UNIVERSITY OF ÉVORA

SOCIAL SCIENCE SCHOOL

DEPARTAMENT OF PSYCHOLOGY

Clinical utility of the Personal Questionnaire

Rita de Pádua Antunes

Supervisor: Ph.D Célia Sales, University of Évora and University of Porto

Co-supervisor: Dr. Robert Elliott, University of Strathclyde

MASTER IN PSYCHOLOGY

Specialization area: *Health and Clinical Psychology*

Dissertation

Évora, 2017

UNIVERSIDADE DE ÉVORA

SOCIAL SCIENCE SCHOOL

Master in Psychology

Specialization in Health and Clinical Psychology

Clinical utility of the Personal Questionnaire

Rita de Pádua Antunes

Supervisor:

Ph.D. Célia Sales

Co-supervisor:

Ph.D. Robert Elliott

January 11, 2017

Acknowledgements

To my supervisor, Ph. D. Célia Sales for her essential guidance, availability and support through this process. Thank you for sharing your wisdom and for believing in me! I hope we have more opportunities to work together in the future.

To my co-supervisor, Ph. D. Robert Elliott, for inspiring me to conduct this study. Despite the time constraints and the distance, you manage to be present along this process. Thank you so much for your efforts and for all the knowledge you shared.

To Dra. Eunice Silva, Dr. João Pereira, Dra. Filipa Vieira, Dra. Maria Araújo, Dra. Susana Almeida and Prof. Luís Faísca for the crucial collaboration and availability.

To the therapists who answered the request to complete the Utility-PQ on-line survey. Without you this study wouldn't be possible.

To Lena Selway, for her time and kindness in volunteering for reviewing the linguistic of this paper.

To my friends Ana Pólvora, Bruno Ribeiro, Daniel Guerra and Mário Mateus, for the unconditional support, for earing my concerns and for always believing in my abilities. I'm very lucky to have all of you as friends!

To Filomena and Emílio Vigia, Isilda and João José Rodrigues for the motivation given to me through this process. Thank you for being a part of my life!

To my brother, Francisco de Pádua Antunes, for all the support and help.

To Tiago Vigia, for the tireless support and love given to me every day. I believe the best relationships are the ones that give you time and space for personal growth and that help you to think positively about yourself and the world. You give this to me consistently… I wish I could express how grateful I am!

To my mother, Maria da Conceição Pádua, for her presence, patience and unconditional support. Without your persistence and strength, none of this would have been possible!

Clinical Utility of the Personal Questionnaire

Abstract

The demand to implement routine outcome assessment in mental health care services calls for measures with clinical utility, i. e, feasible to therapists, acceptable to clients and generalizable to settings. This research aims to explore the clinical utility of a patient-generated measure, the Personal Questionnaire (PQ). An on-line survey was designed (study I) and administered to an international sample of 25 therapists with experience using the PQ (study II). Results suggest that the PQ is perceived as a clinically significant and fairly practical measure, useful not only in assessing outcome but also in various clinical tasks. Furthermore, it is relatively well accepted by clients and it is extremely generalizable to different clients, clinical approaches and settings. Specific suggestions to increase the PQ's clinical utility are provided. Exploring therapists' perspectives and practices will improve the appropriateness of measures to real-world clinical settings.

Key-words: Clinical utility; Personal Questionnaire; Therapist experiences; Idiographic measures; Practice-based research.

A utilidade clínica do *Personal Questionnaire*

Abstract

O movimento para implementar a avaliação rotineira de resultados nos serviços de saúde mental pede medidas com utilidade clínica, i. e, práticas para terapeutas, aceitáveis para clientes e generalizáveis para contextos clínicos. Este estudo tem como objetivo explorar a utilidade clínica de uma medida gerada pelo cliente, o *Personal Questionnaire* (PQ). Um questionário *on-line* foi desenvolvido (estudo I) e administrado a uma amostra internacional de 25 terapeutas com experiência de uso do PQ (estudo II). Os resultados sugerem que o PQ é considerado um instrumento valioso para a prática clínica, relativamente prático, útil como indicador de resultado e também como ferramenta clínica. Adicionalmente, é bem aceite pelos clientes e bastante generalizável para diferentes clientes, abordagens terapêuticas e contextos clínicos. Sugestões específicas para melhorar a utilidade clínica do PQ são fornecidas. Explorar as perspetivas e práticas dos terapeutas face a medidas de resultado possibilita uma melhor adequação à prática clínica.

Palavras-chave: Utilidade clínica; Questionário Pessoal; Experiências dos terapeutas; Medidas ideográficas; Investigação baseada na prática.

Contents

1. Introduction 1
2. Theoretical Background 3
2.1. Routine Outcome Assessment 3
2.2. Clinical Utility of Outcome Measures 5
2.2.1. Feasibility 6
2.2.2. Acceptability 7
2.2.3. Generalizability.. 9
2.3. Outcome Assessment: Nomothetic and Idiographic Approaches 11
2.4. The Personal Questionnaire (PQ): A patient-generated outcome measure 14
2.4.1. Development of the PQ 14
2.4.2. The PQ Procedure 15
2.4.3. Research on the PQ in Clinical Practice 16
2.4.4. Psychometric Properties of the PQ.. 17
3. Rationale and Aims of the Study 21
4. Method 25
4.1. Study I.. 25
4.1.1. Participants 25
4.1.2. Procedure... 25
4.2. Study II... 26
4.2.1. Participants 26
4.2.2. Instrument and procedure 28
5. Results 33
5.1. Study I 33
5.2. Study II... 36
5.2.2. Feasibility 39
5.2.3. Acceptability 48
5.2.4. Generalizability... 50

6. Discussion 57
6.1. How the PQ is used in routine clinical practice? 57
6.2. How feasible is the PQ? 57
6.3. How acceptable is the PQ? 60
6.4. How generalizable is the PQ? 61
6.5. Limitations and suggestions for future research 63
7. Conclusions 65
Appendix A – Personal Questionnaire Form 67
Appendix B - Framework Matrix of the focus group discussion 69
Appendix C – Utility-PQ (English version) 75
Appendix D – Utility-PQ (Portuguese version) 91
Appendix E – Content Analysis 107
Appendix F - What to consider when assessing the clinical utility of measures 109
References 111

List of Tables

Table 1. The components of clinical utility. 11
Table 2. Benefits and limitations of nomothetic and idiographic measures. 14
Table 3. Participants of the Focus Group 25
Table 4. Sociodemographic information of the participants 27
Table 5. Analysis procedures for the indicators of feasibility 30
Table 6. Analysis procedures for the indicators of acceptability 31
Table 7. Analysis procedures for the indicators of generalizability 31
Table 8. Framework Matrix 33
Table 9. Suggestions of the focus group participants to increase clinical utility 35
Table 10. How do therapists use the PQ in clinical practice? 37
Table 11. Descriptive statistics of protocol adhesion of the PQ administration procedures 41
Table 12. Therapists' suggestions to increase feasibility of the PQ procedure 42
Table 13. Descriptive statistics of length of the PQ administration and interpretation 43
Table 14. Descriptive statistics of the variable ethical appropriateness of the PQ 45
Table 15. Descriptive statistics of value for practice of the PQ 45
Table 16. Descriptive statistics of emotional effect of the PQ to the client 48
Table 17. Descriptive statistics of the clients' general receptiveness 49
Table 18. Descriptive statistics of the appropriateness of the PQ to different age groups 50
Table 19. Descriptive statistics of the client variables that may hinder administrating the PQ 51
Table 20. Adaptations of the PQ procedures for different client features and needs 52
Table 21. Descriptive statistics of the degree of applicability of the PQ 53
Table 22. Descriptive statistics of the appropriateness of the PQ to diverse clinical approaches 54
Table 23. Descriptive statistics of the easiness of the PQ to diverse clinical settings 55

List of Figures

Figure 1. Descriptive statistics of training needs of the PQ 44
Figure 2. Descriptive statistics of therapist openness to use the PQ 48

1. Introduction

In the past few decades, the mental health care services worldwide have been challenged in order to introduce strategies to systematically monitor clients' progress in therapy (e.g. Brown, Burlingame, Lambert, Jones, & Vaccaro, 2001). In this context, routine outcome assessment has emerged as the approach that enables the assessment on an ongoing basis of clients' progress during therapy, with this information available to the therapist (e.g. Boswell, Kraus, Miller, & Lambert, 2013). However carrying out daily outcome assessments in every patient of every service requires tools that are appropriate for the clinical context, i.e., tools that present clinical utility.

The main goal of this research is to explore the clinical utility of the most popular patient-generated outcome measure, the Personal Questionnaire (Elliott, Mack, & Shapiro, Simplified Personal Questionnaire Procedure, 1999; Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007, for the Portuguese version), from the psychotherapist perspective. Firstly, we developed a self-administered questionnaire to explore therapists' views, behaviors, perceived difficulties and benefits of using the PQ in routine clinical practice. In a second study we administered an online survey to therapists with experience using the PQ in order to explore its clinical utility.

2. Theoretical Background

2.1. Routine Outcome Assessment

In the last 25 years, an increasing emphasis on the ongoing measurement of outcome in mental health services has emerged at international level (Brown, Burlingame, Lambert, Jones, & Vaccaro, 2001; Ellwood, 1988; Essock, Olfson, & Hogan, 2015; Kisely, Adair, Lin, & Marriot, 2015; Puschner, Becker, & Bauer, 2015). This trend necessarily involves implementing strategies able to regularly assess outcome. Howard, Moras, Brill, Martinovich, and Lutz (1996) first proposed the systematic measurement of client responses to treatment with this information available for the therapist, enabling to assess and improve treatment outcome. This practice grounded on patient-focused research (Sundet, 2012), has no uniform definition (Overington & Ionita , 2012; Slade, 2002). However, it is generally refered to as “routine outcome assessment”, which is the term choosen for this research due to its emphasis on the continuous nature of assessment.

In mental health, “outcome” refers to the changes on the client’s health attributable to a psychological intervention (Slade, 2002). Consequently, routine outcome assessment is the strategy of periodic measurement or assessment of client change over the course of treatment (Siebum, Pijl, & Sander de Wolf, 2015; van Noorden, van der Wee, Zitman, & Giltay, 2012). Routine outcome assessment contrasts with pre-post assessments due to its systematic nature and the possibility of providing the therapists with ongoing feedback about treatment response. The resulting data can be used in two different levels.

At client level, it provides direct feedback of individual change, both to therapists and clients (Sytema & van der Krieke, 2013). Depending on the choice of measurement instruments, detailed information about diagnosis, several domains of symptoms, complaints and psychosocial functioning can be assessed in every phase of treatment. The first and principal aim of routine outcome assessment is to support clinical decision-making at client level in the daily practice of mental health services (Sytema & van der Krieke, 2013). This decisions might include whether to continue or to alter treatment when symptom reduction is not happening as expected.

At the aggregated level, routine outcome assessment data can be used for diverse purposes, such as monitoring (with the aim of assessing and improving

treatments within teams or services), research (in order to search for evidence on treatment outcomes in a region or country) and benchmarking (to make comparisons betweens teams or services, allowing invertors to choose between service providers (e.g. insurance companies) or to monitor the quality of services). In summary, at aggregated level routine outcome assessment allows to evaluate, compare and improve quality of care (e.g. Smits, Claes, Stinckens, & Smits, 2014; van Noorden, van der Wee, Zitman, & Giltay, 2012). The resulting data may prove valuable for facilitating the presentation of the outcomes of therapy to others, such as the government and stakeholders. Hence, routine outcome assessment is advocated by many as a viable pathway to gather and present data regarding psychotherapy's effects, which can lead not only to the recognition of the value of interventions, but also to enhance collaboration between healthcare providers and to improve access to psychological care for individuals who need it (Nordal, 2012).

Though the trend for routine outcome assessment has been mostly motivated by programmes and systems, there is an increasing recognition of the benefits of adopting this approach. In fact, the importance and benefits of psychological assessment, and specifically of routine outcome assessment, is encouraged both by researchers and professional organizations.

Recent research documents rates of deterioration in clients in the range of 5% to 10% (Hansen, Lambert, & Forman, 2002) and points out that 30% to 40% of clients do not benefit from treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004). Furthermore, therapists seldom record client deterioration even when significant (Hatfield, McCullough, Frantz, & Krieger, 2010, cit. in Fitzpatrick, 2012), which might be due to difficulty in noticing when clients are deteriorating (Hannan, et al., 2005). Implemeting strategies to measure client's outcome in a systematic manner may be a possible solution to this issue. In fact, Brown, Burlingame, Lambert, Jones and Vaccaro, point out that "monitoring outcomes during treatment can contribute to even better outcomes" (p. 934, 2001). Similarly, Boswell, Kraus, Miller, and Lambert (2013) argue that implementing monitoring strategies is associated with decrease of the risk of client deterioration. Implementing routine outcome measurement is also perceived as valuable for clinical decision-making and is associated with the development of treatment plans, the identification of the need of additional professional education and training, and helping clients recognize their own progress in therapy (e.g. Nordal, 2012; Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007; Siebum, Pijl, & Sander de Wolf, 2015).

Despite the potential advantages of implementing routine outcome assessment in mental health care and the increasing availability of measures, many psychotherapists remain skeptic or resistant towards routinely monitoring client's outcome in therapy (Carlier, et al., 2012; de Beurs, et al., 2011; Garland, Kruse, & Aarons, 2003; Gilbody, House, & Sheldon, 2002; Hatfield & Ogles, 2004; Trauer, Callaly, & Herrman, 2009; Trauer, Gill, Pedwell, & Slattery, 2006; Slade, 2002). In fact, compared to other disciplines, psychologists tend to rate outcome measures as less useful (Trauer, Callaly, & Herrman, 2009).

2.2. Clinical Utility of Outcome Measures

It can be challenging for therapists to find outcome measures that meet the particular needs of their clinical practice settings (Nordal, 2012). Finding the right measure for a particular clinical setting involves not only the consideration of psychometric properties, but also of aspects of clinical utility. The American Psychological Association (2002) defines clinical utility as the dimension that addresses the extent to which a treatment will be effective in the clinical practice setting, regardless of demonstrated efficacy in research settings. The concept of clinical utility is found on the literature to be related with the usefulness or suitability for sustainable and meaningful use of psychological interventions (e.g. APA, 2002; Johns, et al., 2015), diagnostic measures or criteria (e.g. Hall, et al., 2014) and also of outcome measures (e.g. Fitzpatrick, Davey, Buxton, & Jones, 1998) in typical clinical settings, being the latter the focus of the present study. In this paper, we address the clinical utility as the property that concerns the ability of an outcome measure to be used in real-world settings, addressing the capacity of therapists to use and of clients to accept the instrument, and its range of applicability in different clinical practice settings. Therefore, the clinical utility includes three domains or components: the feasibility for therapists of applying the instrument in actual clinical practice, the acceptability of the instrument by clients with distinct clinical and personal traits, and the generalizability across settings (APA, 2002; Fitzpatrick et al., 1998).

There is a growing awareness in the field of psychotherapy research concerning the need to conduct comprehensive assessments of measures that go beyond the traditional psychometric analysis (e.g. Blount, et al., 2002). This movement involves the consideration of the clinical utility of measures and is vital to increase the quality and suitability of outcome measures to routine clinical practice. However, whilst there is

less agreement on the conceptualization of clinical utility, there is even fewer about how it should be assessed. In the past decade, several researchers were involved in studies of outcome measures that go beyond the conventional psychometric analysis (e.g. Blount et al., 2002; Miller et al., 2003; Sales et al., 2007). Nevertheless, to our knowledge, there is no study that explores the clinical utility of outcome measures in a holistic fashion, only some of its components are the target of research.

2.2.1. Feasibility

Feasibility aims to answer the question "is this measure practical and valuable for therapists?" Therefore, it is intimately related with the balance between burden and value of administering and processing a measure (Fitzpatrick et al., 1998). Research shows that for the majority of therapists, practical concerns seem to be the primary reason why they are not using outcome measures on a routine basis, including issues such as paperwork burden, time burden, additional human resources, financial costs, unavailability of information technology, among others (Brown, Burlingame, Lambert, Jones, & Vaccaro, 2001; Fitzpatrick, 2012; Miller, Duncan, Brown, Sparks, & Claud, 2003; Trauer, Gill, Pedwell, & Slattery, 2006; Garland, Kruse, & Aarons, 2003; Gilbody, House, & Sheldon, 2002; Hatfield & Ogles; 2004; Hatfield & Ogles, 2007). Excessive burden in health care professionals may disrupt clinical care, hence it is crucial to assess the impact involved in collecting and processing the data from outcome measures (Fitzpatrick et al., 1998). Furthermore, research shows that clinical staff views and acceptance of instruments can make a significant difference to increase acceptability by clients (Bernard et al., 1995, cit. in Fitzpatrick et al, 1998).

Feasibility addresses aspects such as brevity, simplicity, availability, and clinical value of a measure. Brevity concerns how long it takes to administer and process a measure (Fitzpatrick et al., 1998; Slade, Thornicroft, & Glover, 1999). If a measure is perceived by a clinician as excessively time consuming, it is probable that protocol adhesion and routine use are low. Intimately related to brevity is simplicity, which refers to the ease to understand and administer the instrument. Reasons why psychotherapists do not use outcome measures often include lack of clarity about the way to present and use the resulting data in useful ways (Deyo and Patrick, 1989, cit in Fitzpatrick et al., 1998; Trauer, Gill, Pedwell, & Slattery, 2006). As such, the protocol should be clear, informing the therapist of the purpose of the measure, how long it will take to administer, when and how to complete it and what to do with the resulting data

(Slade, Thornicroft, & Glover, 1999). It should also be capable of being used without formal or long hours of training (Fitzpatrick et al., 1998). In fact, researchers argue that training and assistance leads to higher rates of use of these measures, as well as higher perceived usefulness (Callaly, Hyland, Coombs, & Trauer, 2006; Smits, Claes, Stinckens, & Smits, 2014; Trauer, Callaly, & Herrman, 2009; Trauer, Pedwell, & Gill, 2009). Furthermore, the measure should be available, meaning that it should be free, and easily accessible from the distributor (APA, 2012).

Finally, an outcome measure should be clinically useful to therapists by providing significant information and assisting in clinical tasks (Slade, Thornicroft, & Glover, 1999). Concerns regarding usefulness of outcome measures are transversal in several research findings (Jensen-Doss & Hawley, 2010; Miller, Duncan, Brown, Sparks, & Claud, 2003; Trauer, Gill, Pedwell, & Slattery, 2006). Therapists tend to doubt that measures actually tell them anything they could not learn directly from clients, in other words, they might not be sure about the relevance of measures over using clinical judgement alone. Miller and colleagues (2003, p. 98) even point out that "many therapists see outcome measurement as an encumbrance to the process and an obstacle to forming alliances with clients". Moreover, some authors report that for many therapists routine outcome measurement is simply an "add-on" from actual clinical work and relevant only to management and government parties (Miller, Duncan, Brown, Sparks, & Claud, 2003; Trauer, Gill, Pedwell, & Slattery, 2006).

2.2.2. Acceptability

Acceptability addresses client's willingness and ability to comply with the administration procedures. If it is important to ensure that outcome measures have high feasibility for the psychotherapists, it is also crucial that the instrument is well accepted by the clients. Thus, acceptability addresses the question "how acceptable is an instrument for respondents to complete?" (Fitzpatrick et al., 1998). Reasons why clients may refuse to respond particular instruments may include mode of administration, length of the measure, psychological distress involved in the administration, client values, culture, personal preferences and health status, appearance and legibility of the instrument and, finally, language and cultural applicability (APA, 2012; Bowling, 2005; Fitzpatrick, et al., 1998; Slade, Thornicroft, & Glover, 1999). Sprangers and colleagues (1993, cit. in Fitzpatrick et al., 1998) suggest that early on in the development of an instrument this property should be assessed by eliciting views of

clients about the instrument, for example by means of a structured interview in which they are asked whether they found any items difficult, absurd or distressing or whether important issues were omitted.

Response rate is identified by Fitzpatrick and collaborators (1998) as a strong indicator of acceptability. Higher response rates are related to higher acceptability. Conversely, higher refusal rates and missing responses rates are associated with lower acceptability. For instance, if clients do not respond to a measure or certain items, the measure might be difficult to understand, distressing or absurd for the client.

Acceptability can be determined by mode of instrument administration. Researchers argue that respondents express positive preference for face-to-face interview opposed either to self-complete or telephone based administration (Bowling, 2005; Weinberger et al., 1996, cit. in Fitzpatrick et al., 1998), translating in higher response rates and lower missing responses when instruments are personally administered (Bowling, 2005). Moreover, the interviewer's skills may have influence in respondent's acceptance of the instrument. For instance, a motivating, empathetic interviewer can "increase response and item response rates, maintain motivation with longer questionnaires, probe for responses, clarify ambiguous questions (…)" (Bowling, 2005, p.282). In terms of burden to respondents, face-to-face interviews are also indicated as the less problematic method of administration, since it only requires that respondent and interviewer speak the same language, and to have basic verbal and listening skills (Bowling, 2005). Connected to mode of administration is its duration. Research reports that the longer it takes for clients to complete an outcome measure, the more they tend to get tired and to lose motivation to respond (Ware, 1984, cit. in Fitzpatrick et al., 1998). Consequently, researchers argue towards a decrease in length and number of items in order to increase acceptability of measures (Burisch, 1984, cit. in Fitzpatrick et al., 1998).

Acceptability may be influenced by the degree to which the measure is experienced as probing yet unobtrusive nor distressing (Slade et al. 1999). Some measures were found to be upsetting or depressing for clients (Blount et al., 2002). As such, it is clearly desirable to design measures that do not increase distress in clients probably already coping with cognitive, emotional and/or physical discomfort in some degree. Moreover, the process of outcome assessment might be despairing to clients when there is no progress (Pereira, Pedro, Guerra, & Sales, 2016).

Concerns about relevance to clients have also been reported, for instance, Gilbody and colleagues (2002) found that one third of their study participants felt the measures do not appropriately capture clients' concerns. Moreover, Fitzpatrick (2012) refers that one of the motives of her resistance to routine outcome assessment was the fear of the reactions that the clients might have towards the measures. In a more recent study, residents of a therapeutic community manifested skepticism about the purpose of assessment when administration of measures were not integrated in the sessions (Pereira, Pedro, Guerra, & Sales, 2016).

Other factors associated with the likelihood of completing a questionnaire include features of the layout such as appearance and legibility and, lastly, language (Slade, et al. 1999) and cultural applicability (Fitzpatrick et al., 1998).

2.2.3. Generalizability

According to APA (2002), generalizability reflects "the extent to which an effect of a treatment is robust and therefore will be replicated even when details of the context are altered". In other words, this component of clinical utility refers to the range of applicability of a given instrument across different settings. Clients' characteristics, psychotherapists' characteristics and variations across settings are found as major determinants of generalizability, as well as the interaction among them.

Several client variables may influence the effect of an outcome measure, such as age and developmental level, gender, sex, language, ethnic background, religion, socioeconomic status, sexual orientation and physical condition. The clinical presentation of the client, as idiosyncratic as it is concerning severity, comorbidity and external stressors, is also an important factor (APA, 2002).

If clients' characteristics influence the generalizability, also psychotherapists' variables might play an important role in the applicability of an outcome measure in a certain setting. Different psychotherapists have different training, skills and experience, as well as distinct personal features as gender, language and ethnic background. Variables like theoretical orientation and education degree were identified as influencing forces of therapists willingness to use outcome measures. Regarding theoretical orientation, Hatfield and Ogles (2004) found that insight oriented therapists are less likely to use outcome measures than cognitive or behavioral therapists. On the topic of education degree, doctoral-level clinicians expressed more positive opinions

than master's-level clinicians (Jensen-Doss & Hawley, 2010). Moreover, differences between client's and the psychotherapist's characteristics (including language, sex, gender, ethnicity and background) might affect generalizability (APA, 2002). Moreover,

Setting variables are also determinant. Using a client-based outcome measure in a clinical context, for instance, the private practice, is different of doing so in a context with distinct characteristics, such as a psychiatric inpatient unit. Therefore, it is expected to find a different degree applicability of a certain instrument across various settings (APA, 2002). Jensen-Doss and Hawley (2010) found that private practitioners saw less benefit to formal assessment over clinical judgment in comparison to clinicians working in other settings. In contrast, Smits and colleagues (2014) found that private practitioners and clinicians from inpatient mental health clinics present more positive attitudes towards monitoring, when in comparison to clinicians working in subsidized outpatient services. Concerning the source of payment, health care professionals whose primary source of income comes from institutionalized sources were more likely to use outcome measures than were those whose primary source of income was from fee-for-service or managed care/private insurance (Hatfield & Ogles, 2004). The generalizability has been explored with specific populations and in different therapeutic settings, such as psychiatric care (including general hospitals and therapeutic communities), drug addiction services (including outpatient services and therapeutic communities) (Alves, Sales, & Ashworth, 2013), university counseling clinics (Lucas & Gonzalez, 2012), health psychology (e.g. psycho-oncology), and specific therapeutic contexts (e.g. Psychodrama) in private practice (Cruz, Sales, Moita & Alves, 2013) (see Table 1).

Table 1. *The components of clinical utility.*

Feasibility	Acceptability	Generalizability
Brevity	Method of administration	Clients' characteristics
Simplicity	Time of administration	Psychotherapists' characteristics
Availability	Psychological distress	Setting's characteristics
Value for practice	Relevance	
	Appearance, legibility, language and cultural applicability	

2.3. Outcome Assessment: Nomothetic and Idiographic Approaches

Measurement approaches in mental health care can be classified in a continuum of client involvement (Fitzpatrick, Davey, Buxton, & Jones, 1998). At one extreme, psychotherapists and researchers make judgements with minimum input from the client, for instance, when making inferences about the clinical condition only by observation without considering the client perspective (Sales & Alves, 2012). At the opposite extreme are the measures that assess "health, illness, and benefits of healthcare interventions from the client's perspective" (Fitzpatrick et al., 1998, p. iii). These measures are named patient-based measures, as they are largely determined by the client, such as self-report instruments.

In mental health, the traditional way to assess the client perspective is by using standardized tools that consist of a series of psychometrically predetermined items to by rated by the clients on a scale. This method is known as a *nomothetic approach* (from the Greek "nomos" which means "law"), and it is based on the assumption that the content of the items reflect dimensions that are common to a population's perspective (Sales & Alves, 2012). As such, this method allows to locate the client on those universal dimensions, comparing their score with population norms. The use of nomothetic measures is the most widely used strategy to assess treatments and is perceived as advantageous. Firstly, because these measures are administered and processed with ease (Hédinsson, Kristjánsdóttir, Ólason, & Sigurdsson, 2013). Secondly, they allow the definition of population-based normative data, including

finding clinical cut-off scores (Evans, Margison, & Barkham, 1998). Thirdly, these outcome measures are applicable to a wide range of clients and, fourth, they are reliable when assessing clinical significant change (Barkham, et al., 2001; Lutz, et al., 2005). However, there is a limitation in these measures: because the items are based on dimensions that are common to a clinical population, these measures may have items irrelevant to the particular concerns of the client (Thornicroft & Slade, 2014). This has a negative impact on the instrument's sensitivity to change and increases the probability of ignoring pertinent individual-specific problems (Ashworth, Evans, & Clement, 2008; Ashworth, et al., 2007; Hédinsson, Kristjánsdóttir, Ólason, & Sigurdsson, 2013).

The limitations of the nomothetic approach claimed for different assessment strategies in the mental health field. Allport once wrote, "as long as psychology deals with universals and not with particulars, it won't deal with much" (1960, p.146, cit. in Elliott et al., 2016). In line with this statement, a more personalized approach has grown, which uses a specific type of patient-based tools: the individualized, or patient-generated measures (PGM) (Ashworth, et al., 2004). According to Fitzpatrick and colleagues, these are "instruments in which the respondent is allowed to select issues, domains or aspects that are of personal concern that are not predetermined by the investigator's list of questionnaire items" (1998, p.12). That is, instead of imposing a standardized list of potential answers to the client, these measures' items are suggested by the client. PGM have a standardized format, but it is the client who defines the contents to be assessed. That way, they include open-ended questions, which are generated by the client alone or in collaboration with an interviewer (the psychotherapist, the researcher or other practitioner), that later are rated by the client, for instance, in an anchored scale that measures the psychological distress associated with an item. As a result, each client has their own tailor-made questionnaire, which only includes issues relevant for the client. Hence, PGM follow an *idiographic approach* (from the Greek "idios" which means "own" or "private"), because they invite the client to indicate themes with personal meaning (Sales & Alves, 2012). In summary, since the clinical condition of each client is unique and that psychological distress is always diverse and multifaceted, it may be appropriate to have measures able to capture each cliet uniqueness (Ashworth, Evans, & Clement, 2008; Ashworth, et al., 2004; Ashworth, et al., 2005; Brooks & Davies, 2008; Donnelly & Carswell, 2002; Hansson, Berglund, & Ohman, 1987; Sales & Alves, 2012; Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007). Measures like the PGMs offer that possibility.

PGM can be used for outcome assessment and to access therapy session processes (Sales & Alves, 2012). In the first case, they are called patient-generated outcome measures (PGOM) and contain problems or goals for therapy stated by the client himself, such as target complaint questionnaires (Elliott et al., 2016). Items are rated according to the level of distress that they cause and outcome is measured by change on these patient-generated items. In the latter case, they are known as patient-generated process measures (PGPM) and elicit the client experience of treatment processes. That way, PGPM are designed to reflect the client "sensations, perceptions, thoughts and feelings during and with reference to therapy sessions" (Elliott & James, 1989, p. 444, cit. in Sales & Alves, 2012). These measures allow the identification of relevant treatment variables, through the client perspective.

The use of individualized measures comes with various benefits. Firstly, these measures are considered client-friendly, since they give voice to the client's own concerns. Secondly, clinical improvement is assessed through topics of significance to the client. As a consequence, they present higher sensitiveness to clinical change and higher content validity (Fitzpatrick et al, 1998; Hédinsson et al., 2013). That is, because they address difficulties relevant to the client, idiographic instruments are more highly responsive to therapeutic interventions than nomothetic instruments. Thirdly, time is not wasted assessing irrelevant topics (Sales & Alves, 2012; Wagner & Elliott, 2001). Fourthly, they are flexible and adaptable to variations of clients' characteristics, such as economic status, education, and personality (Sales & Alves, 2012). Fifth, they facilitate the definition of client's goals to work on in therapy, which have impact in the client's willingness and commitment in the therapeutic process (Turner-Stokes, 2011). Finally, researchers have found that topics identified with individualized measures were not reflected in nomothetic measures (Ashworth, et al., 2007; Neves, 2015; Sales & Alves, 2012), meaning that the individualized approach adds great value to measurement of change in mental health care.

Despite the multiple benefits that come with using these measures, the idiographic approach is still viewed with resistance. One possible reason is the perceived low practical feasibility compared to nomothetic instruments. Firstly, because they tend to be complex and time consuming both to administer and process. Secondly, most of them require interviewer participation, therefore involving training in some degree. Lastly, as they reflect idiosyncratic themes, it is difficult to compare results with other clients, thus they are perceived as incapable of giving generalizable data (Fitzpatrick et al, 1998) (see Table 2).

Considering the characteristics of these two approaches, several authors argue that they are complementary rather than exclusionary, hence it would be advantageous to follow an approach that combines the two different types of measures (Meier, 2008, cit in Hédinsson et al., 2013; Sales et al., 2007). Recently, instrument have been developed following a hybrid approach (see Sales & Alves, 2012).

Table 2. *Benefits and limitations of nomothetic and idiographic measures.*

Nomothetic Measures		**Idiographic Measures**	
Benefits	**Limitations**	**Benefits**	**Limitations**
Population-based normative data	Irrelevance of items for some clients	Capture the uniqueness of each client	Unable to produce population-based norms
Psychometrically reliable and valid	Less sensitive to change	Items are relevant to the client	Psychometrically unreliable
Clinical cut-off scores	Underreport client-specific problems	Highly sensitive to clinical change	Low practical feasibility
Easy administration and interpretation		Flexible and adaptable to diverse clients	

2.4. The Personal Questionnaire (PQ): A patient-generated outcome measure

2.4.1. Development of the PQ

The original Personal Questionnaire (PQ) was developed by Shapiro (1961), motivated by the lack of strategies for the clinical psychologist to measure client changes of specific psychological difficulties, while capable of making comparisons between different clients and different difficulties. This measure was quite different of the commonly used questionnaires at that time because a unique questionnaire was built for each client, tailored to their unique concerns. However, the original PQ was burdensome and time consuming. Its construction took about five hours and each subsequent application and scoring required approximately thirty minutes (Shapiro, 1961). Latter, Shapiro's method was revised and modified (Elliott, et al., 2016)

2.4.2. The PQ Procedure

The PQ (Elliott, Mack, & Shapiro, Simplified Personal Questionnaire Procedure, 1999; Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007, for the Portuguese version) is a target complaint measure which is individualized to each client. It is designed to capture the client's unique psychological difficulties and to measure changes in these issues in a consistent manner during therapy. The PQ is generated from a semi-structured interview in pre-therapy (commonly in the first therapy session) where the client completes a blank Problem Description Form in collaboration with the therapist, a researcher or other practitioner. From this process it is intended to emerge a list of difficulties in the client's own words that they wishes to work on in therapy.

The materials needed in order to administer the PQ consist on small pieces of paper or index cards, the blank PQ Form for writing in the items (for the first application) and the Problem Description Form completed (for subsequent administrations). The PQ procedure and materials are available on-line (http://www.experiential-researchers.org/instruments/elliott/pqprocedure.html) and in appendix A.

Generating the items. The first step for completing the blank PQ Form is generating the items. The client is asked to describe the main difficulties that are the motive of seeking psychotherapy. This step is like a brainstorming session, where it should be attempted to identify as many potential items as possible (fifteen is the advised number of draft items). It is recommended that the list of draft items should include one or two difficulties from five areas, namely, symptoms, mood, specific performance/ activity (e.g. work), relationships and self-esteem. As such, if the client does not mention a difficulty of a specific area, the interviewer should ask the client if they have any problem in that area that they wish to target in therapy. The items generated should be the most important in the client's view.

Refining the items. The second step consists in helping the client to clarify the items. The interviewer writes each draft item onto separate index cards and in the process each difficulty is carefully discussed with the client to make sure that it reflects their chief concerns and that it is phrase correctly. A checklist is provided in order to ensure the quality of the items:

- it should reflect a problem rather than a goal,
- it is an issue that the client wants to work on in therapy,
- it regards a specific difficulty, rather than a general, vague problem,

- it refers to single difficulty, requiring that multiple problems are separated into different items,
- it is in the client's own words,
- it is not redundant with another item.

When all items are wrote down, the interviewer should ask if the client wants to include any other difficulty, until they feel the list is complete. The interviewer then reviews the items one by one with the client, confirming each item and deleting or combining repetitive items. A list of eight to twelve items should be obtained when possible.

Prioritizing the items. In this step, the client is asked to organize the index cards according to their importance in their point of view. In rank ordering each item is written down on the respective card.

Rating the PQ. The client is requested to rate how much each difficulty has bothered him/her during the past week using a seven-point anchored scale (1= *not at all*; 2= *very little*; 3= *little*; 4= *moderately*; 5= *considerably*; 6= *very considerably*; 7= *maximum possible*). These ratings consist in the client's initial baseline score for the PQ. In addition, the interviewer may ask the client to indicate the duration of each problem, using a seven-point anchored scale (1= *less than 1 month*; 2= *1-5 months*; 3= *6-11 months*; 4= *1- 2 years*; 5= *3-5 years*; 6= *6-10 years*; 7= *more than 10 years*). Although this is an optional procedure, it can be useful for establishing a retrospective baseline for the PQ.

Prepare the PQ. The final step consists of writing down the PQ items onto a blank PQ Form. Copies should be made for future use, leaving space for adding more items later if the client wishes to. The previously defined items can also be crossed out.

These five stages process take roughly twenty to thirty minutes to complete, which can be achieved at pre-therapy stage. On posterior administrations, clients only re-rate the items for severity, which can be done in less than five minutes.

2.4.3. Research on the PQ in Clinical Practice

The PQ is considered the most popular patient-generated outcome measure, since it was used in eleven published studies (Sales & Alves, in press). With the goal of helping psychotherapist to routinely use the PQ in their clinical work, it has been included in the Individualized Patient Progress System (IPPS, Sales & Alves, 2012), a

personalized outcome management web-based system. The most recent version of the PQ has been integrated with standardized outcome measures in various contexts of psychotherapy research. Most of these studies have been conducted in the context of the International Group for Personalizing Health Assessment, a practice-based research network (Sales, Alves, Evans, & Elliott, 2014).

Sales and colleagues (2007) conducted a study about psychotherapists' perspectives on the routine use of the PQ in clinical practice which showed that approximately 60% of the participants used the PQ for clinical and research purposes. The psychotherapists surveyed used the PQ for various clinical tasks, especially for session preparation (92% of participants) and session discussion (75%). They perceived the PQ with moderate to good usefulness both for clinicians and for clients. Several benefits for the therapist were identified by respondents, such as session to session outcome monitoring (38%) and to know the specific complaints of the client (33%). Amongst the limitations of the PQ, the research reports the exclusive focus on complaints (48%) and therapist overload of information (24%). Regarding benefits for the client, respondents indicated the possibility for specification and structure for the client's complaints (39%) and the ability to give space for the client's point of view (22%). Disadvantages for the client included focus on complaints (33%) and unrealistic expectations about the therapeutic process (14%). Despite the disadvantages indicated, 92% of participants stated that they were open to integrate the PQ in their clinical practice.

2.4.4. Psychometric Properties of the PQ

Elliott and colleagues (2016) conducted a study with the general aim of establishing the psychometric parameters of the Personal Questionnaire. This study involved data bases from three countries, namely, United States of America, Scotland and Portugal. Five key measurement parameters were established, such as (1) basic descriptive data on PQ items (referring to number of items, severity ratings and prior duration of difficulties), (2) internal consistency (including internal reliability and factor structure), (3) temporal structure (including test-retest reliability and time series parameters), (4) convergent validity with other measures of psychological distress and lastly (5) sensitivity to change (both pre-post therapy and week-to-week).

Descriptive data on PQ items. Firstly, the mean number of PQ items across samples was approximately 10. Regarding severity ratings, the overall mean value for

client distress at pre-therapy stage was around 5, corresponding to feelings of “considerable” distress during the previous week by the average client. This information has valuable implications for establishing clinical cut-offs (pointing to a value of 3.25). Lastly, regarding prior duration of problems, in general clients rated their problems as having bothered them for 3 to 5 years.

Internal consistency. The clients’ PQs generally had good internal reliability at pre-therapy, with a mean alfa of .80. Between-client reliability was slightly higher (.80) than within-client (.70). The average client had a small number of items that behaved inconsistently with the remainder, resulting in one or two separate factors. Elliott and collaborators (2016) interpreted this data as an indicator of the importance of assessing clients not only in terms of a final, overall score but also on individual items and of the latent value in testing for and using secondary factors on the PQ.

These findings contradict the criticism that individualized measures are over-specific because, although seen as a unidimensional measure, the PQ shows a tendency to measure more than one thing. Another criticism towards the PQ concerns the non-comparability across clients, which prevents the calculation of group mean scores or the creation and use of normative data to interpret the PQ. However, this study points out to the possibility of using individualized factor analyses to cluster problems by content and to make specific comparisons.

Temporal structure. This dimension answers the question how consistent is the PQ over time. Analyses of temporal structure indicated high levels of between-client variance (58%), moderate overall test-retest reliability over the pre-therapy period (between intake and first session) (r =.57), and high within-client session-to-session lag-1 autocorrelations (.82).

Convergent validity. Comparisons between the PQ and other outcome measures showed a good convergent validity, with an overall correlation of .56. Although large, this value is not large enough to indicate redundancy with standardized outcome measures. The PQ nevertheless does measures a different dimension.

Sensitivity to change. Results indicate that the PQ appears to be sensitive to client change. The average client showed large pre-post gains, with standardized mean differences varying from .8 to 1.7. Clients that have had focused, time-limited treatments for specific problems showed the larger effects. Additionally, overall reliable change intervals were also large, with a value of 1.67 for pre-post change and 1.4 points for week-to-week change.

Overall, the work of Elliott and colleagues (2016) indicates that although it is a patient-generated measure, the PQ meets criteria for an evidence-based outcome measure that can be valuable in clinical practice and provide useful data for group and case study designs.

3. Rationale and Aims of the Study

Notwithstanding the importance of having outcome tools evidenced to be valid and reliable, traditional psychometric analysis is insufficient when selecting outcome measures for use in actual clinical practice settings (e.g. Blount et al., 2002). Many aspects differentiate a real-world clinical context from a research setting, including time constraints, material and human resources, client and psychotherapist characteristics, setting features and others, which may render a tool unfeasible, inappropriate, and non-generalizable to other care settings. As a result, psychotherapists' experiences concerning the use of such measures tend to be comprehensibly negative. Therefore, studies in the field of clinical utility are of great importance. A growing number of studies have addressed one or more properties of clinical utility, (e.g. Blount et al., 2002; Crawford, 2011; Miller et al., 2003; Sales & Alves, 2007). However, to our knowledge, there are no studies so far fully exploring the clinical utility of an outcome measure.

In response to the need to assess the clinical utility of outcome measures, this study will focus on an individualized outcome measure – The Personal Questionnaire – with good psychometric properties (Elliott et al., 2016) and considered useful by therapists a few years ago (Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007). This research has two main goals. First, to develop an instrument of assessment of all dimensions of the clinical utility of the PQ, either referred in the literature or suggested by therapists (study I). The second objective is to inquire therapists about the clinical utility of the PQ for daily use in the clinical practice (study II). Therefore, this study aims to answer the following research questions:

1) How therapists use the PQ in their clinical practice?
2) How feasible is using the PQ in real-world clinical settings?
3) How acceptable is the PQ for the clients?
4) How generalizable is the PQ to different clinical settings?

Since a method or instrument for assessing the clinical utility of outcome measures was not found in the literature review, it was necessary to develop a strategy to explore the adequacy of the PQ to routine use in clinical practice (study I). Therefore, the first step was searching the literature for variables and definitions of clinical utility of outcome measures. Later, the literature findings were debated in a group of experts – therapists that have used the PQ in clinical practice – using a focus group methodology. Given the difficulty in accessing this sample population, purposive

sampling was chosen to select participants for the focus group discussion. Using this recruitment method, it was attempted to enhance sample coverage by joining psychotherapists from different clinical backgrounds (Barbour, 2001).

The focus group is a qualitative technique that involves a moderator-facilitated discussion with a group of people about a specific topic of interest. When consulting with members of the target population, this technique enables generating qualitative data that can be used to both enrich and extent what is known about a concept, in this case, the PQ's clinical utility. In this way, the in-depth discussion of topics can generate important information to be used in item development and that is why focus groups are widely recognized as helpful in constructing questionnaires (Vogt, King, & King, 2004). Furthermore, this methodology has the potential benefit of increasing the content validity of items (Haynes et al., 1995, cit. in Vogt, King, & King, 2004).

In order to analyze the focus group data, a framework analysis was conducted. This is a strategy used within social and health sciences for the management and analysis of qualitative data that allows for both *a priori* concepts as well as new topics to guide the development of an analytic framework (Ritchie & Spencer, 1994, cit. in Parkinson, Eatough, Holmes, Stapley, & Midgley, 2015). The use of this method of data analysis allowed the identification of significant thematic areas to consider when assessing the clinical utility (Gale, Heath, Holmes, Stapley, & Midgley, 2015).

Using the contents that emerged from the focus group, a questionnaire containing important thematic areas to consider when assessing the clinical utility of the PQ was developed: the Utility-PQ. The Utility-PQ corresponds to an opinion questionnaire, in which several themes indicated by a group of experts, in the focus group, were used in a questionnaire. Besides opinions, the Utility-PQ asks about behaviors and aims to describe how the PQ is used in routine clinical practice and what difficulties and benefits it brings for therapists. Given the nature of this self-report measure, it would not be appropriate to apply procedures of psychometric analysis, since it does not measure psychological constructs.

The on-line survey was tested through a small pilot study. Five independent psychotherapists who had clinical experience using the PQ were invited to complete and comment on the survey. The participants were asked to express their viewpoints about the survey's appearance and clarity, language, time to complete, appropriateness of items, and others. The survey was adapted according to the participants' suggestions in order to increase appropriateness and easiness to

understand and complete. In study II, the on-line survey – the Utility-PQ – previously developed and tested in study I was administered to a sample of therapists both at national and international levels.

4. Method

4.1. Study I

4.1.1. Participants

Four psychotherapists who have used the PQ in clinical practice were invited by e-mail. The participants were female clinical psychologists with ages ranging from 34 to 45 years old. The participants had an average of 3.5 years of experience using the PQ and have used the PQ in a diversity of settings, including private practice, health psychology, group therapy, specific therapeutic contexts such as psychodrama, and research. The characteristics of the participants are exposed in more detail on Table 3.

Table 3. *Participants of the Focus Group*

	Participant 1	Participant 2	Participant 3	Participant 4
Education	Doctoral degree	Doctoral degree	Master degree	Doctoral degree
Professional Occupation	College professor	College professor	Clinical Psychologist	Clinical Psychologist
Clinical Approach	Emotion-focused therapy	Cognitive-behavioral therapy	Emotion-focused therapy	Emotion-focused therapy
Experience using the PQ	2 years	4 years	4 years	4 years
Context of administration	- Group therapy - Psychodrama - Research	- Group therapy - Research	- Private practice - Psycho-oncology	- Private practice - Psycho-oncology

4.1.2. Procedure

The focus group had a duration of approximately 95 minutes. It was audio recorded with the consent of the participants. Confidentially and anonymity were

guaranteed to the participants. The focus group discussion was moderated by the author of this paper.

The focus group followed a semi-structured interview with five main moments: (1) reasons and goals for using the PQ (e.g. “what are your goals using the PQ?”); (2) views about benefits and limitations of using the PQ (e.g. “what does it offer that other measures don’t?”, “what could be different?”); (3) easiness of administration and analysis of the PQ (e.g. “do you find it difficult to use the PQ? For what reasons?); (4) perspectives on client’s acceptance of the PQ (e.g. “how do clients react to the PQ?”); (5) how generalizable the PQ is for different clients and settings (e.g. “is it possible to administer to all clients?”, “is it advisable for different work contexts?”). The focus group ended when all the participants shared and discussed their perspectives about the themes that emerged. Before ending the focus group, a verbal summary of the meeting was elaborated by the moderator and corroborated by the participants.

Using the audio recording, a transcription of the focus group discussion was prepared. After familiarization with the interview, labels that described the topic of an important quotation were applied to the transcription. Later, these labels were grouped into preset categories (the domains of clinical utility found in the literature review) and new categories (thematic areas of clinical utility that were not provided in the literature), forming the framework matrix. Illustrative quotations of the participants were also included into the matrix.

4.2. Study II

4.2.1. Participants

An e-mail message inviting participation was sent to the Society for Psychotherapy Research (SPR) server list, as well as to centers, teams and individuals who were known to have used the PQ. The co-supervisor of this paper as also shared the link to the survey through social networks, such as his blog and Facebook page. The broad diffusion of the on-line survey makes it difficult to calculate a maximum possible sample. However, based on the invitations sent directly to individuals and teams, we estimate that the survey reached a minimum of 200 therapists and counsellors. A sample of 25 participants was obtained, equivalent to an estimated response rate of 12.5%, both at national and international levels. Criteria of inclusion

were professional occupation as psychotherapist or counsellor and previous experience with the PQ in clinical context.

Most participants were female (76%, *n*= 19), aged from 24 to 55 years old (M= 34.52, SD= 8.699). In this sample, 18 psychotherapists were Portuguese (72%) and 6 were from the United Kingdom (24%) with clinical experience varying from 32 years to less than one year (M= 7.604, SD= 7.735). Regarding educational levels, half of the participants had a master's degree (52%, *n*= 13), one fifth had a PhD (20%, *n*= 5) and one fifth had postgraduate studies (20%, *n*= 5). Concerning theoretical orientation, 40% of the participants followed a Cognitive-Behavioral approach (*n*= 10) and 28% followed a Person-centered/ Experiential/ Humanistic approach (*n*= 7). Lastly, with regard to professional identification, 64% of the participant see themselves as both therapists and researchers (*n*= 16), 20% only as therapists (*n*= 5) and 16% as primarily researchers (*n*= 4). Sociodemographic information is displayed in detail on Table 4.

Table 4. *Sociodemographic information of the participants*

Variable	M (SD)	*n* (%)
Age	34.52 (8.699)	
Gender		
Male		6 (24)
Female		19 (76)
Residence		
Portugal		18 (72)
United Kingdom		6 (24)
Other		1 (4)
Education level		
Pre-bologna university degree		2 (8)
Master's degree		13 (52)
PhD		5 (20)
Postgraduate Studies		5 (20)
Years of clinical experience	7.64 (7.735)	
Clinical Approach		
Cognitive-Behavioral		10 (40)
Person-centered/ Experiential/ Humanistic		7 (28)

Systemic	1 (4)
Integrative	2 (8)
Emotion-focused	2 (8)
Existential-phenomenological therapy	1 (4)
Psychodrama	1 (4)
Other	1 (4)
Professional identification	
Therapist exclusively	5 (20)
Both therapist and researcher	16 (64)
Primarily a researcher	4 (16)

Note. M = Mean; SD = Standard deviation.

4.2.2. Instrument and procedure

The Utility-PQ is an on-line survey designed to capture the relative magnitude of the psychotherapists' opinions and experiences using the PQ in routine clinical practice. It aims to assess the clinical utility of this individualized measure in a holistic manner by exploring feasibility, acceptability and generalizability. It combines a set of items asking the participant to make a series of quantitative assessments about the PQ by means of measurement forms like Likert scales and other fully anchored rating scales. It also includes one open-answer question. It contains five sections as follows:

Section A: Personal Information. This first section aimed to collect significant sociodemographic information of the participants, including gender, country of residence, education, clinical experience, clinical approach and professional identification as therapist, researcher or both.

Section B: PQ Administration Setting. Information concerning the setting of administration of the PQ is collected, such as time of experience using the PQ, work setting, application format, clinical purposes to PQ administration, and others.

Section C: Views of the PQ. Section C was designed to capture the participant's experience using the PQ by asking them to complete the questions from their point of view as psychotherapist. Subjects included are the training needed to use the PQ, protocol adhesion and modifications, and adaptability to different clients, psychotherapists and therapeutic settings.

Section D: Client Views of the PQ. The fourth section targeted the client acceptability of the PQ. Participants were asked to think about client reactions toward using the PQ in two different moments: the construction interview and subsequent administrations during treatment.

Section E: Benefits and limitations of the PQ. The final section targeted perceived benefits and limitations of the PQ and asked participants the degree of acceptance and openness to use the PQ in routine clinical practice.

In order to reach as many psychotherapists as possible, both at national and international levels, the Utility-PQ was developed as an on-line survey in two languages (Portuguese and English). The equivalence of meaning of the two versions was improved by multiple revisions by members of our team from both nationalities and independent collaborators. The English and Portuguese versions of the questionnaire are available on-line (http://goo.gl/forms/9lUABeLcuW for the English version; http://goo.gl/forms/Hc6aUTjnmC, for the Portuguese version) and in appendix (see appendix C for the English version and appendix D for the Portuguese version).

Participants were recruited between September and December of 2015 mostly through e-mail messages inviting participation. Data was collected through an internet survey, using free web-based software (available in https://www.google.com/forms/about/). Independent access to the two versions was attempted by means of separate links in the message requesting participation. All the data collected by the on-line survey were automatically stored in an Excel spreadsheet.

Later, the software IBM SPSS Statistics 21® was used in order to carry out frequency distributions and descriptive statistics of the variables. We calculated:

- the percentage of psychotherapists that indicated each response option to the items,
- the arithmetic mean and standard deviation of items rated in Likert-type scales (aggregated rating scales or individual rating items with numerical response formats with at least five response options can be treated as continuous data (Harpe, 2015)),
- and finally, the mean indicator score. To calculate global means, the mean response scores of negative items (that is, items in each a higher score means lower clinical utility) were reversed, so that the higher the mean, the better are the experiences of the participants using the PQ.

Tables 5, 6 and 7 describe in detail the analysis procedures carried out to each domain of clinical utility.

Table 5. *Analysis procedures for the indicators of feasibility*

Indicator	Measurement	Scoring	Meaning
Protocol adhesion	13 items rated from 0 (never) to 4 (always)	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate higher protocol adhesion (items 11, 12 and 13 are reverse coded to calculate mean scores)
	Open answer	Percentage for each of the six categories that emerged from content analysis[1]	Higher percentages indicate more psychotherapists sharing the same perspectives
Brevity and Simplicity	2 items rated from 0 (strongly disagree) to 4 (strongly agree)	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate high brevity (item 1 is reverse coded to calculate mean scores)
	1 item of multiple choice[2]	Percentage of endorsement of each option	Less time needed for training indicate high simplicity
Ethical appropriateness	1 item rated from 0 (strongly disagree) to 4 (strongly agree)	Mean score (minimum: 0; maximum 4) and percentage for each item	Higher score indicate high ethical appropriateness (item 1 is reverse coded to calculate mean score)
Value for practice	19 items rated from 0 (strongly disagree) to 4 (strongly agree)	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher score indicate high ethical appropriateness (item 6, 7, 10, 12, 18, is reverse coded to calculate mean scores)
Openness	1 item of multiple choice[3]	Percentage of endorsement of each option	Higher satisfaction indicate high openness

[1] See Appendix B.
[2] Four options corresponding to amount of time necessary to learn how to use the PQ.
[3] Three options corresponding to levels of satisfaction of using the PQ routinely.

Table 6. *Analysis procedures for the indicators of acceptability*

Indicator	Measurement	Scoring	Meaning
Emotional effect	3 items rated from 0 (strongly disagree) to 4 (strongly agree)	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate positive emotional effect (items 1, 2 and 3 are reverse coded to calculate mean scores)
General receptiveness	2 items rated from 0 (not at all receptive) to 4 (totally receptive)	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate high receptiveness

Table 7. *Analysis procedures for the indicators of generalizability*

Indicator		Measurement	Scoring	Meaning
Generalizability to clients	Age groups	4 items rated from 0 (quite inappropriate) to 4 (quite appropriate)[4]	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate high generalizability to clients of different age groups
	Other client features	10 items (participants were allowed to indicate all that apply)	Percentage of endorsement of each item	Higher percentages indicate the features more hindering of the PQ administration
	Adaptability to clients' needs and features	4 items rated from 0 (never) to 4 (always)	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate higher adaptability of the procedures to different client needs and features
	Degree of applicability	1 item of multiple choice[5]	Percentage of endorsement of	Higher percentage intervals of clients

[4] A fifth option is provided which corresponds to a non-response (5= *I don't know*) in order to avoid forcing participants to select an option when they have no knowledge of the situation illustrated in the item

[5] Five options corresponding to percentage intervals of clients.

		each option	indicate high applicability
Generalizability to psychotherapists: clinical approach	10 items rated from 0 (quite inappropriate) to 4 (quite appropriate)[6]	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate high generalizability to psychotherapists of different clinical approaches
Generalizability to settings	8 items rated from 0 (quite difficult) to 4 (quite easy)[7]	Mean score (minimum: 0; maximum 4) and percentage for each item; also mean indicator score	Higher scores indicate high generalizability to settings

[6] *Idem*.
[7] *Idem*.

5. Results

The section 5.1 is dedicated to the presentation of results of study I, that is, the results of the framework analysis of the focus group debate that gave origin to the self-administered questionnaire. The following section, 5.2, consists in the display of the results of the administration of the self-administered questionnaire.

5.1. Study I

From the framework analysis of the focus group debate transcription, a matrix with the thematic areas, codes and respective quotations of the participants was developed (see Appendix B, or Table 8 for a simplified version). Globally, most of the themes found in the literature were addressed by the participants of the focus group. Furthermore, new topics have emerged from consulting with members of the target population (e.g. ethical concerns). Additionally, suggestions and adaptations to increase clinical utility have emerged (see Table 9).

Table 8. *Framework Matrix*

	Thematic areas	Codes	Extract from transcript
Feasibility	Brevity	Time of administration/ interpretation	"It's time consuming." (P1)
	Value for practice	Benefits for practice	"Building it involves the client differently (…) he becomes more responsible for his treatment." (P3) "It's reusable." (P3)
	Openness	Protocol adhesion	"The procedure says to list about 10 items. I don't do that. I think it's an exaggerated number." (P1)

		Ethical appropriateness	"The PQ can create dilemmas about confidentiality… when the construction interview is conducted by other than the therapist."(P1)
Acceptability	Features of the instrument	Idiographic approach	"Patients are pleased to have a subjective evaluation during treatment (...) They see their own evolution, assessed by themselves." (P4)
	Method of administration	Integrated use in treatment	"I think that, for the patients, the PQ is part of the intervention." (P2)
		Frequency of administration	"I think patients get a little bit tired of the PQ along the treatment process… It´s like 'I don't want to think about that anymore, let me enjoy my therapy'." (P1)
	Emotional effect	Psychological distress	"The client lists his concerns, thus he will have the expectation that they will be intervened." (P1)
Generalizability	Clients' characteristics	Clinical condition	"Since the PQ involves an almost constant evaluation, categorization… in people with obsessive symptoms I think (administering the PQ) is a risk. I don't know if it increases symptoms." (P1)
		Other client features	"It is a major advantage, it can be applied to people of various socio-economic and education levels." (P3)

	Psychotherapists' characteristics	Clinical experience	"(Administering the PQ) implies all the clinical skills involved in establishing a therapeutic relationship... creating a safe environment for the client to think… it also implies that the psychologist is able to pay close attention to non-verbal cues." (P1)
	Variations across settings	-	"To me it is so much easier to apply the PQ in private practice because people seek psychological treatment (…) thus they are more motivated and involved in the process." (P4)

Note. P1, P2, P3 and P4 indicate the participant to whom the quotation belongs.

Table 9. *Suggestions of the focus group participants to increase clinical utility*

Domain	Suggestions
Feasibility	"I guess it would be better for us and for the patients if we focus on bringing the items from the relationship only, without using draft cards and forms." (P4) "I believe 4 to 6 items are enough." (P2) "(In group therapy) I think building a PQ for the entire group would be advantageous." (P2)
Generalizability	"With patients with reduced mobility, I write the items on post-it so they don't slide around." (P1) "With visually impaired patients, or illiterate patients, it's me who writes the items in the form." (P2)

Note. P1, P2, P3 and P4 indicate the participant to whom the quotation belongs.

From the framework matrix of the focus group discussion and the literature review, it was possible to extract critical indicators of the clinical utility of the PQ and to understand how the general thematic areas found in the literature apply to the use of the PQ in routine clinical practice (see Appendix F for a summary of the important areas to explore when assessing clinical utility of a measure). These indicators were crucial when generating the items of the on-line survey, the Utility-PQ.

5.2. Study II

5.2.1. How therapists use the PQ?

Most therapists conduct themselves the PQ construction interview (72%, *n*= 18) opposed to delegate the task to a researcher or other practitioner (see Table 10). A large percentage of the participants (72%, *n*= 18) have used the PQ for a period of time ranging from 1 to 5 years. The most known (96%, *n*= 24) and frequently used (92%, *n*= 23) administration format of this measure is by paper and pencil and some therapists (28%, *n*= 7) use computerized systems of outcome management like IPPS and CORE-Net, which allow to monitor the clients' progress through the PQ. However, the majority of therapists (almost 70%) do not use electronic systems to manage/register PQ data.

Concerning the amount of clinical cases in which the participants administer the PQ, almost half (48%, *n*= 12) of the participants use the PQ with 50% of their clients or more. More than half (56%, *n*= 14) of the respondents have used the PQ in university clinics and 32% (*n*= 8) in the private practice. The majority of the participants use the PQ in three moments of the therapeutic process: at the first therapy session (56%, *n*= 14), during therapy (84%, *n*= 21) and at the last therapy session (72%, *n*= 18). Concerning frequency of administration, 68% (*n*= 17) of the participants use the PQ with fixed regularity (e.g. every two weeks) opposed to variable regularity (when considered relevant).

The clinical tasks where the PQ is mostly used are the assessment of the client's progress and the monitoring of the evolution of specific problems (both indicated by 100%, *n*= 25, of the participants), doing it both with the client, other practitioners and individually (64%, *n*=16, and 48%, *n*= 12, respectively). In addition, 40% (*n*= 10) of the participants indicated to "sometimes" use the PQ data to talk to clients about treatment planning.

Table 10. *How do therapists use the PQ in clinical practice?*

Variable	N (%)
Who usually performs the PQ construction interview?	
Me (the psychotherapist)	18 (72)
A researcher	7 (28)
For how long, approximately, have you used the PQ in routine clinical practice?	
Less than 1 year	4 (16)
Between 1 and 5 years	18 (72)
Between 5 and 10 years	2 (8)
More than 10 years	1 (4)
Which PQ application format(s) have you used?	
Only paper and pencil	24 (96)
Integrated into IPPS	7 (28)
Integrated into CORE-NET	1 (4)
Which PQ application format(s) do you use more often?	
Only paper and pencil	23 (92)
Integrated into IPPS	1 (4)
Integrated into CORE-NET	1 (4)
Among the clinical cases you see in your practice, in how many do you administer the PQ?	
0% to 25%	8 (32)
25% to 50%	5 (20)
50% to 75%	7 (28)
75% to 100%	2 (8)
Near 100%	3 (12)
In which work setting(s) have you used the PQ?	

Psychiatric outpatient	5 (20)
Psychiatric inpatient	3 (12)
Primary health care	2 (8)
Health/ hospital psychology	4 (16)
Substance abuse	1 (4)
University clinics	14 (56)
Private practice	8 (32)
Other	2 (8)
In which stage(s) of the therapeutic process have you used the PQ?	
Screening	2 (8)
Referral	1 (4)
Assessment	12 (48)
First Therapy Session	14 (56)
Pre-therapy (unspecified)	5 (20)
During Therapy	21 (84)
Last Therapy Session	18 (72)
Follow up	8 (32)
How often do you administer the PQ during treatment?	
With fixed regularity (e.g. every two weeks)	17 (68)
With variable regularity (e.g. when I find it relevant)	8 (32)
How often do you use the PQ to talk with your clients about treatment planning?	
Never	1 (4)
Seldom	7 (28)
Sometimes	10 (40)
Often	7 (28)

Almost always	0 (0)

For what clinical purposes do you administer the PQ?

	With the therapeutic team/ supervisor or the psychotherapist alone	With the client	Both	None
	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**
Assess the client's progress	5 (20)	4 (16)	16 (64)	0 (0)
Check the evolution of specific problems	4 (16)	9 (36)	12 (48)	0 (0)
Bridge between sessions	2 (8)	4 (16)	7 (28)	12 (48)
Summarize the session	1 (4)	3 (12)	4 (16)	17 (68)
Reframe the difficulties or problems	4 (16)	6 (24)	7 (28)	8 (32)
Treatment planning	6 (24)	3 (12)	9 (36)	7 (28)
Session preparation	9 (36)	2 (8)	3 (12)	11 (44)
Session discussion	5 (20)	6 (24)	5 (20)	9 (36)
Case supervision	16 (63)	2 (8)	2 (8)	5 (20)

5.2.2. Feasibility

Protocol adhesion

Administering a patient-generated measure like the PQ requires developing its content with the client. This process is accomplished in the first application of the PQ, when a semi-structured interview is conducted in order to identify the PQ items, to rank order them according to importance to the client and rate them regarding duration and intensity of distress. To explore the degree of adequacy of the PQ construction

interview, the participants were requested to indicate the frequency in which they follow the PQ administration procedures as described in the protocol (see Table 11).

The most complied procedures (mean response scores superior to 3.5), were rating the items according to degree of distress and rank ordering the items according to their importance for the client (both done "always" by 80% of the respondents, *n*= 20), making sure the items reflect the client chief concerns (followed by 76% of the participants, *n*= 19), including problem duration ratings and writing the problems in the PQ form after they have been defined and clarified (both done "always" by 68% of the respondents, *n*= 17). The procedure less complied with, which 4% (*n*= 1) of the respondents "never" and 28% (*n*= 7) "seldom" choose to follow is generating a draft list of 15 difficulties. The item with higher variance of responses, that is, that stimulated more disagreement between the respondents is the use of small pieces of paper for the draft items (SD=1.491).

The therapists introduce some modifications to the PQ construction protocol (see Table 11): not using pieces of paper for the draft items and postponing the PQ construction interview, in order to guarantee that there is a strong therapeutic alliance before applying the PQ. The least introduced variation was skiping administration procedures because of the length of the protocol, which was seldom (28%, *n*=7) or never (36%, *n*= 9) done by the participants.

Overall, the global adhesion of therapists to the PQ construction procedures is high, with a global mean of 3.05[8] (SD=.584) in 4.

---

[8] To calculate the mean indicator score the scores of the items 11, 12, and 13 were reverse coded.

Table 11. *Descriptive statistics of protocol adhesion of the PQ administration procedures*

Utility-PQ Items	M (SD)	**Never** *n* (%)	**Seldom** *n* (%)	**Sometimes** *n* (%)	**Often** *n* (%)	**Always** *n* (%)
1. I make an attempt to search for problems from areas such as: symptoms, mood, specific performance/activity, relationships and self-esteem.	3.40 (.764)	0 (0)	1 (4)	1 (4)	10 (40)	13 (52)
2. I help the client generate a draft list of 15 difficulties or problems.	2.36 (1.221)	1 (4)	7 (28)	4 (16)	8 (32)	5 (20)
3. I use small pieces of paper for the draft items.	2.84 (1.491)	2 (8)	5 (20)	2 (8)	2 (8)	14 (56)
4. I make sure that the items are specific difficulties or problems, rather than goals or vague, multiple problems.	3.32 (.852)	0 (0)	1 (4)	3 (12)	8 (32)	13 (52)
5. I help the client reach 8 to 12 final PQ items.	2.64 (1.221)	1 (4)	4 (16)	6 (24)	6 (24)	8 (32)
6. I make sure that the PQ reflects the client's chief concerns.	3.72 (.542)	0 (0)	0 (0)	1 (4)	5 (20)	19 (76)
7. I have clients rank order the items based on their importance.	3.60 (.957)	1 (4)	0 (0)	2 (8)	2 (8)	20 (80)
8. I have the client indicate the degree of distress caused by each problem.	3.80 (.408)	0 (0)	0 (0)	0 (0)	5 (20)	20 (80)
9. I include the problem duration ratings.	3.56 (.712)	0 (0)	0 (0)	3 (12)	5 (20)	17 (68)
10. I write the problems in the PQ form after they have been defined and clarified.	3.52 (.918)	1 (4)	0 (0)	1 (4)	6 (24)	17 (68)

11. I make sure I have a moderately strong therapeutic alliance with the client prior to the PQ administration.	2.32 (.988) (*)	4 (16)	5 (20)	11 (44)	5 (20)	0 (0)
12. The difficulties or problems are identified and refined only through dialog (not using pieces of papers).	1.88 (1.453) (*)	6 (24)	1 (4)	7 (28)	6 (24)	5 (20)
13. I skip some administration procedures because it is a lengthy process.	2.72 (1.308) (*)	9 (36)	7 (28)	4 (16)	3 (12)	2 (8)

Note. M = Mean; SD = Standard deviation. (*) Items 11, 12 and 13 were reverse coded to calculate mean scores.

Most of the therapists did not made any suggestions and indicated the PQ "has always worked fine how it is" or "no suggestions, as long as it is possible to adapt to the client's needs". However, 6 therapists suggested some modifications, for instance, "stop writing down the draft items on small pieces of paper" or "make simpler the process of selecting the client difficulties" (see Table 12 and Appendix E).

Table 12. *Therapists' suggestions to increase feasibility of the PQ procedure*

Thematic category	*n* (%)
No suggestions	14 (56)
E.g. "It has always worked fine how it is", "No suggestions, as long as it is possible to adapt to the client's needs."	
Simplify the administration procedures	6 (24)
E.g. "Stop writing down the draft items on small pieces of paper"; "make simpler the process of selecting the client difficulties."	
Ask the client to think about the items beforehand	2 (8)
E.g. "Giving the client more time to consider their issues i.e. giving them more information before they meet with the researcher so they come prepared with a list in mind. I think this would help more anxious clients."	

Make the PQ a fully self-administered instrument	1 (4)
"Make it possible for the client to complete the PQ all by himself."	
Include a comprehensive quotation system	1 (4)
"Include a comprehensive quotation system that allows for the therapist to ensure the quality of the items formulated with the client."	
Test data	1 (4)
"Test data."	

Brevity and Simplicity

Regarding the time involved in using the PQ, 36% of the therapists (*n*= 9) rated the PQ as time consuming. However, most therapists (52%, *n*= 13) considered that the PQ allows to save time and sessions (see Table 13).

Table 13. *Descriptive statistics of length of the PQ administration and interpretation*

Utility-PQ items	M (SD)	Strongly disagree	Disagree	Neither	Agree	Strongly agree
		***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**
1. The PQ is time consuming.	1.84 (1.028) (*)	0 (0)	8 (32)	8 (32)	6 (24)	3 (12)
2. The PQ saves time and sessions since it allows a structured review of difficulties or problems and establishing therapeutic goals all at the same time.	2.32 (.802)	0 (0)	5 (20)	7 (28)	13 (52)	0 (0)

Note. M = Mean; SD = Standard deviation. (*) Item 1 was reverse coded to calculate mean scores.

Concerning simplicity of the PQ, the therapists were asked about training requirements. The majority of the therapists considered that it is possible to learn how to use the PQ in one to three hours of training (56%, *n*= 14) or less (36%, n= 9) (see Figure 1).

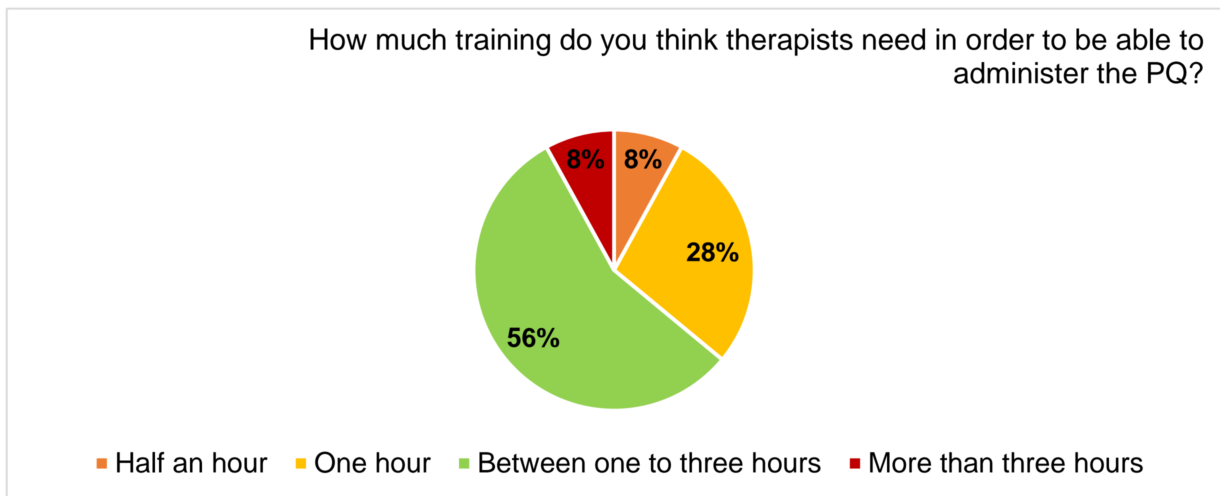

Figure 1. Descriptive statistics of training needs of the PQ

Ethical appropriateness

Since the PQ administration might be conducted by other practitioner than the therapist (e.g. a researcher), using the PQ might create dilemmas regarding confidentiality. The majority of the therapists "disagreed" (56%, *n*= 14) or "strongly disagreed" (24%, *n*= 6) with this potential ethical concern (see Table 14).

Table 14. *Descriptive statistics of the variable ethical appropriateness of the PQ*

Utility-PQ Items	M (SD)	Strongly disagree	Disagree	Neither	Agree	Strongly agree
		n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
1. The PQ creates dilemmas regarding confidentiality.	3.4 (.676) (*)	6 (24)	14 (56)	5 (20)	0 (0)	0 (0)

Note. M = Mean; SD = Standard deviation. (*) Item 1 was reverse coded to calculate mean scores.

Value for practice

The most beneficial characteristics of the PQ for clinical practice identified by the participants were: the ability of assisting in the process of defining therapeutic goals, helping clients to think more thoroughly about their difficulties and the impact these have on their lives, promoting client involvement and responsibility in the treatment, and, lastly, the ability of the PQ to capture the client point of view. Overall, the global mean is equal to 2.81[9] (SD=.345) in 4, suggesting the participants perceive the PQ as having high value for practice (see Table 15).

Table 15. *Descriptive statistics of value for practice of the PQ*

Utility-PQ Items	M (SD)	Strongly disagree	Disagree	Neither	Agree	Strongly agree
		n (%)	*n* (%)	*n* (%)	*n* (%)	*n* (%)
1. The information provided is useful in clinical decision making.	2.76 (1.052)	2 (8)	1 (4)	2 (8)	16 (64)	4 (16)
2. The PQ helps to build diagnostic hypotheses at the	2.84	1 (4)	2 (8)	2 (8)	15	5 (20)

[9] To calculate the mean indicator score the scores of the items 6, 7, 10, 12 and 18 were reverse coded.

pre-treatment stage.	(.987)				(60)	
3. The PQ assists in the process of defining therapeutic goals.	3.68 (.557)	0 (0)	0 (0)	1 (4)	6 (24)	18 (72)
4. The PQ helps clients think more thoroughly about their difficulties and the impact these have on their lives.	3.40 (.577)	0 (0)	0 (0)	1 (4)	13 (52)	11 (44)
5. The PQ provides knowledge about history of the difficulty	2.76 (.831)	0 (0)	2 (8)	6 (24)	13 (52)	4 (16)
6. The PQ tends to lead to the diffusion of therapeutic goals because there are too many items.	2.88 (.726) (*)	4 (16)	15 (60)	5 (20)	1 (4)	0 (0)
7. The PQ results in information overload for the therapist.	3.36 (.569) (*)	10 (40)	14 (56)	1 (4)	0 (0)	0 (0)
8. The PQ promotes working alliance between therapist and client.	3.12 (.600)	0 (0)	0 (0)	3 (12)	16 (64)	6 (24)
9. The PQ promotes client involvement and responsibility in the treatment.	3.32 (.627)	0 (0)	0 (0)	2 (8)	13 (52)	10 (40)
10. The PQ excessively focuses on difficulties or problems.	1.44 (.917) (*)	0 (0)	4 (16)	6 (24)	12 (48)	3 (12)
11. The PQ provides feedback to the therapist about their performance.	2.44 (.807)	1 (4)	2 (8)	8 (32)	13 (52)	1 (4)
12. The information provided by the client on the PQ may not be trustworthy.	2.12 (1.092) (*)	3 (12)	7 (28)	5 (20)	10 (40)	0 (0)
13. The PQ can provide a warning of emerging problems in treatment.	2.52 (.872)	0 (0)	3 (12)	9 (36)	10 (40)	3 (12)

14. The PQ provides information about personal and family resources.	2.24 (.970)	1 (4)	3 (12)	13 (52)	5 (20)	3 (12)
15. The PQ makes it possible to monitor the client's progress session to session.	3.12 (.833)	0 (0)	0 (0)	7 (28)	8 (32)	10 (40)
16. The PQ enables a prognosis at the pre-treatment stage.	1.56 (.821)	3 (12)	7 (28)	13 (52)	2 (8)	0 (0)
17. The PQ emphasizes the client point of view.	3.24 (.926)	1 (4)	0 (0)	2 (8)	11 (44)	11 (44)
18. The PQ may cause anxiety in the therapist about lack of progress or deterioration in the client.	2.00 (1.118) (*)	3 (12)	6 (24)	4 (16)	12 (48)	0 (0)
19. The possibility of being modified during treatment makes the PQ a dynamic and reusable tool.	3.48 (.653)	0 (0)	0 (0)	2 (8)	9 (36)	14 (56)

Note. M = Mean; SD = Standard deviation. (*) Items 6, 7, 10, 12 and 18 were reverse coded to calculate mean scores.

Openness

Finally, in order to assess the general openness and acceptance of the PQ, the participants were requested to say to what extent they enjoy using the PQ in routine clinical practice. Results are displayed in Figure 2. Almost half (48%, *n*= 12) of the therapists like “very much” and 52% (*n*= 13) like “moderately” using the PQ.

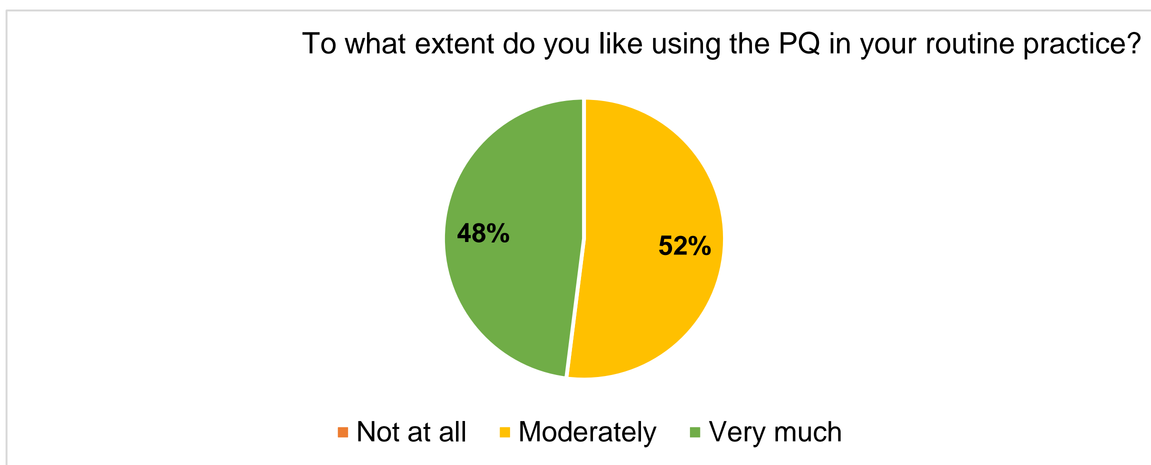

Figure 2. *Descriptive statistics of therapist openness to use the PQ*

5.2.3. Acceptability

Emotional effect

An indicator of client acceptability is the degree of emotional distress that comes with completing the PQ. The characteristic of the PQ that the respondents perceived as more prone to induce psychological discomfort in clients is the potentially unclear relationship between the therapist and the professional with whom they do the PQ construction interview (that can be done by other than the therapist, for instance, a researcher). More than one fifth (24%, *n*= 6) of the participants "agreed" that "the relationship between the therapist and the researcher in generating the PQ might confuse the client" although a significant percentage (44%, *n*= 11) "neither agree nor disagree" with this item (see Table 16). Regarding the other two items, the therapists do not seem to consider that the PQ causes emotional distress in clients.

Table 16. *Descriptive statistics of emotional effect of the PQ to the client*

Utility-PQ items	**M (SD)**	**Strongly disagree** *n* **(%)**	**Disagree** *n* **(%)**	**Neither** *n* **(%)**	**Agree** *n* **(%)**	**Strongly agree** *n* **(%)**
1. Extensive listing of problems is harmful for the client (multiplies problems).	2.92 (1.038) (*)	8 (32)	10 (40)	5 (20)	1 (4)	1 (4)

2. The PQ sets up unrealistic expectations about the therapeutic process (ie, solving all problems in the list).	2.68 (.988) (*)	6 (24)	8 (32)	8 (32)	3 (12)	0 (0)
3. The relationship between the therapist and the researcher in generating the PQ might confuse the client.	2.08 (.759) (*)	0 (0)	8 (32)	11 (44)	6 (24)	0 (0)

Note. M = Mean; SD = Standard deviation. (*) Items 1, 2 and 3 were reverse coded to calculate mean scores.

General receptiveness

The clients' receptiveness of the PQ was assessed regarding two different moments. Concerning the PQ construction interview at first application, 68% of the therapists (*n*= 17) considered that the clients feel "moderately receptive" about the PQ. However, in subsequent administrations during therapy, the majority of therapists (64%, *n*=18) perceive the clients as more receptive towards the PQ (see Table 17). In general, the clients' receptiveness to the PQ is moderate, with a global mean of 2.54 (SD=.61) in 4.

Table 17. *Descriptive statistics of the clients' general receptiveness*

Utility-PQ items	**M (SD)**	**Not at all receptive** *n* **(%)**	**Slightly receptive** *n* **(%)**	**Moderately receptive** *n* **(%)**	**Very receptive** *n* **(%)**	**Totally receptive** *n* **(%)**
1. In general how would you rate your clients' receptiveness and acceptance of the PQ procedure at their first contact?	2.32 (.690)	0 (0)	1 (4)	17 (68)	5 (20)	2 (8)
2. In general how would you rate your clients' receptiveness and acceptance of the PQ	2.76 (.779)	0 (0)	1 (4)	8 (32)	12 (48)	4 (16)

procedure in subsequent contacts?

Note. M = Mean; SD = Standard deviation.

5.2.4. Generalizability

Generalizability to clients

The age group that the PQ is considered most appropriate to is adults (M= 3.92, SD= .400). Oppositely, children were considered the age group to which the PQ is less generalizable (M= 2.60, SD= 1.756). Overall, the global mean is 3.26[10] (SD=.775) in 4, suggesting that the PQ is highly generalizable to different age groups.

Table 18. *Descriptive statistics of the appropriateness of the PQ to different age groups*

Utility-PQ items	M (SD)	Quite inappropriate	Moderately inappropriate	Neither	Moderately appropriate	Quite appropriate	I don't know
		***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**
1. Children	2.60 (1.756)	3 (12)	5 (20)	5 (20)	4 (16)	2 (8)	6 (24)
2. Adolescents	3.72 (.843)	0 (0)	0 (0)	1 (4)	10 (40)	9 (36)	5 (20)
3. Adults	3.92 (.400)	0 (0)	0 (0)	1 (4)	0 (0)	24 (96)	0 (0)
4. Elders	3.40 (1.155)	1 (4)	1 (4)	1 (4)	9 (36)	10 (40)	3 (12)

Emotional dysregulation and difficulty putting internal processes and contents into words were the client variables identified by the participants as hindering the PQ

[10] The calculation of the global mean was done without including the option "I don't know".

administration, both indicated by 84% (*n*= 21) of the therapists. The least endorsed client characteristics were "perception of the PQ as too difficult" (8%, *n*= 2), and "physical disability/ limitation" (12%, *n*= 3) (see Table 19).

Table 19. *Descriptive statistics of the client variables that may hinder administrating the PQ*

Utility-PQ items	*n* (%)
Difficulty putting internal processes and contents into words	21 (84)
Emotional dysregulation	21 (84)
Cognitive limitation	14 (56)
Avoidance of distressing emotions or thoughts	13 (52)
Tendency to talk too much or in an overly abstract or rationalized way	13 (52)
Physical pain	9 (36)
Low education	8 (32)
Psychopathological features	6 (24)
Physical disability/limitation	3 (12)
Perception of the PQ as too difficult.	2 (8)

Some therapists conduct some variations to the protocol in order to adapt to the client characteristics. The most frequent adaptations include: postponing the PQ administration if the client is emotionally dysregulated (72% of the respondents do this adaptation "often" or "always", *n*= 18) and writing down the client's rank ordering of the items if the client is illiterate or visually impaired (60% of the respondents do it "often" or "always", *n*= 15) (see Table 20).

Table 20. *Adaptations of the PQ procedures for different client features and needs*

Utility-PQ item	M (SD)	Never *n* (%)	Seldom *n* (%)	Sometimes *n* (%)	Often *n* (%)	Always *n* (%)
1. I postpone the PQ administration if the client is emotionally dysregulated.	2.96 (1.207)	1 (4)	3 (12)	3 (12)	7 (28)	11 (44)
2. When working with clients with limited mobility, I write down identified difficulties on post-it notes so they don't slide around.	1.84 (1.573)	9 (36)	0 (0)	7 (28)	4 (16)	5 (20)
3. If the client is illiterate or visually impaired I write down the client's rank ordering of the items for them.	2.60 (1.658)	6 (24)	0 (0)	4 (16)	3 (12)	12 (48)
4. I help the client regulate dysregulated emotion, ensuring that they are able to take part in the PQ administration.	2.44 (1.387)	3 (12)	3 (12)	7 (28)	4 (16)	8 (32)

Note. M = Mean; SD = Standard deviation.

Despite the diverse client variables that may hinder generalizability, a large percentage of respondents (92%, *n*= 22) consider that the PQ can be used routinely with more than 50% of clients (see Table 21).

Table 21. *Descriptive statistics of the degree of applicability of the PQ*

Utility-PQ items	*n* (%)
What percentage of clients is the PQ applicable to?	
0% to 25% clients	0 (0)
25% to 50% clients	2 (8)
50% to 75% clients	14 (56)
75% to 100% clients	4 (16)
Near 100% clients	4 (20)

Generalizability to psychotherapists

The clinical approach to which the PQ is considered most appropriate to is the Person-centered/ Experiential/ Humanistic approach, with the large majority of therapists (84%, *n*=21) rating the PQ as "very appropriate" (see Table 22). In second place is Cognitive-Behavioral Therapy, with 76% of the participants considering the PQ "very appropriate" to this approach as well. On the opposite side, 20% of the therapists found the PQ "quite inappropriate" or "moderately inappropriate" for Psychodynamic/ Psychoanalytic approach. Overall, the therapists perceived the PQ as highly generalizability to different clinical approaches, with a global mean of 3.90 (SD=.540) in 4.

Table 22. *Descriptive statistics of the appropriateness of the PQ to diverse clinical approaches*

Utility-PQ items	M (SD)	Quite inappropriate *n* (%)	Moderately inappropriate *n* (%)	Neither *n* (%)	Moderately appropriate *n* (%)	Quite appropriate *n* (%)	I don't know *n* (%)
1. Psychodynamic/ Psychoanalytic	2.38 (1.360)	2 (8)	3 (12)	1 (4)	7 (28)	3 (12)	9 (36)
2. Cognitive-Behavioral	3.63 (.875)	0 (0)	2 (8)	0 (0)	3 (12)	19 (76)	1 (4)
3. Cognitive	3.81 (.512)	0 (0)	0 (0)	1 (4)	2 (8)	18 (72)	4 (16)
4. Behavioral	3.82 (.395)	0 (0)	0 (0)	0 (0)	4 (16)	18 (72)	3 (12)
5. Person-centered-experiential/ Humanistic	3.91 (.288)	0 (0)	0 (0)	0 (0)	2 (8)	21 (84)	2 (8)
6. Systemic	3.70 (.470)	0 (0)	0 (0)	0 (0)	6 (24)	14 (56)	5 (20)
7. Structured/ Brief	3.84 (.375)	0 (0)	0 (0)	0 (0)	3 (12)	16 (64)	6 (24)
8. Art	3.08 (.996)	0 (0)	1 (4)	2 (8)	4 (16)	5 (20)	13 (52)
9. Integrative	3.61 (.698)	0 (0)	0 (0)	2 (8)	3 (12)	13 (52)	7 (28)
10. Phenomenological-existential [a]	-				1 (4)		

Note. M = Mean; SD = Standard deviation. The calculation of means was done without including endorsement of the option "I don't know". [a] Indicated by a participant.

Generalizability to different settings

Considered by participants as the settings where applying the PQ is the easiest are university clinics (64%, *n*=16) and private practice settings (56%, *n*=14). On the opposite side, participants indicated the psychiatric outpatient (20%, n=5) and the psychiatric inpatient (12%, *n*=3) as the settings where using the PQ is the most difficult (see Table 23). In summary, the global mean is 3.49 (SD=1.026) in 4, suggesting that the PQ is highly generalizability to distinct settings.

Table 23. *Descriptive statistics of the easiness of the PQ to diverse clinical settings*

Utility-PQ items	**M (SD)**	**Quite difficult**	**Moderately difficult**	**Neither**	**Moderately easy**	**Quite easy**	**I don't know**
		***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**	***n* (%)**
1. Psychiatric outpatient	2.07 (1.685)	5 (20)	0 (0)	1 (4)	5 (20)	3 (12)	11 (44)
2. Psychiatric inpatient	1.71 (1.204)	3 (12)	3 (12)	3 (12)	5 (20)	0 (0)	11 (44)
3. Primary health care	2.50 (1.155)	1 (4)	2 (8)	4 (16)	6 (24)	3 (12)	9 (36)
4. Health/ hospital psychology	2.44 (1.031)	1 (4)	2 (8)	3 (12)	9 (36)	2 (8)	8 (32)
5. Substance abuse	2.75 (1.183)	0 (0)	4 (16)	1 (4)	6 (24)	5 (20)	9 (36)
6. University clinics	3.71 (.561)	0 (0)	0 (0)	1 (4)	4 (16)	16 (64)	4 (16)
7. Private practice	3.59 (.590)	0 (0)	0 (0)	1 (4)	7 (28)	14 (56)	3 (12)
8. Schools[a]	-					2 (8)	

Note. M = Mean; SD = Standard deviation. The calculation of means was done without including endorsement of the option "I don't know". [a] Indicated by a participant.

6. Discussion

The present study aimed to deepen our knowledge on how therapists integrate PQ in their routine practice, and their experiences regarding its feasibility, acceptability, and generalizability.

6.1. How the PQ is used in routine clinical practice?

Most therapists in our sample indicated they use PQ on a regular basis in their clinical practice, at the beginning of therapy (at the assessment stage, first therapy session or pre-therapy without specification), during therapy and at the last session. Some therapists also used the PQ in follow-up sessions. These results suggest that PQ is used to monitor progress in an ongoing, in line with its potential indicated in a previous survey by Sales and colleagues (2007). Though the PQ is already integrated in electronic monitoring systems such as IPPS and Core-Net, therapists used it essentially in the paper and pencil format. The clinical tasks in which the PQ is mostly used were monitoring the client's progress in general and in specific difficulties. It is also used in case supervision with the team, treatment planning, reframing the difficulties and discuss the session with the team or with the client. The PQ was more rarely used to summarize, prepare or bridge between sessions. The clinical uses of the PQ reported in this study are in line with the findings of Sales and colleagues (2007).

Though the PQ is an outcome measure, it indicated by its users as a valuable tool in clinical tasks. This might explain the high openness of therapists to use it in daily clinical tasks. This openness was already reported in 2007 by Sales and collaborators, (92% of the participants indicated openness) and corroborated by the present study, with enjoying moderately or very much to use the PQ in their clinical practices. However, implementation of the PQ in routine clinical practice is not as widespread as it could be: in one hand, therapists use it with less than 50% of the clients, on the other hand, the small base of PQ users available for this study suggests that the PQ might not be widely implemented across clinical settings.

6.2. How feasible is the PQ?

According to the therapists it takes one to three hours or less to learn how to use the PQ. This suggests that this measure does not require complex, long training, thus pointing towards its simplicity. Furthermore, the PQ barely requires material or financial

resources: the PQ form is the only material extremely necessary and it is available online for free. This favors the simplicity of this measure and makes it more feasable.

A theme that emerged in the focus group was ethical appropriateness of the PQ, since the construction interview might create dilemmas about confidentiality when done by other than the therapist. Concerns about confidentiality were also found by Hatfield and Ogles (2004) as one of the top reasons why therapists are reluctant towards outcome measures. However, the inquired therapists do not seem to share this concern with the participants of the focus group, hence suggesting the PQ is ethically appropriate.

In general, the therapists in our sample considered the PQ is feasible for routine use in clinical practice. Therapists' adhesion to the PQ administration procedures was globally high, suggesting adequacy of the protocol to routine clinical practice. Thought the PQ construction includes highly structured steps and might take more than half an hour, most therapists considered to follow all instructions and rarely skip steps or modify the protocol in order to increase practicality. However, therapists reported some difficulties especially in generating the items, namely in identifying the recommended number of difficulties for the draft list of items (approximately 15 problems), and using index cards or pieces of paper for the draft items. Moreover, therapists suggested modifications: "reduce the number or draft items and final items", "make simpler the process of selecting the client difficulties", "include the rating of problem duration and intensity in the same table", and "stop writing down the draft items on small pieces of paper (or leave it as an optional procedure)". There were also interesting suggestions about how to increase feasibility by modifying the PQ in order to make it adequate for the client to complete without an interviewer ("make it possible for the client to complete the PQ all by himself") and to ask the client to come prepared with a list of difficulties in mind ("I'd consider sending out a PQ at the point of referral for the client to complete online beforehand, which can then get refined and ranked during the first session"). Though these modifications could increase the feasibility of the PQ, it is pertinent to consider whether it will influence the resulting data. For instance, by overly simplifying the process of generating the items one might endanger the quality of the final items, and thus its ability to assess client outcome properly.

The underlying motives for these suggestions might be diverse. For instance, the therapists of the focus group indicated emotional distress and physical pain as important factors when choosing to use the index cards: "people sometimes come with

immediate problems… with great emotional distress or even physical pain… and it (using index cards) would be disrespectful to the patient". Similarly, a participant of the Utility-PQ indicated that asking the client to think about the difficulties they want to include in the PQ beforehand "would help it more anxious clients". On the other hand, both the simplification of item generation steps and self-completion of the PQ might be asked in order to reduce time burden. Though most of the therapists in this study considered the PQ allows to save time and sessions, a large percentage perceives it as time consuming. Previous research (Sales et al., 2007) also pointed out time burden as a disadvantage of this measure. Several studies (e.g. Gilbody, House, & Sheldon, 2002; Hatfield & Ogles, 2004) identified practical concerns, and especially time burden, as determinant for therapists resistance towards outcome measures and found that therapists struggle to find ways to minimize it.

The PQ was perceived by the therapists as having high value for their clinical practices. This is consistent with the findings of Sales and colleagues (2007). The principal benefits for practice of the PQ are presented below. For the therapist:

- It is useful in clinical decision making:
  - Helps to build diagnostic hypotheses at the pre-treatment stage;
  - Provides information about history of the difficulties;
  - Can provide a warning of emerging problems;
  - It can be used as a clinical tool to establish therapeutic goals besides being used as a target complaint measure (it is versatile);
- Allows monitoring the client's progress session to session;
- Captures effectively the client's views;
- It does not lead to information overload for the therapist nor to dispersion of therapeutic goals due to the number of items.

The PQ is also perceived as useful for the client:

- It has positive effects in client involvement and responsibility in the treatment;
- Helps the client to learn to specify and structure their difficulties;
- Promotes working alliance between therapist and client.

However, therapists indicated two potential problems for the value for practice of this measure. Firstly, the information from the PQ may cause anxiety in the therapist about lack of progress or deterioration in the client, though this might happen with

several outcome measures. Secondly, risk of excessive focus on the clients' point of view, particularly on their difficulties. The therapist could get too centered in the problems, possibly hindering their capacity to think in alternatives (also consistent with Sales and colleagues (2007). These results regarding the clinical value of the PQ are different from the general tendency of therapists to perceive measures as having low value for practice and favoring the use of clinical judgement alone instead (Jensen-Doss & Hawley, 2010). Furthermore, the PQ seems to provide the information that therapists find useful and value in an outcome measure (see Hatfield & Ogles, 2004).

6.3. How acceptable is the PQ?

The clients' receptiveness towards the first administration of the PQ was perceived by the therapists as moderate. This result suggests that the first application, dedicated to the PQ construction interview, is more critical to acceptability than the following applications. One possible explanation is that the PQ administration might be unexpected for clients, as the focus group participants pointed out. Administrating the PQ for the first time involves thorough thinking of the difficulties, which will probably cause emotional distress. Hence, the client might feel skeptic or reluctant towards completing the measure. For this reason, some therapists suggested that clients should have the opportunity to reflect about the difficulties they want to work on in therapy beforehand: "*Giving the client more time to consider their issues (…) so they come prepared with a list in mind.*" However, the therapists considered that the clients' receptiveness tends to increase in posterior applications, which might mean that the completion of the PQ tends to become a beneficial experience for clients as therapy progresses.

Concerning the impact that completing the PQ has in the client emotional state, the therapists consider that generally it does not cause distress to the client. However, they pointed out that when the construction interview is done with a researcher the client might feel confused. A possible explanation to this result can be found in the focus group discussion, where the participants pointed out that the clients are inclined to perceive the PQ as part of the treatment and not as a separate procedure. Thus, when a member of the therapeutic team besides the therapist administers the PQ, the role of this measure in the treatment might not be clear to the client, which consequently might have negative repercussions in accepting this measure. Similar findings were reported by Pereira and colleagues (2016), where residents in a

therapeutic community manifested doubts about the purpose of outcome measures when administered outside therapy sessions and ask for a better integration of those in the therapeutic process. Once again, the context of administration seems to be determinant for acceptability and the way it is conducted should be carefully thought through.

It is important to consider that the acceptability was accessed through the therapists' perspectives, although this domain targets the client point of view of the instrument. In future studies, it would be pertinent to capture perspectives on the PQ directly from the client in order to fully assess acceptability. Other researchers are already exploring this possibility using the method of focus group (Pereira, Pedro, Sales, & Guerra, 2016).

6.4. How generalizable is the PQ?

Therapists consider the PQ is applicable to a wide range of clients, settings, and within diverse therapeutic approaches. Generalizability to clients will be considered firstly. The PQ was perceived as highly generalizable to different age groups, and especially appropriate to adults. The age group to which the PQ was considered less generalizable – though still appropriate – was children. Sitting in a chair facing another person talking about psychological difficulties might feel foreign and troubling to children (Friedberg & McClure, 2002), in addition, since the PQ relies on verbal and cognitive capacities, the administration of such a measure to youngsters should be carefully considered. There is no formally defined age limit to apply the PQ, thus it would be pertinent to test and possibly to adapt the PQ to different age groups including children.

In addition to age, other client characteristics were found as potentially hindering of administering the PQ, such as emotional dysregulation and difficulty putting internal processes and contents into words. It is important to clarify the impact these variables have on administration. Does the difficulty lie in generating good items, thus potentially encumbering their reliability in assessing client progress? Or does the difficulty lie in spending extra time? If the latter case scenario is true, although less feasible, the PQ might be used as a helpful screening tool since it allows to detect symptoms at an early stage (e.g. when completing the PQ, difficulties like avoidance of thinking about upsetting events can emerge). Despite the difficulties that different client characteristics might have in administering the PQ, this study showed that therapists believe the PQ

can be used routinely with more than 50% of clients. However, as referred earlier in this section, actuality the PQ is used with less than 50% of the clients. In the light of this study's results, the more probable explanation to this lies in concerns related to time burden.

Regarding generalizability to the therapists' clinical approaches, the PQ was found to be highly generalizable to different clinical approaches, and especially appropriate to person-centered/ experiential/ humanistic approaches, structured/ brief therapy, and cognitive behavioral therapy. In contrast, psychodynamic/ psychanalytic was considered the approach to which the PQ is the least appropriate. This resonates with the results from Hatfield and Ogles (2007), which concluded that insight oriented therapists (in which are included psychodynamic and psychanalytic therapists) are inclined to have negative attitudes towards outcome measures when compared to cognitive-behavioral therapists. The differences among these clinical approaches, namely, its assumptions, philosophies and structure of the therapeutic process might be the explanation to these results. Specifically, the psychodynamic approach holds that human behavior is influenced by drives, conflicts and impulses which are primarily unconscious (Plante, 2005). Clients wouldn't be aware of the psychological problems that are targeted in psychodynamic therapy, thus, outcome or therapeutic success shouldn't be measured based on the difficulties that the client can identify in the beginning of the therapeutic process. On the other hand, the PQ's list of psychological difficulties might create the expectation that those are the goals of therapy. As such, instruments in which the items are selected by the clients might not be in line with this approach, whereas other outcome measures are seen as more appropriate (see Apostolou, Ward, & Yakeley, 2016).

Finally, the PQ was considered by therapists as highly generalizable across diverse clinical settings. However, it seems to be more appropriate to settings with less time constraints, such as university clinics and private practices. In contrast, the setting where using the PQ seems to be the most challenging is the psychiatric inpatient. These results are similar to the findings of Smits, Claes, Stinkens and Smits (2014), which noticed that private practitioners show more positive attitudes towards monitoring, whereas clinicians in subsidized settings reported the most negative attitudes.

6.5. Limitations and suggestions for future research

There are some limitations regarding the sample. Firstly, since the participants are therapists who use the PQ, there might be a tendency to perceive this measure more positively than therapists that do not use it in their clinical practices. As a consequence, results might be biased at a certain degree and cannot reflect the views of therapists in general. Secondly, a large percentage of therapists was cognitive-behavioral or person-centered/ experiential/ humanistic and worked on university clinics and private practices, which might have biased the results regarding generalizability. In addition, there was a relatively small base of PQ users available for this study, limiting sample size.

There are also some limitations regarding the method of data collection. Data was collected through an online survey, and though this method presents the benefit of saving time and resources (Evans & Mathur, 2005), it has some limitations. Respondents might not have been capable of conveying the level of detail of interest, whether it could have been due to misunderstanding of instructions or due to the absence of a skilled interviewer who could probe for more in-depth answers (Evans & Mathur, 2005). Other potential limitations to consider are social desirable responding and limited self-awareness of respondents (Barker, Pistrang, & Elliott, 2002). However, as a self-report measure, the Utility-PQ has the benefit of collecting respondents' own perspectives directly (Barker, Pistrang, & Elliott, 2002), which was the principal aim of this study. Furthermore, consultation with members of the target population through focus group was conducted prior to the development of the instrument and data was used to inform item development, which enhances content validity (Vogt, King, & King, 2004). In addition, the Utility-PQ was tested through a small pilot study with five psychotherapists with the aim of ensuring clarity of instructions and phrasing of the items.

Both because of the reduced sample size and the nature of the Utility-PQ – which does not measure psychological constructs but experiences and views – we considered it was not possible nor appropriate to carry out psychometric analysis (Urbina, 2004). This instrument corresponds to an opinion self-report survey, in which several themes indicated by a group of experts in the focus group were used. Besides opinions, the Utility-PQ asks about behaviors and experiences of use of the PQ in routine clinical practice. As such, it would not be appropriate to carry out procedures of psychometric analysis, since it does not measure psychological constructs. However,

this study can be a first step towards the development of a questionnaire of attitudes of therapists about the routine use in clinical practice of the PQ. Scales of attitudes are considered psychological scales and are broadly used (Vaughan & Hogg, 2014). This step could be achieved by increasing sample size and identifying latent psychological constructs through exploratory factor analysis, for instance (samples with a minimum of 100 participants are advised for conducting factor analysis; see Zao, 2009). Following this strategy, it would be theoretically possible to identify variables that influence therapists' attitudes towards using the PQ in routine clinical practice. Then, a psychological scale would be designed, selecting items from the former version and creating new items in order to assess the new variables.

To our knowledge, the present research consists in the first steps in a relatively new research field, being the first attempt to assess the clinical utility of an outcome measure in a systematic and comprehensive manner. The principal gains of this research include the providence of a matrix of aspects to consider when assessing the clinical utility of any measure, which can serve as foundation for future surveys of behaviors and experiences of users of outcome measures and even attitude scales. Furthermore, it provides data that the PQ is clinically useful and gives specific suggestions to improve this measure and consequently to enhance its use in routine clinical practice.

7. Conclusions

Overall, therapists perceived the PQ has a clinically useful tool, adaptable to the constraints and demands of routine implementation in real-world clinical settings. It was considered a simple, fairly practical, and clinical significant measure both to therapists and clients. Besides being an outcome measure, it is a helpful tool in various clinical tasks, including identifying both psychological difficulties and therapeutic goals, building preliminary diagnostic hypothesis, gathering information about the history of the difficulties, and others. It is relatively well accepted by clients and it is highly generalizable to clients with different ages, clinical situations, and other features, as well as to therapists from different clinical approaches and to various clinical settings.

However, there are there are still a few adjustments to make if feasibility is to be increased and specifically protocol adhesion. The therapists in our sample point to a key weakness of the PQ: they consider generating the items a complex process. Nevertheless, this study helps in the identification of specific difficulties and offers suggestions given by its users in order to improve this measure.

If routine outcome assessment is to be widely implemented in mental health care settings, the quality of outcome measures must be guaranteed. This involves a focus beyond psychometrics and into the clinical utility of the measures. A measure that is feasible, acceptable and generalizable is more prone to be used routinely. Therefore, it is essential to explore the therapists' – and the clients' – perspectives and practices regarding outcome measures. Using that strategy, it is possible to identify potential problems and delineate possible solutions for the limitations of a measure, thus opening a pathway to improve it in order to generate quality outcome data without disrupting clinical care.

Appendix A – Personal Questionnaire Form

PERSONAL QUESTIONNAIRE

Client ID

Today's date:

Instructions: Please complete before each session. Rate each of the following problems according to how much it has bothered you during the past seven days, including today.

	Not At All	Very Little	Little	Moderately	Considerably	Very Considerably	Maximum Possible
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7
Additional Problems: 11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7

Personal Questionnaire Duration Form

Client ID

Today's date:

Instructions: Please rate how long each of your problems has bothered you at roughly the same level (or higher) as it does now.

	less than 1 month	1 - 5 months	6 - 11 months	1 - 2 years	3 - 5 years	6 - 10 years	more than 10 years
1.	1	2	3	4	5	6	7
2.	1	2	3	4	5	6	7
3.	1	2	3	4	5	6	7
4.	1	2	3	4	5	6	7
5.	1	2	3	4	5	6	7
6.	1	2	3	4	5	6	7
7.	1	2	3	4	5	6	7
8.	1	2	3	4	5	6	7
9.	1	2	3	4	5	6	7
10.	1	2	3	4	5	6	7
11.	1	2	3	4	5	6	7
12.	1	2	3	4	5	6	7

Appendix B - Framework Matrix of the focus group discussion

	Thematic areas	Codes	Extract from transcript
Feasibility	Brevity	Time of administration/ interpretation	“It’s time consuming.” (P1)
	Value for practice	Purpose of use	“The PQ makes it possible to identify with ease the main difficulties of the patient.” (P4) “Allows listing symptoms or concerns about different areas, such as family, personal, professional…" (P4) “I also use it to set intervention goals.” (P4) “(The PQ allows) making adjustments to the intervention based on the feedback that it provides." (P2) “Being the individual patient to build the items, as opposed with other questionnaires where they’re predetermined and irrelevant for some patients is really advantageous.” (P2)

	"It is good to have this individualized measure that follows the entire treatment." (P2)
	"Actually, the PQ is not artificial at all. It provides an x-ray which allows psychologists to identify all patients (when a researcher does the PQ's construction interview)." (P1)
	"It opens a communication pathway between the therapist and the client." (P3)
Benefits for practice	"The identification, organization, the search for the client's own words to define his problems... is something that meets preliminary aspects of therapeutic tasks." (P4)
	"Building it involves the client differently (…) he becomes more responsible for his treatment." (P3)
	"It seems to me a flexible instrument." (P3)
	"It's reusable." (P3)

	Openness	Protocol adhesion	"The procedure says to list about 10 items. I don't do that. I think it's an exaggerated number." (P1) "That part of the index cards ... we don't do anything like that." (P4) "With patients with great emotional distress it would not be adequate to do tasks of paper and pencil instead of being entirely focused on patients concerns." (P4) "The first three items are the most significant and usually they are the main therapy goals." (P3) "(In group therapy) I think building a PQ for the entire group would be advantageous." (P2) "I guess it would be better for us and for the patients if we focus on bringing the items from the relationship only, without using draft cards and forms." (P4) "I believe 4 to 6 items are enough." (P2) "I think it isn't useful to struggle to elicit more items (…) we risk creating problems where there are none." (P3)
		Ethical concerns	"(In group therapy) it's obviously impossible to work everyone's issues in a limited number of sessions." (P2) "The PQ can create dilemmas about confidentiality… when the construction interview is conducted by other than the therapist."(P1)
Acceptability	Features of the instrument	Idiographic approach	"Patients are pleased to have a subjective evaluation during treatment (...) They see their own evolution, assessed by themselves." (P4) "I think patients aren't expecting an interesting new questionnaire that is theirs alone… they realize it's tailored to their personal issues." (P3)
	Method of	Integrated use in treatment	"I think that, for the patients, the PQ is part of the intervention." (P2)

	administration	Frequency of administration	“I think patients get a little bit tired of the PQ along the treatment process… It´s like ‘I don’t want to think about that anymore, let me enjoy my therapy’.” (P1) “During the treatment, sometimes patients’ give me hints… showing me they are not in the mood to rate the PQ… and I respect those hints.” (P4)
	Emotional impact	Psychological distress	“The client lists his concerns, thus he will have the expectation that they will be intervened.” (P1) “It is a little bit like the metaphor of that Charlie Chaplin video: we’re there to assemble the watch, we identify and join all the little pieces, and in the end we put it in a bag and give it back unassembled to the patient... because the patient’s issues will not be intervened, or will not intervened at that time.” (P1)
Generalizability	Clients’ characteristics	Clinical condition	“Since the PQ involves an almost constant evaluation, categorization… in people with obsessive symptoms I think (administering the PQ) is a risk. I don’t know if it increases symptoms.” (P1) “The type of client that poses more challenges in using the PQ is the one that has a hard time identifying psychological issues (...) but trying is a productive exercise.” (P4) “Those (patients) who start to talk, and talk, and talk... to set up the items is difficult sometimes (...) but that’s a step on working the problem.” (P3) “People sometimes come with immediate problems… with great emotional distress or even physical pain… and it would be disrespectful to the patient (to administer the PQ in the first session, or to do it with the draft cards)." (P4)

	Other client features	"I think PQ is appropriate for everyone… more than other measures (…) Even for people with physical disabilities." (P1) "It is a major advantage, it can be applied to people of various socio-economic and education levels." (P3) "With patients with reduced mobility, I write the items on post-it so they don't slide around." (P1) "With visually impaired patients, or illiterate patients, it's me who writes the items in the form." (P2)
Psychotherapists' characteristics	Clinical experience	"If we have some professional experience, we feel more comfortable with the procedures" (P2) "(Administering the PQ) implies all the clinical skills involved in establishing a therapeutic relationship... creating a safe environment for the client to think… it also implies that the psychologist is able to pay close attention to non-verbal cues." (P1)
Variations across settings	-	"Here (psycho-oncology) people often don't know what psychology is nor why they are sent to this consultation. There are many stages to go before administering the PQ, like developing a notion of what the psychological dimension is (…) because people are in the hospital to treat a very serious physical illness (…) and people that reach us are often used to adopt a passive attitude … they're not expecting to be involved in anything or even to think about themselves." (P4) "To me is so much easier to apply the PQ in private practice because people seek psychological treatment (…) thus they are more motivated and involved in the process." (P4) "We work in a public hospital, half of the patients have the fourth grade or less, come from villages, are farmers (…) they aren't used to working with paper, pencil, writing…" (P4)

Appendix C – Utility-PQ (English version)

In the context of a research to obtain the master's degree in Clinical and Health Psychology from the University of Évora, we request your participation through the completion of this survey. Its purpose is to study the clinical utility of the Personal Questionnaire, an individualized tool that allows the assessment of clients' progress in psychotherapy.

The survey takes about 20 minutes to complete. In order to complete the survey, participants must be psychotherapists or counsellors who uses or have used the PQ in their routine clinical practice.

The nature of your participation is entirely voluntary and the anonymity and confidentiality of the collected data is guaranteed. The data will be used solely in this research and analyzed statistically.

We value your collaboration and ask you to answer as honestly as possible.

We thank you in advance for taking part.

A. Personal Information

1. Age:*[11] ___________

2. Gender:*
   O Female
   O Male
3. Country:* _____________

[11] The answer is mandatory in all questions marked with (*).

4. Education:*

   O Pre-Bologna University degree

   O Master's degree

   O PhD

   O Postgraduate studies

   O Other: ____________

5. Years of experience/ clinical practice:* ____________

6. Please, indicate the option that best describes you as a professional.*

   O Psychodynamic/ Psychoanalytic

   O Cognitive/ Behavioural

   O Cognitive

   O Behavioural

   O Person-centered-experiential/ Humanistic

   O Systemic

   O Structured/ Brief

   O Art

   O Integrative

   O Other: ____________

7. Please, indicate the option that best describes you as a professional.*

   O Solely a clinician/ therapist.

O Both a clinician/therapist and a researcher.

O Primarily a researcher.

B. PQ Administration Setting

1. Who usually performs the PQ construction interview?*

O Me

O A researcher

O Other: ___________

2. For how long, approximately, have you used the PQ?*

O Less than 1 year

O Between 1 and 5 years

O Between 5 and 10 years

O More than 10 years

3. Among the clinical cases you see in your practice, in how many do you administer the PQ?*

O 0% to 25%

O 25% to 50%

O 50% to 75%

O 75% to 100%

O Near 100%

4. What age group/s do you mostly see in your clinical practice?*

Please indicate all that apply.

O Adolescents

O Adults

O Elders

5. What therapy format do you mostly use in your clinical practice?*

Please indicate all that apply.

O Individual

O Families

O Couples

O Groups

6. What type/s of pathology do you mostly see in your clinical practice?*

Please indicate all that apply.

O Schizophrenia and other psychotic disorders

O Bipolar and related disorders

O Depressive disorders

O Anxiety disorders

O Obsessive-compulsive and related disorders

O Trauma- and stressor-related disorders

O Somatic symptom and related disorders

O Disruptive, impulse-control, and conduct disorders

O Feeding and eating disorders

O Substance-related and addictive disorders

O Personality disorders

O Other: ___________

7. Which PQ application formats have you used?*

Please indicate all that apply.

O Only paper and pencil

O Integrated into IPPS

O Integrated into CORE-NET

8. Which PQ application formats do you use more frequently?*

O Only paper and pencil

O Integrated into IPPS

O Integrated into CORE-NET

9. In which work setting(s) do you use / have you used the PQ?*

Please indicate all that apply.

O Psychiatric outpatient

O Psychiatric inpatient

O Primary health care

O Health/ hospital psychology

O Substance abuse

O University clinics

O Private practice

O Other: ___________

10. In which stage(s) of the therapeutic process do you use / have you used the PQ?*

Please indicate all that apply.

O Screening

O Referral

O Assessment

O First Therapy Session

O Pre-therapy (unspecified)

O During Therapy

O Last Therapy Session

O Follow up

O Other: ___________

11. How often do you administer the PQ during treatment?

O With fixed regularity (e.g. every two weeks).

O With variable regularity (e.g. when I find it relevant).

12. How often do you use the PQ to talk with your clients about treatment planning?*

Use the following scale: 1, Never; 2, Seldom; 3, Sometimes; 4, Often; 5, Almost always.

	1	2	3	4	5	
Never	O	O	O	O	O	Almost always

13. For what clinical purposes do you administer the PQ?*

Please specify if you do it by yourself, with the therapeutic team or supervisor and/or in collaboration with the client.

	The therapist alone, with the therapeutic team, with the supervisor	With the client	Both	None
a. Client's progress assessment	O	O	O	O
b. Check the evolution of specific problems	O	O	O	O
c. Bridge between sessions	O	O	O	O
d. Summarize the session	O	O	O	O
e. Reframe the difficulties or problems	O	O	O	O
f. Treatment planing	O	O	O	O
g. Session preparation	O	O	O	O
h. Session discussion	O	O	O	O
i. Case supervision	O	O	O	O

13.1. Other clinical purpose.

Please specify: _____________

C. Views of the PQ

Please complete the following section from your point of view as a therapist or clinician.

1. How much training do you think therapists need in order to be able to administer the PQ?*
   - O Half an hour
   - O One hour
   - O Between one to three hours
   - O More than three hours

2. The following items make reference to the PQ construction interview procedure. How often do you follow these procedures?

	Never	**Seldom**	**Sometimes**	**Often**	**Always**
a. I make an attempt to search for problems from areas such as: symptoms, mood, specific performance/activity, relationships and self-esteem.	O	O	O	O	O
b. I help the client generate a draft list of 15 difficulties or problems.	O	O	O	O	O
c. I use small pieces of paper for the draft items.	O	O	O	O	O
d. I make sure that the items are specific difficulties or problems, rather than goals or vague, multiple problems.	O	O	O	O	O
e. I help the client reach 8 to 12 final PQ items.	O	O	O	O	O
f. I make sure that the PQ reflects the client's chief concerns.	O	O	O	O	O
g. I have clients rank order the items based on their importance.	O	O	O	O	O
h. I have the client indicate the degree of distress caused by each problem.	O	O	O	O	O
i. I include the problem duration ratings.	O	O	O	O	O
j. I write the problems in the PQ form after they have been defined and clarified.	O	O	O	O	O

3. Some therapists feel the need to adapt the procedure of administration. Please indicate the options that match your experience.*

	Never	**Seldom**	**Sometimes**	**Often**	**Always**
a. I make sure I have a moderately strong therapeutic alliance with the client prior to the PQ administration.	O	O	O	O	O
b. I provide some psychoeducation prior to the PQ	O	O	O	O	O

administration (for example, explain some aspects related to psychological functioning and/or therapeutic process).					
c. I help the client regulate dysregulated emotion, ensuring that they are able to take part in the PQ administration.	O	O	O	O	O
d. I postpone the PQ administration if the client is emotionally dysregulated.	O	O	O	O	O
e. The difficulties or problems are identified and refined only through dialog.	O	O	O	O	O
f. When working with clients with limited mobility, I write down identified difficulties on post-it notes so they don't slide around.	O	O	O	O	O
g. If the client is illiterate or visually impaired I write down the client's rank ordering of the items for them.	O	O	O	O	O
h. I skip some administration procedures because it is a lengthy process.	O	O	O	O	O

4. What suggestions do you have for modifying the original PQ procedure?*

---

5. In your experience, which client variables may hinder administrating the PQ as described in the manual?*

   Please indicate all that apply.

   O Low education

   O Emotional dysregulation (e.g. high level of anxiety)

   O Cognitive limitation

   O Physical pain

   O Physical disability/limitation

   O Avoidance of distressing emotions or thoughts

O Difficulty putting internal processes and contents into words

O Perception of the PQ as too difficult

O Tendency to talk too much or in an overly abstract or rationalized way

O Psychopathological features

O Other: _______________

6. What percentage of clients is the PQ applicable to?*

O 0% to 25% clients

O 25% to 50% clients

O 50% to 75% clients

O 75% to 100% clients

O Near 100% clients

6.1. How appropriate do you think the PQ is throughout the following age groups?*

	Quite inappropriate	**Moderately inappropriate**	**Neither inappropriate nor appropriate**	**Moderately appropriate**	**Quite appropriate**	**I don't know**
a. Children	O	O	O	O	O	O
b. Adolescents	O	O	O	O	O	O
c. Adults	O	O	O	O	O	O
d. Elderly	O	O	O	O	O	O

7. How easy is it to implement the PQ in the following therapeutic settings?*

	Quite difficult	Moderately difficult	Neither difficult nor easy	Moderately easy	Quite easy	I don't know
a. Psychiatric outpatient	O	O	O	O	O	O
b. Psychiatric inpatient	O	O	O	O	O	O
c. Primary health care	O	O	O	O	O	O
d. Health/ hospital psychology	O	O	O	O	O	O
e. Substance abuse	O	O	O	O	O	O
f. University clinics	O	O	O	O	O	O
g. Private practice	O	O	O	O	O	O

7.1. Other therapeutic setting.

Please specify: ______________________

7.2. How easy is to implement the PQ in the therapeutic setting that you have referred above?

Use the following scale: 1, Quite difficult; 2, Moderately difficult; 3, Neither difficult nor easy; 4, Moderately easy; 5, Quite easy.

	1	2	3	4	5	
Quite difficult	O	O	O	O	O	Quite easy

8. How appropriate do you think the PQ is for therapists from the following therapeutic approaches?*

	Quite inappropriate	Moderately inappropriate	Neither inappropriate nor appropriate	Moderately appropriate	Quite appropriate	I don't know
a.Psychodynamic/ Psychoanalytic	O	O	O	O	O	O
b. Cognitive-Behavioural	O	O	O	O	O	O
c. Cognitive	O	O	O	O	O	O

d. Behavioural	O	O	O	O	O	O
e.Person-centred-experiential/ Humanistic	O	O	O	O	O	O
f. Systemic	O	O	O	O	O	O
g. Structured/ Brief	O	O	O	O	O	O
h. Art	O	O	O	O	O	O
i. Integrative	O	O	O	O	O	O

8.1. Other therapeutic approach.

Please specify: ______________________

8.2. How appropriate do you think the PQ is for therapists from the therapeutic approach that you have referred above?

Use the following scale: 1, Quite inappropriate; 2, Moderately inappropriate; 3, Neither inappropriate nor appropriate; 4, Moderately appropriate; 5, Quite appropriate.

	1	**2**	**3**	**4**	**5**	
Quite inappropriate	O	O	O	O	O	Quite appropriate

D. Client Views of the PQ

We ask you now to think about general client reactions towards using the PQ.

1. In general how would you rate your clients' receptiveness and acceptance of the PQ procedure at their first contact (on the PQ construction interview)?*

O Not at all receptive

O Slightly receptive

O Moderately receptive

O Very receptive

O Totally receptive

2. In general how would you rate your clients' receptiveness and acceptance of the PQ procedure in subsequent contacts (during therapy)?*

O Not at all receptive

O Slightly receptive

O Moderately receptive

O Very receptive

O Totally receptive

E. Benefits and Limitations of the PQ

Some therapists find some benefits and limitations in using the PQ in the routine clinical practice.

1. Please indicate your degree of agreement according to the following scale:*

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. The information provided is useful in clinical decision making.	O	O	O	O	O
b. Extensive listing of problems is harmful for the client (multiplies problems).	O	O	O	O	O
c. The possibility of being modified during treatment makes the PQ a dynamic and reusable tool.	O	O	O	O	O
d. The PQ helps to build diagnostic hypotheses at the pre-treatment stage.	O	O	O	O	O
e. The PQ assists in the process of defining therapeutic goals.	O	O	O	O	O
f. The PQ helps clients think more thoroughly about their difficulties and the	O	O	O	O	O

impact these have on their lives.					
g. The PQ provides knowledge about history of the difficulty.	O	O	O	O	O
h. The PQ creates dilemmas regarding confidentiality.	O	O	O	O	O
i. The PQ tends to lead to the diffusion of therapeutic goals because there are too many items.	O	O	O	O	O
j. The PQ results in information overload for the therapist.	O	O	O	O	O
k. The PQ sets up unrealistic expectations about the therapeutic process (ie, solving all problems in the list).	O	O	O	O	O
l. PQ promotes working alliance between therapist and client.	O	O	O	O	O
m. The PQ promotes client involvement and responsibility in the treatment.	O	O	O	O	O
n. The PQ exclusively focuses on difficulties or problems.	O	O	O	O	O
o. The PQ provides feedback to the therapist about their performance.	O	O	O	O	O
p. The information provided by the client on the PQ may not be trustworthy.	O	O	O	O	O
q. The PQ is time consuming.	O	O	O	O	O
r. The PQ can provide a warning of emerging problems in treatment.	O	O	O	O	O
s. The PQ provides information about personal and family resources.	O	O	O	O	O
t. The PQ saves time and sessions since it allows a structured review of difficulties or problems and establishing therapeutic goals all at the same time.	O	O	O	O	O
u. The PQ makes it possible to monitor the client's progress session to session.	O	O	O	O	O
v. The PQ enables a prognosis at the pre-treatment stage.	O	O	O	O	O
w. The PQ emphasizes the client point of view.	O	O	O	O	O
x. The PQ may cause anxiety in the therapist about lack of progress or deterioration in the client.	O	O	O	O	O
y. The relationship between the therapist and the researcher in generating the PQ might confuse the client.	O	O	O	O	O

1.1. Other benefit.

Please specify: _______________

1.2. Other limitation.

Please specify: _______________

2. To what extent do you like using the PQ in your routine practice?*

O Not at all

O Moderately

O Very much

3. If you don’t use the PQ already in your routine clinical practice, how open would you be to doing so?

O Not at all

O Moderately

O Very much

Appendix D – Utility-PQ (Portuguese version)

No âmbito da realização de uma investigação para a obtenção do grau de Mestre em Psicologia Clínica e da Saúde pela Universidade de Évora, solicitamos a sua participação através da concretização do presente questionário. O seu objetivo prende-se com o estudo da utilidade clínica de um instrumento idiossincrático de avaliação do progresso do cliente em psicoterapia, o Questionário Pessoal.

O preenchimento do questionário requer cerca de 20 minutos. É condição obrigatória para a participação nesta investigação ser psicoterapeuta ou psicólogo clínico e ter aplicado o PQ na sua prática clínica rotineira.

O caráter da sua participação é inteiramente voluntário e garantimos total anonimato e confidencialidade da informação recolhida, que será apenas utilizada no âmbito desta investigação e analisada estatisticamente.

Salientamos a importância da sua colaboração para este estudo e pedimos que responda com a maior honestidade possível.

Agradecemos antecipadamente a sua imprescindível colaboração.

A. Dados Demográficos

8. Idade:*[12] ___________

9. Género:*

O Feminino

O Masculino

[12] A resposta é obrigatória para questões marcadas com *.

10. País:*

11. Habilitações Literárias:*

O Licenciatura Pré-bolonha

O Mestrado

O Doutoramento

O Pós-graduação

O Outro: ___________

12. Anos de experiência/ prática clínica:* ___________

13. Orientação teórica/ abordagem terapêutica.*

O Psicodinâmica/ Psicanalítica

O Cognitivo-Comportamental

O Cognitiva

O Comportamental

O Humanista/ Centrada no cliente

O Sistémica

O Estruturada/ Breve

O Arte

O Integrativa

O Outra: ___________

14. Por favor indique a opção que melhor o/a carateriza como profissional.*

O Unicamente psicoterapeuta.

O Tanto psicoterapeuta como investigador.

O Principalmente investigador.

B. Contexto de Administração do PQ

14. Habitualmente, quem conduz a entrevista de construção do PQ?*

O Eu

O Um investigador

O Outro: ___________

15. Há quanto tempo, aproximadamente, utiliza o PQ?*

O Menos de 1 ano

O Entre 1 e 5 anos

O Entre 5 e 10 anos

O Mais de 10 anos

16. De entre os casos clínicos que recebe em quantos, aproximadamente, utiliza o PQ?*

O 0% a 25%

O 25% a 50%

O 50% a 75%

O 75% a 100%

O Aproximadamente 100%

17. Que faixa(s) etária(s) recebe com maior frequência na sua prática clínica?*

Por favor, indique todas as opções que se aplicam.

O Crianças

O Adolescentes

O Adultos

O Idosos

18. Que formato(s) terapêutico(s) utiliza com maior frequência na sua prática clínica?*

Por favor, indique todas as opções que se aplicam.

O Individual

O Familiar

O Casal

O Grupos

19. Que tipos de psicopatologia recebe com maior frequência na sua prática clínica?*

Por favor, indique todas as opções que se aplicam.

O Esquizofrenia e outras perturbações psicóticas

O Perturbações bipolares e relacionadas

O Perturbações depressivas

O Perturbações da ansiedade

O Perturbações obsessivo-compulsivas e relacionadas

O Perturbações relacionadas com o trauma e *stress*

O Perturbações do sintoma somático e relacionadas

O Perturbações do controlo do impulso e da conduta

O Perturbações alimentares

O Perturbações relacionadas com o abuso de substâncias

O Perturbações da personalidade

O Outra: ___________

20. Em que formatos já utilizou o PQ? *

Por favor, indique todas as opções que se aplicam.

O Papel e caneta

O Integrado no IPPS

O Integrado no CORE-NET

21. Que formato de aplicação do PQ utiliza com maior frequência? *

O Papel e caneta

O Integrado no IPPS

O Integrado no CORE-NET

22. Em que contexto(s) clínico(s) utiliza/ utilizou o PQ? *

Por favor, indique todas as opções que se aplicam.

O Ambulatório Psiquiátrico

O Internamento Psiquiátrico

O Cuidados de saúde primários

O Psicologia da Saúde/ Hospitalar

O Abuso de substâncias

O Clínicas universitárias

O Clínica privada

O Outra: ___________

23. Em que fase(s) do processo terapêutico utiliza/ utilizou o PQ?*

Por favor, indique todas as opções que se aplicam.

O Triagem

O Encaminhamento

O Avaliação

O Primeira sessão de terapia

O Pré-terapia (não especificado)

O Durante a terapia

O Ultima sessão de terapia

O Sessão de seguimento

O Outra: ___________

24. Num processo terapêutico, com que regularidade aplica o PQ?

O Com regularidade fixa (ex. de duas em duas semanas).

O Com regularidade variável (ex. quando creio ser pertinente).

O Outra: ___________

25. Com que frequência fala com o seu cliente sobre o planeamento do tratamento utilizando o PQ?*

Utilize a seguinte escala: 1, Nunca; 2, Raramente; 3, Por vezes; 4, Frequentemente; 5, Quase sempre.

	1	2	3	4	5	
Nunca	O	O	O	O	O	Quase sempre

26. Para que tarefa(s) clínica(s) utiliza o PQ? *

Por favor, especifique se as realiza sozinho, com a equipa terapêutica ou supervisor e/ou em colaboração com o cliente.

	Sozinho, com a equipa, com o supervisor	**Com o cliente**	**Ambas as opções**	**Não se aplica**
a. Avaliação do progresso do cliente.	O	O	O	O
b. Verificação da evolução de problemas específicos.	O	O	O	O
c. Realização de uma ponte entre sessões.	O	O	O	O
d. Sumarização da sessão.	O	O	O	O
e. Reenquadramento de dificuldades ou problemas.	O	O	O	O
f. Planeamento do tratamento.	O	O	O	O
g. Preparação da sessão.	O	O	O	O
h. Discussão da sessão.	O	O	O	O
i. Supervisão de casos clínicos.	O	O	O	O

26.1. Outra tarefa clínica em que utiliza o PQ.

Por favor, especifique: ____________

C. Perspetiva sobre o PQ

Por favor, complete a seção seguinte de acordo com a sua perspetiva como terapeuta.

9. Quanto tempo de treino considera ser necessário para habilitar um terapeuta a administrar o PQ?*

O Meia hora

O 1 hora

O Entre 1 a 3 horas

O Mais de 3 horas

10. Os itens seguintes referem-se ao protocolo da entrevista de construção do PQ. Com que frequência segue estes procedimentos?

	Nunca	**Raramente**	**Por vezes**	**Frequentemente**	**Sempre**
a. Exploro com o cliente diferentes áreas, tais como: sintomas, humor, funcionamento laboral ou académico, relações interpessoais e autoestima.	O	O	O	O	O
b. Ajudo o cliente a gerar uma lista preliminar com cerca de 15 dificuldades ou problemas.	O	O	O	O	O
c. Utilizo pequenos pedaços de papel para os itens preliminares.	O	O	O	O	O
d. Certifico-me de que os itens refletem dificuldades ou problemas específicos, ao invés de objetivos ou problemas vagos.	O	O	O	O	O
e. Ajudo os clientes a alcançar 8 a 12 itens finais.	O	O	O	O	O
f. Certifico-me que o PQ reflete as áreas de maior preocupação para o cliente.	O	O	O	O	O
g. Peço ao cliente para hierarquizar os itens com base na sua importância.	O	O	O	O	O

h. Peço ao cliente para classificar os itens de acordo com o grau de mal-estar sentido.	O	O	O	O	O
i. Incluo no formulário a duração temporal das dificuldades do cliente.	O	O	O	O	O
j. Depois de definidas e clarificadas, escrevo as dificuldades ou problemas no formulário do PQ.	O	O	O	O	O

11. Alguns terapeutas sentem necessidade de adaptar o procedimento de administração do PQ. Com que frequência realiza as seguintes modificações?*

	Nunca	**Raramente**	**Por vezes**	**Frequentemente**	**Sempre**
a. Certifico-me que existe uma aliança terapêutica moderadamente forte antes de aplicar o PQ.	O	O	O	O	O
b. Faço psicoeducação antes de aplicar o PQ (por exemplo, explico alguns aspetos a respeito do funcionamento psicológico e/ou do processo terapêutico).	O	O	O	O	O
c. Ajudo o cliente a regular-se emocionalmente, assegurando que se encontra capaz de participar na administração do PQ.	O	O	O	O	O
d. Se o cliente se encontrar demasiado perturbado adio a aplicação do PQ.	O	O	O	O	O
e. As dificuldades ou problemas são unicamente definidas e clarificadas através do diálogo.	O	O	O	O	O
f. Com clientes com mobilidade reduzida, escrevo as dificuldades em post-its para ser mais acessível.	O	O	O	O	O
g. Com clientes analfabetos ou com dificuldades visuais, escrevo as hierarquizações dos itens por eles.	O	O	O	O	O
h. Salto alguns procedimentos porque a administração é um processo moroso.	O	O	O	O	O

12. Que sugestões faz para modificar o protocolo original do PQ?*

____

____

13. De acordo com a sua experiência clínica, que variáveis do cliente podem dificultar a administração do PQ tal como descrita no manual?*

Por favor, indique todas as opções que se aplicam.

O Baixa escolaridade

O Desregulação emocional (ex. níveis elevados de ansiedade)

O Limitações cognitivas

O Dor física

O Deficiência/ limitação física

O Evitamento de emoções ou pensamentos perturbadores

O Dificuldade em colocar em palavras processos e conteúdos internos

O Perceção dos procedimentos do PQ como demasiado difíceis

O Tendência para falar demasiado, de modo abstrato ou demasiado racionalizado

O Caraterísticas da psicopatologia do cliente

O Outra: _______________

13.1. Se, na questão anterior, assinalou a opção "Caraterísticas da psicopatologia do cliente", por favor especifique quais.

____

14. A que percentagem de clientes considera o PQ aplicável?

O 0% a 25% dos clientes

O 25% a 50% dos clientes

O 50% a 75% dos clientes

O 75% a 100% dos clientes

O Aproximadamente 100% dos clientes

14.1. Em que medida considera o PQ adequado para cada uma das seguintes faixas etárias?*

	Bastante desadequado	**Ligeiramente desadequado**	**Nem adequado nem desadequado**	**Ligeiramente adequado**	**Bastante adequado**	**Não sei**
a. Crianças	O	O	O	O	O	O
b. Adolescentes	O	O	O	O	O	O
c. Adultos	O	O	O	O	O	O
d. Idosos	O	O	O	O	O	O

15. Em que medida considera o PQ aplicável nos seguintes contextos clínicos?*

	Bastante difícil	**Moderadamente difícil**	**Nem difícil nem fácil**	**Moderadamente fácil**	**Bastante fácil**	**Não sei**
a. Ambulatório psiquiátrico	O	O	O	O	O	O
b. Internamento psiquiátrico	O	O	O	O	O	O
c. Cuidados de saúde primários	O	O	O	O	O	O
d. Psicologia da saúde/ hospitalar	O	O	O	O	O	O
f. Abuso de substâncias	O	O	O	O	O	O
g. Clínicas universitárias	O	O	O	O	O	O
h. Clínica privada	O	O	O	O	O	O

15.1. Outro contexto clínico.

Por favor, especifique: _______________________

15.2. Em que medida considera o PQ aplicável no contexto clínico que indicou na questão anterior?

Utilize a seguinte escala: 1, Bastante difícil; 2, Moderadamente difícil; 3, Nem fácil nem difícil; 4, Moderadamente fácil; 5, Bastante fácil.

	1	**2**	**3**	**4**	**5**	
Bastante difícil	O	O	O	O	O	Bastante fácil

16. Em que medida considera o PQ adequado para os terapeutas das seguintes abordagens terapêuticas/ orientações teóricas?*

	Bastante desadequado	**Ligeiramente desadequado**	**Nem adequado nem desadequado**	**Ligeiramente adequado**	**Bastante adequado**	**Não sei**
a. Psicodinâmica/ Psicanalítica	O	O	O	O	O	O
b. Cogntivo-Comportamental	O	O	O	O	O	O
c. Cognitiva	O	O	O	O	O	O
d. Comportamental	O	O	O	O	O	O
e. Centrada no cliente/ Humanista	O	O	O	O	O	O
f. Sistémica	O	O	O	O	O	O
g. Estruturada/ Breve	O	O	O	O	O	O
h. Arte	O	O	O	O	O	O
i. Integrativa	O	O	O	O	O	O

16.1. Outra abordagem terapêutica/ orientação teórica.

Por favor, especifique: ______________________

16.2. Em que medida considera o PQ adequado para terapeutas da abordagem que indicou na questão anterior?

Utilize a seguinte escala: 1, Bastante desadequado; 2, Moderadamente desadequado; 3, Nem adequado nem desadequado; 4, Moderadamente adequado; 5, Bastante adequado.

	1	**2**	**3**	**4**	**5**	
Bastante adequado	O	O	O	O	O	Bastante desadequado

D. Perspetiva do cliente sobre o PQ

Pedimos-lhe agora que considere as reações habituais dos seus clientes quando usa o PQ.

1. Como classificaria a recetividade e aceitação global dos seus clientes perante a administração do PQ num primeiro contacto?*

(Isto é, na entrevista de construção do PQ)

O Nada recetivos

O Ligeiramente retivos

O Moderadamente recetivos

O Muito recetivos

O Totalmente recetivos

2. Como classificaria a recetividade e aceitação global dos seus clientes perante a administração do PQ em contactos subsequentes (isto é, durante a terapia)?*

O Nada recetivos

O Ligeiramente recetivos

O Moderadamente recetivos

O Muito recetivos

O Totalmente recetivos

E. Benefícios e Limitações do PQ

Alguns terapeutas encontram benefícios e/ou limitações a respeito da administração rotineira do PQ na prática clínica.

1. Por favor, indique em que medida concorda com as afirmações seguintes de acordo com a seguinte escala:*

	Discordo fortemente	Discordo	Não concordo nem discordo	Concordo	Concordo fortemente
a. O PQ fornece informação útil para a tomada de decisão clínica.	O	O	O	O	O
b. A listagem exaustiva de problemas é prejudicial para o cliente (multiplica os problemas).	O	O	O	O	O
c. A possibilidade de modificar o PQ ao longo do tratamento torna-o um instrumento dinâmico e reutilizável.	O	O	O	O	O
d. O PQ ajuda a levantar hipóteses de diagnóstico na fase de pré-tratamento.	O	O	O	O	O
e. O PQ é útil para a definição de objetivos terapêuticos.	O	O	O	O	O
f. O PQ auxilia os clientes a refletir sobre as suas dificuldades e no impacto que estas têm na sua vida.	O	O	O	O	O
g. O PQ fornece dados sobre a história da dificuldade.	O	O	O	O	O
h. O PQ cria dilemas a respeito da confidencialidade.	O	O	O	O	O
i. O PQ tende a levar à difusão de objetivos terapêuticos devido à grande quantidade de itens.	O	O	O	O	O
j. O PQ resulta em excesso de informação para o terapeuta.	O	O	O	O	O
k. O PQ cria expectativas irrealistas sobre o processo terapêutico (ex. resolver todos os problemas que constam na lista)	O	O	O	O	O
l. O PQ promove o estabelecimento da aliança terapêutica.	O	O	O	O	O

m. O PQ promove a responsabilização e envolvimento do cliente no tratamento.	O	O	O	O	O
n. O PQ foca-se exclusivamente nas dificuldades ou problemas do cliente.	O	O	O	O	O
o. O PQ fornece feedback ao terapeuta acerca do seu desempenho.	O	O	O	O	O
p. A informação fornecida pelo cliente pode não ser fidedigna.	O	O	O	O	O
q. O PQ envolve um processo moroso.	O	O	O	O	O
r. O PQ pode ajudar a prever o aparecimento de obstáculos no tratamento.	O	O	O	O	O
s. O PQ fornece informação sobre recursos pessoais e familiares.	O	O	O	O	O
t. O PQ permite poupar tempo e sessões pois possibilita simultaneamente a identificação estruturada de dificuldades e o estabelecimento de objetivos terapêuticos.	O	O	O	O	O
u. O PQ torna possível monitorizar o progresso do cliente sessão a sessão.	O	O	O	O	O
v. O PQ permite realizar um prognóstico na fase de pré-tratamento.	O	O	O	O	O
w. O PQ enfatiza o ponto de vista do cliente.	O	O	O	O	O
x. O PQ pode causar ansiedade no terapeuta devido à falta de progresso ou deterioração do cliente.	O	O	O	O	O
y. A relação entre o terapeuta e o investigador na construção do PQ pode confundir o cliente.	O	O	O	O	O

1.1. Outro benefício.

Por favor, especifique:: _______________

1.2. Outra limitação.

Por favor, especifique:: _______________

2. Em que medida gosta de utilizar o PQ na sua prática clínica?*

O Nada

O Moderadamente

O Bastante

3. Se não utiliza já o PQ na sua prática clínica com regularidade, quão disponível estaria para o fazer?

O Nada

O Moderadamente

O Bastante

Appendix E – Content Analysis

	What suggestions do you have for modifying the original PQ procedure?
Thematic category	**Transcript of the participants' answers**
No suggestions	"No suggestions" (P2) "I find that the original procedure works well for most clients" (P4) "None" (P6) "It has always worked fine how it is" (P7) "The clients feedback is always positive" (P9) "Nothing in particular" (P11) "Nothing to change" (P12) "No suggestion, as long as it is possible to adapt to the client's needs" (P13) "None" (P15) "None" (P16) "No suggestions" (P18) "It seems to me the PQ is fine how it is" (P19) "None" (P23) "None" (P25)
Test data	"Test data" (P1)
Ask the client to complete the PQ/ think about the items beforehand	"I'd consider sending out a PQ at the point of referral for the client to complete online beforehand, which can then get refined and ranked during the first session. Perhaps as an overall theme of 'slowing the questionnaire down' - what I mean by this, it that asking someone to write down all their problems can feel quite abrupt. Giving the client more time to reflect on this could be helpful (and probably different for different clients). For example ""between now/within the next two weeks before you next see your therapist,

	please write down a list of symptoms, or problems, that are interrupting your life or wellbeing." (P3) "Giving the client more time to consider their issues i.e. giving them more information before they meet with the researcher so they come prepared with a list in mind. I think this would help more anxious clients." (P5)
Simplify the administration procedures	"Reduce the number or draft items and final items" (P8) "Make simpler the process of selecting the client difficulties." (P10) "Simplify the first steps" (P17) "Include the rating of problem duration and intensity in the same table" (P20) "Stop writing down the draft items in small pieces of paper (or leave it as an optional procedure)" (P21) "Stop using pieces of paper" (P22)
Make the PQ a fully self-administered instrument	"Make it possible for the client to complete the PQ all by himself." (P14)
Include a comprehensive quotation system	"Include a comprehensive quotation system that allows for the therapist to ensure the quality of the items formulated with the client." (P24)

Appendix F - What to consider when assessing the clinical utility of measures[13]

	Domain	Indicators	
	FEASIBILITY		
Components	Brevity/ Length		L + FG
	Simplicity/ Complexity	Flexibility/ Adaptability	FG
		Training needs	L
		Legibility of the protocol and of the form	L
		Resources needed (administration by and interviewer, materials…)	L
	Relevance/ Value	Purpose of use	FG
		Value to practice	L + FG
	Acceptance/ Openness	Protocol adesion	L + FG
		Ethical concerns	FG
		Compatibleness with theoretical orientation	L
	ACCEPTABILITY		
	Features of the instrument	Time of administration	L
		Approach (idiographic vs. nomothetic)	FG
		Appearance and legibility	L
		Translation and cultural applicability	L
	Method of administration	Integrated use in treatment	FG
		Face to face interview	L
		Frequency of administration	FG
	Client distress, values, culture, and personal preferences	-	L
	GENERALIZABILITY		
	Clients' characteristics	Clinical condition	L + FG
		Education level	L + FG
		Physical condition	L + FG

[13] L: Found in the literature; FG: Found in the Focus Group discussion.

		Other client features (age, gender, language, ethnicity, religion…)	L + FG
	Psychotherapists' characteristics	Professional clinical experience (training, skills, experience, theoretical orientation…)	L + FG
		Other psychotherapist features (age, gender, language, ethnicity, religion…)	L
	Variations across settings	Differences between clinical practice contexts (e.g. resources available)	L + FG

References

Alves, P., Sales, C., & Ashworth, M. (2013). Enhancing the client involvement in outcomes: a study protocol of personalized outcome measurement in the treatment of substance misuse. *BMC Psychiatry, 13*, 337-343. doi:10.1186/1471-244X-13-337

Ashworth, M., Evans, C., & Clement, S. (2008). Measuring psychological outcomes after cognitive behavior therapy in primary care: A comparison between a new patientgenerated measure "PSYCHLOPS" (Psychological Outcome Profiles) and "HADS" (Hospital Anxiety and Depression Scale). *Journal of Mental Health, 18*, 1-9. doi:10.1371/journal.pone.0027378

Ashworth, M., Robinson, S., Evans, C., Shepherd, M., Conolly, A., & Rowlands, G. (2007). What does an idiographic measure (PSYCHLOPS) tell us about the spectrum of psychological issues and scores on a nomothetic measure (COREOM)? *Primary Care and Community Psychiatry, 12*, 7-16.

Ashworth, M., Robinson, S., Godfrey, E., Parmentier, H., Sheperd, M., Christey, J., . . . Matthews, V. (2005). The experiences of therapists using a new client-centred psychometric instrument, 'PSYCHLOPS' ('Psychological Outcome Profiles'). *Counselling and Psychotherapy Research, 5*, 37-41.

Ashworth, M., Shepherd, M., Chistey, J., Matthews, V., Wright, K., Parmentier, H., . . . Godfrey, E. (2004). A client-generated psychometric instrument: the development of "PSYCHLOPS". *Counseling and Psychotherapy Research, 4*, 27-31.

American Psycological Association (2002). Criteria for Evaluating Treatment Guidelines. *American Psychologist, 57*(12), 1052–1059. doi:10.1037//0003066X.57.12.1052

Barbour, R. S. (2001). Checklists for improving rigor in qualitative research: a case of the tail wagging the dog? *British Medical Journal, 322*, 1115-1117.

Barker, C., Pistrang, N., & Elliott, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners* (2 ed.). Chichester, West Sussex: John Wiley & Sons, Ltd.

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., & et al. (2001). Service profiling and outcomes benchmarking using the CORE-OM:

toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology, 69*, 184-196.

Blount, C., Evans, C., Birch, S., Warren, F., & Norton, K. (2002). The properties of selfreport research measures: Beyond psychometrics. *Psychology and Psychotherapy: Theory, Research and Practice, 75*, 151-164. doi:10.1348/147608302169616

Boswell, J. F., Kraus, D. R., Miller, S. D., & Lambert, M. J. (2013). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research*, 1-14. doi:10.1080/10503307.2013.817696

Bowling, A. (2005). Mode of questionnaire administration can have serious effects on data quality. *Jounal of Public Health, 27*(3), 281-291. doi:10.1093/pubmed/fdi03

Brooks, M., & Davies, S. (2008). Pathways to participatory research in developing a tool to measure feelings. *British Journal of Learning Disabilities, 36*, 128-133. doi:10.1111/j.1468-3156.2007.00476.x

Brown, G. S., Burlingame, G. M., Lambert, M. J., Jones, E., & Vaccaro, J. (2001). Pushing the quality envelope: A new outcomes management system. *Psychiatric Services, 52*(7), 925-934. doi:10.1176/appi.ps.52.7.925

Callaly, T., Hyland, M., Coombs, T., & Trauer, T. (2006). Routine outcome measurement in public mental health: results of a clinician survey. *Australian Health Review, 30*(2), 164-173.

Carlier, I., Meuldijk, D., van Vliet, I., van Fenema, E., van der Wee, N., & Zitman, F. (2012). Routine outcome monitoring and feedback on physical or mental health status: evidence and theory. *Journal of Evaluation in Clinical Practice, 18*, 104-110. doi:10.5750/ejpch.v1i1.640

Crawford, M. J., Robotham, D., Thana, L., Patterson, S., Weaver, T., Baber, R., . . . Rose, D. (2011). Selecting outcome measures in mental health: the views of service users. *Journal of Mental Health, 20*(4), 336-346. doi:10.3109/09638237.2011.577114

Cruz, A. S., Sales, C. M. D., Moita, G., & Alves, P. (2011, September). *Individualized Patient-Progress System: yes, we are using it and we just love it!.* Paper presented at The 4th Regional Mediterranean Congress of the International Association for Group Psychotherapy and Group Processes, Porto, Portugal.

de Beurs, E., den Hollander-Gijsman, M., van Rood, Y., van der Wee, N., Giltay, E., van Noorden, M., . . . Zitman, F. (2011). Routine outcome monitoring in the Netherlands: practice experiences with a web-based strategy for the assessment of treatment outcomes in clinical practice. *Clinical Psychology and Psychotherapy, 18*, 1-12. doi:10.1002/cpp.696

Donnelly, C., & Carswell, A. (2002). Individualized outcome measures: a review of the literature. *Canadian Journal of Occupational Therapy, 69*, 84-94.

Elliott, R., Mack, C., & Shapiro, D. (1999). *Simplified Personal Questionnaire Procedure*. Retrieved from Network for Research on Experiential Psychotherapies: http://www.experiential-researchers.org/instruments/elliott/pqprocedure.html

Elliott, R., Wagner, J., Sales, C. M., Rodgers, B., Alves, P., & Café, M. J. (2016). Psychometrics of the Personal Questionnaire: A Client-Generated Outcome Measure. *Psychological Assessment, 28*(3), 263–278. doi:10.1037/pas0000174

Ellwood, P. M. (1988). Outcomes management - A techonology of patient experience. *The New England Journal of Medicine, 318*(23), 1549-1556. doi:10.1056/NEJM198806093182329

Essock, S. M., Olfson, M., & Hogan, M. F. (2015). Current practices for measuring mental health outcomes in the USA: International overview of routine outcome measures in mental health. *International Review of Psychiatry, 27*(4), 296–305. doi:http://dx.doi.org/10.3109/09540261.2015.1014314

Evans, C., Margison, F., & Barkham, M. (1998). The contribution of reliable and clinically significant change methods to evidence-based mental health. *Evidence Based Mental Health, 1*, 70-72. doi::10.1136/ebmh.1.3.70

Evans, J. R., & Mathur, A. (2005). The value of online surveys. *Internet Research, 15*(2), 195-219. doi:10.1108/10662240510590360

Fitzpatrick, M. (2012). Blurring Practice–Research Boundaries Using Progress Monitoring: A Personal Introduction to This Issue of Canadian Psychology. *Canadian Psychology, 53*(2), 75-81. doi:10.1037/a0028051

Fitzpatrick, R., Davey, C., Buxton, M. J., & Jones, D. R. (1998). Evaluating client-based outcome measures for use in clinical trials. *Health Technology Assessment, 2*(14), 1-86.

Friedberg, R. D., & McClure, J. M. (2002). *Clinical Practice of Cognitive Therapy with Children and Adolescents: The Nuts and Bolts.* New York: The Guilford Press.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13*(117), 1-8.

Garland, A., Kruse, M., & Aarons, G. (2003). Clinicians and Outcome Measurement: What's the Use? *Journal of Behavioral Health Services & Research, 30*(4), 393-405.

Gilbody, S., House, A., & Sheldon, T. (2002). Psychiatrists in the UK do not use outcome measures. *Britsih Journal of Psychiatry, 180*, 101-103. doi:10.1192/bjp.180.2.101

Hall, C., Walker, G., Valentine, A., Guo, B., Kaylor-Hughes, C., James, M., . . . Hollis, C. (2014). Protocol investigating the clinical utility of an objective measure of activity and attention (QbTest) on diagnostic and treatment decision-making in children and young people with ADHD. *British Medical Journal, 4*, 1-9. doi:10.1136/bmjopen-2014-006838

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology, 61*, 155–163. doi:10.1002/jclp.20108

Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychotherapy dose–response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9*, 329–343. doi:10.1093/clipsy.9.3.329

Hansson, L., Berglund, M., & Ohman, R. (1987). Individualized measures of outcome versus standardized rating scales in evaluation of in-hospital psychiatric treatment. *Acta Psychiatrica Scandinavica, 75*, 275-282. doi:10.1111/j.1600-0447.1987.tb02789.x

Harpe, S. E. (2015). How to analyse Likert and other rating scale data. *Currents in Pharmacy Teaching and Learning*(7), 836-850. doi:10.1016/j.cptl.2015.08.001

Hatfield, D., & Ogles, B. (2004). The use of outcome measures by psychologists in clinical practice. *Professional Psychology: Research and Practice, 35*, 485-491. doi:10.1037/0735-7028.35.5.485

Hatfield, D., & Ogles, B. (2007). Why Some Clinicians Use Outcome Measures and Others Do Not. *Administration and Policy in Mental Health & Mental Health Services Research, 34*, 283-291. doi:10.1007/s10488-006-0110-y

Hédinsson, H., Kristjánsdóttir, H., Ólason, D., & Sigurdsson, J. (2013). A validation and replication study of the patient-generated measure PSYCHLOPS on an Icelandic Clinical Population. *European Journal of Psychological Assessment, 29*, 89-95. doi:10.1027/1015-5759/a000136

Howard, K., Moras, K., Brill, P., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy: Efficacy, effectiveness, and patient progress. *American Psychologist, 51*(10), 1059-1064. doi:10.1037//0003-066X.51.10.1059

Jensen-Doss, A., & Hawley, K. M. (2010). Understanding barriers to evidence-based assessment: Clinician attitudes toward standardized assessment tools. *Journal of Clinical Child and Adolescence Psychology, 39*(6), 885-896. doi: 10.1080/15374416.2010.517169

Johns, L., Oliver, J., Khondoker, M., Byrne, M., Jolley, S., Wykes, T., . . . Morris, E. (2015). The feasibility and acceptability of a brief Acceptance and Commitment Therapy (ACT) group intervention for people with psychosis: The ‘ACT for life’ study. *Journal of Behavior Therapy and Experimental Psychiatry, 50*(2016), 257-263. doi:10.1016/j.jbtep.2015.10.001

Kisely, S., Adair, C., Lin, E., & Marriot, B. (2015). Routine outcome measures in Canada. *International Review of Psychiatry, 27*(4), 1-10. doi:10.3109/09540261.2014.994594

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert, *Bergin and Garfield’s handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). New York, NY: Wiley.

Lucas, P., & Gonzalez, A. J. (2012, March). *Process and outcome in psychodrama: a longitudinal study.* Paper presented at The II International Congress of Psychoanalytic Psychodrama, Lisbon, Portugal

Lutz, W., Leach, C., Barkham, M., Lucock, M., Stiles, W., Evans, C., & et al. . (2005). Predicting change for individual psychotherapy clients based on their nearest neighbors. *Journal of Consulting and Clinical Psychology, 73*, 904-913. doi:10.1037/0022-006X.73.5.904

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D. A. (2003). The Outcome Rating Scale: A Preliminary Study of the Reliability, Validity, and Feasibility of a Brief Visual Analog Measure. *Journal of Brief Therapy, 2*(2), 91-100.

Neves, I. T. (2015). *Validation study of the Portuguese version of PSYCHLOPS.* Dissertation , Social Science School, University of Évora, Department of Psychology, Évora.

Nordal, K. C. (2012). Outcomes measurement benefits psychology. *American Psychological Association, 43*(1), 51-52. Retrieved from http://www.apa.org/monitor/2012/01/perspectives.aspx

Overington , L., & Ionita , G. (2012). Progress Monitoring Measures: A Brief Guide. *Canadian Psychology, 53*(2), 82-92. doi:10.1037/a0028017

Parkinson, S., Eatough, V., Holmes, J., Stapley, E., & Midgley, N. (2015). Framework Analysis: A Worked Example of a Study Exploring Young People's Experiences of Depression. *Qualitative Research in Psychology*, 1-21. DOI: 10.1080/14780887.2015.1119228

Pereira, J., G., Pedro, C., Guerra, D., & Sales, C. (2016, January). *Adequação e significado do processo de avaliação da Casa de Alba: O ponto de vista dos residentes.* Paper presented at The 11º National Congress of Health Psychology, Lisbon, Portugal.

Plante, T. G. (2005). *Contemporary Clinical Psychology* (2 ed.). New Jersey: Johyn Wiley & Sons, Inc.

Puschner, B., Becker, T., & Bauer, S. (2015). Routine outcome measures in Germany. *International Review of Psychiatry, 27*(4), 329-337. doi:10.3109/09540261.2015.1014025

Sales, C. M., & Alves, P. (in press). Patient centered assessment in psychotherapy: A review of individualized tools. . *Clinical Psychology: Science and Practice*.

Sales, C., & Alves, P. (2012). Individualized patient-progress systems: why we need to move towards a personalized evaluation of psychological treatments. *Canadian Psychology, 53*, 115-121. doi:10.1037/a0028053

Sales, C., Alves, P., Evans, C., & Elliott, R. (2014). The Individualised Patient-Progress System: A decade of international collaborative network. *Counselling and Psychotherapy Research, 14*, 181-191.

Sales, C., Gonçalves, S., Fragoeiro, A., Noronha, S., & Elliott, R. (2007). Psychotherapists Openness to Routine Naturalistic Idiographic Research. *Mental Health and Learning Disabilities Research and Practice*, 145-161.

Shapiro, M. (1961). A method of measuring changes specific to the individual psychiatric patient. *British Journal of Medical Psychology, 34*, 151-155.

Siebum, W., Pijl, Y., & Sander de Wolf, G. (2015). Routine outcome monitoring and process quality in mental health care: a descriptive study in daily practice. *Journal of Evaluation in Clinical Practice, 21*, 620-625. doi:10.1111/jep.12352

Slade, M. (2002). What outcomes to measure in routine mental health services, and how to assess them: a systematic review. *Australian and New Zealand Journal of Psychiatry, 36*, 743–753. doi:10.1046/j.1440-1614.2002.01099.x

Slade, M., Thornicroft, G., & Glover, G. (1999). The feasibility of routine outcome measures in mental health. *Social Psychiatry and Psychiatric Epidemiology, 34*, 243-249.

Smits, D. F., Claes, L., Stinckens, N., & Smits, D. J. (2014). Clinicians' Attitudes Towards Outcome and Process Monitoring: A Validation of the Outcome. *Administration and Policy in Mental Health, 41*(5), 634-641. doi:10.1007/s10488-014-0597-6

Sundet, R. (2012). Therapist Perspectives on the use of Feedback on Process and Outcome: Patient-Focused Research in Practice. *Canadian Psychology, 53*(2), 122-130. doi:10.1037/a0027776

Sytema, S., & van der Krieke, L. (2013). Routine outcome monitoring: A tool to improve the quality of mental health care? In G. Thornicroft, M. Ruggeri, & D. Goldberg, *Improving Mental Health Care: The Global Challenge* (1st ed., pp. 246-263). John Wiley & Sons, Ltd.

Thornicroft, G., & Slade, M. (2014). New trends in assessing the outcomes of mental health interventions. *World Psychiatry, 13*, 118-124. doi:10.1002/wps.20114

Trauer, T., Callaly, T., & Herrman, H. (2009). Attitudes of mental health staff to routine outcome measurement. *Journal of Mental Health, 18*(4), 288-296. doi:10.1080/09638230701879177

Trauer, T., Gill, L., Pedwell, G., & Slattery, P. (2006). Routine outcome measurement in public mental health - what do clinicians think? *Australian Health Review, 30*(2), 144-145.

Trauer, T., Pedwell, G., & Gill, L. (2009). The effect of guidance in the use of routine outcome measures in clinical meetings. *Australian Health Review, 33*(1), 144-151. doi:10.1071/AH090144

Turner-Stokes, L. (2011). Goal attainment scaling and its relationship with standardized outcome measures: A commentary. *Journal of Rehabilitation Medicine, 43*, 70-72. doi:10.2340/16501977-0656

Urbina, S. (2004). *Essentials of Psychological Testing*. New Jersey: John Wiley & Sons, Inc.

van Noorden, M., van der Wee, N., Zitman, F., & Giltay, E. (2012). Routine outcome monitoring in psychiatric clinical practice: background, overview and implications for person-centered psychiatry. *European Journal for Person Centered Healthcare, 1*(1), 103-111.

Vaughan, G., & Hogg, M. (2014). *Social Psychology.* (7, Ed.) Australia: Pearson.

Vogt, D. S., King, D. W., & King, L. A. (2004). Focus Groups in Psychological Assessment: Enhancing Content Validity by Consulting Members of the Target Population. *Psychological Assessment, 16*(3), 231–243. doi:10.1037/1040-3590.16.3.231

Wagner, J., & Elliott, R. (2001). The Simplified Personal Questionnaire. *Manuscript submitted for publication*.