

Vermont Center for Collaborative Assessment

Two Spring Street Montpelier, Vermont 05602
802-229-4974 vcca@someware.com www.someware.com/vcca

Collaborative Assessment: An Alternative to Psychological Evaluation

Bruce J. Chalmer¹

Collaborative assessment is a problem-solving approach that applies ideas from narrative therapy as an alternative to psychological evaluation. Collaborative assessment seeks to invite the people who are affected by a problem to work together against the problem, rather than against each other. The “heat” is put on the problem, not on any one person. This frees people to assume responsibility for opposing problems, rather than engaging in blame or other damaging practices.

Collaborative assessment and ideas from narrative therapy

If you are familiar with narrative ideas, you are familiar with the flavor of the conversations involved in a collaborative assessment. (See, for example, Freedman and Combs (1996), Smith and Nylund (1997), and White (1989) for discussions of narrative therapy.) In a collaborative assessment, a facilitator (or two or more facilitators) meets with the people involved with the situation, in whatever groupings seem appropriate. The facilitator asks about the problem’s effects on people and people’s effects on the problem, and seeks to elucidate participants’ preferences concerning those effects. “Thick” descriptions—i.e., descriptions that present the situation in context, with recognition of its multifaceted nature, inviting rich associations and multiple possibilities—are privileged over “thin” descriptions such as diagnoses or normative classifications. The conversations are deconstructive, in that the facilitator asks questions that tend to uncover assumptions, cultural and institutional prescriptions, and other forces that act to favor some possibilities over others. By uncovering those forces and their effects, the conversations invite participants to consider and express their preferences regarding those effects. Unique outcomes—i.e., events in people’s lives that do not fit the problem-defined (and problem-constituting) narrative—are identified and expanded upon, thereby serving as a window through which alternative, preferred narratives can be viewed. The result of this process, just as in narrative therapy, can be to open possibilities for action that were not previously available or visible to participants.

Collaborative assessment differs from usual applications of narrative therapy primarily in that it can be invoked in situations for which the people involved are not seeking “therapy” per se. Instead, collaborative assessment is offered as an alternative to psychological

¹ Psychologist in private practice, Montpelier, Vermont, and director of the Vermont Center for Collaborative Assessment. I can be reached via email at bruce@somewareinvt.com, or by postal mail at 2 Spring Street, Montpelier, VT 05602, USA.

evaluation.² For example, schools often arrange for psychological evaluations as part of determining eligibility for special education or other services. Courts arrange for such evaluations in situations involving child custody or visitation disputes, in criminal proceedings, and in alternative procedures such as diversion or reconciliation programs. Individuals, parents, organizations, or people working with them such as lawyers, therapists, or medical professionals arrange for such evaluations to help them determine how to proceed or get unstuck. Although these same people may also arrange for therapy in some situations, the circumstances in which they request psychological evaluation are different.

Collaborative assessment in contrast to psychological evaluation

The table below summarizes the differences between collaborative assessment and psychological evaluation, focusing on five areas: purpose, subject, method, product, and criterion.

	Psychological evaluation	Collaborative assessment
Purpose	Diagnosis/classification	Problem-solving
Subject	A person (or system) assumed to have one or more problems (i.e., the person “has” the problem)	A problem (or several) distressing to one or more people (i.e., the problem is the problem)
Methods	Standardized tests designed to diagnose and measure the subject according to norms, and to fulfill administrative expectations Interviews focused on the subject’s characteristics as interpreted by the evaluator	Collaborative conversations among the people involved with the problem, focused on how they are affected and how they have been effective against it Standardized procedures used (if at all) to provide additional descriptive data
Product	A report containing the evaluator’s diagnoses, interpretations, and recommendations, written in professional language from a detached, expert perspective	Solutions generated and implemented by the people affected by the problem; a written summary or other documentation, if needed, written in everyday language
Criterion	“Objective” accuracy	Usefulness for the people involved

² For simplicity, I am using the term “psychological evaluation” to encompass a variety of procedures that incorporate some common assumptions. Other names include psychological assessment, family assessment, forensic evaluation, et al.

Purpose

In psychological evaluation, the evaluator examines an individual³ using various techniques, with the goal of diagnosing, classifying or measuring the individual according to one or more taxonomic schemes. The process can be seen as a kind of data reduction,⁴ in which extraneous details, considered random “noise,” are pared away by the use of standardized techniques so as to reveal the underlying structures that presumably give rise to the problem at hand. Implicit in this approach is that those underlying structures exist independently of their observation and description; it is the job of the evaluator to identify and describe them as accurately as possible. Thus, the influence of the evaluation process itself, including the evaluator, on the individual being evaluated is considered distortion, to be avoided to the extent possible (hence the use of carefully standardized procedures).

Also implicit in this approach is that diagnoses are meaningful and useful constructs independently of their instantiation—in other words, that it is meaningful to talk about how to solve a particular *type* of problem, independently of the particular persons who are affected by it. Once we have decided that someone’s problem is attention deficit disorder, or appendicitis, we can invoke expert knowledge to design treatment strategies, consulting a system of knowledge which is itself organized by diagnosis.⁵ In effect, we seek to classify persons according to diagnostic criteria so that we can access knowledge relevant to treatment; in so doing, we necessarily view the individual person as an instance of the diagnosis. The idiosyncrasies of how a particular diagnosis is manifest in a particular individual are important to the conscientious clinician, but those idiosyncrasies are viewed primarily in terms of how they might require adjustment of the usual treatment for the diagnosis. The diagnosis occupies the foreground. (This same reasoning dictates the use of diagnosis as the main basis for third-party payers’ payment decisions. Particular circumstances may require adjustment, but the default assumption is that given a particular diagnosis, a particular course of treatment will be offered, and deviations from that course require justification, especially if the deviations involve additional cost. “Best practice” schemas reflect a similar viewpoint.)

Collaborative assessment (like narrative therapy) is based on a very different view of reality in general and problem-solving in particular, a view contrary to the reductionist approach implicit in psychological evaluation. In collaborative assessment, the facilitator works from the assumption that life as lived by real people is far richer in its details and potential

³ As noted above, some forms of evaluation examine wider systems such as families, although in such cases the evaluation usually includes measures of the individuals as well. For simplicity, I will describe the more usual case of individual evaluations, although my comments could apply equally to evaluations of wider systems based on the same assumptions.

⁴ Data reduction refers to the process of summarizing a large number of observations using a (relatively) small number of derived measures, for the sake of scientific parsimony. Calculating an average, for example, allows the researcher to summarize the general magnitude of a set of numbers using a single indicator.

⁵ Indeed, a basic rationale for diagnostic schemes is to facilitate the organization of knowledge—see, for example, the DSM-IV (American Psychiatric Association, 1994).

meanings than any possible description or generalization of it (White, 1989), and that therefore no particular description—including a diagnosis—can capture all of the possibilities inherent in a situation that people experience as problematic. Moreover, the narratives that we construct to make sense of our lives are not simply neutral, after-the-fact descriptions, but are constitutive, in that our narratives profoundly affect our understanding of events, our interpretations of others' and our own motives, and even our perceptions.⁶ In other words, not only do narratives provide us with an understanding of our experience, they actually serve to shape our experience. In this regard, diagnoses are not merely incomplete as descriptions, but also, like any other narrative, have real effects in how the situation is constituted. Although collaborative assessment does not preclude the use of diagnoses or other expert knowledge, such knowledge is not inherently privileged in the conversation over other views. Instead, participants are invited to deconstruct expert views in the same manner as other views of the situation, so they can consider the effects of adopting those views and their preferences regarding those effects. The goal of the process is not to arrive at a “true” description, but rather to arrive at an approach that works for the particular people involved in this particular context.⁷

Thus, collaborative assessment seeks the opposite of a reductionist description: it seeks to engage the participants in describing the situation more richly, in context, with full recognition of the multi-determined, multi-storied nature of life. From such “thick” descriptions, problems can be resolved in ways that may have been otherwise inaccessible.

⁶ See, for example, David Abram's (1996) discussion. Abram, drawing on the philosophy of Maurice Merleau-Ponty, elucidates the active, participatory nature of perception and traces the effects of certain linguistic developments in Western culture, particularly the phonetic alphabet, on perceptual experience.

⁷ What, then, of the function of diagnostic taxonomies as ways of organizing information? How might collaborative assessment allow access to useful knowledge gained from past experience, if not by consulting a corpus of expert knowledge organized by diagnosis? Further, how can collaborative assessment add to that corpus of knowledge, if its results are not amenable to diagnostic categorization? One answer is that collaborative assessment (like narrative therapy) invites participants to express knowledge as stories, involving particular times, circumstances, places, and characters, rather than as disembodied information. As these stories are told, and re-told—facilitated by, among other media, publications such as this one—they become part of the lore of the community, available for retelling whenever members of the community deem them relevant. What makes someone think of a particular story as relevant is undoubtedly much broader than similarity of diagnosis, or any other single feature. As I noted previously, the point is not that diagnostic categories are precluded in collaborative assessment, but rather that the process seeks to counter the tendency of diagnostic language to claim “truth” to the exclusion of other possibilities. As an example of this tendency, I have heard one psychodynamically-trained therapist describe attending group supervision sessions as part of his training, in which the supervisor would often interrupt a trainee's presentation of a case by holding up two fingers, which immediately shut off the conversation. After puzzling about this, the trainee asked one of his colleagues what this meant, and was informed that the two fingers represented the supervisor's pronouncement of an Axis II diagnosis—i.e., a “personality disorder”—which rendered further discussion moot since such disorders are “known” to be not amenable to therapeutic treatment.

Subject⁸

Psychological evaluation treats a person as its subject, and presumes that the person “has” one or more problems to be diagnosed. The subject of the evaluation is, of necessity, someone other than the evaluator (in fact, this notion is so embedded in the concept of psychological evaluation that it seems odd to mention it). The evaluator stands outside the problem and its host, and from this advantageous perspective can examine the person in whom the problem resides, and can determine how the person’s characteristics (or the interaction of that person’s characteristics and environmental influences) give rise to the problem. Since, it is assumed, problems may be based on structures within the subject not accessible to the subject’s consciousness, but which nevertheless produce observable manifestations, the evaluator is often able to discern more about the problem than the subject can, and may need to use techniques whose purposes and details are hidden from the subject lest the subject’s knowledge skew the results. The evaluator must be unaffected by the problem in any personal way, lest his/her feelings contaminate the results (hence the usual practice of calling in an evaluator who is unacquainted with the subject), and the evaluation process should have as little effect on the subject as possible, so as not to confound the characteristics of the subject with the effects of the evaluation itself. This implies that a therapist working with the subject should generally not serve as the evaluator. Treatment (which, it is hoped, *will* affect the subject) is logically and procedurally distinct from evaluation.

Collaborative assessment, by contrast, treats the problem as its subject—as the narrative therapy maxim says, “The person is not the problem, the problem is the problem.” In other words, the problem is viewed as an entity unto itself, not tied irrevocably to anyone. The facilitator’s role is to work together with other participants to solve the problem. In this way, everyone stands in the advantageous position of the evaluator in psychological evaluation: separate from the problem, thereby able to consider its effects and their own preferences concerning those effects. The participants (including the facilitator) are all affected in various ways by the problem, and the process inevitably affects the situation (ideally, for the better). No distinction is drawn between “assessment” and “treatment.”

Methods

The methods used in psychological evaluation are designed so that variability from subject to subject is attributable to “true” variation between subjects, rather than to variations in the evaluation process; moreover, the methods should be accurate indicators of the underlying

⁸ I am using the term “subject” in the sense it is used on most social science research, referring to the entity that is the focus of research procedures. This usage of “subject” is as opposed to its grammatical sense, referring to the entity that, at least in the active voice, is the actor in a sentence. Thus, curiously, the “subject” of a research study would generally be the *object* of sentences used to describe the study were the study written in the active voice. (For example, “I tested the subject using the WISC-III.”) In traditionally written scientific papers and evaluation reports, the researcher/evaluator writes in the passive voice (“the subject was tested using the WISC-III”), thereby rendering the subject of the sentence the object of the action, and obscuring the existence of the researcher/evaluator altogether. This practice is entirely in keeping with the assumptions of psychological evaluation discussed above, in that the evaluator’s influence is supposed to be minimized, and the report itself a description of truths about the subject rather than a story told from the evaluator’s particular, embodied point of view.

constructs that bear on the issues that brought about the evaluation. In other words, the methods should be both reliable and valid measures of the subject's characteristics that are relevant to the problem at hand. For this reason, psychological evaluations use normed⁹ measures with strictly controlled administration procedures whenever possible.

Results that are unusual in the population are generally considered of particular clinical significance. Even procedures with non-numerical results such as clinical interviews are conducted in a way that allows the evaluator to compare the subject's responses with those the evaluator has encountered from other subjects. The general assumption is that "normal" results—using the term in its literal sense meaning close to average—indicate desirable or at least non-problematic functioning, whereas non-normal results need closer examination as possible indicators of pathology.

In general, the choice of methods is considered the province of the evaluator, who bases this choice on the particular traits or characteristics of the subject considered relevant to the situation, the availability of procedures to measure those traits or characteristics, and the evaluator's own training.

Some of the procedures used in psychological evaluation have become so conventional that they have been written into administrative requirements. For example, special education eligibility rules in Vermont (as in many other locations) nearly always require IQ testing (among other procedures) as part of the process to demonstrate eligibility based on certain kinds of learning disabilities. Similarly, the rules require (or strongly suggest) that certain behavior checklists be used as part of demonstrating eligibility based on "emotional/behavioral disability." In evaluations ordered as part of court proceedings, the use of standardized procedures may not be required explicitly, but the use of standardized procedures serves to protect the evaluator from challenges to his/her competence; if the procedure was administered correctly, the results are easily defended as based on published procedures of widely accepted validity.

In collaborative assessment, the primary method is the kind of conversations described above, focusing on the effects of the problem on participants, participants' effects on the problem, and their preferences regarding those effects. In the course of these conversations, participants (including the facilitator) might suggest other methods as well, including expert consultations (e.g., vision/hearing screening, neurological or other medical testing, drug/alcohol screening, learning style diagnosis) which often involve standardized testing of one or more participants by one or more experts. If so, those experts are viewed as participants in the process like all others, not uttering disembodied "truths" but rather telling stories from their particular viewpoints. The facilitator may need to point out that professional narratives often tend to be privileged, in terms of their importance in the eyes of people in authority, over those of other participants, and invite participants to consider the effects of that tendency and their own preferences about how to view professional

⁹ A "normed" procedure is one which has been administered to a sample of individuals presumed to represent the population, and the distribution of scores (or other results) is published. With a normed procedure, an individual's results can be compared with those of the normative sample, and, by inference, with the population.

narratives. As with the case of diagnoses, the idea here is not to preclude or detract from the utility of expert opinions, but rather to situate those opinions as the ideas of particular people from particular points of view, so that participants can be freer to enact their own judgments about how to make use of them.

When administrative requirements call for particular standardized procedures, collaborative assessment can incorporate those procedures, treating the results in the same way as any other expert opinion.

Product

The main product of a psychological evaluation is a report written by the evaluator, summarizing the evaluator's conclusions (often diagnostic conclusions). The report is written from a detached, expert perspective, focusing on the subject's characteristics as inferred (by the evaluator) from the procedures used, and recommendations from the evaluator on how to proceed in the treatment of whatever problems were diagnosed. The evaluator's own role is minimized, since, after all, if the report implied that the results might have been substantially different had the procedures been performed by a different evaluator, the results would be deemed invalid. The subject is not a co-author of the report (again, this is so embedded in the concept as to be odd to point out explicitly).

The report itself is the culmination of the psychological evaluation process—it serves as a focus for others with power in the situation to consider how to proceed. As a professional, expert opinion, it is generally accorded much greater weight than the opinions of non-professionals involved with the situation, especially those of the subject of the evaluation. For example, school staff responsible for determining eligibility for special education services and designing individual education plans will often incorporate the evaluation report into the documentation supporting their decisions, and will give the evaluator's recommendations considerable weight in justifying expenditures for particular services. Court-ordered evaluations often become part of the case record, and judges may consider psychological evaluation an objective, scientific way to help them decide the "truth" in cases that otherwise resist revealing it.

Although the evaluator hopes not to make the situation worse, there is no expectation that the evaluation process will make it better either; rather, the evaluation is intended to provide the information that can help the treatment phase be more effective. There is no mechanism to evaluate the effects of the evaluation process itself. As a professional, the evaluator can be held accountable for malpractice via disciplinary actions, but if the evaluation was performed in accordance with generally accepted standards, the evaluator, as an outsider in the situation, is rarely apprised of the effects of the evaluation once the report is submitted.

In collaborative assessment, the main "product," ideally, is the resolution of the problem(s) that brought about the assessment, so that the participants no longer see their situation as dominated by the problem, or have found ways of dealing with its effects that they find preferable to the ways they had previously. In other words, the intended product of a collaborative assessment is the same as the intended product of (other kinds of) therapy: the

people feel better and the problem(s) they came in with are taken care of to their satisfaction.¹⁰ Even when the people involved don't feel that the problem has been resolved, the process, it is hoped, will at least have opened up additional possibilities for action, or at least not made the situation worse. Since there is no rigid distinction between assessment and treatment, the facilitator focuses on the effects of the assessment process from its inception—indeed, since the goal is not “truth” but rather problem-solving, maintaining awareness of and accountability for the effects of the process is a primary concern of the facilitator.

As part of the process of collaborative assessment, the facilitator and/or other participants may create documentation of various kinds. Narrative therapists often use letters, certificates, and other kinds of documents, and the spirit of the documentation in collaborative assessment is similar: documents can serve as tangible, visible expressions of preferred narratives, having powerful effects on people's lives. In collaborative assessment, a document might take the form of a written summary of the process, drawn mainly from participants' comments and descriptions as noted by the facilitator. Like other aspects of the process, the role of the summary is to support participants' preferred narratives, and the potential effects of the summary are explicitly considered by the facilitator in drafting it.¹¹

Unlike psychological evaluation, a collaborative assessment may not result in a summary document at all if the facilitator and other participants do not see a need for one.¹²

Criterion

The main criterion for determining the success of a psychological evaluation is its accuracy—i.e., the degree to which the report presents an objectively correct description of the aspects of reality relevant to the problem at hand. In effect, the evaluation process is a

¹⁰ I recognize that this is not the only way of defining the intended end result of therapy, but I think most consumers and practitioners of therapy, as practiced in Western consumer-oriented cultures where psychological evaluation is practiced, would endorse it as reasonable.

¹¹ This does not imply that the summary, or any other part of the process, “sugar-coats” or avoids difficulties and disagreements. As Michael White has noted, narrative therapy is not about “pointing out positives” or applauding achievements, both of which tend to put the therapists' views and preferences at the center of the discussion instead of those of the people seeking therapy. Rather, the idea is to elicit participants' own evaluations of events and circumstances in their lives, thereby inviting and empowering them to act according to the meanings they prefer. Often those preferred meanings take the form of strongly stated opposition to the effects of oppressive problems on people's lives, and a written summary describing that opposition would include a description of those effects—far from sugar-coating.

¹² However, the meaning of a written summary in collaborative assessment is affected considerably by the positioning of collaborative assessment as an alternative to psychological evaluation. Since evaluations emphasize the report as the main product of the process, the people who arrange for collaborative assessment may well expect a similar report at the end of the process. More importantly, they may expect to use a written summary from a collaborative assessment as if it were a psychological evaluation report, and accord it expert authority. I have found this expectation a mixed blessing: It is useful, in that a document that is written specifically to support developments judged preferable by the participants is accorded respect by people in power; on the other hand, I have found that the expectation that the report will contain diagnostic or other reductionistic statements can be frustrating both for me and for the people who hire me as the facilitator, especially when administrative requirements call for such statements.

measuring device, and it is successful to the extent that the measurements it yields are accurate and relevant indications of “true” characteristics of the subject. There is no way to know in any given situation how accurate a particular measurement is of some construct; instead, the evaluator relies on the choice of procedures known to be valid, as demonstrated in validation studies. Given the use of valid measures, applied correctly under proper conditions, the results are assumed accurate. It is the evaluator’s responsibility to determine if the conditions were indeed proper for the measures used; typically, the report includes a statement to the effect that the results can or cannot be considered valid in view of the conditions (based on, for example, the subject’s level of cooperation).

Although observations of the subject’s behavior during the process are usually included as part of the data to be interpreted, there is generally no statement about how useful the subject found the process; the main concern is accuracy. The report may be good news or bad news for the subject or others involved (or, in the case of adversarial proceedings, good news for some and bad news for others), but the main thing is that it be accurate news.

In collaborative assessment, the main criterion for success is whether the people involved find it useful. Since the process is more like the unfolding of a story than the application of a measurement device, accuracy has a limited meaning; the overall issue is not whether the process is seen as a “correct” story, but whether it is seen as a “good” story. This does not imply a disregard for accuracy or correctness in making particular assertions—indeed, accuracy in expert evaluations such as medical diagnoses can be crucially important to the usefulness of the process. However, it does imply that the importance of accuracy in a collaborative assessment is rather like the importance of accuracy in a historical novel: it makes it a better, more generative and evocative story.

Of course, the people involved in a situation might not agree on the usefulness of the process, any more than they necessarily agree on other aspects of life. Moreover, people differ in how much power they have to have their preferences heard, based on cultural constructions of gender, race, sexual orientation, age, social class, etc. To the extent that the facilitator can invite participants to consider the effects of these constructions, the process can enable suppressed voices to be heard.

Collaborative assessment as a counter-practice

Collaborative assessment is a problem-solving approach, grounded in the ideas of narrative therapy, that can be offered as an alternative to psychological evaluation. In fact, collaborative assessment could be described simply as narrative therapy by another name. So why coin another name?

Just as narrative therapy can be considered a kind of counter-practice (White, 1989) to the practices of structuralist therapies, collaborative assessment can be considered a kind of counter-practice to the practices of psychological evaluation. And just as narrative therapy represents, among therapeutic modalities, not merely a set of techniques but a discursive position that questions certain practices of dominant therapeutic culture, so collaborative

assessment can be considered a way of extending the narrative therapy critique into additional settings. As such, the offering of collaborative assessment as an alternative is intended to challenge dominant practices, not simply suggest a different procedure.

What are some of the dominant practices that collaborative assessment questions? And why might people choose the alternatives collaborative assessment offers? Those dominant practices include:

- practices of normalizing judgment
- practices that obscure, replicate and intensify existing power relations
- practices that reduce possibilities for action
- practices of imposition and deception
- practices that promote disconnection between professional and personal values

Practices of normalizing judgment: Psychological evaluation nearly always involves the use of normed measures, with the implicit assumption that scores outside the normal (average) range may be clinically significant. If the abnormal scores are on the end of the scale considered to represent pathology, the individual is often labeled, using terms such as disordered, disabled, deficient, dysfunctional, or mentally ill. People subjected to such labels are often marginalized and subjugated in ways ranging from having their voices and concerns discounted or patronized, to being subjected to treatments and “interventions” of various kinds, to imprisonment (e.g., “involuntary hospitalization”).¹³ In literary terms, psychological evaluation produces stories that might be considered morality plays, in which deviations from cultural norms are righteously punished, albeit with some sympathy for the sinners.¹⁴

Collaborative assessment, by contrast, seeks to “thicken” narratives that are preferred by the participants in the process—stories that are often very different from, and suppressed by, narratives of normalizing judgment. Thus, collaborative assessment is integrally concerned with deconstructing normalizing judgments, rendering such judgments visible and available for people to evaluate in terms of their own preferences. In literary terms, collaborative assessment tends to produce stories that might be considered docudrama, choosing its camera angles on the basis of meaning to the people involved rather than cultural norms.¹⁵

Practices that obscure, replicate and intensify existing power relations: The practices of psychological evaluation represent an application of what Michael White, influenced by Michel Foucault, has called “modern” power—i.e., power that engages people not through

¹³ I do not mean to imply that I disagree with the use of coercive practices such as imprisonment in all circumstances. Nor do I mean to imply that labels are invariably destructive in their effects—for example, many people express great relief when some aspects of their experience are labeled as reflective of a disorder or disease needing treatment, rather than a moral shortcoming deserving of censure. I *do* mean to imply that the language commonly used to describe marginalizing or coercive practices often obscures the power of those rendering the normative judgments that underlie the practices.

¹⁴ For similar reasons, I have found that nearly all of the evaluation reports I have read—and written—have been mind-numbingly boring, when not infuriating.

¹⁵ I readily admit that summary reports of collaborative assessments are not always literary gems either!

direct restriction or coercion, but through practices that induce people to shape their own lives in accordance with normalizing judgments. By couching its judgments in terms of measurements on (apparently) empirical continua (e.g., disordered/healthy, deficient/superior, inappropriate/appropriate) rather than in terms reflecting the operation of personal values by an observer (e.g., annoying to me/enjoyable for me, different from me/similar to me, easy for me to work with/difficult for me to work with), psychological evaluation invites people to accept these judgments as “objective” truth, rather than opinion, and thereby participate in their own subjugation. Thus, psychological evaluation acts to obscure the power relations that operate in the rendering of normative judgments. And, by rendering those power relations inaccessible to consideration and questioning, psychological evaluation serves a conservative function, protecting and enhancing the power of those in relatively privileged positions.

The practices of collaborative assessment are intended to render existing power relations visible and accountable, so that people in positions of less power are enabled to question the judgments made about them.¹⁶

Practices that reduce possibilities for action: The reductionist approaches used in psychological evaluation are not merely “thin” in the sense that they attempt to summarize complex realities in parsimonious descriptions; they are thin in that they narrow the range of actions considered available to the people involved. Indeed, the usefulness of diagnosis in some settings, such as medicine, is precisely that it can quickly reduce the branches of the decision tree down to a small number of reasonable choices.

In situations in which psychological evaluation is used, the narrowing of options is likely to lead people along well-worn tracks, mapped according to dominant understandings of the territory. For example, a guidebook for one widely used behavioral measure, the Achenbach Child Behavior Checklist (CBCL), advises, “When the clinician first interviews parents, it is often helpful to use the completed CBCL (and, if possible the scored profile) as a basis for interviewing, after an initial discussion of the parents' reasons for coming to the service. The clinician can begin by asking if the parents have any questions about the CBCL. This provides an opportunity for them to spontaneously raise questions about particular items and to elaborate on their responses.” (Achenbach, 1983) In other words, not only does the checklist lead the parents through a set of normative judgments of their child’s behavior, it also serves (when used in this recommended manner) to focus the discussion on those

¹⁶As bell hooks (1984) noted:

One of the most significant forms of power held by the weak is “the refusal to accept the definition of oneself that is put forward by the powerful.” Elizabeth Janeway calls this the “ordered use of the power to disbelieve.” She explains:

It is true that one may not have a coherent self-definition to set against the status assigned by the established social mythology, and that is not necessary for dissent. By disbelieving, one will be led toward doubting prescribed codes of behavior, and as one begins to act in way that can deviate from the norm in any degree, it becomes clear that in fact there is not just one right way to handle or understand events.

Women need to know that they can reject the powerful's definition of their reality--that they can do so even if they are poor, exploited, or trapped in oppressive circumstances.

judgments. The “initial discussion of the parents’ reasons” for being there is relegated to the status of ice-breaking pleasantries, before the real work begins.

Collaborative assessment, in its application of narrative ideas, is designed to seek out possibly interesting paths that, though visited, may not appear on the map—and map them, rendering them viable choices for future journeys. Rather than narrowing the range of options for action, collaborative assessment works to widen them.

Practices of imposition and deception: The procedures used in psychological evaluation are often unpleasant for the subject, as anyone who has performed enough evaluations knows. But, like their medical colleagues,¹⁷ practitioners of psychological evaluation are trained to accept this as a necessary evil, since the benefits of “accurate” evaluation are presumed to outweigh the cost to the subject in temporary suffering. In fact, expressions of discomfort with or outright objection to an evaluation task, or refusal to comply with the evaluator’s instructions, are treated as data about the subject—more grist for the interpretive mill.

Some of the reasons people might find evaluation procedures unpleasant is that the procedures are often tedious, intrusive, insulting, and/or of little apparent relevance to their concerns or to the issues at hand.¹⁸ Moreover, the evaluation report is apt to contain interpretations and descriptions, offered as expert judgment, that are highly discrepant from the preferred views of the person being described. The evaluation procedures and the report are imposed on the subject, unless the subject has the power to prevent it (which is rarely the case).

Regarding intrusiveness, many procedures are specifically designed to extract information out of a potentially unwilling subject by tactics of obfuscation or deception. For example, in the manual for the Thematic Apperception Test (Murray, 1943), a widely used procedure in which a person is instructed to tell stories about a series of pictures, the author states

If the pictures are presented as a test of imagination, the subject’s interest, together with his [sic] need for approval, can be so involved in the task that he forgets his

¹⁷ The people who gave us the phrase, “This might cause some slight discomfort...”

¹⁸ The issue of apparent relevance is also known as “face validity,” a term often used dismissively in discussions of test validation as if it were a kind of “fake” validity. Nunnally’s (1978) text on psychometric theory notes:

In applied settings, face validity is to some extent related to public relations. For example, teachers would be reluctant to use an achievement test unless the items ‘looked good.’ Less logical is the reluctance of some administrators in applied settings, e.g., industry, to permit the use of predictor instruments which lack face validity. Conceivably, a good predictor of a particular criterion might consist of preferences among drawings of differently shaped and differently colored butterflies, but it would be difficult to convince administrators that the test actually could do a good job of selecting employees. (pp. 111-112)

The implication is that if the procedure is a good predictor, the experience of the person undergoing the procedure is a largely irrelevant consideration. Scientific truth is privileged over mere human experience, especially the experience of those at the bottom of the hierarchy, on whom the tests are being imposed.

sensitive self and the necessity of defending it against the probings of the examiner, and, before he knows it, he has said things about an invented character that apply to himself, things which he would have been reluctant to confess in response to a direct question. As a rule the subject leaves the test happily unaware that he has presented the psychologist with what amounts to an X-Ray picture of his inner self. (pp.3-4)

The evaluator and subject are thus cast into adversarial roles, with the subject trying to defend against the intrusions of the evaluator, and the evaluator trying to outwit the subject to penetrate the subject's defensive shell.

Collaborative assessment promotes a very different relationship among the participants—indeed, the term “collaborative” is specifically intended to challenge the “evaluator versus subject” mindset.

Practices that promote disconnection between professional and personal values: How are otherwise compassionate people induced to engage in the kinds of practices outlined above? One answer, of course, is that the people practicing psychological evaluation are largely unaware of negative effects of those practices, or feel that any negative effects are justified by the benefits. As noted previously, the procedures of psychological evaluation generally do not provide the evaluator with feedback about effects of the procedures themselves on the subject, not only because the procedures lack mechanisms for this, but because the subject's expressed reactions are considered part of the data to be interpreted. The evaluator is conceptually insulated from considering the effects of his/her practices; if the subject resists or expresses objection, the evaluator's job is to find ways around the resistance, duly recording the subject's observed reactions in the “behavioral observations” section of the report.

But effects on the subject are not the only effects left unexamined by psychological evaluation practices. What about the effects of those practices on the evaluator? Although people can be trained to ignore their misgivings about engaging in practices of subjugation, the incongruity between the values inherent in those practices and their own personal values can extract a toll.¹⁹

The language of professionalism contributes to this incongruity by inviting people to separate from their personal values when they are acting as professionals. People who would readily endorse values of respect and mutuality as important to them in their relationships with others can, when cast as professionals, engage in practices that they would be ashamed of in other contexts, if they were able to observe themselves in action. One indicator of this disconnection between personal and professional values is that professionals often talk about the people who consult them very differently when those people are absent than they would in their presence. It was such a realization (among others) that led Tom Andersen and his colleagues (Andersen, 1991, 1999) to open their conversations to the people on the other side of the one-way mirror, reversing the light and sound to transform

¹⁹ Becoming aware of that toll is, I would guess, a big part of what attracted many people to narrative ideas in the first place.

the hidden plotters of strategy of earlier approaches into visible, accountable reflecting teams.

The ideas of collaborative assessment invite professionals to reconnect with their personal values. Again, the term “collaborative” is specifically intended to suggest a team of people working together, all of them influencing and being influenced by the situation in various ways. To work collaboratively implies that the facilitator strives for transparency, situating comments and questions in her/his own experience rather than disembodied “truth.” Although the experiences, concerns and preferences of the participants who sought help remain at the center, the facilitator’s own sense of his/her own life is also enriched through the process.

References

- Abrams, D., 1996. *The Spell of the Sensuous: Perception and Language in a More-Than-Human World*. NY: Pantheon.
- Achenbach, T., 1983. *Manual for the Child Behavior Checklist*. Burlington, VT: ASEBA (available at www.uvm.edu/~cbcl)
- American Psychiatric Association, 1994. *Diagnostic and statistical manual of mental disorders, fourth edition*. Washington, DC: American Psychiatric Association.
- Andersen, T., 1991. *The reflecting team: Dialogues and dialogues about the dialogues*. New York: W.W. Norton.
- Andersen, T., 1999. “The reversal of light and sound.” *Gecko*, 1999 volume 2. Adelaide, Australia: Dulwich Centre Publications.
- Freedman, J., & Combs, G., 1996. *Narrative therapy: The social construction of preferred realities*. New York: W.W. Norton.
- hooks, b., 1984. *Feminist theory: from margin to center*. Cambridge, MA: South End Press.
- Murray, Henry A. and the Staff of the Harvard Psychological Clinic, 1943. *Thematic Apperception Test Manual*. Harvard University Press.
- Nunnally, J., *Psychometric theory, second edition*. New York: McGraw-Hill.
- Smith, C., & Nylund, D. (eds.), 1997. *Narrative therapies with children and adolescents*. New York: Guilford Press.
- White, M., 1989. *Selected papers*. Adelaide, Australia: Dulwich Centre Publications.