Client and Caregiver Perceptions of Feedback Following Psychodiagnostic Assessment

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Client and Caregiver Perceptions of Feedback Following Psychodiagnostic Assessment

Abstract
Providing assessment feedback to clients is an ethical responsibility of psychologists and an essential component of the feedback process. Despite this fact, little empirical attention has been given to the process and impact of providing assessment feedback to clients. Research has contributed general guidelines for providing effective feedback to clients, as well as models for how to structure a feedback session. In addition, research indicates that clinicians believe that feedback is helpful for clients and in turn, clients prefer feedback that is client-centered. Across the literature on feedback there are common themes of providing personalized, collaborative feedback in an empathic and caring way that meets the specific needs of the client. The aim of the current study was to assess clients’ perceptions and experiences of psychodiagnostic feedback with respect to their impressions of the utility of feedback and of the impact of the clinician. Results indicated that clients and caregivers found feedback to be helpful, useful, and overall were satisfied with receiving assessment feedback. In addition, clients’ feelings of being both understood and treated respectfully by the clinician were significant predictors of overall satisfaction. Clients’ experiences of learning new information, reinforcing previously known information, or viewing the results as inaccurate did not significantly predict ratings of usefulness. Clients’ experiences of not viewing the results as inaccurate did significantly predict ratings of helpfulness. Despite the limitations of the study, the findings have clinical implications with regard to how clinicians should conceptualize and conduct assessment feedback with clients. Overall, the results provide further evidence for the utility of feedback and future research should continue to explore this construct.

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CLIENT AND CAREGIVER PERCEPTIONS OF FEEDBACK FOLLOWING PSYCHODIAGNOSTIC ASSESSMENT

A THESIS
SUBMITTED TO THE FACULTY
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APPROVED:
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CLIENT PERCEPTIONS OF ASSESSMENT FEEDBACK

ABSTRACT

Providing assessment feedback to clients is an ethical responsibility of psychologists and an essential component of the feedback process. Despite this fact, little empirical attention has been given to the process and impact of providing assessment feedback to clients. Research has contributed general guidelines for providing effective feedback to clients, as well as models for how to structure a feedback session. In addition, research indicates that clinicians believe that feedback is helpful for clients and in turn, clients prefer feedback that is client-centered. Across the literature on feedback there are common themes of providing personalized, collaborative feedback in an empathic and caring way that meets the specific needs of the client. The aim of the current study was to assess clients’ perceptions and experiences of psychodiagnostic feedback with respect to their impressions of the utility of feedback and of the impact of the clinician. Results indicated that clients and caregivers found feedback to be helpful, useful, and overall were satisfied with receiving assessment feedback. In addition, clients’ feelings of being both understood and treated respectfully by the clinician were significant predictors of overall satisfaction. Clients’ experiences of learning new information, reinforcing previously known information, or viewing the results as inaccurate did not significantly predict ratings of usefulness. Clients’ experiences of not viewing the results as inaccurate did significantly predict ratings of helpfulness. Despite the limitations of the study, the findings have clinical implications with regard to how clinicians should conceptualize and conduct assessment feedback with clients. Overall, the results provide further evidence for the utility of feedback and future research should continue to explore this construct.
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# CLIENT PERCEPTIONS OF ASSESSMENT FEEDBACK

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vi</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>ASSESSMENT FEEDBACK CONSIDERATIONS</td>
<td>1</td>
</tr>
<tr>
<td>General Assessment Feedback Considerations</td>
<td>2</td>
</tr>
<tr>
<td>Assessment Feedback Considerations for Specific Populations</td>
<td>4</td>
</tr>
<tr>
<td>Children and Adolescents</td>
<td>4</td>
</tr>
<tr>
<td>Research Participants</td>
<td>6</td>
</tr>
<tr>
<td>When Assessment Feedback is Contraindicated</td>
<td>7</td>
</tr>
<tr>
<td>CLINICIANS AND ASSESSMENT FEEDBACK</td>
<td>8</td>
</tr>
<tr>
<td>Clinician Perceptions of Assessment Feedback</td>
<td>8</td>
</tr>
<tr>
<td>Clinician-Rated Significant Events in Assessment Feedback</td>
<td>9</td>
</tr>
<tr>
<td>CLIENTS AND ASSESSMENT FEEDBACK</td>
<td>10</td>
</tr>
<tr>
<td>Client Perceptions of Assessment Feedback</td>
<td>10</td>
</tr>
<tr>
<td>Client-Rated Significant Events in Assessment Feedback</td>
<td>11</td>
</tr>
<tr>
<td>LITERATURE SUMMARY</td>
<td>12</td>
</tr>
<tr>
<td>RATIONALE FOR THE CURRENT STUDY</td>
<td>14</td>
</tr>
<tr>
<td>Hypotheses</td>
<td>15</td>
</tr>
<tr>
<td>METHODS</td>
<td>16</td>
</tr>
<tr>
<td>Participants</td>
<td>16</td>
</tr>
</tbody>
</table>
CLIENT PERCEPTIONS OF ASSESSMENT FEEDBACK

LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Summary of Intercorrelations, Means, and Standard Deviations</td>
<td>22</td>
</tr>
<tr>
<td>Table 2</td>
<td>First Block Regression Coefficients</td>
<td>26</td>
</tr>
<tr>
<td>Table 3</td>
<td>Second Block Regression Coefficients</td>
<td>27</td>
</tr>
<tr>
<td>Table 4</td>
<td>Summary of Intercorrelations, Means, and Standard Deviations</td>
<td>29</td>
</tr>
<tr>
<td>Table 5</td>
<td>Usefulness Regression Coefficients</td>
<td>30</td>
</tr>
<tr>
<td>Table 6</td>
<td>Helpfulness Regression Coefficients</td>
<td>31</td>
</tr>
</tbody>
</table>
Introduction

Echoed by the American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct, feedback for psychological assessments has become a crucial component of the psychodiagnostic process (American Psychological Association [APA], 2002; Ward, 2008; Gass & Brown, 1992). Despite this ethical mandate, little has been written about psychological assessment feedback procedures and outcomes (Lillie, 2007; Pope, 1992; Smith, Wiggins, & Gorske, 2007). In studies that have investigated this construct, assessment feedback has been shown to have clinical utility and the ability to produce positive change for clients. Thus, it serves as a powerful element of therapeutic and assessment processes (Allen, Montgomery, Tubman, Frazier, & Escovar, 2003; Brenner, 2003; Finn & Tonsager, 1992, 1997; Newman & Greenway, 1997). As providing assessment feedback is an ethical responsibility of psychologists and has been shown to have clinical utility, it is imperative to evaluate client perceptions of the feedback session following assessment to ascertain what elements of receiving feedback most resonate with and are most likely to benefit clients. The following literature review begins with a discussion of general assessment feedback considerations, then presents considerations for specific populations including children/adolescents and research participants, as well as when providing assessment feedback is contraindicated. Next, the current literature addressing clinician perceptions of assessment feedback and clinician-rated significant events in assessment feedback is discussed. Finally, current literature addressing client perceptions of assessment feedback and client-rated significant events in assessment feedback is reviewed.

Assessment Feedback Considerations

Even though there is no agreed upon method for conducting an assessment feedback session, there are a number of considerations provided within the current literature to guide
clinicians in the process of conducting a feedback session. These recommendations include both general considerations and specific considerations for unique populations.

**General Assessment Feedback Considerations**

Most of the literature on the topic of assessment feedback speaks to general guidelines and recommendations that aid clinicians in providing appropriate and useful feedback to clients. Gass and Brown (1992) outlined a general format to guide an assessment feedback session for individuals with brain dysfunction that is applicable to all clients. Gass and Brown’s recommended format includes the following components: (a) reviewing the purpose of testing, (b) defining the tests used, (c) explaining test results, (d) describing strengths and weaknesses, (e) addressing diagnostic and prognostic issues, and (f) providing recommendations. This format provides a structure mirroring the different sections of a typical assessment report. Koocher and Rey-Casserly (2003) similarly described the importance of addressing the original referral question and purpose of the testing in the feedback session. In addition, it is important to review any third party involvement (i.e., a court, an employer, or a school) that was discussed during informed consent, especially with regard to the limits of confidentiality and releases of information (Koocher & Rey-Casserly, 2003). Another consideration for the format of the feedback session includes being flexible in order to accommodate the specific needs of a client, as well as actively encouraging participation of the client, including reactions and questions (Pollack, 1988). Berg (1985) discussed using the client’s own language, beginning with material that is most important to the client, and consideration of the practicality of specific results for the client as elements contributing to the value of feedback. Finn and Tonsager (1997) cited patient motives as having an influence on the clinical utility of assessment; they suggest that feedback be guided by the client’s desires for self-verification, self-enhancement, and self-efficacy/self-discovery. In doing so, the client will be the most receptive to and most benefit from the
feedback. Further, the basic principles of effective therapeutic communication should be applied (e.g., using empathy, listening effectively, and reflecting back what is heard) to an assessment feedback session, just as they would apply to a psychotherapy session (Finn, 1996).

Within the general domain of assessment feedback, specific approaches to conducting feedback, including consumer- and communication-focused, have been suggested as options for improving the feedback experience. Consumer-focused assessment feedback has been presented as a means to enhance the clinical utility of feedback, as focusing on the consumer is critical in most of the current approaches to marketing health care services (Brenner, 2003). Brenner (2003) advocated five considerations to enhance the clinical utility of feedback: (a) eliminate jargon, (b) focus on referral questions, (c) individualize assessment reports, (d) emphasize client strengths, and (e) write concrete recommendations. Gorske (2008) advocated the use of a humanistic model for providing feedback to clients receiving neuropsychological assessment, specifically focusing on providing feedback in a therapeutic and collaborative manner. The specific steps of the humanistic model for providing assessment feedback include: (1) introducing the purpose of the session, (2) developing life implication questions, (3) providing feedback about strengths and weaknesses, and (4) discussing summary statements and recommendations (Gorske, 2008). Lillie (2007) suggested applying aspects of Kiesler’s Interpersonal Communication Therapy (ICT) to assessment feedback, positing that ICT has the potential to increase the probability that results are heard, accepted, integrated, and acted upon. ICT utilizes Kiesler’s circumplex model of interpersonal interactions, which provides a framework for understanding communication within relationships. With respect to feedback, this framework can be applied to the relationship between assessor and assessee (Lillie, 2007). Within the personality assessment domain, Finn and Tonsager (1997) advocated using assessment feedback as an intervention in itself and outlined three objectives for the entire
assessment process: (a) develop and maintain empathic connections, (b) work collaboratively to define assessment goals, and (3) share and explore assessment results.

Overall, assessment feedback considerations across the literature include employing empathy, using understandable language, providing real-life examples, giving recommendations, answering questions, and tailoring the feedback session to the specific needs of the client. Further, a number of specific models have been presented as methods for enhancing the experience of feedback including a consumer-focused model, a communication-focused model, a humanistic approach, and using assessment feedback as an intervention in itself. Though these considerations apply to almost all individuals, there are additional considerations that apply to specific populations of individuals receiving assessment feedback.

**Assessment Feedback Considerations for Specific Populations**

Within the current literature there are two specific populations that have been deemed as having unique needs with respect to feedback. Both youth and research participants are vulnerable populations that warrant special considerations when receiving feedback.

**Children and adolescents.** Child and adolescent assessment involves a set of unique issues relative to adult assessment that include considering the developmental level of the client, obtaining consent and assent, incorporating information from collateral sources, and providing recommendations tailored to the child or adolescent. Since children and adolescents cannot consent to assessment, feedback is generally provided to the caregiver. With these issues in mind, there are a number of considerations specific to engaging in assessment feedback with children and adolescents, as well as with caregivers. However, how feedback should be communicated to a child or adolescent continues to be an area for further exploration.

With respect to providing personality assessment results to parents of adolescents, Braaten (2007) advocated that feedback be conducted in a way that is informative, empathic, and
supportive of parental emotional expression. Tharinger et al. (2008) supported using a collaborative approach when providing assessment feedback to parents and preadolescent children. Pollack (1988) suggested that feedback sessions include significant adult family members that are influential in the child’s life. He also suggested encouraging active participation (ideas, questions, expression of feelings) from all persons present, emphasizing that conclusions were based on data drawn from multiple sources, and tailoring feedback to parents’ presumed intellectual abilities, specifically taking into account factors such as educational background and familiarity with psychological assessment practices (Pollack, 1988). Griffen and Christie (2008) also highlighted the importance of including significant family members, as well as other adults (e.g., teachers or counselors), in the feedback session. Further, there should be a discussion about who will be receiving the assessment report (e.g., the child’s school) during the feedback session, and if possible, with permission from the family, verbal feedback be given to teachers over the phone if they cannot attend the feedback session (Griffen & Christie, 2008). A common theme across these recommendations is the inclusion of parents and caregivers in the feedback session, specifically in a collaborative and emotionally supportive way.

With respect to how feedback should be communicated directly to children, there are a limited number of suggestions provided in the literature. Tharinger et al. (2008) proposed providing assessment feedback to children through the use of fables, allowing the results to be communicated in a way that is tailored to the emotional capacities of the child. Griffen and Christie (2008) suggested translating psychological terms into more kid-friendly versions (e.g., using the term remembering instead of memory). Further, they advocated giving the child “Top Tips” note cards as a way of providing recommendations to the child (Griffen & Christie, 2008). From the limited literature available, providing assessment feedback to children appears to
involve utilizing creative and developmentally appropriate methods for both engaging the child’s attention for the feedback session and delivering recommendations.

**Research participants.** As research participants constitute a unique population of individuals that undergo psychological assessment, it follows logically that providing assessment feedback to this group involves some distinct procedures. Section 8.08, Debriefing, of the Ethical Principles of Psychologist and Code of Conduct directs researchers to provide the opportunity for participants to receive appropriate information regarding the nature, results, and conclusions of the research (APA, 2002). Even though there is controversy in the field about whether to provide participants with research results, this mandate allows for the disclosure of assessment results to individual participants. Research addressing assessment feedback with research participants has highlighted a number of considerations specific to this population.

Lefaivre, Chambers, and Fernandez (2007) described research assessment feedback considerations for parents of children who serve as research participants. They stated that when assessment feedback with research participants is warranted, the feedback should be sensitive and considerate to protect the dignity and welfare of the participant. Further, feedback should be conducted face to face with a qualified researcher when the results of the assessments are highly complex, ambiguous, or when the results have significant negative implications (i.e., clinical diagnosis; Lefaivre et al., 2007). Information specific to a research setting that should be incorporated into assessment feedback includes the following: (a) the title and purpose of the study as they appear in the informed consent, (b) the contact information of the principal investigator, (c) the names and types of assessment measures administered and who administered them, and (d) the importance and need of informing future persons conducting further psychological testing about the feedback received following the study (Lefaivre et al., 2007).
Though these recommendations were described in the context of research involving children, the considerations undoubtedly apply to adult research participants as well.

In addition to general feedback considerations, both youth and research participants require special considerations when receiving feedback. Overall, when conducting feedback with youth it is important to be supportive of the caregivers’ emotions, to include significant family members and adults when possible, and to convey feedback directly to youth in a way that is developmentally and emotionally appropriate (Braaten, 2007; Griffen & Christie, 2008; Pollack, 1988; Tharinger et al., 2008). Overall, when conducting feedback with research participants it is important that feedback be conducted in person, that the dignity and welfare of the participant is maintained, that study contact information is included, and that participants are educated about the importance of informing future providers of their participation in research (Lefaivre et al., 2007).

When Assessment Feedback is Contraindicated

Though clinicians have an ethical obligation to provide explanatory feedback to the individuals that they assess, there are situations in which providing feedback to a client is not warranted. Koocher and Rey-Casserly (2003) discussed when not to provide feedback to an individual based on the nature of the clinician-client relationship. They cited the following examples of relationships in which providing assessment feedback to an individual may not be indicated: (a) organizational consulting, (b) preemployment or security screening, and (c) some forensic evaluations (Koocher & Rey-Casserly, 2003). Without exception, the manner of feedback to be provided and any limitations to providing feedback must be explicitly defined to the assessee prior to the evaluation, and should be communicated in both written and verbal formats (Koocher & Rey-Casserly, 2003). Overall, there are circumstances in which providing feedback to a client is not warranted and in such situations the client must be explicitly informed.
prior to the evaluation (Koocher & Rey-Casserly, 2003). Research investigating clinician perceptions of assessment feedback offers valuable insight into how clinicians view and conduct feedback with their clients. The following section reviews the available literature in this topic area.

Clinicians and Assessment Feedback

With respect to the current literature addressing perceptions of assessment feedback, research has mostly focused on clinicians’ perceptions of the content and process of feedback. Overall, writings in this domain are extremely limited with just a small number of studies available on this topic area. Although the following section reviews the available literature, it should be noted that further research is needed in this area.

Clinician Perceptions of Assessment Feedback

To the researchers’ knowledge, there is one published study examining clinicians’ perceptions of the feedback process. In an investigation of psychologists’ impressions of feedback, Smith et al. (2007) found that 72% of the 719 psychologists surveyed reported that their clients found feedback information to be helpful and productive. This finding was positively correlated with the amount of time dedicated to the feedback session. Clinicians also reported when feedback was related in a way that was understandable and accurate, it helped clients to feel motivated to follow recommendations. Further, clinicians stressed the importance of conducting feedback in person (Smith et al., 2007). In Smith et al.’s (2007) study, the amount of experience the clinician had in conducting assessments was positively related to their comfort with the feedback process, as well as the likelihood of them engaging in a collaborative style of feedback.
Clinician-Rated Significant Events in Assessment Feedback

Even though the research investigating clinician perceptions of assessment feedback is highly limited, clinician-rated significant events in the assessment feedback session have been studied and provide valuable information for clinicians to be cognizant of when conducting feedback. In an investigation of significant events in a psychological assessment feedback session, Ward (2008) identified four areas that clinicians rated as significant moments in the feedback process: (a) client involvement in the process of feedback including being attentive to the client’s engagement level and the clinician’s interest in the client’s interpretation of the results, (b) challenges that clinicians encounter during the feedback session including having concerns about the impact of the results on the client, providing results contrary to clients’ previously held conceptions, and providing results related to emotional functioning, (c) indications of successful feedback including concrete recommendations, an overall summary or causal explanation, clients resonating emotionally with results, and experience of clinician-client collaboration, and (d) clinician’s experience of indicators of a transformative experience on the behalf of the client including clients developing an explicit understanding of the results where there was previously only a tacit understanding and clients moving from a negative and global self-image to a more nuanced appreciation of strengths and weaknesses.

From the available research on clinicians and assessment feedback it appears that clinicians believe that clients find assessment feedback to be useful. Further, clinicians cited the following factors as being implicated in a positive feedback experience: (a) amount of time dedicated to providing feedback, (b) using understandable and accurate language, and (c) conducting feedback in person (Smith et al., 2007). Clinicians also appear to become more comfortable providing assessment feedback as they gain more experience doing so (Smith et al., 2007). Finally, four areas have been identified by clinicians as significant factors in the feedback
session including client involvement, facing challenging moments, indicators of a successful feedback session, and signs that the feedback is meaningful to clients (Ward, 2008). An essential adjunct to examining clinicians’ perceptions of assessment feedback is looking at clients’ perceptions. The following section reviews the available literature investigating client perceptions of assessment feedback.

**Clients and Assessment Feedback**

Information regarding client perceptions of assessment feedback is crucial to a clinician’s ability to provide effective feedback and to conduct successful feedback sessions. The limited research exploring assessment feedback and client perceptions and experiences has involved investigating the impact of feedback on clients, factors influencing clients’ reactions to feedback, and client-rated significant events in the feedback session (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Allen et al., 2003; Hanson, Claiborn, & Kerr, 1997; Ward, 2008).

**Client Perceptions of Assessment Feedback**

In an investigation of the effects of assessment feedback on rapport and self-enhancement, Allen et al. (2003) found that when personalized assessment feedback was given to individuals compared to only general feedback about the assessment measure, clients reported higher rates of rapport with the examiner and fewer negative feelings about the assessment experience. In addition, individuals who received personalized assessment feedback found the information to be more valuable compared to individuals who only received general feedback (Allen et al., 2003). Ackerman et al. (2000) examined the interaction between therapeutic alliance and in-session process during the assessment phase of treatment for individuals seeking outpatient treatment at a university-based community clinic. The authors found that clients did not need to receive good news for them to rate the feedback as good. Further, if the clients experienced the feedback session to be a collaborative undertaking with the clinician, they were
more likely to have rated the feedback session as good (Ackerman et al., 2000). In comparing two styles of test interpretation, interactive and delivered, for personality and vocational measures given to university honors students receiving ongoing career counseling, Hanson et al. (1997) found that students who received an interactive test interpretation rated their feedback sessions as deeper and found their clinicians to be more expert, trustworthy, and attractive compared to those who received a delivered test interpretation.

**Client-Rated Significant Events in Assessment Feedback**

In an investigation of significant events in the feedback process as rated by assessors and assessees, Ward (2008) cited three significant components of the feedback session that affected the assessees’ experiences. Assessees in this study were young adults seeking psychological assessment for various reasons. First, assesses noted the impact of the assessor on their impressions of feedback. The impact of the assessor included seeing the clinician as a benevolent figure, feeling understood by the clinician, and being included in the process of feedback, which were noted as important components for a positive feedback experience. Alternately, the amount of information the assessor gained about the client through the assessment process was associated with discomfort on the part of some assessees during the feedback session. Second, receiving emotionally difficult, unwanted, or discordant news impacted assessees experiences of feedback. Specifically, assessees cited the difficulty of processing upsetting results, experiencing unwanted results as a loss of possibilities, and receiving information that substantiated previously held thoughts about themselves that had yet to be confirmed. The third significant event that affected assessees experiences of assessment feedback was assessees’ experiences of moving from an attitude of self-blame for some global and critical deficiency toward feelings of autonomy and an attitude of informed action, which
was facilitated through the specificity and personalized nature of the information presented by the clinician.

Thus, the available research investigating clients and assessment feedback suggests that clients prefer feedback that is personalized, collaborative, and interactive (Ackerman et al., 2000; Allen et al., 2003; Hanson et al., 1997). Also, clients do not need to receive good news in order to rate the feedback as positive (Ackerman et al., 2000). Finally, three areas have been identified by clients as significant factors in a feedback session including the impact of the clinician, the impact of receiving emotionally difficult, unwanted, or discordant news, and the impact of moving from an attitude of self-blame to an attitude of informed action (Ward, 2008).

**Literature Summary**

In summary, providing assessment feedback is an ethical responsibility of psychologists and is an essential component of the assessment process in most cases (APA, 2002; Gass & Brown, 1992). The nature of the current literature on the topic of assessment feedback is highly limited and warrants further study (Lillie, 2007; Pope, 1992; Smith et al., 2007). Most of the writings in the area of assessment feedback focus on general guidelines and recommendations for clinicians providing assessment feedback. The structure of a feedback session often mirrors the structure of an assessment report (Gass & Brown, 1992). It is important for clinicians to address the referral question(s) and to be flexible with the format of the feedback session (Koocher & Rey-Casserly, 2003; Pollack, 1988). Assessment feedback should be client centered, use understandable language, involve the client in the feedback process, and cover areas that are relevant to the client (Berg, 1985). Effective communication strategies employed in the therapeutic relationship should also be applied to the feedback session, including empathy and reflective listening (Finn, 1996).
A number of models have been proposed as effective means for conducting assessment feedback. These models include consumer-focused feedback, communication-focused feedback, a humanistic approach, and using feedback as an intervention in itself (Brenner, 2003; Finn & Tonsager, 1997; Gorske, 2008; Lillie, 2007). There are also individual considerations for conducting feedback with specific populations. When conducting a feedback session with a child or adolescent, which almost invariably includes a parent or guardian, it is important to consider the role of the parent, the developmental level of the child or adolescent, and to conduct feedback in a collaborative style (Braaten, 2007; Griffen & Christie, 2008; Pollack, 1988; Tharinger et al., 2008). With respect to assessment feedback and research participants, there is special information to include (i.e., title of study, contact information, etc.) in the feedback session, which should be done face to face with a qualified researcher (Lafaivre et al., 2007). Finally, when providing assessment feedback is contraindicated, the client should be fully informed of the limitations prior to testing, which may occur in an organizational-consulting context, preemployment screening, or in some forensic evaluations (Koocher & Rey-Casserly, 2003).

Although there is some research investigating clinician and client perceptions of assessment feedback, the available literature is highly limited and warrants further study. Overall, the available literature addressing clinicians and assessment feedback indicates that clinicians believe that clients find feedback to be useful, that feedback should be conducted in person, and that more experience in conducting feedback equates with more comfort in providing feedback to clients and engaging in a collaborative style (Smith et al., 2007). In addition, the literature speaks to four clinician-rated significant experiences in a feedback session including client involvement, indications of successful feedback, facing challenges, and a transformative experience for clients (Ward, 2008). With respect to the available literature about clients’
perceptions of assessment feedback, clients prefer personalized feedback provided in a collaborative style (Allen et al., 2003). In addition, clients do not need to hear good news to view the feedback as useful (Ackerman et al., 2000; Hanson et al., 1997). Clients also rated three significant experiences in a feedback session including the impact of the clinician, a transformative experience, and receiving emotionally difficult results (Ward, 2008).

Although specific models and considerations for providing feedback have been described, there are commonalities within the literature addressing assessment feedback. Across the topic areas of general feedback guidelines, considerations for specific populations, and clinician and client perceptions, there are common themes of providing personalized, collaborative feedback in an empathic and caring way that meets the specific needs of the client. These themes appear to be the core elements of providing effective feedback to clients.

**Rationale for the Current Study**

Given the limited nature of the current literature addressing client perceptions and experiences of assessment feedback, further research in this area is warranted. Though much of the available information pertaining to assessment feedback concerns guidelines for feedback procedures, empirical studies are limited in number and in generalizability. Further, the current research addressing client perceptions and experiences of assessment feedback has a number of limitations including small sample sizes, homogeneity of sample demographics, and issues related to internal validity (Allen et al., 2003; Hanson et al., 1997; Ward, 2008). Therefore, the purpose of the following investigation was to expand understanding of client and caregiver perceptions and experiences of psychodiagnostic assessment feedback. Specifically, it is hoped that the research will elucidate whether clients and caregivers find the assessment feedback session beneficial and expose aspects of the feedback session that clients consider valuable. For the purpose of this study, clients were defined as adults seeking consultation assessment services.
of their own volitions. Caregivers were defined as guardians who were seeking consultation assessment services for a child, adolescent, or developmentally delayed adult. By clarifying what clients and caregivers find to be the most important components of the feedback session, clinicians may be able to improve feedback practices by better tailoring feedback sessions to client needs.

As part of a larger study investigating the quality, nature, and basic practices of assessment feedback, client and caregiver perceptions and experiences of feedback were collected following neuropsychological assessment feedback sessions.

The following research questions were examined with respect to client and caregiver perceptions and experiences of the feedback session: (a) do clients/caregivers find feedback to be useful and/or find it helpful?, (b) are clients/caregivers satisfied with the feedback they received?, (c) how do positive clinician variables impact clients’/caregivers’ experience?

**Hypotheses**

1. It was hypothesized that clients/caregivers will find assessment feedback to be useful, as indicated by ratings of usefulness significantly higher than 1 (not at all).

2. It was hypothesized that clients/caregivers will find assessment feedback to be helpful, as indicated by ratings of helpfulness significantly higher than 1 (not at all).

3. It was hypothesized that clients/caregivers will be satisfied with the feedback overall, as indicated by ratings of overall satisfaction significantly higher than 1 (not at all).

4. It was hypothesized that overall satisfaction with assessment feedback, as rated by clients/caregivers, will be related to higher ratings of positive clinician variables. More specifically, higher client ratings of being understood by the clinician, the clinician as empathic and caring, and treated respectfully by the clinician, will predict higher overall satisfaction.
Methods

Participants

The participants for this study were clients and caregivers of clients who received a psychodiagnostic evaluation between January 2010 and May 2010 through one of two university training clinics located in the Pacific Northwest. One clinic was located in an urban area and the second clinic was located in a suburban area. Specifically, the participants of this study were those individuals who agreed to participate in this research study following a psychodiagnostic evaluation feedback session. All clinic clients and caregivers who completed a psychodiagnostic evaluation outside of the context of therapy and who could read and understand the questionnaires in English were eligible to participate. Participants were excluded from the study based on the following criteria: (a) individuals with limited English language proficiency who were unable to read the questionnaires in English, (b) individuals who were evaluated by the bilingual assessment team, (c) individuals who did not fully complete their psychological evaluation, (d) individuals who did not attend a feedback session, and (e) individuals evaluated in the context of ongoing therapy by their therapist at one of the clinics.

Sample Characteristics

Participants in the sample ranged in age from 17 to 63 (average age was 31.67), with 46.7% male, 53.3% female, and 0% other. Ethnicity within the sample was distributed as follows: 86.7% Caucasian (N = 13), 6.7% Latino/Hispanic (N = 1), and 6.7% Asian/Asian Pacific/Asian Indian (N = 1). Education within the sample was distributed as follows: 13.3% completed some high school (N = 2), 6.7% finished high school (N = 1), 33.3% completed some college (N = 5), 33.3% finished college (N = 5), and 13.3% attended graduate or professional school (N = 2).
**Procedure**

Participation in the study was solicited by student clinicians following the assessment feedback session and prospective participants were provided a cover letter that described the nature of the study and served as informed consent. The study was approved by the Institutional Review Board at Pacific University. Student clinicians included practicum students who were under the supervision of a licensed psychologist. There were eight student clinicians who provided consultation assessment services and two Pacific faculty (full-time and adjunct) who supervised these services. Explicit consent was not obtained to help ensure participant anonymity. Rather, participation in the study was taken as evidence of the client’s consent. Individuals who agreed to participate in the study were given a hard copy of the feedback questionnaires. The participant was given the option of completing the questionnaires on site or to take them home, though the student clinicians were asked to encourage participants to complete the questionnaires on site to increase the likelihood of retaining the data. Participants who completed the questionnaires on site returned the forms to the front desk of the clinic in a sealed envelope. Clinic staff placed the sealed envelopes in a secure location, a locked file drawer, to be retrieved by research staff. Those individuals who did not want to complete the questionnaires on site were provided with a self-addressed, stamped envelope and asked to mail the questionnaires back to the clinic.

**Measures**

Two survey questionnaires were constructed specifically for this study. At the time of this study, the researchers knew of no existing, well-validated measures that address assessment feedback perceptions and experiences. The questionnaires were expected to take approximately 5-10 minutes to complete.
The first questionnaire included both quantitative and qualitative questions about assessment feedback components (Appendix A). In addition to demographic questions and logistical items about the overall assessment process, the questions reflected concepts from the literature that are considered important components of the feedback session. These items were presented in a number of different rating scales. Clients were asked to rate items concerning their experience of information provided in the feedback session on a 7-point Likert scale ranging from 1 (not at all) to 7 (very much). These items reflected the following concepts related to receiving feedback: understanding, usefulness, new things learned or not, perceived accuracy, referral questions answered, other questions answered, treated respectfully, understood by clinician, and satisfaction. Dichotomous (yes/no) items included questions about the provision of a written report, referrals, knowledge of next steps, and desire for more follow-up sessions. Clients were asked to rank order the following components of the feedback session with respect to each item’s usefulness: talking about strengths, talking about weaknesses, examples or illustrations, overall summary, listening to the results, reading the results, going over a diagnosis, talking about recommendations, and having questions answered. Clients were also asked to provide any other comments about their feedback session experience.

The second questionnaire included rating scales and dichotomous items for different characteristics of feedback cited in the literature that relate to the clinician’s role (Appendix B). Items were presented on a 7-point Likert scale ranging from 1 (not at all) to 7 (very much) and reflected the following clinician characteristics: used understandable language, answered referral question, answered other questions, provided real world examples, explained the testing, explained the limitations of the testing, was empathic and caring, and provided ideas of what to do after testing. Dichotomous (yes/no) items addressed whether a referral for further services
was provided, whether further testing was recommended, and if a diagnosis was provided. Only a portion of the data collected from the surveys was used in the present study.

Results

Preliminary Analyses

Prior to conducting inferential statistics, the data were examined to identify any missing data and potential outliers. One data point was missing for the item evaluating the extent to which the clients believed that the clinician was empathic and caring. Upon investigation of the original questionnaire, it appeared that this participant did not fill out one page of the questionnaire including this item. Therefore, this data point was assessed to be missing completely at random. Analyses involving this questionnaire item were run without this case.

Two other participants did not report the total number of testing hours and therefore their data for this question are missing. As this questionnaire item did not affect tests of the study hypotheses, no further action was warranted.

In order to identify potential outliers, both univariate and multivariate outliers were assessed. Univariate outliers were assessed by standardizing raw scores and evaluating $z$-scores. Using the criterion of $z$-scores greater than +3.00 or less than -3.00, one outlier was detected in the “results were not an accurate representation” variable. Analyses utilizing this variable were run with and without the outlier and these results are reported in the exploratory hypotheses section. Multivariate outliers were assessed using Mahalanobis distance. With respect to the main hypothesis, a chi-square distribution was used to determine a cutoff score of 16.27, using an alpha value of $p < .001$ and 3 degrees of freedom. No multivariate outliers were identified, as no Mahalanobis distance values exceeded the cutoff score. Mahalanobis distance values ranged from .33 to 9.14. With respect to the exploratory hypotheses, a chi-square distribution was used to determine a cutoff score of 16.27, using an alpha value of $p < .001$ and 3 degrees of freedom.
No multivariate outliers were identified, as no Mahalanobis distance values exceeded the cutoff score. Mahalanobis distance values ranged from .23 to 8.09.

**Descriptive Statistics**

Means and standard deviations for the measured variables are presented in Table 1. Independent samples $t$-tests were conducted to determine if there were differences in the sample with regard to gender for the following variables: find feedback useful, find feedback helpful, and overall satisfaction with feedback. The test comparing gender and the “useful” variable were not significant, $t(8.43) = 1.18, p = .27$, indicating that females ($M = 6.75, SD = .46$) and males ($M = 6.29, SD = .95$) did not differ in ratings of usefulness. The test comparing gender and the “helpful” variable were not significant, $t(13) = 1.39, p = .19$, indicating that females ($M = .88, SD = .23$) and males ($M = .68, SD = .31$) did not differ in ratings of helpfulness. The test comparing gender and the “overall satisfaction” variable were not significant, $t(13) = 1.46, p = .17$, indicating that females ($M = 6.75, SD = .46$) and males ($M = 6.29, SD = .76$) did not differ in ratings of overall satisfaction. Therefore, there were no differences within the sample with regard to gender on the variables of usefulness, helpfulness, and overall satisfaction.

On average, clients waited 1.47 weeks between their first contact with the clinic and their first testing session (53.3% of the sample waited one week and 46.7% of the sample waited 2 weeks). The total number of testing sessions ranged from two to more than five with the average number of sessions being 3.47 (13.3% had two sessions, 46.7% had three sessions, 20.0% had four sessions, and 20.0% had five or more sessions). The total number of hours testing ranged from 4 hours to 14 hours ($M = 10.38, Mdn = 11$). On average clients waited 3.8 weeks for the feedback session following the completion of testing with the number of weeks ranging from 3 weeks to more than 4 weeks. The length of feedback sessions ranged in length from 15-20
minutes to more than 60 minutes, with the majority of clients (46.7%) reporting feedback sessions ranging from 40-60 minutes.

Zero-order correlations were computed for all demographic and hypothesis variables and are presented in Table 1. The results of the correlations indicate a high degree of relationship among the following variables: find feedback useful, find feedback helpful, overall satisfaction with feedback, feeling understood by the clinician, and viewing the clinician as empathic and caring. All intercorrelations among the aforementioned variables are significant at the .05 level and most are significant at the .01 level. All 15 bivariate correlations among variables (excluding demographic variables) were positive and ranged from .02 to .88. Of particular interest is the degree of relationship among the useful, helpful, and satisfaction variables. At the zero-order level, it appears that these variables are not separate constructs, but appear to be tapping into the same concept.
Table 1
Summary of Intercorrelations, Means, and Standard Deviations (N=15)

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
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<td>.47</td>
<td>.44</td>
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<td>-.38</td>
<td>-.38</td>
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<td>3. Education</td>
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<td>.39</td>
<td>.46</td>
<td>.31</td>
<td>.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Find it useful</td>
<td>--</td>
<td></td>
<td>.84**</td>
<td>.56*</td>
<td>.57*</td>
<td>.52*</td>
<td>.02</td>
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<td></td>
</tr>
<tr>
<td>5. Find it helpful</td>
<td>--</td>
<td></td>
<td>.84**</td>
<td>.88**</td>
<td>.85**</td>
<td>.27</td>
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<td>6. Overall satisfaction</td>
<td>--</td>
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<td>.72**</td>
<td>.40</td>
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<td>7. Understood by clinician</td>
<td>--</td>
<td></td>
<td>.84**</td>
<td>.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Was empathic and caring</td>
<td>--</td>
<td></td>
<td></td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9. Treated you respectfully</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>14.74</td>
<td>.52</td>
<td>1.58</td>
<td>.74</td>
<td>.83</td>
<td>.64</td>
<td>.62</td>
<td>.61</td>
<td>.59</td>
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</table>

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)
Main Hypotheses

To examine the hypothesis that clients/caregivers would find assessment feedback to be useful, a one-sample $t$-test was conducted on the usefulness ratings to evaluate whether this mean was significantly different from 1, the “not at all” rating. For a one-sample $t$-test, the assumption of independence states that scores on the dependent variables are independent of each other and the participants represent a random sample from the population. Scores on the dependent variables are independent of each other and therefore the assumption of independence was met in this respect. However, the sample does not represent a truly random sample from the population, as participants were self-selected individuals who sought and/or were referred for evaluation services, and who chose to seek those services at a doctoral training clinic that operates on a sliding scale. For a one-sample $t$-test, the assumption of normality states that the dependent variable is normally distributed in the population. To address this assumption, skewness and kurtosis coefficients were evaluated. Using a cutoff of -2.00 and +2.00, the dependent variable met the normality assumption as both coefficients were within the acceptable range (skewness coefficient = -1.33; kurtosis coefficient = .47). The sample mean of 6.53 ($SD = .74$) was significantly different from 1, $t(14) = 5.53, p = 7.21^{-14}$. The 95% confidence interval for the usefulness rating mean ranged from 5.12 to 5.94. The results of this analysis support the conclusion that clients find assessment feedback to be useful.

To examine the hypothesis that clients/caregivers would find assessment feedback to be helpful, a one-sample $t$-test was conducted on the helpfulness ratings to evaluate whether this mean was significantly different from 1, the “not at all” rating. Skewness and kurtosis coefficients were outside the acceptable range (-2.00 to +2.00). The skewness coefficient was -2.01 and the kurtosis coefficient was 4.87, indicating that the distribution was highly negatively skewed and leptokurtic. In general, a one-sample $t$-test is considered robust to violations of
normality, but these violations are a limitation. Therefore, the data were transformed using a reflect and inverse transformation strategy, which is utilized for severely negatively skewed distributions (Mertler & Vannatta, 2005). Following the transformation, the skewness coefficient fell within the acceptable range (-.64), as did the kurtosis coefficient (-1.44). The sample mean of 6.47 ($SD = .83$) was significantly different from 1, $t(14) = -2.98, p = .01$. The 95% confidence interval for the helpful rating mean ranged from -.37 to -.06. The results of this analysis support the conclusion that clients find assessment feedback to be helpful.

To examine the hypothesis that clients/caregivers would be satisfied overall with assessment feedback, a one-sample $t$-test was conducted on the overall satisfaction ratings to evaluate whether this mean was significantly different from 1, the “not at all” rating. The skewness coefficient (-1.09) and the kurtosis coefficient (.40) were both within the acceptable range (-2.00 to +2.00), indicating that the distribution was not skewed. The sample mean of 6.53 ($SD = .64$) was significantly different from 1, $t(14) = 5.53, p = 9.12^{15}$. The 95% confidence interval for the satisfaction rating mean ranged from 5.18 to 5.89. The results of this analysis support the conclusion that overall clients are satisfied with assessment feedback.

To examine the hypothesis that client/caregiver overall satisfaction with assessment feedback would be predicted by higher ratings on positive clinician variables (understood by clinician, clinician was empathic and caring, and treated respectfully by clinician), a hierarchical multiple regression was conducted. As two of the positive clinician variables (i.e., understood by clinician and clinician was empathic and caring) were highly correlated (.84), these variables were collapsed and entered as one block in the analysis. The treated respectfully by clinician variable was not highly correlated with the other two variables, clinician was understanding (.33) and clinician was empathic and caring (.14), and therefore was entered as its own block. The assumption of linearity was assessed using bivariate correlations of all dependent variables with
the independent variable. The assumption of linearity was met for both the understood by clinician variable \((r = .84)\) and the clinician was empathic and caring variable \((r = .72)\), as both variables were highly correlated with overall satisfaction. The treated respectfully by the clinician variable was moderately correlated with overall satisfaction \((r = .40)\) and therefore satisfies the linearity assumption. The assumption of homoscedasticity was assessed using Levene statistics for the independent variables. All tests were significant \((p < .05)\), indicating that the variance of the residuals was not constant across all values of the independent variables. This is a limitation to the results; specifically, that too much weight may be given to the variable that had the largest error variance (i.e., clinician was empathic and caring). The residuals were not normally distributed for all independent variables indicating that the distributions were negatively skewed, as skewness and kurtosis coefficients were outside the acceptable range (-2.00 to +2.00). The data were then transformed using a reflect and square root transformation strategy, which is utilized for moderately negatively skewed distributions (Mertler & Vannatta, 2005). Following the transformation, the skewness coefficients fell within the acceptable range (ranging from -1.27 to -1.78), as well as the kurtosis coefficients (ranging from -.25 to 1.57). In addition, tolerance coefficients and variance inflation factor (VIF) values for the predictor variables were examined to determine multicollinearity. Tolerance values less than .20 and VIF values greater than 10 are considered problematic. Tolerance values ranged from .49 to .63 and VIF values ranged from 1.59 to 2.04. Therefore, there was no indication of multicollinearity.

The linear combination of the first block of predictor variables (i.e., understood by clinician and clinician was empathic and caring) was significantly related to overall satisfaction, \(R^2 = .50, \text{Adjusted } R^2_{\text{adj}} = .41, F(2, 11) = 5.42, p = .02\). The sample multiple correlation coefficient was .71 \((R)\), indicating approximately 50% of the variance in overall satisfaction in the sample can be accounted for by the linear combination of the first block of positive clinician
variables. Of the two predictors included in the analysis one (understood by the clinician) was found to be statistically significant, or the slope was found to be significantly different than zero. The 95% confidence interval around the regression coefficient was .38 to 3.16. The squared semipartial correlations represent the proportion of total variance in overall satisfaction that is explained uniquely by a given independent variable after other predictors in the model have been controlled. In this analysis, feeling understood by the clinician accounted uniquely for approximately 36% of the variance in overall satisfaction. A summary of regression coefficients for the first block is presented in Table 2 and indicates that one of the two variables significantly contributed to the prediction equation over and above the other.

### Table 2

*First Block Standardized Regression Coefficients, Zero-Order, and Squared Semipartial Correlations (N = 15)*

<table>
<thead>
<tr>
<th></th>
<th>( \beta )</th>
<th>( t )</th>
<th>( r )</th>
<th>( sr^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understood by the clinician</td>
<td>.76</td>
<td>2.81*</td>
<td>.70</td>
<td>.36</td>
</tr>
<tr>
<td>Empathic and caring</td>
<td>-.09</td>
<td>-.09</td>
<td>.30</td>
<td>.006</td>
</tr>
</tbody>
</table>

*  \( p < .05. \)

When the second predictor block (i.e., treated respectfully by the clinician) was added to the model, there was a 17% gain in predictive power. The linear combination of both blocks of predictor variables was significantly related to overall satisfaction, \( R^2 = .67, \) Adjusted \( R^2_{adj} = .57, F(3, 10) = 6.75, p = .01. \) The sample multiple correlation coefficient was .82 (\( R \)), indicating that approximately 67% of the variance in overall satisfaction in the sample can be accounted for by the linear combination of positive clinician variables. Of the three predictors included in the analysis two (i.e., understood by clinician and treated respectfully by clinician) were found to be statistically significant, or the slope was found to be significantly different than zero. The 95%
confidence intervals around the regression coefficients were as follows: understood by clinician (.05, 2.59) and treated respectfully by clinician (.03, 2.43). The squared semipartial correlations represent the proportion of total variance in overall satisfaction that is explained uniquely by a given independent variable after other predictors in the model have been controlled. In this analysis, feeling understood by the clinician accounted uniquely for approximately 18% of the variance in overall satisfaction and, as noted earlier, being treated respectfully by the clinician accounted uniquely for approximately 17% of the variance in overall satisfaction. A summary of regression coefficients with the addition of the second block is presented in Table 3 and indicates that two of the three variables significantly contributed to the prediction equation over and above the other. The results of this analysis support the conclusion that feeling understood significantly contributes to clients’/caregivers’ overall satisfaction with feedback. In addition, being treated respectfully by the clinician moderately contributes to overall satisfaction with feedback, above and beyond what being understood by the clinician and empathic and caring contribute.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>$\beta$</th>
<th>$t$</th>
<th>$r$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understood by the clinician</td>
<td>.56</td>
<td>2.31*</td>
<td>.70</td>
<td>.18</td>
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<tr>
<td>Empathic and caring</td>
<td>-.37</td>
<td>-1.43</td>
<td>.37</td>
<td>.07</td>
</tr>
<tr>
<td>Treated respectfully</td>
<td>.59</td>
<td>2.29*</td>
<td>.69</td>
<td>.17</td>
</tr>
</tbody>
</table>

* $p < .05.$

**Exploratory Hypotheses**

With the aim of expanding the main hypotheses evaluating usefulness and helpfulness, these variables were analyzed in relation to the following variables examining clients’ experiences of feedback: learned things you did not know, reinforced things you already knew,
and results were not an accurate representation. Specifically, two exploratory hypotheses were established: (a) to what extent are experience variables (i.e., learned things you did not know, reinforced things you already knew, and results were not an accurate representation) predictive of client/caregiver ratings of feedback as useful, and (b) to what extent are experience variables (i.e., learned things you did not know, reinforced things you already knew, and results were not an accurate representation) predictive of client/caregiver ratings of feedback as helpful. The means, standard deviations, and intercorrelations among the variables are presented in Table 4. The results of the zero-order correlations indicate a high degree of relationship among the following variables: find feedback useful and find feedback helpful, learned new things and reinforced things, find it useful and not accurate, find it helpful and not accurate, and reinforced things and not accurate. Of all of the intercorrelations, four were significant at the .05 level and one was significant at the .01 level. Of the 10 bivariate correlations among variables, four were positive and ranged from .02 to .84. Six of the correlations were negative and ranged from -.08 to -.65.

To address the outlier identified during preliminary analyses for the not an accurate representation variable, analyses to test each hypothesis were run with and without the outlier. Removing the outlier did not impact the significance of the results of either hypothesis test and therefore the results presented include the outlier. The assumptions of linearity and homoscedasticity were examined using scatterplots and boxplots and were found to be satisfied. Normality was determined using skewness and kurtosis coefficients and was found to be sufficient for both the learned things you did not know and the reinforced things you already knew variables. The results were not an accurate representation variable was found to be sufficient after employing an inverse transformation strategy, which is utilized for severely positively skewed distributions (Mertler & Vannatta, 2005). Multicollinearity was assessed using
Table 4

Summary of Intercorrelations, Means, and Standard Deviations (N=15)

<table>
<thead>
<tr>
<th>Variables</th>
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<th>2</th>
<th>3</th>
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<td>1. Find it useful</td>
<td>--</td>
<td>.84**</td>
<td>.25</td>
<td>-.08</td>
<td>-.57*</td>
</tr>
<tr>
<td>2. Find it helpful</td>
<td>--</td>
<td>.28</td>
<td>.02</td>
<td>-.65*</td>
<td></td>
</tr>
<tr>
<td>3. Learned new things</td>
<td>--</td>
<td>--</td>
<td>-.55*</td>
<td>-.11</td>
<td></td>
</tr>
<tr>
<td>4. Reinforced things</td>
<td>--</td>
<td>--</td>
<td>-.52*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Not accurate</td>
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<table>
<thead>
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<th>M</th>
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<th>6.47</th>
<th>4.93</th>
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<tbody>
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<td>.83</td>
<td>1.39</td>
<td>1.54</td>
<td>.59</td>
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</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

tolerance and VIF values and found to be adequate. To examine to what extent experience variables (i.e., learned things you did not know, reinforced things you already knew, and not an accurate representation) were predictive of client/caregiver ratings of feedback as useful and as helpful, two multiple linear regressions were conducted. For the first multiple linear regression, the linear combination of predictor variables was not significantly related to ratings of usefulness ($p = .07$). A summary of regression coefficients is presented in Table 5 and indicates that one of the variables significantly contributed to the prediction equation over and above the others; however, the overall prediction equation was not significant.
Table 5

*Useful Standardized Regression Coefficients, Zero-Order, and Squared Semipartial Correlations (N = 15)*

<table>
<thead>
<tr>
<th></th>
<th>$\beta$</th>
<th>$t$</th>
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<th>$sr^2$</th>
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<td>Learned new things</td>
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<td>.42</td>
<td>.25</td>
<td>.01</td>
</tr>
<tr>
<td>Reinforced things</td>
<td>-.32</td>
<td>-1.09</td>
<td>-.08</td>
<td>.06</td>
</tr>
<tr>
<td>Not accurate</td>
<td>.72</td>
<td>2.87*</td>
<td>-.57</td>
<td>.40</td>
</tr>
</tbody>
</table>

* $p < .05.$

For the second multiple linear regression, the linear combination of predictor variables was significantly related to ratings of helpfulness, $R^2 = .54$, $Adjusted \ R^2_{adj} = .42$, $F(3, 11) = 4.34$, $p = .03$. The sample multiple correlation coefficient was $R = .74$, indicating approximately 55% of the variance in helpfulness ratings in the sample can be accounted for by the linear combination of the specific client experiences of the results. Of the three predictors included in the analysis, one (results were not an accurate reflection) was found to be statistically significant, or the slope was found to be significantly different than zero. The 95% confidence interval around the regression coefficient was .82 to 4.45. The squared semipartial correlations represent the proportion of total variance in overall satisfaction that is explained uniquely by a given independent variable after other predictors in the model have been controlled. In this analysis, not viewing the results as an inaccurate reflection accounted uniquely for approximately 43% of the variance in helpfulness ratings. A summary of regression coefficients for the analysis is presented in Table 6 and indicates that one of the variables significantly contributed to the prediction equation over and above the others.

The results of the first regression analysis do not support the conclusion that the experience variables of learning new things, reinforcing already known information, and viewing the results as inaccurate are significant predictors of client/caregiver usefulness ratings. The
results of the second regression analysis do support the conclusion that not viewing the results as inaccurate contributes to clients’/caregivers’ ratings of helpfulness.

Table 6

* Helpful Standardized Regression Coefficients, Zero-Order, and Squared Semipartial Correlations (N = 15)

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<td>Learned new things</td>
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<td>Reinforced things</td>
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<td>.02</td>
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<tr>
<td>Not accurate</td>
<td>.74</td>
<td>3.20*</td>
<td>-.65</td>
<td>.43</td>
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</table>

* p < .05.

Discussion

As research on the topic of assessment feedback is highly limited and tends to focus on guidelines for conducting feedback (Berg, 1985; Finn, 1996; Gass & Brown, 1992; Koocher & Rey-Casserly, 2003; Pollack, 1988), it is important this construct be explored. Within the literature, general feedback guidelines include structuring feedback like the sections of an assessment report, addressing the referral question(s), being flexible, employing effective communication strategies, and being client centered (Berg, 1985; Finn, 1996; Gass & Brown, 1992; Koocher & Rey-Casserly, 2003; Pollack, 1988). There are also suggestions for providing feedback to specific populations including children/adolescents and research participants, as well as situations in which providing feedback may be contraindicated (Braaten, 2007; Griffen & Christie, 2008; Koocher & Rey-Casserly, 2003; Pollack, 1998; Tharinger et al., 2008). Further, specific models have been proposed as ways to structure feedback including consumer-focused, communication-focused, and humanistic, as well as using feedback as an intervention in itself (Brenner, 2003; Finn & Tonsager, 1997; Gorske, 2008; Lillie, 2007). Research specifically addressing clinician perceptions of feedback demonstrates that clinicians believe that clients find
feedback to be useful (Smith et al., 2007). Clinicians’ experiences of client involvement in feedback, indications of successful feedback, challenges in providing feedback, and transformative experiences for clients are components that clinicians have cited as impacting feedback (Ward, 2008). With respect to client perceptions of feedback, clients prefer feedback that is personalized, collaborative, and further, they do not need to hear good news to view feedback as good (Ackerman et al., 2000; Allen et al., 2003; Hanson et al., 1997). Clients have cited the impact of the clinician, transformative experiences, and receiving emotionally difficult results as incidents that impact their experiences of feedback (Ward, 2008). The aim of the current study was to examine clients’ and caregiver’s perceptions and experiences of psychodiagnostic feedback, specifically looking at their impressions of utility, helpfulness, satisfaction, and the potentially influential factors to each. Additionally, information regarding clients’ reactions was assessed to determine the possible impact of the type of information received on perceptions of usefulness and helpfulness. The study sample consisted of clients/caregivers who received psychodiagnostic assessment feedback following an evaluation at an outpatient training clinic.

As expected, clients’ and caregivers’ ratings of usefulness, helpfulness, and overall satisfaction were significantly higher than the “not at all” rating on the questionnaires. Clients and caregivers found the feedback that they received to be useful, helpful, and they were satisfied overall with the feedback that they received. These findings are consistent with the current literature addressing the utility of assessment feedback. Previous research has indicated that both clients and clinicians find feedback to be useful and helpful (Ackerman et al., 2000; Allen et al., 2003; Hanson et al., 1997).

To further understand the impact of the clinician on clients’ perceptions of assessment feedback, positive clinician variables including being understood by the clinician, viewing the
clinician as empathic and caring, and being treated respectfully by the clinician were assessed. The results indicated that being understood by the clinician significantly uniquely predicted clients’ and caregivers’ overall satisfaction, and being treated respectfully also uniquely predicted their overall satisfaction but to a lesser degree. Clients and caregivers were more satisfied with feedback overall when they viewed the clinician as understanding them and when they felt they were being treated respectfully by the clinician. This finding is consistent with previous literature that has highlighted the impact of the clinician on clients’ experiences of feedback including feeling understood by the clinician (Ward, 2008). Interestingly, viewing the clinician as empathic and caring did not significantly uniquely contribute to clients’ overall satisfaction. One explanation for the lack of significance for the empathic and caring variable is that it was highly correlated with being understood by the clinician. Being understood by the clinician and viewing the clinician as empathic and caring had too much shared variance to uniquely predict client overall satisfaction independently. Therefore, it appears that these two variables (being understood by the clinician and the clinician was empathic and caring) were tapping into the same construct. Perhaps clients’ experiences of feeling understood by the clinician were perceived as synonymous with believing the clinician to be empathic and caring, and therefore the empathic and caring variable did not significantly uniquely contribute to explaining client overall satisfaction. This is consistent with literature discussing the importance of empathy and viewing the clinician as a benevolent figure (Finn, 1996; Ward, 2008).

In order to further expand clients’/caregivers’ perceptions of feedback as useful and helpful, these constructs were examined in the context of the following variables examining clients’ experiences of feedback: learned things you did not know, reinforced things you already knew, and results were not an accurate representation. The result of the first exploratory hypothesis investigating the impact of client experience variables on ratings of usefulness was
not significant, indicating that clients and caregivers learning new things, receiving information reinforcing already known things, or viewing the results as not accurate did not predict their ratings of feedback as useful. The result of the second exploratory hypothesis investigating the impact of client experience variables on ratings of helpfulness was significant, indicating that the linear combination of predictor variables was related to ratings of helpfulness. Specifically, clients and caregivers not viewing the results as inaccurate significantly predicted ratings of helpfulness. The variables of viewing the results as not accurate and viewing the feedback as helpful were negatively correlated such that as clients and caregivers perceived the results to be more inaccurate, the less helpful they rated the feedback. This finding suggests that clients and caregivers may expect to learn new things from assessment results, and if they view the results as inaccurate it leads to lower perceptions of helpfulness. Accordingly, there may be a subtle distinction between viewing the experience of learning new things as positive and viewing those new things as not fitting with clients’ experiences of themselves and therefore as inaccurate negative. It may be important to explore in future research factors or characteristics that lead clients to perceive feedback as inaccurate.

There are a number of limitations to the current study. First, the small sample size in this study is a limitation, as some of the data violated assumptions of normality and needed to be transformed. In addition, a larger sample size would have ensured greater confidence in the significance of the \( p \)-values and created a more representative sample of individuals who receive assessment feedback, thus increasing the study’s generalizability. In general, the clients and caregivers tended to be educated with 80% having at least some college education. This is unlikely to be the characteristics of most individuals seeking services at community mental health centers. A second limitation to the study pertains to instrumentation issues. The variables within the study were measured using unvalidated questionnaires developed specifically for the
study, as the researchers knew of no pre-existing, well-validated measures at the time of the study. Further, each of the variables was measured using a single item on the questionnaires, therefore calling into question the construct validity of each variable. For example, it is possible that a single item assessing helpfulness does not adequately tap into the construct of helpfulness. This was also evident in that the variables of being understood by the clinician and viewing the clinician as empathic and caring were highly correlated and may have been measuring the same construct. Third, participants for the study were self-selected and the results may not be representative of the range of perceptions and experiences that clients have. There are a number of possible explanations for why the results may not be representative. Clients who had more negative experiences during the feedback session may have been less likely to complete the survey afterward. Perhaps some clinicians were better at engaging clients to complete the surveys immediately following the feedback session.

Despite the limitations of the study, the results have clinical implications with regard to how clinicians should conceptualize and conduct assessment feedback with clients. First, the results support the claim that assessment feedback has value for clients and therefore, clinicians should be cognizant of the importance of providing clients with assessment feedback results. More specifically, clinicians can begin to tailor how they conduct feedback, by ensuring that clients feel that they are understood by the clinician and that clinicians are treating clients respectfully. Clinicians should be mindful that these factors play a role in clients’ overall satisfaction with receiving feedback. Second, it may be important for a clinician to assess whether a client views the results as inaccurate, as this appears to impact whether clients view feedback as helpful. Overall, the results of the study provide some structure and guidance to clinicians who are conducting assessments with their clients.
The limitations of the present study’s findings and the continued lack of research exploring the construct of assessment feedback warrants continued research in this area (Lillie, 2007; Pope, 1992; Smith et al., 2007; Ward, 2008). Broadly speaking, the examination of feedback-related constructs could be advanced through improved measurement tools. At the time of this study, there was no known measure examining clients’ perceptions of assessment feedback. By creating and validating measurement tools such as questionnaires evaluating perceptions of various aspects of feedback sessions and various reactions to feedback, researchers could better evaluate this construct. For example, a specific measurement examining feedback satisfaction would help to improve the validity of the current research findings. Future directions should include validating the findings of the current study while addressing its limitations. Factors of age, ethnicity, education, nature of referral question, and other issues of diversity should be examined for their potential impact on the assessment feedback process (Dana, 2005). It would be worthwhile to evaluate what makes clients view feedback as inaccurate, as the results of the current study indicated that this view lowers perceptions of helpfulness. In addition, by examining the differences between client and caregiver perceptions of receiving assessment feedback, clinicians could continue to tailor feedback sessions to meet the unique needs of specific types of clients. For example, clients and caregivers may differ in the types of information considered to be useful or helpful. Another direction for research includes investigating specific factors that are covered in the feedback session (e.g., reviewing results, providing a summary, discussing strengths and weaknesses, etc.) to better determine what components of a feedback session clients find to be the most valuable. Further, as clients prefer feedback that is conducted in a collaborative manner, research should continue to expand the concept of what constitutes collaborative feedback, both for clients and clinicians (Ackerman, et al., 2000). Future research should also examine if there is congruence between
clients’ and clinicians’ perceptions of feedback, and if not, where the differences exist. By expanding the research in the area of assessment feedback, clinicians will be able to serve client needs more ethically and effectively.

The aim of the current study was to examine clients’ and caregivers’ perceptions and experiences of feedback and to provide further support for the utility of assessment feedback. The results of this study support the assertion that clients and caregivers find feedback to be useful, helpful, and are satisfied with feedback overall. In addition, clients and caregivers feeling understood by the clinician and feeling treated respectfully contributes to overall satisfaction. Further, not viewing assessment results as inaccurate contributes to perceptions of feedback as helpful. Although this study provides further support for the utility of feedback, it is only a small step in expanding the research on psychological assessment feedback and there remains an overall lack of research in the field exploring this topic (Lillie, 2007; Pope, 1992; Smith et al., 2007; Ward, 2008). Future directions for research are abundant and their investigation necessary for improving the quality of feedback provided to clients. As providing feedback to clients is an ethical responsibility of psychologists (APA, 2002) and the literature regarding feedback is lacking, it is imperative that it continues to be a topic of investigation in research.
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Client Perceptions of Assessment Feedback

CID ______

Date: __________

Name of your clinician: ___________________

Age: __________

Gender:  1. Female  2. Male  3. Other

Ethnicity:
   1. Caucasian
   2. African/ African American
   3. Latino/Hispanic -- Please specify group___________________________
   4. Asian/ Asian Pacific/ Asian Indian-- Please specify group (e.g. Chinese, Chinese-American) __________________________
   5. Native American
   6. Middle eastern – Please specify group __________________________
   7. Other -- Please specify group___________________________

4). Please identify the highest level of education that you completed.
   1. Some grade school
   2. Finished grade school
   3. Some high school
   4. Finished high school
   5. Business or technical school
   6. Some college
   7. Finished college
   8. Attended graduate or professional school
   9. Received a professional degree

5). When did you first seek services at the clinic? ___________(month and year)

6). How long did you wait between your first contact with the clinic and when you began testing?
   1. One week
   2. Two weeks
   3. Three weeks
   4. Four weeks
   5. More than four weeks

7). How long did the testing take?

   Number of sessions:  1  2  3  4  5 or more
8). How long did you wait for your feedback session after the testing was complete?
   1. Less than one week
   2. One week
   3. Two weeks
   4. Four weeks
   5. More than four weeks

9). How much time was spent on the feedback session?
   1. 15-20 min.
   2. 20-40 min.
   3. 40-60 min.
   4. More than 60 min.

10). Did you understand the feedback that was given to you?
    
    1 2 3 4 5 6 7
    Not at all Very much

11). Did the feedback answer your referral question?

    1 2 3 4 5 6 7
    Not at all Very much

12). Did/Do you find the feedback useful?

    1 2 3 4 5 6 7
    Not at all Very much

With respect to the feedback, how do you feel?

13). I feel that I learned things I didn’t know.

    1 2 3 4 5 6 7
    Not at all Very much

14). I feel that the feedback reinforced things I already knew.
15). I feel that the results were *not* an accurate representation.

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16). Did you feel understood by the clinician?

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17). Were you treated respectfully by the clinician?

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18). Do you feel that your questions were answered?

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19). Were you given written report to take home?

1. Yes
2. No

20). Were referrals given? 1. Yes 2. No

21). Would you have liked referrals? 1. Yes 2. No

21). Do you know what your next steps should be following the assessment?

1. Yes
2. No

22). Would you have liked more follow-up sessions with the clinician?

1. Yes
2. No

23). Which parts of the feedback session were the most helpful to you? Please rank the following: 1, 2, etc.

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24). Overall, how satisfied are you with the feedback given to you?

1 2 3 4 5 6 7
Not at all Very much

25). Please provide any other comments about your assessment experience:
Characteristics of Feedback – Client

The following criteria have been identified as characteristics of feedback. Please rate each of the following for your feedback session.

1). The clinician used understandable language.

1 2 3 4 5 6 7
Not at all  Very much

2). Your referral question was answered (the reason for which you sought the assessment).

1 2 3 4 5 6 7
Not at all  Very much

3). The clinician answered your questions.

1 2 3 4 5 6 7
Not at all  Very much

4). The clinician provided examples of how the results might look in the real world.

1 2 3 4 5 6 7
Not at all  Very much

5). The clinician explained the testing.

1 2 3 4 5 6 7
Not at all  Very much

6). The clinician explained the limitations of the testing.

1 2 3 4 5 6 7
Not at all  Very much

7). The clinician was empathic and caring.
### CLIENT PERCEPTIONS OF ASSESSMENT FEEDBACK

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8). The clinician gave you ideas of what to do after testing.

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9). The clinician referred you to further services.
   1. Yes
   2. No

10). The clinician recommended further testing.
    1. Yes
    2. No

11). The clinician provided a diagnosis.
    1. Yes
    2. No