Are Clinicians Asking the Right Questions?  
The Role of Metaperceptions as an Assessment Tool  
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Self-reports and clinician reports of personality pathology are often less accurate or diagnostic of pathology than are acquaintances’ reports. The current commentary outlines how clinicians and researchers might tap into the information acquaintances have about clients by asking clients to describe how other people might describe them.

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Man is least himself when he talks in his own person. Give him a mask, and he will tell you the truth. (Oscar Wilde)

The target article (Samuel, 2015) raises several theoretical, methodological, and practical issues about the assessment of personality pathology, and many of these issues apply to the field of clinical science more broadly. I briefly comment on one of the main findings, which is that clinician ratings of personality pathology may be less valid than previously thought. What information do treating clinicians fail to detect and why, and how can the validity of clinicians’ reports be improved? There are several possible explanations for clinicians’ blind spots (e.g., idiosyncratic and inconsistent assessment) and solutions for improving their accuracy (e.g., structured assessment methods). My goal is to expand upon one of the explanations offered in the target article, specifically the idea that therapy is a narrow context that may limit clinicians’ ability to observe pertinent features of personality pathology. I also propose a practical solution that might improve clinicians’ accuracy in research and in practice.

WHAT INFORMATION DO CLINICIANS FAIL TO DETECT AND WHY?  
To my knowledge, no study has compared the personality cues that are available in therapy to those that are available in a client’s everyday life. Yet, it is likely that therapy provides a limited range of cues given that informant reports provide incremental validity over self-reports (Miller, Pilkonis, & Morse, 2004), whereas practicing clinician ratings do not (Samuel et al., 2013). Which aspects of personality pathology might practicing clinicians fail to observe in therapy? Indirect evidence suggests that clinicians have some knowledge of clients’ neuroticism but lack knowledge of their interpersonal, evaluative traits. Self- and informant reports of neuroticism are equally valid indicators of personality pathology, but informant reports of evaluative, interpersonal traits (i.e., agreeableness, conscientiousness) are more accurate indicators of pathology than are self-reports (Carlson, Vazire, & Oltmanns, 2013). Given that clinicians’ ratings do not provide incremental validity over self-reports, it may be that the contextual limitations of therapy make clinicians’ perceptions similar to self-ratings (i.e., most accurate for neuroticism, least accurate for interpersonal traits). Indeed, the focus of therapy is likely on negative thoughts and emotions (i.e., neuroticism), but information about interpersonal behavior may be more ambiguous. Client–therapist interactions provide some clues about a client’s interpersonal traits, but the clinician is unable to observe the important variability in a client’s behavior in other contexts or with other people (Funder, Kolar, & Blackman, 1995; Furr & Funder, 2004). Likewise, clients might describe their behavior in therapy, but people have poor insight into their own behavior, especially evaluative behavior (Gosling, John, Craik, & Robins, 1998). Thus, information about important features of personality pathology is either missing or biased in therapy.

HOW CAN THE VALIDITY OF CLINICIANS’ REPORTS BE IMPROVED?  
One way to improve the validity of clinicians’ reports is to incorporate informant reports into assessment. The combination of self- and informant reports improves the
validity of personality pathology assessment (Clifton, Oltmanns, & Turkheimer, 2004; Klonsky, Oltmanns, & Turkheimer, 2002; Lawton, Shields, & Oltmanns, 2011); informant reports are easy to obtain, and most informants are willing to participate without compensation (above 75% response rate; Vazire, 2006). The call for clinicians to incorporate informant reports into research and in practice is not new (Oltmanns & Turkheimer, 2009). Despite the mounting evidence of their utility and feasibility, clinicians do not incorporate informant reports into therapy. Perhaps they believe that asking for informant reports violates a client’s privacy or might damage the client–therapist relationship. Clients might also resist involving informants in their treatment for privacy reasons, or they might believe that the people in their lives are the problem.

If informant reports are not practical, can clinicians access the information that informants have about a client without contacting them? I predict that some of the information informants know about clients can be gleaned by asking clients to describe how informants perceive them. Metaperceptions, or people’s beliefs about how others see them, may be a useful assessment tool for at least two reasons. First, one of the major blind spots in self-knowledge is awareness of one’s own behavior because internal experiences, such as intentions, are more salient than behavior. Metaperceptions require perspective taking, which might encourage people to consider their behavior more than their intentions. For example, Jon might consider the times he intended to be on time when he describes his conscientiousness, but he might focus on his actual behavior when he thinks about how his friends would describe him. Second, self-perception is largely influenced by self-enhancement and self-verification motives, meaning ego-protective motives prevent people from admitting to negative qualities or to traits that contradict firmly held self-views. However, people might be more willing to admit this information when describing how other people perceive them. For example, critical people might describe themselves as opinionated but admit that others see them as critical. In sum, as the opening quote by Oscar Wilde suggests, metaperceptions might provide people with a mask that allows them to talk about themselves in a more honest manner.

ARE METAPERCEPTIONS ACCURATE?

Metaperceptions are accurate for core personality traits (i.e., Big Five) and for evaluative and pathological traits (Carlson & Kenny, 2012). People have insight into their reputation as well as the different impressions they make across social contexts, particularly for interpersonal traits (agreeableness; Carlson & Furr, 2009). They also seem to know whether and when their metaperceptions are accurate for specific individuals (Carlson & Furr, 2013). Thus, asking people to describe how others see them provides some insight into the actual impressions they actually make on others.

Metaperceptions are most useful for assessment purposes if people can make valid distinctions between how others see them and how they see themselves. Put another way, metaperceptions must provide information that is unique from self-views but also a valid reflection of others’ actual impressions. Fortunately, recent work suggests that, indeed, people are aware of how other people see them differently from how they see themselves, an ability called meta-insight (Carlson, Vazire, & Furr, 2011). For example, people might see themselves as kind but realize if and when someone sees them as less kind. Given that metaperceptions are fairly accurate and that people have meta-insight, metaperceptions may provide valid information about others’ actual perceptions that is not contained in self-perceptions.

Do people with personality pathology have accurate metaperceptions or have meta-insight? Given that personality pathology is ego-syntonic, one might predict that people higher in pathology would have less insight into others’ impressions. Yet, people with pathology are aware that others see them as being difficult, and they realize how other people see them differently from how they see themselves (Oltmanns, Gleason, Klonsky, & Turkheimer, 2005). For example, people higher in subclinical narcissism see themselves more positively than others do on desirable traits (e.g., intelligent), but they realize that others do not share their positive self-views (Carlson, Vazire, & Oltmanns, 2011). Thus, asking people with personality pathology to describe how other people perceive their personality may reveal how others actually see them.
FUTURE DIRECTIONS
Exploring whether metaperceptions provide valid information about personality pathology will involve identifying accuracy criteria that are independent of self- and clinicians’ reports. Perhaps the most informative and objective criterion is the client’s behavior. Advances in technology make measuring actual behavior in everyday life quite feasible. For example, the Electronically Activated Recorder (EAR; Mehl, Pennebaker, Crow, Dabbs, & Price, 2001), which is a palm pilot device worn on an individual’s outer clothing that records random snippets of audible behavior (e.g., conversation topics), has revealed a great deal about personality and personality pathology (e.g., narcissism is associated with arguing; Holtzman, Vazire, & Mehl, 2010). Other accuracy criteria are available (e.g., experience-sampling; Trull & Ebner-Priemer, 2009) and no one method is best, but comparing perceptions to actual behavior will reveal a great deal about blind spots in personality pathology. In fact, this line of research might also reveal which personality cues are available inside versus outside of therapy. This information could reveal whether clinicians’ blind spots are due to cue availability or to cue utilization.

If metaperceptions do provide valid information above and beyond self-views, clinicians may consider including metaperception questions in unstructured, structured, or semi-structured interviews or in self-report questionnaires. Some items in existing assessment tools are phrased as metaperceptions (e.g., “others consider me stuck up”; “people seem to think I’m odd”). Perhaps more items should be phrased in this way.

Of course, it is possible that metaperceptions for some forms of personality pathology reflect skewed views of the world that are not in line with others’ views and do not reflect what the individual is actually like. If true, metaperceptions may still have assessment value if they are systematically associated with specific forms of pathology. Thus, the utility of metaperceptions may be twofold. Accurate metaperceptions might reveal what people are actually like and can be used to supplement self-reports, whereas inaccurate metaperceptions might identify certain forms of pathology. Either way, understanding how people with pathology think others see them will be a fruitful avenue for future research and may improve the accuracy of clinicians’ perceptions.

SUMMARY
As the opening quote suggests, people might provide more valid answers about who they really are when given a mask, in this case, when describing themselves as others see them. The target article (Samuel, 2015) proposes that future research should compare the accuracy of self-, informant, and clinician reports to shed light on which aspects of personality pathology clinicians fail to detect and why. I hope that this line of work also explores whether metaperceptions improve the validity of clinicians’ reports.

REFERENCES


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