
Epistemological and Ethical Challenges in Standardized Testing and Collaborative Assessment

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Abstract

In this article, the author proposes that although treating clients humanistically may appear to be in conflict with the goal of objectivity in clinical assessment, they are not incompatible; and, indeed, as it is shown, the clinical psychologist has a responsibility to hold both goals in mind in order to achieve the most useful and accurate evaluations. Psychological assessment does not have to aim to remain exclusively in the realm of the “hard” sciences. Nor should assessment be relegated to the realm of pure subjectivity. The triangulation of narratives, particularly in collaborative assessment, provides a means of unifying theories, languages, and ways of producing knowledge and of being professionally responsible.

Keywords

epistemology, assessment, responsibility, collaboration, narratives

Early in 1972, Earl C. Brown, in “Assessment from a Humanistic Perspective,” was among the first to articulate a view of the relationship between interpersonal observations and information from personality testing that was

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not founded on the natural science model (Dilthey, 1927). Brown emphasized the importance of the clinician's self-awareness and acknowledgment of the impossibility of understanding clients independently of their interpersonal and relational contexts. The same client will appear different in interaction with different assessors or in different assessment situations. Brown then went on to detail many relational features that later appeared in Collaborative Assessment (Fischer, 2000) and Therapeutic Assessment (i.e., respect and acceptance, reduction of the power imbalance between assessor and client, and the importance of defining the contract for the assessment; Finn, 2007). Brown felt these qualities would support a mutual, trustful, and positive connection with the client.

Also of note, Brown (1972) seemed to take a strong position regarding formal personality testing. He never mentioned personality testing in describing his ideal humanistic assessment, and throughout his article he emphasized the shortcomings of a psychometric approach. The reader is left with the impression that the use of personality testing in humanistic psychology is untenable. Brown criticized psychological testing as a dehumanizing practice, which robbed clients of their resources and dignity, and illuminated only their psychopathology.

As it happens, a complete rejection of personality testing has never occurred, even among humanistic psychologists. In fact, over the years, many psychologists have been actively involved in finding a way to integrate interpersonal and psychometric aspects of psychological assessment, and some have even gone on to develop psychometric tests of humanistic constructs. (See MacDonald & Friedman, 2002 for a review of these efforts.) One of the people most influential in defining a human-science approach to psychological assessment over the past 40 years is Constance Fischer.

In one of her first articles, in 1970, Fischer advocated a radical shift in the philosophy of science by adopting a human-science methodology in psychological assessment. Fischer argued that a positivistic/reductive approach hinders the integration of psychometric and interpersonal information because it tends to treat peoples' motives and needs as "entities" that can be best understood by a "neutral, objective observer." Given these premises, clinicians in human sciences who do not believe in the explanatory capacity of test-related constructs would be forced to reject formal psychological testing completely.

However, Fischer (1973) introduced a differentiation between "[using] test materials" and "administering tests" (p. 41). According to Fischer, clients and clinicians can use test materials to understand how clients' experiences and behavior change in relation to contexts with different meanings for them. In contrast, when assessors "administer" tests to clients, they often reach

much more generalized, overencompassing, and stereotypical profiles. In subsequent articles, in 1977 and 1979, Fischer laid out a precise view of psychological testing grounded in the phenomenology of Heidegger (1926/1962) and Husserl (1913/1962), in which she defined the aim of assessment as understanding the clients' "situated intentionality" (Fischer, 1979, p. 116). By this, she means that the insights into clients derived from assessment are snapshots capturing a moment of tension between who they have been and who they are in the process of becoming (Fischer, 1980). In these early writings, Fischer stressed that the goal of personality assessment is to provide descriptions rather than classifications, to understand rather than explain, and to intervene constructively rather than passively observe.

In her recent articles, Fischer (2000, 2002) further developed a distinction she made earlier between "natural-science findings" and "human-science practices" (Fischer, 1980, p. 103). Information obtained from standardized testing, when viewed as "natural-science findings," implies an understanding of people in terms of "facts" about their condition, for example, 'Mr. Smith has a depressive personality.' According to Fischer, this kind of presumptive objectivity is not congruent with a human-science perspective. "Human-science practices require their own standards for objectivity, such as specification of what was visible and under what circumstances" (Fischer, 1980, p.102). She introduced ways to collaborate directly with clients asking them to provide instances of times when they experienced the behavior she anticipated from the test patterns. Together with clients, Fischer refined their understanding of those instances and explored times and situations in which they were different, for example, "Today, when I asked Mr. Smith about his elevated score on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) Depression scale, he talked, with tears running down his face, about how hopeless he felt about his wife's cancer and how he could feel relief from his depressed mood in times of devotion to work and volunteering." The information from the MMPI-2 would be treated much as one would "a colleague's perspectival impression from a clinical examination" (Fischer, 1980, p. 81).

Fischer (1985/1994) described her approach to clients as "individualized psychological assessment." The epistemology underlying this approach to clients is different from that held by most developers of standardized tests. This fact may help explain some recent critiques (Del Corno, 2009) and concerns (Andronikof, 2009) about Collaborative Assessment, advanced by clinicians endorsing a more traditional psychodiagnostic stance, who say they have little or no interest in exploring how their clients co-construct their worlds. Although these authors have not yet published their arguments, in

conferences they have said that they intend to protect a traditional assessment practice from the threat of Collaborative and Therapeutic Assessment. These authors' challenge to collaborative assessment is both epistemological and ethical.

In their view, a nonpositivistic approach to assessment is dangerous because it overemphasizes subjective, situational factors, which will eventually lead to a loss of scientific objectivity and knowledge. These authors' critiques hark back to earlier arguments about the unreliability of clinical judgment in psychology (Meehl, 1954; Milholland, 1964), and are in-line with the comments of some contemporary researchers who advocate computerized and "objective" assessment practices and who view DNA screenings as ideal models for personality assessment (e.g., Wood, Garb, Lillienfeld, & Nezworski, 2002). In this vein, even if there is growing empirical evidence that clinical subjective judgment can be reliable under specific conditions (i.e., with low to moderate levels of inference, when the clinicians can draw from their own experience, and with the help of clinical decision-making tools; Westen & Weinberger, 2005), computerized procedures would be more reliable and cost-effective in making complex decisions regarding diagnosis and treatment planning, given also the serious difficulties clinicians have in making inferences from large amounts of complex data (Lilienfeld, Lynn, & Lohr, 2003). This argument is also made on ethical grounds. In fact, Dawes (2005) describes two sets of reasons for why relying on empirical and statistical algorithms to make difficult decisions has an ethical consequence. The first is that, whenever possible,

a superordinate "ought" (e.g., that we ought to make best possible predictions for our clients) can combine with an empirical "is" (e.g., that in a wide variety of qualitatively diverse contexts statistical prediction rules outperform clinical combination methods) to yield a specific "ought" (e.g., that in this context, we should use a statistical prediction rule). (p. 1249)

In other words, since ethical practice means making the best predictions for our clients and since research shows the best predictions are based on statistics, ethical clinicians will leave aside their subjectivity. The second is that, given the impossibility of drawing case-specific indications from general research findings, nevertheless such findings should be used at least to guide ethical choice about what *not* to do. In Dawes's (2005) words:

what (we believe) we know empirically and theoretically about psychological principles does, however, set bounds in ethical practice. Although it would be ideal to limit principles to the hortatory “do this,” such bounds provide minatory principles about what we ought not to do. (p. 1251)

Interestingly, the same Dawes (2005), while strongly advocating actuarial predictions, concludes by stressing that one of their advantages with respect to clinical ones is the fact that their fallibility is measurable (the part of the variance that is not accounted for by predictors), and the author proposes that sharing with clients the limits of our best tools of knowledge about their issues, is in itself ethical.

In the rest of the article, I will describe how collaborative assessment can connect “natural-science” methods and data with “human science” methods and meanings.

A Narrative Outlook on Assessment

To overcome the dichotomy between postmodern and logical positivist (Meehl, 1954) approaches to psychology in the field of psychological testing and assessment, Stephen E. Finn and Mary Tonsager (1997) addressed systematically the conceptual differences. The authors proposed a viable solution to the apparent clash between the positions described above and suggested that standardized testing and collaborative assessment could be two different yet complementary practices.

Finn and Tonsager (1997) pointed out that the two approaches’ main areas of divergence concerned the following: the aims (description vs. understanding), the assessment process (unilaterally managed vs. codirected), the testing perspective (objective nomothetic tools vs. occasions to see the world from the clients’ point of view), the focus (test scores vs. participants’ experiences and observations), and the role of the clinician (abstinent and objective vs. participant–observer). Still, the authors considered such differences to be complementary. On the one hand, clinicians could enhance the transformative impact of the interpersonal experience of the assessment without “compromising in any way the valid and reliable test information that is collected” (Finn & Tonsager, 1997, p. 382). Indeed, “for an assessment to be beneficial to a client, it must be based on sound data, accurate test interpretations, and a thorough knowledge of the research and psychometric principles underlying a test” (p. 383).

Finn and Tonsager (1997) did not mention one other important difference between traditional and collaborative assessment, namely the view of what

the “reality” to be assessed is, an issue that has been debated, for example, concerning the relative benefits of quantitative and qualitative research. Golafshani (2003) compared quantitative and qualitative research on a number of dimensions and highlighted the foundations of the two approaches: quantitative research implies endorsing logical positivism and sharing the assumption that “social facts have an objective reality” and that “variables can . . . be identified and relationships measured” (p. 598). In contrast, in qualitative research, the basic assumptions are that rather than “dissociating” themselves from the research and believing that they are measuring an objective Truth, researchers have to come to terms with and accept that their own involvement plays a role in the production of the results (Winter, 2000).

In the same vein, in a standardized approach to testing, clinicians tend to see reality as something “out there,” which can be described by applying the same measure to a number of subjects representative of a given population. On this basis, clinicians infer their clients’ characteristics from the comparison of their data and those of the population. From this point of view, reality is considered something that exists in itself, and the client is an object whose properties *need to* and *can be* objectively assessed. In contrast, in a human-science approach, the client’s reality has a different status: It is seen as a story or narrative that is molded in the dialogue between clients and clinicians.

In this regard, from a postmodern perspective, a point that is often overlooked is that both standardized testing and collaborative testing, similar to both quantitative and qualitative research, are metaphors for more or less structured ways of producing knowledge. In this vein, if one modified Fischer’s (1980) assertion that “truth is interpersonal” (p. 101) to read “*one kind of truth is interpersonal,*” it would make it much easier to consider at the same time that “one kind of truth is statistical.” In keeping with a definition of psychological assessment given by Friedman and MacDonald (2006) as “an activity based on the systematic gathering of information within a professional relationship that is aimed at providing the least biased description and/or explanation of client functioning within the constraints of allowable resources” (p. 515), we may think of collaborative assessment as a semistructured way of producing knowledge grounded simultaneously in a view of reality as something “out there,” and in another view of reality as something inherent to the clinician’s dialogue with the client. Both views would be equally true, in themselves; both views would bring elements to the story that is written about the clients’ problems. At the same time, the two views would rely on different definitions of reality.

With one definition of reality, we may think of psychological tests as quantitative, standardized, reliable, and valid tools whose interpretation relies on reference samples and clinical studies. From this perspective, the information

obtained from testing may be used to create “stories written with numbers.” In this framework, the administration of the testing and the integration of the test data and observations are treated *as if* they objectively existed in a reality independent of the clinician.

It is worth noting that many of those experts who recommend that clinicians integrate in formal reports quantitative data and images from the testing verbalizations (Aronow, Reznikoff, & Moreland, 1995; Stricker & Gold, 1999; Weiner, 2000), particularly with projective tests such as the Rorschach, are still operating within a natural science view of reality. The aim in focusing on testing images and contents is for the assessor to integrate aspects of the “story written with numbers” with so-called idiographic aspects of the clients, identified for example among Rorschach responses with human movement and minus form quality (see, in this regard, Exner, 1989). The resulting report would include elements of a “story written with numbers” and elements of a “story with personal meanings” about the client. These scholars recommend that the clinician integrate normative and idiographic findings in personality assessment, but they never mention the possibility of involving the client in this process; thus, they remain in a framework in which data exist independently from the observer.

The collaborative assessors’ proposal that clients and clinicians together find the meaning of their production would require an epistemological shift and a different view of “reality.” Clinicians and clients would approach the common goal of discussing, explaining, and understanding findings through their reciprocal skills and expertise. Clinicians would participate in this process as experts in psychological theories and metaphors while clients would be enlisted as experts in their own lives (Anderson & Goolishian, 1992). In this dialogue, the “facts” would get molded into “a piano duet for four hands.” In this process, three types of stories are taken into account: the stories “written with numbers” (the test data), the stories “written with personal meanings” (the images and verbalizations that account for the client’s personal meanings), and the stories “written by four hands” (the interactions between client and clinician). This latter step is central to Collaborative and Therapeutic Assessment, because the assessor’s selection of specific testing data from different aspects of the “story written with numbers” allows or hinders the client in modifying and finding new options for constructively merging aspects of the “stories written with numbers,” of the stories with “personal meanings,” and of the “stories written by four hands.”

Hence, if the process of selecting aspects of the stories to compare and discuss with the client is an assessor’s task, it raises questions concerning the assessor’s personal responsibility. How one copes with information coming

from different epistemologies and how one selects data at this point requires the assessor to be aware of his or her role in orienting the future process. Again, the epistemological challenge parallels an ethical one.

Personal Responsibility in Psychological Assessment

The contemporary Milan Approach clinicians Bianciardi and Bertrando (2002) suggest that how ethical principles tend to be defined depends on the clinician's assumptions about the scientific status of psychology. The authors followed Cushman's (1995) assertion about the scientific status of psychology that since Freud's "talking cure" revolution, psychology has aimed for a classic "hard science" status by seeking objective foundations, reducing the relativity of clinical decision making, and establishing clear and homogeneous intervention protocols with predictable outcomes. But still today, there is wide disagreement among psychologists about the possibility of achieving this goal. Many psychologists, particularly academic, cognitive, behavioral, and biological psychologists continue to pursue this aim. Many others, particularly those coming from postmodern psychoanalytic, narrative, social constructionist, constructivist, deconstructivist, humanistic, and feminist perspectives, the authors claim, have come to terms with the impossibility of objective foundations and accepted a "human-science," yet rigorous, status for psychology (Giorgi, 1995).

In a similar vein, Bianciardi and Bertrando (2002) suggested that the clinician's responsibility can be thought of either as practical or as logical/epistemological. With regard to practical responsibility, the clinician assumes that reality can be objectively understood and known scientifically. From this perspective, clinicians' choices would be considered ethical if they adopt and rely on standardized procedures evaluated according to effectiveness criteria.

If clinicians are more skeptical about the possibility of knowing psychological truth, they will instead be likely to endorse logical and epistemological criteria of responsibility. That is, they will try to maintain awareness of their own role in creating and influencing the observed "objects," (epistemological responsibility), and they will try to use coherent theories to account for the facts of which they are knowingly authors (logical responsibility). This criterion of responsibility has been further articulated by Cigoli and Scabini (2006, 2012) according to the primary aim of ethical action: increasing the subjects' degrees of freedom within their systems as opposed to acknowledging and supporting the bond that connects people, family members, and different generations.

Within collaborative assessment, the clinician is often struggling with ethical choices about what to do when Dawes's (2005) "oughts" are conflicting. For example, Rorschach S-CON (suicide constellation) and DEPI (Depression Index) values are positive, hence suggesting the possible need for hospitalization, but the client asserts that hospitalization would make him feel even more depressed and increase his sense of personal failure. On the one hand, in fact, in terms of practical responsibility, relying on formal interpretation of standardized tests with acceptable reliability and validity coefficients is the right way (the "ought") to know the psychological features of the client. Relying on actuarial statistical prediction rules (where available) is the right way to assess the likelihood of clients behaving in specific ways. On the other hand epistemological responsibility would require clinicians to reflect on the relationship between their implicit (or explicit) assumptions about psychology, what is good or wrong, and their clinical choices. The outcome of the choice would then be assessed in terms of the impact on the bond that connects both the people within the clinical relationship and their relationships with significant others.

In this regard, I wish to present the concept of *triangulation of narratives* (elsewhere described as "epistemological triangulation"; Aschieri, Finn, & Bevilacqua, 2010). The concept of triangulation has been widely described by qualitative researchers (Barbour, 1998; Denzin, 1970; Denzin & Lincoln, 1998, see also Thurmond, 2001, for a review). Triangulation means "to use two or more aspects of research to strengthen the design, increasing the ability to interpret the findings" (Thurmond, 2001, p. 253). In psychological qualitative research, triangulation may involve several aspects of a study (Table 1): the choice of investigators, the use of explanatory theories, the methods of obtaining data, and the use of research methodologies. For example, investigator triangulation refers to the use of more than one researcher in order to enhance the internal validity of the study. Theoretical triangulation involves the use of multiple theories to explain a given phenomenon, thus providing a wider and deeper understanding of it. Data triangulation provides multiple sources of information on which the investigators can base their inferences.

Triangulation of narratives serves to (a) define an ethical practice for assessors who wish to orient their "ought to do" with respect to the clients and (b) help assessors to select the pieces of stories (from test data, test images, and interpersonal exchange) in order to have a positive impact on client's development. Triangulation of narratives can help assessors to reflect on their "ought to do" because it leads to the use of different lenses to evaluate the course of the assessment. In this sense, being aware of the different

Table 1. Typologies of Triangulation

Type of Triangulation	Processes Involved
Data sources	Comparing data collected across different times, places, and types of people involved in the study
Investigator	Using more than one observer, coder, or data analyst in the study
Methodological	Collecting data with different procedures within one method (i.e., self-report and demographic data within a quantitative method) or between different methods (i.e., quantitative self-reports and qualitative focus groups)
Theoretical	Interpreting the same phenomenon using different theories and hypotheses
Narratives	Considering different views of reality underlying different ways of producing knowledge about clients

kinds of reality on which our knowledge rests can be highly demanding. It requires extra effort to address issues that otherwise are not frequently dealt with in psychological assessment. Triangulation of narratives brings one to consider carefully, for example (a) the impact of the test administration context on the way tests are introduced to the client, on the client’s responses to the tests, and on the tests’ interpretation; (b) the influence of the assessors’ implicit theories of psychopathology on their choice of specific tests; or (c) the impact of the assessor’s actions and attitudes on the client’s problematic behaviors displayed in the sessions.

Hence, the assessors are encouraged to think in terms of the impact that their view of clinical relationships might have on clients, along with their choices and their implications for the assessment and treatment. Believing that a test permits knowing the “Truth” about a client increases the risk that the clinician will forget that “the story written with numbers” is valid only within the epistemology that “created” it. When a clinician forgets this simple principle, the likelihood of approaching the client as an expert, a teacher, and a moralizer (Cecchin, 2004) increases. Clinicians might inadvertently start acting as if they “knew” the cause of the problem. This hubris permits the clinician to feel entitled to teach the clients (who are unaware of their personal features and hence at a disadvantage) the supposedly “right” behavior or to correct their faulty values and attitudes. The same high Scale 2 (Depression) score on the MMPI-2 can take on completely different meanings in exchanges with clients, depending on this (lack of) awareness. If the

clinician brings to the relationship a conception of depression as measured by the test (a quantity assessed with reference to an expected range of scores), the “ought” in the feedback can easily become (a) to influence clients to alleviate depression through treatment (psychological and/or pharmaceutical), (b) to give good advice (physical exercise, etc.), and possibly (c) to correct the bad and negativistic values harbored by the clients that are inappropriately interfering with their well-being. The present writer has never met a single assessor who has not—at least once—believed that he or she knew what clients should do to sort out their problems, simply on the basis of his or her own theories and knowledge. Fortunately, nowadays the voice of the assessor as an infallible expert is much weaker than it was a few decades ago (Bertrando, 2007), and instead, it is much more common for assessors to be curious about the fact that their clients are openly opposing or subtly refusing the recommendations derived from the testing.

Still, on the other hand, we do not want to consider test scores on an equal standing with a colleague’s perspectival opinion, as this would downplay the relevance of MMPI-2 data: In a structured setting, when comparing hundreds of people living in the same conditions, the single client’s “really” shows some features connected to the construct of depression. Triangulation of narratives serves to pay due respect to the “story written with numbers” and to engage the client as an active author of a story that frames them within new meanings that grow in the relationship. Will the depression bear witness to the strength of the client who went on working and taking care of things while testing in the 98th percentile of MMPI Scale 2? Might depression be a defense against feeling anger for being unduly shamed in the past? The curiosity that leads clinicians to engage with clients in order to seek the meanings of their “stories written with numbers” is directly connected to a position of “not knowing” (Anderson & Goolishian, 1992) and to a systemic approach to reality (Cecchin, 1987).

In each case, epistemological responsibility should be the orienting factor in deciding which parts of the “story written with numbers” should launch the discussion: that is, helping clients both to feel that their pain is appreciated and to be active and responsible for their choices. This way, collaborative psychological assessment might allow assessors to encompass all the kinds of responsibilities detailed so far. In fact, our primary practical ethical responsibility as assessors is to ensure that we have adequate training in how to administer a test, as well as in scoring it (when necessary), and that we know the empirically based meanings of test scores. Hence, we can endorse a psychometric stance and rely on the standardized tests as means to compose ethical, practically responsible stories about clients’ subjectivities from an

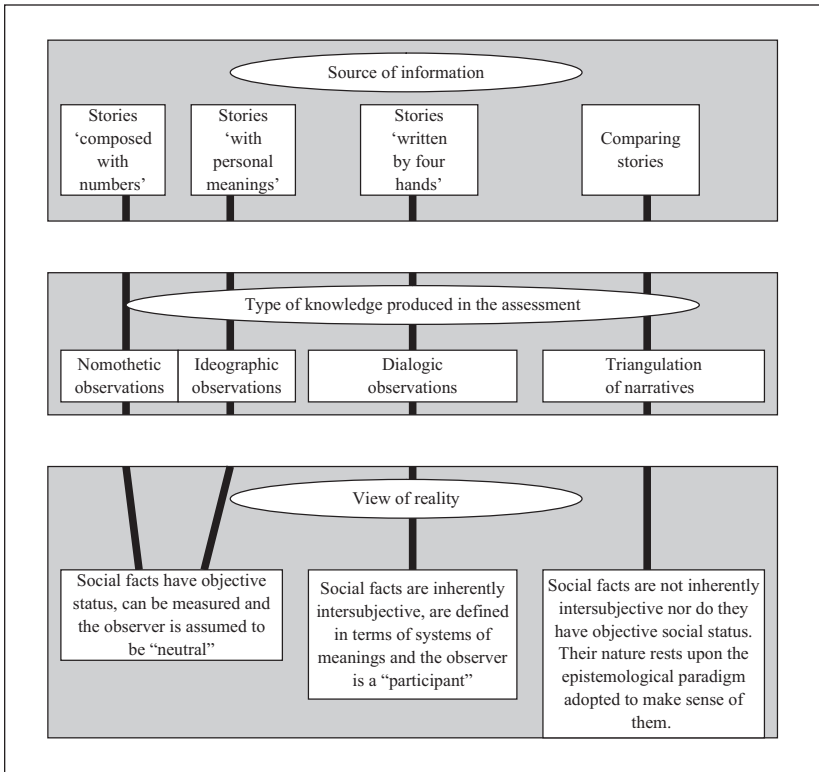


Figure 1. Triangulation of narratives

“empirical and experimental point of view.” From a logical perspective, we are responsible for our case formulations and for the fit between our observations and the theories we choose to apply to give to those observations a meaning. Finally, we can endorse a subjective stance by being mindful that for us, making sense of the data depends on the perspective from which we observe them. This higher level of epistemological responsibility refers to our awareness that the various types of information that we are working with (the test data and the interaction) belong to different paradigms, and that the clinical choices depend on the position we assume with regard to these sources of information, being aware of the relational consequences that these choices imply (Figure 1).

Therapeutic Assessment Illustrating the Triangulation of Narratives

In a typical Therapeutic Assessment (Finn, 2007), we would start by explaining to clients that we want to know what questions and issues they are struggling with, or what they cannot make sense of in their behavior and their relationships. We can also ask other mental health professionals working with our clients to give us their perspective about clients' struggles and to pose their own questions for the assessment. In doing all this, we would also be aware—as much as possible—of our own role in shaping the dialogue that stems from these questions. In this part of the assessment, “Truth” would correspond to the intersubjective matrix of meanings that emerges from the stories with which the client, the referring professional, and the clinician define themselves and the presenting problems (Aschieri et al., 2010).

Then we may want to switch to a standardized phase of the assessment, where instead of sharing parts of our case formulation with clients (Bertrando & Arcelloni, 2006), we would advise them that we want to use tests to gain information that might be helpful in fulfilling their goals for the assessment. In this part of the process, we would use our comprehensive knowledge of a test's nature, constructs, administration, and scoring to obtain protocols that are as reliable as possible, in order to determine the location of the subject with reference to a particular population or group. During an interpretation phase, it is imperative that we not draw inferences from test scores that go beyond the criteria against which the test was validated. For example, we could say that a client with a low Scale 2 (Depression) score on the MMPI-2 was dissimilar from patients formally diagnosed with depression (i.e., the original criterion group). But, we would be on shaky ground concluding that the person must have had a depressed parent and therefore was in “reaction formation” against all depressive affects. However, we may select specific idiographic images and scores from the test material that give individualized meaning and flavor to our formulation. The end result is our story written with “numbers and personal meanings” about the client.

In the following phase, we would engage our clients in exploring the relationship of the test data to the individual meanings and goals of the assessment. During this dialogue, clinician and client would go through a “hermeneutic circle” as extensively described by Fischer (2000), linking test results to subjective feelings and opinions and to the shared experiences and observations developed during the course of the assessment, hence unpacking meanings multiple times, seeing and checking different options in each iteration. It is in this part of the assessment that full **epistemological triangulation** would take

place, and the clinician could consider separately, yet simultaneously, findings from standardized testing and interpersonal meanings. In this way, the clinician chooses which parts of the “stories written with numbers” to share with the client, which ones to reject as possible testing errors, and which to keep to herself for clients who seem not yet ready to hear them.

Let us examine a case example to explain how the triangulation of narratives helps endorse an ethical position in psychological assessment. Marc, 39 years old, was an attractive and cheerful engineer who sought a Therapeutic Assessment to ascertain if anything wrong in his “mind” could in any way be connected to the pain he felt in his chest. After several medical examinations, no definite organic causes to the chest pain had been found. He started to have pain attacks in his chest during the frequent flights he had to take for the projects he was following in different countries. Because of this problem, he started to have difficulty keeping up with his job demands.

During our first session he said he was torn: On one hand, he wanted to have the exact diagnosis of his problem, so to be able to fix its causes; on the other, he felt that it would be hugely disappointing for him to discover that his emotions had been causing his problem. Rather, he thought of himself as an independent, open, and easygoing man, and he said he never saw himself as having any psychological problem. From the first meeting, I felt torn too. On one hand, I was truly on his side: I liked his agreeability, his sense of humor, and his way of making jokes about the theories psychology developed about the mind–body connection. I shared with him my belief that medical exams do not always immediately find the exact cause of true medical disease, and I supported his desire to go on looking during the course of the psychological assessment for the right medical treatment that could help him. On the other hand, I was aware of the theories according to which unexpressed emotions can put bodily functions under stress to the point that an individual can start feeling pain, and I started to think about how this information might have a favorable impact on Marc.

When we came to testing, his valid MMPI-2 and Rorschach indicated he was open to the assessment and authentically interested in understanding the causes of his pain ($L = 43T$, $K = 56T$; $R = 26$, $\Lambda = 0.60$). Indeed, the MMPI-2, showing a “Conversion V” (Scale 1 = 69T, Scale 2 = 53T, Scale 3 = 67T; Friedman, Lewak, Nichols, & Webb, 2001) and a score of 79T on Scale 9, told the story of a man who was likely to develop somatic symptoms in response to stress, deny negative emotions, and seek the approval of others for his choices. The Rorschach added new pieces to Marc’s “story written with numbers”: He was harboring deep-seated depression and loneliness (DEPI = 5; CDI [Coping Deficit Index] = positive), a tendency to refrain

from emotional involvement ($Afr = 0.43$), perhaps because of the uncontrollable behavior he had when he was overwhelmed by emotion ($C = 2$). From the MMPI-2 research on people with his code type, it became clear that this narrative should not be used to challenge Marc's preexisting story. In fact, clients of this sort tend to drop out of treatment or fight against the new information if their belief is challenged that they suffer only somatic problems and are relatively free of psychological troubles.

When triangulating this story about Marc with the interpersonal story we were developing together, I realized that the most important starting point was the fact that—no matter what the cause—“[1-3] individuals can develop real physical symptoms because of the stress placed on their musculoskeletal and organ system by the inhibition of feelings” (Friedman et al., 2001, p. 243). This piece of the “story written with numbers” helped me to see Marc as really struggling with a real pain in the chest and allowed him to feel seen and understood in that his physical troubles were taken seriously. Triangulation of narratives helped me value the information from standardized testing, coordinating it with the story that was unfolding in the sessions, and using it in the service of enhancing our alliance, that is, meeting his “strong needs for attention, affection, and sympathy” (Friedman et al., 2001, p. 240). The appreciation of the “reality” of his chest pain allowed him to consider the possible implications of the emotions involved in his physical problem. He said he felt alone, with nobody really paying attention to his pain, and he was happy about the test showing he was not “making the pain up.” In the following sessions, we explored how “being alone with his pain” was not a new experience for him. When Marc was 11 years old, his father had his first stroke, followed in the next 8 years by several other episodes of heart problems. He admitted he was scared, anxious, and worried by those episodes, and we agreed that those fears might also have been because of the lack of information and emotional support from the other adults at that time. We agreed that while growing up without enough emotional support from the adults around him, he had to “adaptively” shut down his feelings. In the sessions, we started then to draw connections between his tendency to focus on the physical pain and his ability to shut down his emotions. The story we were writing together brought us to conclude that perhaps there was not a causal relation between emotions and his pain to the chest. Nevertheless, the more he could allow himself to feel emotions the more his attention was not focused on the pain, and the pain looked less hard to bear. We then discussed under which conditions it was safe for Marc to feel emotions, and at one point he told me, “This is what you psychologists are for, right?” He then agreed to be referred for psychotherapy to another colleague at the Center. Since the end of the assessment, Marc has started to travel again and is still attending his psychotherapy.

In this case, the story we were writing together had to incorporate little by little the results of the formal testing. Triangulating the intersubjective narrative with the formal testing helped me be sensitive to the slow pace that Marc needed to incorporate in his self-view the part of his “written with numbers” story that was dramatically different, but possibly necessary for his development.

Conclusions

Finn and Tonsager’s (1997) view of standardized testing and the collaborative use of testing stressed the respect that we, as scientist-practitioners, can give to normative, valid, and reliable measurements, while at the same time paying the highest respect to our clients’ subjectivities. Also, in part due to Fischer’s pioneering (1970, 1985/1994) and long-standing work, recently Friedman and MacDonald (2006) noted, in reply to Brown’s (1972) and others’ early skepticism about the impact of tests, that assessment can be growth-oriented and holistic, can include the client as a collaborator, and can be practiced ecologically. They point out that several of the common biases against assessment are related more to the way clinical assessment was sometimes carried out than to its principles and potentialities.

Endorsing the triangulation of narratives in psychological assessments can enrich clinical practice. This approach allows us to acknowledge different types of truth in our work with clients, encouraging us to follow “best practices” in the standardized part of the assessment while also encouraging us to reflect on our role and influence on the relational process in which the assessment is embedded. When we work in this framework, involving our clients in their own assessments, we are better able to help both clients and the professionals working with them who receive our reports.

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Bio



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