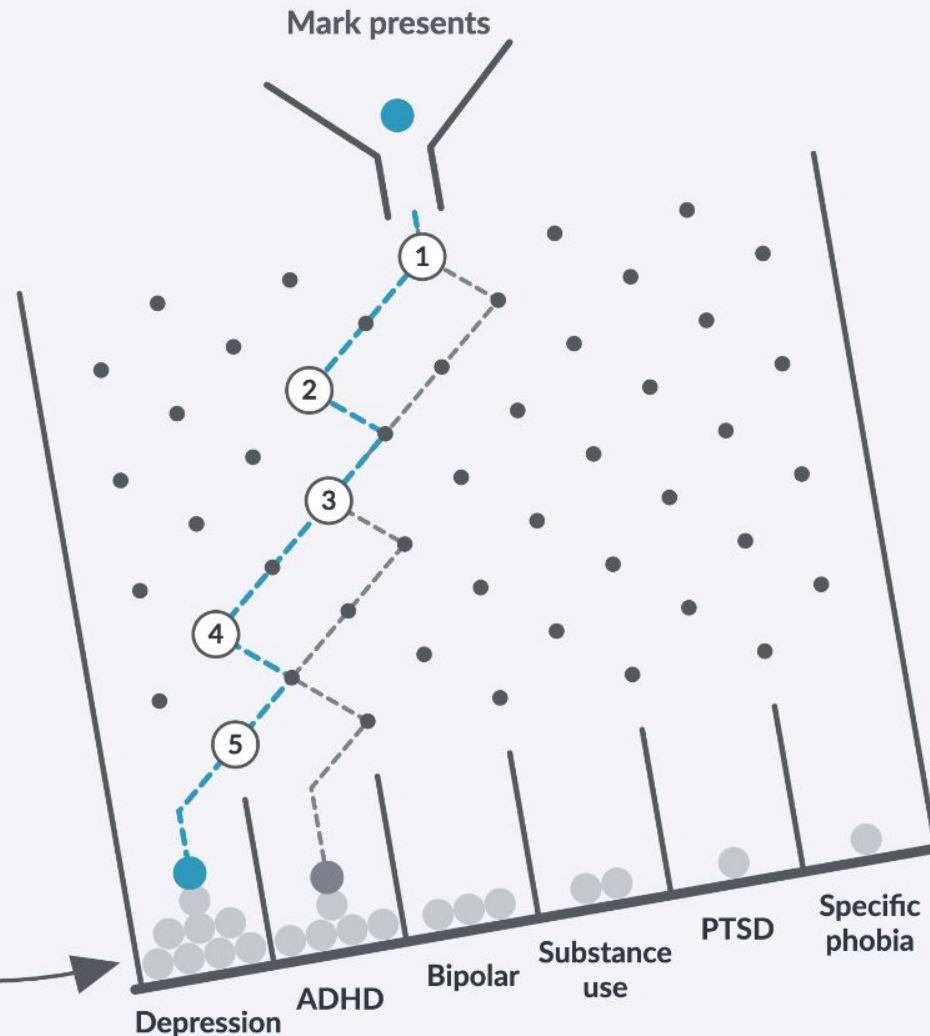
- Mania (97th), Eating Pathology (89th) and Harmful Substance Use (83rd) are elevated.
- ADHD is also Clinically Significant (96th)
- ⚠ The Risk panel shows suicidal thoughts and a plan.

- ① Which clinician they see first
- ② What the referral letter says
- ③ Which measure gets sent
- ④ Their mood on the day
- ⑤ What they choose to mention

--- Visit 1: GP

---- Visit 2: self-referral

The referral question tilts the board

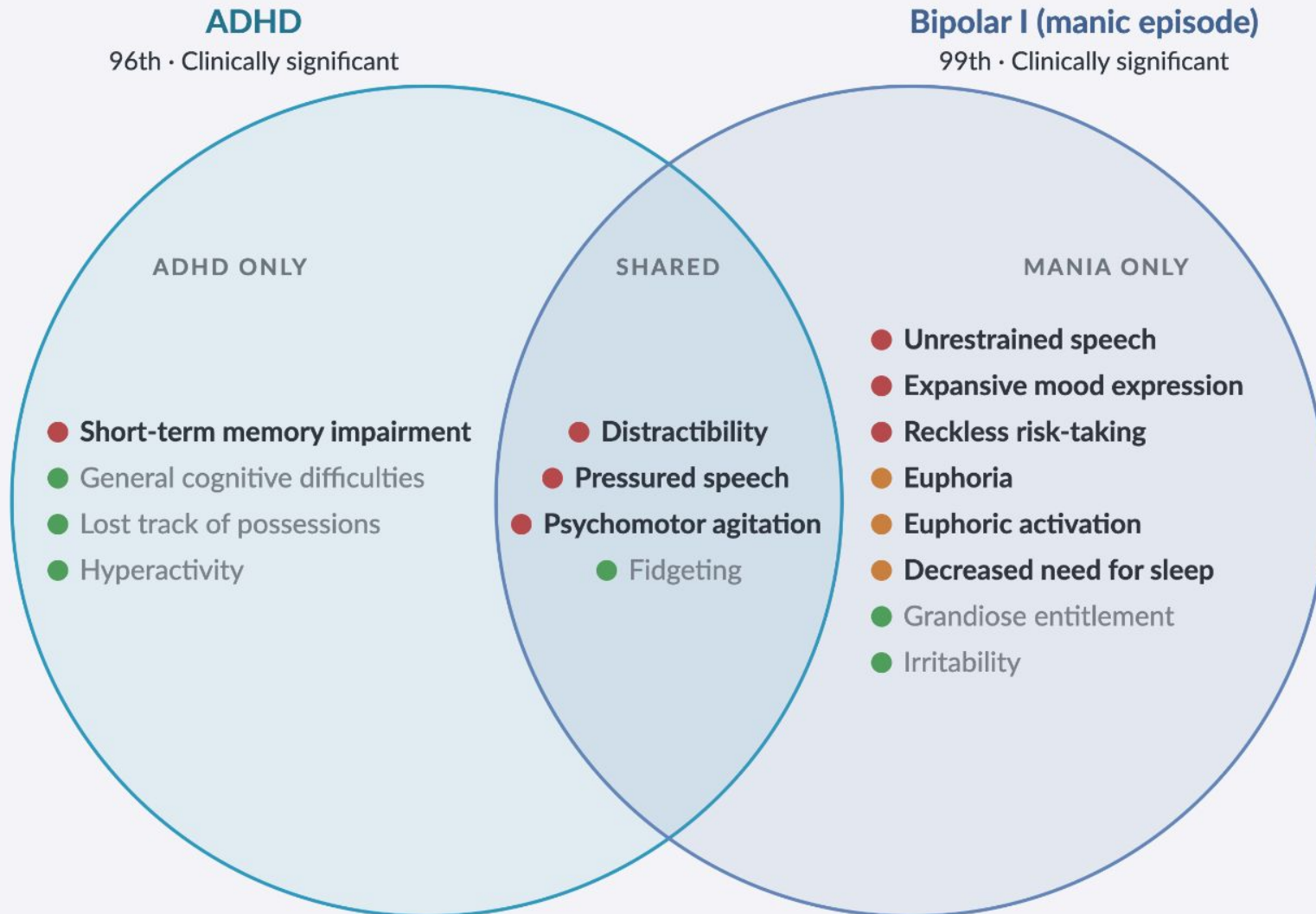


Mental Health Condition	Proportion of Participants
Depression	0.85
ADHD	0.95
Bipolar	0.95
Substance use	0.75
PTSD	0.65
Specific phobia	0.95

- Not elevated
- Elevated
- Clinically significant

The MAPsy scores every slot, whichever path Mark took.

Both of Mark's scales share three Clinically Significant symptoms



Shared symptoms raise both scores

Distractibility, pressured speech and psychomotor agitation are Clinically Significant. Each one counts towards ADHD and mania.

The mania side is high

Six of the eight mania-only clusters are Elevated or Clinically Significant.

The ADHD side is mostly low

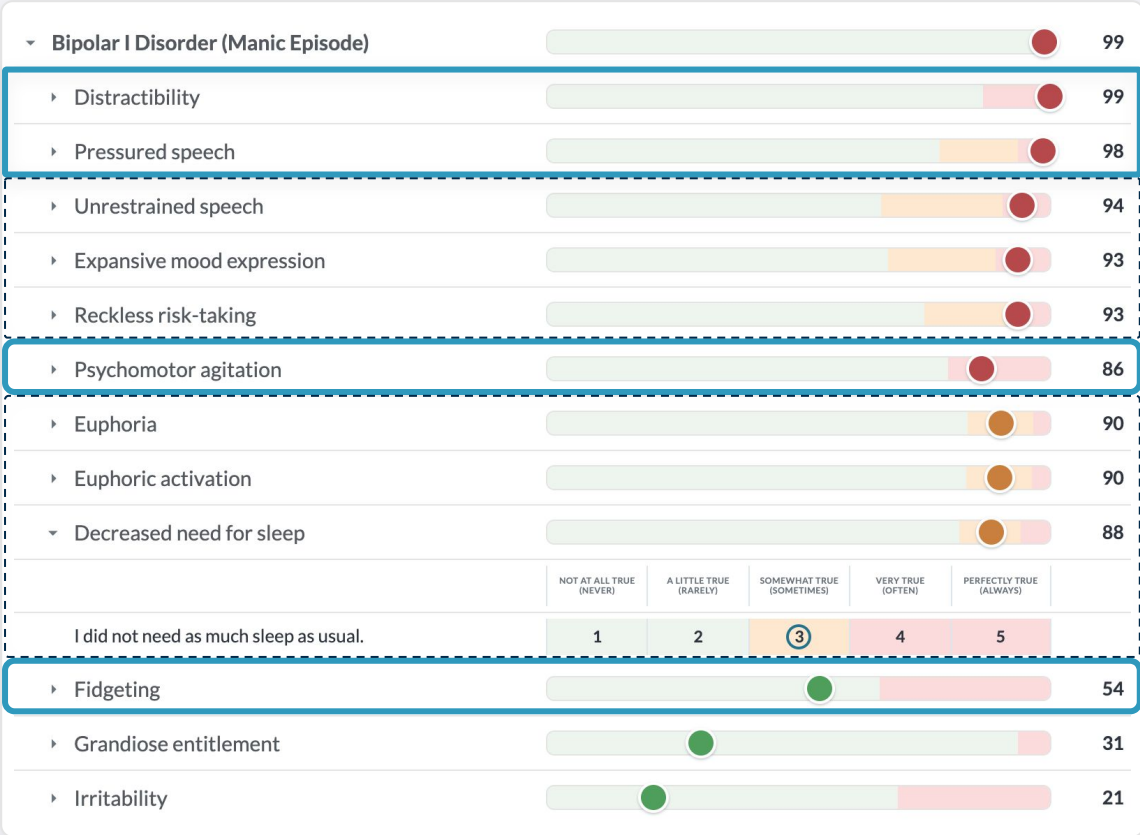
Only short-term memory impairment is high. The other three ADHD-only clusters are not elevated.

● Not elevated ● Elevated ● Clinically significant

Do his symptoms come in episodes, or have they been there since childhood?

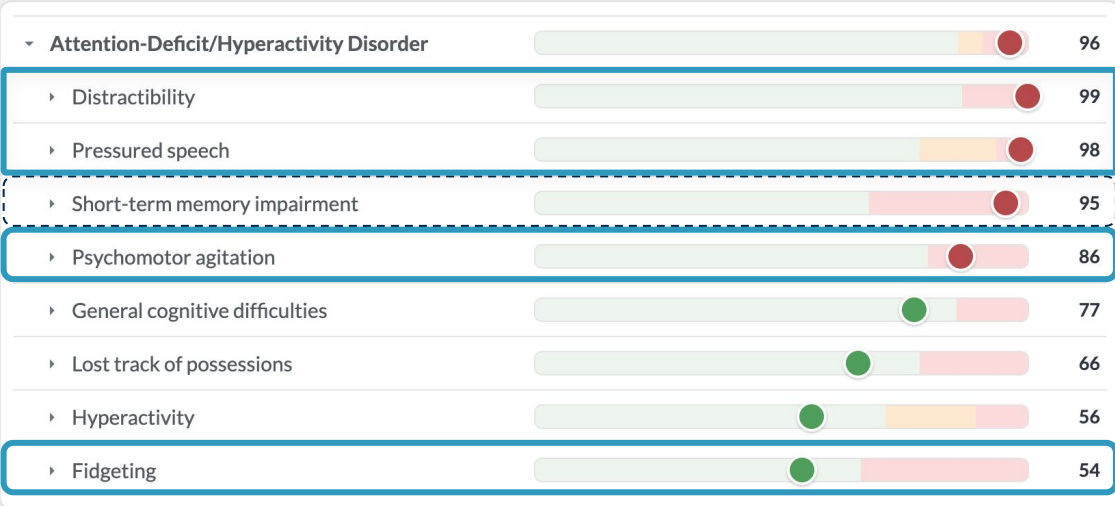
Is it mania or ADHD? Compare what the scales share

● Bipolar I Disorder (Manic Episode) • 99th



☐ Shared by both scales ☒ Specific to one scale

● Attention-Deficit/Hyperactivity Disorder • 96th



This question decides it

Three of the four clusters that raise the ADHD score also raise the mania score. Do the symptoms come in episodes, with high mood and less need for sleep? Or have they been there since childhood?

Here's a plan for Mark

1 Check risk

Mark has frequent suicidal thoughts and a plan. He is impulsive and uses substances. Assess risk first, and keep mixed features in mind.

FROM THE REPORT

▲ Risk of Self-harm or Suicide
The respondent indicated risk of self-harm or suicide.
— I thought that the world would be better off if I were dead. [Perfectly true (Always)]
— I thought about killing myself. [Very true (Often)]
— I had a specific plan for killing myself. [A little true (Rarely)]
It is recommended to follow suicide risk assessment protocols to determine the nature, severity, and immediacy of the risk.

2 Interview for what a questionnaire can't capture

- Map his mood episodes over time. Ask how long the highs last and what happens to his sleep.
- Ask what happened on the antidepressant: his mood, his sleep, and how long it lasted.
- Check whether inattention started before age 12 and showed up in more than one setting. Ask someone who knew him then.
- Ask when his symptoms occur relative to his cocaine and alcohol use.

3 Choose measures

MDQ	lifetime (hypo)mania
GBI	bipolar spectrum
ASRS	adult ADHD, self
ASRS-O	adult ADHD, observer
WURS-25	childhood ADHD
AUDIT	alcohol use
DUDIT	drug use
EDE-Q	eating



Formulation Clarify his mood history before treating attention problems, and involve his GP or psychiatrist early. In bipolar I, guidelines advise against antidepressants on their own, and stimulants without a mood stabiliser can trigger mania.

Jess was referred for depression and PTSD



Jess, 27

she/her • Adult reference sample

REFERRAL

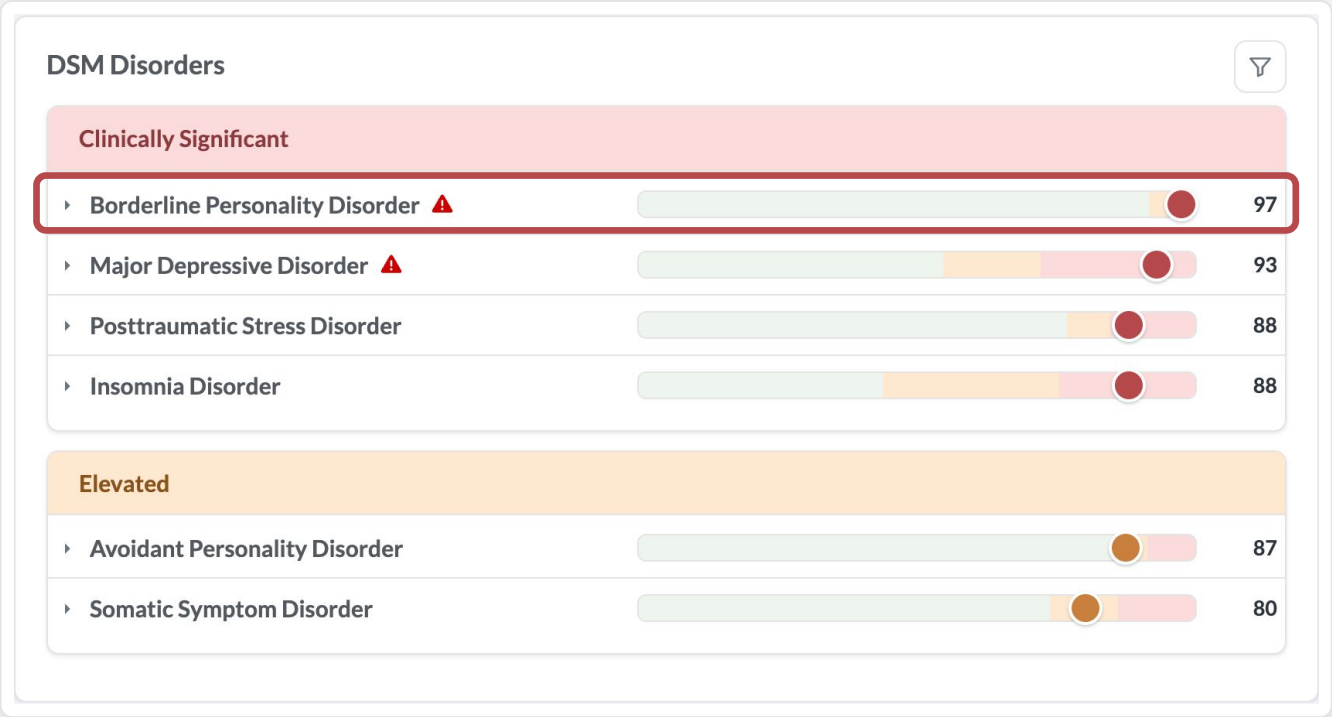
Jess was referred from the ED after her second overdose this year. Her GP wrote “depression and PTSD from childhood”.

NOW

Her relationships start intensely and end in crisis. She is terrified of being left. Her rage “comes out of nowhere”, and hours of shame follow. She loses time and finds texts she doesn’t remember sending. She sleeps three or four hours a night.

SHE SAYS

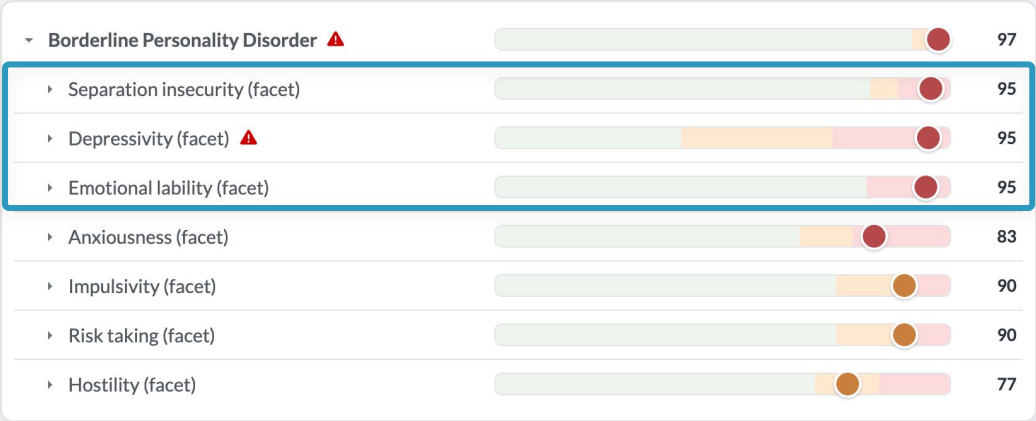
“I don’t know who I am when I’m not with someone.”



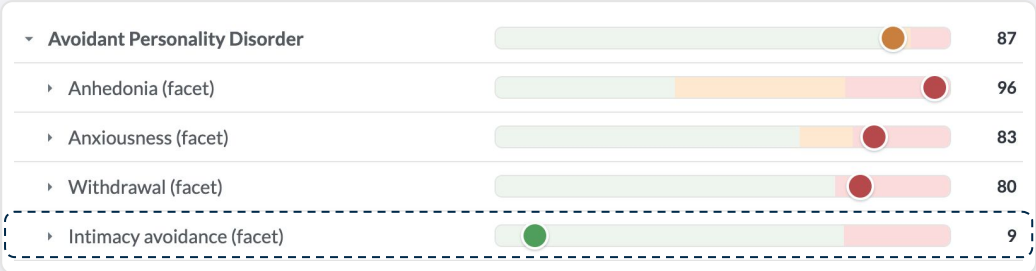
- Internalising (86th) and Detachment (84th) are elevated.
- Externalising at the 91st percentile is Not Elevated
- She rated an attempt and a plan as “perfectly true”.

Jess's PTSD score mostly reflects general distress

● Borderline Personality Disorder • 97th

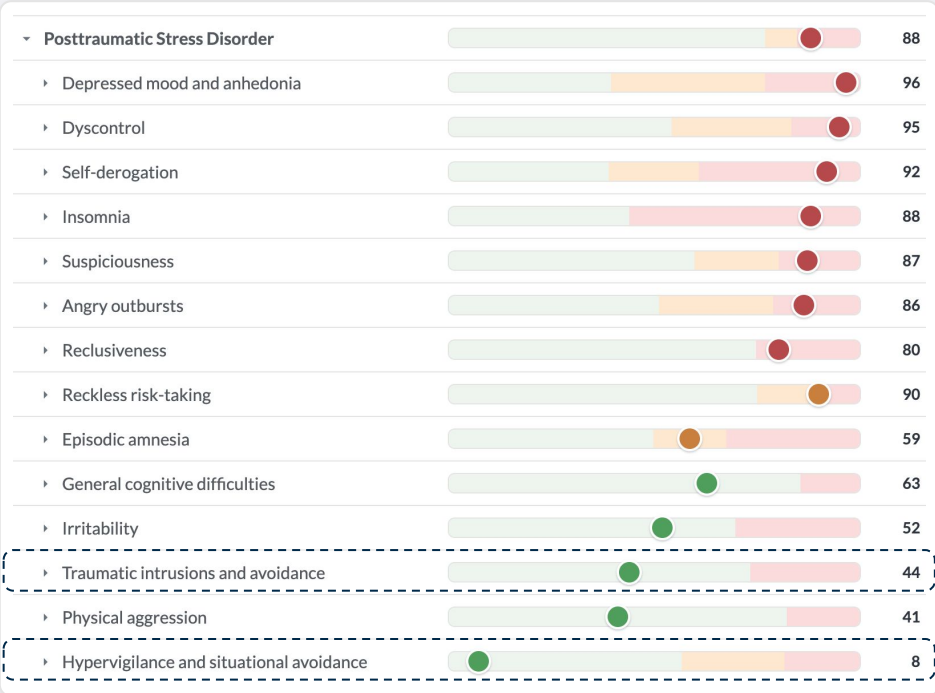


● Avoidant Personality Disorder • 87th



Intimacy avoidance is at the 9th percentile. Jess wants closeness and is afraid of losing it.

● Posttraumatic Stress Disorder • 88th



☐ Drive the high score ☐ Core features that are low

The trauma clusters are not elevated (intrusions 44th, hypervigilance 8th). Low mood, anger, self-derogation and poor sleep produce the high score.

Here's a plan for Jess

1 Check risk

Jess rated a suicide attempt and a specific plan as “perfectly true”. Assess risk and make a safety plan that day, and decide on the level of care.

FROM THE REPORT

▲ Risk of Self-harm or Suicide
The respondent indicated risk of self-harm or suicide.
— I attempted suicide. [Perfectly true (Always)]
— I had a specific plan for killing myself. [Perfectly true (Always)]
— I thought that the world would be better off if I were dead. [Perfectly true (Always)]
It is recommended to follow suicide risk assessment protocols to determine the nature, severity, and immediacy of the risk.

2 Interview for what a questionnaire can't capture

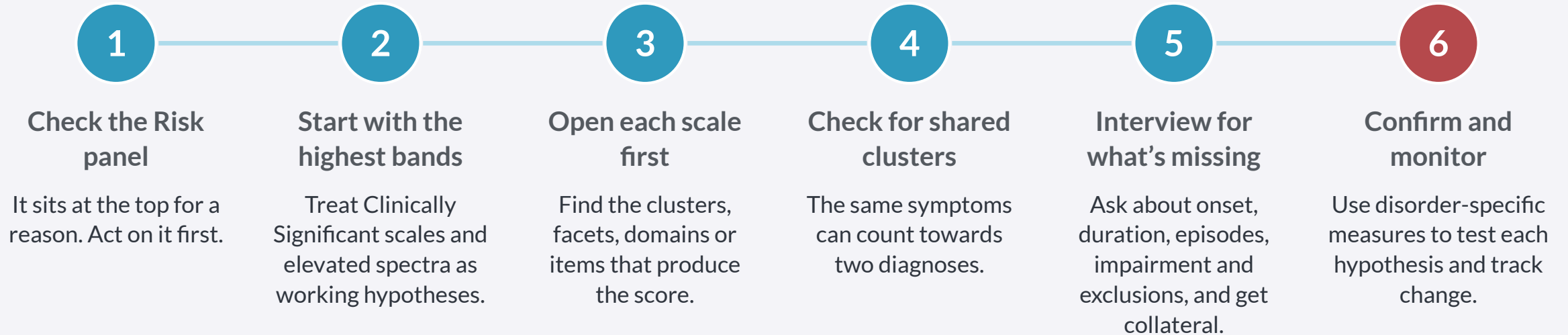
- Assess the borderline criteria with a structured interview such as the SCID-5-PD.
- Take a trauma history. Ask whether there was a Criterion A event and whether she has intrusions.
- Ask about dissociation, including amnesia and identity alteration.
- Ask about her sleep and how she functions during the day.

3 Choose measures

MSI-BPD	BPD screen
BSL-23	BPD severity
PID-5-SF	trait profile
LEC-5	trauma exposure
ITQ	PTSD and CPTSD
MID-60	dissociation
AIS	insomnia
DERS	emotion regulation

 **Formulation** Treatment can target distress, externalised negative affect and disinhibition across her diagnoses. DBT-informed work on emotion regulation suits these targets. Improving her sleep is a realistic early goal.

Use these six steps whenever something flags



SHARED CLUSTERS IN TODAY'S CASES

Mark

ADHD and mania

These share distractibility, pressured speech and psychomotor agitation.

Sam

Autism, OCPD and NCD

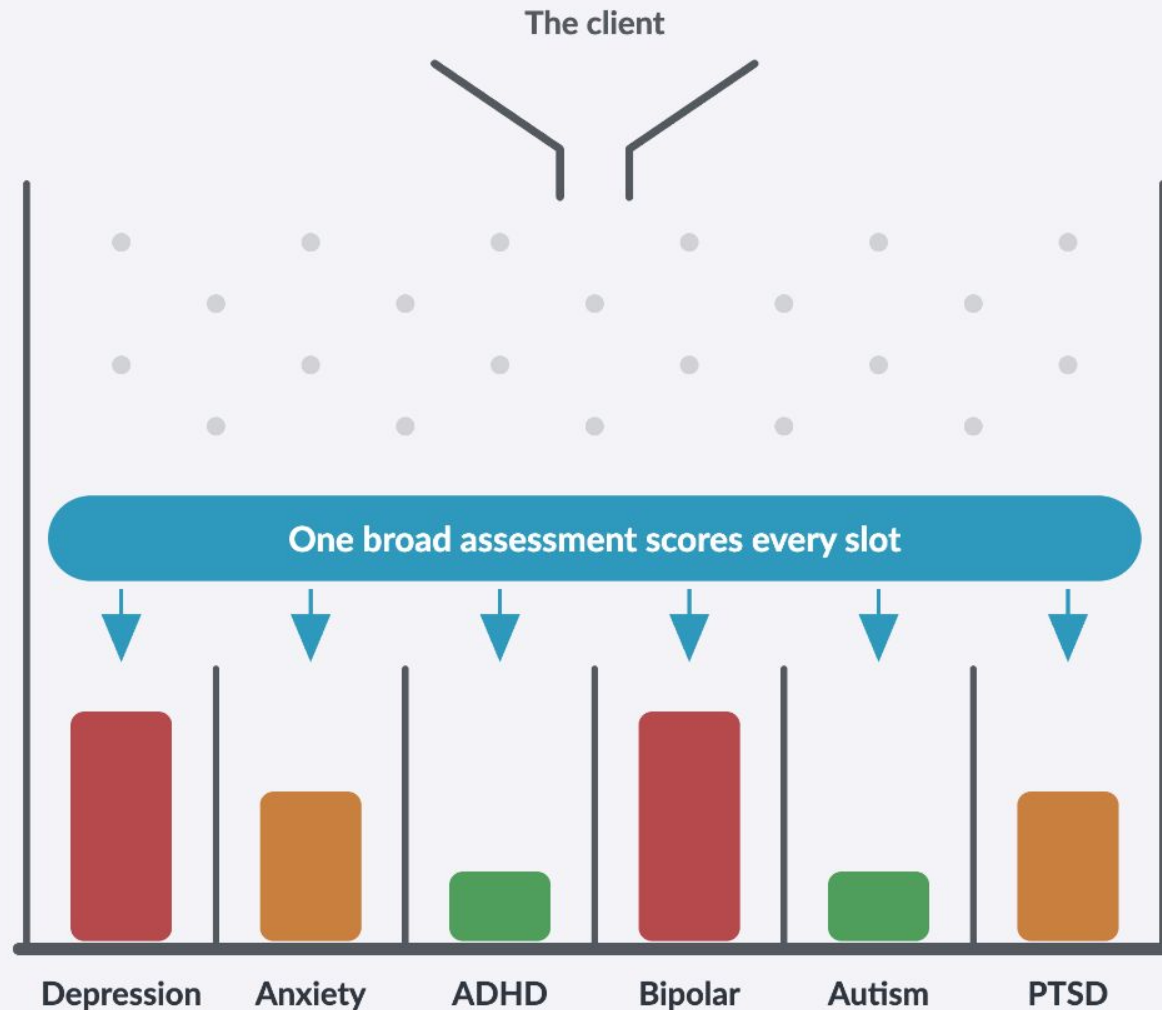
These share perseveration, language and social cognition.

Jess

PTSD, depression and BPD

These share low mood, anger, self-derogation and sleep problems.

With a broad assessment, the path matters less



Illustrative profile. The board is level: the referral no longer decides where we look.

WHAT WE WANT THE MAPSY TO DO

It checks every slot

One assessment covers the areas the referral didn't ask about.

It shows what drives each flag

You can open any score down to the items and the client's answers.

It points to the next step

Each flag becomes a hypothesis for the interview and targeted measures.

● Not elevated ● Elevated ● Clinically significant

Seeing the whole picture

References

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).

Baker, S. T. E., et al. (2026). Multilevel Assessment of Psychopathology (MAPsy): Manual. NovoPsych.

Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them. *Academic Medicine*, 78(8), 775–780.

Forbes, M. K., et al. (2024). Elemental psychopathology: Distilling constituent symptoms and patterns of repetition in the diagnostic criteria of the DSM-5. *Psychological Medicine*, 54(5), 886–894.

Forbes, M. K., et al. (2025). Reconstructing psychopathology: A data-driven reorganization of the symptoms in the Diagnostic and Statistical Manual of Mental Disorders. *Clinical Psychological Science*, 13(3), 462–488.

Fried, E. I., & Nesse, R. M. (2015). Depression is not a consistent syndrome: An investigation of unique symptom patterns in the STAR*D study. *Journal of Affective Disorders*, 172, 96–102.

Fusar-Poli, L., Brondino, N., Politi, P., & Aguglia, E. (2022). Missed diagnoses and misdiagnoses of adults with autism spectrum disorder. *European Archives of Psychiatry and Clinical Neuroscience*, 272(2), 187–198.

HiTOP Consortium. (2025). B-HiTOP overview.
<https://www.hitop-system.org/hitop-self-report-measures>

Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617–627.

Kotov, R., et al. (2017). The Hierarchical Taxonomy of Psychopathology (HiTOP): A dimensional alternative to traditional nosologies. *Journal of Abnormal Psychology*, 126(4), 454–477.

Nusslock, R., & Frank, E. (2011). Subthreshold bipolarity: Diagnostic issues and challenges. *Bipolar Disorders*, 13(7–8), 587–603.

Nylander, L., Holmqvist, M., Gustafson, L., & Gillberg, C. (2013). Attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) in adult psychiatry: A 20-year register study. *Nordic Journal of Psychiatry*, 67(5), 344–350.

Regier, D. A., et al. (2013). DSM-5 field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses. *American Journal of Psychiatry*, 170(1), 59–70.

Stengler, K., et al. (2013). Mental health treatment seeking among patients with OCD: Impact of age of onset. *Social Psychiatry and Psychiatric Epidemiology*, 48(5), 813–819.

Viktorin, A., et al. (2017). The risk of treatment-emergent mania with methylphenidate in bipolar disorder. *American Journal of Psychiatry*, 174(4), 341–348.

Yatham, L. N., et al. (2018). Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disorders*, 20(2), 97–170.

Zimmerman, M., & Mattia, J. I. (1999). Psychiatric diagnosis in clinical practice: Is comorbidity being missed? *Comprehensive Psychiatry*, 40(3), 182–191.