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Clinical Significance of Therapeutic Approach to Treatment Planning

***Abstract**: Psychological assessment has long been reported as a key component of clinical psychology. This paper examined and shed light on the complexities surrounding the clinical significance of therapeutic approach to treatment Planning. To achieve this objective, the paper searched and used the PsycINFO and PubMed databases and the reference sections of chapters and journal articles to analysed the underlying themes: 1) a strong basis for the usage of therapeutic approach to psychological assessment in treatment plans, 2) explained the conceptual meaning of clinical significant change in therapeutic assessment, 3) used initial theory to explain the therapeutic mechanisms of change in clinical practice, 4) analysed the empirically documenting clinically significant change in therapeutic assessment. Finally, the study suggested that though therapeutic assessment is not sufficient for the systematic study of psychotherapy outcome and process, it is still consistent with both the lay-man and professional expectations regarding treatment outcome and also provides a precise method for classifying clients as "changed" or "unchanged" on the basis of clinical significance criteria.*

***Key words**: Therapeutic approach, psychological assessment, clinical significance change, treatment outcome*

Introduction

Psychological assessment is to some degree of a crossroads. Though, research has long suggested its importance to treatment (Meyer et al., 2001), raising this issue among psychologists reliably revealed robust and conflicting opinions. While evidence continue to show its relevance and application in clinical activities (Norcross, Karpiak, & Santoro, 2005), drops in graduate training in assessment (e.g., Curry & Hanson, 2010) and changed reimbursement from managed mental health care (e.g., Eisman et al., 2000) consistently influenced its usage in clinical practice. Though, much has been done in the past to promote in usefulness to treatment planning, their outcomes are yet to be proved and analysed systematically (Finn, Fischer, & Handler, 2012). Therefore, there is need for research to emphasise the significance of therapeutic assessment to treatment or the clinical utility, of therapeutic assessment in therapy.

This shifts in psychological assessment, particularly, as it related to envision and collective oriented therapy blown a new life into the debate on clinical significant change in clients 'treatment outcome. The emergence of therapeutic models of assessment, such as *therapeutic assessment* (Finn, 2007; Finn & Tonsager, 1997), provides a conceptual framework and research methodology for reviewing the relevance of therapeutic approach to treatment. The measures and models that come from this paradigm shift were categorized as therapeutic assessment (Finn, Fischer, & Handler, 2012). These were shared and documented by various scholars (e.g., Meyer et al., 2001) as a concept that prompts therapeutic change in treatment. Despite this development, clinicians still found it hard to agree on whether a change in clients 'condition can be attributed to the therapeutic assessment (Chambless and Ollendick, 2001). This is especially true within the era of evidence-based practices (see Chambless and Ollendick, 2001). Nonetheless, the assessment of change remained a problematic issue, with many theoretical and methodological questions still unanswered

Beutler and Moleiro, 2001) and Hollon and Flick (1988) offered evidence to support this argument. They emphasised the difference between effective and specific, effective, and perhaps effective therapies in clinical practice. According to his specification, a treatment is labelled effective, specific and clinically significant when a therapy is 'significantly superior to a pill or psychological placebo in at least two independent research settings' (p. 18). For instance, if a psychological assessment is more beneficial than when there was no treatment in at least two settings, it is considered as effective and clinically significant. On the other hand,

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if the therapeutic efficacy is only supported by single evidence, the assessment is thought-out as possibly efficacious, pending replication. These positions echoed the reflection of the question "What does clinician mean when they talk about change as clinically significant?" However, the answers to this are not, of course, the operational meanings in use but the ideas it designed to signify. That is why till now there were contrary views on what makes an therapeutic assessment clinically significant.

Purpose

This article brings together several empirical findings that support the clinical significance of therapeutic assessment in treatment planning. It also aimed at answering some of the questions regarding the clinical significant change during or before treatment. The paper linked therapeutic assessment to intervention process that identified, described, and managed clients' functioning, clinical impression, and therapeutic needs. To achieve these objectives, the paper empirically outlined the following; 1) examined the conceptual meaning of clinical significant change in therapeutic assessment, 2) used initial theory to explain the therapeutic mechanisms of change in psychological assessment, and analysed the common deficiency identified in treatment validity, and lastly, 3) gathered empirical evidence to supports the clinical significant change in therapeutic assessment in clinical practice.

Methodology

This paper analysed and reviewed empirical literature that highlights the clinical significant of therapeutic approach to treatment planning. The study collated and reviewed relevant articles, books, journals, and meta-analysis on clinical significant of therapeutic approach to psychological assessment. Both the ERIC and PSYCHLIT databases were searched using the following key words: therapeutic approach, clinical significant change, and treatment planning. This procedure initially reported about 1650 articles, journals, technical reports, paper presentation, case studies and book chapters covering more than 28 year period. Based on the abstracts retrieved from this initial 1650 plus articles and publications, the search was lessened to a relatively few hundred of studies that are pertinent, current and relevant to the theme of this paper. The contents of the remaining several hundred of articles cum journals were further scrutinised and only those that reported empirical findings were kept aside and used, while others were left out of further consideration. The process shows that only a few studies documented empirical findings on clinical significance of therapeutic approach to treatment in clinical practice. To verify references, manual searches of relevant journals and articles related to the paper are performed.

Historical Perspectives on therapeutic model of assessment

Therapeutic assessment is a short-term highly organized hypothetically and scientifically grounded method of psychological assessment. This method though arguable, was established by Stephen Finn and his professional colleagues and was significantly swayed by the humanistic school and self-psychology. Historically, therapeutic intervention was linked to the work of the humanistic crusade of the 1950s and 1960s. Though, many humanistic oriented clinicians (Rogers, 1951) were strongly against the use of psychological assessment, its experimental utility continues to grow over the years and was crucial for effective treatment plan in clinical practice.

The periods between the 1960s and 1970s also saw scholars such as Goldman (1972) described assessment and treatment as "a failure marriage" (p. 213). Besides, some of these scholars also had a long-held conviction that professional involvement of clients in assessment was injurious and unhealthy (e.g., Eisman et al., 2000). Of most interest among this view is the way they put a diverse twist on psychological assessment and is response method. For instance, some psychologist looked at psychological assessment as a therapeutic interpersonal knowledge rather than a clean reductionist practice (Riddle, Byers, & Grimesey, 2002). Despite the avalanche of criticism, therapeutic assessment continue to spread and covers important and specific areas such as (a) assisting service users to develop questions they need to solved through the assessment and testing, (b) gathering contextual evidence associated to their problems, (c) using previous assessment (d) engaging clients in partnership and making logic of the results, and last but not the least, provide immediate response to clients' early questions (Finn, 2007).

The lack of uniformity in the ethical guiding principle in the 1990s has been identified as limiting professional sharing of assessment outcome with clients (e.g., forensic evaluations; American Psychological Association, 2002; Curry & Hanson, in press; Smith, Wiggins, & Gorske, 2007). This set up a major change paradigm-wise in the assessment-related behaviour and research foci and ushered in different types of therapeutic models that continue to influence the treatment of mental health disorders (Finn, 2007; Gorske & Smith, 2008; Riddle et al., 2002; Tharinger, Finn, Wilkinson, & Schaber, 2007; Wygant & Fleming, 2008). The question remains, why therapeutic approach to treatment? Do the approach therapeutic enough to bring about appropriate changes in client's 'condition. So far, this question continue to face empirical test, and till now, no agreement was made on the issue.

Conceptual Meaning of Clinically Significant Change in Therapeutic assessment

In recent time, the interest in clinical significance of therapeutic assessment has grown not only in psychological research but also in other health related research measuring the quality of life and patient-reported outcomes (see

Crosby, Kolotkin, & Williams, 2003). Clinical significance in a normal sense is refers to as getting back to normal functioning. Specifically, clinically significant change occurs when there is a big change in symptoms, an average change in symptoms, and no change in symptoms. Though many contradictory claims had been made regarding the relation of the volume of change and clinical significance, the issue is still open for debate.

In therapeutic assessment, the degree of change is the most remarkable characteristic of the meaning of clinical significance. Earlier research on therapeutic assessment pointed toward a rather large dependable change in symptoms and coming back to normative levels as primary manifestations of clinical significance. In the field of psychology for example, clinical significance is typically related to the expression *clinically meaningful change* (*CMC*; see, e.g., Jacobson et al., 1984). In this perspective, it means "the practical value or significance outcome of an intervention, i.e., whether a treatment makes genuine changes in clients life or to other significant people in their life" (Kazdin, 2001, p. 455).

The idea that any volume of change in therapeutic assessment might be clinically significant is not casuistry, but rather expresses that clinical significance can and does mean many things. These differs base on the kind of problems and the objectives of treatment, as some illnesses may be too plain a criterion. Clinical significance was founded on the postulation that clients came for treatment with a belief to get better or improve their condition. Even in situations where the criterion is too severe, the body of research, along with users of psychological services, hope to see how frequently can a client attained the normal functioning after treatment. Though, there were many other thought to this, nonetheless, the degree of change in a given client must be statistically dependable, i.e., it must get beyond the level of what could be sensibly ascribed to a mere chance or measurement error. The final treatment outcome in a given client is also ascribed as a double criterion for clinically significant change: (a) the extent of the change has to be statistically dependable and (b) at the time of discharge, client's condition must be in a level that makes them indistinguishable or at equilibrium with well-functioning people. However, if clients show a sign that was statistically reliable, but the treatment outcome to a certain degree was dysfunctional, then the client is considered as "better but not recuperated." Further, if a client is finally found in a functional range at the end of the treatment, and the extent of the adjustment is not statistically dependable, then the process cannot justified whether or not the variation found in the treatment outcome is clinically significant. Lastly, if the degree of change is statistically consistent and the client found himself within the usual limits on the variable of interest, the client can be adjudged to have "recovered." This metric offers the clinicians the opportunity to analyse how often the statistically significant decline can occur in therapeutic assessment by recognized clients who displayed a statistically dependable change opposite to those that suggested an improvement.

General considerations that determined the clinical significance of therapeutic approach to treatment

Therapeutic assessment is based on the empirically supported psychological therapies. By this marker, i refer to those psychological treatments that have been exposed to assessment using the recognized methods of psychological science. Though, much has been said and written about this, some of the frequently used terms were *empirically validated*, *empirically supported*, and *empirically evaluated*. These terms are still contestable in psychological research till date. For example, the first connotation explained that a treatment has already been validated (Garfield, 1996), and proved effective. However, this does not mean the validation is completed and closed, and the therapeutic assessment does not produce a thorough success (Kendall, 1989). Besides, the method of assessment is not resolved even if a number of studies offered supportive proof on it. The second expression means that the treatment has been supported, with the condition that the backing comes from a suitable empirical study. The third idiom indicated that the treatments are empirically evaluated, that is, they have been empirically sustained. Though, this is not unambiguous.

The meaning of clinical significance in therapeutic assessment is not completely faultless, because there was little evidence supporting the measures. Though, the belief in some quarters is that the approach lacked empirical support and that scientific evidence on the subject showed its ineffectiveness to treatment. This was related to the newness of the measures for the concept. This opinion seems to have taken on a life of its own, as scholars echoed it to one another, also were mental health professionals, administrators, and policymakers. With each recurrence, its seeming reliability develops. At some stage, there appears no need to query or re-examine it because "everybody" sees it to be so.

The scientific evidence also says a different story about the effectiveness of therapeutic assessment to treatment as significant number of studies backs its effectiveness and efficiency in treatment plans. The inconsistency found between the insights and proof among scholars was due, in part, to preconceived notion in the spreading of research findings and the lingering dislike by mental health professionals for its emergence as alternative to traditional method of assessment. With the emergence of empirical findings that supported its relevance and significance to treatment, scholars and practitioners greeted the development enthusiastically and were excited to debate and publicize them. Also, therapeutic assessment faced the problem of identification as to whether it has a significant impact on their clients 'condition. Even when changes has been identified in clients, the clinicians still find it hard to decide whether clients has returned to normality, and to what extent is the positive change that occurred in their lives. This is actually challenging as it focused more on clinical rather than statistical significance change (Ogles, Lunnen, & Bonesteel, 2001).

Another way of hypothesizing therapeutic change in clients is to look at those coming for treatment as part of a dysfunctional population and those who have completed treatment as not part of the population anymore. This can be operationalized as follows: (a) the level of effectiveness resultant to treatment should fall outside the range of the dysfunctional population, where range is demarcated as ranging to two standard deviations beyond the mean for that population. (b) The level of effectiveness resultant to treatment should be within the level normal population, That is, within two standard deviations of the mean of the population group. (c) The range of effectiveness subsequent to treatment should place client nearer to the mean of the functional group than the dysfunctional group. This third meaning of the clinically significant change is the least illogical. This is because the definition was founded on a probability that scores would end in dysfunctional versus functional population distributions. Lastly, clinically significant change is determined when a post-treatment score falls within the functional populace on the variable of interest. When this standard is met, it is statistically more probable to be drawn from the functional than the dysfunctional populace.

Furthermore, a body of knowledge also used different methods of analyses to explain clinical significant change in therapeutic assessment; This include: comparisons with normal controls (Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999), measuring of quality of life (Gladis, Gosch, Dishuk, & Crits-Christoph, 1999), and ordering clients conditions into worsened, unchanged, enhanced, or recuperated categories (Jacobson & Truax, 1991). Moreover, out of all these categorizations, the Jacobson et al. process was the most commonly acceptable method of measuring the clinical significant change in clinical practice. However, Ogles et al. (2001) stated that 53% of work documenting clinical significant change during the last decade used the method designed by Jacobson et al. or a difference thereof. Further, what makes Jacobson and Truax (1991) taxonomy more exceptional and widely accepted was its ability to combine data on individual's pre- to post-therapy functioning on an outcome measure with normative evidence.

Theoretical basis for Clinical significant change in Therapeutic Assessment

Both in applied research and in clinical practice the significance of assessing clients 'change in treatment has long been acknowledged. The use of the traditional evaluation for treatment plan was criticized for its ineffectiveness and lack of clarity particularly, on measuring change in client's condition. However, quantifying clients 'condition and measuring the significance of their treatment is very cumbersome, to say the least challenging. Though, the *Null hypothesis significance testing provides professionals with* valuable information during treatment, it failed to highlight the significance of the estimated effect as it partly relied on sample size (Thompson, 2002). While the *measures of outcome size has been used* to cover this constraint, the more the observed outcome is, the more likely it relates to a clinically meaningful change. Even though it was reported that this type of measures hinged on the variability of the analysed scores, it was also agreed that a large outcome does not ineludibly linked with an important effect (Jacobson, Roberts, Berns, & McGlinchey, 1999; Kazdin, 2001). Though, the null hypothesis significance testing and the measures of outcome size are used to analyse the difference between group averages, they failed to detect the individual change in treatment outcome. They also failed to stipulate whether or not there is a particular change in clients 'condition and at what percentage (Jacobson & Truax, 1991). Therefore, the limitations of statistical tools in assessing intervention outcome prompted the change from statistical to clinical significance (see Kendall, 1999; Ogles, Lunnen, & Bonesteel, 2001).

Initial Theory on Therapeutic Mechanisms of change in Psychological Assessment

Research on treatment outcome has long probed why psychological assessment is theoretically therapeutic and clinically significant. Most of these studies sought for a particular assessment a tool that brings about therapeutic change in treatment. However, this thought prompted two caveats in the treatment of mental health disorders. Firstly, it was found that the mechanisms for change are not functioning in all the psychological assessments. That is, the mechanism for change was only appropriate for a collective approach in psychological assessment (Finn & Tonsager, 2002) and the other professionals (Purves, 2002). Although parts of this theory are yet to be tested empirically; it was a resultant of wide clinical experience. The theory found that basic human intentions are resolved by personality assessment and by other effective psychotherapies. Besides, this theory also sees clients' self-verification as an important tool for clinical significant change in therapeutic assessment. The theory postulated that clients who are ready and willing to partake in a treatment are expected feedbacks and proof that sees their opinion about self and that of the people around them as approved by others. This motive is refers to as a self-verification. According to initial theory, it is severe when clients had an experience that tested their schemas or that of people around them particularly when the therapist gave clients a feedback that was extremely opposite of their self-thought. This if happened may affect the treatment outcome.

Secondly, the theory established that human aspiration should be respected and admired by others and that it is good to consider one-self as decent. This is refers to as self-enhancement. This motive was highlighted by object-relation psychotherapy (Winnicott, 1975) and poignantly cleared in applied psychological assessment. Surprisingly, a significant number of clients assessing psychotherapy had negative self-concepts about self and this often revealed during the start of the assessment. For instance, a client might asked why he/she is lazy or loser

in a relationship through feedback, clients' assessment scores can be positively used to change this negative assumptions. A client who sees himself as "lazy" because he characteristically achieves little success in life might be advised after the use the MMPI-2 test that he/she is clinically unhappy. Additionally, clients might be advised that been depressed have an emotional impact on his/her energy level, or that depression affects people ability to complete their basic daily chores. Such explanations helped clients to develop positive change and views about their behaviour. It also helped clients to improve the negative ways they interpret things, thus, increased their self-esteem and promotes positive change (Newman & Greenway, 1997).

Thirdly, the ego psychologist (e.g., Freud, 1936) emphasised the human necessity for exploration, mastery, and control, i.e., self-efficacy/self-discovery. This assumption lately formed the foundation of Bandura's (1994) theory of self-efficacy. Base on this, assessment must design in a way that would tackle such desires and offered clients with fresh facts about their personality. Also, a therapy must be efficient to organize evidence on clients' life experience. This action created an exhilarating "aha" experience for clients and upsurge their self-efficacy and knowledge. This kind of therapeutic process is called naming clients' experiences and it promotes clinical significant change in treatment. This was obvious in the work conducted by Corsini (1984) where he reported that through new information clients mix and made common sense from a number of apparently dissimilar incidences, i.e., to create new answers to their problems (e.g., "taking my antidepressant medication makes me feel better and productive."), and fashioned a perfect likelihoods future (e.g., "If this problem is over, I perhaps might complete my college degree).

Empirically documenting clinically significant change in Therapeutic Assessment

In considering the determination of clinical significance of therapeutic assessment to treatment, evaluating the effectiveness of treatment can be done by the combination of objective empirical data and qualitative observational data. Empirically supported therapeutic assessment is refers to as treatments that had been exposed to assessment using the accepted methods of psychological science. That is a therapy must be supported with the condition that the support comes from an acceptable empirical study. However, the existence of a research backing approach does not automatically imply that the approach is effective in a new contextual environment (generalizability). At the same time, lack of research does not imply that an approach is faulty, but rather shows that the method is yet to be fully confirmed. Also, an approach that worked for one group of people does not mean it would be effective for other diverse group.

Therefore, clinicians must identify the strengths and feebleness of therapeutic interventions by using the art of science and not just a "gut feeling." This means that for treatment to bring about clinically significant change, the foundation of the therapy, particularly; is philosophical orientation must be grounded on empirical science. Although the clinical philosophy that guides therapeutic assessment in clinical practice is complex as well as comprehensive, clinicians are expected to provide objective evaluations of treatment effects on their clients. This is very essential because it impact positively on clients' physical, intellectual and spiritual well-being, as well as enhancing their health and development in the mind, body and spirit.

Apart from this, empirical evaluations of treatment must offer the measurements of clinical significant change that are independent of the therapist's opinions. The main objections to this notion are mostly from the clinicians themselves. Research shows that most clinicians believed that "data" cannot dictate to them the work; they "know" and that the treatments they offered to their clients are based on their professional knowledge (Kipnis, 1994). While internal attributions for positive upshots are usually healthy, therapists are misled by taking the recognition for client improvements rather than controlling the alternate reasons of the outcomes (Kipnis, 1994). Thus, for an empirically supported therapeutic assessment, evidence should be resulting from research clinics in addition to the initiator of the treatment.

Furthermore, a cursory scanning of the literature on therapeutic assessment revealed little on is therapeutic values. It is astounding to know that limited organized empirical studies were carried out on the subject. This mean that research on therapeutic approaches has not been comprehensively established and that they are not necessarily good. For instance, van der Kolk, (1996) maintained that as at 1996 there was only one research study on treatment of post-traumatic stress in children.

Finn and Tonsager (1992) measured the clinical significant change in therapeutic assessment using the clients who participated in a short-term psychological assessment at the university counselling centre. Thirty-two clients participated and completed the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) in the study and were given an hour feedback session using the shared method established by Finn (1996). Also, twenty-nine clients in a control group were examined and given the same level of therapeutic treatment (i.e., supportive nondirective psychotherapy) as alternative to a test feedback. Likened with the clients in the control group, those participants who took part in the MMPI-2 test indicated a substantial drop in symptomatic pain and an upsurge in their self-esteem both instantaneously after their feedback meeting and after two weeks. Similarly, the participants also showed a sign of confidence about their difficulties after the short-term assessment.

Newman and Greenway (1997) sustained and duplicated the research conducted by Finn and Tonsager (1992) at Australian university counselling service and found that those clients who engaged in the brief assessment displayed high self-esteem and a declined in symptomatology after more than two follow-up. Although

the outcome sizes were fewer than those established by Finn and Tonsager (1992), the variations of those who participated in the assessment were clinically and statistically significant. Besides, the positive report from the client's assessment was linked to the feedback given to them as well the better-quality of the design and it shows that their actions are not related to their participation in the MMPI-2.

Also, a recent meta-analysis study conducted by Abbass, Kisely, and Kroenke (2009) on short-term psychodynamic therapy for somatic disorders conducted on 23 studies involving 1,870 patients suffering from a wide range of somatic conditions (e.g., dermatological, neurological, cardiovascular, respiratory, gastrointestinal, musculoskeletal, genitourinary, immunological) reported 0.69 and 0.59 for improvement in general psychiatric and somatic symptoms respectively. However, among the studies on health care utilization, it was found that 77.8% reductions in health care use were due to psychodynamic therapy.

Another meta-analysis examined the clinical significance of both the psychodynamic psychotherapy (14 studies) and CBT (11 studies) for personality disorders (Leichsenring & Leibing, 2003) provided additional evidence of the effectiveness of therapeutic approach to treatment. The study was reported in the *American Journal of Psychiatry* and found that the mean length of treatment and the mean follow-up period between *pre*-treatment to post treatment demonstrated the effectiveness of therapeutic assessment to treatment outcomes.

In addition, a current review of short term (average of 30.7 sessions) psychodynamic therapy for personality disorders (Messer & Abbass, in press) reported effect sizes of 0.91 and 0.97 for general symptom and interpersonal functioning improvement respectively. These meta-analyses typify the current and methodologically rigorous assessments that explained the clinical significant change in therapeutic assessment.

Furthermore, Finn and Bunner (1993) studied the impacts of test response on psychiatric inpatients' contentment with the tests when they are in the hospital. Their findings show that clients who were given feedback were considerably more contented with assessments and reported clinical significant change in their condition than those without any feedback. In fact, among those who received no feedback, 40% of them showed signs of dissatisfaction with the assessments process compared to 0% of those who got a feedback. This lent credence to earlier research conducted by Newman and Greenway's (1997) and further confirmed that given clients feedbacks is highly important by promote clinical significant change in their condition and offers them positive value from the psychological assessment.

Additionally, Shedler–Westen Assessment Procedure (SWAP; Shedler & Westen, 2007; Westen & Shedler, 1999a) was used to assess the clinical significant change in therapeutic assessment. The methods sustained the clinical significance of therapeutic assessment by established the inner capacities and resources that evolved from the process. For example, SWAP measured a wide range of personality approaches, both healthy and pathological. The instrument demonstrated high reliability and validity relative to a wide range of criterion measures (Shedler & Westen, 2007; Westen & Shedler, 2007) and supported the clinical significance of therapeutic approach to mental health treatment (Westen & Shedler, 1999a).

Though, not much has been done on outcome studies that measure changes in inner capacities and resources using SWAP, the two research works on the issue raised a fascinated promises and suggested ways for future research on clinical significant change in therapeutic assessment. One of this is a case study of a woman diagnosed with borderline personality disorder and assessed with the SWAP at the beginning of treatment and again after two years (Lingiardi, Shedler, & Gazzillo, 2006). Apart from the significant reductions in SWAP scales that measure psychopathology, the patient's SWAP scores revealed the following effects: an increased capacity for compassion and greater sympathy to others' needs and emotional state; increased capability to identify other viewpoints, even when feelings ran high; increased ability to ease and soothe herself; increased recognition and consciousness of the significances of her actions; increased ability to express herself orally; more precise and well-adjusted insights of people and situations; a greater capacity to appreciate humor; and, possibly most essential, she had come to accept the throbbing past experiences and had found sense in them and developed from them.

These outcomes indicated a significant change in client's condition by increased the score on the SWAP Healthy Functioning Index over the course of treatment, therefore, confirmed the clinical significance of therapeutic assessment to treatment.

Discussion

The debate about attaining clinical significance change in therapeutic assessment continues to take a centre stage in psychotherapy research. Though, this process are facing crucial challenges critical to their history, the problems will definitely reduce if clinicians and researchers embraced empirically treatment validity and work toward attaining clinical significance change in their dealing. The review of literature consistently and repeatedly shows the need for clients and therapist to attain the normal level of functioning likes their counterparts at the end of treatment (Jacobson et al., 1999; Jacobson & Truax, 1991; Westen, Novotny, & Thompson-Brenner, 2005), and that the return to normal functioning should be used to define the clinical significance. This and other evidence shows why the debate on clinical significant moved beyond infrequent reference by a group of clairvoyant observers (e.g., Meyer et al., 2001) to a sprightly subject for argument and examination (Riddle et al., 2002). Based on this, this review is consistent with and brings up to date those of other reviews on clinical significant change in therapeutic assessment.

Also, research on therapeutic intervention in treatment planning has gone a long way to offers evidence that

support its clinical significance to treatment plan. This did not come out of the blue but was part of the debate for a more effective and clinically supported therapeutic change in clinical practice. Though the proponent of clinical significance of therapeutic approach have long canvasing it's importance to treatment outcome, nonetheless there are still preponderance of assumptions based on minor numerical effects of little practical meaning and inclination toward over construing group variances that are not beneficial to clients, but yet used by scientists to check their a priori hypotheses. Clients enter therapy with the belief of getting better, and not just to have a statistically reliable improvement. Thus, until clinicians and researchers are ready to advice their clients and society on their inability to return clients to normal functioning, this will continue to strike us as a sensible standard to yarn for.

One of the intent of this paper was to provide an overview on the clinical significance of therapeutic approaches to treatment planning. This is important particularly, for readers who have not been open to therapeutic procedure or those who have not heard it presented by a contemporary practitioner who used them for clinical practice. Another reason was to show the considerable empirical support that validates the clinical significance of therapeutic approach to treatment outcomes. In the course of writing this paper, I could not help being bump by a number of ironies. One of this is that most scholars and practitioners who dismissed therapeutic approaches to psychological assessment in passionate tones; often do so in the name of science. Some champion a science of psychology based wholly in the experimental process, but forget the fact that the same experimental process produces results that support both the therapeutic ideas (e.g., Westen, 1998) and treatments. In light of the rise in empirical findings, blanket statements that therapeutic approaches lack scientific backing and cannot be clinically significant to treatment (e.g., Barlow & Durand, 2005; Crews, 1996; Kihlstrom, 1999) are no longer defensible.

Secondly, it is also worth mentioning that relatively few clinicians are familiar with the research reviewed in this paper, particularly on the efficacy of therapeutic approach to treatment plans. Many clinical professionals and educators appear ill-prepared to react to challenge on clinical significant change from evidence-oriented contemporaries, students, and policymakers, despite the amassing of superior empirical evidence supporting the significance of therapeutic approach to treatment. Just as anti – assessment feeling may have obstructed spreading of the idea in academic environments, distrusted of theoretical research methods may have hindered is dissemination to psychotherapy groups (see Bornstein, 2001). Though such behaviour is now changing, nevertheless, this can only be gradual.

Lastly, scholars and academicians also shared the blame for the poor state and the use of therapeutic approaches to treatment (Shedler, 2006b). Many researchers take for granted that clinicians are the intended users of clinical research (e.g., Task Force on Promotion and Dissemination of Psychological Procedures, 1995), but many of the psychoanalysis outcome studies and meta-analyses reviewed in this paper are obviously not carved for practitioners. If clinicians are indeed the intended "users" of therapeutic assessment, then research on psychological assessment, particularly, on clinical significant change must be user friendly (Westen, Novotny, & Thompson-Brenner, 2005).

Conclusion

The strength of therapeutic approach to treatment is that it measured change in individual client level. In fact, some of these literatures specifically mentioned and pointed towards its long-term survival in clinical practice. Surprisingly, one of the empirical challenges in attaining significant change in therapeutic assessment is how to isolate and control variables as most therapeutic approaches used multiple methods, and this makes it hard to decide what change emanated from a particular components. This is true when considered a severe mental health service for a child and family system that used holistic and ecological approach. However, there were empirical researches that emphasised the components of treatment that are likely to be more effective than when the component is missing. Therefore, clinical psychologists should endeavour to accustom themselves with the principle and practice of clinical significant change in therapeutic assessment, as this is relevant for gauging treatment outcomes in clinical practice.

To sum up this review, therapeutic assessment is a strategy for improving treatment (e.g., Finn, 2007). and it helped clinical professionals to achieve constructive and clinical significant change in clients (e.g., Finn, 2007). Methods such as the SWAP are relevant to treatment plans and can be integrated in future research as a process for gauging the clinical significance change in therapeutic assessment. Though methodological boundaries prevent drawing causal conclusions from the reviewed studies, nevertheless, it proposed that therapeutic assessment is not only used to ease symptoms but also advance inherent capacities and resources that allow clients to reach clinical significant change or optimal treatment condition. Whether or not all clinician use therapeutic approach during treatment or researchers studies them, it is clearly an intervention process that support people desired positive change and outcomes in their life. Perhaps this is why psychologist, irrespective of their own theoretical orientations, tends to choose the method for assessment in clinical practice (Norcross, 2005).

Recommendation and Future direction

Therefore, the future research should focus on the clinical significance of therapeutic approach to treatment plans, particularly, on client's characteristics, treatment selection and outcomes. Based on this, the following recommendations were suggested:

1. Future research on psychological assessment should focus on information regarding clients and therapist demography and be more consumers relevant.

2. Psychology professional body should embraced professional development training that focus on therapeutic models. This will go a long way to effect client change and improve treatment processes.
3. Policy makers should re-examine and embrace proficiency standards and guidelines for psychological assessment practice that focus on basic features of therapeutic models.
4. Clinical psychologist should identify successful models of treatment decision making in light of patient preferences.
5. Lastly, efforts should be channelled towards enabling training on ethics, proficiency and evidence based practice in therapeutic assessment. This will go a long way to rectify the undesirable attitudes about psychological assessment in clinical practice.

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