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Psychological Test Feedback: Canadian Clinicians' Perceptions and Practices
Commentaires sur les tests psychologiques: perceptions et pratiques des cliniciens canadiens

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ABSTRACT
This study explores Canadian clinicians' perceptions of test feedback (TFB) and how those perceptions influence their practice. This secondary analysis of open-ended qualitative data extends a previous study with similar research questions conducted by Jacobson et al. (2015). A case study design and consensual qualitative research (CQR) data analysis procedure was utilized to enhance the trustworthiness of the results. The findings indicate that clinicians give TFB in a variety of settings. Clinicians emphasize the importance of providing tailored and collaborative TFB, of attending to ethical issues related to TFB, and of improving academic training in TFB. Also, clinicians discuss unique situations in which feedback is provided to a third party rather than to the testing individual. Clinical implications such as increased practical training for providing TFB are discussed. Future research could investigate the outcomes of TFB provision.

RÉSUMÉ
Cette étude analyse la façon dont les cliniciens canadiens perçoivent les commentaires sur les tests et l'influence que cela exerce sur leur pratique. Cette analyse secondaire

de données qualitatives ouvertes prolonge une étude antérieure soulevant des questions de recherche similaires menée par Jacobson et coll. (2015). Pour améliorer la fiabilité des résultats, on a eu recours à une procédure d'analyse de données de conception d'étude de cas et de recherche qualitative consensuelle. On a observé que les cliniciens fournissent des commentaires sur les tests (CST) dans divers contextes. Ils insistent sur l'importance de fournir des CST collaboratifs et taillés sur mesure, de bien prendre en compte les enjeux éthiques liés aux CST, et d'améliorer la formation théorique en ce domaine. De plus, les cliniciens discutent de situations uniques dans lesquelles les commentaires sont communiqués à une tierce partie plutôt qu'à la personne testée. On aborde aussi les implications cliniques, comme une formation pratique accrue sur la communication des CST. Des recherches ultérieures pourraient analyser les résultats de la communication des CST.

Psychological assessment and testing have tremendous empirical support for their validity, effectiveness, and clinical utility (Kubiszyn et al., 2000; Meyer et al., 2001; Poston & Hanson, 2010). This evidence is wide-ranging, spanning the domains of measuring clinical symptoms, performing differential diagnoses, evaluating functional behaviour, predicting mental health and psychotherapy outcomes, and even serving as a therapeutic intervention (Kubiszyn et al., 2000; Meyer et al., 2001; Poston & Hanson, 2010).

Despite the potential benefits, practitioners of psychological assessment have faced pressures, due in part to limits placed on test selection, on the number of sessions allowed for assessment, and on monetary reimbursement (Kubiszyn et al., 2000; Meyer et al., 2001). One key aspect of effective and ethical psychological assessment practice is communicating the clinician's integrated and interpreted findings from psychological test results (Haverkamp, 2013; Meyer et al., 2001). For example, the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2017) stipulates that clinicians should "provide suitable information … about the results of assessments, evaluations, or research findings to the individuals and groups … involved. This information would be communicated in ways that are developmentally, linguistically, and culturally appropriate, and that are meaningful and helpful" (p. 21).

Different terminologies exist and in some research papers are actually commingled and treated as synonyms, like *psychological assessment feedback* and *test feedback* (Groth-Marnat & Wright, 2016; Meyer et al., 2001; Poston & Hanson, 2010), even though they are conceptually and practically different. Testing data may, for example, comprise only a portion of the feedback. Still, for the sake of clarity and in keeping with past research and with the essence of the data examined here (Curry & Hanson, 2010; Jacobson et al., 2015), we use *test feedback* (TFB) throughout the article.

The provision of TFB has accumulated evidence for its therapeutic utility. For example, Poston and Hanson (2010) conducted a meta-analysis of psychological

assessment with collaborative feedback as a therapeutic intervention, finding significant evidence for its efficacy on a variety of therapy outcomes (Cohen's $d = 0.367$) and processes (Cohen's $d = 1.117$). Experimental studies of psychological assessment and TFB as an intervention are also finding significant effects on outcome variables such as therapeutic alliance (Ackerman et al., 2000; Hilsenroth et al., 2004), self-reported symptoms (De Saeger et al., 2014; J. D. Smith et al., 2015), self-esteem (Finn & Tonsager, 1992; Newman & Greenway, 1997), and perceptions of the assessor's helpfulness (Hanson & Claiborn, 2006; Hanson et al., 1997).

As an intervention, TFB is a particularly salient component of collaborative approaches to assessment, such as therapeutic assessment (TA). TA is a semi-structured collaborative assessment approach developed by Finn (2007) that is characterized by an explicit, stepwise model. The approach draws heavily from humanistic psychology and places focus on relationship building, empathy magnification, and client engagement. The communication of test results in a relevant, personalized, and understandable manner is a critical aspect of the collaborative stance in TA. For example, Finn (2007) recommended ascertaining clients' degree of wondering about themselves before testing and tailoring the presentation of results to answer those personally driven questions.

There is accumulating evidence for the efficacy of TA compared to traditional information-gathering approaches to assessment (Finn & Tonsager, 1992, 1997; Newman & Greenway, 1997; J. D. Smith et al., 2015). Based on this accumulated body of research, recommendations are being made for more clinical training on TFB, for greater clinician awareness of its power and its potential, and for the revision of standards and benchmarks for psychological assessment (Jacobson et al., 2015; Poston & Hanson, 2010).

Several studies have examined clinicians' perceptions and experiences with TFB in the United States and Canada (Bennett-Levy et al., 1994; S. R. Smith et al., 2007; Ward, 2008). Most recently, Curry and Hanson (2010) and Jacobson et al. (2015) examined clinicians' TFB practices in the U.S. and in Canada, respectively, using a sequential explanatory mixed-methods investigation (Hanson et al., 2005). Curry and Hanson (2010) found that most clinicians provide verbal TFB and prepare clients for feedback. A small minority of clinicians encouraged clients to generate personally relevant questions. Many clinicians also indicated that their predoctoral and internship training did not help prepare them to provide TFB. The findings also show that some clinicians do not offer TFB because of the context of assessment (e.g., forensic setting or employment screening) and/or the perception that the feedback could potentially be harmful. Clinicians also noted a lack of formal training in TFB. Instead, they learned how to give TFB primarily through self-instruction and through trial and error.

Curry and Hanson's (2010) research topic and method were replicated recently in a Canadian sample (Jacobson et al., 2015). Jacobson et al.'s (2015) results

showed that most Canadian clinicians report providing TFB, making deliberate efforts to ensure client understanding and giving clients opportunities to ask questions. However, only a minority of clinicians encouraged clients to generate personally relevant questions. In contrast to Curry and Hanson, most clinicians in Jacobson et al.'s study stated that graduate and postgraduate training prepared them effectively to provide TFB. Clinicians learned TFB skills primarily through practicum/clinical experience, self-instruction, and trial and error.

Clinicians also reported that their primary reason for not giving feedback was a lack of opportunity or precedent in their area of work, particularly if the client and the test-taking individual were different parties (e.g., forensic settings). The findings of Jacobson et al. (2015) aligned closely with those of Curry and Hanson (2010), which suggested that TFB practices of American and Canadian clinicians were notably similar. However, training in TFB remains an area for improvement across both countries.

The purpose of the present qualitative study is to obtain a deeper understanding of Canadian clinicians' perceptions of TFB, their usage of TFB, factors that influence TFB practices, and the nature of TFB training. This study was significant for three main reasons. First, the experience of practitioners in using TFB is not well understood. The current study contributes to an experiential understanding of how clinicians use TFB. Second, there is little published research on current TFB practices and scarce empirical evidence on the effective provision of TFB (Gass & Brown, 1992; S. R. Smith et al., 2007; Ward, 2008). The present study benefits the field by elaborating further on the themes that contribute to the provision of TFB and shedding light on the nature of effective TFB. Third, there was consistent survey evidence supporting the importance of training in psychological assessment (Clemence & Handler, 2001; Piotrowski & Belter, 1999; Stedman et al., 2000).

However, there was also a dearth of published research examining how to train graduate students and practitioners effectively on specific aspects of psychological assessment, such as TFB. The few available studies specific to TFB training have been exploratory, highlighting the importance of experiential learning, contextual considerations, and the need for trainees to see the clinical utility of psychological assessment (Haydel et al., 2011; J. D. Smith & Egan, 2017). The present study might inform training programs on psychological assessment by identifying what works in training clinicians to provide TFB.

The present study is a secondary analysis of previously unanalyzed qualitative data from the work of Jacobson et al. (2015)—specifically, open-ended comments obtained from their original national survey of 399 Canadian clinicians. There were several potential benefits of conducting a secondary analysis of this dataset. The present analysis built on questions raised from the original study through more focused and targeted research questions, thereby strengthening the empirically grounded findings that arose from the primary analysis. Approaching the

dataset from a new analytic perspective that was distinct from the original data collection context may broaden the exploration and examination of the central phenomenon. Lastly, the present study offered the opportunity to maximize the utility of the original data collection and represented an efficient use of the dataset (Ziebland & Hunt, 2014). As the original study prioritized quantitative data and qualitative interview data as part of the sequential explanatory mixed-methods approach, the open-ended dataset was not analyzed, formally or informally. This study approaches that dataset from a different perspective and with different research questions. This secondary dataset was the sole data source for this study.

The overarching research question (RQ) for this study was: "What are Canadian clinicians' perceptions of test feedback (TFB)?" Three additional qualitative questions encompass the explanatory follow-up purposes of this study:

1. (RQ1). How do Canadian clinicians' perceptions of TFB affect their use and practice of TFB?
2. (RQ2). How do factors such as area of practice, helpfulness of training, and type of training affect the practice of TFB?
3. (RQ3). How is training in TFB for Canadian clinicians primarily practical?

As the purpose of this study was exploratory and qualitative, ad-hoc hypotheses about the RQs were not devised.

Methods

Participants

A census sampling approach of the Canadian Psychological Association (CPA) membership directory was used, resulting in a list of 2,763 potential participants who were surveyed. A total of 433 responses were returned, and 34 surveys were excluded from the analysis because they did not meet the inclusion criteria for the study. The inclusion criteria for the survey specified that respondents must be (a) licensed/registered psychologists, (b) currently administering psychological assessments as part of their practice, and (c) CPA members in good standing.

The participants consisted of 399 licensed Canadian psychologists, for a response rate of 14.4%. A slight majority of respondents were female (64.9%), and nearly all identified as European-Canadian/White (90%). Most were affiliated with clinical psychology (54.1%), followed by school psychology (21.8%) and counselling psychology (15.2%). Most of the participants held Ph.D.s (76.9%), although some possessed Psy.D.s (2.5%) or were master's level clinicians (12.8%). Nearly half (43%) of the respondents worked in private practice. Participants typically engaged in assessments to answer referral questions (79.4%) and/or for diagnostic purposes (69.2%) and used three or four different tests in each assessment. Out of the 399 respondents, 247 provided written narrative responses to the open-ended survey questions.

Measure

The survey from Jacobson et al. (2015) had 40 items that examined participants' utilization of psychological assessments in practice, purposes underlying the use of assessments, contexts of assessment use, instruments used, and the extent to which participants engaged in aspects of Finn's (2007) therapeutic assessment (TA) approach to psychological assessment. In addition, the survey items inquired about general TFB practices, including the format of TFB delivery, intentions around clarifying test results, the utility of graduate and postgraduate training in learning to provide TFB, the primary format of training, and demographics.

Lastly, there were two open-ended items inviting respondents to comment on the topic of TFB. One open-ended question asked respondents the following: "Are there any other uses of psychological assessments that apply to your practice? If so, please describe them below." There were 129 participant comments in response to that question. The second open-ended question asked respondents the following: "Is there anything else you believe is relevant to the practice and/or training of clinicians providing clients with test feedback that was not sufficiently covered in this questionnaire? If so, please describe it below." There were 118 participant comments in response to that question. In total, 247 rich responses out of 399 survey respondents were the primary source of data for the present study. Moreover, as indicated earlier, they were not included in Jacobson et al.'s (2015) original analyses.

Procedure

The study received formal ethics approval from the University of Alberta research ethics board. This study used a modified form of consensual qualitative research (CQR) analytic procedures, as described by Hill et al. (1997) and Hill et al. (2005). CQR is used to generate a linguistic description of a phenomenon through a focused study of a small number of cases. As a qualitative approach, CQR has constructivist philosophical assumptions with some post-positivist elements (Hill et al., 1997; Hill et al., 2005). There is an emphasis on the socially constructed nature of both reality and meaning. The approach recognizes the effect of the researcher's expectations and biases on interpreting data. As such, the central component of CQR analysis is the strategy of using a team consensus process to make judgments and to interpret data and, in this way, account for researchers' individual biases. The process of analysis in CQR is inductive and iterative, and it centres on this team consensus–based coding method to account for differences in how team members view, rate, and interpret data. For this study, the research team used the CQR analytic procedure to perform secondary analysis on a more constrained form of textual data. We believe this usage was within the spirit of the CQR approach, which aims to provide a qualitative approach that is clear, comprehensible, and implementable (Hill et al., 2005).

The CQR analytic method was chosen for the following reasons. CQR is a team-based consensus coding process that improves the trustworthiness and defensibility of the data interpretation by accounting for individual team members' biases on the topic of interest. The first author is a novice at qualitative research, therefore having analytic team members with more research experience as part of the consensus-building process facilitated the author's reflexivity in interpreting data and forming conclusions. Finally, the structured, step-by-step nature of the CQR analytic procedure helped the research project by simplifying the analysis procedure and by providing justification for rigour in this study.

The primary modification made to the CQR analytic method was applied to small chunks of textual data in the form of survey comments rather than the rich interview data typical of the case study. Studies have set a precedent in applying the CQR analytic procedure to datasets with many cases. For example, Stanghellini et al. (2014) investigated the occurrences of abnormal bodily phenomena in patients with schizophrenia by analyzing data from 550 clinical interviews. In that Stanghellini et al. study, the CQR method was used to accomplish a specific task: to identify and to classify different categories of abnormal bodily phenomena from a large amount of data.

Other modifications in this study include the fact that the consensus process was used only with a subset of the comments. Afterwards, the first author completed the application of the CQR analytic steps to the remaining comments. Lastly, in the typical CQR procedure, an auditor is used after each phase of the analysis, but in this study, auditing was performed only after the cross-analysis phase. These modifications were due to time and resource restrictions on the research project.

After the core analytic team was assembled, open-ended survey data were obtained from the primary researcher (Jacobson et al., 2015). The textual data were then distributed to the entire analytic team. The analytic process, as outlined by Hill et al. (1997), consisted of three main steps, described below.

Domain Coding

The core analytic team utilized an initial "start list" of domains based on an understanding of the literature and of the survey questions. Domains are general topic areas used initially to cluster information (Hill et al., 1997). During this phase of the analysis, additional domains were generated by individual team members and discussed during the consensus meetings. The four members of the research team coded a proportion of the comments for this study independently ($n = 75$). Comments selected for the analysis were chosen based on greater length and perceived complexity. During consensus meetings, the team members discussed the domain designation for each reviewed comment until an agreement was reached among all members as to the best domain for that comment. The

first author then completed the domain coding for all the remaining comments not discussed during the meetings.

Core Idea Abstraction Within Domains

Core members of the analytic team independently reviewed the raw text for comments within each domain and developed a clear, concise summary version of each selected comment. These core idea abstractions involve very little interpretation and stay very close to the explicit meaning of the textual data (Hill et al., 1997). Team members then discussed these abstractions in consensus meetings until a consensus version for each comment was reached. The first author then completed core idea abstraction for all the remaining comments not discussed during the meetings.

Cross-Analysis

Core members of the analytic team examined the consensus core idea abstractions within each domain to identify themes or patterns within the data. Each team member independently conducted a thematic analysis on abstracted comments within each domain to generate categories. This category creation involved looking for similarities across the comments for each domain. The team consensus process was then employed to refine the independently developed categories. Afterwards, the first author completed the cross-analysis for all the remaining comments not discussed during the meetings.

Auditing

To ensure that the procedures for CQR were followed and to address possible analytic biases within the analytic team, the consensus domain coding, core abstraction, and cross-analysis for the selected comments were audited by a researcher external to the core team to provide additional feedback on their findings (Hill et al., 1997). The auditor provided feedback to the core analytic team on the accuracy of the coding, on potential biases, and on the adherence to the CQR analytic procedure. The team considered this feedback in a consensus meeting, and necessary changes to the coding were made. The finalized categories were described in a general written narrative that also outlined the typical themes within each domain with supporting evidence from the comments.

Team Composition

The core analytic research team for this study had four members. In addition, there was one auditor external to the team. Typically, in the research literature, a core analytic team for CQR consists of two to five team members. In our study, the analytic team's composition and numbers were chosen based on interest in the project, as there is a lack of empirical consensus on what constitutes an ideal CQR analytic team (Hill et al., 2005). To facilitate the clarity and trustworthiness of

the consensus process for this study, each member of the core analytic research team prepared before the first meeting a statement of biases and expectations related to the topic: TFB and psychological assessment. There are themes shared across these statements.

Three of the four members of the team have experience with providing TFB. Three of the four members expressed a positive view of TFB—that it could be beneficial to clients and could help guide their future treatment. This is an acknowledged source of potential bias within the analytic team. Two members of the team mentioned how assessments could be harmful when done inappropriately (e.g., reducing people to labels). Two members of the team also discussed specifically the relationship between assessment and diagnostics. The auditor was external to the core analytic team but also had background and training in psychological assessment, TFB, and TA. This separateness from the team ensured that the auditor would provide a fresh perspective unbiased by the core analytic team.

The core analytic team participated in nine team consensus meetings for a total of 17 hours spent on team coding and discussion. Discussions were documented through meeting minutes by a designated person at each meeting. In addition, each team member conducted individual coding in preparation for team consensus meetings. The number of hours each member spent coding independently was not documented. The auditor reviewed the results from the consensus meetings and provided documented feedback and suggestions to the analysis that the core analytic team considered.

The typical methods to address and ensure researcher reflexivity, such as memoing or maintaining an ongoing research process journal, were not utilized in this study. Researcher reflexivity is defined as the recognition of the researcher's bias and subjective interpretation of the data, reflecting critically on their interpretation, and understanding their role in generating knowledge (Braun & Clarke, 2013). The first author's own efforts to maintain researcher reflexivity involved reflecting on personal biases at the start of the study in the reflective statement, recording minutes at each consensus meeting, and reflecting on the discussion and team dynamics between meetings.

Results

Table 1 summarizes the domains, the categories, and the number of cases for each category. The CQR analytic method identified general content domains in the textual data, and within those domains, categorical descriptions were generated through a consensus-based cross-analysis process. The findings for RQ1 are encompassed by the domains of "Attitudes and Beliefs," "Ethics," and "Use and Practice." The "Use and Practice" domain contained descriptive information on the specific contexts where respondents utilized assessment and TFB as well as descriptions of how these practices were encompassed within general

Table 1
Cross-Analysis of Survey Data on Clinician Perceptions of TFB

Domain and category	Number of cases
Attitudes and beliefs (11 cases)	
Best clinical practice (variant)	5
Concerns around testing (variant)	6
Effectiveness (28 cases)	
Collaborative approach to feedback (variant)	3
Integrated interpretation of testing (variant)	4
Presentation of findings (variant)	7
Tailoring feedback to the client (variant)	8
Value of feedback (variant)	3
Ethics (11 cases)	
Competency in assessment (variant)	4
Standards of practice in assessment (typical)	7
Feedback (23 cases)	
Context dependent (variant)	4
Feedback to third party (variant)	8
Feedback to caregivers (variant)	8
Training (44 cases)	
Academic training (variant)	3
Experiential training (variant)	17
Feedback skill development (variant)	11
Gaps in training (variant)	14
Use and Practice (138 cases)	
Clinical psychological assessment (variant)	5
Facilitating clinical practice (variant)	57
Forensic/legal assessment (variant)	18
Health psychological assessment (variant)	11
Industrial/organizational assessment (variant)	14
Neuropsychological assessment (variant)	7
Psychoeducational assessment (variant)	23
Testing (variant)	3
Vocational assessment (variant)	7

Note. Categories with 2 or fewer cases were labelled invariant and are not presented in this table.

clinical activities. The "Attitudes and Beliefs" and "Ethics" domains then built on this description by outlining respondents' concerns and issues with current practice. The results for RQ2 were captured by the domains of "Feedback" and "Training." The "Feedback" domain encompassed respondents' discussion of how their area of practice influenced how they deliver TFB. The "Training" domain addressed the inadequacies of training and how it can serve as a barrier for TFB provision. The answers for RQ3 were summarized primarily by the "Training" domain as well. In that domain, respondents discussed their experiences with training, outlined what aspects were helpful, and identified gaps in current TFB training. Finally, the domain of "Effectiveness" summarized important information about respondents' opinions of effective TFB practices, which does not fall under the purview of any of the three sub-questions but was within the overarching RQ of "What are Canadian clinicians' perceptions of TFB?" As such, this domain was summarized separately.

We used Hill et al.'s (1997) established criteria for interpreting categories based on frequency. A category is considered *general* when it applies to all cases, as *typical* when it applies to more than half of the cases, and as *variant* if it applies to less than half. Categories that apply only to one or two cases are labelled *invariant* and are excluded from the findings based on that criterion. In this study, our textual data were many open-ended survey comments. Individual cases rarely fell into more than one category, thus using the established criteria would mean that every category would be labelled invariant. As such, we modified the classification criteria that were based originally on Hill et al.'s (1997) guidelines.

The criteria for categories were modified to count the frequency *within* each domain (i.e., a *general* category applies to all cases within the domain, a *typical* category applies to over half, and a *variant* category applies to under half but greater than two) so that the findings could be presented and discussed more meaningfully. One additional consideration in the analysis is that information on the context of the participant comments (e.g., the demographics of the specific participant that made the comment and the work setting of each participant) was absent due to anonymity procedures for participant confidentiality. As such, the context of the comments is not a factor in the analysis and reporting of the findings.

Research Question 1: How Do Canadian Clinicians' Perceptions of TFB Affect Their Use and Practice of TFB?

Use and Practice

Clinicians reported practising assessment and TFB in a variety of areas, which are summarized under seven variant categories: clinical psychological assessment, forensic/legal assessment, health psychological assessment, industrial/organizational assessment, neuropsychological assessment, psychoeducational assessment, and vocational assessment. The clinical psychological assessments

included personality testing and work on hospital psychiatric units. Forensic/legal assessments encompassed personal injury claims, eligibility assessments for government benefits, and court-ordered assessments. Health psychological assessments covered independent medical examinations, assessments of surgical readiness, and assessments for rehabilitation work. Industrial/organizational assessments were conducted in the workplace, particularly for the hiring process. Neuropsychological assessments were used for cognitive rehabilitation planning, neuropsychological diagnoses, and capacity decisions. Psychoeducational assessments were used to identify students' educational needs and to help individuals with intellectual disabilities access resources. Psychoeducational assessors often worked in a school setting. Lastly, vocational assessments encompassed career psychological and vocational interest exploration through assessment.

Finally, one small variant category had comments listing the specific tests that clinicians used, such as the Wechsler scales and the Beck Depression Inventory-II. Another variant category described the functional purposes of assessment and TFB, such as using assessment to inform treatment planning and to generate clinical hypotheses. Other purposes for psychological assessment noted in this category were to form treatment recommendations, to monitor progress, to screen for disorders and symptoms, to diagnose disorders, to help clients and caregivers understand the client's issues better, to conduct risk assessments, and to facilitate multicultural work.

Attitudes and Beliefs

Clinicians typically reported concerns related to testing practices, expressing beliefs that other clinicians were over-interpreting test results, relying too heavily on percentile ranks, and overemphasizing intelligence testing. A variant category related to clinicians' beliefs about what constitutes best clinical practice was also present; such beliefs included the importance of integrating test results. This category had a wide range of content associated with good clinical practices. These included writing assessment reports that are useful and understandable to clients, integrating test results with a client's history and presenting concerns, and explaining the implications of testing to clients.

Ethics

There was a typical category: clinicians' TFB-related ethical concerns revolved around awareness and knowledge of the relevant professional standards for assessment, especially the regulatory requirement that TFB must be provided in a way that could be understood. There was also a variant category encompassing clinicians' concerns about practitioner competency with psychological assessment. These listed concerns included interpreting intelligence tests incorrectly, practitioners with inadequate psychometrics training, the use of psychological

assessments by untrained human resources staff, and the use of tests with populations for whom they had not been standardized.

Research Question 2: How Do Factors Such as Area of Practice, Helpfulness of Training, and Type of Training Affect the Practice of TFB?

Feedback

In the domain of "Feedback," there are three variant categories: feedback to third parties, feedback to caregivers, and context dependency. Feedback to third parties referred to situations where clinicians provide TFB to a third party like a lawyer or an organizational hiring committee instead of to the test-taking individual. Feedback to caregivers referred to a similar situation where the clinicians' testing client is a child, in which case TFB is given primarily to caregivers. Lastly, the clinicians discussed how TFB often depends on the context where it is delivered.

Training

Clinicians discussed TFB training under four variant categories. However, in addressing this RQ, only the variant category of current gaps in training will be addressed. Clinicians recognized several gaps in current TFB training practices, often citing that such skills were self-taught. Other areas in current TFB training deemed inadequate by clinicians included delivering verbal feedback, communicating bad news, developing a personal assessment approach, and conveying the implications of results to clients. One comment also expressed concerns about academic instructors themselves lacking training and experience with assessment.

Research Question 3: How Is Training in TFB for Canadian Clinicians Primary Practical?

Training

The remaining three variant categories within this domain were academic training, experiential training, and clinicians' expected TFB skills. Academic sources of TFB learning were identified as readings, class discussions, and conversations with professors. Many clinicians also mentioned experiential forms of TFB learning such as practica, internships, and employment as impactful in their education. Clinicians also outlined TFB skills that should be a part of training, such as developing an effective feedback style, delivering bad news to clients, communicating results to clients in an understandable manner, and integrating test results with other sources of information to form a comprehensive assessment.

Effectiveness

Five variants encompassed clinicians' descriptions of what constituted effective TFB practice. One variant category discussed the importance of adopting a collaborative approach that involved clients in the TFB process. Clinicians also

emphasized the test interpretation process. They mentioned specifically the integration of information from test results with other sources like client histories and presenting problems. Clinicians' responses also indicated that the presentation of results was important; this included discussion of both the "how" of presenting results effectively (i.e., visually) and the "why" of whether results should be shared at all. Clinicians also appreciated the value of providing TFB to clients. Finally, the most frequent category in this domain was the concept that TFB needs to be tailored to the client in order to be effective. This is exemplified in the following comment:

> It's an art to take something that consists of a lot of theory and technical information and to turn it into something that an untrained person will understand and then use as a springboard for the next steps. Clinicians need to find more down-to-earth phrases and descriptors that make sense to most people when explaining results.

Discussion

The purpose of this secondary analysis was to obtain a deeper understanding of Canadian clinicians' perceptions regarding TFB. This was accomplished through a rigorous analysis of open-ended survey comments via CQR analytic procedures. The results of this analysis answered the RQ "What are Canadian clinicians' perceptions of TFB?" and more specifically provided explanatory information on three sub-RQs:

1. How do Canadian clinicians' perceptions of TFB affect their use and practice of TFB?
2. How do factors such as area of practice, helpfulness of training, and type of training affect the practice of TFB?
3. How is training in TFB for Canadian clinicians primarily practical?

The results of this investigation showed that clinicians conduct TFB and psychological assessment in a variety of settings ranging from health to forensic to psychoeducational settings. Clinicians also described beliefs that TFB practices such as integrating and interpreting test results and communicating assessments results in an understandable manner were vital. In addition, clinicians were concerned that many in their profession were not aware of provincial and national standards of practice in assessment that require the provision of feedback following psychological testing (CPA, 2017). Finally, clinicians also connected the utility of psychological assessment and TFB to other aspects of clinical practice, such as treatment planning, progress monitoring, and client engagement.

Together, these results supported the notion that clinicians view TFB as a required and valuable aspect of practice, which in turn contributes to the prolific reported usage of TFB in clinical practice (Jacobson et al., 2015). Other surveys

of clinicians find similar perceptions related to the utility of feedback (Curry & Hanson, 2010; S. R. Smith et al., 2007). However, the beliefs surrounding TFB as a practice standard or as a necessity for ethical practice were not captured in prior research (Curry & Hanson, 2010; Jacobson et al., 2015).

In the present study, concerns with providing TFB to third parties were found. Clinicians noted that when practising in a forensic setting, the assessment process often excluded direct TFB to the testing individual because the assessment client is often the legal system itself rather than the test-taking individual. In the industrial/organizational setting, the hiring organization is considered the assessment client and as such receives the TFB directly, rather than the testing individual. Clinicians noted a similar arrangement with TFB provision for child clients, with findings more often being delivered to caregivers rather than to the child, depending on the child's age. In contrast, clinicians who reported working with children/adolescents in Jacobson et al. (2015) were significantly more likely to provide TFB to caregivers. One possible interpretation of these disparate findings is that clinicians label giving TFB to caregivers rather than to the child as a "legitimate" TFB but view providing TFB to an institution rather than an individual as a distinctly different activity.

Training in TFB was also a major explanatory area for this study. Experiential training such as learning through practica, self-study, supervision, and general clinical exposure and experience was a prevalent theme. Clinicians also emphasized the perceived inadequacies with current TFB training and, along this line of thinking, what should be taught to address these gaps. These gaps in training, particularly at the graduate level, were related to subjects such as providing verbal feedback, integrating test results, and explaining the implications of test results.

These results suggest that although most clinicians perceived their academic training as helpful, there were many specific aspects of TFB where training is considered inadequate at the graduate level by clinicians (Curry & Hanson, 2010; Jacobson et al., 2015; May & Scott, 1991). As such, self-study and trial-and-error approaches to developing feedback skills became necessary. This is a concern because such unsystematic approaches to learning are not aligned with the ethics of competency for scientist-practitioners (Navab et al., 2016).

Canadian clinicians also have a varying landscape of beliefs surrounding what constitutes effective TFB practices. The categories under the "Effectiveness" domain suggested that clinicians have an implicit understanding and appreciation of TFB practice based on TA principles. This approach is characterized by collaboration, empathy, the use of the client's language, and assessment-inspired interventions (Finn & Tonsager, 1997; Fischer, 2000).

For example, clinicians felt that tailoring feedback to the individual client in a manner that is understandable was critical to effective TFB. Clinicians reported that "putting their heads together" with the client was also a key element of

effective practice and utilized TFB to facilitate treatment planning. The research evidence on the effectiveness of specific TFB practices is quite sparse.

Groth-Marnat and Wright (2016) recommended that clinicians provide direct, accurate, and understandable TFB under the following guidelines: outline the rationale for assessment and address client misconceptions, use clinical judgment to select the most essential information to convey, integrate information into the client's context of life through collaboration, and tailor language to the client. Since Groth-Marnat and Wright drew on the research of Ackerman et al. (2000), Finn (2007), and Finn and Tonsager (1997) to formulate these recommendations, there is a strong alignment with the TA approach.

In a recent chapter by Aschieri et al. (2016), the authors summarized the evidence for TA and highlighted essential skills and techniques for facilitating successful, impactful psychological assessment. These skills were not unique to the TA approach but could apply to a variety of assessment-related situations and contexts. The skills involve building an empathic relationship through active listening, accurate mirroring to facilitate the therapeutic process, scaffolding to engage the client in the assessment, and circular questioning to form connections between the client's experiences. Other critical techniques identified by Aschieri et al. were modulating shame reactions through normalization and/or immediacy, psychoeducation about the nature and prevalence of disorders, and mentalization about the meaning of emotional experiences in the assessment. Although these recommendations were comprehensive, there is limited direct research evidence cited in support of these specific practices, which implied that clinical experience was the primary source of these suggestions. Given the dearth of evidence in this area in the context of TFB, there is potential in future exploratory and explanatory research on this topic.

Limitations

The nature of this study, as a secondary analysis of open-ended survey comments, presented several clear limitations. First, and perhaps most importantly, the study employed an atypical dataset consisting of many cases, with each case individually containing a limited amount of textual data. The typical dataset for case studies consists of rich, in-depth textual data focused on a single case or on a small number of cases (Creswell et al., 2007). As such, one could argue that there was a mismatch between the chosen analytic method and the dataset that detracts from the strength of the study's findings. Second, the original survey data collection addressed a different set of RQs. However, this study intended to serve as an exploratory follow-up to that original study.

Additionally, the RQs selected were closely related and relevant to the context of the original data collection. Third, some researchers argue that because qualitative research has a specific "context" underlying the analysis (i.e., the biases of the researcher, the researcher's insights, the research setting, and

the experience of collecting the data), it is not appropriate to conduct secondary qualitative analyses (Ziebland & Hunt, 2014). However, because the contexts for data analysis were relatively similar and the CQR method was chosen to enhance the trustworthiness of the analysis, the advantages of conducting this secondary analysis such as the heuristic value and cost effectiveness outweighed any methodological risks.

Fourth, as part of the research ethics procedures for confidentiality, the demographic information connected to participant comments was removed from the dataset before starting the study. As such, information about the individual who initially made the comment was not available to frame the analysis and interpretation. Fifth, there were some non-responses to the open-ended survey questions, and as such, the viewpoints of those participants were not represented in the analysis. Thus, it is possible that unique perspectives on TFB were not captured in this study as a result. Lastly, this study retained all the limits of the original study, such as a relatively low response rate (14.4%), the potential self-selection bias from those who responded, demand characteristics, and the ethnic/cultural characteristics of the sample. Limitations with the original survey instrument were also inherited, such as not collecting age data and not translating the survey into French (Jacobson et al., 2015).

There were several limitations based on the criteria for methodological rigour for CQR. The CQR approach was designed for use with rich, contextualized single-case data, often in the form of interviews (Hill et al., 2005). However, in this study, the method was applied to localized segments of information in the form of survey comments. Although this usage was outside of the original intention of the CQR approach, there were beneficial aspects of attempting to apply this approach to a new type of problem.

Employing the CQR method enhanced the general trustworthiness of the current analysis by integrating a structured and transparent analytic procedure that bolstered validity and interpretability. Previous researchers have explored extensions of the CQR method to other forms of data such as coded medical interviews (Stanghellini et al., 2014). Although the consensus process was used in each phase of the study, only a proportion of the comments was coded by the entire team. The first author completed the coding of the other statements post-consensus, which raises the possibility of researcher bias for that subset of coding activity. Another CQR procedural criterion was the use of an auditor between each phase of the analysis (i.e., after domain coding, core idea abstraction, and cross-analysis). In this study, auditing was reserved solely for the phase following cross-analysis because of time and resource restrictions. Finally, the labelling criteria for reporting the results of the CQR analysis were modified as a necessity based on the nature of the case data (see the findings section above for the full justification of this decision).

Implications for Psychological Practice and Training

The results of this study have implications for clinicians. Training in psychological assessment should place greater emphasis on practical, experiential approaches in the interpretation of test results and in the process of communicating those results to clients. The ability to communicate findings to clients in an understandable manner should be considered an important competency in clinical practice. Clinicians should also be aware that TFB provision can be strongly influenced by the practice setting, particularly when there are third-party clients. Finally, clinicians should educate themselves on the standards of assessment practice and other relevant assessment-related guidelines for their jurisdiction of practice.

Implications for Future Research

Many fruitful areas of research on the topic of the psychological assessment of TFB remain. A crucial prerequisite to such research would be clear operational definitions for the clinical outcomes of feedback provision. Researchers have used a variety of process and outcome measures to represent effectiveness in psychological assessment, including symptom change post-assessment, self-ratings of various personality and emotional factors (e.g., hope), therapeutic alliance ratings, client satisfaction, client attendance, and even idiographic outcome measurements developed collaboratively with the research participant/client (Finn & Tonsager, 1992; Newman & Greenway, 1997; J. D. Smith et al., 2010).

A consistent definition and conceptualization of "effective" TFB would facilitate future quantitative and mixed-methods evaluations of TFB techniques, approaches, and philosophies. Consistent use of assessment outcome measures across studies, such as the Assessment Questionnaire-2 (AQ-2; Finn et al., 1995; Finn & Tonsager, 1997), would also facilitate outcome comparisons. In this study, clinicians referred frequently to practice elements that they consider to be effective or right. Still, it is unclear what criteria clinicians were using to make this evaluation. Future qualitative or mixed-methods exploratory research on clinicians' expected or desired outcomes from providing TFB to clients and the development of conceptual definitions and measurements for those outcomes would facilitate more specific research.

A specific issue that arose in this study and in past studies examining clinicians' perceptions about TFB involves third-party clients (Jacobson et al., 2015; Curry & Hanson, 2010). New RQs focusing on this assessment issue from an ethical or experiential perspective would be enlightening, such as an investigation of clinicians' experiences providing TFB to third parties or of the ethical assumptions made by clinicians in third-party TFB situations. A qualitative grounded-theory approach to develop an overarching understanding of how clinicians navigate third-party client TFB situations or a phenomenological approach investigating clinicians' experience with these situations would be interesting and appropriate.

Future research explicitly targeting the development of effective training programs for both verbal and written TFB is needed. Researchers have argued for the importance of teaching psychological assessment in graduate training based on a drop in the use of psychological assessment in clinical practice and on concerns about ethics and competence (Haverkamp, 2013). This was reflected in a recent special section of the *Journal of Personality Assessment* on teaching, training, and supervision in personality and psychological assessment.

In the issue, J. D. Smith (2017) argued that in a field that emphasizes evidence-based practices and competent clinical activity, there exists a need for greater attention to teaching personality assessment, training and supervision of psychological assessment, and establishing a culture of ongoing education and peer consultation to maintain the quality and relevance of the practice of psychological assessment. Topics in this special section included the potential benefits of exposure to personality assessment at the undergraduate level (Roche et al., 2017), a qualitative investigation of a required psychological assessment course that incorporates Finn's TA paradigm (J. D. Smith & Egan, 2017), an article exploring the relationship between different conceptual models of psychological assessment and their training and practice (Blais & Hopwood, 2017), a discussion of an assessment course design based on Bloom's taxonomy (Ramirez, 2017), a survey of directors of clinical psychology doctoral programs on training in psychological assessment (Mihura et al., 2017), an exploratory study of supervision practices related to assessment (Iwanicki & Peterson, 2017), and a discussion of professional training and consultation in assessment beyond graduate training (Evans & Finn, 2017). Training in psychological assessment remains a diverse topic with a breadth of avenues for inquiry.

Conclusion

Findings from the current study show that clinicians utilize TFB in a variety of practice settings. Clinicians provide TFB because they consider it an ethical imperative and a necessity for effective practice and because they have previous experience with the value of offering TFB. Clinicians discussed the notable situation of providing TFB to various parties beyond the testing individual, which suggested that the practice setting and context are highly influential. However, they are also concerned about TFB being conducted unethically by other practitioners.

Clinicians also reflected on the usefulness of experiential training in learning TFB but also emphasized perceived gaps in graduate training on giving feedback. Lastly, clinicians also connected practice elements based on TA principles with effective TFB provision, such as tailoring feedback to clients and collaborating to make sense of results.

In many respects, this study raised many more questions than it answered. TFB is an integral aspect of effective, evidence-based psychological assessment. The integration of psychological assessment into the core competencies of

psychotherapy practice, clinical training, and applied psychology is becoming more widespread and explicit (Anchin et al., 2016). As such, the delivery of competent psychological assessment could become a universal skill set for future clinicians.

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