**Psychiatr. Pol. ONLINE FIRST Nr 316: 1–15**
Published ahead of print 11 June 2023
www.psychiatriapolska.pl
ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
DOI: https://doi.org/10.12740/PP/OnlineFirst/162574

# Questionnaire for the Perception of Psychotherapy Process by the Psychotherapist (QPPP) – a preliminary presentation of a research tool

Marta Szwajca, Klaudiusz Kudła, Krzysztof Szwajca, Natalia Śmierciak, Maciej W. Pilecki

Clinic of Child and Adolescent Psychiatry and Psychotherapy, Chair of Psychiatry, Faculty of Medicine, Jagiellonian University Medical College

**Summary**

**Aim.** The emotional reactions of the therapist in the treatment process constitute the core of therapeutic work, but they are poorly represented in research area. The article presents the results of work on the creation of a new tool – *Questionnaire for the Perception of Psychotherapy Process by the Psychotherapist* (QPPP).

**Method.** The Questionnaire containing 267 statements assessing cognitive, affective and behavioral reactions of psychotherapists in interaction with a specific patient was uploaded on the website. The link to the website, together with a request to complete the questionnaire, was sent to the members of the Psychotherapeutic Societies. The study involved 159 therapists, working mainly psychodynamically (91.95%). The analysis of basic descriptive statistics of test items and exploratory factor analysis by principal components method with varimax rotation were used.

**Results.** The work resulted in creating a tool consisting of 75 items grouped into 6 scales: "Positive cooperation with the patient", "Therapist burdened with commitment", "Therapist in the centre of negative interest", "Therapist with no room for intervention", "The overwhelmed/ overloaded therapist", "The helpless/disengaged therapist". High Cronbach's alpha reliability of all distinguished factors was demonstrated at the level from 0.79 to 0.94. The data analysis also made it possible to create initial sten standards for therapists working in the psychodynamic approach.

**Conclusions.** A tool was developed to assess emotions of the therapist in relation to the client. The QPPP contains generally understandable terminology, independent of the therapist's dominant modality. The questionnaire can have many practical, both scientific and clinical, applications.

**Key words:** psychodynamic therapy, supervision, psychotherapy

## Introduction

Psychotherapy is an effective method of treating mental health disorders, and the changes that occur as a result are usually positive [1, 2]. However, the type of research which has dominated over the years and which searched for the sources of therapy effectiveness in the specific techniques used failed to provide a coherent picture with practical implications [3]. It is a common opinion that research results do not reflect the reality of therapeutic practice [4]. In a survey of over a thousand North American psychotherapists, out of more than forty suggested research topics, they indicated the following as the most important ones for their clinical practice (regardless of age or dominant therapeutic orientation): research on the therapeutic relationship, mechanisms of change in psychotherapy, and factors related to the therapist's role in the treatment process [5]. These expectations are most definitely justified. It was unequivocally confirmed that the quality of the therapeutic relationship is closely related to the results of therapy [6], both in relational-oriented and non-relational-oriented therapies [7, 8]. It should be emphasized that the therapist's ability to establish an emotional relationship with the client and adequately react to their emotions is the basis of the psychotherapy process [9]. The relational dimension of psychotherapy is the emotions and attitudes that the client and the therapist have towards each other, and the psychological bond that connects them, based on these feelings and attitudes. However, the therapeutic relationship is a complex construct and a phenomenon that is difficult to grasp, conceptualized in various ways, which makes it difficult to compare the results and fosters methodological inconsistencies [10]. The most common subject of empirical research is the working alliance (also known as the therapeutic covenant), understood as the client's and the therapist's agreement as to the goals of therapy, cooperation and experiencing a mutual emotional bond [11].

But still the emotional aspects of the relationship are analyzed by a relatively small number of qualitative studies, extremely rare experimental studies (with an independent observer who observes the therapy process, for example, through a one-way mirror) and surprisingly few quantitative studies, with a clear predominance of research on the evaluation of the emotional aspects of the therapeutic relationship by clients [12]. Therapists are rarely examined. For example, a recent meta-analytical review on the relationship between emotional expression and psychotherapy outcomes found 42 studies evaluating clients' emotional expression, but only 13 studies analyzing it in therapists [13]. Despite the fact that the first empirical works analyzing the emotional reactions of therapists to patients come from the mid-1950s [12], knowledge on this subject is growing slowly. The meta-analytical review which confirmed the importance of recognizing countertransference and working with it [14] contains only 27 studies, and the most recent meta-analysis – assessing the relationship between psychotherapists' characteristics (their skills, interpersonal functioning, etc.) and the effectiveness of psychotherapy – analyzed only thirty studies covering 1,338 therapists [15]. It shows that the relational skills of psychotherapists and their interpersonal functioning have a stronger impact on the results of therapy than the attitudes or values they profess.

Psychodynamic therapies are the most focused on the analysis of the relational dimension of psychotherapy. They think of the client and the therapist in terms of unconscious conflicts, internal structures or deficits [16], assess transference and countertransference (collectively referred to as transference configuration), that is unconscious projection by the patient on the therapist of feelings previously experienced towards significant people and transferring the therapist's own experiences to the patient in response to the transfer of the client. Understanding one's own feeling of countertransference allows the therapist to formulate interpretations of the patient's unresolved conflicts and as such becomes an important source of knowledge about him or her [17]. The analysis of the course of therapy is based on the assessment of transference and countertransference feelings. The therapist's feelings are therefore crucial for the course of psychotherapy. However, it is believed that it is difficult to study phenomena that are by definition "unconscious" [18]. Therefore, there are few psychodynamically oriented empirical studies on the emotional components of the therapeutic process, especially those that would meet the criteria of randomized, controlled analyses [19].

Those that arise have departed from the traditional psychoanalytical model that places great emphasis on differentiating between what is real and what is "imagined" in the relationship. Using the old conceptualization of Ralph Greenson [20], the former consists of a working alliance and a real configuration (authenticity, realistic perception of the other, their objective features and attitudes),while the transference relation means that the real figure of the therapist is obscured by the fantasies of the patient addressing to the therapists their feelings, expectations and ideas about what the therapist expects from him or her, coming from the past [21].

The works that analyze the therapist's emotions in relation to the client are dominated by the contemporary, integrative definition of "comprehensive countertransference" [22] (also adopted by the authors of this work), which recognizes all emotional reactions of the therapist towards the patient as a phenomenon subject to analysis, without distinguishing their nature. Their source can be both the psychotherapist (we can talk about the therapist's habitual needs and behavior patterns) and the client (therapist's reactions to specific clients). For example, a therapist with a personal anger problem confronted with hostility of the client and confused by perceived hostility towards him or her, may repress or suppress it by communicating to the client the acceptance of his or her person and the rage-causing behavior. In this relatively new type of understanding that abstracts from traditional psychoanalytic thinking, the concept of countertransference is more and more often replaced by terms such as "psychotherapists' emotional reaction patterns", "emotional responses to the patient" or "interpersonal affective patterns" [12]. In the remainder of the text, the concepts of countertransference and emotional reaction/response to the client will be used as equivalent.

The emotional response, following the cognitive paradigm, is not limited to experiencing emotions in the strict sense (affective experiences such as feelings of excitement, pleasure or anger), but also includes:

– cognitive processes that help in interpreting the situation that triggers an emotional reaction; this so-called cognitive emotional activity is the labeling of

emotions, appraisal of the sensed experience, planning or eliciting control mechanisms to deal with the emotional situation;
- physiological responses activated by agitation;
- behaviors that are often (but not always) expressive, goal-directed and adaptive [23].

The tools used to assess the emotional aspects of the therapeutic process should evaluate all of these components. However, the most commonly used tools to study the emotional components of the therapeutic process are those that are limited to examining only the therapeutic covenant or working alliance, such as: WAI-S (Working Alliance Inventory-Short) [24]; ARM (Agnew Relationship Measure) [25]; HAQ-I (Helping Alliance Questionnaire) [26]; CIS (Collaborative Interaction Scale) [27]; CAPLAS (California Psychotherapy Alliance Scale) [28]. In turn, the FWC-58 (Feeling Word Checklist-58) [29] is limited to a list of words describing the affective experience of the therapist. It should also be noted that the above-mentioned questionnaires were developed in conditions differing from those in Poland in terms of language and culture. After all, psychotherapy, a field at the intersection of medical and human sciences, is extremely sensitive to cultural contexts. Practicing psychotherapists are part of culture and, depending on the cultural context, they modify their theories and develop new practices [30]. For this reason, the aim of the study was to build a new questionnaire, and not to translate an existing one into Polish.

In Poland, research in this area has been conducted by, among others, the Academic Psychotherapy Centre at the Faculty of Psychology at the University of Warsaw. The research was done using a medical history questionnaire created by the local team, which described the course of the completed therapeutic process from the patient's perspective [31]. A similar method was used by the team of the Family Therapy Outpatient Clinic of the Child and Adolescent Psychiatry Clinic of the Jagiellonian University Medical College, sending in 2002 questionnaires to families treated by the team in the years 1992–1996 [32]. On the other hand, the team led by Prot-Klinger [33] adapted a 12-item questionnaire to measure the therapeutic relationship (Scale to Assess the Therapeutic Relationship – STAR), which was used to examine the patients and therapists of the community psychiatry centre. To the best of the authors' knowledge, this was the only Polish study that took into account the emotional perspective of therapists.

The purpose of this report is to present the results of work on a tool that examines the emotional reactions of the therapist during psychotherapy. This tool makes it possible to describe the therapist's experiences in relation to working with a particular client, covering the emotional (e.g., anger or disappointment with the therapy experienced by the therapist), cognitive (e.g., the possibility of naming phenomena appearing in therapy) and behavioral sphere (e.g., tendencies for the therapist to shorten or lengthen sessions).

The presented questionnaire is a tool created with the significant participation of Polish psychotherapists, embedded in the Polish context, analyzing the emotional responses of the therapist to individual patients. It can be important both for quantita-

tive research, as well as for monitoring the course of therapy for therapeutic purposes (improved quality of therapy) or supervision.

## Material and method

### Constructing the original version of the questionnaire

The research team that created the original set of questions for the *Questionnaire for the Perception of Psychotherapy Process by the Psychotherapist* **(**QPPP) consisted of people with diverse practical (people with a specialization in psychiatry, with a specialization in clinical psychology, with certificates of psychotherapy or certificates of a psychotherapy supervisor) and theoretical experience (people with a master's degree in psychology, doctors of medical sciences or a habilitated doctors of medical sciences). The questions were developed as part of group meetings, during which individual items of the questionnaire were created and discussed.

Research team formulated 300 items assessing the cognitive, affective and behavioral reactions of psychotherapists when interacting with particular patients, for example, "I'm extending the session with the patient" or "During the session with the patient, I feel the need to change my body position more often" (behavioral responses); "I feel ignored while working with this patient" or "I feel angry with this patient" (emotional reactions); "The patient idealizes me" or "The patient tends to make detailed descriptions – little contributing to the content of the meetings" (cognitive reactions). The items referred to the emotions experienced by the therapist during the session. They were supplemented with items about the setting changes introduced by the therapist or physiological states appearing in the therapist during the psychotherapeutic session. Some of the issues were also related to the perception of the patient's characteristics (e.g., "The patient demonstrates self-observation and self-reflection"), the therapeutic alliance (e.g., "The patient's declared willingness to work during therapy is only apparent") or the dynamics of the course of therapy (e.g., "I find it difficult to finish a session with this patient").

The questionnaire items are written using clear and simple language, without reference to the theoretical concepts of a given therapeutic school, so that the instrument could be used by psychotherapists in any modality.

### Pilotage

Ten people participated in the pilot study, most of them were psychotherapy supervisors, people with long therapeutic work experience (at least 20 years), most of them had the titles of doctors or professors, with psychiatric or psychological education. People participating in the pilot were asked to comment on the structure of the tool, in particular to assess the accuracy of the items. The comments of people participating in the pilot study mainly concerned minor changes in the form of questions, consideration of adding additional questions or removing similar items. As a result of the analysis of the responses of the competent judges, a questionnaire containing 267 statements

was created with a 7-point response scale (1 – "Strongly disagree"; 2 – "Disagree"; 3 – "Somewhat disagree"; 4 – "Neither agree or disagree"; 5 – "Somewhat agree"; 6 – "Agree"; 7 –"Strongly agree"). The items were preceded by a short survey concerning the psychotherapist's personal details, such as gender, age, education, and professional experience. The data collected in the survey will be subject to further analysis in subsequent publications. The investigators asked the therapists to complete a questionnaire based on a relationship with the patient they had recently worked with, and the assessment was based on the last 3 meetings.

## Research of therapists

The questionnaire and short survey were uploaded on a website that allows for on-line answers. The link to the website, together with a request to complete the questionnaire, was sent to the members of Psychotherapy Section of the Polish Psychiatric Association, the Polish Psychologists' Association, the Polish Society of Psychodynamic Psychotherapy, and the Scientific Society of Psychodynamic Psychotherapy. The data were being collected for 3 months. In the end, the study covered 159 therapists, differing in terms of age, gender, and professional experience. The average age of the respondents was 42 years (*SD* 10.69; min. 26, max. 79), and the average declared number of years of experience in psychotherapy was 11.88 years (*SD* 9.57; min. 1 year; max. 47 years). Most respondents had a degree in psychology (76%) (Table 1). Women accounted for 81% of all respondents. 88% of people had completed a course in psychotherapy that entitled them to obtain a certificate, 33% had obtained the certificate. Most psychotherapists had learned psychotherapy as part of psychodynamic training (91.95%), some therapists indicated that they had trained in more than one therapeutic approach (Table 2). Their principal place of work was a private office (56.16%), less often a psychiatric ward (17.81%), an outpatient clinic with a contract with the National Health Fund (12.33%), a psychological clinic (8.90%) or a Specialist Psychological Clinic (4.79%).

Table 1. **Declared education of the respondents**

| | |
|---|---|
| Psychologist | 76.77% |
| Psychiatrist | 7.10% |
| Sociologist | 3.23% |
| Teacher | 14.84% |

Table 2. **Which main psychotherapy approach did you learn therapy in?**

| | |
|---|---|
| Systemic | 16.11% |
| Psychodynamic | 91.95% |
| Existential | 3.36% |
| Cognitive-behavioral | 3.36% |

*table continued on the next page*

| | |
|---|---|
| Gestalt | 4.03% |
| Psychoanalytic | 10.74% |

## Results

### Initial data reduction

The analyses were performed using the IBM SPSS Statistics 26.0 software with macro SPSS R-menu R-Factor v 2.4.2. [34].

The first step involved analysis of the basic descriptive statistics of the test items. Items whose variance was <1 were excluded from the analyses. On that basis, 45 test items were excluded. Additionally, 31 questions with high skewness and kurtosis, indicating a significant asymmetry of the distribution of answers, were excluded. In total, 76 items were excluded during the first phase of data reduction.

### Factor analysis

The next step involved an exploratory factor analysis using the principal component method with varimax rotation. The initial analysis identified 44 factors with an eigenvalue above 1 (Kaiser criterion), however, based on the Cattell criterion, it was possible to distinguish from 3 to 8 factors. Therefore, it was necessary to conduct further analyses in order to select the most optimal number of factors.

Due to the lack of clear information on the number of factors that should be included in the structure of the questionnaire, in order to determine their optimal number, several alternative methods were used, which led to a decision to adopt the 6-factor solution. The following modes were selected: Velicer's Minimum Average Partial Test (VAMP), Comparison Data (CD), Parallel Analysis, OC, and AF [34]. Based on CD, 6 factors were extracted. The six-factor solution had the lowest RMSR value (0.320).

In the next step, an exploratory factor analysis was performed for 6 factors. The 6-factor solution was validated with OC and Parallel Analysis. For VMAP, 12 or 13 factors were distinguished, for AF – 1 factor. Therefore, the optimal choice was to choose the 6-factor solution. Items with factor loadings below 0.5 were excluded from the analysis. The analysis of the entire data allowed to distinguish six factors, which together consist of 75 items.

Table 3 presents information on the reliability of the extracted factors. The analysis showed high reliability of all individual factors (reliability ranging from 0.79 to 0.94).

Table3. **Reliability test using Cronbach's alpha**

| | F1 | F2 | F3 | F4 | F5 | F6 |
|---|---|---|---|---|---|---|
| Reliability | 0.884 | 0.837 | 0.912 | 0.791 | 0.898 | 0.943 |
| % of variance | 21.29 | 5.42 | 4.54 | 3.39 | 3.03 | 2.91 |

Preliminary descriptions of individual scales, based on the identified factors, are included below. It should be noted that the proposed characteristics of the scales were developed by members of the research team during joint discussions.

### Scale I "Positive cooperation with the patient"

This scale consists of 16 items referring to the therapist's positive attitude towards working with the client, the hope for change, and emphasizing positive cooperation (e.g., "The patient is able to notice the internal causes of their issues"). The scale refers to the psychotherapist's description of the patient as someone who has a positive attitude to therapy and has the ability to self-mentalize, gain adequate insight into their internal states, has the ability to think reflectively and is capable of self-reflection.

The items included in this scale may be associated with the assessment of the patient as having a correct personality structure, capable of entering into dependency relationships, having the ability to reflect at the level of combining various aspects of his or her life and experience with memories from the past and attitude towards the therapist.

A positive assessment of the course of therapy by the therapist is complementary to such an image of the patient. High scores on this scale may indicate that the therapist sees positive changes in the client and has a positive attitude towards working with them. However, they can also mean excessive idealization of the patient and the relationship with them.

### Scale II "Therapist burdened with commitment"

This scale consists of 9 items and refers to the reactions and desires appearing in the therapeutic relationship that trigger the therapist's desire to cross the boundaries, to go beyond the therapeutic role and framework due to the strong bond with the client and the desire to maintain a relationship with them ( e.g., "I want to take special care of this patient"). The items included in this scale mostly refer to the desires to cross the framework of setting or to go beyond the attitude of neutrality typical of psychodynamic therapy.

A high score on this scale may be a manifestation of the patient's characteristics that make insight work difficult, such as emotional instability or excessive dependence. The interpretation of the scale as part of the concept of countertransference indicates a response that is complementary to the patient's idealization, including excessive willingness to provide the patient with care, to be close with them and engage in their matters.

We may also be dealing here with the activation of reparative desires towards the patient as a result of one's own unresolved difficulties from the developmental period.

### Scale III "Therapist in the centre of negative interest"

This scale consists of 15 items (e.g., "I have been experiencing mounting accusations from the patient") and describes mainly negative emotions that arise in the relation-

ship between the therapist and the client. The scale describes the countertransference feelings appearing in the therapist, which are a response to the therapeutic situation with the dominant or particularly burdensome context of the therapist's feeling that the patient is very focused on them. The scale is dominated by aspects relating to the patient's negative transference and response to them. The prevailing feelings the therapist experiences from the client are anger, irritation, hostility. The therapist has the impression that the patient perceives them as uninvolved and uninterested in their difficulties.

A high score on the scale may reflect both the patient's characteristics and the negative transference to the therapist. It may also be the result of the therapist's failure to work through the patient's anger response.

### Scale IV "Therapist with no room for intervention"

This scale contains 6 items (e.g., "The patient talks constantly and won't let me speak") and describes the therapist's emphasis on the client's behavior, which hinders the therapy process by preventing the therapist from being active, creating and communicating interventions, and limiting their role to a container. The scale reflects the therapist's feeling that the client's behavior and activity leave no room for the therapist to intervene. This scale may refer to both the therapist's countertransference experiences and be a response to the patient's resistance manifested by excessive activity or their characteristics resulting in a lack of interest in the opinions and perspectives of other people on the patient.

With a high score on this scale, it is also worth considering how important the therapist's attitude (withdrawal and low involvement) may be, provoking hyperactive behavior of the patient.

### Scale V "The overwhelmed/overloaded therapist"

This scale consists of 10 items that relate mainly to the challenges of working with the client, which motivate the therapist to analyze the course of therapy (e.g., "More often than when working with other patients, I am now faced with dilemmas that I want to supervise").

A high score on the scale may be associated with very burdensome and engaging psychopathology of the client. It can also refer to countertransference phenomena resulting in the therapist's excessive involvement in the patient's affairs. If it becomes a pattern in the descriptions of many patients treated by the therapist, this may be a sign of occupational burnout.

### Scale VI "The helpless/disengaged therapist"

This scale consists of 19 items describing the therapist's negative thoughts and beliefs regarding the psychotherapy process and the relationship with the client (e.g., "The thought of another meeting with the patient makes me reluctant"). They are

manifested primarily by avoiding thinking about the client, somatic reactions, and lack of faith in the progress in therapy.

A high score on the scale describes countertransference phenomena of a particularly negative nature. They are associated with feelings of incompetence, lack of influence or desire not to take care of the patient. In therapeutic processes in the psychodynamic model, this type of countertransference is associated with identification with powerless negative aspects of the parental object. Similarly to Scale V, if the high score shows up in the descriptions of multiple patients treated by the therapist, it may be a sign of their professional burnout.

High scores on both Scale V and Scale VI indicate that the therapist is going through some extremely unsettling experiences, which are conducive to occupational burnout and therefore require support and supervision.

Moreover, it should be noted that the data analysis made it possible to create initial sten standards relating to individual scales.

## Discussion

The presented questionnaire is one of the few tools analyzing the therapist's emotional contribution to the relationship with the client and, according to the authors' knowledge, the only tool of this type developed in Poland. Its roots are associated with psychodynamic sensitivity and (partially) psychodynamic conceptualization of the psychotherapy process. However, it describes universal phenomena using simple, generally understandable terminology independent of the therapist's dominant modality (a broader description of the universalist understanding of the concept of countertransference can be found in the introduction).

The QPPP focuses on the emotional responses of the therapist, going beyond the simplified description of countertransference treated as an artifact that hinders the therapist in their correct identification with the patient and their effective treatment. It is not limited to distinguishing the so-called positive and negative types of countertransference behavior – based on factor analysis, it also offers a complex picture of relational processes. This makes it easier for the therapist to identify a complex palette of feelings and assign them to specific domains. The psychometric properties of the tool are satisfactory and indicate its internal consistency.

The conducted analyses allowed for developing a tool consisting of 75 statements and 6 scales ("Positive cooperation with the patient," "Therapist burdened with commitment," "Therapist in the centre of negative interest," "Therapist with no room for intervention," "The overwhelmed/overloaded therapist," "The helpless/disengaged therapist"), which describes various dimensions of the therapist-client relationship during the therapeutic process.

It should be noted that in clinical applications, the interpretation of the results in particular scales should be related to the dynamics of the therapeutic process. The result can be read directly as a rational analysis of oneself, the patient and the relationship, but it can be a derivative of entanglement in own countertransference feelings. Therefore, the questionnaire provides knowledge that requires individual interpretation.

There are a lot of practical applications – both scientific and clinical – of the questionnaire. When it comes to empirical applications, it can also be useful to combine the experiences of many therapists to identify common patterns of emotional response (countertransference) in relationships with particular groups of patients. So far, it has been initially demonstrated (with a small empirical basis) that there are relationships between clients' motivation to therapy and the nature of countertransference, relationships between the emotional reactions of therapists and the personality symptoms presented by patients, and it has been shown that stronger negative feelings occur when therapists work with lower functioning patients [35]. In addition, these countertransference reactions cannot be explained by the theoretical orientation of the therapist (they are universal, regardless of the modality) [36]. A coherent emotional reaction to specific personality disorders confirms empirically diagnostic utility of the analysis of emotional response in therapy. Similarly, the only Polish research assessing the perspective of therapists in the description of the therapeutic relationship [33] showed that they perceived it as more problematic in working with patients with more severe symptoms and poorer functioning in life – the therapy of patients with psychotic diagnoses treated in the community was investigated. This direction of research is therefore extremely promising.

The questionnaire's focus on issues that are important for therapists and for clinical practice makes their participation in empirical research on psychotherapy more likely [5]. Meta-analyses of works on the importance of countertransference for the effectiveness of psychotherapy [14, 37] indicate a significant and strong relationship between work on the therapist's emotional response (developing countertransference in a relationship) and the effectiveness of psychotherapy. Therefore, the questionnaire can also be used to improve clinical practice, for the purposes of individual work or supervision of the therapeutic process (the questionnaire supports the analysis of countertransference feelings instead of acting them out in action). All the more so because identifying the emotional aspects of a relationship is difficult, especially in the process of teaching psychotherapy.

There is extensive evidence that the degree of working alliance in the early stages of therapy (within the fifth session) are particularly strong predictors of positive therapeutic outcomes. The largest number of studies is devoted to this stage [38]. The development of countertransference in the course of therapy, the impact of the therapist's emotional reactions on the course of therapy, etc. are much less explored in terms of research. Thus, the content which makes up the core of the supervision processes is still barely present in the area of empirical research. In addition, it has been empirically confirmed that changes in the therapist's countertransference usually precedes the improvement in the client's functioning [40].

It seems that the discussed questionnaire can be used at various stages of the therapeutic process, because it is not limited to examining only the therapeutic covenant or working alliance that is of particular importance at the beginning of the session [38], but covers broader phenomena, such as the therapist's emotional reactions.

The structure of the group that took part in the research on the questionnaire largely corresponds to the data from the nationwide study on the psychotherapists' environment

in Poland [40]. In this study, as in the national study [40], there was a visible predominance of women, people with psychological education, and finally therapists working in the psychodynamic modality. It seems, therefore, that the data from the research group can be largely regarded as representative of the psychotherapist community. At the same time, it should be noted that in our study, however, the advantage of psychodynamic therapists was much greater than in the study by Suszek et al. [40]. The characteristics of the group and the collected data made it possible to create preliminary sten standards for individual scales in relation to therapists working in the psychodynamic approach.

## Limitations of own research

The self-report nature of the assessment means that it only identifies the thoughts and emotions which the therapist is aware of, remembers, and wants to report [41]. This poses obvious questions concerning the therapist's insight and objectivity. The method must include the question about the level of recognizing one's own defenses and emotional attitudes as well as distortions related to the need for social approval. For example, it is possible that it is not coincidental that the responses indicating eroticized countertransference are not statistically significant (and therefore did not make it into the final version). This suggests that future studies should pool the results from the observer's countertransference analysis and the patient survey.

The tool can be used to assess the quality of the therapeutic relationship and thus support work to strengthen the alliance. However, we know from the literature that the assessments made by therapists show only moderate agreement with the assessments of clients [42]. Thus, the predictive validity of the questionnaire, in the understanding of the relationship between the results and the effectiveness of therapy or the willingness of clients to continue it, requires further research.

An important limitation of this study is the fact that the research group was relatively small, as it consisted of 159 therapists, therefore the results should be treated as preliminary. In addition, it seems that the structure of the study group was not sufficiently diverse. In further work on the questionnaire, more diverse data should be obtained, also from psychotherapists of other therapeutic modalities, so that the questionnaire has norms for therapists independent of the dominant approach.

Another limitation of the study is the fact that the study was conducted via the Internet. There is a concern that the standardization of the survey situation was not fully maintained, because it is not known whether and what interfering factors could have influenced the course of the survey (it was not verified whether the respondents used the Internet service at work, at home or in a public place, which type of equipment they used). Moreover, although a link to a website, together with a request to complete the questionnaire, was sent specifically to members of Psychological, Psychiatric and Psychotherapy Societies, the researchers did not control the identity of people participating in the study. Due to the lack of direct contact, there was no complete certainty that the people invited to the study were really who they claimed to be.

Moreover, it should be noted that the validity of the tool was not analyzed due to the lack of comparative methods.

## Recapitulation

As a result of the analyses, the *Questionnaire for the Perception of Psychotherapy Process by the Psychotherapist* was developed that includes 75 items grouped into six scales. Each of the scales describes different dimensions of the healer-client relationship during the therapeutic process. The psychometric properties of the tool are satisfactory and indicate its internal consistency. QPPP contains simple, generally understandable terminology independent of the dominant modality of the therapist. The questionnaire also has preliminary sten standards for therapists working in the psychodynamic approach. The questionnaire helps the therapist identify a complex palette of feelings and assign them to specific domains. It can have many practical applications – both scientific and clinical.

## References


1. Lambert MJ, Bergin AE. *Achievements and limitations of psychotherapy research*. In: Norcross JC, Goldfried MR, editors. *Handbook of psychotherapy integration*. New York: Basic Books; 1992. P. 94–129.
2. Czabała JC. *Wyniki badań nad psychoterapią – ich użyteczność dla praktyki klinicznej*. Psychoter. 1994; 4(91): 33–40.
3. Lambert MJ, Ogles BM. *The efficacy and effectiveness of psychotherapy*. In: Lambert MJ, editor. *Bergin and Garfield's Handbook of psychotherapy and behavior change*. New York: Wiley; 2004. P. 139–193.
4. Cooper M. *Efektywność psychoterapii i poradnictwa psychologicznego. Wyniki badań i praktyka kliniczna*. Warsaw: Institute of Health Psychology; 2010.
5. Coco GL. *Efficacy of psychotherapeutic treatments: Research based on clinical practice*. Ricerca Psicoanalitica 2021; 32(2): 387–401.
6. Cuijpers P, Reijnders M, Huibers MJ. *The role of common factors in psychotherapy outcomes*. Annu. Rev. Clin. Psychol. 2019; 15: 207–231.
7. Norcross JC, Lambert MJ. *Evidance-based therapy relationship. The third task force*. In: Norcross JC, Lambert MJ, editors. *Psychotherapy relationships that work*, vol. 1: *Evidence-based therapist contributions*. Oxford: Oxford University Press; 2019. P. 1–21.
8. Sass-Stańczak K, Czabała JC. *Relacja terapeutyczna – co na nią wpływa i jak ona wpływa na proces psychoterapii*. Psychoterapia 2015; 1(172): 5–17.
9. Greenberg L. *The therapeutic relationship in emotion-focused therapy*. Psychotherapy (Chic.). 2014; 51(3): 350–357.
10. Gelso CJ, Hayes JA. *Psychoanalityczna wizja relacji terapeutycznej*. In: Gelso CJ, Hayes JA. *Relacja terapeutyczna*. Gdansk: Gdansk Psychological Publishing House; 2005. P. 159–187.
11. Bordin ES. *The generalizability of the psychoanalytic concept of the working alliance*. Psychotherapy: Theory, Research & Practice 1979; 16(3): 252–260.
12. Kächele H, Erhardt I, Seybert C, Buchholz MB. *Countertransference as object of empirical research?* Int. Forum Psychoanal. 2015; 24(2): 96–108.
13. Peluso PR, Freund RR. *Therapist and client emotional expression and psychotherapy outcomes: A meta-analysis*. Psychotherapy (Chic.). 2018; 55(4): 461–472.

14. Hayes JA, Gelso CJ, Hummel AM. *Managing countertransference*. Psychotherapy (Chic.). 2011; 48(1): 88–97.
15. Lingiardi V, Muzi L, Tanzilli A, Carone N. *Do therapists' subjective variables impact on psychodynamic psychotherapy outcomes? A systematic literature review*. Clin. Psychol. Psychother. 2018; 25(1): 85–101.
16. Gabbard GO. *Psychiatria psychodynamiczna w praktyce klinicznej*. Krakow: Jagiellonian University Press; 2015.
17. Tonnesmann M. *Przeniesienie i przeciwprzeniesienie*. In: Budd S, Rusbridger R, editors. *Współczesna psychoanaliza brytyjska*. Warsaw: Ingenium Publishing House; 2008. P. 231–249.
18. Aleksandrowicz JW. *Psychoterapia. Podręcznik dla studentów, lekarzy i psychologów*. Warsaw: PZWL Medical Publishing; 2000.
19. Levy RA, Ablon JS, Kächele H, editors. *Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence*. New York: Springer Science & Business Media; 2011.
20. Greenson RR. *The technique and practice of psychoanalysis*. New York: International Universities Press, Int.; 1967.
21. Gelso CJ, Hayes J. *Countertransference and the therapist's inner experience: Perils and possibilities*. New York: Routledge; 2008.
22. Gelso CJ, Hayes JA. *Przeciwprzeniesienie. Wkład terapeuty w „nierzeczywistą" relację*. In: *Relacja terapeutyczna*. Gdansk: Gdansk Psychological Publishing House; 2005. P. 86–111.
23. Kleinginna PR Jr, Kleinginna AM. *A categorized list of emotion definitions, with suggestions for a consensual definition*. Motiv. Emot. 1981; 5(4): 345–379.
24. Tracey TJ, Kokotovic AM. *Factor structure of the Working Alliance Inventory*. Psychol. Assess. J. Cons. Clin. Psychol. 1989; 1(3): 207–210.
25. Agnew-Davies R, Stiles WB, Hardy GE, Barkham M, Shapiro DA. *Alliance structure assessed by the Agnew Relationship Measure (ARM)*. Brit. J. Clin. Psychol. 1998; 37(2): 155–172.
26. Luborsky L, Johnson S, McLellan T. *The Penn Helping Alliance Questionnaire (HAQ-I): Its composition and its research supports*. Philadelphia, PA: University of Pennsylvania; 1994.
27. Colli A, Lingiardi V. *The Collaborative Interactions Scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy*. Psychother. Res. 2009; 19(6): 718–734.
28. Gaston L. *Reliability and criterion-related validity of the California Psychotherapy Alliance Scales – Patient version*. Psychol. Assess. J. Cons. Clin. Psychol. 1991; 3(1): 68–74.
29. Røssberg JI, Hoffart A, Friis S. *Psychiatric staff members' emotional reactions toward patients. A psychometric evaluation of an extended version of the Feeling Word Checklist (FWC-58)*. Nordic J. Psychiatry 2003; 57(1): 45–53.
30. Józefik B. *Psychoterapia jako dyskurs kulturowy*. Psychiatria Polska. 2011; 45(5): 737–748.
31. Szymańska A, Dobrenko K, Grzesiuk L. *Cechy pacjenta, jego doświadczenia z przebiegu psychoterapii i skuteczność psychoterapii*. Rocz. Psychol. 2016; 19(3): 583–603.
32. Józefik B, Wolska M, Ulasińska R, Iniewicz G. *Ocena terapii z perspektywy pacjentów i ich rodzin: opracowanie wyników ankiety*. Psychoter. 2003; 2(125): 69–84.
33. Sosnowska M, Prot-Klinger K, Scattergood M, Paczkowska M, Smolicz A, Ochocka M. *Relacja terapeutyczna w psychiatrii środowiskowej z perspektywy pacjenta i terapeuty*. Psychiatr. Pol. 2011; 45(5): 723–735.

34. Courtney M, Gordon R. *Determining the number of factors to retain in EFA: Using the SPSS R-menu v2 0 to make more judicious estimations*. Pract. Assess. Res. Eval. 2013; 18(1): 8.
35. Nissen-Lie HA, Dahl HS, Høglend PA. *Patient factors predict therapists' emotional countertransference differently depending on whether therapists use transference work in psychodynamic therapy*. Psychother. Res. 2020; 14: 3–15.
36. Colli A, Tanzilli A, Dimaggio G, Lingiardi V. *Patient personality and therapist response: An empirical investigation.* Am. J. Psychiatry 2014; 171(1): 102–108.
37. Hayes JA, Gelso CJ, Goldberg S, Kivlighan DM. *Countertransference management and effective psychotherapy: Meta-analytic findings*. Psychotherapy (Chic.). 2018; 55(4): 496–507.
38. Machado D de B, Teche SP, Lapolli C, Tavares BF, Almeida de LSP, Silva da GB et al. *Countertransference and therapeutic alliance in the early stage of adult psychodynamic psychotherapy*. Trends Psychiatry Psychother. 2015; 37(3): 133–142.
39. Löffler-Stastka H, Blueml V, Boes C. *Exploration of personality factors and their predictive impact on therapy utilization: The externalizing mode of functioning*. Psychother. Res. 2010; 20(3): 295–308.
40. Suszek H, Grzesiuk L, Styła R, Krawczyk K. *Kto i w jaki sposób prowadzi psychoterapię w Polsce. Część II. Wyniki ogólnopolskiego badania*. Psychiatria 2017; 14(2): 90–100.
41. Johsen Dahl HS. *Therapists' feelings in psychodynamic therapy: A study of self-reported countertransference and long-term outcome*. Oslo: University of Oslo; 2012.
42. Shick Tryon G, Collins Blackwell S, Felleman Hammel E. *A meta-analytic examination of client–therapist perspectives of the working alliance*. Psychother. Res. 2007; 17(6): 629–642.

Address: Marta Szwajca
Jagiellonian University Medical College
Chair of Psychiatry, Clinic of Child and Adolescent Psychiatry and Psychotherapy,
31-501 Kraków, Kopernika Street 21 A
e-mail: marta.szwajca@uj.edu.pl