National Survey of Canadian Psychologists' Test Feedback Training and Practice: A Mixed Methods Study

by

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Abstract

In recent decades, researchers have conducted a number of test feedback (TFB) studies – that is, studies of providing psychological assessment and testing results to clients. This sequential explanatory mixed methods study replicated and extended an earlier inquiry into TFB training and practice of American psychologists, using a Canadian sample. The extent to which psychologists provide TFB to clients, and how effectively training programs are preparing them to do so were examined through a national survey of 399 Canadian psychologists. Quantitative results indicate Canadian psychologists provide TFB to clients most of the time, while identifying some room for improvement in terms of meeting professional ethical standards and guidelines. Specifically, 91% of respondents reported providing some form of TFB to clients frequently or more often; 77% indicated doing so almost always, while 5.5% reported providing TFB rarely or never. Verbal was the most commonly indicated TFB format. Approximately 1/4th of respondents indicated graduate training in psychological assessment did not prepare them to provide TFB to clients effectively, while 13% identified post-graduate training as ineffective in learning to provide TFB. Recently graduated psychologists were not more likely to provide TFB than earlier graduates, nor were they more likely to endorse graduate or post-graduate training as helpful in learning to provide feedback. Experience-based forms of instruction in graduate training (e.g., practicum) positively correlated with respondents' providing TFB to clients, as did finding post-graduate training helpful. The qualitative phase explored the experiences and perspectives of six Canadian psychologists: three who regularly provided TFB to clients and three who did not. All respondents indicated learning through a self-instruction process and trail-and-error. This method of learning was related to respondent's supervisor's level of involvement/perceived skill, inadequate academic preparation/support, and the complexity of

assessment and TFB. All three non-TFB respondents indicated conducting assessments primarily in forensic settings, and each shared their willingness and preference for providing TFB to clients whenever possible. These respondents identified a lack or opportunity/precedent as the primary reason for not delivering TFB to clients consistently. This rationale was related to a perceived discrepancy between the client and the test-taker, as well as practical, legal and conventional barriers to providing TFB to test takers. Consistent with mixed methods studies, the quantitative survey data and qualitative interview data were integrated to explain and shed light on the results as a whole, providing an enhanced understanding of the TFB training and practice of Canadian psychologists. Limitations of the study, and potential directions for future research are presented and discussed.

Preface

This thesis is a replication and extension of an earlier study published in 2010 by K. T. Curry and W. E. Hanson entitled, "National Survey of Psychologists' Test Feedback Training, Supervision, and Practice: A Mixed Methods Study", *Journal of Personality Assessment*, vol. 92, issue 4, 327-336. In consultation with the authors who designed the survey (Curry & Hanson, 2010) I, Ryan Jacobson, revised and edited the instrument in order to inquire more intentionally into specific test feedback (TFB) activities, facilitate a more consistent response format, allow more open-ended responses, and optimize its relevance for a Canadian sample. I was responsible for all aspects of data collection and analysis, as well as the manuscript composition. With the exception of the survey instrument and study design, which was largely based on the researcher of Curry and Hanson (2010), this thesis is otherwise an original work by Ryan Jacobson. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name "The Practice and Training of Providing Test Feedback among Canadian Psychologists", No. 40995 on December 16, 2013, after which data collection and analysis commenced.

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I would also like to thank Dr. Karen Buro for her willingness to consult with me on this study. I realize we did not get to implement many of your suggestions due to the scope of this project Karen. Still, I really appreciate your generosity with your statistical expertise, as you helped me clarify my thinking, understanding and overall approach. I would like to thank Dr. Kyle Curry, as well, for being open to replication his research, and for consulting with me on this project. It was a real benefit for me to hear about what you learned as you conducted the original study, Kyle. Thank you. I would also like to thank Dr. Andrew Howell for his ongoing support and mentorship. I am really not sure if I would be here if it was not for you, Andrew. You have been a true teacher, mentor, and source of inspiration for me on more levels than you know. Thank you so much.

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Table of Contents

Page

Abstract....ii

Preface....iv

Acknowledgments....v

Table of Contents....vii

List of Tables....ix

List of Figures....x

Glossary of Terms and Variables....xi

1. INTRODUCTION AND LITERATURE REVIEW

1.1 Presenting Test Feedback to Clients in the Professional Practice of Psychology....1

1.2 Significance of Present Study....4

1.3 Collaborative/Therapeutic Approaches to Psychological Assessment....6

1.3.1 Collaborative Individualized Assessment....7

1.3.2 Therapeutic Assessment....8

1.3.3 Collaborative/Therapeutic Assessment....10

1.4 Assessment and Test Feedback Training....11

1.5 Review of Research on Test Feedback and Collaborative/Therapeutic Assessment....14

1.5.1 Overview of Collaborative/Therapeutic Assessment Research....15

1.6 Survey Research....18

1.7 Outcome Research....21

1.8 Process Research....34

1.9 The Present Study....39

1.10 Rationale for Mixed Methods Design....41

1.11 Research Questions....41

1.12 Quantitative and Qualitative Data Collection....42

1.13 Research Hypotheses....43

2. METHOD

2.1 Quantitative Data Collection: Participants, Survey Instrument, and Procedure....44

2.2 Quantitative Data Analysis....52

2.3 Qualitative Data Collection: Participants, and Interview Procedure....53

2.4 Qualitative Data Analysis 56
2.4.1 Researcher-as-Instrument: Potential Biases and Personal Reactions 58
2.5 Mixed Methods Procedure 62
3. RESULTS
3.1 Quantitative Results 63
3.1.1 Test Feedback Practices 63
3.1.2 Test Feedback Training 64
3.1.3 Factors Associated with Psychologist's Test Feedback Practice 66
3.2 Qualitative Results 71
3.2.1 Test Feedback Results 71
3.2.2 Non-Test Feedback Results 81
4. DISCUSSION
4.1.1 Integration of Quantitative and Qualitative Data 99
4.1.2 Limitations 102
4.1.3 Directions for Future Research 105
4.1.4 Practice and Training Implications: Moving TFB Forward 107
4.1.5 Conclusion 109
5. REFERENCES 111
6. APPENDIXES 125

List of Tables

Page

1. Frequency of Using Assessments for Specific Purposes 46
2. Frequency of Engaging in Specific Collaborative/Therapeutic Feedback Activities 48
3. Frequencies and Format of Providing Test Feedback to Clients 65
4. Agreement that Academic Training was Helpful in Learning to Provide Test Feedback 67
5. Primary Mode of Instruction in Graduate and Post-Graduate Training 68
6. Correlations among Factors Associated with Providing Test Feedback 71
7. Correlations among Age-related Factors Associated with Providing Test Feedback 72
8. Group 1 Test Feedback Qualitative Themes 74
9. Group 2 Non-Test Feedback Qualitative Themes 84

List of Figures

Page

1. Mixed Methods Procedure 62

Glossary of Terms and Variables

Test feedback (TFB) is defined as the process of presenting test results, along with an interpretation of those results, to the client in a manner that renders them understandable, meaningful and useful for the client. This definition is based on Lichtenberg and Goodyear's (1999) concept of test interpretation in which the clinician (1) makes sense of the test results, (2) presents the test results, along with an interpretation of those results, to the client, and (3) aids the client in processing and integrating the presented information.

Therapeutic Assessment (TA) refers to the empirically based, semi-structured form of collaborative assessment developed and refined by Finn and colleagues (cf. Finn, 2007). Based on a humanistic theoretical orientation, this model draws on aspects of self-psychology, and emphasizes client engagement, understanding and transformation.

Information Gathering Assessment (IG) refers to more traditional approaches to psychological assessment intended to communicate information about the client (e.g., describing current level of functioning, communicating diagnoses, answering referral questions, etc.). Information gathering models typically emphasize assessor objectivity, nomothetic comparison, and can inadvertently perpetuate a power imbalance between the client and the clinician (cf. Finn, Fischer & Handler, 2012).

Collaborative Individualized Assessment (CIA) refers to the model of assessment pioneered by Constance Fischer (e.g., Fischer, 1978; 2000). Rooted in phenomenological psychology, CIA values collaboration (i.e., "co-laboring") between clients and clinicians throughout the assessment process.

Collaborative/Therapeutic Assessment (C/TA) refers to an amalgam of the leading theories in the collaborative assessment paradigm (CIA and TA), resulting in an empirically

based model of psychological assessment that also facilitates the effective provision of TFB to clients, thereby fulfilling ethical obligations and realizing multiple therapeutic benefits.

therapeutic assessment (ta) refers to all other approaches that seek to positively impact clients through psychological assessment, but do not utilize the TA model articulated by Finn and colleagues, and do not necessarily use collaborative methods beyond providing TFB to clients. These approaches differ from the traditional IG assessment model with respect to their (1) goals, (2) process, (3) view of tests, (4) focus, (5) view of the assessor's role, and (6) what constitutes assessment success and failure (Finn & Tonsager, 1997).

Psychological Assessment as a Therapeutic Intervention (PATI) refers to the use of psychological assessment instruments coupled with personalized, collaborative feedback. It is based on the Collaborative/Therapeutic assessment model and also focuses on client understanding and transformation.

Purpose variables refer to the various uses of psychological assessments, such as answering specific referral questions, measuring treatment outcomes, monitoring client change, using assessments as a therapeutic intervention, etc.

Context variables refer to the settings in which, and the individuals with whom, clinicians use psychological assessments. These include with an interdisciplinary treatment team, with adults, with adolescents, etc.

Instrument variables refer to the various categories of assessment instruments that clinicians use in their practice such as intellectual, behavioural, neuropsychological, etc.

TA variables refer to the extent to which respondents engage in distinct steps prescribed by Finn (1996) and consistent with the C/TA model when providing TFB. Examples include

obtaining assessment-specific consent, and encouraging the client to generate personally relevant questions that the assessment might help answer.

TFB variables refer to the extent to which respondents provide TFB to clients and the formats in which they do so (e.g., written or verbal).

TFB clarification variables refer to the extent to which respondents are intentional about promoting clients' understanding of the test results. For example, making a deliberate effort to highlight any relevant implications resulting from the assessment.

Training variables refer to the extent to which respondents found their graduate and post-graduate training effective in preparing them to provide TFB to clients, the total proportion of training in assessment that focused explicitly on providing TFB, and the primary means of that instruction (e.g., lecture, role-playing, practicum).

Years since graduation refers to the number of elapsed calendar years between the dates the respondents completed their highest graduate degree in psychology and the data collection/analysis phase of the present study.

Demographic variables refer to respondent's biological sex, the cultural/ethnic group they most strongly identify with, their primary practice setting, theoretical orientation, and affiliation with various sections of the Canadian Psychological Association.

Client typically refers to the individual presenting for the assessment, but is also used to refer to the referral source in assessments involving third parties (e.g., parents, lawyers).

Test Taker invariably refers to the individual presenting for the assessment.

Chapter 1: Introduction and Literature Review

Psychologists play a unique role among mental health professionals, one that is characterized by the development, administration and interpretation of psychological tests (Meyer, Finn, Edye, Kay, et al., 2001). To be sure, testing is an integral and multi-dimensional aspect of psychological practice that can provide a wealth of valuable information both to and about clients. Psychologists are also ethically obligated to share assessment results with clients whenever possible, an exchange that is frequently referred to as 'test feedback' (TFB). This ethical responsibility of psychologists to present and explain test results to clients is evident in the American Psychological Association's Ethical Standard 9.10: "Psychologists take reasonable steps to ensure that explanations of results are given to the individual or designated representative" (American Psychological Association, 2002). Relevant sections from the Canadian Code of Ethics for Psychologists (2000) state that psychologists are to "provide suitable information about the results of assessments, evaluations, or research findings to the persons involved, if appropriate and if asked. This information would be communicated in understandable language." The code states elsewhere that psychologists are to "Protect the skills, knowledge, and interpretations of psychology from being misused, used incompetently, or made useless by others" (Section III.15; Section IV.11, Canadian Psychological Association, 2000). Arguably, the most effective way to fulfill these ethical and professional obligations is through providing TFB to clients in a way that renders results understandable, meaningful and useful for them.

Despite the ethical mandate to share test results with clients, survey research has demonstrated that psychologists do not provide TFB to clients consistently (Bennett-Levy, Klein-Boonschate, Batchelor, McCarter et al., 1994; Curry & Hanson, 2010; Smith, Wiggins &

Gorske, 2007). There is also strong, empirically supportive evidence to suggest clients experience considerable benefits as a result of receiving TFB (cf. Allen, Montgomery, Tubman, Frazier & Escovar, 2003; Newman & Greenway, 1997; Poston & Hanson; 2010). In light of these salutary effects, and of the ethical requirements to present results to clients, anything less than consistent and comprehensive TFB is both curious and concerning. Unfortunately, based on the existing research, some attention and perhaps concern is warranted. One possible explanation for the inconsistent provision of TFB is that some psychologists may not be fully aware of the relevant ethical standards and guidelines. Another is that psychologists may not be sufficiently trained to provide TFB, and some research and practice literature suggests that training is an important determinant of psychologists' TFB practices (cf. Curry & Hanson, 2010; Handler & Smith, 2013). Another potential explanation is psychologists perceiving a discrepancy between the 'client' and the test taker (e.g., forensic assessments, competency evaluations, insurance claims, etc.), in which case the recipient of TFB may not always be the individual presenting for assessment. It is imperative to understand whether or not Canadian psychologists are currently providing TFB to clients consistently, and ascertain how training programs are preparing them to do this, if at all.

The purpose of this sequential-explanatory mixed methods research (MMR) study was to examine the extent to which Canadian psychologists provide TFB to clients, and to determine whether or not training programs are effectively preparing them to do so. This purpose is expressed through the following four research questions (RQs). First, "to what extent do psychologists active in assessment deliver TFB to clients?" Second, "how does graduate and post-graduate training prepare psychologists to provide TFB?" Third, "what factors are associated with psychologists providing or not providing TFB? Finally, a fourth MMR question

–considered necessary for studies collecting and analyzing quantitative and qualitative data (Creswell & Plano Clark, 2011)– inquired, "how do the narrative experiences of practicing psychologists provide a better understanding of their TFB practice as indicated in the quantitative results, including how graduate and post-graduate training influenced them in this regard?"

This study is a replication and extension of a previous inquiry into the practice and training of American psychologists providing TFB that also utilized a sequential MMR design (Curry & Hanson, 2010). Through a national survey of clinical, counselling and school psychologists yielding a usable response rate of 48.5% (n = 468), Curry and Hanson (2010) found that 91.7% of respondents reported providing TFB to clients at least sometimes, 35% reported doing so all of the time, and 2.8% reported never providing TFB. Recently graduated clinical psychologists reported providing TFB to clients more consistently than clinical psychologsts who earned their degrees earlier, although no such trend was found among non-clinical (i.e., school and counselling) psychologists. Almost 1/3rd of respondents indicated pre-doctoral training was minimally helpful in learning to provide TFB, and finding pre-doctoral training helpful was not associated with actually providing TFB. However, finding post-doctoral training helpful was positively correlated with providing TFB. The primary method of learning indicated by respondents consistently providing TFB was through trial-and-error and the most common reason for not providing TFB was conducting assessments in forensic settings – acceptable practice according to ethical exemptions (cf. APA, 2002).

Aside from Curry and Hanson (2010) and a handful of other studies (cf. Bennett-Levy, Klein-Boonschate, Batchlor, McCarter et al., 1994; Smith, Wiggins & Gorske, 2007; Ward, 2008) questions concerning whether and how psychologists provide TFB have not been

explored empirically, and there are no known studies examining TFB practices among Canadian psychologists. Indeed, a number of studies attest to the prevalence of research on assessment-related activities, such as administration, interpretation, interviewing etc., while highlighting the paucity of studies explicitly examining the provision of TFB (Gas & Brown, 1992; Pope & Vetter, 1992; Smith, Wiggins & Gorske, 2007). Smith et al. (2007) emphasized the lack of research oriented around TFB with reference to Crosson (2000), who suggested the impact of psychological assessment is found in the interpretations and recommendations psychologists make based on the test results, rather than the results per se. This issue of test interpretation, which parallels TFB, pertains to how psychologists use assessment data in practice. Lichtenberg and Goodyear (1999) conceptualized test interpretation as a three-phase process in which the clinician (1) makes sense of the test results, (2) presents the test results, along with an interpretation of those results, to the client, and (3) aids the client in processing and integrating the presented information. For the purposes of the present study, TFB is conceptualized as the process of presenting test results, and an interpretation of those results, to the client in a manner that renders them understandable, meaningful and useful – this conceptualization is captured in steps 2 and 3 of Lichtenberg and Goodyear's (1999) model. A TFB exchange is often referred to as a 'debrief' or a 'case consultation'. Ideally, these sessions take place in person, but other means are often employed (e.g., telephone, online video conferencing, or written reports). Issues germane to the practice and training of Canadian psychologists providing clients with TFB are the primary foci of this study.

Significance of the Present Study

Administering, interpreting, and presenting results based on psychological tests constitutes a specialized professional activity unique to psychologists. However, very few

studies –none in Canada– have examined psychologists' TFB practices and training. Similarly, the extent to which training programs are preparing psychologists to provide TFB remain largely unexplored. In light of psychologists' ethical mandate to inform clients about test results, as well as the empirically established benefits TFB offers to the processes and outcomes of therapy, the primary objective of this study was to determine the extent to which Canadian psychologists provide TFB to clients, and to explore whether and how training programs are preparing them to do so. A second objective was to identify factors associated with Canadian psychologists providing/not providing TFB to clients. Such factors include specialization, level of education, years since graduation, specific assessment activities, employment settings, and the nature of clientele one works with in practice. These factors were selected in order to get a better sense of how diverse practice settings, training experiences etc. coincide with psychologists' TFB practice. These first two objectives were realized through a national survey of licensed Canadian psychologists.

In light of the many benefits TFB offers to the consumers of psychological testing, it is essential to understand if Canadian psychologists are using any sort of model to guide their TFB practices and, if they are providing TFB consistently, how they learned to do so. It is also important to understand the reasons why some Canadian psychologists might not be regularly offering TFB to clients, and thereby not meeting established ethical guidelines. As such, in the next section, the literature review focuses on two distinct areas. First, on the growing body of empirical literature attesting to the effectiveness of collaborative/therapeutic models of assessment, establishing their utility as frameworks that can guide and facilitate more effective TFB practice, training and research. Second, on the published empirical research conducted on providing clients with TFB to date.

Collaborative/Therapeutic Approaches to Psychological Assessment

Meyer et al. (2001), summarizing the principal uses of psychological assessment, contended assessments can be used to (a) describe clients' current functioning; (b) confirm, refute, or modify clinician's impressions; (c) identify therapeutic needs, highlight issues likely to emerge in treatment, recommend interventions, project likely outcomes; (d) aid differential diagnosis of emotional, behavioural, and cognitive disorders; (e) monitor treatment progress, evaluate intervention impact and identify emerging issues; (f) manage risk, minimize legal liability, and identify potentially deleterious treatment effects; and (g) provide skilled and empathic feedback as a therapeutic intervention in its own right. Mental health professionals have traditionally regarded psychological assessment as a means of gathering information about a client, with the intention of diagnosing disorders and planning treatment/interventions using a nomothetic approach, contrasting the presenting client with a larger group of individuals to which they can be meaningfully compared (Finn, Fischer & Handler, 2012). Many of the uses articulated by Meyer et al. (2001) are consistent with a traditional information gathering (IG) assessment paradigm, which is a useful and beneficial approach for clients and clinicians in many respects. According to the IG approach, the prevailing view among psychologists up until the midpoint of the 20th century was that test results were complex and threatening to clients (Groth-Marnat, 2003) and that very little, if any, FB should be provided as sharing test results was potentially "dangerous and harmful" (Klopfer, 1954, p. 603). However, around the same time, psychologists began exploring alternative approaches that involved the client in the assessment process to a much greater extent. For example, as early as 1945, therapists began encouraging clients to interpret their own projections based on administrations of the Rorschach or Thematic Apperception Test (Murray, 1943), yielding a number of therapeutic benefits such

as increased insight (cf. Jacques, 1945; Luborsky, 1953). In a similar way, Harrower (1956) argued that clients should be encouraged to discuss their own Rorschach projections together with their therapist in her projective counselling method, which also had a positive impact on the clients' treatment progress. More recently, several collaborative assessment models have emerged and evolved that are perhaps best referred to collectively as Collaborative/Therapeutic Assessment (C/TA). These models suggest, in contrast with the IG paradigm, that psychological assessment can be a relational and therapeutic exchange that promotes clients' self-verification, self-enhancement, and self-efficacy (Finn & Tonsager, 1997).

Collaborative Individualized Assessment. Collaborative Individualized Assessment (CIA) is a model of assessment that was pioneered by Constance Fischer (cf. Fischer, 1978, 2000). The approach is rooted in phenomenological psychology, and values client-clinician collaboration (i.e., "co-laboring") throughout the assessment process in an effort to promote individualized assessments, emphasizing ecological validity from the clients' perspective. In contrast with traditional IG approaches that tend to objectify clients, CIA regards collaboration as therapeutic in its own right. Fischer (2000), articulating the major tenets of her model, described CIA as an approach that (1) values collaboration with clients, treating them as active agents; (2) contextualizes and situates the assessment and results into the lived world of the client; (3) intervenes through facilitating new ways of thinking and being; (4) describes the client and their challenges in detail, using their own words whenever possible; (5) respects complexity, holism, ambiguity and individuality as opposed to relying on reductionist approaches or normative comparison. "The goal is understanding rather than explanation" (Fischer, 2000, p. 6).

Therapeutic Assessment. Therapeutic Assessment (TA) is an empirically based assessment model developed by Stephen Finn (cf. Finn, 1996; Finn & Tonsager, 1992, 1997), who continues to refine and advance this approach with his colleagues at the Center for Therapeutic Assessment in Austin, Texas. According to its founders, TA is "a semi-structured from of collaborative assessment that uses psychological testing as the centerpiece of a brief therapy" (Finn & Tonsager, 2002, p. 10). This collaborative and humanistic approach began when Finn became interested in using assessment as a brief therapeutic intervention, initially by exploring the therapeutic utility of TFB. Through continued collaboration with other researchers and clinicians, incorporating aspects of self-verification theory (Swann, 1997) and CIA (Fischer, 1978), Finn articulated a useful and flexible model that could be readily taught to clinicians and graduate students to capitalize on the many benefits that TA research began to demonstrate. In the TA model, the clinician operates as a therapeutic agent, and change is fostered through collaboratively enhancing the clients' understanding of themselves (Finn & Tonsager, 1997). Critical aspects of TA include (1) helping clients to generate personally relevant questions they would like addressed through the assessment, (2) collecting relevant background information pertaining to the clients' questions, (3) exploring past testing-related hurts, (4) involving clients as active agents throughout the assessment process, including collaboratively discussing test results in order to address their initial questions (Finn, 1996, 2007). A more detailed description of the TA process is provided elsewhere (cf. Finn, 1996).

Early research suggested that clients experience a therapeutic benefit simply through the clinician sharing their test results with them (Finn & Tonsager, 1992). Other researchers soon replicated these results, leading them to conclude that TFB should be given to all recipients of psychological assessments (Newman & Greenway, 1997). Since these initial studies, empirical

research has demonstrated that TA offers a substantive benefit to the outcomes and processes of therapy, including decreased client symptomatology, improved treatment alliance, heightened compliance with treatment recommendations, enhanced self-esteem and increased levels of hope, with global composite effect sizes (Cohen's *d*) hovering around .40 (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hanson, Claiborn, & Kerr, 1997; Hilsenroth, Peters & Ackerman, 2004; Meyer, et al., 2001; Ougrin, Zundel, Ng, Habel, et al., 2013; Poston & Hanson, 2010).

The developers of TA have suggested that the term therapeutic assessment (ta) be used to refer to all other approaches that seek to positively impact clients using psychological assessments, but do not utilize the TA model articulated by Finn, and may not use collaborative methods beyond providing TFB to clients (Finn, 2007). These approaches all differ substantially from the traditional IG model, and are similar to one another in many respects, with each of them emphasizing "(a) developing and maintaining empathic connections with the client, (b) working collaboratively with clients to define individualized assessment goals, and (c) sharing and exploring assessment results with clients" (Finn & Tonsager, 1997, p. 378). Examples of other collaborative approaches include the Therapeutic Model of Assessment (Hilensroth & Cromer, 2007), Collaborative Therapeutic Neuropsychological Assessment (Gorske & Smith, 2008) and several other clinicians who refer to their work as Collaborative Assessment (Purves, 2002; Engleman & Frankel, 2002). Although all of these approaches focus on reducing the power imbalance between client and clinician, the founders of CIA and TA have suggested "it might be useful to say that collaborative assessors place more emphasis on understanding than on transformation, whereas those calling their approach Therapeutic Assessment or therapeutic assessment appear to prioritize client change" (Finn, Fischer & Handler, 2012, p. 10).

Collaborative/Therapeutic Assessment. Collaborative/Therapeutic Assessment (C/TA) is best understood as a streamlining of the leading collaborative approaches to assessment (i.e., CIA and TA). This amalgam is based on the high level of agreement and congruence that exists between these approaches. Of their shared features, respect for clients is paramount, and respect is expressed in a number of specific activities that include obtaining assessment-specific consent, relating to clients as experts on themselves, involving/valuing clients' as active collaborators, working together to find novel solutions to typical problems, providing comprehensive TFB, and acknowledging the clients' contribution in all documentation (Finn et al., 2012). They also have many shared values and perspectives, including (a) a relational conceptualization of assessment, (b) valuing compassion and curiosity over judgment and classification, (c) a genuine desire to help clients directly through the assessment, (d) a unique perspective on tests (i.e., viewing tests as "empathy magnifiers", Finn, 2007), and (e) maintaining flexibility in the application of the C/TA model (Finn et al., 2012).

According to its founders, C/TA represents "a major paradigm shift in how assessment is typically viewed" (Finn & Tonsager, 1992, p. 286), in that the underlying intent is therapeutic as opposed to diagnostic. By virtue of its collaborative nature and humanistic theoretical basis, the C/TA model is well suited to counselling contexts, but need not be limited to those settings. In fact, proponents suggest the C/TA and IG paradigms are not mutually exclusive, but complementary (Finn & Tonsager, 1997, 2002). In light of the ethical requirement that psychologists share test results with clients, and given its theoretical and empirical basis, C/TA is a highly useful model for TFB across the diverse contexts in which psychological assessments are used, including with children, adolescents, and families (cf. Tharinger., Finn, Gentry, Hamilton, et al., 2009). Moreover, because C/TA intentionally focuses on the clinician-client

relationship, it is able to capitalize on the benefits of the working alliance, which has been shown by extensive research to be one of the best predictors of psychotherapy treatment outcome (Orlinsky, Ronnestad, & Willutski, 2004). Curry and Hanson (2010) highlighted that correctly administered TA leaves the client feeling better, promotes client engagement in the assessment process, and meets the ethical requirements to share test results with clients. As such, TFB delivered in a manner consistent with the C/TA model is very likely to be understandable, meaningful and useful to the client, thus fully embodying ethical practice.

Assessment and Test Feedback Training

Based on a review of the psychological assessment research literature published between 1960 and 1990, Watkins (1991) made 14 conclusions substantiating the continued use of assessments in clinical practice, and underscoring the importance of promoting assessment competence in graduate training programs. However, not all subfields or specializations within psychology (clinical, counselling, school, neuropsychology, etc.) view assessment in the same way, nor are graduates from these programs necessarily on equal footing in terms of competence. For example, the use of psychological assessment in counselling settings has historically been an issue of some debate. Goldman (1972) argued that counsellors often lack the requisite training in test administration, scoring and interpretation to provide useful FB beyond that required for classification, even referring to the assessment-counselling relationship as “the marriage that failed”. Other research has demonstrated that assessment training in graduate programs in general is often deficient relative to the expectations that are placed on clinicians in internship and employment settings (Clemence & Handler, 2001; Krishnamurthy, VandeCreek, Kaslow, Tazeau et al., 2004; May & Scott, 1991; Stedman, Hatch, & Schoenfeld, 2000). While it has been argued that inadequately trained psychologists should be limited in the

degree to which they perform assessments until they can demonstrate measurement competency (Goldman, 1972; Prediger, 1994), Hohenshil (1996) emphasized the pragmatic reality that counselling psychologists are required by employers, licensing bodies, and insurance providers to formally diagnose developmental problems and mental disorders as part of their practice, despite what may be insufficient training.

On the other hand, researchers also suggest that assessment competency must extend beyond the realm of psychometrics, measurement, administration and interpretation to include an explicit focus on TFB (e.g., Curry & Hanson, 2010; Poston & Hanson, 2010). Handler and Smith (2013) asserted that students of psychological assessment have more difficulty learning to provide TFB to clients than they do with any other aspect, emphasizing the importance of learning these skills through a combination of coursework and supervised practice. Dana (1985) also alluded to the importance of TFB training, highlighting the tendency for clinician's to deliver incomplete FB as a consequence of not considering (1) their motivation for providing it, (2) the clients' ability to access resources and utilize TFB, and (3) the absence of established criteria for determining what is/is not adequate TFB. He asserted that considering the impact of each of these factors, including interaction among them, promotes feedback coherence making it more comprehensible, meaningful and manageable for the client (Dana, 1985). Brenner (2003) argued that building relationships, collaborating with clients, and providing ongoing FB are fundamentally important to the validity of any assessment. He identified 5 research-based responses to enhance the relevance of assessment: (1) Eliminate jargon, (2) focus on referral questions, (3) individualize reports, (4) emphasize client strengths, and (5) include concrete recommendations. Interestingly, all of these recommendations pertain directly to TFB, and making progress in these areas denotes a crucial role for training programs in equipping future

practitioners. Although counselling programs may have ample room for improvement in terms of instilling measurement competency, they arguably have much to offer in exemplifying TFB competence. By utilizing collaborative assessment models to advance TFB practice, training and research, counselling psychologists have an opportunity to carve out a unique and critical role among assessment professionals.

Curry and Hanson (2010) made a number of research-based recommendations for graduate students learning psychological assessment, arguing for an increased focus on TFB competence. First, they recommended that relevant ethical principles and codes be highlighted throughout the training process to promote familiarity with appropriate standards and guidelines. Second, they recommended that educators familiarize themselves with the published literature and research-based models that can facilitate more effective TFB practice, training and research. Third, that graduate students learn to provide TFB in a variety of ways including modeling, role-playing, and in vivo debriefing sessions, emphasizing the need for students to get hands-on experience providing TFB and to receive immediate FB from professors and supervisors in this area. Fourth, that students be made aware of psychologists' tendency to feel apprehensive about delivering undesirable TFB (i.e., 'breaking bad news'), arguing that trainees should instead understand the capacity of TFB to realize numerous therapeutic benefits in those cases (cf. Merker, Hanson, & Poston, 2010). Finally, that various national councils, task forces, researchers, and educators regard TFB as an integral assessment competency in its own right.

Curry and Hanson's (2010) study has received four Social Science Citation Index (SSCI) citations and 10 Google Scholar citations since publication four years ago. One of the SSCI studies examined offenders' perceptions of risk factors increasing the likelihood of future offending (Holliday, King, & Heilbrun, 2013); another focused on the clinical case applications

of personality assessments (Smith, Erard & Handler, 2013), and a third on the effects of delivering written versus verbal neuropsychological TFB (Fallows & Hilsabeck, 2013). One of the meta-analyses regarding the effects of PATI (Hanson & Poston, 2011) was a self-citation. While these citations are encouraging, the absence of extensive activity in the research community suggests these recommendations have, thus far, gone largely unnoticed. However, the extent to which educators and trainees are embracing these or similar recommendations remains to be seen.

Review of Research on Test Feedback and Collaborative/Therapeutic Assessment

Here, for this study, the PsychINFO database was searched using the terms "feedback and psychological assessment". The search was de-limited to include only peer reviewed journal articles published in the English language, using human subjects between 1980 and the present. The rationale for reviewing relatively recent studies was based on the C/TA model not becoming widely known or practiced until the mid 1990s, and the desire to include enough literature to provide sufficient historical context while focusing on the most relevant publications. Single participant case studies, conference presentations, and unpublished theses or dissertations were not included. The search produced a total of 83 results. Of these 83 articles, 25 were empirical studies focusing on clinician's TFB practices; the rest were either unrelated (e.g., focusing on TFB for clinicians, scale development/validation, etc.), theoretical in nature, or could not be located. In addition to the PsychINFO literature search, a number of outcome and process studies that examined the treatment efficacy and clinical utility of TFB were also included, most of which utilized the C/TA model. All told, this review consisted of 30 studies, (four survey studies, 20 outcome studies – organized according to dependent variables– and six process studies).

Overview of Collaborative/Therapeutic Assessment Research. To date, research has provided strong, empirically supportive evidence that the C/TA model offers many benefits to the processes and outcomes of assessment and treatment. Positive effects for adults, children, adolescents and couples presenting with a variety of problems have been demonstrated with both outpatient and inpatient populations. These include decreased client symptomatology, improved treatment alliance, heightened compliance with treatment recommendations, enhanced self-esteem and increased levels of hope, with global composite effect sizes hovering around .40 (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Hanson, Claiborn, & Kerr, 1997; Hilsenroth, Peters & Ackerman, 2004; Meyer, et al, 2001; Ougrin, Zundel, Ng, Habel, et al., 2013; Poston & Hanson, 2010). However, there are a number of limitations to this accumulating research. First, a sizable proportion of the C/TA publications are theoretical in nature, articulating the development or philosophical foundations of the model (cf. Finn & Tonsager, 2002), or arguing for the applicability of C/TA to a particular population or context (cf. Theringer, Finn, Hersh, Wilkinson, et al., 2008). Second, much of the empirical research on the C/TA model is made up of clinical/case studies or narratives (cf. Hamilton, Fowler, Hersh, Austin, et al., 2009; Wygant & Flemming, 2008). Although designs of this nature serve to illustrate different applications of the C/TA model, they are extremely limited in their ability to establish treatment effects, effect sizes, or generalizability beyond their particular context. Third, the existing outcome research uses relatively small sample sizes, very few studies have been replicated, and follow-up, when present, is typically sort-term. Fourth, much of the outcome research involves treatment components that are not unique to C/TA and might be better explained by different change mechanisms or processes (e.g., common factors; cf. Wampold, 2001), limiting the extent to which the therapeutic effects of C/TA can be directly attributed to it (Lilienfeld et al, 2011).

What is lacking are well-designed experimental studies that control for potential confounds as well as dismantling studies that tease apart the unique contributions and active components of C/TA corresponding to its improved outcomes.

Survey research thus far has examined the prevalence of psychologists providing TFB to clients, among other professional activities. Quantitative designs using descriptive statistics predominate, although one study utilized a MMR design. Half of the studies employed random sampling, and the other, census-sampling strategies. Interestingly, three of the four survey studies inquired with psychologists with just one surveying clients who recently completed a neuropsychological assessment. Broadly speaking, the results indicate the majority of psychologists favor the provision of TFB to clients, and most report doing so in some form. However, the results also suggest that TFB is not provided consistently, identifying ample room for improvement in this area. A common strength of the existing studies is that they underscore the importance of providing TFB to clients and identify important factors involved in this activity (e.g., clinicians' training, practice setting, level of experience). However, these studies offer little in terms of establishing how clients benefit from receiving TFB, and how those benefits might be enhanced.

The 20 outcome studies reviewed focus on the effects of clients receiving TFB on the outcomes of therapy/treatment. Typical RQs are as follows: "What effect does a collaborative assessment approach, including TFB, have on client symptomatology, treatment alliance, compliance with treatment recommendations, self-esteem?" Quantitative studies using experimental and quasi-experimental designs predominate; the majority use convenience-samples composed of community-based adult outpatients or undergraduate students. In general, these studies demonstrate that clients experience tangible benefits as a result of TFB, with

average effect sizes falling in the small to medium range. The primary strength of this body or research is the experimental designs employed suggest a causal relationship between receiving TFB and improved treatment outcomes. However, outcomes in these studies largely rely on self-report measures, making demand characteristics a legitimate threat to internal validity (cf. Nichols & Maner, 2008). The frequently utilized repeated measures design is also prone to a number of threats to internal validity (i.e., history, maturation, testing effects; Shadish, Cook, & Campbell, 2002) that are often insufficiently addressed or discussed. The most notable weakness of these studies, however, is they fail to identify specific therapeutic components (i.e., the 'active ingredients') of C/TA and TFB that account for its beneficial effects.

The six process studies reviewed focus on specific TFB activities taking place during the assessment, most of which involve making a connection between a specific activity (e.g., providing written versus verbal TFB) and a particular outcome (e.g., clients' ratings of session impact). Typical RQs focus on specific processes such as delivery format or style. For example, "What impact does a personable versus detached/factual interpretation style in a TFB session have on participants' perception of their test results?" One qualitative study explored the processes underlying significant TFB events from both the clients' and the clinician's perspective; however, experimental and quasi-experimental quantitative designs predominate. The majority of studies are conducted on adult outpatient populations and undergraduate students, typically using convenience-sampling strategies with existing clients presenting for treatment at community or university-based mental health clinics. The primary strength of these studies is they identify specific processes that are significant for clients in terms of them deriving benefits from TFB, providing important clues regarding its curative mechanisms. A common weakness of these studies is they often use existing convenience samples, as opposed

to random samples from target populations. As a result, the extent to which the results from these studies can be generalized beyond these samples (i.e., to those who do not present for treatment, and who may be less motivated to improve) remains unknown, qualitative studies notwithstanding.

Survey Research

In one of the first published survey studies, Berndt (1983) examined professional and ethical issues relevant to psychologists providing TFB through a national survey. A random sample of 100 members of the Society for Personality Assessment received a brief survey by mail, resulting in a useable return rate of 72% (n = 72). Results indicated the majority of respondents reported regularly providing TFB to clients on both objective and projective personality tests. However, the extent of the FB delivered depended on the clients' personal and cognitive strengths, the type of instrument used, the purpose of the assessment, and several clinician factors (i.e., perceived role, temperament, habit). This study highlighted the general willingness and tendency of psychologists to provide TFB to clients to some extent and in some form, and identified a number of factors that appear to have a bearing on psychologists' TFB practices. However, it also indicated ample room for growth in the profession in meeting established ethical guidelines.

Bennett-Levy, Klein-Boonschate, Batchlor, McCarter et al. (1994) explored the experiences of clients' recently completing a neuropsychological assessment. In this study, the authors used a census sampling technique, mailing questionnaires to 253 clients who had been assessed at one of five Australian outpatient clinics during the previous six months. The survey yielded a useable response rate of 51% (n = 129). Measures included respondents' global evaluation of their assessment experience, their affective experience, level of confidence, and

the impact of the assessment on how they viewed their abilities and their future. The results indicated only 68% of respondents received in-person TFB, and 67% (98.5% of those receiving TFB) identified in-person FB as helpful. Only 26% of respondents indicated receiving written TFB, and 59% indicated they would have benefited from more FB. Respondents identified the overall experience of the assessment as either positive (56%) or neutral (35%); 47% felt 'about the same' following the assessment, while 36% reported feeling better than when they came. Sixty percent of respondents reported experiencing similar levels of confidence following the assessment than prior to it, while 28% indicated feeling more confident. Finally, almost half of respondents (47%) reported viewing their abilities differently, and 44% indicated viewing their futures differently following the assessment. Factors shown to impact clients' assessment experience included, (1) the clients' expectations of the assessment, (2) whether or not the clinician prepared the client, (3) the perceived relevance of the assessment, (4) the length of test administration, and (5) whether or not they were given understandable TFB. Most importantly, over a third of respondents reported not receiving TFB, and a clear majority indicated they would have benefited from more extensive FB.

Smith, Wiggins and Gorske (2007) conducted a survey of psychologists in the U.S. who regularly conduct neuropsychology and personality assessments to determine how consistently clinicians provide TFB to clients. The authors randomly sampled potential respondents from three professional rosters, and recruitment efforts yielded a usable response rate of 22% (n = 719). The results indicated that the majority of respondents (71%) frequently provide in-person TFB to clients, and that most clinicians (72%) perceive that clients experience TFB as 'positive and helpful'. Interestingly, more experienced psychologists were more likely to approach the assessment in a collaborative manner than their less experienced colleagues. Psychologists who

conduct personality assessments were also more likely to include the client in interpreting the test results than those conducting neuropsychological assessments, which the authors attributed partially to the nature of personality assessments and partially to the influence of C/TA theory and research on TFB practices, citing Finn and Tonsager (1997) and Fischer (2000). This study also provides support for the general tendency of psychologists to present TFB to clients to some extent. It also suggests that psychologists' level of experience and the type of instruments used may have an impact on their TFB practices.

Curry and Hanson (2010) examined the practice and training of providing clients with TFB among American psychologists. Utilizing a sequential explanatory MMR design, the authors sought to shed light on psychologists' provision of TFB to clients, highlighting typically unexplored aspects of assessment such as the clients' level of involvement in the assessment process and the degree to which training programs prepare psychologists to provide TFB. Through a national survey of clinical, counselling and school psychologists using a random sampling strategy yielding a usable response rate of 48.5% (n = 468), Curry and Hanson (2010) found that 91.7% of respondents reported providing TFB to clients at least sometimes, 35% reported doing so all of the time, and 2.8% reported never providing TFB. Recently graduated clinical psychologists were more likely to report providing TFB than those who earned their degrees earlier, although this difference was not observed in non-clinical psychologists. Almost a third of respondents indicated that pre-doctoral training was minimally helpful in learning to provide TFB, and finding pre-doctoral training helpful was not associated with actually providing TFB. However, the perceived helpfulness of post-doctoral training positively correlated with providing TFB. The primary method of learning indicated by respondents who provide TFB was trial-and-error and the most common reason for not providing TFB was

conducting assessments in forensic settings, in keeping with ethical exemptions (cf. APA, 2002). These results highlight the common, though inconsistent practice of providing TFB to clients, suggesting that training and the context in which assessments are conducted are important factors in TFB practice.

Outcome Research

Meta-Analysis of Psychological Assessment as a Therapeutic Intervention. Poston and Hanson (2010) conducted a meta-analysis of 17 published empirical studies examining Psychological Assessment as a Therapeutic Intervention (PATI). The authors computed 70 effect sizes involving 1496 participants, yielding a global composite effect size falling in the medium range (d = 0.423), with 66% of treatment group means falling above those of control and comparison groups. These results suggest that psychological assessment, coupled with personally relevant and collaborative TFB, has a significant and sizable impact on the outcomes and processes of treatment. In response, Lilienfeld, Garb and Wood (2011), argued that Poston and Hanson (2010) might have overestimated the beneficial effects of PATI, claiming that a number of questions remained unaddressed. Specifically, Lilienfeld et al. (2011) argued that, because the analyses included studies involving treatment components besides those prescribed by PATI, improved outcomes could not be directly attributed to it. They also raised the possibility that clients receiving PATI may improve as a result of the Forer, or better-known Barnum, effect (cf. Meehl, 1956), and pointed out that a number of studies yielding nonsignificant results were excluded from the analysis. In response, Hanson and Poston (2011) published another meta-analysis that incorporated the suggestions made by Lilienfeld et al. (2011), re-analyzing the data from the original study. They computed 71 effect sizes, yielding a global effect size of d = .403, thereby substantiating their original results and the overall

efficacy of PATI. They also offered a number of alternative explanations that might account for the beneficial effects of PATI other than the Barnum effect (i.e., social influence, common factors, and self-psychology). Finally, Hanson and Poston (2011) emphasized the need for further collaborative study, involving proponents and critics alike, to identify the specific change mechanisms of PATI.

Symptomatology, Self-Esteem and Hope. Several studies have examined the effect of C/TA on client symptomatology, self-esteem and hope with adult outpatient populations. Finn and Tonsager (1992) used a 2 (group) X 3 (time) repeated measures experimental design to examine the benefits of providing verbal TFB to clients based on the results of an objective personality assessment (*MMPI-2*). Participants (n = 61) were selected from a treatment waitlist at a university counselling center and randomly assigned to either the treatment or control condition. Treatment and control groups did not differ systematically with respect to age, sex, or elapsed time since treatment, and demonstrated pre-treatment equivalency on all outcome variables. The authors manipulated the presence of verbal collaborative TFB, as articulated by Fisher (1985), based on clients' *MMPI-2* results. The treatment group (n = 32) evidenced significantly higher levels of hope and increased self-esteem, as well as decreased symptomatic distress following treatment relative to controls (n = 29) with an overall effect size in the large range (Cohen's d = 0.85). Interestingly, the treatment group indicated even lower levels of distress and higher levels of self-esteem at 2-weeks follow-up than immediately after TFB, suggesting an increase in the benefits of TFB over time. While there are a number of methodological problems with this study (e.g., controls did not complete an *MMPI-2*; specific TFB components accounting for improvements in the treatment group were not identified), it

provided some evidence that psychological testing can be a therapeutic intervention in its own right.

Newman and Greenway (1997) sought to replicate the results of Finn and Tonsager (1992). Accordingly, the authors also used a 2 (group) X 3 (time) repeated measures experimental design to examine the benefits of providing TFB to clients based on *MMPI-2* results. Participants (n = 60) were selected from a treatment waitlist at a university-counselling center, and randomly assigned to one of 2 conditions. The authors manipulated the presence of collaborative, empathetic TFB. As hypothesized, the treatment group evidenced higher levels of hope and increased self-esteem, as well as decreased symptomatic distress following treatment relative to controls, with an overall effect size in the small range (d = 0.35). Specifically, clients in the treatment group reported a significant increase in self-esteem immediately following the FB session, and a further increase at 2-weeks follow-up. The treatment group also indicated significant declines in symptomatic distress between the FB session and follow-up. While Finn and Tonsager (1992) found that clients identifying the assessment process as a positive experience evidenced more substantial changes on outcome variables, Newman and Greenway (1997) did not find that client satisfaction was associated with decreased distress or improved self-esteem. They also found that changes in outcome variables were not related to the clients' level of private self-consciousness, type or extent of psychopathology, or their attitude toward mental health professionals. As in the original study, Newman and Greenway (1997) were not able to identify specific therapeutic components of providing TFB to clients. However, they did make a number of methodological improvements (most notably, both treatment and control groups completed an *MMPI-2*), and provide further support for the therapeutic value of sharing test results with clients. It also suggested that the clients' ability to benefit from TFB may not be

impacted to a great extent by a number of factors previously regarded as influential (e.g., psychopathology; attitude toward clinician), resulting in the conclusion that "feedback should be offered to all clients" (p. 129).

An experimental study by Allen, Montgomery, Tubman, Frazier and Escovar (2003), examined the effects of TFB on rapport and self-enhancement. Participants were a convenience sample of undergraduate university students (n = 83) who completed an inventory of personality styles. Those in the treatment group receiving personalized TFB after completing the measure evaluated both the examiner and the FB session more positively than those who received generic FB about the inventory. Participants in the treatment group also evidenced significantly higher scores on measures of self-verification, self-esteem, and self-discovery/understanding than those who received generic FB, with an overall effect size in the large range (d = 0.85). These results suggest that rapport may be a necessary precursor to the working alliance and that the therapeutic utility of the C/TA model may be, at least in part, a result of its capacity to establish rapport and enhance clients' self-image.

A clinical effectiveness study by Holm-Denoma, Gordon, Donohue, Waesche et al., (2008) examined clients' emotional response to TFB that involved communicating a diagnosis. Using a within-subjects design with a sample of community-based adult outpatients (n = 53), the researchers measured clients' mood and attitude toward therapy at five points during the assessment process. Clients' emotional response and attitude were measured using the Global Assessment of Functioning (GAF) and the positive and negative Visual Analogue Scale (VAS). Clients evidenced significant increases in positive emotions, including hope and validation as they progressed through treatment, and particularly following the TFB session (F = 6.28, p < .001). While clients evidenced a significant decrease in negative emotion (i.e., fear and shame)

over time, substantial decreases were not observed following the TFB session ($F = 2.64$, $p > .05$). These results suggest that diagnostic TFB communicated in a therapeutic way can elevate positive emotions in clients, and that diagnostic FB does not necessarily increase negative emotion. If delivered in the context of a supportive and collaborative assessment, diagnostic TFB may actually increase positive emotion in clients.

Compliance with Treatment Recommendations. Ackerman, Hilsenroth, Baity, and Blagys (2000), studied the impact of the clinician's approach to assessment on clients' in-session processes, including their wiliness to comply with treatment recommendations. The authors used a community-based sample of adult outpatients with a range of *DSM-IV* diagnoses seeking treatment at a university-based outpatient mental health clinic. They found that participants in the treatment condition ($n = 38$) receiving an assessment consistent with the C/TA model were significantly more likely to complete the assessment and engage in subsequent treatment relative to controls ($n = 90$) who completed an assessment conducted according to the IG approach, with an overall effect size falling in the small to medium range ($d = 0.42$). The clinician-client relationships that developed during assessment were associated with positive working alliances in subsequent therapy and participants in the treatment group were more likely to follow through with treatment recommendations. These results indicate that TFB delivered according to the C/TA model can establish the foundation for a solid working alliance, which has been shown to be a key predictor of psychotherapy outcome (cf. Orlinsky, Ronnestad, & Willutski, 2004).

Ougrin, Ng, Low, and Zundel (2008) conducted a pilot study examining the impacts of C/TA on self-harming adolescents complying with treatment recommendations. Using a quasi-experimental design, the authors assigned participants ($n = 38$) to either the treatment group ($n =$

19), receiving a psychosocial assessment according to the C/TA model, or the control group (n = 19) receiving assessment as usual (AAU). The study was conducted over a period of five months with all eligible adolescents receiving one form of assessment only. Participants were outpatient adolescents referred to one of two inner-city London (UK) hospitals for a variety of self-harm behaviours. The groups were matched to control for the effects of demographic variables, and demonstrated satisfactory pre-treatment equivalence. Seven mental health professionals received 10 hours of training in TA, along with continued evaluation and supervision. Three of these clinicians implemented the TA model on all eligible referrals (i.e., self-harming adolescents) while the remaining clinicians continued with AAU. Assessment of all participants involved a standard psychosocial history and risk assessment, while the treatment group received an added TA component (written TFB). The results indicated that those in the treatment group were significantly more likely to attend the first follow-up appointment after the assessment ($X^2 = 3.89$, $p < 0.05$), and to engage in subsequent treatment ($X^2 = 4.49$, $p < 0.05$). These results provide some evidence that C/TA is an effective means of improving treatment compliance among self-harming adolescents, and that it may be an efficacious brief intervention in risk assessment situations in its own right.

Therapeutic Alliance in Subsequent Psychotherapy. Hilsenroth, Peters and Ackerman (2004) examined the relationship between the therapeutic alliance formed during psychological assessment using the C/TA model on the working alliance in later psychotherapy. The study involved diverse adult outpatient clients (n = 42) presenting for treatment at a university-based community outpatient clinic, all of who had at least one *DSM-IV*, Axis I diagnosis. Using established and validated rating scales, the authors measured the working alliance from the perspective of both clients and clinicians at the conclusion of the TFB session, and again in the

early and later stages of subsequent psychotherapy. Working alliance ratings following the assessment were consistent with ratings in subsequent psychotherapy, and were significantly higher than controls participating in an assessment using an IG approach, with an overall effect size in the large range (d = 1.02) These results indicate assessment involving collaborative, personally relevant TFB promotes the formation of client-clinician bonds, setting the stage for effective treatment.

Suicide Attempts and Days in Hospital. Jobes, Wong, Conrad, Drozd, et al. (2005) conducted archival research to determine the effectiveness of a collaborative model for assessing suicidality. The collaborative assessment and management of suicidality (CAMS) is a clinical model that was developed by the authors for identifying, assessing and managing suicidal outpatients – one that emphasizes a collaborative/interactive approach to suicidal risk assessment (RA) intentionally designed to establish and enhance the therapeutic alliance, and move away from more directive models. Participants in this study were individuals receiving care at two U.S. Air Force medical group outpatient facilities. The authors retrospectively examined two distinct groups of client-clinician dyads, both of which were receiving CBT for a mood disorder and/or adjustment disorder with a mood component. As such, the CAMS model was employed at only one of these facilities. The groups showed no systematic differences on demographic variables, and demonstrated satisfactory pre-treatment equivalence. The results showed a significant effect for participants in the treatment group (receiving CAMS; n = 25) to resolve their struggles with suicidal ideation more readily (i.e., an average of four fewer sessions) than those in the treatment-as-usual control group (n = 30) with an overall effect size in the medium to large range (d = 0.68). Those in the treatment group also utilized significantly less health care resources in the six-month period following the onset of treatment for suicidality

with an effect size in the medium range ($d = 0.47$). The results of this study suggest that a collaborative approach to suicide RA has a substantive benefit for clients, both in terms of treatment response and reduced demand on healthcare resources.

In a similar way, Vandecreek (2009) argued for the importance of providing clients with TFB regarding difficult issues such as suicide. Drawing on the work of Tharinger, Finn, Hersh, Wilkinson, et al. (2008), in which clients receiving candid TFB in the context of a supportive and collaborative relationship were more open to developing 'a new life story', Vandecreek (2009) argued that similar principles apply to discussing suicidal ideation with clients. Interestingly, Merker, Hanson and Poston (2010) conducted a survey study of licensed psychologists in the U.S. regarding their practice and training of 'breaking bad news' (i.e., providing undesirable or 'negative' TFB) to clients. The results showed that, although the majority of psychologists reported breaking bad news to some extent, they indicated being much more reluctant to break bad news than good news, and psychologists' own level of anxiety was identified as the biggest factor in their reluctance. Taken together, these studies underscore the capacity of C/TA approaches to enable psychologists to provide hard-to-hear TFB in an effective and empathic manner.

Improved Treatment Response for Personality Disorder. Morey, Lowmaster and Hopwood (2010) examined the effects of a manualized cognitive therapy intervention with a C/TA augmentation for borderline personality disorder (BPD) with suicidal ideation in a community-based adult outpatient population. Using a within-subjects repeated measures design, the authors randomly assigned the participants ($n = 16$) to the treatment and control groups, with both groups receiving the manualized intervention, and the treatment group receiving an additional C/TA augmentation based on Finn's (2007) TA model. Both groups

demonstrated pre-treatment equivalence and did not differ systematically on any demographic variables. Although there was considerable attrition, with only 7 participants completing the intervention, the results indicated all participants completing the intervention saw substantial improvement in borderline features from pre to post-test with a large effect size (d = 1.07), as well as improvement in self-harm with an effect size in the medium range (d = 0.48). While the treatment group did not show lower attrition rates, they did demonstrate better treatment response, and a larger improvement over time relative to controls. Though attrition rates pose a serious problem to the generalizability of this study, the results provide some preliminary evidence that C/TA may be a helpful adjunct to improve established treatments for severe personality disturbance.

Distress, Self-esteem, Emotional Reactivity. Aldea, Rice, Gormley and Rojas (2010) conducted a randomized controlled clinical trial on the effects of university students receiving TFB regarding maladaptive perfectionism. Participants were university students (n = 60) self-identifying as maladaptive perfectionists through a prescreening procedure. The researchers randomly assigned participants to either the treatment (TFB) or control (no TFB) condition. Groups did not differ systematically on demographic variables and demonstrated satisfactory pre-treatment equivalence. Clinicians were 'blind' regarding which condition participants were assigned to until immediately before the FB session, although they conducted interviews with participants in both groups. The treatment group evidenced significant reductions in emotional reactivity and symptomatic distress relative to controls, suggesting personalized TBF delivered according to the C/TA model positively impacts maladaptive perfectionism and a number of its associated features.

Public Binge Drinking Rates. Wild, Cunningham and Roberts (2007) examined the impact of providing brief personalized assessment FB on rates of binge drinking. In this community-based randomized control trial, participants interested in receiving self-help materials (n = 1727) were randomly assigned to either the treatment group (n = 877), receiving personalized assessment FB by mail regarding normative drinking rates in the general public, or the delayed-treatment control group (n = 850), receiving the intervention at a later point in time. Using the Alcohol Use Disorders Identification Test as well as frequency and quantity of alcohol consumption as dependent measures, participants completed both pre and post-intervention batteries. The results indicated problem drinkers in the treatment group reported a 10.1% reduction in binge drinking at six-months follow up, producing an overall effect size in the small range (d = 0.21). No change in binge drinking was reported among problem drinkers in the control group, and no differences between pre and post-assessment were observed in non-problem drinkers in either condition. These results suggest that brief personalized FB can positively impact rates of binge drinking among problem drinkers who often do not present for treatment or assessment. Interventions such as this may be effective community-based public health initiatives.

Child Symptomatology and Family Relations. Tharinger, Finn, Gentry, Hamilton et al., (2009) conducted a pilot study on the treatment efficacy of TA with children and their families. The authors utilized a repeated measures case studies design to determine the impact of TA for children. Participants were dyads of clinically referred children presenting with a variety of emotional and behavioural problems and their mothers (n = 14 dyads). Prior to the intervention, mothers and children completed separate batteries that included behavioural, family functioning, client satisfaction, and parental emotion measures. The intervention

consisted of approximately 12 hours of C/TA delivered over the course of 8 sessions by advanced graduate students according to an established protocol, although some flexibility in administration was permitted. The intervention involved ongoing assessment using a variety of behavioural, cognitive, projective and objective personality instruments. Parents attended all sessions, often observing behind a one-way glass, and clinicians provided FB on a continual basis throughout the intervention. Following formal testing, a structured family intervention was held to present/discuss the results in order to "bring them alive" (p. 241), and the final TFB session saw clinicians compose and present a personalized fable to the child based on the assessment results. At the conclusion of the intervention, the same batteries were re-administered to children and parents. Results indicated a significant decrease in mother's ratings of externalizing and internalizing problems, with small to medium (d = 0.41) and small effect sizes (d = .28) respectively. Children and mothers both reported a significant increase in family connections (i.e., improved communication and cohesion) with medium (d = .50) and small to medium effect sizes (d = 0.38) respectively. Lastly, mothers reported a significant increase in positive emotion, and a significant decrease in negative emotion towards their children, with medium (d = .58) and large effect sizes (d = 1.18) respectively. While the small sample size and design (i.e., no control group) limit the ability to detect a treatment effect and to generalize results beyond the participants, this study provides preliminary evidence that C/TA may be an efficacious intervention for children presenting with substantial emotional and behavioural problems and their families.

Smith, Handler and Nash (2010) examined the efficacy of C/TA for preadolescent males presenting with oppositional defiant disorder (ODD) and their families. The authors used several single-case time-series designs (n = 3 families) to track participant change over time.

Participants ranged from 9-12 years of age, met *DSM-IV* criteria for ODD, and were referred by their parents for assessment or therapy to a university-based outpatient clinic. The C/TA intervention followed a comprehensive TA For Families model (cf. Tharinger et al., 2009) involving approximately nine weekly sessions, each of which was 1-2 hours in length. The intervention consisted of an initial meeting, three to four testing sessions, a family intervention session, a summary and discussion session, a child TFB session, and a 60-day follow-up session. A graduate student in clinical psychology conducted the intervention under close supervision by a TA expert. The authors took great care to insure intervention was delivered with fidelity; clients continually and systematically assessed the clinician's competence, and TFB was provided on an ongoing basis. Parents and children completed comprehensive behavioural measures throughout the intervention, and again at follow-up. Results indicated that all children and parents reported substantial improvement in multiple areas of functioning, as indicated by combined dependent variable scores from pre to post-test assessment (Significant *p* values using Bonferroni correction; Case 1 = .008, Case 2 = .025, Case 3 = .008). In two of these cases, parents and children reported further improvements on outcome measures at follow-up. These results provide some evidence that children presenting with behavioural problems and their families experience substantial benefits from TFB and assessment using the C/TA model.

Dyadic Satisfaction and Relational Commitment. Worthington, McCullough, Shortz, Mindes, et al. (1995) examined the impact of receiving personally relevant TFB in the context of couple's therapy. Using an experimental design, the authors manipulated the presence of individualized TFB in a sample of undergraduate couples ($n = 48$). They found that receiving individualized written and oral TFB had a positive, although small effect ($d = 0.14$) on couples' dyadic satisfaction and relational commitment relative to couples who completed inventories

without receiving TFB, suggesting TFB can have beneficial effects on enrichment interventions with couples.

Career Decision-making Self-efficacy and Career-related Beliefs. Luzzo and Day (1999) utilized a repeated-measures experimental design to examine the effects of receiving TFB based on Strong Interest Inventory (SII) results on clients' career decision-making self-efficacy (CDMSE) and career-related beliefs. Participants were undergraduate students (n = 101), all of which completed measures of CDMSE and social cognitive career beliefs. They were then randomly assigned to one of three conditions in which they either completed the SII followed by a group TFB session with a career counselor (n = 52), completed the SII only with no TFB (n = 22), or formed the control group, (n = 25), completing pre and post measures only. Identical measures were then re-administered to all participants following the group TFB session. Participants in the treatment group evidenced significant increases in CDMSE relative to those in other conditions with an effect size in the medium to large range (d = 0.61) Participants in the TFB condition were also more likely to indorse the importance of control, hard work and responsibility in their decision-making process than those completing the SII only, with effect sizes in the medium to large range (i.e., control, d = 0.56; responsibility, d = 0.62; working hard, d = 0.65). These results suggest that vocational/interest inventories coupled with personally relevant, collaborative TFB produce more favorable outcomes in the context of vocational assessment than in the absence of such FB. It also provides some support for the notion that TFB itself enhances treatment outcome beyond the effects of testing.

Extent of Introverted/Extroverted Social Behaviour. Sakamoto, Miura, Sakamoto and Mori (2000), examined in the effects of FB and the type of test administered (popular or academic) on subsequent social behavior. Using a 2 (FB type) X 2 (test type) X 2 (test format)

experimental design, the authors randomly assigned Japanese female undergraduate students (n = 64) to one of 8 conditions. All participants completed either a popular or academic psychological test, in either a multiple choice or open-ended response format, prior to receiving verbal FB from a confederate about whether they were extroverted or introverted. However, the type of FB given was random, and completely unrelated to the results of the test. Results identified a significant main effect for the type of FB delivered ($F = 16.52$, $p < .01$) as participants who received FB suggesting they were extroverted interacted more with a stranger (i.e., a confederate) than those who received FB implying introversion, regardless of test type and format. These results suggested that FB is a highly influential aspect of the testing process that can influence subsequent behaviour, even when it is inaccurate. These results also highlight why C/TA has been criticized for realizing its effects through mechanisms such as subjective validation or via the Forer or Barnum effect (cf. Marks, 2000; Meehl, 1956), underscoring the importance of clinicians remaining falsifiable, ensuring TFB is empirically-based and grounded in the test results.

Process Research

Client Transparency Regarding Emotional Disturbance. Walfish (2011) examined the impact of delivering process FB on clients' minimizing the extent of their emotional difficulties. In this archival study of adult outpatient professionals (n = 53) referred by third parties for comprehensive multidisciplinary competency assessments, participants completed measures of depression, anxiety and anger, as well as a complete *MMPI-2*. Based on the validity scales of the *MMPI-2,* the majority of respondents (59%) yielded invalid 'fake good' profiles as a result of 'defensive' response patterns. After clinicians presented process FB to clients regarding this apparent defensive tendency, coupled with a request for increased

openness and honesty, 90% produced valid profiles on a re-administration of the *MMPI-2*. Significant differences were also observed between pre and post FB administration on 6 of 13 *MMPI* subscales, and on measures of anxiety, anger and depression such that they were more representative of the clients' actual level of functioning in these areas. These results suggest providing process TFB to clients can enhance their willingness to engage in the assessment in a manner that reflects their actual experience, even in potentially adversarial settings where clients may have much to lose.

Significant Feedback Events. Ward (2008) sought to explore some of the processes underlying TFB through the experiences of significant FB events from the perspective of both clients (n = 6) and clinicians (n = 6). Qualitative interviews with six psychological assessment clients and six clinicians were analyzed using thematic analysis, yielding three broad categories for each group. For clients, significant feedback events were related to (1) the importance of the clinician, as evidenced by (a) feeling uniquely understood, (b) ambivalence about the clinicians' interpretive accuracy, understanding and knowledge, and (c) appreciating the clinicians' collaborative approach; (2) experience of receiving unwanted or discordant results; and (3) experiencing a shift in their attitude from general self-blame and personal deficiency to informed action through the assessment, corresponding to (a) enhanced autonomy, (b) normative comparison, and (c) specific, personally relevant TFB. From the clinicians' perspective, significant events were related to (1) the importance of involving the client in the FB process; (2) challenges regarding the specific effects of TFB; (3) indications of successful TFB; (4) clinicians' experience of transformative TFB effects (i.e., making the implicit explicit, promoting a more informed and nuanced understanding of the clients' behaviour over a global negative self-image). These results identify some of the processes by which collaborative TFB

positively impacts clients, regardless of the context of the assessment, and emphasize the importance of engaging collaboratively and empathically with the client throughout the assessment. This study is also unique in several respects; being the only study to exploring TFB experiences of both clinicians and clients, and using a qualitative methodology to explore important processes involved in TFB. As such, it serves as something of an exemplar for future qualitative inquiry in this area.

Delivered Versus Interactive Feedback. Hanson, Claiborn and Kerr (1997) examined the effect of test interpretation (TI) style on clients' ratings of session impact and counselor influence. Participants were undergraduate students (n = 26) presenting for career counselling at a university-based community mental health clinic. The authors randomly assigned participants to condition, with half of the students receiving TFB from clinicians using an interactive TI style, and the other half receiving TFB from clinicians using a delivered TI style. After the initial session, participants completed several personality and career inventories, with clinicians providing TFB to participants in the second session based on the results. The authors manipulated TI style and participants in both conditions completed a thought-listing exercise, as well as several psychotherapy process/outcome measures (i.e., the Session Evaluation Questionnaire; the Counselor Rating Form) following the FB session. The results showed that TI style did not have an effect of clients' cognitive processing, or the favorability of their thoughts. However, TI style was shown to impact clients' evaluations of the 'depth' of the session, and their evaluations of their clinician. More specifically, an interactive TI style was evaluated as being more impactful than a delivered TI style, with an effect size in the large range (d = 1.56). Clients also perceived clinicians who utilized an interactive TI style as more expert, trustworthy, and attractive than those employing a delivered TI style, with an effect size

in the large range (d = 1.21). Counterintuitively, these results suggest that clinicians who adopt a more collaborative approach with clients are seen as more credible than those who provide TFB in a manner that minimally consults or involves them.

Hanson and Claiborn (2006) employed an experimental design to examine the impact of test interpretation (TI) style on participants' perception of their test results, their ratings of the FB session, and of the clinician. Participants were randomly assigned to one of four conditions in which the authors manipulated TI style (interactive/highly involving vs. delivered/less involving) as well as FB favorability (exclusively positive vs. mixed – some positive, some potentially 'negative'). A sample of male and female undergraduate students (n = 46) completed a well-known personality test, and a doctoral counselling psychology student provided them with TFB based on the results later that session. Following TFB, participants in both conditions completed a thought-listing exercise and several psychotherapy process/outcome measures. Contrary to the author's hypotheses, an interactive TI style was not associated with higher rates of cognitive elaboration in clients, nor was it associated with more positive perceptions of the FB session, or of the clinician than the delivered TI style. However, as hypothesized, clients who received exclusively positive TFB endorsed the results as more accurate than those receiving mixed FB, with an effect size in the small range (d = 0.20). Finally, as hypothesized, although TI style had no impact on clients' helpfulness ratings, participants receiving mixed favorability TFB rated the FB session as more helpful those who received exclusively positive TFB, also with a small effect size (d = 0.26). There are a number of implications of this study. First, interpretation style may not influence the clients' perception of the FB session or of the clinician to a great extent. Second, clinicians should remain aware of clients' tendency to endorse or accept exclusively positive results, and ensure that they present the 'whole picture'

including both positive and potentially 'negative' results as –apart from the ethical obligation to present test results accurately– clients experience mixed favorability TFB as more helpful than one-dimensional FB, even if it is uniformly favorable.

Oral Versus Written Feedback. Fallows and Hilsabeck (2013) examined whether written and oral TFB was associated with greater recall of diagnostic information and treatment recommendations than oral FB alone. Participants were a sample of veterans (n = 96) undergoing a neuropsychological evaluation at a Veterans Administration clinic, presenting with dementia (22%), cognitive disorder not otherwise specified (47%) or no cognitive disorder (31%). The authors randomly assigned participants to either the treatment (written + oral TFB) or control groups (oral TFB only), with the groups showing no systematic differences on demographic variables and demonstrating satisfactory pre-treatment equivalence. The written FB constituted a two-page document containing the referral reason and the clinician's summary, impressions and recommendations that were tailored to the client. Both groups were interviewed immediately following the FB session, and again, at 1-month follow up. Although the groups did not differ in their recall of diagnostic information or adherence to treatment recommendations, the treatment group evidenced significantly improved recall for recommendations. The results of this study indicate that including multiple forms of feedback (in this case, written with oral TFB) can improve clients' recall of treatment recommendations, and suggest that clients' prefer to have written TFB as well as oral.

Providing Feedback through Personalized Fables. Tharinger and Pilgrim (2012) examined the impact of including TFB in the form of personalized fables to children undergoing traditional neuropsychological assessment consistent with an IG paradigm. Participants were children and their parents (n = 32 families) presenting with a variety of academic, behavioural

and socio-economic challenges. The authors assigned half of the participants (n = 16) to the treatment group, in which children received TFB in the form of personalized fables after their parents participated in a standard verbal debriefing session. The treatment group completed self-report outcome measures following the debriefing and TBF/fable session. The other children (n = 16) were assigned to the control group, in which children and parents received their TFB/fables after completing the assessment and outcome measures. Results indicated that both children and parents in the treatment group reported higher levels of child learning, more positive child-clinician relations, and a greater sense of collaboration relative to controls. Parents in the treatment group also reported higher levels of satisfaction with the assessment relative to controls. These results suggest that providing children with TFB through personalized fables is an effective way of engaging some of the key processes involved in families benefiting from psychological assessment, alluding to the importance of ensuring TFB is personally relevant and meaningful.

The Present Study

The purpose of this thesis study was fourfold: To (1) examine the extent to which Canadian psychologists provide TFB to clients, (2) explore whether and how training programs are equipping psychologists to provide TFB, (3) identify factors associated with Canadian psychologists' providing/not providing TFB, and (4) explore how the experiences of Canadian psychologists provide a better understanding of their TFB practices. Based on these purposes, a two-phase, sequential-explanatory MMR design was employed, using a national survey to describe current TBF practices and to identify factors associated with psychologists' provision of TFB. Although this study is closely predicated upon previous research (cf. Curry & Hanson, 2010), it represents the first inquiry into TFB practice and training in Canada. The primary

contribution of this study is application oriented. By articulating the extent to which Canadian psychologists provide TFB to clients and the degree to which training programs are preparing them to do so, awareness among psychologists, professional associations, licensing bodies, training institutions etc. can be raised regarding the many benefits of TFB. Ultimately, this heightened awareness will hopefully translate into increased rates of providing TFB to clients, licensing bodies and professional associations adopting more explicit ethical guidelines, and more intentional and comprehensive training for clinicians learning to provide TFB. A secondary scholarly contribution was establishing C/TA as a theoretically and empirically based model to guide more effective TFB research, training and practice.

A sequential-explanatory MMR design is a two-phase model that involves an initial quantitative data collection and analysis phase, followed by qualitative data collection and analysis (Creswell & Plano Clark, 2011; Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). In this design, quantitative data is typically prioritized. The sequential design allows potential respondents to be selected as qualitative data sources based on the initial quantitative results. Mixed methods research also requires integrating (i.e., mixing) the data at district points in the research sequence (Cresswell & Plano Clark, 2011). In a sequential-explanatory design, the data strands are typically integrated at the interpretation phase, following data collection and analysis, effectively using the qualitative results to explain the initial quantitative findings in an attempt to understand them more completely (Hanson et al., 2005). There are a number of published studies in the counselling psychology literature that have utilized this particular design (Chusid & Cochran, 1989; Ordoff & Herr, 1996; Palmer & Cochran, 1998; Wampold, Ankarlo, Mondin, Trinidad-Carrillo et al., 1995; Poasa, Mallinckrodt, & Suzuki, 2000; Curry & Hanson, 2010). Four of these studies focus on vocational counselling, one on cultural diversity,

and the other on the America psychologists' TFB practice and training. Using the qualitative results to better understand, account for and explain the quantitative results, a sequential-explanatory MMR design was used in this study.

Rationale for Mixed Methods Design

The MMR literature underscores the importance of having a rationale for selecting a particular research design (Creswell & Plano Clark, 2011). Greene, Caracelli, and Graham, (1989) identified *complementarity* as the rationale underlying the sequential-explanatory design. According to the authors, complementarity "seeks elaboration, illustration, clarification of results from one method with the results of the other method" (p. 259). Accordingly, this design was used to elaborate, clarify and expand upon the initial survey results by interviewing select respondents to facilitate a more complete understanding of their TFB practice and training. Because the data collected in the quantitative phase may have left out important aspects of the 'bigger picture' of psychologists' TFB practices, a MMR design was used to "increase the interpretability, meaningfulness, and validity of the constructs and inquiry" (Greene et al., 1989, p. 259). In keeping with this design, the quantitative portion was conducted first, and was prioritized over the qualitative phase, prior to conducting follow-up qualitative interviews with select respondents in an attempt to explain the quantitative results, and to explore respondents' experiences in more depth.

Research Questions

Mixed methods research emphasizes the centrality and preeminence of research questions (RQs) as the driving forces behind systematic inquiry (Creswell & Plano Clark, 2011). Based on the RQs posed in the present study, a MMR approach in general is necessary, while a sequential-explanatory design in particular is optimal. In keeping with this design, the

quantitative RQs inquired about (1) the extent to which Canadian psychologists deliver TFB to clients, (2) whether and how graduate and post-graduate training prepared them to provide TFB, and (3) the factors associated with psychologists providing/not providing TFB. The quantitative results were derived from a national survey of Canadian psychologists who regularly conduct assessments as part of their practice, and were then followed up with qualitative interviews with 6 individuals based on their survey responses to understand their motivation for providing/not providing clients with TFB. The qualitative phase provides a more thorough account of the experiences and perspectives of particular respondents as it relates to their TFB practices. Through the qualitative phase, the researcher sought to explore (1) how respondents with insufficient/unhelpful training learned to provide TFB to clients, (2) the motivation and rationale for psychologists not providing TFB to clients consistently, and (3) positive and negative effects of providing TFB to clients based on respondents' perspective and experience.

Quantitative and Qualitative Data Collection

The quantitative data collection for this study involved refining an existing survey instrument that was created for the original study (cf. Curry & Hanson, 2010). The items on the instrument inquired about the purposes underlying respondents' use of assessments, the extent to which they engage in particular TA practices outlined by Finn (1996), training they received in providing TFB, and a number of demographic questions. Quantitative data collection was conducted in a manner consistent with quality survey research (cf. Groves, Fowler, Couper, Lepkowski, et al., 2009) by taking a number of distinct steps: First, by discussing the limits to generalizability (see Discussion). Second, by employing a census sampling technique, including all potential respondents in the sampling frame, thereby eliminating the need for random sampling (cf. Shannon & Bradshaw, 2009). Third, by providing detailed field results, presenting

specific steps taken to improve response rates (see Method). Fourth, by including a copy of the survey instrument (see Appendix A). Qualitative data collection involved conducting six follow-up telephone interviews with individuals selected on the basis of their survey responses in order to clarify and understand their TFB practice and experience more fully.

Research Hypotheses

Based on established ethical and professional guidelines that psychologists share test results with clients (cf. APA, 2002; CPA, 2000), it was hypothesized that (1) the majority of respondents would report providing clients with TFB to some extent, in some form. Based on the importance of training in preparing psychologists to provide TFB, it was also hypothesized that (2) psychologists who found graduate and post-graduate training helpful in learning to provide TFB would report providing TFB more consistently than those who did not. The third and fourth hypotheses were based on the –presumed– increased awareness of the importance of TFB based on accumulating theoretical, practice and research literature. Accordingly, it was hypothesized that (3) recent graduates would report providing TFB to clients more frequently than those who earned their degrees earlier. In a similar way, based on an increased emphasis on TFB in contemporary training programs, it was hypothesized that (4) recent graduates would indicate their training was more helpful in learning to provide TFB than those who earned their degrees earlier.

Chapter 2: Method

Quantitative Data Collection

Quantitative Participants. Using a census sampling technique, 2,763 Canadian Psychologists were invited to complete an online survey in February and March of 2014. In the end, a total of 399 licensed psychologists participated in the study. According to the most frequent demographic responses, a typical, representative respondent was female, from a European-Canadian cultural/ethnic background, with a PhD earned approximately 17.5 years ago, practicing from a cognitive-behavioural theoretical orientation, and working in a private practice setting. According to the available current research, participants in this survey appear to represent Canadian psychologists active in assessment reasonably well (cf. Hunsley, Ronson, & Cohen, 2013; Ionita & Fitzpatrick, 2014). Based on respondents' CPA affiliations, 54.1% (n = 216) specialized in clinical psychology, 21.8% (n = 87) in school psychology, 15.2% (n = 61) in counselling psychology, 13.5% (n = 54) in health psychology, and 13.03% (n = 52) in clinical neuropsychology. The remaining sections all had response rates below 10%. In terms of the various uses of assessments, respondents indicated using assessments most frequently to answer specific referral questions, followed by making/confirming diagnoses, and measuring treatment outcomes/monitoring client change. Respondents indicated using tests least frequently for court-mandated reasons, followed by using tests as a tool for building rapport. Table 1 provides a summary of these results.

Respondents reported holding graduate degrees in psychology for periods of time ranging from 1 to 62 years (M = 17.39, Mdn = 16 years, SD = 11.68). The majority indicated holding a Ph.D (76.9%, n = 307), while 2.5% (n = 10) held a Psy.D, 2% (n = 8) held an Ed.D, 3.8% (n = 15) held an M.Ed, and 12.8% (n = 51) held an MA or MSc. Finally 2% (n = 8) of

respondents indicated holding another form of graduate degree (e.g., Ph.D plus postdoctoral studies in clinical psychology). The majority of respondents (64.9%, *n* = 259) were female and the vast majority (90%; *n* = 358) self-identified as European-Canadian/White. Of the remaining respondents, 2.7% (*n* = 11) identified themselves as Asian/Asian Canadian, 0.7% (*n* = 3) as Aboriginal/First Nations/Canadian Indigenous, 0.25% (*n* = 1) as Metis, 0.5% (*n* = 2) as Hispanic/Latino/Latina,) 0.7% (*n* = 3) as African Canadian/Black. The second most frequently endorsed cultural/ethnic identity category was *other*, with 5% (*n* = 20) self-identifying as Caucasian, European-American, South Asian, Jewish, Middle Eastern, Egyptian, Ukrainian, or Canadian. By far the most common practice setting respondents indicated was private practice (43.3 %, *n* = 173), followed by practicing in a school/school district (11.7%, *n* = 47), followed by *other* (11%, *n* = 44), which included in a university/college psychology department (7.5%, *n* = 30), in a child/adolescent psychiatric or pediatric setting (5%, *n* = 20), general hospital (4.7%, *n* = 19), and in a psychiatric unit/hospital (4.5%, *n* = 18). Each of the remaining eight practice settings included on the survey were endorsed by less than 4.5% of respondents respectively.

Respondents also had the opportunity to describe additional uses of psychological assessments not included in the survey. A sizeable proportion of respondents (34.5%, *n* = 138) provided additional information that was analyzed and coded into several broad categories. They are as follows: Forty respondents (10%) reported using assessments to determine/describe clients' current level of functioning (e.g., fitness evaluations, risk assessments); 28 respondents (7%) indicated using assessments to establish treatment plans/make treatment recommendations, (e.g., determine therapy goals, identify appropriate referrals) while 18 respondents (4.5%) reported using assessments to determine clients' need or eligibility to access resources (e.g., funding, programming, insurance coverage). Less than 4.5% of respondents reported using

Table 1

Frequency of Using Assessments for Specific Purposes

Frequency	RQ	DX	MO	SE	CM	BR	TI	R	T
Never	1.8	5.3	9.0	20.1	61.7	39.1	28.3	28.3	46.9
Rarely	5.5	9.0	29.3	31.1	13.5	28.6	32.3	32.2	18.8
Sometimes	13	16.5	32.1	28.8	6.3	23.1	27.1	27.1	15.5
Frequently	27.8	29.6	20.6	15.8	5.8	7.3	9.5	9.5	12.3
Almost Always	51.6	39.6	9.0	3.8	12.5	1.8	2.8	2.8	6.5

Note. Frequencies are reported in percentages. RQ = answer specific referral questions, DX = make/confirm a diagnosis, MO = monitor treatment outcome/client change, SE = encourage the client to engage in self-exploration, CM = court-mandated reasons, BR = tool for building rapport, TI = therapeutic intervention, R = research purposes, T = training purposes.

assessments for purposes other than those described above.

Respondents also identified various contexts in which, and clientele with whom they use assessments. This item was designed to allow multiple responses, and participants endorsed a mean of 3.25 (*SD* = 1.35) categories. Respondents indicated using assessments with adults most frequently (72.6%, *n* = 290), followed by adolescents (58.6%, *n* = 234), with children (50.3%, *n* = 201), as part of an interdisciplinary treatment team (43.8%, *n* = 175), with clients who experience severe mental illness (42.8%, *n* = 171), and finally, with college/university students (41.6%, *n* = 166). A considerable number of respondents (15.5%, *n* = 62) also indicated using assessments in other contexts including with the elderly, with families, with industry/organizations, and with insurance claimants.

In keeping with existing assessment survey research, respondents were asked to identify different types of assessment instruments they typically use in practice. This item was designed to allow multiple responses and participants endorsed a mean of 3.87 (*SD* = 1.34) categories. Respondents identified symptom-based measures (e.g., BDI, State-Trait anxiety Inventory) most frequently (76.6%, *n* = 306), although it was virtually identical to the prevalence of intellectual instruments (e.g., *WAIS*, *WISC*; 76.4%, *n* = 305). The majority of respondents also indicated using objective personality instruments (e.g., *MMPI*, *MCMI*; 67.1%, *n* = 268) and behavioural measures (e.g., *BASC*, *Conners Rating Scales*; 62.6%, *n* = 250), while 32% (*n* = 128) reported using neuropsychological instruments (e.g., *COGNISTAT*, *RBANS*), and 24.5% (*n* = 98) indicated using vocational/career inventories. A considerable number of respondents also reported using instruments from other categories (32.3%, *n* = 129), including assessing pervasive developmental disorders, memory, pain, achievement, executive functioning, phonological processing, and malingering.

In terms of the frequency of engaging in specific assessment activities consistent with Finn's (1996) TA model, over half of respondents (58.9%, *n* = 235) indicated obtaining assessment-specific consent beyond that required for general services such as counselling *almost always*, while 24.8% (*n* = 99) reported doing so *rarely* or *never*. The majority of respondents (89.5%, *n* = 357) reported preparing clients for the assessment by explaining the purpose, process, and likely outcomes *almost always*, while 0.5% (*n* = 2) indicated doing so *rarely*. Only 16.8% (*n* = 67) reported encouraging the client to generate their own personally relevant questions that could be addressed through the assessment process *almost always*, while 51.4% (*n* = 205) reported doing so *rarely* or *never*. These results are summarized in Table 2.

Survey Instrument The researcher adapted the existing survey developed by Curry and

Table 2

Frequency of Engaging in Specific Collaborative/Therapeutic Feedback Activities

Frequency	OC	PC	ECQ
Never	15	0	24.1
Rarely	9.8	0.5	27.3
Sometimes	7	1.8	18
Frequently	8	8.3	13.8
Almost Always	58.9	89.5	16.8
Missing	1.3	0	0

Note. Frequencies are reported in percentages OC = Obtain assessment-specific consent beyond initial consent to participate in treatment before administering assessments. PC = Prepare clients for the assessment (e.g., by explaining the purpose, process, likely outcomes, etc.). ECQ = Encourage the client to generate their own personally relevant questions that could be addressed through the assessment.

Hanson (2010), resulting in a 40-item instrument entitled *Assessment Feedback Practice and Training Questionnaire* (see Appendix A). Having consulted with the original author, a number of items were revised to maintain a consistent response format, allow more open-ended responses, facilitate more extensive correlational analyses, and enhance the instruments' relevance for a Canadian sample. And, several TFB clarification items were added to inquire more intentionally into specific TFB activities. Having refined several versions of the survey in consultation with its creator, the final draft was pilot tested, whereby copies were sent to two university professors and two licensed psychologists active in assessment in the Edmonton area. Feedback about completion time, sequencing, response format, and wording was solicited.

Having incorporated their input, making minor revisions as needed, the final draft was completed and an online version of the survey was created using *Qualtrics*, a web-based program for creating and distributing surveys (Qualtrics, 2014) before distributing the survey to potential respondents.

The initial question operated as a screen, to identify respondents who did not conduct assessments in their practice. Because the survey was delivered in an electronic format, respondents could not proceed beyond the first item unless they reported using assessments. The second item inquired about the frequency with which respondents use assessments, with response options ranging from 1 (*Rarely*) to 4 (*Almost Always*) on a 4-point Likert scale. All other frequency items used a 5-point Likert scale, with response options ranging from 1 (*Never*) to 5 (*Almost Always*). Items 3 through 12 focused on the purposes underlying respondents' use of assessments predicated on the uses identified by Meyer et al. (2001). Item 12 inquired about other uses of assessments, inviting respondents to describe any additional uses in an open-ended format. Items 13 and 14 inquired about the various contexts in which psychologists utilize assessments, as well as the types of instruments they use. Items 15 through 17 inquired about the extent to which respondents engage in key steps articulated in Finn's (1996) TA model.

Item 18 was designated as the primary TFB item, providing respondents with a conceptualization of TFB and inquiring about their TFB practice independent of a given format. Items 19 through 21 inquired about respondents delivering TFB in various forms (e.g., written or verbal) while items 22 through 24 inquired about respondents intentionally clarifying test results during the TFB process. Items 25 through 30 inquired about the extent to which respondents found graduate and post-graduate training helpful in learning to provide TFB, to provide a global estimate of the percentage of their training that focused explicitly on providing

TFB, and to identify the primary mode of instruction. Item 31 invited respondents to describe anything they felt was relevant to the training and practice of providing TFB that was not sufficiently covered in the survey, and encouraged them to elaborate on any prior responses if desired. Items 32 through 40 were demographic questions inquiring about the highest degree respondents attained, when that degree was attained, their biological sex, culture/ethnic background or identify, primary practice setting, theoretical orientation, and CPA section affiliations. Item 39 inquired about respondents' willingness to participate in a brief follow-up interview exploring their TFB experiences in more depth. Finally, item 40 asked participants if they would like to receive a copy of the results of the study, and if so, to provide an email address or P.O. box where they would like the results sent.

Quantitative Procedure Potential participants were selected from the CPA membership directory. In January 2014, the researcher attempted to contact the CPA administrative office by phone and email to collaborate with them in identifying and approaching potential respondents. Several weeks later, a Membership Assistant replied via email indicating the association was in the midst of a membership renewal campaign and, as a result, they were unable to respond at that time. Due to time constraints, the researcher elected to utilize the CPA membership directory and employed a census sampling strategy, including all potential respondents in the sampling frame (cf. Creswell, 2012; Shannon & Bradshaw, 2002). Accordingly, full members, fellows, and special affiliates of the CPA during the quantitative data collection phase (January – March, 2014) were identified as potential respondents, and sent an email invitation. Because psychologists in Canada are regulated at the provincial/territorial level, with some jurisdictions permitting licensure at the masters' level, the researcher also identified student affiliates as potential respondents provided they had completed at least a masters' degree in psychology and

met the remaining inclusion criteria. Thus, the researcher identified all CPA members meeting inclusion criteria who were willing to post their contact information on the directory (i.e., name, credentials and email address) as potential respondents. Inclusion criteria stipulated that respondents must (1) be licensed psychologists, (2) currently administer psychological assessments as part of their practice, (3) be members of CPA in good standing. As such, potential respondents were excluded if they were not licensed psychologists, if their primary work setting was strictly academic, or if they indicated not using assessments regularly in their practice.

A list of potential respondents' emails (n = 2763) from the directory was derived –no names were included in this list– and email addresses were entered into the *Qualtrics* survey program for distribution. All potential respondents received an email invitation to participate, including a hyperlink to the survey (see Appendix B). Respondents attempting to access the survey had to first indicate reading and understanding the *Information Letter and Consent Form* (see Appendix C), expressing their desire to participate of their own volition before receiving access. Initial invitations were sent February 10th, 2014 and follow-up invitations (see Appendix D) March 5th, 2014 in an attempt to maximize response rate. The survey was active between February 10th and March 26th, 2014. Codes were assigned to respondents' email addresses to identify potential respondents for the qualitative phase, and to facilitate data removal should a respondent wish to withdrawal from the study. All documents and files potentially linking email addresses to respondents were destroyed or deleted after data analysis.

Respondents completed and returned a total of 433 surveys, 34 of which were excluded from analysis as these respondents either did not meet inclusion criteria, or left a substantial proportion of the items unanswered. A number of potential respondents emailed the researcher

indicating that they would not be completing the survey as they no longer conducted assessments, or had recently retired. As a result, a total of 399 viable surveys were received (approximately 2.5% of all Canadian psychologists; cf. Ionita & Fitzpatrick, 2014) representing a usable response rate of 14.4%. While this response rate appears substantially lower than other survey studies in this domain (cf. Bennett-Levy, et al.; Smith, Wiggins, & Gorske, 2007), this is largely a result of different –and incomparable– sampling strategies. Here, a census sampling strategy was utilized, asking all potential respondents to determine whether or not they represent the population of interest by completing/not completing the survey, whereas other sampling strategies require researchers to identify a sampling frame of prospective participants prior to collecting data (Creswell, 2012). In the end, the overall sample size is comparable to that obtained in prior TFB research.

Quantitative Data Analysis

In accordance with the first two RQs, data analysis for the quantitative phase was appropriately straightforward. All items from the *Assessment Feedback Practice and Training Questionnaire* were first coded and entered into statistical software (*SPSS*), yielding a total of 14 variables. The researcher then derived descriptive statistics to address the first two RQs regarding the extent to which Canadian psychologists share TFB with clients, and whether or not graduate and post-graduate training prepared them to do so. The third RQ sought to identify factors associated with respondents' providing/not providing TFB to clients; inferential statistics were used for the correlational analyses (using Pearson's *r*) to determine whether the variables included on the survey (e.g., theoretical orientation, specialization, training, etc.) corresponded with respondents' TFB practices. A more stringent alpha value was selected ($\alpha = .01$) for the correlational analysis to guard against correlations that emerged simply due to chance. A more

stringent alpha value could have been selected by dividing the traditional alpha value ($\alpha = .05$) by the tests conducted (in this case, $\alpha/14 = .003$). However, due to the exploratory and preliminary nature of this research, the median value ($\alpha = .01$) was selected, as the potential error associated with this value was deemed to be a tolerable risk in order to ascertain potentially important TFB practice data. Additionally, in order to get a broad understanding of the variables associated with providing/not providing TFB, all of the relevant TFB activities were incorporated into one TFB variable. By virtue of the strong correlations among 3 of the 4 TFB items (items 18 through 20), and all of the TFB clarification/elaboration items (items 22 through 24) (average Pearson's $r = .69$), a single TFB variable was computed using *SPSS* that was then used for the correlational analyses. In effect, this TFB 'super variable' represents the mean (average) Likert scale score across the TFB variables described above, and was included to collapse IG and C/TA TFB activities into a single variable. This decision was also made on the basis of the exploratory nature of this research among Canadian psychologists.

Qualitative Data Collection

Participants. Purposive sampling is used predominately in qualitative research, and involves selecting particular respondents to address specific research questions (Creswell, 2013; Teddlie & Yu, 2007), and this sampling method was used to select individuals for follow-up interviews to address the fourth RQ. Based on the quantitative data analysis, two groups of individuals were identified. The first group (group 1) was composed of respondents who reported regularly providing TFB to clients, despite insufficient training. The second group (group 2) consisted of respondents regularly conducting assessments, but not providing TFB to clients consistently. In order to be eligible for either group, potential respondents had to indicate their willingness to be contacted for a follow-up interview. Inclusion criteria for group 1

required respondents to either *disagree* or *strongly disagree* that graduate and post-graduate training effectively prepared them to provide TFB to clients (items 25 and 28). They also had to report providing at least one form of TFB either *frequently* or *almost always* on items 18 through 20. Inclusion criteria for group 2 required respondents to indicate either not providing TFB to clients, or doing so inconsistently by endorsing either *sometimes*, *rarely* or *never* on all TFB items.

In total, 32% of respondents (n = 126) indicated they were willing to be contacted for an interview; however only 12 of these participants met inclusion criteria for group 1, and just 8 met criteria for group 2. Using a random numbers generator, 5 respondents were selected from each group and all 10 potential respondents were invited to participate in a follow-up telephone interview via email (see Appendix E). A total of 6 respondents (3 per group) replied to this invitation, and were successfully contacted and interviewed. For group 1 respondents, 2 were female and 1 was male. All held PhDs for periods of time ranging from 1 to 15 years (M = 6; SD = 7.8). For group 2 respondents, 2 were female and 1 was male, and all held PhDs for periods of time ranging from 3 to 33 years (M = 17.33, SD = 15.04).

Interview Procedure A narrative inquiry approach was used to collect and analyze the qualitative data. Narrative approaches are based on the idea that people store knowledge and experience in the form of stories that can later be retrieved through re-telling (Creswell, 2013). However, due to the quantitative emphasis and explanatory nature of the study, typical elements of narrative inquiry were not included (e.g., respondents' narratives are not retold or 'restoried' chronologically; respondents and researcher narratives were not combined into a meta-narrative; cf. Creswell, 2009).

Six brief semi-structured interviews were conducted, ranging in length from 15 to 25

minutes, in which respondents answered questions and shared their assessment-related stories. Having established contact, the *Information and Consent document* (see Appendix F) was reviewed with respondents, describing the purpose of the study, use of their data, confidentiality, anonymity, etc. Prior to beginning the interview, respondents were asked to consent to the conversation being recorded via laptop computer and recording software, having been assured that their responses would remain strictly anonymous. Thus, it was confirmed that respondents freely consented to participating, prior to beginning the audio recording. Respondents from group 1 were asked the following questions: (1) "You indicated on the survey that you regularly provide clients with test feedback despite insufficient formal training. Could you tell me more about how you learned to provide test feedback to clients?" (2) "Based on your experience, do you feel that there are any positive effects for clients receiving test feedback? If so, what are those positive effects, and how might they be enhanced?" (3) "Do you feel there are any potentially negative effects associated with providing test feedback to clients? If so, what are those negative effects, and how might they be mitigated?" (4) "Is there anything else you would like to share regarding your experience or perspective on providing clients with test feedback?" For a more detailed account of the interview process, see the *Qualitative Interview Scripts* document (Appendix G).

Group 2 respondents completed a similar process regarding informed consent, and were then asked the following questions: (1) "You indicated on the survey that you do not regularly provide test feedback to clients. Could you tell me more about that?" (2) "Are there circumstances in which you would provide test feedback? What would your motivation be for providing feedback in those cases?" (3) "Based on your experience, are there positive effects that result from clients receiving test feedback? If so, what are those positive effects, and how

might they be enhanced?" (4) "Do you feel there are potentially negative effects associated with providing test feedback to clients? If so, what are those effects, and how might they be mitigated?" (5) "Is there anything else you would like to share regarding your experience or perspective on providing clients with test feedback?"

For both groups, these questions represent a guiding heuristic, and questions were refined and added as needed during the course of the interviews, which is considered common practice in qualitative research (e.g., Creswell, 2013; Rubin & Rubin, 2012). As the interviews progressed, prompts were used as needed to encourage respondents to elaborate, asking additional questions to clarify understanding, and promoting respondents' exploration of their perspective and experience in more depth and detail.

Qualitative Data Analysis

Having conducted all six interviews, I transcribed the audio recording verbatim. Paying special attention to respondents' rate and intonation of speech, hesitation, vocal inflections, etc., I made commentary notes in the transcript where respondents placed additional emphasis, struggled to express a particular concept, or appeared uncomfortable. Following transcription, I conducted thematic analysis on the data consistent with Labov's (1972) concept of thematic organization, and based largely on the recommendations of Creswell (2013) and Rubin and Rubin (2012). Additionally, despite the absence of a group data analysis process, I also incorporated some aspects of consensual qualitative research (cf. Hill, Knox, Thompson, Williams, & Hess, 2005). Using these frameworks, I allowed codes and themes to emerge naturally during the analysis, taking care not to impose an organization or explanation on the text too hastily. In addition to analyzing the manifest content, I made a deliberate effort to understand what respondents were saying without using words – what they seemed to be

attempting to convey 'between the lines'. However, I also trusted in respondents' ability to present their own ideas and experiences with fidelity in their own words, and in this way, allowed the data to speak for itself.

My analysis consisted of six steps. First, I read the interviews in their entirety in order to get a general impression or 'feel' for the data. Second, I divided each transcript into text segments, separating bodies of text according to transitions in subject matter and meaning. Third, I labeled each text segment with a code – translating, reducing and summarizing the information into what appeared to be essential. Fourth, I reviewed the initial codes, examining whether they conveyed the essence of the original text, and began analyzing codes for emerging themes. Fifth, I combined redundant codes, collapsing those that remained into themes, and comparing these emerging themes with the original text and assigned codes to ensure applicability and consistency. Sixth, I derived over-arching themes by examining the commonalities among the emerging themes as they related to the interview questions across participants. I considered a theme relevant if it was evident in the responses of at least 2 participants, allocating more weight to the themes that corresponded to the original text and assigned codes with more frequency. However, I also considered the emphasis respondents placed on certain text segments during the interview as I conducted the analysis.

I employed member checking to enhance the validity and trustworthiness of the coding decisions, resulting themes and interpretations (cf. Creswell, 2013; Hill et al., 2005). Specifically, I emailed each respondent the results and summary of my analysis, as they related to their interview, providing respondents with the overarching themes and subthemes in the form of a summary table (see Tables 8 and 9) based on the qualitative results in their entirety. However, in order to preserve privacy and reduce inter-respondent pressure/influence, I

presented respondents only with excerpts form their own interview. I asked respondents to review the themes, subthemes, excerpts, and interpretations, prior to endorsing the results, asking them to provide me with corrective feedback if they believed their experience was at all misrepresented or incomplete. With the exception of two minor revisions, all 6 respondents replied by either phone or email, endorsing the results as accurate representations of our conversation and of their TFB perspective and experience, thus consenting to their results being presented in the final report.

Researcher-as-Instrument: Potential Biases and Personal Reactions. Because description invariably involves interpretation, it is critical to identify and discuss the impact ones' own bias, values and judgment has on the research process (cf. Creswell, 2013; Rubin and Rubin, 2012). In order to document and consider the influences I brought to the project as a function of my own experience, I kept a reflexivity journal throughout the qualitative phase in which I attempted to identify and reflected on these influences. My reflection was not so much an endeavor to heighten objectivity, but to ensure I was mindful of the ways my perspective, learning, etc. might lead me to impose an unsubstantiated organization or understanding on the data (e.g., interpreting/presenting a passage of text that in a way that is inconsistent with respondents' experience), and to monitor how I was conceptualizing and relating to various aspects of this study, and this line of inquiry as a whole. The following paragraphs are based on my journal entries.

From my own perspective as a graduate student in a Counselling Psychology training program, I have been greatly influenced by more developmental and humanistic theoretical approaches to therapy and assessment than what would likely be championed in a clinical or neuropsychological training setting. Furthermore, my interest in the C/TA model, coupled with

my experience providing TFB to clients for psychoeducational assessments, has led me to focus on the virtues of TFB, perhaps to the exclusion of its drawbacks. As such, I realize I may have an overly optimistic view of TFB, having approached it primarily on the basis of its therapeutic utility. Providing TFB to individuals who may be dangerous, who may have ulterior motives (e.g., learning and disseminating protected material), or situations in which TFB may not be entirely beneficial are completely foreign to me. Consequently, there is a danger this bias may result in me viewing, relating to, or presenting psychologists who do not regularly provide TFB as though they are ignorant, out of touch, or perhaps even unethical. What is more likely – though not less concerning– is my bias preventing me from appreciating or participating with the complexity and ambiguity that is a reality in contemporary psychological assessment. In other words, my bias places me at risk of painting a simplistic and dogmatic picture that TFB is always a good thing, and that the C/TA model is the most promising means of realizing more effective TFB practice, training and research.

Another source of potential bias is found in my post-positivist epistemological position (cf. Alexander, 1995) – or, more accurately, in my application of that position. Although I maintain that humans can know the world only imperfectly, that we are continuously influenced by our own values, learning, perspective etc., and that we do –on some level– construct our experience, I do believe that there exists an objective reality independent of our perception or position. For this study, this concern is most relevant to my constructivist analysis of participants' use of language to tell their stories and convey their experience. Language is problematic because it is simultaneously constructive and descriptive, both subjective and objective, for speakers and listeners alike. In order to enhance objectivity, I took a predominately surface-level analysis of the data such that I trusted respondents to articulate their

own experience accurately and, in a sense, objectively. I should qualify that what I mean by 'objective' is not that I've transcended my inherent limitations, but that through enhanced awareness of my own subjectivity –and the subjectivity of both experience and language– I believe I can take a slightly more functional and pragmatic approach to respondents' accounts. Unfortunately, I have forgotten the origin, but the essence of this tension, for me, was captured in the following quote: "The only objectivity is subjectivity rendered conscious of itself". This translated to me taking care not to go beyond the data or infer more that the manifest content indicated, thereby allowing the data to 'speak for itself' (cf. Hill et al., 2005). To do this, I focused on the apparent agreed-upon meaning of respondents' words (i.e., as indicated in a dictionary), frequency of word use, and converging meaning among different words and text segments in the data analysis. However, I also considered emphasis, inflection, rate of speech and pauses that seemed to suggest personal meaning or significance for the respondent. Admittedly, these aspects of the data were largely based on my perception/interpretation of them. Because I may have failed to attend to these more or less objective and subjective components of language in an even-handed manner, it is possible that these results were unduly influenced by my own confirmation bias (cf. Kida, 2006). However, I believe my approach was appropriate given the RQs, and the quantitative emphasis of the study. A different more latent analysis would arguably be appropriate for a study on clients' lived experience as it relates to receiving TFB (cf. Ward, 2008).

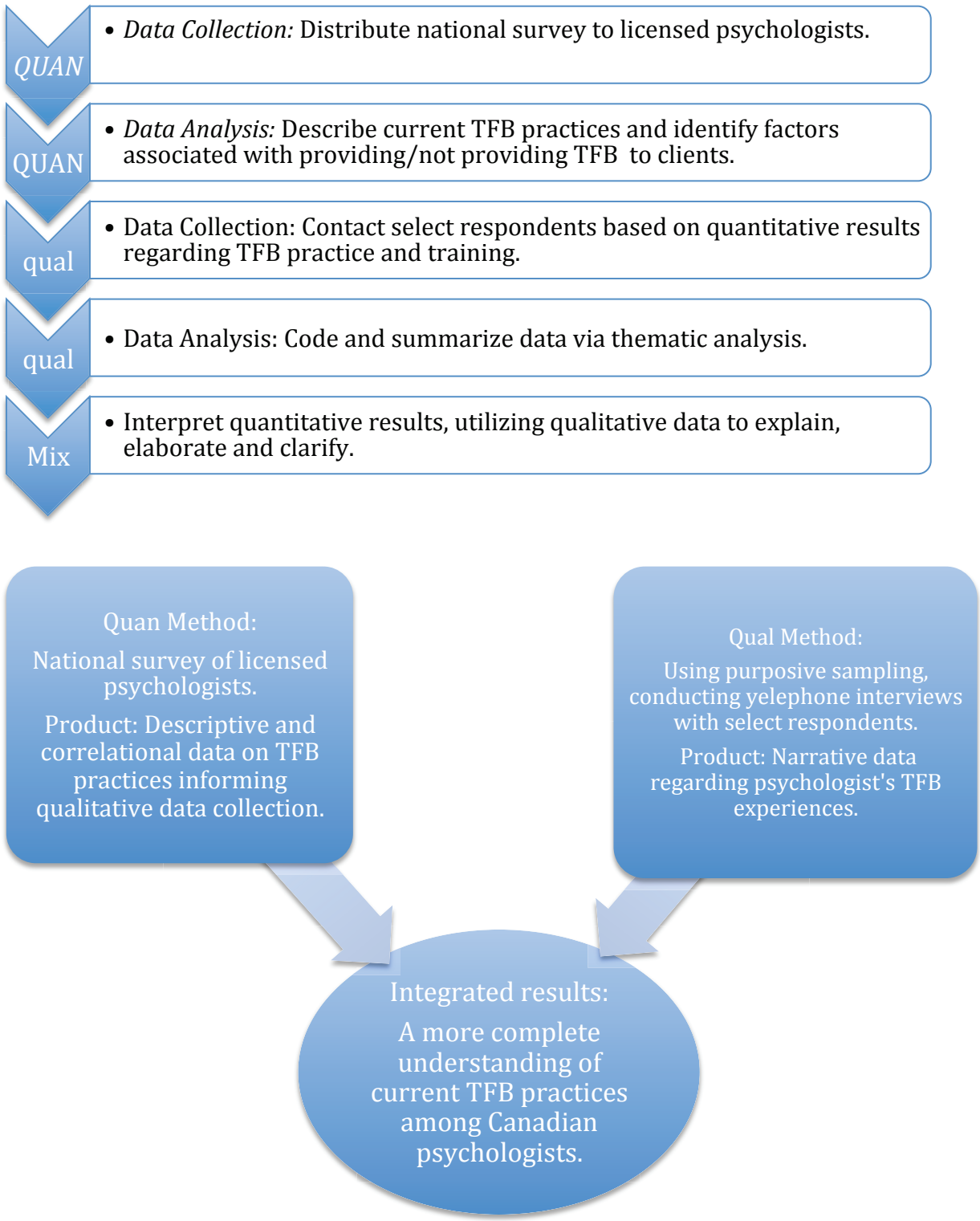
In a similar way, my biases and expectations may have also influenced these results through the manner in which I conducted the interviews. More specifically, my encouraging respondents to explore or elaborate on their experiences may have been inconsistently applied, such that demand characteristics (cf. Nichols & Maner, 2008) may have influenced respondents'

retelling of their stories. For example, an account highly consonant with my expectations or bias may have been less likely to receive a prompt, while discrepant responses may have elicited prompts more readily. In other words, the more respondents shared, the more likely I was to find material that corroborated my own perspective. Moreover, the ethical mandate psychologists have to share test results with clients, coupled with increased awareness of collaborative/therapeutic approaches may have introduced or augmented pressure on respondents to present their TFB practices as more favourable than they were in reality. In an attempt to minimize these influences, I imposed a two-prompt per question limit for all respondents, as well as an overall time limit of 25 minutes that no interview could exceed in an effort to promote equivalence.

Mixed Methods Procedure

The sequential-explanatory MMR design guided all phases of the study. First, the quantitative phase was used to determine the practices and training of Canadian psychologists as it relates to providing TFB. Then the quantitative results were used to identify clinicians whose TFB practice and training fell into one of two distinct groups. Finally, Qualitative data was collected and analyzed to expand and elaborate upon the quantitative results, explaining how the experiences of psychologists provide a better understanding of psychologists' TFB practice and training in Canada. Ultimately, the quantitative and qualitative results were integrated in the Discussion section. Figure 1 provides a visual overview of how the selected MMR design informed and shaped all aspects of this study.

Figure 1. Mixed Methods Procedure



Chapter 3: Results

Quantitative Results

Test Feedback Practices. In terms of the first RQ, focusing on Canadian psychologists' TFB practices, the majority of respondents indicated they provide some form of TFB more often than not. A general feedback item (item 18) was included to provide a conceptualization and to ascertain whether or not respondents reported providing TFB independent of a given format. The sizable majority of respondents (91%, *n* = 363) reported providing TFB *frequently* or more often; 77.2% (*n* = 308) indicated doing so *almost always*, and just 5.5% (*n* = 18) reported providing TFB *rarely* or *never*. Verbal TFB was the most frequently endorsed TFB format, with the majority of respondents (88.2%, *n* = 352) reporting they provide verbal TFB at least *frequently*, and 73.7%, (*n* = 294) indicating they do so *almost always*. Written TFB (i.e., a written report and/or summary) also appears to be common practice, with most respondents (60.2%, *n* = 240) reporting they provide written TFB *frequently* or more often, and 43.9% (*n* = 175) reporting they do so *almost always*. The least commonly indicated form of TFB was providing a copy of the actual test results (i.e., any raw data beyond a percentile rank and descriptor) to the client, as only 13.9% (*n* = 52) indicated doing so *frequently* or more often, and 6.3% (*n* = 25) reported doing so *almost always*. This was the only TFB item yielding omitted responses (*n* = 2), which may indicate these respondents misunderstood the question, or felt uncomfortable answering.

In order to get a better idea of what psychologists actually do when providing TFB, respondents indicated the extent to which they engage in specific clarification/elaboration activities. Based on Lichtenberg and Goodyear's (1999) conceptualization of test interpretation, and common activities in the C/TA model, these TFB clarification items (items 22 through 24)

were designed to determine whether psychologists are intentional about clarifying and/or elaborating on TFB, and to get a sense of how involved clinicians and clients are in the TFB process. The majority of respondents (91.9%; *n* = 367) indicated making a deliberate effort to ensure clients understand the assessments results and TFB *frequently* or more often, while 73.9% (*n* = 295) reported doing so *almost always*. Similar rates of highlighting the relevant implications of assessment results were indicated, with 95.2% (*n* = 380) of respondents reporting they do so at least *frequently*, and 79.7% (*n* = 318) indicating the do so *almost always*. Providing the client with an opportunity to ask questions about test results and to clarify their understanding of TFB also appears to be common practice, as 94.7% (*n* = 378) of respondents indicated doing so at least *frequently* and 86.7% (n = 318) reporting they do so *almost always*. Table 3 provides a summary of these results.

Test Feedback Training. In terms of the second RQ focusing on whether and how training programs are preparing psychologists to provide TFB, 64.9% (*n* = 259) *agreed* or *strongly agreed* that graduate training in psychological assessment did an excellent job preparing of them to provide TFB to clients; 22.1% (*n* = 88) of respondents either *disagreed* or *strongly disagreed*, and 13% (*n* = 52) were undecided. Respondents reported similar rates regarding their post-graduate training, as 65.6% (*n* = 262) *agreed* or *strongly agreed* that post-graduate training effectively prepared them to provide TFB; 13% (*n* =52) either *disagreed* or *strongly disagreed*, and 19.3% (*n* = 77) were undecided. Table 4 summarizes these results. Respondents were also asked to provide a global estimate of the percentage of their assessment training that focused explicitly on TFB at both the graduate and post-graduate levels. Responses varied greatly for both graduate (range = 0 – 100%, *M* = 15.54%, *Mdn* = 10.0, *SD* = 16.75) and post-graduate training (range = 0 – 100%, *M* = 19.98%, *Mdn* = 15.0, *SD* = 19.84) on this item.

Table 3

Frequencies and Format of Providing Test Feedback to Clients

Feedback Type/Activity	Response	Frequency	Percentage
Verbal FB	Never	7	1.8
	Rarely	11	2.8
	Sometimes	29	7.3
	Frequently	58	14.5
	Almost Always	294	73.7
Written Summary/Report	Never	38	9.5
	Rarely	68	17
	Sometimes	53	13.3
	Frequently	65	16.3
	Almost Always	175	43.9
Ensure Understanding	Never	7	1.8
	Rarely	9	2.3
	Sometimes	16	4
	Frequently	72	18
	Almost Always	295	73.9
Highlight Implications	Never	5	1.3
	Rarely	5	1.3
	Sometimes	9	2.3
	Frequently	32	15.5
	Almost Always	318	79.7
Answer Questions	Never	6	1.5
	Rarely	6	1.5
	Sometimes	9	2.3
	Frequently	32	8
	Almost Always	346	86.7

Note. Items were coded on a 5-point Likert scale, ranging from 1 (*Never)* to 5 (*Almost Always*). Verbal Feedback $M = 4.55$, $SD = 0.87$; Written Summary/Report $M = 3.67$, $SD = 1.41$; Ensure Understanding $M = 4.6$, SD = 0.82; Highlight Implications $M = 4.71$, $SD = 0.69$; Answer Questions $M = 4.77$, $SD = 0.69$

More omitted responses were found on this item than any other on the survey, with substantial

missing data for both graduate (13.5%, *n* = 54) and post-graduate training (16.2%, *n* = 65). A considerable number of respondents also expressed having difficulty with this item, indicating the question was either ambiguous or they were unable to recall the amount of time allocated specifically to TFB training accurately.

In addition to enquiring about the helpfulness of their training, respondents were asked to identify the primary method of TFB instruction they received. This item was designed so that response categories were mutually exclusive. By far the most common form of instruction indicated for graduate training programs was practicum/clinical experience (64.4%, *n* = 257) followed by open discussion with professor/supervisor (9%, *n* = 36), not applicable – no instruction was provided (7.5%, *n* = 30), lecture (6.8%, *n* = 27), and modeled by professor/supervisor (6.3%, *n* = 25). The remaining 6% of respondents indicated instruction took place through assigned reading, role-playing or other methods. Practicum/clinical experience was also the most commonly endorsed instruction method in post-graduate training (43.6%, *n* = 174), followed by open discussion with professor/supervisor (24.6, *n* = 98), not applicable – none provided (11.3%, *n* = 45), and modeled by professor/supervisor (9.8%, *n* = 39). Fewer than 4% of respondents indicated learning via lecture, assigned reading, role-playing or other means respectively. Table 5 provides a summary of these results.

Factors Associated with Psychologists' Test Feedback Practice. With respect to the third RQ, a number of factors significantly correlated with respondents' TFB practice. As previously mentioned, in order to get a broad understanding of the factors associated with providing/not providing TFB, all of the relevant TFB activities were incorporated into one TFB variable. Using the criteria for the strength of Pearson's *r* correlations articulated by Dancey and Reidy (2007), by virtue of the strong correlations among 3 of the 4 TFB items, and all of the

Table 4

Agreement that Academic Training was Helpful in Learning to Provide Test Feedback

Training	Response	Frequency	Percentage
Graduate Training	Strongly Disagree	23	5.8
	Disagree	65	16.3
	Neither Agree nor Disagree	52	13
	Agree	153	38.3
	Strongly Agree	106	26.6
	Missing	0	0
Post-grad. Training	Strongly Disagree	10	2.5
	Disagree	42	10.5
	Neither Agree nor Disagree	77	19.3
	Agree	153	38.3
	Strongly Agree	109	27.3
	Missing	8	2.0

Note. Missing refers to omitted responses. Items were coded on a 5-point Likert scale ranging from 1 (*Strongly Disagree)* to 5 (*Strongly Agree)*. Graduate Training $M = 3.63$, $SD = 1.19$. Post-graduate Training $M = 3.79$, $SD = 1.04$

TFB clarification items (Average Pearson's $r = .69$), a single TFB variable was computed using *SPSS* that was then used for the correlational analysis. Although a number of variables were significantly associated with respondents TFB practices, due to the somewhat arbitrary nature of the correlational analysis, and because many of these results were not guided by hypotheses at the outset, only correlations greater than 0.2 (Pearson's *r*) are reported.

Table 5

Primary Mode of Instruction in Graduate and Post-Graduate Training

Mode of Instruction	Graduate	Post-Graduate
Not Applicable (none provided)	30 (7.5%)	45 (11.3)
Lecture	27 (6.8%)	14 (3.5%)
Assigned Reading	10 (2.5%)	3 (0.8%)
Open Discussion with Supervisor/Prof.	36 (9%)	98 (24.6%)
Modeled by Supervisor/Prof.	25 (6.3%)	39 (9.8%)
Role Playing	7 (1.8%)	4 (1%)
Practicum / Clinical Experience	257 (64.4%)	174 (43.6%)
Other	7 (1.8%)	14 (3.5%)
Missing	0	8 (2.0%)

Note. Missing refers to omitted responses.

A number of purpose variables significantly correlated with providing TFB. These included using assessments to make/confirm diagnoses (Pearson's $r = .22$, $p < .01$) and using assessments as a therapeutic intervention ($r = .20$, $p < .01$). Using assessments for court-mandated reasons was negatively associated with providing TFB to clients ($r = -.23$, $p < .01$). Context/client variables that were positively associated with providing TFB included using assessments with adolescents ($r = .31$, $p < .01$) and with children ($r = .39$, $p < .01$). Using assessments with adults negatively correlated with providing TFB to clients ($r = -.22$, $p < .01$). Using assessments in other contexts, including assessing developmental delay, substance abuse, brain injury, testing with geriatric populations, and in industrial/organizational settings, did not

correlate with respondents' TFB practices. Similarly, using assessments with individuals who experience severe mental illness, with university students, or with an interdisciplinary treatment team was not correlated with respondents providing TFB.

A number of instrument variables correlated positively with respondents providing TFB. These include using intellectual ($r = .27$, $p < .01$), and behavioural instruments ($r = .36$, $p < .01$). Although using symptom-based measures and projective personality assessment instruments positively correlated with providing TFB, the strength of these relationships did not meet the established criteria. No association was found between respondents using career inventories or neuropsychological instruments and their TFB practices. Consistent with the empirical TA literature, all three TA variables positively correlated with respondents providing TFB. However, only the correlation between encouraging the client to generate their own personally relevant questions ($r = .28$, $p < .01$) and providing TFB was substantial enough to meet criteria. Preparing the client for the assessment ($r = .19$, $p < .01$) fell just beneath the established cutoff point.

Training variables correlated positively with providing TFB, including respondents finding both graduate and post-graduate training helpful. However, only the association with finding post-graduate training helpful met the criterion threshold ($r = .23$, $p < .01$). The results indicate the extent to which TFB instruction was experience-based or participatory (e.g., practicum, role-playing vs. lecture or assigned reading) correlated positively with providing TFB at both the graduate and post-graduate level. However, in this case, only the association between experience-based instruction in graduate training and providing TFB was substantial enough to meet criteria ($r = .23$, $p < .01$). Moreover, participatory forms of instruction were positively and substantially correlated with finding graduate ($r = .50$, $p < .01$) and post-graduate

assessment training ($r = .45$, $p < .01$) helpful in learning to provide TFB. Table 6 provides a summary of the purpose, instrument, TA, training and affiliation variables correlated with providing TFB to clients.

Contrary to the third hypothesis, years-since-graduation was not associated with respondents' TFB practices, suggesting recent graduates may not be more likely to provide TFB than less recent graduates. The fourth hypothesis was also not supported, as years-since graduation was not correlated with finding either graduate or post-graduate TFB training helpful. In a similar way, respondents' level of graduate training was not associated with their TFB practices. In terms of other demographic variables, respondents' sex was not associated with providing TFB. Ethnic/cultural identity, on the other hand, was weakly correlated with respondents' TFB practices. However, this item was statistically problematic due to 90% (n = 358) of respondents self-identifying as European-Canadian/White, and 5% (n = 20) of the remaining respondents self-identifying with other ethnic/cultural backgrounds (some of which included redundant categories such as Canadian). Given this lack of heterogeneity, and 'noise' between response options, this item could not be meaningfully interpreted.

Of the eight practice-setting variables analyzed, only working in a school or school district significantly –and positively– correlated with providing TFB, although this association was not substantial enough to meet criteria. None of the 13 theoretical orientation variables or the majority of CPA section affiliation variables correlated with respondents' providing TFB, with a few notable exceptions. Affiliation with the Psychologists in Education section correlated positively with respondents providing TFB ($r = .24$, $p < .01$), as did affiliation with the Developmental Psychology section ($r = .21$, $p < .01$). Conversely, affiliation with the Criminal Justice section was negatively associated with providing TFB ($r = -.29$, $p < .01$). Table 7

Table 6

Correlations among Factors Associated with Providing Test Feedback

	TFB	DX	CM	TI	IN	EQ	EI	PG	CJ
DX	.22*	1							
CM	-.23*	.00	1						
TI	.20*	.09	.00	1					
IN	.27*	.27*	.04	.00	1				
EQ	.28*	.13*	.00	.19*	.06	1			
EI	.23*	.18*	-.05	.04	.05	.13	1		
PG	.23*	.08	.02	-.02	.03	.12	.30*	1	
CJ	-.29*	-.12	.43*	.03	.03	-.08	-.07	-.08	1

Note. * Correlations are significant at the $\alpha = 0.01$ level (2-tailed). DX = using assessments to make/confirm diagnoses, CM = using assessments for court-mandated reasons, TI = using assessments as a therapeutic intervention, IN = using intellectual assessment instruments, EQ = encouraging clients to generate their own personally relevant questions, EI = experience-based graduate level TFB instruction, PG = finding post-graduate TFB training helpful, CJ = affiliation with the Criminal Justice CPA section.

provides a summary of age-related factors associated with providing TFB to clients.

Qualitative Results

Test Feedback Results. Results from thematic analyses are presented below. Four over-arching themes, along with the subthemes from which they were derived, are presented in Tables 8 and 9. Excerpts from the original transcripts are also presented below. Pauses, stutters, and non-essential vocalizations were omitted to enhance readability.

Theme 1: Self-instructed learning and Trial-and-Error. The first question asked of the TFB Group 1 was: "You indicated on the survey that you regularly provide test feedback to clients, despite insufficient formal training. Could you tell me more about how you learned to

Table 7

Correlations among Age-related Factors Associated with Providing Test Feedback

	TFB	AD	AL	CH	BH	DP	PE
AD	-.22*	1					
AL	.31*	.00	1				
CH	.39*	.09	.00	1			
BH	.36*	.27*	.04	.00	1		
DP	.21*	.13*	.00	.19*	.06	1	
PE	.24*	.18*	-.05	.04	.05	.13	1

Note. * Correlations are significant at the $\alpha = 0.01$ level (2-tailed). AD = using assessments with adults, AL = using assessments with adolescents, CH = using assessments with children, BH = using behavioural instruments, DP = affiliation with the Developmental Psychology CPA section, PE = affiliation with the Psychologists in Education CPA section.

provide test feedback?" The over-arching theme that emerged among Group 1 respondents was learning by trial-and-error and self-instruction. Relevant subthemes that mapped onto this broader theme included (a) supervisor's level of involvement/skill (b) inadequate academic preparation/support and (c) the complexity of assessment and TFB.

For example, Sue (pseudonym) works primarily with young offenders and complex needs youth. She earned her Ph.D 15 years ago, and currently conducts comprehensive assessments, initiating interdisciplinary treatment plans involving many stakeholders. In her response to this initial question, Sue indicated her graduate training was minimally helpful in her learning to provide TFB (reiterating "a little bit. . . ."), necessitating her learning through a process of trial-and-error. She described how she had to acquire her TFB skills largely on her own, and as a result of her supervisor's level of involvement. In her response, she also implied a relationship between the complexity of the assessment and one's ability to provide TFB.

> Sue: *I learned a little bit in my graduate work when we were doing feedback for children, psycho-educational and psychological assessments, a little bit. . . . It was trial and error. I had a supervisor in my initial workplace help me go through a few things and make sure I was [providing FB], but it was mainly trial and error. . . . We had some basic skills, we would give feedback on you know WISC, WIAT, all those basic tools, but not specific tools for case planning or more complex cases.*

Pam (pseudonym) earned her PhD in 2013. She works primarily in a hospital setting and currently conducts assessments with adults of various ages. Her response to this initial question also implicated learning through trial-and-error, and observational learning, indicating virtually no exposure to TFB exchanges prior to her internship. She also highlighted the important role her therapy training and experience had for learning to provide TFB, describing her process of learning to interact with clients based on their ability to understand, and her attempts to make FB more meaningful and accessible for them. She also talked about the importance of receiving FB from supervisors in the learning process, making an interesting connection between ending/terminating a course of therapy and concluding an assessment.

> Pam: *A big part of it [learning TFB] was that a lot of clients often have difficulty understanding the material presented in the reports. They also have problems remembering what I tell them. It was particularly true at a site where I was providing neuropsych feedback to people with brain injuries. They had problems understanding very complex information. I thought it would be helpful to provide diagrams and some brief summaries of the information presented in the feedback session for them to take home with them and to read later on when they needed that information. . . . I think my therapy experience helped a lot with that [learning to provide TFB]. Understanding the [my] case conceptualization and I guess the person's unique cognitive problems and how to interact with them based on those – I think that was really important. I think therapy skills played a big role. . . . It was mostly trial and error. I may have sat in on maybe a couple of feedback sessions in the very early*

Table 8

Group 1 Test Feedback Qualitative Themes

I.	Self-instructed Learning and Trial-and-Error
	a. Supervisors' level of involvement/perceived skill
	b. Inadequate academic preparation/support
	c. Complexity of assessment and TFB
II.	Enhancing Understanding that Benefits Clients in Tangible Ways
	a. Relationship between assessment and therapy/treatment
	b. Importance of considering the clients' needs
	c. Situating TFB into the clients' real-life context
III.	Presenting TFB in a Manner that guards against Misunderstanding/Misinterpretation
	a. Emotional arousal preventing understanding
	b. Mechanisms that mitigate misunderstanding
IV.	The Conditional/Contingent Nature of TFB
	a. Enhancing accessibility through simplicity and repetition
	b. Heightening perceived relevance of TFB through strengths-based approaches
	c. The significance and therapeutic utility of TFB

stages of my training but I hardly saw any until internship.

Gary (pseudonym) works in corrections for the federal government. Having earned his PhD in 2012, he primarily conducts forensic assessments and competency evaluations with adult populations, often in the context of an interdisciplinary team. His response to this first question also indicated learning through trial and error, along with modeling and observational learning of supervisors and mentors. Interestingly, he pointed out how continued professional education was more helpful to him than formal academic instruction in acquiring his TFB skills,

describing how didactic assessment training might be more effective if it's provided in pragmatic, ecologically valid ways ("I didn't find that the academic setting was particularly useful. . . .")

> Gary: *Well, kind of trial and error, and just listening to other people talk, and watching a couple of people who were either supervisors or identified as mentors if you will – watching them provide feedback and then kind of extrapolating from that, and using that as a basis for my own modeling of their behaviour, or not.*

Theme 2: Enhancing Understanding that Benefits Clients in Tangible Ways. The second question posed was, "Based on your experience, do you feel that there are any positive effects for clients receiving test feedback? If so, what are those positive effects, and how might they be maximized?" The over-arching theme that emerged from this question was the capacity of TFB to enhance understanding, coupled with the importance of using that understanding to benefit clients in tangible ways. In some cases, enhanced understanding pertained to the client understanding their own challenges/problems better; in other cases it focused on the shared understanding of the client and the clinician, or for peripheral individuals involved in the assessment (e.g., case workers, teachers). Various subthemes that mapped onto this broader theme included (a) the relationship between assessment and therapy/treatment, (b) the importance of considering the clients' needs and (c) situating TFB into the clients' real-life context.

For example, Pam's response to this question highlighted the capacity of TFB to promote the clients' understanding of themselves and their experience. In describing the therapeutic utility of TFB, she suggested that clients' understanding is actually linked to TFB being providing in a therapeutic way, allowing clients to integrate and make sense of the test results and their experience. She went on to describe how this benefit can be enhanced through

situating TFB into the everyday context of the clients by using multiple methods to make it more personally meaningful ("visual diagrams, using metaphors, incorporating examples . . ."), and including significant others in the clients' life, thus enlisting support for the client and making the exchange more relational.

> Pam: *Absolutely, I think that [TFB] can be really therapeutic, definitely. I've heard people talking about how much they benefited from assessment feedback in the same way that they talk about benefiting from therapy. . . . Just to understand their condition. A lot of times people haven't had any mental health services in the past and this is their first understanding of anything about their mental health . . . it sheds a tremendous amount of light on the problems that they've been having and helps them make sense of their experience.*

In a similar way, Gary's response described how, for him, TFB is connected to therapy/treatment. He frames the interplay between counselling and assessment, as well as the exchange between client and clinician as one that takes place on an ongoing basis ("So it's a conversation. It's a dialogue that's going on all the time. . . ."). He also mentions the importance of TFB incorporating aspects beyond the test results into the TFB before highlighting how TFB can promote a strengths-based understanding of the clients' abilities, using that understanding to inform their continued work together, while seeking to benefit the client in practical ways – in this case, by identifying substance abuse as an area of concern.

> Gary: *Certainly . . . For most of the clients that I see, the assessment informs ongoing counselling and then the ongoing counselling informs, in-turn a reciprocal relationship, ongoing community-based risk assessment – so it's a conversation. It's a dialogue that's going on all the time. It's less about the test results and more about the global assessment of how they're doing, what they're doing, etc. The test results are a component of that, but only a component.. . . . And often I think the test results potentially could be perceived as being rather pejorative in nature. If you do an IQ*

screener, [why would I be?] telling somebody that they have a low average IQ . . . Why am I doing this? 'I'm doing it because in a global context it helps me understand what your [the clients'] capabilities are, how you solve problems, and how quickly you think, and so on and so forth. And it'll help me develop a plan to work with you, maximize your strengths, and to work to try to emphasize again what you can do as opposed to zeroing in on what you can't do… We're also often asked to speak to, in a really kind of gross way, the presence of psychopathology, and again when you're working with an offender population there's a high incidence… Most of the time, many of those things are not really relevant. Substance abuse is if it's an ongoing concern, but I don't end up getting into DSM-5 with them – [instead it's] 'in a practical way, this is an issue for you'.

Theme 3: Presenting Feedback in a Way that Guards Against Misunderstanding. The third question enquired, "Do you feel there are any potentially negative effects associated with providing test feedback to clients? If so, what are those negative effects, and how might they be minimized?" The over-arching theme that emerged from the analysis of this question was the danger of clients misunderstanding or misinterpreting TFB. Respondents identified the manner in which TFB is presented (i.e., emphasizing demeanor over content, or the how as opposed to the what of TFB) as the most effective way to guard against the danger of misunderstanding. The subthemes that mapped onto this overarching theme included (a) emotional arousal preventing understanding, and (b) mechanisms that mitigate misunderstanding. With regard to minimizing potentially harmful effects, virtually all respondents spoke to the importance of context, as well as presenting TFB in a tactful, respectful manner, while not diminishing the accuracy or truthfulness of the test results.

For example, Sue identified the difficulty that emotional arousal (i.e., feeling "scared", "upset") can pose to clients appreciating the purpose of TFB, making it difficult for them to understand and benefit from it. She repeatedly came back to emphasizing the manner in which

TFB is given (e.g., "you have to provide it in such a way . . . ", "give it in such a way . . . "), identifying the how of presentation as an important process in mitigating misunderstanding. She also described the importance of investing the necessary time and energy to present TFB that is supported by the data ("factual, accurate . . . "), the importance of repetition, of connecting data to the clients' lived context ("This is why we're doing this right now, based on this piece of data. . . . "), and of the context itself ("context is everything when it comes to communicating results in a way that makes them understandable. . . . ").

Pam's response to this third question also implicated the potential of TFB being misunderstood as a result of emotional arousal ("can be overwhelming . . . "), and the importance of presenting FB in a way that makes it understandable (i.e., with "finesse and clinical skill . . . "). For Pam, this appears to denote providing TFB that involves adequate explanation, clarifying clients' understanding, and avoiding misinterpretation. She also went on to describe the importance of training/education, encouraging clients' to ask questions, and of making TFB a more familial/relational activity in order to minimize misunderstanding.

> Pam: *I guess it would depend on the method of delivery. It involves a lot of finesse and clinical skill to provide certain kinds of assessment feedback for sure. . . . I think providing complicated information can be overwhelming to a client without adequate explanation and ensuring that the client actually understands the results of the assessment and the recommendations. I think that can possibly be detrimental; they may misunderstand and they may take things more negatively than they ought to.*

Like Sue, Gary's response to this question emphasized the potential danger of misunderstanding, also highlighting the way TFB is given. He underscored the importance of context ("if it's done out of context, or the results are presented out of context. . . . ") and of conscientious ("tactful or discreet. . . . ") report writing in avoiding the harmful effects, being mindful of the potential for clients and/or third parties to misunderstand or misrepresent results.

Theme 4: The Conditional/Contingent Nature of Test Feedback. The final question posed to group 1 respondents inquired, "Is there anything else you would like to share regarding your experience or perspective on providing clients with test feedback?" The over-arching theme that emerged from this question was that effective TFB is conditional, that it depends upon a number of other important processes. Subthemes that mapped onto this overarching theme included (a) enhancing accessibility through simplicity and repetition (b) heightening the perceived relevance of TFB through strength-based approaches, and (c) the significance and therapeutic utility of TFB.

Sue's response to this final question highlighted the importance of delivering TFB in a way that makes it accessible for the client. She identified simplicity and specificity as the primary means of achieving this, describing the importance of ongoing TFB ("Feedback should be a process . . ."), and the importance of an interpersonal exchange (i.e., verbal FB) to ensure clients' understanding. She also describes how jargon can compromise accessibility, making an important connection between psychologists' proclivity for jargon and their training.

> Sue: *I think that's it's critical for us to be able to provide feedback verbally and to provide summaries that are so simple that anybody who is a non-psychologist can follow them. . . . Feedback should be a process and again you have the initial feedback, and you have the written feedback. It's better to have verbal feedback as you can go through things with the clients in a very specific way so that they get it. And make the assumption that even the simplest recommendation may not be understood, even by people in the mental health field because of our jargon. We have to make it very simple. . . . Being able to do that in a very, very specific way and being very clear with recommendations is critical. . . . That takes practice right? And I like things that are jargon free, but even for me it's really hard. By the time we get out of our training, we become so jargon and intellectually focused we forget that we have to make it very simple.*

Gary's response to this final question suggests that effective TFB depends upon its relevance from the clients' perspective. Based on his experience in community-based risk assessment, for Gary, this translates into adopting more strengths-based, even-handed approaches to ensure clients remain interested, motivated and engaged, even in cases when the FB might be predominately 'negative'. He also described the importance of including strengths-oriented TFB, particularly when assessments take place on an ongoing basis. Finally, Gary spoke of the importance of appreciating the power imbalance that is often at play in traditional assessment contexts, implying that psychologists should actively work to minimize this disparity through processes such as empathy.

> Gary: *I think one of the issues in corrections is that a culture has developed wherein we're quite skilled at articulating what an individual's deficits are, and articulating negative aspects of their behaviour or personality attributes, et cetera – not good at providing a strength-based, more solution-focused orientation, and so they [clients] don't want to read the stuff. I suspect they're not motivated to pore over the results of these assessments because it just seems often quite negative in focus. And who would want to read a lot of stuff that's quite uncomplimentary? That's what they read all the time about themselves. . . . I think if you're going to work with people and mitigate risk in the community, you have to be able to say what people can do. Certainly you have to spell out what the risk factors are, but I mean articulate what they can do. . . . I've become a bit more conscious of the need to be able to couch things in slightly more positive terms, and so the feedback that they [clients] get [is more positive], because I see these clients usually many times after I've concluded an assessment, it's an ongoing process. So it's a starting point for conversation if you will. . . . I think people [psychologists] need to get comfortable in their own skin and put themselves in the shoes of the individual that they're assessing. There's a huge power imbalance, I think we forget about that really easily. These people are in a highly vulnerable circumstance . . .*

Pam's response to this final question highlighted her conceptualization of TFB as the most significant aspect of the assessment experience. She described how, for her, there is no meaningful distinction between assessment and therapy, implying that effective TFB depends upon the degree to which the client experiences it as therapeutic. She also sheds light on her earlier responses, implying an intrinsic connection between assessment/TFB and therapy.

> Pam: *I think in many ways the feedback given to the clients is the most important part of the assessment process. It's the most important result. I think that focusing on that [TFB] is just as important as focusing on test interpretation or report writing. . . . To compare it again to therapy in terms of determining a successful outcome . . . there is that critical component in both cases [therapy and assessment] which is therapeutic value. . . . And I see them as similar in some ways for sure. Assessment can lead to therapy recommendations but assessment can also be a therapy in a sense because it involves that feedback component.*

Non-Test Feedback Results. Results from thematic analyses for group 2 are presented below. Five overarching themes and subthemes are presented in Table 9. As before, excerpts from the original transcripts are presented, with minimal edits.

Theme 1: Lack of Opportunity or Precedent. Respondents in group 2 were first asked about their experiences of not providing TFB to clients. Mindful of the ethical mandate that psychologists have to share test results, special care was taken to be non-judgmental and not to inadvertently shame respondents in any way. Accordingly, the first question inquired, "You indicated on the survey that you do not regularly provide assessment feedback to clients. Could you tell me a little more about that?" Virtually all respondents indicated they do not provide TFB to clients because they conduct assessments in contexts in which the 'client' (i.e., the referral source, or entity to whom the results are thought to belong) may not be test taker. Interestingly, all respondents also indicated they were willing to provide TFB to clients so long

as the referral source (e.g., court appointed lawyer) consented to them sharing the test results with the test taker, and that any barriers that would otherwise prevent them from providing TFB were removed. The overarching theme that emerged based on the analysis of group 2 respondents was that TFB was not given due to a lack of opportunity or precedent. Subthemes that mapped onto this broader theme included (a) perceived discrepancy between the client and the test taker and (b) practical, legal and professional/cultural barriers to providing TFB.

Barry (pseudonym) is a psychologist who earned his PhD in 1981. He currently conducts mostly forensic assessments involving personal injury, disability, and human rights claims. His response to the first question indicated he provides TFB to the 'client', but that the client and the test taker are not generally regarded as the same person. He described how he is quite happy to provide TFB to test takers, but indicates that doing so in the assessments he does is not normative practice, that there is rarely an opportunity to do so, and that there are numerous barriers that need to be removed or overcome to facilitate a TFB exchange. He also described how differences in clients' perspective regarding the circumstances/context of the assessment have a bearing on how interested they are in TFB, implying a notable distinction between assessment conducted with individuals who are seeking treatment for themselves, and those that involve third parties ("views it from a different perspective than somebody who's looking to get help . . . ").

> Barry: *I am pretty much exclusively a forensic psychologist . . . The client [in the assessments I do] is not the person I actually assess. The client is either their [the test taker's] lawyer, an insurance adjustor, a defence lawyer, or some other entity like a union representative, and those are the people who get the feedback. The person getting assessed theoretically could come around at some time in the distant future after the assessment, after whatever legal steps have taken place, and ask for feedback, and I would be happy to give it to them at that time. That seldom happens*

> *really; very rarely, because largely my reports are used for dealing with or negotiating compensation claims or other issues of that sort, and the person who gets assessed probably sees the report but views it from a different perspective than somebody who's looking to get help with a specific clinical problem, or who is looking for personal growth or things like that.*

Sarah (pseudonym) earned her PhD in 1998. She conducts assessments primarily with adult populations in forensic settings. Her response to this question also indicated her willingness to provide TFB to the test taker. However, similar to Barry, given the nature of the work she does, there is often limited opportunity and practical barriers ("if it's easy for me to have access to them . . .") to her providing TFB.

> Sarah: *Well that mostly just has to do with practical issues. So if I'm doing a risk assessment with somebody who's been incarcerated, and if it's easy for me to have access to them to show them their report, then I'm happy to do that. . . . A lot of the time, if it's a presentence report for example, I see them for the interview but then I never see them again. So even if I wanted to give them feedback, there's just no mechanism by which I can do that.*

Joanna (pseudonym) earned her PhD in 2011, and conducts forensic and high-risk employment screening/selection assessments (e.g., security, corrections, paramilitary personnel). Her response to this first question also indicated a lack of opportunity, practical issues, the perceived appropriateness of sharing test results with clients in some cases ("depending on why the client was referred . . ."), and the non-normative practice of providing TFB to test takers in the forensic community ("I guess it's just not standard procedure. . . .").

> Joanna: *Partially, it [not providing TFB] is because I don't have the opportunity. The client is coming maybe on a referral from the court or their lawyer to have an assessment done. So I meet with the client, usually face-to-face for several hours, and then they do a battery of psychometric tests. They're usually brought into the clinic maybe for a full day, day and a half, and then the report is written, so the clients' not*

Table 9

Group 2 Non-Test Feedback Qualitative Themes

I.	Lack of Opportunity/Precedent
	a. Perceived discrepancy between 'client' and test taker
	b. Practical, legal and professional/cultural barriers
II.	Onus on the Consumer to Initiate/Pursue TFB
	a. Legal, logistical and monetary barriers
III.	Providing Opportunity for Objective Learning
	a. Enhancing clients' understanding of their unique challenges
	b. Increasing clients' awareness of treatment options and implications
	c. Clients' level of motivation and interest
IV.	Feedback Implications Threatening Understanding or Engagement
	a. Clients' ability to access treatment
	b. Clients feeling overwhelmed by the emotions associated with the implications of TFB
	c. Taking results out of context
V.	Importance of TFB Training
	a. Promoting understandable TBF through accessible language
	b. Assuming responsibility for ones' own assessment competence
	c. Difficulty of learning to provide TFB requiring multi-modal learning

usually available to come back to my office. Sometimes it's about availability and sometimes it is because, I guess it's just not standard procedure. . . . Sometimes that [providing TFB] is an option; sometimes it's not, depending on why the client was

referred, what the specific question was. I guess I'm saying a lot of the time there's just not an opportunity to tell the client.

Theme 2: Onus on the Consumer to Initiate/Pursue Feedback. Group 2 respondents were then asked, "Are there circumstances in which you would provide clients with test feedback? How would those settings differ from your current practice?" The over-arching theme that emerged from respondents on this question was that that the onus to initiate the TFB exchange lies with the client/consumer, whether that is the test taker, a third party, or both. Subthemes that mapped onto this broader theme pertained to the legal, pragmatic and monetary barriers that need to be removed or minimized in order to make providing TFB more viable.

Barry responded to this second question again by indicating his willingness to provide TFB. In describing the circumstances in which he would provide TFB, he indicated that initiating that exchange is up to the client/consumer ("that's always initiated by the consumer. . ."), and that TFB would generally take place in instances where the clients' legal representative is the referral source. He also described legal barriers that would need to be removed to facilitate providing TFB ("until their lawyer releases that report . . .").

In a similar way, Sarah's response to this second question indicated her willingness and preference to provide TFB to the test taker if she is has the opportunity ("if I have easy access . . ."), and if she is being compensated ("there has to be room in the contract for me to do that . . ."). She proceeds to make an interesting comment, indicating she would be more likely to provide TFB with clients she is also treating. She went on to describe how she believes clients can benefit from TFB ("that's how they're going to learn something . . .") before reiterating some of the practical difficulties and barriers associated with providing TFB in forensic settings.

Sarah: *I provide feedback if I have easy access to the client again. So, if they're incarcerated and I'm back at the institution, then it's easy to see them first and then*

> *have them go through the report. If I'm doing treatment with them, then it's easy for me to make sure that I show them the assessment report before we start treatment. And so there's a dollars and cents thing around that as well. If I'm doing that [providing TFB] then it's billed hours, and so whoever it is that's paying me, there has to be room in the contract for me to do that right. So there are the practicalities of having access to the person, there's also the practicality of getting paid to do that work. . . . the feedback would be great to go to the person because that's how they're going to learn something, but I have to be able to actually do that right. Usually it's hard enough getting them into the chair just the first time.*

Joanna's response to this question also highlights her willingness to provide TFB if practical and monetary barriers are removed. She described how recommending therapy would be an instance in which she would feel ethically bound to provide TFB, regardless of whether or not she is being compensated. However, during the member checking process, Joanna clarified that she would provide brief TFB if it was requested and if the client could come into the office (i.e., "low cost and/or low time commitment. . . ."). During member checking, Joanna also expressed her perspective that providing TFB, even at the clients' request, is unreasonable if psychologists are not being compensated, or would lose money in the process.

> Joanna: *Often, in a lot of these cases, if the assessment is being paid for by Legal Aid, Legal Aid's not going to fund feedback sessions. . . . In private practice I would not be paid to provide a feedback session. . . . In some cases it would mean I'd have to maybe go to a prison. I'd have to take a half a day off work and go somewhere. That's not going to happen; it's not feasible. Let's say if I was recommending therapy, I'd provide feedback if it was ever requested. . . . I would do that even if it wasn't being paid for because I think I'd be morally and ethically obliged to do that.*

Theme 3: Providing Opportunity for Objective Learning. Group 2 respondents were then asked, "Based on your experience, are there positive effects that result from clients receiving assessment feedback? If so, what are those positive effects, and how might they be

enhanced?" The over-arching theme that emerged from responses to this question was that TFB provides clients with an opportunity for objective learning. Relevant subthemes that mapped onto this broad theme included (a) enhanced understanding of their unique challenges, (b) increased awareness of treatment options and implications, (c) the importance of client motivation and interest.

Barry's response to this question suggests he believes test takers are most likely to benefit from TFB through increased understanding of their challenges, and a greater level of awareness of their treatment options and implications of treatment, emphasizing the utility of verbal TFB. However, he went on to describe, based on his experience and perspective, how clients he sees are unlikely to pursue TFB, implying the clients' level of interest and motivation are important factor in psychologists not providing TFB in assessments involving third parties. His response also highlights the lack of involvement and engagement test takers often have in third party assessments, such that they may not remember their clinician's name ("I'm sure that a whole lot of people I assess don't even remember my name. . . .").

> Barry: *In those few cases, it may be that they get a better understanding of the report. They may get a better understanding of things like treatment implications because I would probably discuss that in greater detail with them at that time, as well as the nature of treatment. They could certainly have some benefit in that regard. Now they may get that benefit from reading the report itself. My reports are pretty explicit, but they may get more information about things like treatment options than what I would give out in a report. . . . I mean [with verbal FB] certainly you can provide a lot more information to people about appropriate treatments and the content of those treatments for their particular mental health problems.*

Sarah's response to this question suggests that test takers can learn something about themselves, and understand themselves and their behaviour with a greater degree of objectivity

through TFB. However she also described how the motivation and interest of the test taker is often an obstacle to realizing that understanding, suggesting this lack of interest/motivation is the product of the adversarial nature of the legal system coercing them into the assessment ("They're being forced to be assessed . . .") as well as the focus of the assessment ("it's in particular to a specific behaviour that's usually very negative . . .").

> Sarah: *Well, only if they're interested in the assessment. A lot of times these clients aren't particularly, right? You're doing the assessment through the [legal] system and the clients aren't interested in the results, or they do a lot of minimizing and they'll look at 'OK, in this section, I've only behaved this way in this particular moment in time, but I'm not always doing this'. So they tend to blow off a lot of the assessment unless they're actually interested in making some changes. . . . They are being forced to be assessed . . . So it's in particular to a specific behaviour that's usually very negative, and they tend to kind of put it in a box, that it isn't all about them, it's all about an incident.*

Joanna's response to this question also indicated the capacity of TFB to facilitate objective learning for the client, suggesting that providing test takers with the opportunity to shape the assessment more, to have some input ("to be given a voice. . . .") on the process is a way to potentially enhance the benefits of TFB. She went on to describe how incorporating the perspective of the client into forensic assessments would be helpful, indicating forensic test takers perhaps could –and ideally should– be more involved in the assessment and TFB process.

> Joanna: *I think it [TFB] helps give them an objective perception of their behaviour and their personality, or how they're being perceived. . . . And part of what you're doing in forensics is you're also providing a bit of, like actuarial data, providing a bit of comparison. 'Where do you fall compared to other people who have committed this crime?'. . . [Regarding enhancing the benefits of TFB] One of the things that I think is important in the forensic world is that it [a TFB session] might offer the opportunity for them to correct any errors. . . . So it would give them a chance to make corrections,*

> *or to at least to be given a voice. . . . It would be really lovely if people could read the reports and then I could say 'this is their [the test takers'] comments' or 'this is their perception on it too'. But we don't have that opportunity.*

Theme 4: Feedback Implications Threatening Understanding or Engagement. Next, Group 2 respondents were asked, "Do you feel there are any potentially negative effects associated with providing clients with TFB? If so, what are these negative effects, and how might they be mitigated?" The over-arching theme that emerged from responses to this question was the danger of the implications associated with assessment preventing test takers from understanding TFB or successfully engaging in treatment. Various subthemes loaded onto this broader theme, including (a) the ability to access treatment (b) being overwhelmed by the emotions associated with TFB (c) taking results out of context.

Barry responded to this third question by describing how test takers can struggle with the implications of TFB in terms of the scope and cost of treatment ("feel overwhelmed by the treatment recommendations . . .") such that they may not understand, or may be discouraged from pursuing treatment. He described the regrettable reality that many clients receiving psychological assessment may not have the ability to access treatment ("that means their mental health is unaffordable. . . ."), and proceeded to highlight how results can be readily misunderstood or misinterpreted by test takers when they are taken out of context or not sufficiently explained. He identifies in-person TFB as the primary means by which these negative effects can be mitigated.

> Barry: *Certainly there are negative effects . . . In terms of giving verbal feedback, I think some of the negative consequences are that they may feel overwhelmed by the treatment recommendations and the amount of work that might go into trying to fix things. Remembering that the majority of the people I see tend to have some significantly disabling mental health problems that probably are going to require*

> *significant energy on their part to get better, and very often they are individuals with limited resources. For example, if you were to tell somebody that they probably need a 30 hour course of some form of cognitive behavioural therapy for some combination of anxiety and mood problems, and they realize that the asking price for private sector psychological therapy is around $200 an hour . . . you're suggesting they ought to be spending $6,000 out of their own pocket for rehabilitation. I think the dilemma with that, and we don't fully appreciate this, is that for some people, that means their mental health is unaffordable. . . . There is also so much information there that it would be easy for an anxious person who's being assessed to find something alarming in the report. That is actually not an uncommon occurrence. When they see the report that they get alarmed by something, whether it's a discussion of some kind of personality issue or some other test data that they take out of context because it was interpreted from their own perspective as opposed to the perspective of a psychologist, and they then become alarmed. That may cause them distress and may lead them to misinterpret what's happening . . . Certainly these are very negative repercussions. Now of course you can soften those repercussions if you provide in person feedback, but, by and large, there are legal constraints to doing that . . .*

Joanna's response to this question also speaks to the 'high-stakes' nature of assessment in forensic settings, and how the level of emotional arousal ("too emotionally involved. . . .") that accompanies assessment in these contexts can often lead to test takers misunderstanding or misinterpreting TFB ("they're not really in a position to absorb some of the information . . ."). She also described her concern that test takers may learn some things through TFB that, depending on the results, might not be entirely helpful ("it could be harmful . . .").

> Joanna: *Definitely, misunderstanding . . . taking it [TFB] out of context. I find that forensic clients are probably more inclined to misunderstand results because they're too emotionally involved. With forensic reports there's a lot of consequences, right. I mean based on my report somebody might go to jail versus continue to live in the community . . . So they're not really in a position to absorb some of the information*

that we're giving them. I mean they have an alternative need, which is totally understandable in the moment. . . . They want to look really good and so they're giving you all their good stuff . . . and sometimes we are supporting them and looking at their strengths and [at other times] their weaknesses. But sometimes when they're not good [desirable] reports, I'm concerned that it could be harmful [to clients], and yeah sometimes I actually think it could be really hurtful . . .

Theme 5: Importance of Test Feedback Training Finally, Group 2 respondents were asked, "Is there anything else you would like to share regarding your experience or perspective on providing clients with test feedback?" The overarching theme that emerged from this question was the importance of training in learning to provide TFB. Various subthemes that mapped onto this overarching theme included a) promoting understandable TFB through accessible language, b) assuming responsibility for ones' own assessment competence, and c) the difficulty of learning to provide TFB requiring multi-modal learning.

Barry's response emphasized the importance of learning to provide accessible TFB to non-psychologists who may not have the same knowledge base or training. In his response, he suggests that jargon can be a major impediment to clients/consumers understanding test results, making an interesting and novel suggestion for graduate programs to consider implementing to aid the acquisition of this skill.

Barry*: I suppose one of the things that I think that they could do in graduate programs would be to have an exercise whereby you run practice reports through consumers who are, without violating people's confidentiality of course, through consumers who aren't psychologists, like non-psychologist staff members or other students in different disciplines. [Have them] Read reports and say 'how understandable is this and how much of this is jargon that you can't understand?' so that you could actually get people to write reports that can communicate to non-mental health third parties. By and large the vast majority of psychological*

> *assessment work is aimed at consumers who do not have the similar academic background to psychologists. It's very seldom that one actually writes a report where the primary consumer is going to be another psychologist.*

Sarah's response to this question highlighted the importance of trainees ensuring that they get what they need from training programs in terms of assessment competence. She suggests that the responsibility ultimately lies with the student to seek out the requisite training ("making sure that whatever institution you attend actually trains you."). Her response also suggested that doctoral level training is likely more effective in preparing psychologists to work in certain settings, while emphasizing the variability in training programs, with the implication that not all psychologists attain assessment competence.

> Sarah: *Like everything else, it just needs to be a little bit more continuing education and a little bit more basic training. There's just such a wide variety of training. I have a doctorate and so I find I was fairly well trained for the work that I do. I see a lot of people who aren't and who don't have the requisite coursework, who really don't know what they're doing. So it just becomes about making sure that whatever institution you attend actually trains you.*

Joanne's response highlighted the difficulty of learning to provide TFB requiring multi-modal learning (i.e., in-class discussion, supervision, and practical experience). She emphasized how providing TFB is particularly challenging in cases when it is undesirable ("especially when it's unpleasant. . . ."), describing how psychologists' desire to help can actually impede their ability to provide hard-to-hear TFB effectively. Although she speaks to the importance of using established criteria to teach TFB in academic settings ("there needs to be clear academic guidelines . . .") her response also emphasized the limitations of classroom instruction and the important role of learning TFB in real-life settings as well. It is important to note that the

example she uses in the following excerpt pertains to employment screening, while her previous responses were oriented around forensic assessments.

> Joanne: *Yeah, I think it's something that should be part of discussion in class and also a part of supervision. It's very hard to give feedback to people, especially when it's unpleasant. I think psychologists like to help people and we're not very good at telling people negative things, unpleasant things. . . . I mean sometimes you can't learn this stuff in a class; you can talk about it and you can practice it, but it really is about working with a good supervisor, talking [about TFB] and doing it. . . . I mean you need to be straight, you need to be clear; there needs to be some clear kind of academic guidelines with what to do. Most of us, I think, a lot of psychologists, we're just generally uncomfortable. It's very uncomfortable to tell somebody, 'well on testing, even though you're telling me everything's fine in your life, you're coming up as slightly depressed and anxious and therefore I'm not going to give you this really great job that you've been working for 10 years on'. Who wants to tell somebody that?*

Chapter 4: Discussion

This study utilized a sequential-explanatory mixed methods research (MMR) design to examine Canadian psychologists' test feedback (TFB) training and practice. In this replication of an earlier study by Curry and Hanson (2010), four broad research questions (RQs) were addressed. The first focused on the extent to which psychologists, deliver TFB to clients. The second, on the degree to which graduate and post-graduate training programs prepare psychologists to provide TFB. The third sought to identify factors associated with psychologists providing or not providing TFB, while the fourth inquired about how the experiences of practicing psychologists provide a better understanding of their TFB practices including how graduate and post-graduate training influenced those practices.

In terms of the first RQ focusing on the extent to which Canadian psychologists provide TFB to clients, as hypothesized, the majority of Canadian psychologists indicated they do provide some form of TFB to clients most of the time, as 91% of respondents indicated providing TFB to clients *frequently* or more often. Consistent with previous survey research (Curry & Hanson, 2010; Rupert et al., 1999; Smith et al., 2007), verbal TFB was the most commonly indicated format, with 88.2% of respondents reporting they provide verbal TFB at least *frequently*. As such, it appears that TFB practices among Canadian psychologists are largely consistent with ethical standards and guidelines that psychologists share test results with clients (cf. APA, 2002; CPA, 2000). It is likely that third party assessments, in which the 'client' and the test taker are seen as different individuals (e.g., in forensic assessments), account for the 9% of respondents indicating they do not provide TFB consistently, particularly given that 18.3% of respondents in this study reported using assessments for court-mandated reasons. Still, because the extent to which Canadian psychologists conducting third party assessments provide

TFB is not known, this gap may indicate a discrepancy between current TFB practices and existing ethical standards and guidelines.

In comparison with Curry and Hanson's (2010) findings indicating 91.7% of American psychologists provide some form of TFB to clients *sometimes* or more often, the present results appear to suggest higher rates of providing both verbal (88.2% > 65.5%) and written TFB (60.2% > 43%) among Canadian psychologists. However, according to a comparison of means based on 5-point likert scales –employed in both studies– the difference between verbal TFB among Canadian ($M = 4.55$, $SD = 0.87$) and American psychologists ($M = 3.90$, $SD = 1.03$) was not significantly different ($t = 0.48$, $p > 0.05$). Likewise, differences in providing written TFB among Canadian ($M = 3.67$, $SD = 1.41$) and American psychologists ($M = 3.31$, $SD = 1.28$) are not significantly different ($t = 0.19$, $p > 0.05$). Although different sample sizes, variances, and scale descriptors makes for suboptimal comparison, based on the available data, there is insufficient evidence to conclude that the TFB practices among Canadian and American psychologists are meaningfully different.

With regard to the second RQ focusing on whether and how training programs are preparing psychologists to provide TFB, the results suggest there is considerable room for improvement. A sizeable proportion of psychologists did not finding graduate or post-graduate training helpful in learning to provided TFB, with approximately 1/3rd of respondents indicating either neutral or negative experiences. This finding is consistent with Curry and Hanson (2010), and with existing literature suggesting training in psychological assessment is often deficient in instilling assessment and TFB competence in graduates (Handler & Smith, 2013; Stedman, Hatch, & Schoenfeld, 2000). Possible explanations that have been offered for this occurrence include training programs responding to the influence of managed care limiting the funding

available for psychological assessments, and insufficient training program resources (Belter & Piotrowski, 2001; Curry & Hanson, 2010).

In the present study, practicum/clinical experience was the most commonly indicated TFB instruction method in both graduate and post-graduate training. As hypothesized, and consistent with Curry and Hanson (2010), respondents who found post-graduate training helpful in learning to provide TFB were more likely to report providing TFB consistently, while those who found graduate training helpful were not. Interestingly, the extent to which respondents' graduate training was experience-based (e.g., practicum, role playing vs. lecture or assigned reading) corresponded to their providing TFB more consistently; however, this was not the case for post-graduate training. Respondents who received experience-based instruction were also more likely to report finding both graduate and post-graduate training helpful in learning to provide TFB. The most likely explanation for this pattern of results is that respondents in this study found experience-based instruction (i.e., learning by doing) more effective than didactic approaches, not only in learning how to provide TFB, but in learning to value the activity (which is relational in nature), and coming to appreciate its importance, therapeutic utility and treatment efficacy such that it impacted subsequent practice. The stronger association between TFB practice and experience-based learning at the graduate level likely speaks to the variability of instruction methods in graduate training programs (cf., Handler & Smith, 2013; Krishnamurthy et al., 2004), with experience-based instruction being experienced as more helpful. The more consistently experience-based nature of post-graduate training likely accounts for the comparatively weak association between participatory instruction in post-graduate training and providing TFB – which makes sense when one considers respondents who found post-graduate training helpful, regardless of training type, were more likely to report

consistently providing TFB. Although these findings do not establish a causal relationship, they do suggest that training has a significant bearing on psychologists' subsequent TFB practice.

Based on the proliferation of collaborative/therapeutic approaches to assessment in recent decades (Finn, Fischer & Handler, 2012), as well as prior research, it was hypothesized that recently graduated psychologists would provide TFB more consistently than those earning their degrees earlier. In a similar way, based on increased awareness of collaborative/therapeutic assessment models, and a presumed emphasis on the importance of TFB in contemporary training programs, it was also hypothesized that recently graduated psychologists would report finding TFB training more helpful than earlier graduates. However, the results did not support either of these hypotheses. This is consistent with Curry and Hanson (2010) on both counts, with the exception that recently graduated clinical psychologists were more likely to provide verbal TFB in the original study – a result that did not materialize in this study. Taken together, these results suggest that contemporary training programs are not preparing psychologists to provide TFB to clients more effectively than those of the past. However, an alternative explanation is that psychologists graduating at earlier points in time may be learning to provide TFB through means other than formal academic training (e.g., continued professional education, work experience, consultation) such that their practice is comparable to recent graduates.

Regarding the third RQ that sought to identify factors associated with psychologists' TFB practices, in addition to the training variables already discussed, a number of context variables were also associated with respondents' TFB practices. Based on the pattern of results, the age of the test taker appears to play an important role in psychologists providing TFB to clients. Specifically, psychologists who use assessments with children and adolescents were more likely to report providing TFB, while psychologists who use assessments with adult

populations were less likely to report providing TFB, which is unexpected, given that C/TA was first developed with University-aged clients (Finn & Tonsager, 1992). Furthermore, respondents affiliated with the Psychologists in Education and Developmental Psychology CPA sections were more likely to report providing TFB to clients consistently, also implicating age as a determining factor. This pattern of results also converges with the finding that psychologists using behavioural instruments were more likely to report providing TFB. Behavioural instruments are utilized predominately with children and youth, and are often components of psychoeducational assessments (Reynolds & Kamphaus, 2004; Sattler, 2008). The most likely explanation of these results is that youth are typically referred for assessments for developmental, behavioural and educational purposes, with the intention of understanding their difficulties such that they can be better helped and supported. (cf. Sattler, 2008), which is not always the case with adults.

Another related pattern of results that emerged with respect to the third RQ suggests that Canadian psychologists are less likely to provide TFB to clients in assessments that involve third parties –the legal/judicial system in particular, which incidentally, is consistent with ethical exemptions (e.g., College of Alberta Psychologists Practice Guidelines, 2013). Psychologists who use assessments for court-mandated reasons and those affiliated with the Criminal Justice CPA section were both less likely to report providing TFB consistently than their colleagues. The negative association between respondents using assessments with adults and providing TFB is also relevant as the circumstances surrounding adult assessments are often quite different in that they are more likely to involve third parties (Frank & Elliot, 2000), and adult clients are less likely to have beneficent advocates or caregivers than are children and students. Issues pertaining to client motivation, interest and capacity to understand TFB when conducting

substance abuse, brain injury, child custody, competency or forensic assessments are also more salient when the test taker is an adult (Nagliere & Graham, 2003). Essentially, the process of conducting assessments and providing TFB becomes more complicated with adult populations due to the involvement of third parties.

Integration of Quantitative and Qualitative Data

Mixed methods research requires the integration of the quantitative and qualitative data strands at one of five distinct points in the research sequence (Creswell & Plano Clark, 2011). In keeping with the sequential-explanatory MMR design, the data strands were integrated at the point of interpretation, whereby the results from the qualitative interviews were used to explain and shed light on the survey results. Additionally, interviewees were selected based on their quantitative survey responses, which represents yet another form of integration (at the point of data collection). Ultimately, this corresponds to the fourth RQ that sought to understand the experiences of six psychologists representing two distinct groups. Based on the results, psychologists who regularly provide TFB to clients despite insufficient training appear to be learning this skill primarily through self-instruction and trial-and-error. This is consistent with Curry and Hanson (2010) who, likewise, found that psychologists learn to provide TFB largely on their own through similar processes (i.e., trial-and-error), often identifying didactic classroom instruction as absent or ineffective. For the present study, respondents learning in this way corresponded to their supervisor's level of involvement/perceived skill, inadequate academic preparation, and the complexity of assessment and TFB outstripping didactic training methods. These results shed some light on the processes involved in psychologists experiencing their TFB training as deficient, and highlight the importance of experience-based learning. Taken together with the quantitative data, the results suggest that learning by doing may be the

most effective TFB training approach. However, it is important to note that experience-based learning does not necessarily involve trial-and-error, and more effective didactic training approaches may see future practitioners learning to provide TFB because of their academic training, rather than in spite of it.

Psychologists who reported not providing TFB to clients consistently indicated conducting assessments primarily in forensic settings, and identified a lack of opportunity or precedent in their assessment contexts as the primary reason for not providing TFB. In keeping with previous research (cf. Curry & Hanson, 2010; Smith, Wiggins & Gorske, 2007), all respondents expressed their willingness and preference to provide TFB whenever possible/feasible. Respondents' experience of not providing TFB was a result of a perceived discrepancy between the 'client' and the test taker, and of practical, legal, monetary and cultural/professional barriers preventing them from doing so. Respondents also indicated their perspective that the onus to initiate or pursue TFB lies with the consumer/client, and that barriers need to be removed to make TFB sessions more feasible. These results shed some light on the quantitative results, suggesting the primary reason 9% of respondents do not regularly provide TFB to clients is a lack of opportunity. They also help to explain the negative association between providing TFB to clients and (1) using assessments for court-mandated reasons and (2) affiliation with the Criminal Justice Section of CPA. These results are largely consistent with Curry and Hanson (2010), and do not appear to represent a deviation from established ethical standards and guidelines (cf. College of Alberta Psychologists, 2013).

Both groups of respondents identified enhanced learning and understanding as the primary benefit of providing TFB to clients, with some notable differences between them. Respondents who indicated providing TFB inconsistently identified the opportunity for

objective learning as the primary benefit of receiving TFB. This theme corresponded to promoting clients' understanding of their unique challenges or situation, increasing their awareness of treatment options and implications, and the important role that the clients' level of motivation and interest plays in them deriving a benefit from TFB. Conversely, and consistent with the C/TA model (cf. Finn, Fischer & Handler, 2012), for respondents who regularly provide TFB, the importance of enhancing understanding was connected to using that understating to benefit clients in tangible ways. This understanding corresponded to the reciprocal relationship between assessment and therapy/treatment, the importance of considering the clients' practical needs, and of situating TFB into the lived context of the client. These results shed light on the positive association between providing TFB to clients and (1) using assessments as a therapeutic intervention and (2) encouraging clients to generate their own personally relevant questions. Based on the integration of the data strands, these results suggest that psychologists who regularly provide TFB to clients conceptualize assessment in a manner that is more consistent with the C/TA model, and provide some insight into how that model shapes their assessment and TFB practices.

Both groups of respondents identified clients/consumers misunderstanding or misinterpreting TFB as its primary potential negative effect, again with notable differences. Respondents who do not provide TFB consistently identified the implications of TFB potentially threatening the clients' understanding of the results or their successfully engaging in treatment. This theme corresponded to the clients' ability to access treatment, feeling overwhelmed by the emotions or implications associated with the results (e.g., being incarcerated), and the danger that TFB could be taken out of context. Conversely, respondents regularly providing TFB emphasized the importance of presenting TFB in such a way that

guards against the pitfalls of misunderstanding or misinterpretation. This emphasis on the manner in which TFB is given corresponded to the potential danger of emotional arousal preventing understanding, and specific mechanisms that guard against misunderstanding including accuracy, repetition, respect, explanation/clarification, and the importance of context. These qualitative results partially account for the relative prevalence of verbal TFB indicated on the survey, with 88.2% of respondents providing verbal TFB *frequently* or more often, as opposed to 60.2% providing written TFB *frequently* or more often. Respondents in both groups spoke to their preference for verbal TFB in terms of it being more conducive to thorough and in-depth explanations of test results, ensuring clients' understanding, and providing them with an opportunity to ask questions. This result is encouraging, as verbal TFB permits more dialogue and reciprocal client-clinician interaction than written formats, (cf. Finn, 2007). However, written TFB allows the clinician to relay a considerable amount of information, and the client can refer back to the document indefinitely if needed. Arguably, there is some benefit to incorporating both forms of TFB, as some research demonstrates (cf. Fallows & Hilsabeck, 2013).

Limitations

This study has a number of limitations in the area of generalizability. First, a census sampling strategy was used in which all potential/available respondents meeting inclusion criteria were invited to participate. This study utilized a census sampling technique, yielding a large sample but a relatively low response rate (14.4%). It is also important to specify that this is a census technique and not a census proper; as such, the population of interest may differ from the sampling frame in important ways, potentially limiting the degree to which the results generalize beyond participants in this study. However, according to the available current

research, participants in this survey do appear to represent Canadian psychologists active in assessment reasonably well (cf. Hunsley, Ronson, & Cohen, 2013; Ionita & Fitzpatrick, 2014). Another limitation pertains to respondents self-selecting (cf., Shadish, Cook, & Campbell, 2002), with the implication that the results may reflect the perspectives of psychologists predisposed to participating in research of this nature more than they do the population of interest. The reality of demand characteristics inadvertently encouraging respondents to provide a more desirable account of their TFB practices, or discouraging respondents who provide TFB less consistently from participating, may also result in a more favourable, less accurate picture of TFB practices than exists in reality (cf. Nicols & Maner, 2008). The ethnic/cultural invariability of the sample also limits the generalizability of these results, as respondents were overwhelmingly European-Canadian/white; private practice was identified as the primary practice setting far more often than any other category, and the majority of respondents self-identified as clinical psychologists. Based on the assumption that specializations likely differ in their assessment and TFB practices (cf. Clemence & Handler, 2001) the degree to which these results reflect psychological assessment in Canada, in all its diversity, may be limited.

The correlational analysis used in this study also poses a number of limitations. While correlations identify the presence of relationships among variables, they cannot speak to the nature of those relationships. To be clear, none of the associations reported in this study establishes a causal link between any of the variables examined and Canadian psychologists' TFB practices. Another limitation of the correlational analysis pertains to the factors associated with providing TFB to clients. First, it should be noted that not all correlations are created equal, and the small magnitude of many of the reported associations limits the degree to which they can be argued to correspond to psychologists' TFB practices. Second, because many of the

reported correlations were not guided by hypotheses or an overarching TFB theory at the outset, and because associations may emerge that mean nothing simply due to chance, these results may be criticized on the basis of 'data fishing' (cf. Selvin & Stuart, 1996). However, the adopted approach was the most appropriate to answer the research question posed, and a number of precautions were taken in light of these limitations.

Perhaps most importantly, there are a number of limitations presented by the survey instrument itself. First, because the psychometric properties and factor structure of the instrument are not known (and, for that matter, not the focus of the study), it cannot be stated definitively whether or how the instrument maps onto psychologists providing TFB to clients. Second, in the spirit of study replication, the decision was made to include several potentially problematic items – to maximize the comparability with Curry and Hanson (2010). However, despite attempts to enhance clarity using more precise language and alternative response formats, two items that proved to be problematic in the original study also had to be omitted from this study. The item inquiring about whether respondents provide a copy of test results to clients (item 20; see Appendix A) was omitted from analysis. As the study progressed, it became apparent this item did not correspond with providing TFB to clients as conceptualized. The items asking respondents to provide a global estimate of the proportion of classroom instruction dedicated specifically to providing TFB (items 26 and 29; see Appendix A) were also omitted due to a large number of missing responses and participants indicating they were not confident in their ability to answer accurately. Third, because the survey instrument allowed respondents to endorse multiple options in some cases –including *other*– the extent to which the survey data can be used to answer other specific questions is limited (e.g., "Is there a relationship between conducting developmental delay assessments and providing TFB?"). The

decision to utilize the current form of the instrument was based on maintaining a reasonable completion time and response rate, as well as the exploratory nature of this research among Canadian psychologists. Finally, several components that should have been included in the survey were overlooked. First, respondents were not asked about their age, which poses some limitations to generalizability and comparability with existing studies. Also, the instrument was not translated into French, unfortunately forcing Francophone respondents to complete the existing English version. This represents a definite oversight for a national survey study of Canadian psychologists.

The qualitative component also presents a number of limitations. First, although qualitative methods are typically not intended to enhance generalizability, it should be stated explicitly that the present qualitative results are not intended to represent the experiences or perspectives of any psychologists beyond this study. Second, although member checking was used to enhance the validity and trustworthiness of the results, the researcher conducted the qualitative data collection and analysis in isolation. As such, some important aspects of respondents' experience may have been overlooked or underemphasized, while others may have been underscored as a result of the researcher's expectations, experience, values, etc. Third, interviews were conducted with the providers of TFB rather than the recipients, and discrepancies between the perspectives of psychologists and clients on the subject of TFB may be considerable. Finally, the nature of qualitative research, as a form of interpretive inquiry, poses other limits to this study that are discussed elsewhere (see Method).

Directions for Future Research

While operationally defining TFB through general description of assessment activities has sufficed to date, a unifying theory of TFB and what it entails is necessary to advance future

research in this area. This denotes creating an empirically based theoretical construct, requiring collaboration among diverse educators, researchers and professionals. A more substantiated measure of TFB could then be developed, with identifiable psychometric properties. Analyzing and integrating components of the C/TA model, TI framework, and the survey instrument used in the present study may be promising places to begin (cf. Finn & Tonsager, 1997; Lichtenberg & Goodyear, 1999; Curry & Hanson, 2010). In a similar way, researchers and clinicians should collaborate to develop TFB process and outcome measures (cf. Lambert, Hansen, & Harmon, 2010) for both clients and clinicians to monitor the effective provision of TFB. Tools such as this would be easy to implement in training and research settings alike, and Finn's Assessment Questionnaire-2 (AQ-2) is an existing tool that may be helpful to model in this regard (Finn & Tonsager, 1992). Future research should also explore more sophisticated quantitative techniques to examine the relationships between the variables identified in this and other TFB studies. For example, using logistical regression, and treating TFB as a binary variable, researchers could model the probability of psychologists providing TFB every time.

Teasing apart and delineating TFB practices among psychologists as it relates to specialization and practice setting represents an important line of inquiry. Researchers could achieve this by employing quota-sampling strategies to engineer samples that are more representative of the target population. The relatively high rates of psychologists conducting assessments in private practice settings may be an area of particular interest. The observation that assessments are being increasingly outsourced to specialists in private practice (cf. Nagliere & Graham, 2003) may negatively impact the consistent provision of TFB. The pressure to remain competitive in the private sector and the influence of managed care may result in clinician's regarding TFB as superfluous to the actual assessment, perhaps presenting the TFB

'option' to clients in a 'batteries not included' fashion. This would be particularly unfortunate, given TFB's known treatment benefits (cf. Poston & Hanson, 2010).

Future research on what works in training psychologists to provide TFB is also needed. Whether the seemingly equitable TFB practices of early and more recently graduated psychologists are better explained by inadequate training or continued professional education/evolution remains unclear. This represents an important line of inquiry for future research to address, and longitudinal research designs on graduates with comparable training, tracking their professional development/education activities and TFB practices over time, may be helpful in answering this question. Although it is often mentioned in tandem with academic and practical/clinical training, given its salient role in attaining assessment and TFB competency, future research should examine the specific effects of supervision on TFB practice, which would likely be amenable to longitudinal or retrospective (e.g., archival) research designs. Research on the value that practitioners currently place on TFB, as well as their rationale for that assigned value, is also needed in order to identify barriers to implementing more explicit TFB practice and training standards and guidelines, and to facilitate 'buy-in' among diverse assessment professionals. Further qualitative study is also needed to explore the TFB experiences of both clients and clinicians (cf. Ward, 2008). Once the processes involved in effective TFB are better understood, experimental studies can be designed that control for potential confounds (e.g., common factors) as well as dismantling studies that tease apart and explicitly identify the active components TFB and C/TA.

Practice and Training Implications: **Moving TFB Forward**

There are a number of implications for practice and training emanating from the results of this study. While one might argue for the importance of disseminating these results to

existing professionals, it is more likely that they will find 'traction' among current and future trainers and trainees. Based on that assumption, the section will focus more on training implications. First, training programs should value TFB as an integral aspect of any psychological assessment, and regard its provision as a unique competency to be attained through a variety of didactic approaches. This denotes educating trainees on relevant ethical standards/guidelines (including exceptions to them), assigning appropriate TFB-related reading, and in-class discussion oriented around understanding the complexity and importance of TFB. Second, trainees should become familiar with both the IG and C/TA assessment models, developing their understanding of these divergent approaches, and ultimately being encouraged to appreciate their compatibility. Third, learning to provide TFB should employ a sequential continuum of experience-based modalities, including instructors modeling of exemplars and TFB faux pas, in-class role-playing, and –most importantly– ample opportunity to provide TFB to clients in the context of supervised practice, complete with FB from supervisors. Fourth, trainees should be educated about the complexity of assessments involving third parties, and how they can be successfully navigated to optimally benefit clients. This might include bringing in guest lecturers active in third party assessments (e.g., in forensic settings) to share their experience, orient students to relevant important concerns, and speak to the potential benefits of providing TFB to test takers despite existing barriers and/or unfavourable attitudes. Finally, in keeping with the ethical principal of responsible caring (CPA, 2000), psychologists active in assessment need to advocate for test takers to receive TFB whenever possible. This requires a deliberate effort from researchers, educators, and clinicians to inform third parties about the many benefits of receiving TFB, and in all but the most extreme cases, to regard TFB as the *sine qua non* of any effective psychological assessment.

Conclusion.

By way of conclusion, it is worth nothing that the responses from the seemingly distinct qualitative groups are actually quite similar in many respects. Taken as a whole, both groups see providing TFB as a highly beneficial and important professional activity, with potential benefits and drawbacks of providing TFB, as well as important areas for growth in the profession being much more similar across respondents than they are different. When invited to discuss any additional aspects of TFB they thought relevant or important, both groups responded in a way that was highly reminiscent of Brenner's, (2003) recommendations to (1) Eliminate jargon, (2) focus on referral questions, (3) individualize reports, (4) emphasize client strengths, and (5) include concrete recommendations. Indeed, respondents described how TFB depends on heightening accessibility, eliminating jargon, enhancing relevance through strengths-based approaches, the significance and therapeutic utility of TFB, the importance of training in learning to provide understandable TFB, and the difficulty of assessment and TFB requiring multi-modal learning (i.e., in-class instruction, discussion in supervision, and practical hands-on experience). In fact, all respondents expressed views that were, to some extent, consistent with Brenner's (2003) recommendations, suggesting these might be helpful guidelines in establishing more effective TFB practices.

Based on the present results, on balance, the divergent TFB practices of Canadian psychologists appear to be best accounted for by (1) the age of the test taker (2) the clinician's training experiences, and (3) conducting assessments that involve third parties –the legal/judicial system in particular– the intersection between assessment and third parties making the provision of TFB a much more complex and nuanced process than it is in other settings. Psychological Assessment represents a diverse, intricate and important professional activity that is unique to

psychologists. Although there is no shortage of challenges associated with improving this enterprise –TFB being no exception– assessment psychology will arguably continue to define the profession, informing and impacting the lives of all individuals who participate in it. Hopefully, the current line of inquiry will make that impact all the more beneficial as we continue to learn about how to most effectively provide TFB to the consumers of psychological assessments.

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Appendix A

Assessment Feedback Practice and Training Questionnaire

This questionnaire examines the training and practice of Canadian psychologists providing test feedback to their clients based on the results of psychological assessments. It should take approximately 10 minutes for you to complete. Your participation is greatly appreciated.

1. Do you currently use psychological assessment instruments in your practice? Examples include: MMPI-2, WAIS-IV, BDI-II, State-Trait Anxiety Inventory, Strong Interest Inventory, etc.

__ Yes
__ No

2. How often do you use psychological assessments in your practice?

__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

3. How often do you use assessments to answer specific referral questions?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

4. How often do you use assessments to make or confirm a diagnosis?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

5. How often do you use assessments to measure treatment outcomes or monitor client change?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

6. How often do you use assessments to assist or encourage clients to engage in self-exploration?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

7. How often do you use assessments for court mandated reasons (e.g., to determine competence, for child custody hearings, forensic evaluations, etc.)?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

8. How often do you use assessments as a tool for building rapport?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

9. How often do you use assessments as a therapeutic intervention?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

10. How often do you use assessments for research purposes?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

11. How often do you use assessments for training purposes?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently

__ Almost always (with a large percentage of clients)

12. Are there any other uses of psychological assessments that apply to your practice? If so, please describe them below.

_____

_____

_____

13. In which of the following contexts do you use assessments? Please check all that apply.

__ In an interdisciplinary treatment team
__ With clients who experience severe mental illness
__ With adults
__ With college/university students
__ With adolescents
__ With children
__ Other (please specify below)

_____

_____

14. Which of the following types of assessment instruments do you typically use? Please check all that apply.

__ Intellectual (e.g., WAIS, WISC, Standford Binet, KABC)
__ Behavioural (e.g., BASC, Conners)
__ Objective Personality (e.g., MMPI, MCMI, 16-PF)
__ Projective Personality (e.g., Rorschach, Thematic Apperception Test)
__ Career Inventory (e.g., Strong Interest Inventory, Self-Directed Search)
__ Symptom-based measures (e.g., BDI, State-Trait Anxiety Inventory)
__ Neuropsychological (e.g., COGNISTAT, RBANS)
__ Other (please specify below)

_____

_____

15. How often do you obtain assessment-specific consent beyond initial consent to participate in treatment (e.g., counselling) before administering assessments?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

16. How often do you prepare clients for the assessment (e.g., by explaining the purpose, process and likely outcomes)?

__ Never

__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

17. How often do you encourage clients to generate their own personally relevant questions that could be addressed through the assessment process?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

18. How often do you provide test feedback to clients based on assessment results? That is, how often do you provide an interpretation of test results directly to the client in order to make the results as understandable, meaningful and useful as possible for them (typically this would take place in an assessment debriefing or case consultation)?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

19. How often do you provide <u>verbal</u> test feedback (as described in the previous item) directly to the client?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

20. How often do you provide <u>written</u> test feedback in the form of a summary report of the assessment results directly to the client?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

21. Excluding protected materials (e.g., standardized intelligence test protocols), how often do you provide clients with raw assessment data beyond a percentile rank and descriptor? Examples include raw scores, composite scores, T-scores, etc.

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

22. How often do you make a deliberate effort to ensure that clients have understood the assessment results as well as the test feedback you provided (i.e., by asking them directly)?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

23. How often do you make a deliberate effort to highlight any relevant implications of the assessment results when providing test feedback to clients?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

24. How often do you provide clients with an opportunity to ask any questions they may have about the assessment results and to clarify their understanding of the test feedback provided to them?

__ Never
__ Rarely (with a small percentage of clients)
__ Sometimes
__ Frequently
__ Almost always (with a large percentage of clients)

25. To what extent do you agree with the following statement: My graduate training in psychology (including coursework and practicums) did an excellent job equipping and preparing me to provide test feedback to clients, ensuring that assessment results are as meaningful and useful to them as possible.

__ Strongly Disagree
__ Disagree
__ Neither Agree nor Disagree
__ Agree
__ Strongly Agree

26. In your estimation, what percentage of your graduate training in psychological assessment focused explicitly on how to provide clients with test feedback?

---

27. Of the training you received in providing clients with test feedback during your graduate degree, what was the primary mode of instruction/learning?

__ Not applicable (no instruction was provided)
__ Lecture
__ Assigned reading
__ Open discussion with professor or supervisor
__ Modeled by professor or supervisor
__ Role-playing
__ Practicum / Clinical experience
__ Other (please specify below)

---

28. To what extent do you agree with the following statement: My post-graduate training experience did an excellent job equipping and preparing me to provide test feedback to clients, ensuring that assessment results are as meaningful and useful to them as possible.

__ Strongly Disagree
__ Disagree
__ Neither Agree nor Disagree
__ Agree
__ Strongly Agree

29. In your estimation, what percentage of your post-graduate training in psychological assessment focused explicitly on how to provide clients with test feedback?

---

30. Of the training you received in providing clients with test feedback during your graduate degree, what was the primary mode of instruction/learning?

__ Not applicable (no instruction was provided)
__ Lecture
__ Assigned reading
__ Open discussion with professor or supervisor
__ Modeled by professor or supervisor
__ Role-playing
__ Practicum / Clinical experience
__ Other (please specify below)

---

31. Is there is anything else you believe is relevant to the practice and/or training of psychologists providing clients with test feedback that was not sufficiently

covered in this questionnaire? If so, please describe it below. You can also utilize the space provided to elaborate on any of your previous responses if you desire.

_____
_____
_____
_____
_____
_____

32. Please Indicate the highest degree you have attained.

__ Ph.D.
__ Psy.D.
__ Ed.D.
__ M.Ed.
__ M.A. / M.S.
__ Other (please specify below)

_____

33. When did you earn this degree (in what year)?

_____

34. What is your sex?

__ Male
__ Female

35. What ethnic/cultural background do you identify most strongly with?

__ European Canadian / White
__ Aboriginal / First Nations / Canadian Indigenous
__ Inuit
__ Metis
__ Asian / Asian Canadian
__ Hispanic / Latino / Latina
__ African Canadian / Black
__ Other (please specify below)]

_____

36. Which of the following <u>best</u> describes your primary practice setting?

__ Armed Forces
__ Child / Adolescent Psychiatric or Pediatric
__ Community Mental Health Center
__ Consortium
__ General Hospital
__ Medical School
__ Outpatient Clinic

__ Prison / Correctional Facility
__ Primary Care Network
__ Private Practice
__ Psychiatric Unit / Hospital
__ School / School District
__ University / College Psychology Department
__ University / College Counselling Center
__ Other (please specify below)

_____

37. Which of the following best describes your theoretical orientation (please limit your response to 2 selections)?

__ Behavioural
__ Biological (i.e., Neurological, Chemical)
__ Cognitive Behavioural
__ Eclectic
__ Existential
__ Feminist
__ Humanistic
__ Interpersonal
__ Process-Experiential
__ Psychoanalytic / Psychodynamic
__ Systems
__ Other (please specify below)

_____

38. Which section(s) of CPA are you affiliated with or involved in? Or, which domains pertain most closely to your area of expertise and/or practice (please select all that apply)?

__ Aboriginal Psychology
__ Addiction Psychology
__ Adult Development and Aging
__ Brain and Cognitive Sciences
__ Clinical Psychology
__ Clinical Neuropsychology
__ Community Psychology
__ Counselling Psychology
__ Criminal Justice Psychology
__ Developmental Psychology
__ Environmental Psychology
__ Extremism and Terrorism
__ Family Psychology
__ Health Psychology
__ History and Philosophy of Psychology

__ Industrial / Organizational Psychology
__ International and Cross-Cultural Psychology
__ Psychoanalytic and Psychodynamic Psychology
__ Psychologists in Education
__ Psychologists in Hospitals and Health Centers
__ Psychology in the Military
__ Psychologists and Retirement
__ Psychopharmacology
__ Psychophysiology Special Interest Group
__ Quantitative Methods
__ Religion
__ Rural and Northern Psychology
__ Sexual Orientation and Gender Identity
__ Social and Personality Psychology
__ Sport and Exercise Psychology
__ Students of Psychology
__ Teaching of Psychology
__ Traumatic Stress Section
__ Section for Women and Psychology
__ Other (please specify below)

_____

39. Would you be willing to participate in a brief follow-up interview (approximately 20 minutes)? The purpose of these interviews is to explore the experiences of psychologists in providing clients with test feedback. Interviews will be conducted by telephone or online video conferencing (e.g., Skype). Please note that you are not consenting to participate by responding "yes", only that you are open to discussing the possibility with the researchers.

__ Yes. I am willing to be contacted (**please provide an email address or telephone number below, along with an area code and optimal time of day to call**).
__ No thanks.

40. If you would like to receive a copy of the results of this survey, please check the appropriate box below.

__ Yes. Please provide me with a copy of the results of this survey via the following email or P.O. box address.
__ No thanks.

Appendix B

Initial Email Invitation

Dear Colleague,

This is an invitation for you to complete a brief survey regarding the assessment practices of psychologists in Canada. The results will be used in a study I am conducting for my masters' thesis project at the University of Alberta. Assessment is a vital aspect of professional practice that arguably distinguishes psychologists from other mental health professionals. While a number of studies have sought to determine the various uses of tests by psychologists (i.e., what tests are commonly used in practice, and for what purposes), this study is unique as it examines how the results of tests are used, and how results are presented to clients. Your assistance in completing this survey is greatly appreciated. Thank you very much for you input, and for your time.

While more detailed information is available by clicking on the survey link (below), you should be aware of some important points:
1) This study received ethics approval in December of 2013 from the University of Alberta's Research Ethics Board.
2) Your contact information was obtained through the Canadian Psychological Association membership directory.
3) It should take approximately 10 minutes for you to complete the survey.

Sincerely,

Ryan Jacobson, B.A.
University of Alberta
Dept. of Educational Psychology
6-102 Education North
Edmonton, AB.
T6G 2G5
(780) 935-6153
rjacobso@ualberta.ca

Follow this link to the Survey:
Take the Survey

Or copy and paste the URL below into your internet browser:
https://qtrial.qualtrics.com/WRQualtricsSurveyEngine/?Q_SS=50kRZje0gbwy6Lr_4ZVPsCZYEu12Opf&_=1

Follow the link to opt out of future emails:
Click here to unsubscribe

Appendix C

Follow-Up Email Invitation

Dear Colleague,

This is a reminder about an invitation you received recently to complete a brief survey regarding the assessment practices of psychologists in Canada. The results will be used in a study I am conducting for my masters' thesis project at the University of Alberta. Assessment is a vital aspect of professional practice that arguably distinguishes psychologists from other mental health professionals. While a number of studies have sought to determine the various uses of tests by psychologists (i.e., what tests are commonly used in practice, and for what purposes), this study is unique as it examines how the results of tests are used, and how results are presented to clients.

While more detailed information is available by clicking on the survey link (below), you should be aware of some important points:
1) This study received ethics approval in December of 2013 from the University of Alberta's Research Ethics Board.
2) Your contact information was obtained through the Canadian Psychological Association membership directory.
3) It should take approximately 10 minutes for you to complete the survey.
4) If you've already taken the survey or responded to this invitation, please disregard this message.

Your assistance is greatly appreciated. Thank you very much for you input, and for your time.

Sincerely,
Ryan Jacobson, B.A.
University of Alberta
Dept. of Educational Psychology
6-102 Education North
Edmonton, AB. T6G 2G5
rjacobso@ualberta.ca
(780) 935-6153

Follow this link to the Survey:
Take the Survey

Or copy and paste the URL below into your internet browser:
https://acsurvey.qualtrics.com/WRQualtricsSurveyEngine/?Q_SS=3WznTNDd4gKX5aJ_4ZVPsCZYEu12Opf&_=1

Appendix D

Quantitative Phase Information Letter and Consent Form

INFORMATION LETTER and CONSENT FORM
The Practice and Training of Providing Test Feedback among Canadian Psychologists.

Research Investigator:
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Supervisor:
Dr. William Hanson, Ph.D
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780-492-5245

Background This study examines the training and practice of Canadian psychologists in providing test feedback to clients based on the results of psychological assessments. We selected your name from the Canadian Psychological Association membership directory, and will be using the results of this study in a thesis project, in partial fulfillment of the requirements of Mr. Jacobson's masters' degree. We may also potentially publish the results in an academic journal, or present them at a research conference. It is important that you are aware that we are both members of the Canadian Psychological Association (CPA). However, in no way do we represent the interests of the CPA, or its members. The CPA has not commissioned this research and has no vested interest in this study or special relationship with us.

Purpose The purpose of this research is to explore test feedback practices among Canadian psychologists. More specifically, we seek to describe the frequency with which test feedback is provided to clients, identify the format(s) in which feedback is provided, identify specific training psychologists receive in providing test feedback, and determine their motivation for providing or not providing test feedback to clients. There is currently no published research pertaining to test feedback practices among Canadian psychologists. Given the empirically supported capacity of assessment feedback to improve treatment processes and outcomes, this study addresses a considerable gap in our knowledge base, and represents an important line of inquiry with potentially significant implications for clinical practice and training nationally.

Study Procedures
We will be conducting this research over the course of the next 2 to 4 months. If you choose to participate in this study, we invite you to complete a questionnaire that will take approximately ten minutes. The questions focus on your use of assessment instruments as well as the practice, training and motivation associated with providing test feedback to clients. The survey also asks a number of demographic questions so we can provide a description of the sample of participants in this study. These questions pertain to your level of education, when you completed your degree, the setting of your primary practice, your theoretical orientation, sections of the CPA you are affiliated with, as well as your sex and ethnic/cultural identity.

Benefits Aside from providing the opportunity for you to reflect on your practice, we do not foresee any direct benefit for you as a participant in this study, and there is no payment or other compensation for your involvement. If you do choose to participate, you may benefit by increasing your knowledge of assessment practice and training, and you will be making a valuable contribution to helping us better understand current assessment practices in Canada.

Risks We do not anticipate you encountering any risks as a result of participating in this study. While there may be risks associated with participation, they are presently unknown to us. We will advise you as soon as we become aware of any potential risk or learn of anything that might affect your willingness to be involved.

Voluntary Participation You are free to choose not to participate in this study, and you will experience no negative consequences whatsoever as a result. You are also free to discontinue your participation at any time (by exiting/closing the survey window) without fear of negative repercussions, and you can modify your participation by skipping any questions you would prefer not to answer. If you choose to discontinue participation at a later point in time, you can request that your data be removed from the study and we will gladly remove/destroy your data (this request can be facilitated any time up until the point at which the data is rendered anonymous).

Confidentiality & Anonymity
All your questionnaire responses will be kept strictly confidential. We will maintain all data and study materials securely, and will be the only individuals who will be able to access your data at any point. An identification number will be used on the questionnaire in place of your name, and the link between your name and the identification number will be destroyed once data collection is complete. When your data is entered into an electronic database, no identifying information will be included, so that data will thereafter be anonymous. With the exception of optional open-ended responses (which will remain strictly anonymous), only aggregate (group) data from this survey will be examined and reported in the final research report. In the event that you are contacted for a follow-up interview, we will thoroughly explain the uses of your data prior to conducting the interview. As previously mentioned, we may published these results at some point in an academic journal or present them at a research conference. We may also seek to use the results of this study in future research. However, the Research Ethics Board of the University of Alberta will first approve any future use of your data.

Further Information The University of Alberta's Research Ethics Board has approved this study by virtue of its adherence to ethical guidelines in conducting research. We encourage you to contact the board at reoffice@ualberta.ca or at (780) 429-2615 if you have any questions regarding your rights as a participant in this study, or research ethics in general. If you have any further questions pertaining to your involvement in this study, or would like to obtain a copy of the results, feel free to contact us, Dr. William Hanson or Ryan Jacobson, using the contact information provided. Thank you very much once again for your time.

Sincerely,

Ryan Jacobson & William Hanson

I hereby give my consent to participate in the research described above by indicating "yes" below. I understanding that, by consenting, I am agreeing to complete the following survey. I have read and understood the consent form and desire of my own free will to participate.

__ Yes
__ No

Appendix E

Initial Interview Invitation

Dear Colleague,

I hope this finds you well. I'm just writing to follow-up with you regarding a research survey on psychological assessment that you completed several months ago. On the questionnaire, you indicated that you would be open to discussing the possibility of sharing some of your assessment related experiences in a brief telephone interview. Based on your responses, you have been selected as an ideal candidate for an interview and, if possible, I'd like to contact you to discuss the matter further.

You provided a telephone number that I will attempt to reach you at within the next few days. However, I thought I would also contact you by email just to let you know. Feel free to contact me by phone or email if you have any questions at all. I look forward to speaking with you.

Sincerely,

Ryan Jacobson, B.A.
University of Alberta
Dept. of Educational Psychology
6-102 Education North
Edmonton, AB. T6G 2G5
rjacobso@ualberta.ca
(780) 935-6153

You will receive more detailed and complete information regarding your rights as a participant in this study, as well as steps we are taking to ensure your privacy is maintained at all times. The following is brief overview of what your participation entails: Interviews will be recorded and transcribed verbatim, and the results may be published in an academic journal or presented at a research conference. All interview data (recordings and transcriptions) will be kept strictly confidential, and destroyed once data analysis is complete. No identifying information will be included and you will never be identified, or made identifiable as a respondent in this study. You are not obligated to participate in this research, and you can decline to answer any questions you would prefer not to respond to. You are also free to withdraw from this study any point, so long as the final report has not been submitted.

Appendix F

Qualitative Phase Information Letter and Consent Form

INFORMATION LETTER and CONSENT FORM
Study Title: The Practice and Training of Providing Test Feedback among Canadian Psychologists.

Research Investigator:
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whanson@ualberta.ca
780-492-5245

Dear Colleague,

I am writing to follow up on a survey you completed several months ago on your use of psychological assessments and test results. First of all, thank you for taking the time to participate in this study. Your involvement has been a great help to me in this important line of inquiry.

I am conducting follow-up interviews with selected respondents in order to more fully understand their assessment practices. Purposeful sampling is being employed for these interviews and respondents are selected based on their survey responses regarding their experience, training and practice of providing test feedback to clients. Specifically, I hope to better understand the experience of psychologists who do not regularly provide test feedback, do so despite receiving no specific training, or despite finding specific training unhelpful. Based on your responses, you have been identified as an ideal candidate for a follow-up interview. I am writing to obtain your permission to contact you (via telephone, or by Skype) to ask you some additional questions in hopes of more fully understanding your experience, training, practice and approach in the area of assessment.

The interview will take approximately 15 minutes. Our conversation will be recorded (audio only) and transcribed for subsequent analysis. The audio recording will be shut off at any point during the interview upon request. The data from these interviews will not be linked in any way to the survey data from the survey. Data will be analyzed and reported in the final report the form of my masters' thesis. Please be aware that, for these follow-up interviews, individual (verbatim) responses may be included in the final report, though the majority will be presented in aggregate form. The final report may be submitted for future publication and an academic journal, or presentation at various conferences. There are no known risks associated with your participation in this study, and while you may benefit through the opportunity to reflect on your practice, or by increasing your knowledge of assessment practices, there are no direct benefits associated with your participation of which we are aware.

I welcome any questions or comments you may have about this research and your involvement in it. If you have any questions about these interviews, or would like more information, please contact my supervisor, Dr. William Hanson or myself. Should you have any questions regarding your rights as a research participant, or if you wish to report any concerns about this study, you can contact the University of Alberta Research Ethics Office at 780-492-2615 or reoffice@ualberta.ca.

Your participation is entirely voluntary; you are free to decline from being interviewed and you will experience no negative consequences as a result. You are also free to discontinue the interview at any point or decline from answering any questions that make you uncomfortable in any way or cause you distress. If you decide that you would like to withdraw from the study at a later point in time, you can contact us and your data will be omitted and destroyed. Data removal can be accommodated any time prior to the conclusion of the data collection phase. Thereafter, data will be anonymous and we will not be able to identify participants' responses, rendering data removal impossible.

If you agree to participate in a brief interview, please indicate this by signing in the space below. You can also indicate aurally to the researcher that you have read this document in its entirely and desire of your own volition to participate in the research described above.

Sincerely,

Ryan Jacobson

Participant Name: _____ Date : _____

Signature: _____

Appendix G

Qualitative Interview Scripts

GROUP 1 SCRIPT (to be utilized with respondents who regularly provide TFB despite absent or insufficient training)

"First off, I'd like to thank you for your willingness to take part in this second phase of the study on test feedback. Your participation is extremely valuable and very much appreciated. As previously mentioned, your participation in this interview is completely voluntary. You may decline from answering any questions, and you are free to discontinue your participation at any time. With your permission, I would like to record our conversation with a digital recorder. Once we complete the interview, I will transcribe our conversation for analysis, and the results will be included in the final report. After transcription, the audio recording will be destroyed. Please be aware that, while the majority of the results from this study will be presented in aggregate form, individual verbatim responses from this interview may be included in the final report. However, no identifying, or potentially identifying information will be included so you can rest assured that your responses will remain strictly anonymous. The final report may be submitted for future publication in various academic journals and presentation at research conferences. Do you have any questions before we continue?

[Researcher answers any questions the participant may have]

"May I begin recording now?"

[Await participants' response. If 'yes', recording begins]

"You indicated on the survey that you regularly provide test feedback to clients, despite insufficient formal training. Could you tell me more about how you learned to provide test feedback?"

"Based on your experience, do you feel that there are any positive effects for clients receiving test feedback? If so, what are those positive effects, and how might they be enhanced?"

"Do you feel there are any potentially negative effects associated with providing clients with test feedback? If so, what are these negative effects, and how might they be mitigated?"

"Is there anything else you would like to share regarding your experience or perspective on the practice or training of providing clients with test feedback?"

GROUP 2 SCRIPT (to be utilized with respondents indicating they do not offer interpretive assessment feedback to clients, or do so infrequently)

"First off, I'd like to thank you for your willingness to take part in this second phase of the study on test feedback. Your participation and is extremely valuable and very much appreciated. As previously mentioned, your participation in this interview is completely voluntary. You may decline from answering any questions, and you are free to discontinue your participation at any time. With your permission, I would like to record our conversation with a handheld tape recorder. Once we complete the interview, I will transcribe our conversation for analysis, and the results will be included in the final report. After transcription, the audio recording will be destroyed. Please be aware that, while the majority of the results from this study will be presented in aggregate form, individual verbatim responses from this interview may be included in the final report. However, no identifying, or potentially identifying information will be included so you can rest assured that your responses will remain strictly anonymous. The final report may be submitted for future publication in various academic journals and presentation at research conferences. Do you have any questions before we continue?

[Researcher answers any questions the participant may have]

"May I begin recording now?"

[Await participants' response. If 'yes', recording begins]

"You indicated on the survey that you do not provide assessment feedback to clients, or that you do so inconsistently. Could you tell me more about that?"

"Are there circumstances in which you would provide interpretive assessment feedback? What would your motivation be for providing feedback in those cases, and how do they differ from your current practice?"

"Based on your experience, are there positive effects that result from clients receiving assessment feedback? If so, what are those positive effects, and how might they be enhanced?"

"Do you feel there are any potentially negative effects associated with providing clients with assessment feedback? If so, what are these negative effects, and how might they be mitigated?"

"Is there anything else you would like to share regarding your experience or perspective on psychologists providing clients with test feedback?"