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Therapists' Clinical Work Between Sessions: The Post Session Therapist Questionnaire

--Manuscript Draft--

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Dear Editor,

we are pleased to submitted to the Clinical and Counselling Psychology Journal our paper titled
“Therapists’ Clinical Work Between Sessions: The Post Session Therapist Questionnaire”. The
study reports the validation of a new self-report questionnaire able to assess a characteristic of
clinical work that has not been previously considered in the literature: the mental (affective and
rational) work that therapists do between clinical sessions. Results confirmed the importance of this
topic in the construction of a good therapeutic relationship.

This paper has not been submitted for publication elsewhere and it has, from our point of view, the
merit to improve the knowledge concerning a new aspect of the clinical process opening to relevant
implication in clinical practice and training. Authors equally contributed to the ideation and
construction of the tool and the present paper.

Thank you for your attention.

Best regards

Diego Rocco and colleagues

THERAPISTS' CLINICAL WORK BETWEEN SESSIONS

Therapists' Clinical Work Between Sessions: The Post Session Therapist Questionnaire

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Therapists' Clinical Work Between Sessions: The Post Session Therapist Questionnaire

Abstract

Objective: In this paper, we present the development of a new self-report questionnaire to assess a characteristic of clinical work that has not been considered in the literature: the mental (affective and rational) work that therapists do between clinical sessions. The resulting instrument is the Post Session Therapist Questionnaire. *Method:* After consulting the literature and conducting in-depth discussions of the dimensions to be investigated, we generated 40 items through brainstorming. We had 16 experts carefully examine the questionnaire's content validity at various stages and thus obtained 38 pertinent, clear, and unambiguous items. The experts also provided positive evaluations of the questionnaire's instructions and response mode. We then carried out a pilot study with 27 clinicians, who filled out the questionnaire twice, referring to 100 patients in each case. To assess the structural validity of the new instrument, we conducted an exploratory factor analysis using the session ($N = 200$) as the unit of analysis. *Result:* Three factors substantially supported the theoretical dimensions that we conceptualized in the first stage of the research: We called the factors Positive Regard, Comprehension, and Diagnostic Effort. These dimensions have good internal consistency. *Conclusion:* The study's results suggest that these clinical dimensions are meaningful in the development of clinical processes, which encourages further study of the psychometric properties of the questionnaire, with larger samples, so as to consider these results in relationship to the outcomes of the following sessions.

Public health significance of the study: This study highlights the importance of considering in the construction of a positive therapeutic relationship, the features of the clinical work that the therapist does, thinking of the patient between the sessions. By means of a questionnaire, three clinical dimensions emerged: Positive Regard, Comprehension, and Diagnostic Effort. These dimensions have good internal consistency, suggesting they are meaningful in the development of a positive clinical process.

Keywords: Post Session Therapist Questionnaire, common factors, exploratory factor analysis,
psychotherapy process

The relative importance of the treatment method and the therapist–patient relationship has been a source of debate in the psychotherapy research (Norcross & Lambert, 2011; Wampold & Imel, 2015). A possible method for resolving this debate is to consider all process determinants (technical and relational) in their optimal combinations (Laska, Gurman, & Wampold, 2014; Norcross, Beutler, & Levant, 2006; Weinberger, 2016). The American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) tried to overcome this dichotomy by proposing a comprehensive definition of the term *evidence-based practice in psychology*: “the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences” (p. 273).

Norcross (2001) and Norcross and Lambert (2011) systematically analyzed the role of the therapy relationship (TR) in the psychotherapy process, confirming its importance. Lambert and Barley (2001) quantified the influence of TR in the dynamics of the psychotherapy process and its outcomes, stating that “common factors, which include the client–therapist relationship, are . . . significant in contributing to client improvement” (p. 358).

Researchers have come to the same conclusion in a series of studies that have important implications for psychotherapists and clients alike (Norcross, 2002; Norcross & Lambert, 2011). The TR makes substantial and consistent contributions to patient success in all types of psychotherapy, and it explains as much of why clients improve (or fail to improve) as the treatment method does. As a consequence of this finding, it is important to constantly monitor patients’ responses within the TR, and practice and treatment guidelines should emphasize these responses as part of ongoing treatment (Wampold, 2015).

Regarding the factors of TR, a preeminent position among researchers is based on the therapists’ subjective characteristics, which determine the features of the relationship and, consequently, influence the therapeutic outcome (Wampold, 2015; Wampold & Imel, 2015). In a review, Lingiardi et al. (2017) analyzed the impact of therapists’ features on outcomes, noting that, despite the evidence, “only a few studies have shed light on the role of treatment providers” (p. 2).

Wampold (2011) listed 14 characteristics that make therapists effective, including the following: “The effective therapist is aware of his or her own psychological process. . . . The effective therapist reflects on his or her own reaction to the client (i.e., countertransference) to determine if these reactions are reasonable given the patient presentation or are based on therapist issues” (p. 5). Despite this statement, we noted an absence of research on specific measures that are able to detect this reflective attitude in a specific moment of the therapist’s activity between sessions. This activity consists of the mental (affective and rational) work (Semi, 1985) that is necessary to perform after closing a session and before starting the next one. Semi (1985) claimed that the session is truly finished (and the therapist is ready for the following session) only after this elaboration has been completed. This activity could include many components, such as diagnostic reflections, considerations of the patient’s agreeableness, reflections on both the patient’s and the therapist’s motivations, comprehension of the patient’s inner world, and evaluations of the best therapeutic strategies and techniques for that patient. Because all these components are independent of the therapeutic approach, they belong to the TR and, in particular, to the therapeutic process that each therapist individually develops expressing his/her subjective characteristics.

The amount of work performed between sessions is highly variable, ranging from a total absence to a strong presence. This variability can be very informative of a therapist’s attitude toward a patient, as it reveals the therapist’s workload in terms of time and effort spent emotionally and technically understanding a patient’s specific situation. This workload plays a fundamental role in the development of the psychotherapy process, as it can act as the foundation upon which the roles of the TR and the technical factors are deployed. To our knowledge, no research has been conducted to measure therapists’ workloads and the efforts that they spend reflecting about patients’ diagnoses and interpersonal processes, as well as the therapists’ own sympathy or empathy, comprehension of the patients’ functioning, and so on.

The present study is the first attempt to develop a reliable and valid questionnaire that measures therapists’ workloads and the effort they spend reflecting on patients between sessions.

The resulting measure is the Post Session Therapist Questionnaire (PSTQ). Thanks to this questionnaire's characteristics, we should be able to detect and analyze both the quality and the quantity of a therapist's workload between finishing a clinical session with a patient and starting the following session with the same patient.

Dimensions

The aspects of between-session workload are difficult to specifically define; to overcome this difficulty, we looked to various authors for inspiration. Specifically, Rogers (1951) introduced the concept of *positive regard*, Ferenczi (1928/1955; 1933/1955) presented the constructs of *empathic comprehension* and *degree of investment in the patient*, Stern, Hofer, Haft, and Dore (1984) introduced *affective attunement*, and McWilliams (1994) stressed the importance of the *diagnostic focus*.

As a result, we theoretically identified four main dimensions of therapists' between-session work. The first dimension, Agreeableness, refers to the therapists' perception of the patients' agreeableness, in other words refers to the therapists' evaluations of patients' pleasantness (whether positive or negative). This dimension concerns what therapists feel toward patients: whether they find the patients agreeable or disagreeable, and to what extent. The second dimension, Investment, relates to the quantity of time and attention that therapists spend thinking about patients. This dimension describes how much therapists consider between sessions their patients' life events, problems, story and so on. The third dimension, Comprehension, refers to the therapists' level of understanding of the patients. This dimension concerns understanding of the patients' problems and perspectives, and it is related to concepts such as identification and empathy. The final dimension, Diagnostic Effort, refers to the therapists' use of theoretical models to conceptualize clinical cases. This dimension relates to how much the therapist applies theoretical models (regardless of the theoretical basis) to frame patients' personalities, problems, and symptoms.

Aims

In this paper, we aim to examine some aspects of the PSTQ construct's validity using the perspective proposed by Messik (1995), who included all forms of validity in this concept. For construct validity, we could utilize any test to show that the new instrument measures what it has been constructed for. Such tests should be carried out in sequential studies that start with the examination of content validity (Chiorri, 2011). Herein, we investigated the PSTQ construct's content validity (in an a pre-research study) and its structural validity (in a pilot study; Boncori, 1993). Content validity is assessed a priori (before collecting any data) and is grounded in judgments about a test's quality, the correctness of its methodological construction, and (above all) the stimuli's capacity to elicit responses that are pertinent to the variables that the test is meant to measure. Thus, content validity is typically a conceptual analysis of the correspondence between a theoretical construct and the instrument's content (Di Blas, 2008); however, the instructions and response modes should also be checked. On the other hand, structural validity is meant to verify the correspondence between the stimuli's theoretical internal structure and their (empirically determined) internal organization. Structural validity is usually assessed through factor analysis.

Methods

The pre-research

We generated the version of the PSTQ that we used in the pilot study by following the steps described below.

On the basis of the dimensions that, theoretically, should be activated as a result of a clinician's between-session workload, we used brainstorming to generate a 40-item pool of new, ad hoc questions, as well as questionnaire instructions. These items met specific construction criteria; in other words, they had to be formulated in clear, unambiguous, positive, and simple language, and they had to be relevant to the identified dimensions (Chiorri, 2011).

Once we had prepared the first draft of the questionnaire, we performed the first step of the pre-research. To examine the content validity of the new instrument, we presented it to 10 expert

psychologists or psychotherapists.¹ The aim was to check the validity and to gather the experts' suggestions, doubts, and comments so as to properly define the areas in which therapists think about patients and encounters. The result was a 40-item version of the PSTQ.

In the second stage, we sent the 40-item version to six expert researchers in psychotherapy, asking them to judge the clarity of the instructions on a 10-point scale. Moreover, we asked them to judge whether each item was relevant to the underlying dimension (e.g., Agreeableness, Investment, Comprehension, and Diagnostic Effort; we provided a description of each dimension). We revised each item that received at least one negative judgment—if necessary, changing it significantly. We significantly modified or deleted the items that received two or more negative judgments. As a result, we obtained a 38-item list.

In the third step of the pre-research, we administered this 38-item questionnaire to a different group of 10 colleagues.² After they had filled out the questionnaire, we asked them for suggestions regarding the items, the instructions, and the measurement scale so that we could be sure that the questions were eliciting responses from which we could gather insights. This pre-research was an essential test to prepare for the pilot study. Based on the insights that we gathered from this phase, we made changes to improve the items' content validity and formal presentation. At the end of this phase, we obtained a final, 38-item questionnaire (see Table 1). Each item was theoretically linked to one of the four assumed dimensions: 12 items for Comprehension, 10 for Investment, nine for Agreeableness, and seven for Diagnostic Effort. We received no negative judgments regarding the instructions or the response scale, so we maintained their original versions, as reported below.

The respondents used a 5-point Likert scale to answer the questions. We provided the following instructions:

Dear colleague,

¹ This comprised two male and eight female experts with between 3 and 15 years of experience; seven had used the psychodynamic or psychoanalytic approach.

² This comprised three male and seven female experts with between 2 and 5 years of experience; eight had used the psychodynamic or psychoanalytic approach.

We invite you to answer the following questions just before the next consultation interview or session, regardless of whether the patient will be present at that session. Please bear in mind that these questions cover your ideas, considerations, reflections, and feelings about the patient, based on the previous clinical interview or session.

For each question, choose a response on the following scale: 1 (*not at all*), 2 (*slightly*), 3 (*somewhat*), 4 (*pretty much*), and 5 (*very much*).

Pilot Study

This research received the approval of Padua University's Psychological Ethical Committee (No. 1550/2015), and the questionnaire administration took place from September 2016 through May 2018.

Procedure

The present study is part of a larger project that involved clinicians and patients within the Dynamic Psychotherapy Service, a psychological assistance service at Padua University; in this project, a psychodynamic framework is used to provide clinical consultation and therapy sessions for free to the university's students. This service's goal is to help students who are facing situations that cause psychological distress, whether that is relational (e.g., conflictual family life or problems with friends or partners), specific (e.g., eating disorders; addiction; complicated mourning; panic attacks; depression; self-esteem problems; or difficulty in managing anger, anxiety, or sadness), or general (e.g., confusion related to exams or fears about entering the job market after graduation—not linked to cognitive issues). The whole project involves the administration of various questionnaires to both clinicians and patients; these questionnaires have all been validated in Italy (see the Session Evaluation Questionnaire, Rocco, Salcuni, & Antonelli, 2017, and the Session Impact Scale, Rocco, Antonelli, & Salcuni, 2018).

Participants

The clinicians who agreed to fill out the PSTQ comprised 27 clinical psychologists (three males) from several approaches (14.8% systemic, 18.5% constructivist, 22.2% psychoanalytic and 44.4% psychodynamic). Their clinical experience ranged from 2 to 10 years ($M = 3.24$; $SD = 2.49$).

The clinicians were free to accept or refuse participation in the research without penalty, and they were aware that neither their patients nor their supervisors would have access to the individual questionnaires.

The counselors had between one and 12 patients each, and they met with all their clients for at least two sessions each. For this pilot study of the PSTQ, we considered these two initial meetings for 100 patients (200 total sessions); all of the patients were students (70 female, 28 male, and two who did not declare their gender) with a mean age of 22.53 years (range: 19–27; $SD = 1.91$). The patients were enrolled in various faculties at Padua University.

The Tool

The PSTQ is a 38-item clinician self-report questionnaire that can be self-administered between sessions—specifically, immediately before a clinical interview or session (regardless of whether the patient is actually present at that session). We ensured confidentiality using a therapist–patient code.

Results

Statistical Analyses

Because the main purpose of this pilot study is to verify the PSTQ's structural validity, we performed an exploratory factor analysis (EFA) to examine its latent dimensions. Many scholars (e.g., Barbaranelli, 2003; Gerbing & Hamilton, 1996; Tinsley & Tinsley, 1987) agree that in pilot studies of new instruments EFA is preferable to confirmatory techniques (CFA), partly because hypothesis testing using CFA constitutes a less stringent test of the hypothesized structure than it does performing EFA. Furthermore, in practice, in the initial stages of research, researchers have used EFA to verify test structures, even when the dimensions were defined a priori (Di Blas, 2008).

Before carrying out the EFA, we examined the item distributions of the PSTQ. In fact, while

using factor analysis to summarize the relations of a group of variables does not require particular assumptions concerning the distributions' form, the factorial solution is better if they are normal, because the correlation coefficients are more reliable (Barbaranelli, 2003).

We conceived of the PSTQ as a session-by-session measure; as a consequence, we used the session (rather than the therapist) as the unit of analysis for the EFA. In addition, EFA is a descriptive rather than inferential statistical method; for this reason, the sessions' lack of independence within the cases was not a problem (Elliott & Wexler, 1994). Consequently, we carried out an EFA of the therapists' raw PSTQ ratings for all the patients with whom they met and for both sessions in which those patients took part.

Following Barbaranelli (2003), we chose principal-axis extraction, Cattell's scree test (to determine the number of factors), and oblique promax rotation. For the interpretation of the rotated factor loadings, we adopted Hafkenschied's (1993, 2009) rules by considering only items for which the largest factor loading was at least 0.40 and for which the next largest was at least 0.20 lower; we also used the condition that at least four items had to fulfill both these inclusion criteria.

We also assessed the PSTQ's internal structure using the intercorrelations between scores in the dimensions that resulted from the EFA. We performed a reliability analysis for each dimension of the instrument by calculating internal-consistency coefficients (Cronbach's α).

We performed the data analyses using IBM SPSS Statistics 23.0.

Factor Structure

An examination of the distributional properties of the PSTQ items suggested a departure from univariate normality for three questions (Question 14, "Would you mind conducting other clinical interviews with this patient?"; Question 15, "How much time have you spent thinking about this patient since the previous clinical interview?"; and Question 16, "After the end of the interview, did the patient's problems or discomfort remain with you?"); these questions were positively skewed or excessively kurtotic. To normalize these items' distributions, we applied a log transformation (Barbaranelli, 2003; Barbaranelli & D'Olimpo, 2007) and then recomputed their

skewness and kurtosis indexes, all of which were less than or equal to 1 after the transformation.

We conducted tests to ensure that the correlation matrix could be analyzed, and the results were all satisfactory: The determinant was higher than 0, meaning that the variables were not linearly dependent; the Kayser–Mejer–Olkin score was .89, indicating that the sample was adequate; and the Bartlett sphericity score was statistically significant ($p < .001$), signifying that the correlation matrix was different from the identity matrix (Barbaranelli, 2003).

We then conducted a principal-axis analysis, followed by an oblique promax rotation for the therapists' scores on the 38 items of the PSTQ, considering their responses referring to all the patients they met in the two sessions.

The results of Cattell's scree test showed a three-factor solution, with the three factors accounting for 40% of the final total variance: 20%, 12%, and 8%, respectively.

Table 1 shows the factor loadings and communalities for the factors that we extracted from the PSTQ.

Table 1 about here

The first factor included nine PSTQ items from the original Agreeableness dimension, three items from the original Investment dimension, and one from the original Diagnostic Effort dimension. Because these items concerned positive feelings regarding the patients and motivation to see them again, we called this dimension *Positive Regard*. On the second factor loaded eight items from the original Comprehension dimension and one item from the original Investment dimension. We thus have maintained the name *Comprehension*, as this factor nearly entirely overlapped with the hypothesized one. The third factor comprised three items from the original Diagnostic Effort dimension and three items from the original Investment dimension. These items relate to the time that therapists devote to thinking about patients, such as trying to understand their personality or formulating a diagnosis, so we have maintained the original name: *Diagnostic Effort*.

Descriptive Statistics for the PSTQ

On the basis of the EFA results, we calculated the PSTQ scores by taking the means of the bold items in Table 1 (i.e., excluding those with loadings less than 0.40 or those with an even split between factors). Three items were negatively phrased, so we reverse-coded them (see Table 1).

Descriptive statistics and internal consistency are presented in Table 2. The PSTQ scores range from 1 to 5, and the mean scores were around the scale's midpoint.

The dimensions all had at least acceptable internal consistency: excellent for Positive Regard, good for Comprehension, and acceptable for Diagnostic Effort (DeVellis, 2012).

The score distributions of the three dimensions were normal, as supported by skewness and kurtosis values (which were between -1 and $+1$).

Table 2 about here

Intercorrelations Within the PSTQ

We calculated Pearson's linear correlation coefficient (r) for each combination of the three PSTQ scores (Table 3).

Table 3 about here

Interestingly, only positive regard and comprehension are positively and significantly correlated.

Discussion

We were motivated to present the research in this paper by a will to explore a specific theoretical aspect of clinical activity that had not been considered in the literature: the mental (affective and rational) work that therapists do between sessions. Our hypothesis was that this work

would unfold through specific clinical dimensions that can be meaningful in the development of clinical processes and that can even affect therapeutic outcomes. For this purpose we created a new questionnaire: the PSTQ. In this paper we presented studies concerning the construct validity of the PSTQ, in its aspects of content and structural validity, and reliability analysis.

A multistep analysis of the PSTQ's content validity resulted in 38 items that were pertinent to and representative of the domains that we meant to measure. Furthermore, the experts whom we interviewed judged the instructions and the response mode to be clear, unequivocal, and understandable.

After this phase, we proceeded with a pilot study in which we implemented an EFA. The results of this analysis, to a large extent, reproduced the theoretical dimensions that we had originally hypothesized in the a pre-research phase of the questionnaire's construction. The main exception was related to the original Investment dimension, whose items were distributed over the remaining three dimensions. This finding shows that therapists' work between sessions occurs in three dimensions: affective (Positive Regard), understanding-based (Comprehension), and theoretical (Diagnostic Effort). These dimensions all had moderate to excellent internal consistency.

Obviously, to confirm the instrument's construct validity, this structure should be replicated in future research, when more data will be obtained, especially by means of CFA (Kahn, 2006).

The instrument's Pearson's correlation values show that the Positive Regard and Comprehension dimensions are positively related. In other words, the affective component of the therapists' work is strongly linked to the therapists' understanding of the patients' points of view. When therapists are more engaged in terms of affect, their comprehension of the patients increases. On the other hand, the Diagnostic Effort dimension seems to be independent of both affect and understanding. This dimension seems to be a more objective evaluation of the patients' clinical features.

With this first work, we focused on the extension of the therapeutic process outside of the therapeutic setting *strictu sensu* to include the clinical activity conducted within the therapist's mind

between sessions. This work can be considered, at least in part, a foundation on which to deploy relational factors (e.g., empathy and affective attunement; see, e.g., Rocco et al., 2017) to determine the quality of the TR (Laska et al., 2014; Norcross & Lambert, 2011; Wampold, 2015). Once these relational factors have been activated, the technical components can be activated to provide a substantial and consistent contribution to the success of the therapist–patient relationship in psychotherapy. Consequently, what the therapist does regarding the three identified dimensions could be crucial whenever an active effort, or its absence, would be expected to have positive or negative repercussions on the clinical process.

We considered therapists' work as belonging to the common factors because it concerns the TR; it is a part of the process in which therapists deploy subjective initiative, and can be considered part of personal role investment (Orlinsky, Rønnestad, & Willutzki, 2004). Using the classification of therapeutic action that Waltz, Addis, Koerner, and Jacobson (1993) proposed, we can place workload in the *essential but not unique* class, or perhaps in the *acceptable but not necessary* class. The difficulty in placing this process activity could be due to the temporal dimension. In Waltz et al.'s (2015) classification, this process activity occurs *within* the session—which is true for all of the aspects of the four classes. On the other hand, the PSTQ analyzes an activity that occurs in a temporal moment *outside* of the session. Thinking about patients, elaborating on their diagnoses, and focusing on feelings and thoughts related to them—in short, seeking to fully comprehend the patients—can be important enough to be considered an essential ingredient, at least within psychodynamic therapeutic theory.

The first limitation of the pilot study is that it lacked an analysis of the PSTQ's external validity. It was not possible to correlate its scores with those from similar instruments (i.e., to measure convergent validity), as, to our knowledge, no other tool to measure this aspect of the clinical process has been validated. In future research on the psychometric qualities of the PSTQ, when more data will be available, external validity could be checked via opposite-group comparison (e.g., by comparing expert clinicians' scores to those of psychotherapists in training, or

by comparing various psychotherapists' engagement with regard to the patients' diagnoses). If the PSTQ possesses good external validity, then we would expect to find significant differences in such comparisons, especially in the Comprehension dimension, which we would expect to be higher among expert clinicians than among those who are still in training.

Other limitations concern the small numbers of both clinicians and patients in the study's sample, as well as the prevalence of females. Further samples could provide better data for the gender and age variables—perhaps even allowing researchers to determine whether some dimensions are gender- or age-dependent.

In subsequent studies, it would be interesting for researchers to investigate mediational and regression models. According to Rogers (1962), positive regard could be a very basic aspect of the TR, with the other dimensions depending upon it.

A further aspect to explore concerns the effects that the quality and quantity of therapists' work, as measured by the PSTQ, have on subsequent sessions, as evaluated using the Italian versions of the Session Evaluation Questionnaire (Rocco et al., 2017) and the Session Impact Scale (Rocco et al., 2018).

Notwithstanding these limitations, the results of this pilot study of the PSTQ are encouraging and provide cause for further investigations of its psychometric properties, above all for its utility for clinicians illustrated above.

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Table 1

Exploratory Factor Analysis for the PSTQ

	Factors			Communalities
	1	2	3	
36. Are you motivated to meet this patient again?	0.87	0.041	0.019	.79
6. Do you like this patient?	0.85	0.038	−0.030	.75
14. (log ₁₀ , R) Would you mind conducting other clinical interviews with this patient?	0.82	0.058	0.027	.62
1. Do you look forward to the next clinical interview with this patient?	0.81	0.043	0.041	.70
18. Would you be disappointed if this patient did not come to the next clinical interview?	0.77	−0.049	0.15	.62
22. Do you have positive regard toward this patient?	0.77	0.13	−0.16	.68
23. Are you motivated to continue having sessions with this patient?	0.76	0.073	0.076	.67
26. (R) Do you find this patient unpleasant?	0.76	0.059	0.14	.53
31. Does this patient's problem provoke your curiosity?	0.68	−0.030	0.053	.46
35. Do you have respect for this patient?	0.65	0.17	0.031	.57
30. Do you value this patient?	0.59	0.22	−0.11	.50
10. (R) Did you find this patient boring?	0.57	0.065	−0.017	.30
25. In your assessment, how well-suited is this patient for an expressive intervention?	0.48	0.10	−0.026	.28
11. How much are you able to remember of what the patient said during the clinical interview?	0.32	0.015	0.30	.22
21. How appropriate is your therapeutic approach for this patient's problem?	0.28	0.25	0.13	.24
29. In your assessment, how well-suited is this patient for a supportive intervention?	−0.17	0.14	−0.023	.027
34. Do you feel that you understand this patient's actual problem?	0.078	0.72	0.070	.60
32. Were you able to consider the patient's problem in relation to his or her past life events?	0.047	0.67	0.017	.49
37. Is it clear why this patient sought a consultation at this moment in his or her life?	0.001	0.62	−0.11	.38
3. As a psychologist, do you understand why the patient has asked for a consultation?	0.071	0.62	0.088	.47
38. Are this patient's feelings clear?	0.052	0.61	−0.13	.39
28. Were you able to consider the patient's problem in relation to his or her current life events?	0.071	0.56	−0.027	.35
20. Do you understand the importance of this patient's problems in his or her life?	0.012	0.54	0.21	.39
8. How much do you understand about this patient's suffering?	0.26	0.53	0.023	.49
27. Were you able to picture the patient's life environment (persons, places, etc.)?	−0.031	0.47	−0.079	.20
12. How much did you understand regarding the patient's problem—not as a clinician but as a general person?	0.27	0.29	0.027	.23
5. Did you consider whether something is missing in the patient's description of himself or herself?	0.085	−0.20	0.19	.058
15. (log ₁₀) How much time have you spent thinking about this patient since the previous clinical interview?	0.13	−0.26	0.64	.43
7. Have you found sufficient time to think about the clinical interview with this patient?	0.18	−0.17	0.64	.44

17. Have you tried to frame the patient's <i>personality</i> using various diagnostic models?	−0.22	0.038	0.58	.35
4. Did you think about a differential diagnosis for this patient?	−0.029	0.090	0.56	.34
13. Have you tried to frame the patient's <i>problem</i> using various diagnostic models?	−0.20	0.13	0.47	.25
9. Did you think about a diagnostic hypothesis for this patient?	−0.15	0.33	0.47	.34
19. How much time have you spent taking notes about this patient?	0.19	−0.22	0.43	.22
2. Did you think about which kind of therapy this patient needs?	0.029	0.34	0.36	.31
33. How much time have you dedicated to evaluating this patient's psychological resources?	0.031	0.27	0.36	.25
24. Did you consider this patient's level of motivation with regard to having a psychological intervention?	0.091	0.14	0.19	.094
16. (log ₁₀) After the end of the interview, did the patient's problems or discomfort remain with you?	−0.005	0.13	0.17	.052

Note. The data cover 200 total sessions. Bold indicates an item with a factor loading greater than 0.40 and a next largest loading at least 0.20 less than the highest factor loading. R = reverse-coded. (log₁₀) logarithmic transformation of the raw score.

Table 2

Means, standard deviations, skewness, kurtosis, internal consistency reliability (Cronbach's α) and their Confidence Intervals (CI) of the PSTQ

Dimension	<i>n</i>	<i>M</i>	<i>SD</i>	Skewness	Kurtosis	Reliability (Cronbach's α)	95% CI
Positive Regard	13	3.32	.64	−0.72	0.54	.94	[.93, .95]
Comprehension	9	2.97	.50	0.092	0.56	.85	[.82, .88]
Diagnostic Effort	6	2.90	.37	−0.031	−0.26	.71	[.64, .77]

Note. The data cover 200 total sessions.

Table 3

Pearson's r Intercorrelations Among the Three Dimensions of the PSTQ

	Positive Regard	Comprehension	Diagnostic Effort
Positive Regard	—	.53***	.093
Comprehension		—	.074
Diagnostic Effort			—

Note. The data cover 200 total sessions.

*** $p < .001$.