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ABSTRACT

The paper briefly describes assessment practices in terms of their theoretical principles. The practices include: (a) the client is an informed participant even during the assessment process; (b) the referral is situated in terms of actual events; (c) life events are primary data, and test scores are secondary or derived data; (d) interpretation is hermeneutic rather than reductive; (e) the assessment process is interventional as well as evaluative; (f) test activity serves as a lived metaphor for structurally similar past events; (g) comportment through tests provides access to process as well as outcome; (h) representation of actual events is a major means of representational description; and (i) the explanatory system is that of structural description rather than reduction. (Author)

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A PHENOMENOLOGICAL APPROACH TO PSYCHOLOGICAL ASSESSMENT[1]

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This paper presents a sample of phenomenologically grounded principles and actual practices of clinical psychological assessment. Let us look immediately at an instance of this applied phenomenology: my client is an informed participant right from the beginning. I do not try to present a standardized "blank slate" or "stimulus condition" through which the client presumably will inadvertently reveal his true self. Rather, I first share the referral directly with the client, asking him/her to fill me in on the actual life events and circumstances that led up to the abstract referral (e.g., "evaluate suicide potential," "test for IQ," "determine extent of organic dysfunction"). In turn, I share what I know of the referring person's concerns and rationale, as well as what I see as the implications of our upcoming assessment. In this way I not only have acknowledged but also have utilized the client's inevitable meaning-giving to our situation, and I have become more keenly aware of my own (also inevitable) co-constitution of the assessment outcome. Each of us has become better attuned to his responsibility for his own choices, however limited they are.

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As with this introductory example, the following ones too do not appear in the writings of phenomenological theoreticians, but are instead one application of theoretical foundations, especially those of Merleau-Ponty (e.g., 1962, 1968, 1973). In a sense all of the following principles and practices highlight mutually implicatory ramifications of phenomenological psychology's point of departure: human being seen as situated intentionality. "Intentionality" here does imply the everyday sense of purposiveness. However, its philosophical meaning refers more basically to the (differentiable but) unitary character of the person 'and' his world as he lives it. That is, consciousness, whether figurely more bodily or cognitive, "intends," "has in mind," "is directed toward" an already meaningful world rather than merely being impinged upon by external (or mediated) stimuli. "Situated" (in "situated intentionality") is a qualifier referring to our finitude, our always experiencing 'and' behaving in accordance with our situations--our biological/interpersonal/biographical/cultural circumstances. A psychology that acknowledges situated intentionality can also be described as hermeneutic, structural, and dialectical in its approach, as will be illustrated below.

So on with the practices and principles. Let me emphasize that they are not merely conjectural. I have been developing, carrying-out, and teaching them for about eight years. They

have proven viable for a wide range of clients and settings. I will present the practices roughly in their clinical order, with their overlapping principles being repeated in various forms.

Even before involving the client as an informed participant in the assessment itself, I contextualize the referral. That is, I do not act as though there were a universal objective referent for the referral abstractions ("IQ," "suicide potential," etc.). Instead I go directly to the referring person (whether another professional or the self-referred client) and inquire about the decisions facing him/her, the concrete events that led to that dilemma, and the particular meanings to him/her of the referral categories. During this discussion we often discover that the dilemma is an artifact of objectivistic thinking, e.g., "is the client really a this or that?"). To de-reify such conceptions, we explore the contexts in which a troublesome behavior both has and has not occurred, and we try to get in touch with the context as seen by the client and his involved others--including professionals. Thus "testing for IQ" would become an investigation of the client's experience of situations in which he has been relatively effective and ineffective, of his involved others' perceptions of these situations, and of the assessor's sense of how the client approaches and moves through these occasions. In this way, we take into account that even the referral focus is

already co-constituted by at least the professionals and the client, always in the context of personal, social, and scientific values.

Throughout the preliminary and the more intensive assessment procedures, it is life events that are primary data. In contrast to traditional practice, test scores are secondary, derived data. Test scores, categories, and diagnoses are abstractions from particular actions, and these abstractions already are grounded in assumptions about the orderliness of human affairs. Thus to test for IQ typically has been to look for the degree of underlying ability that accounts for current achievement and allows us to predict future accomplishment. I would say that when we test for IQ in that way we have forgotten that Binet originally selected items for his test in order to sample particular achievements that were requisite to further academic development. From my perspective, the client's accomplishment with a test is an instance of his coping with academically oriented tasks; it does not underlie other instances.

True, to make use of primary data, the assessor does interpret, but he does so hermeneutically, "reading behavior" for what relevance it might have for his clinical concerns. His reading is a dialogal one in which his usual understandings are modified as he "listens" actively to this particular client's

situation--the meanings, projects, and limitations through which the now-focal behavior evolved. During this reading the assessor is attuned to more than what is literally present; through my own biography I am in touch with variations of the client's experienced demands, invitations, obstacles, hazy vistas, and so on. Concretely, the "suicidal" client's slouch and downcast gaze speak into not only my past experiences with such persons but also into times in my own life when I have approximated such postures. Since all knowledge occurs through biographical presence, rather than try to "control out" such personal meanings, I try to make explicit use of them--both for understanding and for engaging the client.

My difference from mainstream approaches here is that I do not make a radical separation of this "clinical art" from scientific psychology. As I see it, to be effective, a particular personal access ('art') must be recognized as such and be critically examined to determine with what it is in touch (e.g., is the client resigned, indifferent, depressed, or despairing?). Part of this examination is a reflection into formal, consensual (scientific) knowledge; even my personal history through which I am present to clients includes my training in theory, conceptions, research findings, controversies. Consonantly, and also differing from traditional psychology, I see "objective" tests, data, criteria, and conclusions as consensual but also as unavoidably grounded

in historicity, situatedness, perspectivity, etc. Being explicit about this man-made character of science helps me from lapsing uncritically back into that "natural attitude" in which we view events as being "out there," independent of our perception. More specifically, being circumspect about the origins of science helps me to avoid slipping into anonymous opinion, absolute statements, unsituated conclusions, and deference to presumably immutable laws of nature. Thus, even after consulting an MMPI profile, a Rorschach summary sheet, and assorted norms, I do not come up with a yes-no conclusion or even a probability level of suicide. Instead, I specify what I know of the personal and physical circumstances in which the client could kill himself, I describe in what ways those circumstances already exist, and I suggest changes that could move the client out of suicidal circumstances. This process, although utilizing diverse research and theory, ends with primary data (slumped posture, present home situation, etc.). These data have been refined and understood through reflection on biographical touchpoints and on formal literature, but this interpretation was not a transformation into a different level of reality; there was no reduction to either psychologisms or to natural forces.

Other aspects of phenomenologically informed assessment

are its collaborative and interventional thrusts. When possible, the client works ("co-labors") with the psychologist to differentiate the "whens" and "when-nots" of critical experiaction. For example, the above brain-damaged patient acknowledges that he feels "safe" while drawing the Bender designs down the extreme edge of the paper--just like following the order provided by his morning routine at home. We discover that it is when he envisions being someplace that he used to get to automatically, but now fails to look for a concrete, serial route to it, that he becomes profoundly unrealistic and distressed. Note that these differentiations include not only the physical environment but also the ways the client experiences 'and' shapes his world as he moves through it in his own ways. Admittedly the psychologist cannot directly experience the client's world, and to some degree he is always left to imagine what it must be like. Moreover, the client often is not able to reflect or verbalize effectively. Nevertheless, to whatever extent he can, to that extent the client should help in exploring his world. One reason for this emphasis on interventional collaboration is that experience (the world as lived) is not merely the product of eco-biological processes; it participates in, and is essential to, the complete structure of being human. In particular, intervention into the client's lived world can be transformative of the entire structure (physical/biological/intentional). Indeed,

the client's collaborative participation in the assessment already is a movement toward greater confidence and self-direction, albeit within physical/biological constraints. In other words, even standardized assessment solicits a particular involvement on the client's part, and in that way influences the latter's conduct and sense of self. Phenomenologically grounded assessment acknowledges this inevitable involvement and uses it constructively. Thus the brain-damaged patient and I practiced with the NAIS Block Designs until he began to recognize the feeling of leaping toward finishing; at those times we then practiced looking back to a concrete starting place. This exploration therefore, is not only an assessment of present status but also of viable alternatives.

The above example of the brain-damaged patient's Bender-Gestalt illustrates another theme of phenomenological assessment: test activity serves as a lived metaphor for structurally similar past events. In a sense, the patient's sticking to the paper's margin 'is' his following a laid-out morning routine. Living out the assessment task renders taken-for-granted everyday events available for sharing and for examination of their common constituents and context. But the assessor does not look for "underlying" traits or for interactions among perception, affect, and behavior. To the contrary, the terms "structure" and "metaphor"

are meant to evoke a sense of indivisible wholeness, in which any change is a transformation of the distinguishable constituents as well as of the whole; there is no "element" or "variable" that is more essential or primary than the others. Similarly, the relation of the two terms of the metaphor is not one of logic or of actual identity; rather, the metaphor "Bender behavior 'is' morning routine" jars one out of such analytic modes into one in which the unitariness of perception 'and' meaning/affect is experienced immediately. This comprehension is certainly less clear-cut and efficient than that of traditional partitive analysis, but it is true to life as lived--that realm in which the client himself can recognize the landmarks and changes in terrain that call for shifts in his course. What's more, this recognition does not have to rely on specifiable insight or cognitive articulation; it can be effective as a lived recognition.

Another way of saying this is that comportment through tests provides access to process. Here, "process" refers to the evolution of a physically visible outcome ('end product'). This process is a dialectical one in which the person shapes 'and' is shaped by his lived world as he moves through it. I refer to this sedimented yet creative response to the world's solicitation/repulsion as "style"--the particular way in which an individual, in a particular situation, is at once shaping/shaped.

In the assessment situation, the client and I together observe how he moves through 'and' differentiates the terrain with which I present him. His tracks across the Bender page are a record of the outcome. But I also have access to the history, orientation, projects, solicitations, etc. out of which the visible behavior and tracks take shape if I watch the client moving through the task, myself anticipating intimations of his lived world. More concretely: while watching the brain-damaged patient carefully follow the instructions inherent in the order of the page's edge as well as those inherent in my successive presentation of stimulus cards, I had a sense of his world being one that lacked a planned future; it was a world limited to the present. Then while he was working on the Blocks, I became attuned to an impatient, then anxiously uncertain quality to his movements, which eventually became a flipping of the blocks at random with the patient grandly saying that he could "make them easy." I could now <u>see</u> what I might describe as a living toward what still feels at first like a familiar, reasonable, taken-for-granted future, but one that then unaccountably resists reasonable effort, and becomes a future gamely but desperately related to through an old role ("I can make them easy") even as the future begins to loom now as catastrophic. Note that the above "lived world" and "style," akin in many ways to what is called the "life of the unconscious"

by the psychodynamic tradition, are both available and critical for helping the client to help himself to traverse his terrain in a modified way. If we can momentarily bypass the scientistic tradition of seeing the person and environment as separate and as interacting in a chronological chain of finished events, then we can literally see with a different vision. This non-objectifying vision is an opening into an orderly realm, but one in which the particular viewer's and subject's perspectives and involvements are integral.

This leads to the next theme of phenomenologically grounded assessment, that of its descriptions representational via re-presentation. Specifically, in my assessment report, I describe the client by re-presenting samples of physically visible incidents accompanied by a description of my own access to the incidents. "My own access" is my particular biographical presence, interest, approaches, etc. For example, I might say, "When I sat back and stared at Edward, somewhat in the manner of a stern teacher, his posture stiffened in what I took as defensive defiance." This description is one of "contextualized primary data," and is intended, among other things, to attune the reader to the previously invisible--the style of the client's evolving course. A practical implication is that all the client's involved others have access to the same primary data and style,

and thus can deal directly with him and with one another in terms of life events rather than in terms of abstractions and objectifications. Note also that the client himself can read this sort of report and meaningfully offer his comment on it.

A disclaimer: although the assessor's description is an outcome of his own shaping/shaped relation with the client, and is thus radically perspectival, none of this is to be taken as license for undisciplined subjectivity. To be valid, the description must be capable of holding up as a perspectival variation of what can be seen by any others who sincerely observe the client's comportment. Indeed, readers familiar with the client should recognize what they already knew pre-reflectively.

A second disclaimer: The competent clinician, no matter how sophisticated about phenomenology, is conversant with natural-science clinical research, practices, and conceptions. This practicing clinician is a human-science psychologist, that is, one whose philosophical and basic research method is phenomenological, but who fully recognizes the essential participation of neurophysiology in human affairs. Thus he is not opposed to classifying persons, for example, as "process schizophrenic," provided that such diagnosis doesn't close down further individualized, collaboratively interventional assessment.

A final theme: Throughout this presentation, I have regarded structural description as explanatory. That is, rather than search for underlying personality variables or environmental contingencies to explain a given state of affairs, I describe what I can of that state of affair's holistic whatness, including its process of coming about. Whatever history is operative is in the present (even though looking into the past can help us to have a feel for that present). Similarly, the role of the neurochemical/physiological order is that of participation in the present structural whole, rather than simply that of cause or even of mediation. Fully human processes cannot be reduced to the physiological order; medical specialists, for example, know the seriousness of doing surgery on the heart of the man whose wife has just died in contrast to the heart of the man who is planning his daughter's wedding. Nevertheless, I quickly acknowledge that to the extent that a client's functioning is constricted to the physiological order, to that same extent the assessor's efforts to be psychologically collaborative and interventional are limited. The difference that makes a difference between reductive and structural explanation is that the latter remains open to "the possible," while the former restricts itself to "the necessary"--the irrevocably determined. By remaining open to the influential participation of intentionality, we do sacrifice the apparent neatness of the natural sciences;

however, we gain not only in attunement to specifically human possibility, but in comprehensiveness, in depth, and in respect for the ambiguity within order.

Some concluding comments. It is true that mainstream psychology does carry out many of the above practices even while not making them thematic. Phenomenological psychology as such is not essential for these procedures. But without the support of its explicit grounding and rigorous criteria, clinicians have been seen as loosely subjective or as merely conducting the art side of psychology. And from my point of view they have not been consistent or properly reflective in their practice. In contrast, a thorough-going phenomenologically grounded approach can provide a truly effective integration of (1) the practitioner's sensitivity to the client as individual and as intentional, with (2) the scientist's concern for empirical criteria, consensual judgment, and explication of lawfulness. This integration similarly can be a meeting ground for behavioral and psychodynamic psychologies. The phenomenological approach, even as briefly presented in this paper, also suggests a transcendence of the scientist-professional divisiveness of our clinical training model. Applied phenomenology can be integrative and practical as well as existential.[2]

[2]For details on the practical consequences of human-science (phenomenologically grounded) assessment, see Fischer, 1974, 1976a & b, and 1977b. For more on paradigmatic issues, see Fischer, 1973. For multiple clinical examples and an expanded introductory presentation of the themes of this paper, see Fischer, 1977a.

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