Antunes, R., Sales, C.M.D., & Elliott, R. (2018). The Clinical Utility of the Personal Questionnaire (PQ): A mixed methods study. *Counselling Psychology Quarterly*. doi: 10.1080/09515070.2018.1439451

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. An exploratory sequential research design was used to study the clinical utility of an individualized outcome measure, the Personal Questionnaire (PQ). In a qualitative first phase, a focus group of therapists was conducted to guide the development of a survey. In a quantitative second phase, the survey was administered to an international sample of 25 therapists that integrate PQ in routine clinical work. Results suggested that the PQ is perceived as a clinically significant and fairly practical measure, useful not only in assessing outcome but also for various clinical tasks. Furthermore, it is relatively well accepted by clients and generalizable to different clients, clinical approaches and settings. However, therapists gave specific suggestions for increasing the PQ's clinical utility. Exploring therapists' perspectives and practices will improve the appropriateness of measures for real-world clinical settings.

Keywords: clinical utility; personal questionnaire; therapist experiences; idiographic measures; practice-based research; outcome measures; mixed methods.

The Clinical Utility of the Personal Questionnaire (PQ):

A mixed-methods study

The routine assessment of outcomes in therapeutic settings requires the incorporation of assessment tools into daily clinical care. However, selection of routine outcome measures can be challenging. Besides psychometric properties, tools must be adequate to the real clinical context, according to the nature of clinical work and contingencies of services. In this article we present the results of a mixed methods study on the clinical utility of an individualized outcome measure, the Personal Questionnaire (PQ).

The challenges of routine assessment of outcomes

Managed care is shaping delivery of counselling and other psychological therapies, as policy makers and funding agencies require evidence of the beneficial effects of interventions (Bower & Gilbody, 2010). Outcomes of patients attending services are ought to be assessed on a routine basis and used for monitoring quality (i.e., assessing and improving treatments within teams or services) and for benchmarking (i.e., to make comparisons between teams or services, allowing investors, such as insurance companies, to choose between service providers) (Smits, Claes, Stinckens, & Smits, 2014; van Noorden, van der Wee, Zitman, & Giltay, 2012). Being valuable sources of evidence of treatment effect as it occurs naturally within daily clinical practice, routine outcomes are also central to inform potential users and public in general (Barkham & Mellor-Clark, 2003).

Since routine outcomes assessment changes clinical routine, it is important to ascertain its impact on practice. Positive impacts have been found, namely providing direct clinical information that is useful in clinical decision making (Sytema & van der

Krieke, 2013). Feedback of individual client change has been associated with better treatment outcomes (Brown, Burlingame, Lambert, Jones, & Vaccaro 2001), as well as client recognition of improvement (Boswell, Kraus, Miller, & Lambert, 2013; Nordal, 2012), establishment of the client/therapist relationship (Unsworth, Cowie, & Green, 2012), definition of treatment plans (Siebum, Pijl, & Wolf, 2015), and identification of the need for additional professional training (Fitzpatrick, 2012; Nordal, 2012). Despite these positive aspects, professionals are critical regarding routine assessment of outcomes.

There is scepticism concerning the relevance of outcome measures over using clinical judgement alone (Hatfield & Ogles, 2004, 2007; Jensen-Doss & Hawley, 2010; Jensen-Doss et al., 2017; Miller, Duncan, Brown, Sparks, & Claud, 2003; Trauer, Callaly, & Herrman, 2009). Practitioners report feeling anxious about being evaluated based on clients' outcome, and are concerned with the link between this evaluation and funding allocation, which may lead to competition among services, teams and therapists (Norman, Dean, Hansford, & Ford, 2014; Unsworth, Cowie, & Green, 2012).

Counsellors also feel that using outcome measures alters the way they work and may interfere with the ability of developing confidential, positive therapeutic relationships (Fitzpatrick, 2012; Rizq, 2013; Unsworth, Cowie, & Green, 2012). Rizq (2013) speaks of an disavowal of the therapeutic relationship and feelings, turning therapy into a mere satisfaction of consumer needs. The use of outcome measures may create an emphasis on numbers and disregard specific information about individual clients, treatments and services. In the words of Cooper (2011) "this is the very antithesis of counselling values and practices: reducing the complexity of human-lived experiences into de-individualised, de-contextualised averages" (p.1). Lack of time and resources have also been reported as central reasons for therapists to be sceptical and unwilling to use

outcome measures (Garland, Kruse, & Aarons, 2003; Hatfield & Ogles, 2004; Hatfield & Ogles, 2007; Norman, Dean, Hansford, & Ford, 2014; Trauer, Gill, Pedwell, & Slattery, 2006).

The clinical utility of routine assessment

From the point of view of professionals, incorporating outcome measures in routine care adds pressure on services, teams and practitioners due to the excessive focus on targets, outcomes and protocols, and potential negative impact on therapeutic processes. Hence, it is important to evaluate the practical value of outcome measures, its pros and cons for clinical practice in everyday care contexts, i.e., its clinical utility. The clinical utility of assessment measures is an emerging topic, where discussion has tended to focus on psychological interventions. 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 where it is to applied, regardless of its demonstrated efficacy in research settings” (p. 1056). Clinical utility of psychological treatments includes two components, namely, *generalizability*, defined as “the extent to which an effect of a treatment is robust and therefore will be replicated even when details of the context are altered” (p. 1056); and *feasibility*, which refers to “the extent to which a treatment can be delivered to patients in the actual setting” (p. 1057). Concerning outcome measures, some issues have been pointed out as relevant to defining clinical utility. Slade, Thornicroft and Glover (1999) describe feasibility as the extent to which a measure “is suitable for use on a routine, sustainable and meaningful basis in typical clinical settings, when used in a specified manner and for a specified purpose” (p. 245). On the other hand, Fitzpatrick, Davey, Buxton and Jones (1998) refer to feasibility as “the extent of effort, burden and disruption to staff and clinical care

arising from use of an instrument” (p. iv), hence proposing a definition based on the practical aspects from the clinician point of view. In addition, Fitzpatrick and colleagues (1998) refer to *acceptability*, that is, “how acceptable is an instrument for respondents to complete”.

Based on these definitions, in this study we addressed clinical utility as the ability of an outcome measure to be used in real-world settings, covering the domains of *feasibility*, *acceptability* and *generalizability*. Specifically, we defined *feasibility* as the balance between burden and value of administering and processing a measure, from the point of view of clinical staff. Feasibility addresses aspects such as brevity, simplicity, availability, and the clinical value of a measure. *Acceptability* concerns client’s willingness and ability to comply with the administration procedures. It addresses the level of adherence and its facilitators or barriers, namely the clarity of the structure and instructions, length, appearance and legibility of the measure, emotional reactivity in respondents, respect for client values, culture, personal preferences and health status (APA, 2002; Bowling, 2005; Fitzpatrick, et al., 1998; Slade, Thornicroft, & Glover, 1999). Finally, *generalizability* refers to the range of applicability of a given instrument across different settings. Client characteristics, psychotherapist characteristics and variations across settings are seen as major determinants of generalizability, as well as the interaction among these factors.

The clinical utility of the Personal questionnaire (PQ)

The main goal of this research was to explore the clinical utility of one of the most used individualized measures, the Personal Questionnaire (PQ) (Elliott, Mack, & Shapiro, Simplified Personal Questionnaire Procedure, 1999; Sales, Gonçalves, Fragoeiro, Noronha, & Elliott, 2007, for the Portuguese version). The PQ was

developed by Shapiro in 1961, motivated by the lack of strategies for therapists and counsellors to measure client changes of specific psychological difficulties, while capable of making comparisons between different clients and different difficulties (Elliott et al., 2016). Following an individualized approach to outcome measurement (Sales, 2017), PQ consists on a unique questionnaire built for each client, tailored to his/her unique concerns. The PQ requires a semi-structured interview at pre-therapy (commonly conducted at the first appointment) where the client completes a blank Problem Description Form in collaboration with the therapist, a researcher or other practitioner, often an intake worker. This is intended to provide a list of difficulties in the client's own words that they wish to work on in therapy. This process requires five structured stages that take roughly twenty to thirty minutes to complete (Table 1). On later administrations, clients rate the items for severity, which can be done in a minute or two.

Table 1

Procedures for the PQ Construction Interview

Step	Description
Generate	The client is asked to describe the main difficulties that are the motive for seeking psychotherapy. It is recommended to identify several draft items (approximately fifteen) that regard difficulties from five areas, namely, symptoms, mood, specific performance/ activity, relationships and self-esteem.
Refine	The interviewer writes each draft item onto separate slips of paper, while discussing with the client to make sure that each item reflects a specific, single difficulty that the client wants to be targeted in therapy, phrased in their own words.
Prioritize	The client is asked to organize the items according to their importance from the client's point of view. The rank ordering of each item is written down on the respective card.
Rate	The client rates how much each difficulty has bothered him/her during the past week using a 7-point anchored scale (1= <i>not at all</i> to 7= <i>maximum possible</i>). These ratings can be used as a baseline score. The client may also be asked to indicate the duration of each difficulty, using a 7-point anchored scale (1= <i>less than 1 month</i> to 7= <i>more than 10 years</i>).
Prepare	The items are transferred onto a blank PQ Form. Copies are made for future use, leaving space for adding more items later if the client wishes to.

The PQ meets criteria for an evidence-based, norm-referred measure of psychological distress, with good internal and temporal consistency, strong correlations with nomothetic outcome measures, and ability to detect client change session to session and over the course of therapy (Elliott et al., 2016). In a study conducted by Sales and colleagues (2007), therapists showed openness in using the PQ and perceived it as a useful tool, but issues regarding integration of this measure as a routine procedure remain unknown. In order to ascertain the clinical utility of PQ (i.e., its adequacy and value for daily clinical practice across mental health settings) it is necessary to listen to therapists that have used it for routine outcome assessment: how and when PQ was used, how clients responded to it, how feasible were the administration steps, what eventual adaptations therapists introduced and their suggestions to maximize PQ applicability and value for practice.

Method

Study Design

This study was framed under a two-phase mixed methods design, specifically a sequential exploratory design (Figure 1). By combining quantitative and qualitative data, mixed methods are considered valuable to understand of a research problem (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). Sequential exploratory methods in particular are seen as useful when exploring unknown constructs and informing the development of new instruments (Creswell & Plano Clark, 2007; Hanson et al., 2005).

Figure 1. Study design: Sequential mixed methods.

The first qualitative phase involved conducting a focus group, aiming to accomplish the following aims: (1) *To provide background information about clinical utility of PQ*; (2) *To provide impressions of the PQ, derived from the experience of use in clinical practice*; (3) *To stimulate research ideas that can be explored using quantitative approaches*; (4) *To learn how respondents talk about the phenomenon of interest, therefore informing the design of the survey instrument in terms of content and language*. These aims coincide with the common uses of focus group methodology, described by Stewart and Shamdasani (1990, cit. in Claridge, Parker, & Cook, 2005).

The qualitative data were used to draw items describing the practical use of this measure and, in the second phase, a new survey was designed and administered to a larger sample of professionals that were regular users of PQ. The second phase was conducted to answer the following research questions: (1) *Who are the professionals using the PQ?* (2) *How is the PQ used?* (3) *How feasible is the PQ?* (4) *How acceptable it is for clients?* (5) *How generalizable it is to different settings?*

As the study was framed on the first authors' Master Thesis, all procedures performed in this study were authorized by the University of Évora ethics committee. Participants of both phases of the research were provided with a consent statement and all gave their informed consent.

First phase: Focus Group and Survey Development

Data Collection

Focus group was chosen as an appropriate qualitative methodology after a review of empirical and methodological literature. This methodology is reported in exploratory studies and instrument development and adaptation (Claridge, Parker, & Cook, 2005). The participants were purposively sampled to reflect a range of

characteristics deemed relevant to the theme. Five Portuguese psychotherapists were invited to participate, known by the authors for their extensive experience on using PQ in their practice. One therapist declined participation due to lack of time, resulting in four participants (see Table 2). Some participants worked in the same institution, which contributed positively for discussion and disclosure.

Table 2

Focus Group Participants

	Participant 1	Participant 2	Participant 3	Participant 4
Education	Doctoral degree	Doctoral degree	Master degree	Doctoral degree
Occupation	College professor	College professor	Clinical psychologist	Clinical psychologist
Approach	Emotion-focused therapy	Cognitive-behavioural therapy	Emotion-focused therapy	Emotion-focused therapy
Experience with PQ	2 years	4 years	4 years	4 years
Administration context	Group therapy, psychodrama, research	Group therapy, research	Private practice, psycho-oncology	Private practice, psycho-oncology

A semi-structured approach was used to encourage discussion. Main guiding questions were: (1) *What are the reasons and goals for using the PQ?* (2) *How and when do you use the PQ?* (3) *What are its benefits and limitations?* (4) *How clients react to PQ administration?* (5) *What is the range of applicability of the PQ?* The facilitator was otherwise nondirective, non-evaluative, and supportive. When ending the focus group, a verbal summary of the meeting was elaborated by the facilitator and corroborated by the participants. The focus group lasted 95 minutes. The facilitator was the first author, who learned to conduct a focus group by reading the literature and training with the second author.

Data analysis

A framework analysis was conducted. This strategy is used within social and health sciences for the management and analysis of qualitative data allowing a combination of deductive and inductive methods to develop an analytic framework (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The audio recording was transcribed (stage 1) and after reading the transcription for familiarization with content (stage 2) a first analysis of the manuscript was conducted in order to highlight important quotations. The topic of each quotation was identified using pre-defined (based on literature) or new labels/codes (stage 3). In order to ensure trustworthiness of the analysis, the researchers discussed the definition and application of labels to the transcript. Later, labels and the respective extracts were grouped together into thematic categories, forming a working analytical framework (stage 4 and 5). Finally, all the data was charted into the final framework matrix in Supplemental File 1 (stage 6). The process of analysis was conducted mainly by the first author and audited and discussed with the second author (research supervisor of the first author). Disagreements were discussed with the third author (co-supervisor).

Qualitative results

Three broad dimensions emerged from framework analysis of the focus group discussion, specifically, feasibility, acceptability, and generalizability (Table 3). Participants' perspectives on burden versus value of the PQ regarded the dimension of feasibility. A new theme emerged from the focused group, namely, ethical concerns. Acceptability included the participant's impressions on client willingness and ability to comply with the PQ. Finally, generalizability concerns considerations on the range of applicability of the PQ. Within each broad dimension there were specific themes that

derived from guidelines or that arose spontaneously. Globally, dimensions and themes coincided with the findings of the literature review. Qualitative data included the participants' considerations, experiences, and suggestions, derived from experience of use in clinical practice. Collected data allowed to learn how PQ users talk about its clinical utility, which helped filtering pertinent aspects to consider in the survey, as well as language used.

Table 3

Qualitative themes by dimension

Themes	Description	Example from the focused group
Feasibility		
Brevity	Time for administration and analysis	"It's time consuming"
Ethical appropriateness	Dilemmas and preoccupations	"The PQ can create dilemmas about confidentiality... when the construction interview is conducted by other than the therapist."
Protocol adherence	Compliance or modifications of the procedures	"The procedure says to list about ten items. I don't do that. It's an exaggerated number." "I guess it would be better for us and for the patients if we focus on generating the items from the relationship, without using pieces of paper."
Value for practice	Purposes of use and benefits for clinical practice	"Building it involves the client differently (...) he becomes more responsible for his treatment." "I also use it to set intervention goals."
Acceptability		
Method of administration	Integration in treatment course	"I think that, for the patients, the PQ is part of the intervention."
Emotional impact	Psychological distress	"The client lists his concerns, thus he will have the expectation that they will be intervened."
Generalizability		
Client	Clinical condition, education level, socioeconomic status, and other client variables	"Those (clients) who talk a lot... to set up the items is difficult sometimes." "PQ can be used with people of various socio-economic and education levels." "With patients with reduced mobility, I write the items on

		post-it so they don't slide around."
Therapist	Clinical experience and approach	"(Administering the PQ) implies all the clinical skills involved in establishing a therapeutic relationship... creating a safe environment... being able to pay close attention to non-verbal cues."
Context	Differences across clinical contexts	"It is so much easier to use the PQ in private practice because people seek psychological treatment (...) they are more motivated and involved in the process."

Survey Development

Based on the qualitative data, items were derived for the PQ-Utility survey, often using the participants' own words. For instance, for the dimension *feasibility* and the theme *value*, the focus group transcription "building it involves the client differently (...) he becomes more responsible for his treatment" was transformed into the survey item "The PQ promotes client involvement and responsibility in the treatment." Items were designed with the purpose of eliciting quantitative and qualitative assessments about the PQ by means of measurement forms like anchored scales, multiple choice and open answer items.

A preliminary pool with approximately 200 items was developed by the first author, later revised by the second and third authors individually to eliminate irrelevant/redundant items. The participants of the focus group and two other therapists with experience on the PQ were invited to pilot a draft version of this survey. Telephone interviews were conducted with the participants to solicit feedback on question type, appearance and clarity, language used, time to complete, and completeness of the survey. The survey was adapted accordingly. Since it was developed in two languages (Portuguese and English), the equivalence of meaning was improved by multiple revisions by members of our team from both nationalities and independent collaborators.

The developed survey aimed to describe therapists' perspectives and experiences

with the PQ and was named Utility-PQ. It contains a final pool of 90 items gathered by consensus between the authors: 7 items composing the Personal Information section, 13 for Administration Setting and 70 items assessing clinical utility in three dimensions, namely, feasibility, acceptability, and generalizability. The number of items assessing clinical utility differed for each subdomain, according to the contents emerged in the focus group.

Feasibility includes five sub-dimensions:

- (1) Protocol adhesion: 13 items describing the procedures rated by therapists for their level of compliance in a 5-point scale, from 0= *never* to 4= *always* (e.g. “I include the problem duration ratings”); one open question asking for suggestions to make the protocol more practical.
- (2) Brevity: one multiple choice asking the time needed to learn how to use the PQ; two 5-point scales of agreement concerning time of use, ranging from 0= *strongly disagree* to 4= *strongly agree* (e.g. “The PQ is time consuming”).
- (3) Ethical appropriateness: one 5-point scale of agreement asking therapists if the PQ might create dilemmas regarding confidentiality.
- (4) Value: 19 items referring to benefits and problems of using the PQ, rated for level of agreement using a 5-point scale (e.g. “The PQ assists in the process of defining therapeutic goals”).
- (5) Openness: one multiple choice asking level of satisfaction of using the PQ.

The domain of acceptability includes two sub-domains:

- (1) Emotional impact: three items describing client reactions to the PQ rated in a 5-point scale of agreement (e.g., “extensive listing of problems is harmful for the client - multiplies problems”);

- (2) General receptiveness: two items asking about client receptiveness in the first application when the PQ is constructed and subsequent administrations.

The last domain of generalizability encompasses three areas:

- (1) Clients: four items asking the degree of appropriateness to age groups using a 5-point scale ranging from 0= *quite inappropriate* to 4= *quite appropriate*); one multiple choice with options describing characteristics of clients that might hinder administration (e.g. “physical pain”; “low education”); five items describing protocol adaptations to clients rated by therapists for their level of compliance in a 5-point scale, ranging from 0= *never* to 4= *always* (e.g. “I postpone the PQ administration if the client is emotionally dysregulated”); one multiple choice item requesting therapists to indicate the percentage of clients to which the PQ is applicable.
- (2) Therapists: 9 items requesting the degree of appropriateness to different theoretical models (e.g. “cognitive-behavioural”; “psychodynamic/psychoanalytic”) using a 5-point scale ranging from 0= *quite inappropriate* to 4= *quite appropriate*.
- (3) Contexts: 7 items asking therapists to rate the degree of appropriateness of the PQ in different clinical practice settings (e.g. “private practice”; “psychiatric inpatient”) using the 5-point scale described above.

Second Phase: Administering and Analysing the Survey

Participants

Twenty five therapists responded the survey, the great majority were Portuguese (72%), females (76%), and with mean age of 35 years old (Table 4). Their clinical experience varied from 32 years to less than one year (M= 7.64).

Half of the participants had a master's degree (52%), one fifth had a PhD (20%) and one fifth had postgraduate studies (20%). Concerning clinical approach, 40% of the participants followed a Cognitive-Behavioural approach and 28% followed a Person-centred/ Experiential/ Humanistic approach.

Table 4
Survey Participants

Variable		<i>n</i> (%)	M (SD)
Age			34.52 (8.70)
Years of clinical experience			7.64 (7.74)
Gender	Female	19 (76)	
	Male	6 (24)	
Residence	Portugal	18 (72)	
	United Kingdom	6 (24)	
	Other	1 (4)	
Education level	Master's degree	13 (52)	
	PhD	5 (20)	
	Postgraduate Studies	5 (20)	
	Pre-bologna university degree	2 (8)	
Clinical Approach	Cognitive-Behavioural	10 (40)	
	Person-cantered/ Experiential/ Humanistic	7 (28)	
	Emotion-focused	2 (8)	
	Integrative	2 (8)	
	Other	4 (16)	
Therapy format	Individual	24 (96)	
	Groups	4 (16)	
	Other	2 (8)	
Professional identification	Both therapist and researcher	16 (64)	
	Therapist exclusively	5 (20)	
	Primarily a researcher	4 (16)	
Psychopathology	Depressive disorders	24 (96)	
	Anxiety disorders	23 (92)	
	Trauma- and stressor-related disorders	8 (32)	

	Personality disorders	7 (28)
	Obsessive-compulsive and related disorders	5 (20)
Age groups	Adults	25 (100)
	Adolescents	7 (28)
	Children	6 (24)
	Elders	1 (4)

Note. Participants endorsed multiple options for some items.

Data collection

Data were collected between September and December of 2015. Criteria of inclusion were professional occupation as psychotherapist or counsellor and previous experience with the PQ in clinical context. An e-mail message inviting participation was sent to the Society for Psychotherapy Research (SPR) list-serve, as well as to centres, teams and individuals known by the authors as users of the PQ in clinical practice. The third author as also shared the link to the survey through social networks, such as his blog and Facebook page. Additional e-mail messages were sent later in order to remind contacts to participate. Given the open diffusion format of the on-line survey and because we don't have an estimate of the number of therapists using PQ, it was not possible to estimate the response rate.

Data analysis

Mean values were calculated for items in 5-point scales of all sub-domains as well as global mean scores for these sub-domains. To calculate global means, items in which a higher score meant lower clinical utility were reverse coded, so that the higher the mean, the better are the experiences of the participants using the PQ. Multiple choice items were analysed using percentages of endorsement. For open-ended questions, a thematic analysis was conducted and percentages of therapists that referred

each thematic area were calculated. Data is missing for item 3 of section E because response was not mandatory. Complete descriptive statistics are available in Supplemental File 2.

The exploratory nature of this survey, that ultimately aims to describe experiences and uses with PQ is used in routine clinical practice, did not aim to measure psychological constructs and consequently did not require psychometric analysis.

Survey Results

How is the PQ used?

Most therapists (72%) were using the PQ for one to five years in their practice in university clinics (56%) and private practice (32%) and reported that they usually conducted the PQ construction interview themselves, as opposed to delegating the task to a researcher or other practitioner. However, the PQ was not used with all clients: 28% of the participants used the PQ with 50% to 75% of their clients; and 52% used this measure with less than 50% of their clients. The PQ is used by most therapists in assessment phase (48%) or first therapy session (56%), during therapy (84%), and last session (72%). Some therapists also used it in follow up sessions (32%). PQ was mostly administered in pen and pencil format (92%) but some therapists (28%) reported to have used an electronic system to manage/register PQ data (IPPS, Sales & Alves, 2012, Sales et al, 2014). A significant percentage of therapists reported to use the PQ with fixed regularity during treatment course (68%). The PQ was integrated in routine practice to assess clients' global progress and the monitoring of the evolution of specific problems (both indicated by 100% of the participants), and also served as a basis for case supervision (80%) and treatment planning (72%). Some participants also reported to use the PQ to talk with clients about treatment planning (68%).

How feasible is the PQ?

Overall, therapist adherence to the PQ construction procedures was high, with a global mean of compliance of 3.05 (SD=.58). The most complied-with procedures were rating the items according to degree of distress and rank ordering them based on their importance to the client (both done “always” by 80% of the respondents), and making sure the items reflect the client’s chief concerns (followed by 76% of the participants) (Table 5). The procedures least complied with were generating a draft list of 15 difficulties, listing 8 to 12 difficulties in the form and using pieces of paper for draft items. Modifications to the procedures were reported to be infrequently conducted. For instance, 64% of the participants “never” or “seldom” skip administration procedures.

Table 5

Descriptive Statistics of Items on Protocol Adherence

Items	Never	Seldom	Sometimes	Often	Always
	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
I have the client indicate the degree of distress caused by each problem.				5 (20)	20 (80)
I make sure that the PQ reflects the client’s chief concerns.			1 (4)	5 (20)	19 (76)
I have clients rank order the items based on their importance.	1 (4)		2 (8)	2 (8)	20 (80)
I include the problem duration ratings.			3 (12)	5 (20)	17 (68)
I write the problems in the PQ form after they have been defined and clarified.	1 (4)		1 (4)	6 (24)	17 (68)
I make an attempt to search for problems from these areas: symptoms, mood, activity, relationships and self-esteem.		1 (4)	1 (4)	10 (40)	13 (52)
I make sure that the items are specific difficulties or problems, rather than goals or vague, multiple problems.		1 (4)	3 (12)	8 (32)	13 (52)
I use small pieces of paper for the draft items.	2 (8)	5 (20)	2 (8)	2 (8)	14 (56)
I help the client reach 8 to 12 final PQ items.	1 (4)	4 (16)	6 (24)	6 (24)	8 (32)

I help the client generate a draft list of 15 difficulties or problems.	1 (4)	7 (28)	4 (16)	8 (32)	5 (20)
The difficulties or problems are identified and refined only through dialog (not using pieces of papers).*	6 (24)	1 (4)	7 (28)	6 (24)	5 (20)
I make sure I have a moderately strong therapeutic alliance with the client prior to the PQ administration.*	4 (16)	5 (20)	11 (44)	5 (20)	
I skip some administration procedures because it is a lengthy process.*	9 (36)	7 (28)	4 (16)	3 (12)	2 (8)

Note. Items marked with (*) were reverse coded to calculate global mean.

In general, 56% therapists reported that the PQ “has always worked fine how it is” and made “no suggestions, since it is possible to adapt to the client’s needs”.

However, some therapists suggested modifications: simplification of procedures (24%; e.g. “Stop writing down the draft items on pieces of paper”), ask the client to think about the items beforehand (8%; e.g. “Giving the client more time to consider their issues (...) so that they come prepared with a list in mind”), certify item quality (8%; e.g. “Include a comprehensive quotation system that allows the therapist to certify the quality of PQ items”), make the PQ a self-administered instrument (4%; “Make it possible for the client to complete the PQ all by himself”).

Regarding the time requirements, 36% of the therapists rated the PQ as a time consuming procedure. However, 52% considered that the PQ allows saving time and sessions due to the usefulness of the information that it produces. Moreover, therapists considered that it is possible to learn how to use the PQ in one to three hours of training (56%) or less (36%), and the large majority (80%) stated that PQ does not raise confidentiality concerns.

Therapists perceived the PQ as having high value for clinical practice (global mean = 2.81, SD= .35). The most beneficial characteristics of the PQ for clinical practice were: the ability of assisting in the process of defining therapeutic goals, it’s dynamic and reusable nature, 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 the ability of the PQ to capture the client point of view (Table 6).

Table 6
Descriptive Statistics of Items on Value for Practice

Items	Strongly disagree <i>n</i> (%)	Disagree <i>n</i> (%)	Neither <i>n</i> (%)	Agree <i>n</i> (%)	Strongly agree <i>n</i> (%)
The PQ assists in the process of defining therapeutic goals.			1 (4)	6 (24)	18 (72)
The possibility of being modified during treatment makes the PQ a dynamic and reusable tool.			2 (8)	9 (36)	14 (56)
The PQ helps clients think more thoroughly about their difficulties and the impact these have on their lives.			1 (4)	13 (52)	11 (44)
The PQ promotes client involvement and responsibility in the treatment.			2 (8)	13 (52)	10 (40)
The PQ emphasizes the client point of view.	1 (4)		2 (8)	11 (44)	11 (44)
The PQ promotes working alliance between therapist and client.			3 (12)	16 (64)	6 (24)
The PQ makes it possible to monitor the client's progress session to session.			7 (28)	8 (32)	10 (40)
The PQ helps to build diagnostic hypotheses at the pre-treatment stage.	1 (4)	2 (8)	2 (8)	15 (60)	5 (20)
The PQ provides knowledge about history of the difficulty		2 (8)	6 (24)	13 (52)	4 (16)
The information provided is useful in clinical decision making.	2 (8)	1 (4)	2 (8)	16 (64)	4 (16)
The PQ excessively focuses on difficulties or problems.*		4 (16)	6 (24)	12 (48)	3 (12)
The PQ can provide a warning of emerging problems in treatment.		3 (12)	9 (36)	10 (40)	3 (12)
The PQ provides feedback to the therapist about their performance.	1 (4)	2 (8)	8 (32)	13 (52)	1 (4)
The PQ provides information about personal and family resources.	1 (4)	3 (12)	13 (52)	5 (20)	3 (12)
The PQ may cause anxiety in the therapist about lack of progress or deterioration in the client. *	3 (12)	6 (24)	4 (16)	12 (48)	

The information provided by the client on the PQ may not be trustworthy.*	3 (12)	7 (28)	5 (20)	10 (40)
The PQ enables a prognosis at the pre-treatment stage.	3 (12)	7 (28)	13 (52)	2 (8)
The PQ tends to lead to the diffusion of therapeutic goals because there are too many items. *	4 (16)	15 (60)	5 (20)	1 (4)
The PQ results in information overload for the therapist.*	10 (40)	14 (56)	1 (4)	

Note. Items marked with (*) were reverse coded to calculate global mean.

In addition, the large majority of the participants disagreed (56%) or strongly disagreed (24%) that the PQ creates confidentiality dilemmas. Half of the participants (48%) liked using the PQ “very much” and 52% like “moderately”.

How acceptable for clients is the PQ?

Therapists reported a moderate effect change in some clients’ emotional state following a PQ administration (global mean emotional impact= 2.56, SD=.65). The issue perceived as the most prone to cause distress in clients (“agreed” by 24% of the therapists) was the unclear relationship between the person conducting the PQ construction interview and their therapist (i.e. when it is not the therapist to administer PQ). Nevertheless, a considerable percentage of respondents (32%) “disagreed” with this item. Participants considered that the PQ does not multiply or emphasize problems (32% “strongly disagreed” and 40% “disagreed”) or that it elicits unrealistic expectations about solving all listed difficulties (24% “strongly disagreed” and 32% “disagreed”).

Also, according to the therapists’ experience, the clients’ general receptiveness (willingness or openness) to the PQ is moderate (global mean = 2.54, SD = .61). Acceptability was seen as lower for the PQ construction interview at first application, but still moderate (68% of the therapists estimated that the clients felt “moderately receptive” to it). In subsequent administrations during therapy, the majority of therapists (64%) perceived clients more receptive towards the PQ.

How generalizable is the PQ?

PQ was seen as highly generalizable to different age groups (global mean = 3.26, SD = .78). Most therapists (96%) indicated that PQ is “quite appropriate” to adults and 76% considered “moderately” or “quite appropriate” to adolescents and elders. Oppositely, only 24% found the PQ appropriate to children.

Almost all therapists (92%) considered that the PQ could be used routinely with more than 50% of clients. However, some client variables may hinder clients from adequately engaging in PQ administration, such as: emotional distress and difficulty explaining thoughts and emotions (both 84%), cognitive limitation (56%), avoidance of distressing emotions or thoughts (52%), tendency to talk too much or in an overly abstract or rationalized way (52%), physical pain (36%), low education (32%), psychopathological features (24%), physical disability/limitation (12%), and finally, perception of the PQ as too difficult (8%).

Some therapists reported that they adapt the protocol to the client characteristics, specifically, they postpone the PQ administration if the client is emotionally dysregulated (72%), write down the rank ordering of the items for the client if illiterate or visually impaired (60%), help regulate dysregulated emotion before completing the PQ (48%), and use post-its for writing the draft items with clients with limited mobility (36%).

PQ was viewed as a trans-model measure, highly generalizable to different clinical approaches (global mean = 3.90, SD = .54). The PQ was considered “quite appropriate” within the Person-centred/ Experiential/ Humanistic approach (indicated by 84% of the therapists) and Cognitive-Behavioural (76%). On the opposite side, 20%

of the therapists found the PQ “quite inappropriate” or “moderately inappropriate” for Psychodynamic/ Psychoanalytic therapists (Table 7).

Globally therapists indicated PQ as a highly generalizable measure across settings (global mean = 3.49, SD = 1.03). However, according to 64% of the therapists, PQ is easier to use in university clinics (64%) and in private practice settings (56%), while psychiatric outpatient (20%) and the psychiatric inpatient (12%) are the settings where using the PQ is perceived as the most difficult (Table 7).

Table 7

Descriptive Statistics of Items on Generalizability to Clinical Approaches and Contexts

		Quite inappropriate	Moderately inappropriate	Neither	Moderately appropriate	Quite appropriate	I don't know
		<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)	<i>n</i> (%)
Clinical Approaches	Person-centred-experiential/ Humanistic				2 (8)	21 (84)	2 (8)
	Structured/ Brief				3 (12)	16 (64)	6 (24)
	Cognitive			1 (4)	2 (8)	18 (72)	4 (16)
	Behavioural				4 (16)	18 (72)	3 (12)
	Systemic				6 (24)	14 (56)	5 (20)
	Cognitive-Behavioural		2 (8)		3 (12)	19 (76)	1 (4)
	Integrative			2 (8)	3 (12)	13 (52)	7 (28)
	Art		1 (4)	2 (8)	4 (16)	5 (20)	13 (52)
	Psychodynamic/ Psychoanalytic	2 (8)	3 (12)	1 (4)	7 (28)	3 (12)	9 (36)
Clinical Contexts	University clinics			1 (4)	4 (16)	16 (64)	4 (16)
	Private practice			1 (4)	7 (28)	14 (56)	3 (12)
	Substance abuse		4 (16)	1 (4)	6 (24)	5 (20)	9 (36)
	Primary health care	1 (4)	2 (8)	4 (16)	6 (24)	3 (12)	9 (36)
	Health/ hospital psychology	1 (4)	2 (8)	3 (12)	9 (36)	2 (8)	8 (32)
	Psychiatric outpatient	5 (20)		1 (4)	5 (20)	3 (12)	11 (44)
	Psychiatric inpatient	3 (12)	3 (12)	3 (12)	5 (20)		11 (44)

Discussion

The present study aimed to deepen our knowledge of the clinical utility of the PQ, based on the experience of therapists who have been using this outcome tool in their practice.

Feasibility

In general, therapists found PQ feasible for routine use. Even though PQ construction includes structured steps, most therapists followed the protocol, suggesting its adequacy for routine clinical practice. However, two aspects were criticised: first, the use of pieces of paper for refining the draft items might not be adequate especially with clients experiencing physical pain. This raises concerns with respect to PQ feasibility in health psychology settings, also mentioned in the focus group. Second, the process of generating and refining the items may be compromised when clients are highly distressed or with difficulties to explain thoughts or emotions ("People sometimes come with immediate problems, with great emotional distress or even physical pain... and it would be disrespectful to the patient (...) to do it with the draft cards", Supplemental File 1). Difficulties in the item generation process of individualized measures have previously been referred to in the literature. For example, in a study in a therapeutic community, clients indicated they are not always able to identify their problems, due to lack of self-awareness or because talking about it was stressful (Alves, Sales, & Ashworth, 2013). This is a critical process of the PQ and other individualized measures in which item content depends on the client disclosure.

In face of these and other difficulties, therapists suggested modifications to the PQ administration protocol. Some of these suggestions could be easily implemented, because they do not interfere with the final result, for instance, asking the client to come prepared with a list of difficulties in mind. However, other suggestions would imply a different version of the PQ, for which new psychometric studies would be needed. This includes skipping or leaving it as optional writing down the draft items on small pieces of paper, reducing the number of draft items and final items, and transforming the PQ construction process into a self-report format. Suggestions about developing an item quality system rated by the therapist during the PQ construction interview were offered as well. Considering that client distress, openness, physical pain and other issues may interfere in the process of generating the items, it would be pertinent to develop a system to inform on item reliability, as rated by the person administering PQ.

A large proportion of therapists perceived PQ construction as a time consuming task. Time burden has been pointed to as a determinant of therapist resistance towards outcome measures (e.g., Gilbody, House, & Sheldon, 2002; Hatfield & Ogles, 2004). However, in line with Sales and colleagues (2007), our results showed that therapists are open to use PQ in their practice, even if it requires more time to administer than a standardised outcome measure. This might be explained by the PQ's value for practice: it helps establishing diagnostic hypotheses and therapeutic goals; it contributes to client involvement and responsibility in the treatment; it promotes the working alliance between therapist and client; and it is useful for clinical decision-making. The PQ was also reported to be used in team case supervision, treatment planning, and discussing the session with the client. These results contrast from the general tendency of therapists to perceive outcome measures as having low value for practice and favouring the use of clinical judgment alone instead (Jensen, Doss & Hawley, 2010). Ultimately, most

therapists in this study had the perception that using the PQ saved time and reduced the number of treatment sessions. However, implementation of the PQ in routine clinical practice does not seem to be widespread as expected, since over the therapists in this study used it with less than 50% of their clients. Despite therapists' willingness to use the PQ, settings with more time constraints and less flexible procedures, such as public mental health services, were less prone to its incorporation in clinical routine.

As downside, our study showed that information derived from the PQ may cause anxiety in the therapist in case of lack of progress or deterioration in the client. This phenomenon has also been reported by clients, as a possible negative effect of repetitively being confronted with poor outcome progress (Guerra, Sales, & Pereira, in press; Rizq, 2012). As it has also been observed with other measures, this is possibly related more generally to the process of monitoring progress on a session-by-session basis, and is probably not due to the PQ specifically.

Acceptability

Therapists referred to some concerns regarding the acceptability of PQ by their clients. Specifically, when the PQ is not administered by the therapist, it may be confusing for the client. The focus group findings indicated a possible explanation: clients might be inclined to perceive the PQ as part of the treatment and not as a separate procedure ("For patients, the PQ becomes part of the intervention"); when other professional administers the PQ his/her role in treatment might not be clear to the client. This resonates with testimonies of clients in residential mental health treatment (Guerra, Sales & Pereira, in press), who manifested doubts about the purpose of outcome measures (including PQ) that were not administered by their therapist. It points

to the need for an open discussion with clients about the role of outcome assessment in their treatment process.

Client receptiveness was seen as lower in the first administration than in subsequent applications. We hypothesized that the first administration (the PQ construction interview) might be unexpected for clients, as the focus group participants pointed out (“Patients are not expecting to complete a PQ... it can be overwhelming for some patients, it makes them think about painful aspects of their lives”). The construction interview involves a thorough consideration of the client’s key difficulties, which is likely to cause emotional distress, possibly resulting in reluctance toward the measure. As a potential solution, some survey participants suggested that clients should have the opportunity to reflect on the difficulties they want to work on in therapy beforehand. However, participants reported that client receptiveness tended to increase in later applications, suggesting that the completion of the PQ tends to become a beneficial experience for clients as therapy progresses.

Generalizability

The PQ was perceived as highly generalizable to different age groups, and especially appropriate for adults. However, sitting in a chair facing another person and making a list of psychological difficulties might feel foreign and troubling to children and young people (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. For instance, other individualized measures like the PSYCHLOPS

(Ashworth et al., 2004) have already been adapted to children and teenagers (www.psychlops.org.uk/).

Other client characteristics were found as potentially hindering of administering the PQ, such as emotional distress 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? If yes, implementing the participants' suggestion of a therapist rated item quality system would be a potential solution. Nevertheless, according to the focus group participants, therapists adapt PQ creatively to clients' characteristics, which allows its administration to a wide range of clients ("With patients with reduced mobility, I write the items on post-it so they don't slide around"). A flexible, creative use of measures according to the client and the flow of the session was also reported by Unsworth, Cowie and Green (2012) with regard to other outcome measures.

PQ was found to be highly generalizable to different clinical approaches, although to a less extent for psychodynamic/ psychoanalytic psychotherapy. This resonates with the results from Hatfield and Ogles (2007), which concluded that insight oriented therapists are inclined to have negative attitudes towards outcome measures, and to see them as not useful. The psychodynamic approach holds that human behaviour is influenced by drives, conflicts and impulses that are primarily unconscious (Plante, 2005). Clients would not be aware of the psychological problems that are targeted in psychodynamic therapy, thus, it would not be possible to assess outcome or therapeutic success based on the difficulties that the client can identify in the beginning of the therapeutic process.

Finally, the PQ was considered highly generalizable across diverse clinical settings but more appropriate to settings with less time constraints, such as university clinics and private practices. Also, administering PQ was considered challenging in psychiatric inpatient and outpatient units. These results are similar to the findings of Smits, Claes, Stinkens and Smits (2014), who reported that private practitioners showed more positive attitudes towards monitoring, whereas clinicians in subsidized institutions reported the most negative attitudes. A possible explanation is that the latter are under external pressures for assessing outcome, whereas in private practices therapists have more freedom to choose if, how and when to assess outcome (Smits, Claes, Stinkens, & Smits, 2014). Therefore, the perceived appropriateness of PQ to different settings is also associated with practical and motivational issues, and not exclusively with features of the instrument itself. However, respondents may not have had full knowledge of the appropriateness of the PQ in psychiatric settings, since only 20% had worked there (see Table 1 in Supplemental File 2), although the rating scale included an “I don’t know” option. Therapists’ views on the PQ’s appropriateness to these settings might have developed from hearing from colleagues rather than direct experience; therefore, these results should be interpreted carefully.

Considering the current trend for outcome assessment, guaranteeing that PQ is generalizable to a range of clinical contexts is important before advocating for its wider use. In sum, the PQ was perceived by the therapists in this study as a generalizable tool, suggesting it is likely to be adequate for routine assessment in a diversity of services, to a wide range of clients and by psychotherapists from distinct therapeutic approaches. The PQ can also be integrated into a battery of tools for routine outcome assessment with the majority of clients in a particular service, but adaptation of this measure to younger clients is advised.

Limitations and suggestions for future research

This study had several limitations. Though acceptability concerns client impressions and experiences, this study assessed acceptability through the therapists perspectives on client reactions to PQ. In future studies, it would be pertinent to ask directly to clients using focus groups or surveys.

Our sample was small and largely formed by cognitive-behavioural and person-centred/ experiential/ humanistic oriented therapists working in university clinics and private practices, most of them from Portugal. Because the use of outcome measures is not imposed by Portuguese mental health care services at the moment, these results reflect the perspectives of therapists who voluntarily use the PQ. Therefore, our participants are likely to have a more positive view of the PQ than the general clinical community.

Though the Society for Psychotherapy Research list-serve is most likely an international one, the fact that the participants were mainly from Portugal shows that the e-mail messages directly sent to the authors' mailing list probably had more contacts from Portugal, country of residence of two of the authors, thus reaching more Portuguese therapists. Other possible explanation for the higher response rate of Portuguese therapists might be the recent participation in other studies on PQ (Elliott et al., 2014; Sales et al., 2007). These previous studies might have promoted the use of PQ by Portuguese therapists. Furthermore, this was a sequential exploratory mixed methods study, conducted for a Master Dissertation of a Portuguese University and had a limited time range of completion, increasing the probability of higher response of Portuguese therapists.

To our knowledge, it is not possible to estimate how many therapists are currently using PQ. Materials and procedure for administration and interpretation are provided on-line with no cost associated and there is no database of current users, leading to the absence of a response rate. Consequently, generalization of results should be done with caution.

Conclusions

When selecting outcome measures for routine assessment, a focus beyond psychometrics and toward the clinical utility of measures is desirable. A measure that is feasible, acceptable and generalizable is more prone to be used routinely. To our knowledge, this was the first systematic, comprehensive assessment of the clinical utility of an outcome measure. Our approach and survey provided an operational definition of clinical utility that could be applied to other outcome measures.

Therapists using PQ find it a feasible outcome measure for routine use, with clinically useful inputs, and generally appropriated across all clinical population and suitability to a wide diversity of therapeutic models. Therapists are open to incorporate PQ in their practice but practical constraints of service structure limit clinician autonomy in choosing this measure. Nevertheless, based on our results, wider use of the PQ appears to be justified.

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
- American Psychological Association (2002). Criteria for Evaluating Treatment Guidelines. *American Psychologist*, 57(12), 1052–1059. doi:10.1037//0003066X.57.12.1052
- Ashworth, M., Shepherd, M., Christey, J., Matthews, V., Wright, K., Parmentier, H., Robinson, S., & Godfrey, E. (2004). A client-generated psychometric instrument: the development of “PSYCHLOPS”. *Counselling and Psychotherapy Research*, 4, 27-31.
- Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. *Clinical Psychology and Psychotherapy*, 10, 319-327.
- 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
- 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*, 25(1), 1-14. doi:10.1080/10503307.2013.817696
- Bower, P. & Gilbody, S. (2010). The Current View of Evidence-Based Practice. In Barkham, M., Hardy, G. E., & Mellor-Clark, J. (Eds.), *Developing and*

Delivering Practice-Based Evidence: A Guide for the Psychological Therapies

(pp. 3-20). West Sussex: John Wiley & Sons Ltd.

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

Claridge, T., Parker, D., & Cook, G. (2005). Investigating the attitudes of health-care professionals towards the use of integrated care pathways in a district general hospital: A thematic analysis of focus group discussion. *Journal of Integrated Care Pathways*, 9(2), 57-66. doi: 10.1177/147322970500900203

Cooper, M. (2011). Meeting the demand for evidence-based practice. *Therapy Today*, 22(4), 10-16.

Creswell, J. W. & Plano Clark, V. L. (2007). *Designing and Conducting Mixed Methods Research* (2nd Ed.). California: Sage.

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

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.

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.

- 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 Behavioural Health Services & Research*, 30(4), 393-405.
- Guerra, D., Sales, C.M.D., & Pereira, J. (in press). Practice-based research at Casa de Alba: the perspective of residents on the assessment of outcomes. In J. Pereira, I. Hipólito, & J. Gonçalves (Eds.), *The Neurobiology, Psychotherapy, Pharmacology Intervention Triangle: the need for integration in 21st Century mental health*. London: Vernon Press.
- Hanson, W. E., Creswell, J. W., Plano Clark, V. L., Petska, K. S., & Creswell, J. D. (2005). Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology*, 52(2), 224-235. doi 10.1037/0022-0167.52.2.224
- 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
- Héðinsson, 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

- 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
- Jensen-Doss, A., Smith, A. M., Becker-Haimes, E. M., Ringle, V. M., Nanda, M., Walsh, S. L., Maxwell, C. A., & Lyon, A. R. (2017). Individualized progress measures are more acceptable to clinicians than standardized measures: Results of a National Survey. *Administration Policy in Mental Health and Mental Health Services Research*, 40(5), 1-12. doi: 10.1007/s10488-017-0833-y
- 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.
- 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>
- Norman, S., Dean, S., Hansford, L., & Ford, T. (2013). Clinical practitioner's attitudes towards the use of routine outcome monitoring within child and adolescent mental health services: A qualitative study of two child and adolescent mental health services. *Clinical child psychology and psychiatry*, 1359104513492348.
- Plante, T. G. (2005). *Contemporary Clinical Psychology* (2nd Ed.). New Jersey: John Wiley & Sons, Inc.
- Rizq, R. (2012). The perversion of care: Psychological therapies in a time of IAPT. *Psychodynamic Practice*, 18(1), 7-24.
- Rizq, R. (2013). The language of healthcare. *Therapy Today*, 24(2), 20-24

- Sales, C.M.D. (2017, E-pub Abstract Ahead of Print). Seeing the person in the patient: Making the case for individualized PROMs in mental health care. *Current Psychiatry Reviews*, 13. doi: [10.2174/1573400513666170505111736](https://doi.org/10.2174/1573400513666170505111736)
- 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.
- 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., 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
- 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 (eds.), *Improving Mental Health Care: The Global Challenge* (1st ed., pp. 246-263). John Wiley & Sons, Ltd
- 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., 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

Unsworth, G., Cowie, H., & Green, A. (2012). Therapists' and clients' perceptions of routine outcome measurement in the NHS: A qualitative study. *Counselling and Psychotherapy Research, 12*(1), 71-80.

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.