MANUSCRIPT PUBLISHED IN THE JOURNAL *TRAINING AND EDUCATION IN PROFESSIONAL PSYCHOLOGY*

Adapting the Perseverative Thinking Questionnaire for measuring repetitive negative thinking in clinical psychology trainees

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Abstract

Repetitive negative thinking (RNT) focused on clinical practice might play a relevant role in the emotional difficulties clinical psychology trainees may experience during their training. However, the empirical evidence in this regard is very limited. To begin to address this topic, the current study aimed to adapt and preliminarily test the psychometric properties of the Perseverative Thinking Questionnaire for Clinical Psychology Trainees (PTQ-CPT), a measure of RNT focused on clinical practice. The instructions and 15 items of the Perseverative Thinking Questionnaire (PTQ) were modified to resemble RNT occurring in clinical practice. Four experts evaluated the items, and a 9-item version of the PTQ-CPT was obtained. This version was administered to 412 undergraduates in a Psychology program in Colombia, all of them Spanish speakers. They were also at the beginning of or near their clinical practice. The PTQ-CPT showed excellent internal consistency (alpha of .93). A cross-validation study was conducted to analyze the factor structure of the PTQ-CPT, yielding one-factor structure. The PTQ-CPT showed strong positive correlations with the PTQ, experiential avoidance, emotional symptoms, and obstruction in values; and medium negative correlations with life satisfaction and progress in values. In conclusion, the PTQ-CPT seems to be a valid and reliable measure of RNT focused on clinical practice, which might be used to explore the role of RNT in the stress and learning difficulties experienced by clinical psychology trainees.

Key words: Repetitive negative thinking; Health science trainees; Psychometric analysis; Rumination; Worry.

Public significance of the study:

Clinical psychology trainees might engage in repetitive negative thinking (RNT) in response to the multiple stressors they face in their practice, which can complicate the learning process and

lead to experience emotional difficulties. This study presents the development and initial validation of an instrument designed to measure RNT focused on the clinical practice (PTQ-CPT). The good psychometric properties shown by the PTQ-CPT warrants its use in future research exploring the role of RNT in the learning and emotional adjustment of clinical psychology trainees.

Adapting the Perseverative Thinking Questionnaire for measuring repetitive negative thinking in clinical psychology trainees

Practice in clinical psychology involves a series of interpersonal encounters in which the professionals diagnose, assess, intervene, monitor, and promote mental health among individuals who present some kind of suffering or life challenges. The career to become a clinical psychologist varies among different countries, but it commonly implies some years of intensive theoretical and practical training with the guidance of a clinical supervisor. Clinical psychology trainees usually face a wide range of stressors during their training (Cartwright & Gardner, 2016). The external stressors most commonly indicated by trainees are dealing with patients' suffering, the lack of support and feedback, different opinions between their supervisor and themselves, the need to establish therapeutic alliances, the ambiguity of the clinical diagnosis, attending to clients with severe suicide ideation, the competence for the clinical demand, academic and research obligations, time limitations, and financial difficulties (Cahir & Morris, 1991; Cartwright & Gardner, 2016; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Cushway, 1992; Cushway & Tyler, 1996; Hill, Sullivan, Knox, & Schlosser, 2007; Myers et al., 2012; Pica, 1998; Schwartz-Mette, 2009; Skovholt & Ronnestad, 2003; Szymanska, 2002; Truell, 2001). Additionally, trainees often experience internal stressors such as the perceived difficulties in putting theoretical knowledge into practice, the discrepancy between the idealistic expectations and the reality of clinical practice, the need to heal the patient, and thoughts of incompetence when the results are uncertain or not satisfactory (Hill et al., 2007; Rodolfa, Kraft, & Reilley, 1988).

Due to the above-mentioned stressors, training in clinical psychology is often experienced as particularly stressful (Skovholt & Ronnestad, 2003). Indeed, trainees usually show higher

levels of emotional symptoms than the rest of the staff (Shapiro, Brown, & Biegel, 2007; Vredenburgh, Carlozzi, & Stein, 1999). In this sense, trainees are a unique population that has to manage the consequences of stress, learn to train in knowledge and skills in their new roles, and then provide clinical and therapeutic services to others (Myers et al., 2012). DeAngelis (2002) observed that, although psychologists promote the practice of self-care and stress management with clients, there is a tendency to not apply this to their own mental health.

It is important to note that not all trainees develop emotional difficulties in response to the stressors of clinical training (Cushway, 1992; Myers et al., 2012). In this sense, the way trainees react in response to the above-mentioned stressors seems to be crucial to their adjustment to their role and well-being. Some research supports the latter assertion with similar professionals. For instance, Kroska, Calarge, O'Hara, Deumic, and Dindo (2017) have shown that higher levels of experiential avoidance and decreased engagement in values-based behavior were associated with depression and burnout among medical students. Likewise, Vilardaga et al. (2011) have found that experiential avoidance, cognitive fusion, and values commitment predict burnout after controlling for work-site factors among addiction counselors.

Over the last two decades, there have been multiple efforts to identify transdiagnostic processes (e.g., Harvey, Watkins, Mansell, & Shafran, 2004). One of the most researched transdiagnostic processes nowadays is repetitive negative thinking (RNT; Ehring & Watkins, 2008; Watkins, 2008). RNT comprises thinking processes such as worry and rumination and has been found to be a core feature of emotional disorders such as depression, generalized anxiety disorder, social anxiety disorder, posttraumatic stress disorder, panic disorder, or obsessive-compulsive disorder (e.g., Watkins, 2016). Although thought content is different across these disorders, the thinking process has considerable similarities because it is repetitive, focused on

negative content, intrusive, difficult to disengage from, perceived as uncontrollable, and it captures mental capacity (Ehring et al., 2011).

Importantly, empirical evidence from longitudinal and experimental studies has identified RNT as a common factor in the onset and maintenance of emotional disorders (e.g., Ehring & Watkins, 2008; Harvey et al., 2004; Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Research is also supportive for the view of RNT as an experiential avoidance strategy (e.g., Roemer & Orsillo, 2002; Segerstrom, Stanton, Alden, & Shortridge, 2003) that tends to be the first reaction to triggers (e.g., fear, need for explanations, feelings of uncertainty, etc.) provoked by a wide range of stressors (Ruiz, Riaño-Hernández, Suárez-Falcón, & Luciano, 2016; Ruiz et al., 2018). Paradoxically, RNT usually prolongs negative affect because it is focused on negative content and may lead to engaging in other experiential avoidance strategies such as drinking alcohol, distraction, emotional eating, etc. (Caselli et al., 2013; Nolen-Hoeksema, Stice, Wade, & Bohon, 2007; Wells, 2002). This closes a cycle in which triggers for RNT control behavior with consequent decrease in the engagement in values-based behavior.

Trainees in health professions are prone to engage in RNT because of the stressors and consequent triggers they usually face during clinical practice (e.g., Cartwright & Gardner, 2016; Hill et al., 2007; Myers et al., 2012). For instance, when the trainee realizes that she/he has clients older than her/him, she/he might think: “The clients are not going to trust me,” “They have more experience in life than me,” or “I am too young to work with them.” In response to these thoughts, the trainee might engage in RNT by thinking about her/his competence as a clinical psychologist, even during the clinical sessions. This engagement in RNT would provoke a higher level of stress and a worse performance of the trainee as a therapist because her/his attention is not sufficiently focused on the clinical interaction.

According to the previous example, RNT focused on clinical practice might increase emotional symptoms while also decreasing the trainees' learning and performance. If this idea is correct, training students in disengaging from RNT and focusing on the relevant tasks of clinical practice, as well as on other values-based behaviors, might be an efficacious strategy to promote trainees' well-being and learning. Although the previous hypothesis is appealing, the lack of a measure of RNT focused on clinical practice hinders its empirical analysis. Hence, the aim of the current study is to design and analyze the psychometric properties of a measure of RNT focused on clinical practice.

To accomplish the above-mentioned objective, we adapted the items of the Perseverative Thinking Questionnaire (PTQ; Ehring et al., 2011) to the context of clinical psychology training to develop the Perseverative Thinking Questionnaire – Clinical Psychology Trainees (PTQ-CPT). The PTQ is a content-independent self-report measure of RNT that was designed to evaluate the tendency to engage in RNT when facing negative experiences. A sample of 412 psychology undergraduates of a Colombian university who were at the beginning of or nearing their clinical training responded to a questionnaire package that included the PTQ-CPT, the PTQ, and measures of experiential avoidance, emotional symptoms, life satisfaction and valued living. We expected that the PTQ-CPT would show: (a) good internal consistency, (b) a one-factor structure, (c) medium to strong positive correlations with the PTQ and measures of experiential avoidance (because RNT is an experiential avoidance strategy) and emotional symptoms (because RNT is usually strongly associated with symptomatology), and (d) medium negative correlations with measures of valued living (because RNT makes it difficult to advance in personal values and goals) and life satisfaction (because not advancing in one's own values and goals might decrease life satisfaction).

Method

Item development of the Perseverative Thinking Questionnaire for Clinical Psychology Trainees (PTQ-CPT)

The PTQ was developed in English and German (PTQ; Ehring et al., 2011). To design the PTQ-CPT, we first back-translated the English version of the PTQ into Spanish according to the guidelines suggested by Muñiz, Elosua, and Hambleton (2013). Afterwards, we slightly modified its 15 items to resemble RNT in clinical psychology trainees. Most of the introduced changes consisted of specifying engagement in RNT about issues of clinical practice (e.g., "My thoughts are repetitive" to "My thoughts about the clinical practice are repetitive").

We also modified the instructions given to participants to introduce the questionnaire and normalize the difficulties participants might be experiencing: "Clinical practice is a crucial moment in the training of a psychologist because new responsibilities are assumed and previously developed skills are put into practice. However, it is also normal for clinical practice to generate some doubts, worries, and insecurities. Next, you will be asked to describe how you usually feel and/or react to those thoughts and emotions. Please read the following statements and indicate the measure to which they apply to you when you feel doubts, worries, and insecurity with regard to clinical practice."

The items were then given to four experts who made a qualitative analysis of them. Three of the experts had extensive experience as clinical supervisors and notions in psychometrics. The remaining expert had no experience as clinical supervisor, but was an expert in psychometrics. All of them had Spanish as their first language (3 were Colombian and 1 was a Spaniard). As our aim was to develop a short questionnaire, some of the items were removed before administering the scale to a large sample of participants (see below).

Participants

The sample consisted of 412 undergraduates (mean age = 22.74, *SD* = 3.57; 83.5% were women) of a Colombian university. Approximately half of the participants were studying the 9th semester (57.3%) and the other half were studying the 8th semester (42.7%). Participants in the 9th semester were at the beginning of their clinical practice, whereas those in the 8th semester were receiving training in Clinical Psychology to begin the clinical practice in the next semester. Unlike other countries (e.g., USA), Colombian laws permit undergraduates in Psychology to receive training in clinical psychology and to attend to clients under the guidance of a supervisor. Almost all participants were single (94.4%). Forty percent of the participants had received some kind of psychological or psychiatric treatment in the past, but only 3.7% were receiving treatment when the study was conducted (only 1.2% were taking psychotropic medication).

Instruments

Perseverative Thinking Questionnaire (PTQ; Ehring et al., 2011). The PTQ is a 15-item, 5-point Likert (4 = *almost always*; 0 = *never*) self-report instrument that was designed to evaluate the tendency to engage in RNT when facing negative experiences or problems. Unlike other measures, the PTQ is a content-independent self-report of RNT. It has shown a hierarchical factor structure, with a higher-order factor representing RNT in general and three lower-order factors: (a) core features of RNT, (b) unproductiveness of RNT, and (c) mental capacity captured by RNT. The PTQ has shown excellent internal consistency, high test-retest reliability, and convergent and predictive validity. Permission to translate the PTQ was obtained from the first author. Then, the PTQ was back-translated following the guidelines of Muñiz et al. (2013). Preliminary data from our laboratory indicate that the PTQ possesses excellent internal

consistency in Colombia and a one-factor structure. The alpha of the instrument in this study was .95.

Acceptance and Action Questionnaire – II (AAQ-II; Bond et al., 2011; Spanish version by Ruiz, Langer, Luciano, Cangas, & Beltrán, 2013). The AAQ-II is a general measure of experiential avoidance. It consists of 7 items that are rated on a 7-point Likert-type scale (7 = *always true*; 1 = *never true*). The items reflect unwillingness to experience unwanted emotions and thoughts and the inability to be in the present moment and behave according to value-directed actions when experiencing psychological events that could undermine them. The Spanish version of the AAQ-II has shown good psychometric properties and a one-factor structure in Colombia (Ruiz, Suárez-Falcón, Cárdenas-Sierra et al., 2016). The alpha of the instrument in this study was .91.

Depression, Anxiety, and Stress Scales – 21 (DASS-21; Lovibond & Lovibond, 1995; Spanish version by Daza, Novy, Stanley, & Averill, 2002). The DASS-21 is a 21-item, 4-point Likert-type scale (3 = *applied to me very much, or most of the time*; 0 = *did not apply to me at all*) consisting of sentences describing negative emotional states. It contains three subscales (Depression, Anxiety, and Stress) and has shown good internal consistency and convergent and discriminant validity. The DASS-21 has shown good psychometric properties in Colombia and a hierarchical factor structure (Ruiz, García-Martín, Suárez-Falcón, & Odriozola-González, 2017). The alphas of the instrument in this study were .91, .87, .77, and .83 for the total scale, Depression, Anxiety, and Stress, respectively.

General Health Questionnaire – 12 (Goldberg & Williams, 1988; Spanish version by Rocha, Pérez, Rodríguez-Sanz, Borrell, & Obiols, 2011). The GHQ-12 is a 12-item, 4-point Likert-type scale that is frequently used as screening for psychological disorders. Respondents

are asked to indicate the degree to which they have recently experienced a range of common symptoms of distress, with higher scores reflecting greater levels of psychological distress. The GHQ-12 has shown excellent psychometric properties in Colombia and a one-factor structure (Ruiz, García-Beltrán, & Suárez-Falcón, 2017). The alpha of the instrument in this study was .86.

Valuing Questionnaire (VQ; Smout, Davies, Burns, & Christie, 2014; Spanish version by Ruiz, Suárez-Falcón, Gil-Luciano, & Riaño-Hernández, submitted). The VQ is a 10-item, 6-point Likert (6 = *completely true*; 0 = *not at all true*), self-report instrument designed to assess general valued living during the past week. The VQ has two subscales: Progress (i.e., enactment of values, including clear awareness of what is personally important and perseverance) and Obstruction (i.e., disruption of valued living due to avoidance of unwanted experience and distraction from values). The Spanish version has shown good psychometric properties and a two-factor structure. In this study the alphas were .78 and .76 for Progress and Obstruction, respectively.

Satisfaction with Life Survey (SWLS; Diener, Emmons, Larsen, & Griffin, 1985; Spanish version by Atienza, Pons, Balaguer, & García-Merita, 2000). The SWLS is a 5-item, 7-point Likert-type scale (7 = *strongly agree*; 1 = *strongly disagree*) that measures self-perceived well-being. The SWLS has good psychometric properties and convergent validity. It has also shown good psychometric properties and a one-factor structure in Colombia (Ruiz, Suárez-Falcón, Flórez et al., submitted). The alpha of the instrument in this study was .85.

Procedure

The procedure of this study was approved by the institutional Ethics Committee. Potential participants were invited to participate in the study in a regular class at the beginning of the

academic semester. Students were told that participation was voluntary and the aim of the study was to analyze which psychological variables were associated with the psychological adjustment of clinical psychology trainees. Students who agreed to participate in the study signed an informed consent. Subsequently, they were given a questionnaire package including a sociodemographic form and the Spanish versions of the questionnaires listed above in the following order: DASS-21, GHQ-12, SWLS, VQ, AAQ-II, PTQ, and PTQ-CPT. Participants could cease participating at any given time.

Data analysis

After modifying the 15 items of the PTQ to resemble RNT in clinical psychology trainees, four experts evaluated the PTQ-CPT. All experts assessed the items on a 4-point Likert-type scale (4 = *very*; 1 = *nothing*) according to their representativeness, understanding, interpretability, and clarity. Aiken's V and its 95% confidence intervals (CI) were analyzed, taking into account the suggested cut-point of less than .50 for item inadequacy (Merino-Soto & Livia-Segovia, 2009). Aiken's V was computed with the Excel calculator provided by Rodríguez-Cordón at https://www.researchgate.net/publication/316740035_prueba_V_Excel. Some items of the PTQ-CPT were deleted and some were modified in accordance with the experts' suggestions (see below).

The factor structure of the PTQ-CPT was analyzed by conducting a cross-validation study. This involves splitting the recruited sample in two random subsamples of approximately equal size and conducting an exploratory factor analysis (EFA) with the first random subsample and a confirmatory factor analysis (CFA) with the second subsample. The sample was split into two random subsamples through the SPSS 19©. The EFA in the first subsample was conducted with the software Factor 10.5 (Lorenzo-Seva & Ferrando, 2006). We selected the unweighted

least squares (ULS) extraction method with Direct Oblimin rotation, using polychoric correlations. The number of dimensions was determined by means of the optimal implementation of parallel analysis (PA) based on minimum rank factor analysis (Timmerman & Lorenzo-Seva, 2011). An assessment of unidimensionality was conducted by computing Unidimensional Congruence (UniCo), Explained Common Variance (ECV), and Mean of Item Residual Absolute Loadings (MIREAL) indexes. Values larger than .95 and .85 in UniCo and ECV, respectively, suggest that data can be treated as essentially unidimensional; whereas for the MIREAL, a value lower than .30 suggests unidimensionality (Ferrando & Lorenzo-Seva, 2018). To explore the internal consistency of the PTQ-CPT, coefficient alpha was computed with the first random sample with the SPSS 19, providing 95% CI. Corrected item-total correlations were obtained to analyze the discrimination item index.

A robust weighted least squares (Robust WLS) estimation method using polychoric correlations was adopted to conduct the CFA in the second subsample, using LISREL© (version 8.71, Jöreskog & Sörbom, 1999). We computed the chi-square test and the following goodness-of-fit indexes for the one-factor model: (a) the root mean square error of approximation (RMSEA); (b) the comparative fit index (CFI); and (c) the non-normed fit index (NNFI). According to Kelloway (1998) and Hu and Bentler (1999), RMSEA values of .10 represent a good fit, and values below .05 represent a very good fit to the data. With respect to the CFI and NNFI, values above .90 indicate well-fitting models, and above .95 represent a very good fit to the data.

Lastly, Pearson correlations between the PTQ-CPT and other scales were calculated to assess convergent construct validity.

Results

Qualitative evaluation of the items

In accordance with the ratings of the experts, six items of the PTQ-CPT were deleted. A table with the ratings of the experts for each item can be seen here (INTRODUCE HOTLINK TO THE FILE TABLE S1). Specifically, Items 2, 10, 12, and 13 were eliminated because of low scores on Aiken's V. Item 4 was eliminated because it assumed that clinical practice had begun. Item 7 was also eliminated because it was very similar to Item 3. Four items (Items 1, 8, 11, and 14) were slightly modified in accordance with the experts' suggestions, which improved the item scores to an acceptable Aiken's V value. In conclusion, nine items were retained for the final version of the PTQ-CPT. The final PTQ-CPT version in Spanish can be seen here (INTRODUCE HOTLINK TO TABLE S2), whereas the English translation is presented here (INTRODUCE HOTLINK TO TABLE S3).

Descriptive data and psychometric quality of the items

All items showed good discrimination, with corrected item-total correlations ranging from .66 to .78. Coefficient alpha was .93 (95% CI [.91, .94]). A table with the items of the final version of the PTQ-CPT, their translation into English, corrected item-total correlations and factor loadings obtained in the EFA can be seen in Table 1.

INSERT TABLE 1 ABOUT HERE

Validity evidence based on internal structure

Dimensionality

The first random subsample consisted of 204 participants and was used to conduct the EFA. The mean age of this subsample was 22.77 years (*SD* = 3.75, age range = 19 to 49), 42.8% were in the 8th semester, and 85.4% were women. Bartlett's statistic was statistically significant (1230.2(36), $p < .001$), and the result of the Kaiser-Meyer-Olkin (KMO) test was very good

(.92). The PA suggested extracting only one factor, which accounted for 70.4% of the variance (eigenvalue = 6.34). Factor loadings were high for all items, ranging from .73 (Item 1) to .88 (Item 5). Values of UniCo (.99), ECV (.92), and MIREAL (.21) strongly supported the unidimensionality of the PTQ-CPT. In conclusion, the results of the conducted EFAs suggested that the PTQ-CPT can be treated as a unidimensional measure.

As the previously conducted EFA indicated that the PTQ-CPT seems to be a unidimensional measure, the CFA was conducted to analyze the fit of a one-factor model in the second random subsample (N = 203). The mean age of this subsample was 22.70 years (SD = 3.39, age range = 19 to 46), 43.2% were in the 8th semester, and 81.6% were women. The overall fit of the one-factor model in the PTQ-CPT was good: $\chi^2(27) = 49.409$, $p < .01$; RMSEA = .064, 90% CI [.035, .092], CFI = .99, NNFI = .99. A depiction of the standardized solution of the one-factor model for the PTQ-CPT can be seen here (INTRODUCE HOTLINK TO FIGURE S1).

Validity evidence based on relationships with other variables

The correlations obtained by the PTQ-CPT with other relevant constructs were theoretically coherent (see Table 2). The PTQ-CPT showed strong positive correlations with RNT as measured by the PTQ and with experiential avoidance as measured by the AAQ-II. The PTQ-CPT also showed significant correlations with emotional symptoms as measured by the DASS-21 and the GHQ-12. Lastly, the PTQ-CPT showed significant correlations with measures of satisfaction with life and values. A table presenting the correlations among all the variables of the study can be seen here (INTRODUCE HOTLINK TO TABLE S4)

INSERT TABLE 2 ABOUT HERE

Discussion

This study aimed to design and evaluate the psychometric properties of a self-report measure of RNT focused on clinical practice. In so doing, we modified the 15 items of the PTQ to resemble RNT in clinical psychology trainees. These 15 items were given to four experts to conduct a qualitative evaluation. Six items of the PTQ-CPT were removed, and some were modified in accordance with the experts' suggestions. Subsequently, the 9-item version of the PTQ-CPT was administered to a large sample of undergraduates doing their clinical practice or about to begin it.

The PTQ-CPT showed an excellent internal consistency (alpha of .93). The cross-validation study conducted to analyze the factor structure of the PTQ-CPT strongly supported the unidimensionality of the measure. The PTQ-CPT showed strong positive correlations with RNT as measured by the PTQ and with experiential avoidance as measured by the AAQ-II. It also showed strong positive correlations with emotional symptoms as measured by the DASS-21 and the GHQ-12. Lastly, the PTQ-CPT showed medium negative correlations with measures of satisfaction with life and values.

Implications of the research

These preliminary data show that the PTQ-CPT is a promising measure of RNT focused on clinical practice. Accordingly, the PTQ-CPT might be used by researchers to analyze the role of RNT in the adjustment of trainees to clinical practice and their learning. Furthermore, the PTQ-CPT might be useful for assessment and monitoring purposes for counselors and clinical psychologists attending to trainees. Additionally, the supervisors might use the PTQ-CPT to discuss with the trainee how he or she can face the difficulties of the training and practice. Lastly, in the USA, the PTQ-CPT might be used for Latino trainees, as it has been developed in

Spanish. That might be particularly useful in this context because trainees from cultural minorities might experience additional stressors in their training.

Limitations and future research

Some limitations of the current study are worth mentioning. Firstly, the PTQ-CPT was only administered to undergraduate students of Psychology who were about to do or already doing their clinical psychology practice. Further studies should explore the psychometric properties of the PTQ-CPT with other trainees in health professions. In this regard, the PTQ-CPT was designed without mentioning details about the practice in clinical psychology so that it could be used with trainees in health professions in general. Secondly, the sample of the current study was composed mostly of women. This is to be expected because Psychology is a career with a predominance of women. However, further studies should analyze the properties of the PTQ-CPT in a larger sample of men and explore the factorial equivalence across gender. Thirdly, the psychometric properties of the PTQ-CPT were only analyzed in undergraduate students. Subsequent studies might analyze the properties of the instrument in master or doctorate students. Fourthly, the items of the PTQ-CPT were designed to measure content-independent RNT in the context of the clinical practice. This was done to maximize the applicability of the instrument. However, further studies might design a questionnaire measuring RNT more specifically focused on the response of clinical psychology trainees to specific stressors of the clinical practice. Lastly, the psychometric properties found in this study are exclusive to the Colombian population. Further studies should analyze the psychometric properties and validity of the PTQ-CPT in other Spanish-speaking countries and other languages.

In addition to the abovementioned limitations, future research might use the PTQ-CPT to: (a) describe the degree of RNT among trainees at different levels of training and in different

settings, (b) analyze gender and cultural differences in RNT as well as the correlates of such thinking among different groups, and (c) explore its usefulness as a measure in training studies addressing supervisor alliance and developing competencies.

Conclusion

This study presented the adaptation of the PTQ for clinical psychology trainees (i.e., PTQ-CPT), and for trainees in health professions more generally. The instrument showed excellent psychometric properties and a sound one-factor structure. Further studies might use the PTQ-CPT to analyze the potential maladaptive role of RNT in the emotional symptoms of clinical trainees and their learning.

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Table 1

Item Description of the PTQ-CPT, English Translation, Corrected Item-Total Correlations and Factor Loadings from EFA with the First Random Sample

Items	Corrected item-total correlation (N = 204)	Factor loading EFA (N = 204)
1. Mis dudas sobre la práctica clínica aparecen constantemente en mi mente [My doubts about the clinical practice come my mind constantly]	.67	.73
2. No puedo dejar de preocuparme por mi práctica clínica [I can't stop worrying about my clinical practice]	.72	.79
3. No puedo centrarme en mis tareas cuando me pongo a pensar en la práctica clínica [I can't focus on my tasks when I start thinking about the clinical practice]	.79	.86
4. Mis pensamientos en torno a la práctica clínica son repetitivos [My thoughts about the clinical practice are repetitive]	.77	.84
5. Me quedo atascado en mis preocupaciones acerca de la práctica clínica y no puedo concentrarme en mis estudios [I get stuck in my worries about the clinical practice and I can't concentrate on my studies]	.78	.88
6. Sigo haciéndome las mismas preguntas sobre aspectos de la práctica clínica sin encontrar una respuesta [I ask myself the same questions about aspects of the clinical practice without finding an answer]	.74	.82
7. Me mantengo pensando sobre la práctica clínica todo el tiempo, incluso en momentos en los que hacerlo no es útil o adecuado [I keep thinking about the clinical practice all the time, even when doing so is not useful or appropriate]	.73	.80
8. Mis pensamientos repetitivos en torno a la práctica clínica no son de mucha ayuda [My repetitive thoughts about the clinical practice don't help that much]	.70	.79
9. Mi inseguridad por la práctica clínica absorbe toda mi atención [My insecurity about the clinical practice absorbs all my attention]	.75	.82

Table 2

Pearson Correlations between the PTQ-CPT and other relevant Self-Report Measures

Measures	*r* with PTQ-CPT
PTQ	.50***
AAQ-II	.49***
DASS-21 – Total	.52***
DASS-21 – Depression	.42***
DASS-21 – Anxiety	.43***
DASS-21 – Stress	.48***
GHQ-12	.50***
VQ – Progress	-.28***
VQ – Obstruction	.50***
SWLS	-.27***

***$p < .001$. Note. AAQ-II = Acceptance and Action Questionnaire; DASS-21 = Depression, Anxiety, and Stress Scale – 21; GHQ-12 = General Health Questionnaire – 12; PTQ = Perseverative Thinking Questionnaire; PTQ-CPT = Perseverative Thinking Questionnaire – Clinical Psychology Trainees; SWLS = Satisfaction with Life Scale; VQ = Valuing Questionnaire.