

Clinical significance: A Therapeutic Approach to Psychological Assessment in Treatment Planning

Olusegun Emmanuel Afolabi

Department of Educational Foundation, University of Botswana, Botswana

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) given a strong basis for the usage of therapeutic approach to psychological assessment in treatment plans, 2) explained the conceptual meaning of clinical significant change, 3) answered some of the questions regarding the clinical significance and practicability of therapeutic approach to psychological assessment, particularly during or before treatment, 4) linked therapeutic assessment to change in clients' clinical impression, functioning and therapeutic needs, 5) used initial theory to explain the therapeutic mechanisms of psychological assessment in clinical practice, 6) analysed the empirical studies that addressed and linked empirically supported therapeutic assessment with clinical significant changes in clients. 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.

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Introduction

Psychological assessment is to some degree of a crossroads. Though, research suggests psychological assessment should move from psychometrics and scale development to pragmatic assessment (Haynes, Nelson, & Jarrett, 1987; Meyer et al., 2001), raising the issue among psychologists reliably reveals robust and conflicting opinions. Despite the fact that psychological assessment covers a nontrivial part of clinical activities (Norcross, Karpiak, & Santoro, 2005), the drops in graduate training in assessment (e.g., Belter & Piotrowski, 2001; Curry & Hanson, 2010) and changed compensation from managed mental health care (e.g., Eisman et al., 2000) have incontestably influenced its usage in clinical psychology. Despite this challenges, the idea of using the traditional method of assessment for treatment evaluation was limited in two respects. Firstly, psychological assessments offered no information on the inconsistency in client's response to treatment, despite the relevance of the information regarding within-treatment variability of outcome. Secondly, the psychological effect of assessment has less significant influence on clinical outcome.

Even though much has been done in the past to promote therapeutic approach to psychological assessment, their outcomes are yet to be proved and analysed systematically (Finn & Martin, 1997; Finn, Fischer, & Handler, 2012). The clinical significance of

therapeutic assessment refers to its proficiency to attain the values of competence set by clients, clinicians, and scholars. While there was little agreement about the standards, the available research confirmed many propositions on the issue. Some of the proposed standard includes: a high proportion of clients improving; a level of adjustment that is identifiable by peers and significant others (Wolf, 1978); removal of the current problem (Kazdin & Wilson, 1978); normative levels of effectiveness by the end of therapy (Kendall & Norton-Ford, 1982; Nietzel & Trull, 1988); or changes that meaningfully lessen the risk from other health problems to mention a few.

Additionally, therapeutic assessment lacked clarity utility value and incremental validity and this contributed to dearth of acceptance in clinical practice (Acklin, 1996; Eisman, et al., 1998). The shifts in psychological assessment toward envision and collective oriented therapy blown a new life into the debate surrounding the clinical significance in psychological assessment. The measures and models coming from this paradigm shift were categorized as therapeutic assessment (Finn, Fischer, & Handler, 2012) and were shared and documented by various scholars (e.g., Finn & Tonsager, 1997; Meyer et al., 2001) as a broad case conceptualization that prompts therapeutic change in treatment outcome. However, despite the variability of response to treatment,

clinicians still found it hard to conclude whether a change in clients' condition was attributed to assessment or not (Jacobson, Follette, & Revenstorf, 1984).

Hollon (1998) gave a better analyses of this situation by 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, if the therapeutic efficacy is only supported by single evidence, the assessment is thought-out as possibly efficacious, pending replication. These concerns echoed the reflection of the question "What does clinician mean when they talk about change as clinically significant?" The answers to which the problem is focussed 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 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) a strong basis for the usage of therapeutic approach to psychological assessment in treatment plans, 2) examined the conceptual meaning of clinical significance change in therapeutic assessment, 3) used initial theory to explain the therapeutic mechanisms of psychological assessment, and analysed the common deficiency identified in treatment validity. Lastly, gathered an empirical evidence to supports the effectiveness of therapeutic assessment in clinical practice.

Methodology

This paper analysed and reviewed empirical literature that highlights the complexities, practicability and acceptability of therapeutic approach to psychological assessment in treatment planning. The study collated and reviewed relevant articles, books, journals, and meta-analysis on

therapeutic approach to psychological assessment. Both the ERIC and PSYCHLIT databases were searched using the following key words: psychological assessment, clinical significant change, treatment planning, therapeutic approach, and clinical psychology. 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 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 therapeutic approach to psychological assessment in clinical practice. To verify references, manual searches of relevant journals and articles related to the paper are performed.

Historical Perspectives and Theoretical basis for Therapeutic 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. The method also influenced by the work of Harry Stack Sullivan, Connie Fischer, and Richard Dana. Historically, therapeutic intervention was linked to the work of the humanistic crusade of the 1950s and 1960s. Though, many humanistic oriented clinicians (May, 1958; 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.

Similarly, 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; Fischer, 1972). However, of most interest 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). Yet, despite this criticism, therapeutic assessment still covers the following areas (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). Yet, the question is, thus this approach really therapeutic enough to bring appropriate change in client 'condition. So far, this continues to face empirical test and till now, no agreement was made on the issue.

Conversely, the lack of uniformity in the ethical guiding principle in the 1990s allowed professionals to share the outcome of the assessment with clients except on few notable exceptions (e.g., forensic evaluations; American Psychological Association, 2002; Curry & Hanson, in press; Smith, Wiggins, & Gorske, 2007). This adjustments set up major changes paradigm-wise in assessment-related behaviour and research foci. This historical development ushered in different types of therapeutic models that continue to influence treatment in mental health services (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Callahan, Price, & Hilsenroth, 2003; Finn, 2007; Gorske & Smith, 2008; Riddle et al., 2002; Tharinger, Finn, Wilkinson, & Schaber, 2007; Wygant & Fleming, 2008).

Initial Theory on Therapeutic Mechanisms 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 the particular assessment tools that bring about therapeutic change in treatment. This thought prompted two caveats in treatment of mental health disorders. Firstly, it was stated that the mechanisms for change are not functioning in all psychological assessments. That is, the mechanism for change was only appropriate for a collective approach in psychological assessment (Finn & Tonsager, 2002) and 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 other effective psychotherapies. Besides, the theory also sees clients' self-verification as an important tool for an effective therapeutic assessment. The theory postulated that clients who are ready and willing to partake in psychological assessment are expected feedbacks and proof that sees their opinion about self and that of the people around them as corrected or approved by others. This motive is refers to as a self-verification. According to the theory, it is severe when clients had an experience that tested their schemas or that of people around them. i.e., a partner or acquaintance

given a client a feedback that was extremely opposite of their self-thought.

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 which often revealed during the start of the assessment. For instance, a client might ask 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 their energy level, or that depression affects people ability to complete their basic daily chores. Such explanations helped clients to develop positive change and view about their behaviour. It also helped client to improve the negative ways they interpret things. This increased clients 'self-esteem and promotes shared assessments (Newman & Greenway, 1997).

Thirdly, the ego psychologist (e.g., Freud, 1936; Hartmann, 1958) 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 designed 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 for them as they helped clients to develop the ability to talk about their personal life experiences (e.g., "I'm not an indolent person, I'm unhappy"), to understand the links with people around them (e.g., "Some of my friends I hang out with are experiencing. This was obvious in the work conducted by Corsini (1984). Through new information ("^tbu have a high IQ"), Corsini provided the basis for clients to mix and made common sense from a number of apparently dissimilar incidences, i.e., from the song he enjoyed to why he shined at acrostic puzzles. depression."), 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.'"). These aforementioned

helped clients to solve the need for mastery and control over the environs.

Conceptual Meaning of Clinically Significant Change in Treatment planning

The extent or degree of change is the most remarkable characteristic of the meaning of clinical significance. Earlier research on the concept points toward a rather large, dependable change in symptoms and coming back to normative levels as primary manifestations of clinical significance. Clinical significance in a normal sense is referred to as getting back to normal functioning. Though many contradictory claims had been made regarding the relation of the volume of change and clinical significance, nevertheless, the issue is still open for debate. Specifically, clinically significant change occurs when there is a big change in symptoms, an average change in symptoms, and no change in symptoms.

The idea that any volume of change might be clinically significant is not casuistry but rather expresses that clinical significance can and does mean many things, and these differ based on the kind of problems and the objectives of treatment. Though, this might be opposite in some illnesses and may be too plain a criterion, it is founded on the postulation that clients came for treatment with a belief to better 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 frequent can a client attain normal functioning after treatment. However, there is another thought to this: The degree of change for a given client must be statistically dependable, that is, it must get beyond the level of what could be sensibly ascribed to a mere chance or measurement error. The final outcome is 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 client's show a sign that is statistically reliable but the treatment outcome to a certain degree is dysfunctional, then the client is considered as "better but not recuperated." However, if a client is finally found in the functional range at the end of the treatment, but the extent of adjustment is not statistically dependable, then the process cannot define whether or not the variation reported in treatment outcome is clinically significant.

Lastly, if the degree of change is statistically consistent and the client found himself within usual limits on the variable of interest, the client can be adjudged to have "recovered." This metric offers clinicians the opportunity to know how often

statistically significant decline can occur in treatment by recognized clients who displayed a statistically dependable change in the opposed direction to that suggestive of improvement.

The clinical significance of therapeutic approach to treatment

The meaning of recent measures of clinical significance is not completely faultless, in part because there has been little evidence of the measures. The reason for the scarcity of empirical studies on the concept may be as a result of the fact that the measures are not really new. In fact, the belief in some quarters is that the approach lacks empirical support and that scientific evidence on the subject showed its ineffectiveness to treatment. This opinion seems to have taken on a life of its own, as scholars echoed it to one another, as do 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 says a different story: Significant study backs the effectiveness and efficiency of clinical significant change in therapeutic assessment. The inconsistency between the insights and proof was due, in part, to preconceived notions in the spreading of research findings. Another possible reason for this bias is the lingering dislike by mental health professionals for its emergence as alternative to traditional method of assessment. But, when empirical findings emerged that supported the significance of therapeutic assessment to treatment, many scholars and practitioners greeted them enthusiastically and were excited to debate and publicize them.

The 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. Much has been said and written about its significance to treatment; some of the used terms such as *empirically validated*, *empirically supported*, and *empirically evaluated* are still contestable in psychological research. For example, *the* first connotation means 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 psychological therapies were not produce thorough success (Kendall, 1989). Moreover, this method of assessment is not resolved even if a number of studies offered supportive proof on it. The second expression means that a treatment has been supported, with the condition that the backing comes from a suitable empirical study. The third idiom indicates that treatments are empirically evaluated, that is they have

been empirically sustained; however, this is not unambiguous.

In addition, clinician also faced the problem of identifying whether a treatment have a significant impact on their clients 'condition. For example, assessing a clinical significant change in treatment outcome is based on symptoms of psychopathology, and increasingly complex statistical methods are employed to decide whether a change occurred or not. Even with the identification of the clinical significant change in outcome, 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. However, such questions focused more on clinical rather than statistical significance (Ogles, Lunnen, & Bonesteel, 2001).

Furthermore, a body of knowledge also used different methods to analyse and measure the clinical significant change in therapeutic assessment; among this are 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, Follette, & Revenstorf, 1984; Jacobson & Truax, 1991). However, out of all these categorizations, the Jacobson et al. process was the most commonly accepted method of measuring clinical significance in therapeutic assessment. In addition to this, 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. However, what makes Jacobson and Truax (1991) taxonomy more exceptional was its ability to combine data on individual's pre- to post-therapy functioning on an outcome measure with normative evidence.

On the other hand, another way of hypothesizing this development is to look at the clients coming for treatment as part of a dysfunctional population and those who have completed as not part of that population anymore. This were 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 places that 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. That is the definition was founded on a probability that scores would end in

dysfunctional versus functional population distributions. The 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.

However, some humanistic school argued against clinical significance of therapeutic assessment by opposed and labelled the involvement of clients in the test feedback as injurious (Klopfer, 1954). In spite of their opinions, therapeutic assessment remained a humanistic endeavour that helped clients to adjust to normal functioning (Fischer, 1972; Sugerma, 1978). Also important to therapeutic assessment is the ethical documents of the American Psychological Association (APA, 1990) and work of Pope (1992) which mandated the assessors to always involved clients in treatment process. According to the American Psychological Association (1990), the more the professionals shared information with clients, the better the clients gain from the experience and achieve therapeutic change in outcome. This mean that sharing feedback with clients helped them to form therapeutic interaction, achieve clinical significant change (e.g., Allen, 1981), setting objectives for clinicians (De La Cour, 1986), and change and invigorates "bogged down" treatment (e.g., Cooper & Witenberg, 1985).

To sum it up, a large number of benefits were reported to have come from involvement of clients in therapeutic assessment. Some of this advantage includes: rising in self-esteem, curtailment client isolation, increase clients hope, reduce symptomatology, increase client's self-awareness and thoughtfulness, and increase client's drive for mental health treatment (Finn & Butcher, 1991) to mention a few. In addition to that, sharing the test results with clients is their fundamental rights to professional records (Brodsky, 1972). Therefore, to achieve a clinical significant change in therapeutic assessment, clinicians must be broader in their emphasis and thoughtfulness, and also ready to embraced actions that focus on the client-assessor association, background of the assessed problems, and the psychologist' counter transference.

Empirical Evidence that Support Therapeutic Model of Assessment in Treatment Planning

Evaluating the effectiveness and clinical significance of treatment can be done by the combination of objective empirical data and qualitative observational data. Thus, clinicians should identify the strengths and feebleness of therapeutic interventions by using the art of science and not just a "gut feeling." That is the beginning of any effective therapy, particularly; the treatment philosophical

orientation must be created on empirical science. Though, the clinical philosophy that guides therapeutic assessment in clinical practice was complex as well as comprehensive, clinician are expected to provide objective evaluations of treatment effects. This is very essential because it is their responsibility to impact positively on the physical, intellectual and spiritual well-being of their clients as well as enhancing their health and development in the mind, body and spirit.

Apart from this, empirical evaluations of treatment are essentially important because it offers the measurements of treatment outcome that are independent of the therapist's opinions. Moreover, the main objection to this notion came from the clinicians themselves. Most of the clinicians were of the opinion that "data" are not required to tell them what works; they "know" and that the treatments offered are based on their professional knowledge. 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). However, for an empirically supported psychological assessment, evidence should be resulting from the research clinics in addition to the initiator of the treatment.

Furthermore, a cursory scanning of the literature on psychological assessment revealed little on its therapeutic values. Empirically supported therapeutic assessment is referred to as treatments that had been exposed to assessment using the accepted methods of psychological science. This means that the therapy has been supported with the condition that the support comes from an acceptable empirical study. That is, the evidence in question is empirical in nature. However, it is astounding to know that limited organized empirical studies were carried out on the subject. Besides, 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 groups. This means 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) looked at the impacts of therapeutic assessment on 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 decline 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 as 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 was due to psychodynamic therapy.

Similarly, a meta-analysis examined the effectiveness of both the psychodynamic psychotherapy (14 studies) and CBT (11 studies) for personality disorders (Leichsenring & Leibling, 2003) reported in the *American Journal of Psychiatry* found that the mean length of treatment and the mean follow-up period between pre-treatment to posttreatment demonstrated effectiveness of therapeutic assessment. 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 of the significance of therapeutic approach to treatment in clinical practice.

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 shows that clients who were given feedback were considerably more contented with assessments than those without any feedback. In fact, among the clients that received feedback, 40% of them showed signs of dissatisfaction with the assessments process 0% compared to 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 and clinically significant to them getting a positive value from the psychological assessment.

Additionally, Shedler–Westen Assessment Procedure (SWAP; Shedler & Westen, 2007; Westen & Shedler, 1999a, 1999b) was used to assess the clinical significance of therapeutic approach in treatment. The methods sustained the clinical significance of therapeutic assessment by established the inner capacities and resources that evolved from therapeutic assessment. Moreover, as a clinician-report, 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, 1999b).

Though, not much has been done on outcome studies that measure changes in inner capacities and resources, the two research works on the issue raised a fascinating promises and suggested ways for future research clinical significant 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.

To conclude, much as been said about the significant of therapeutic assessment, only few studies reported its importance to treatment. For example, the study conducted by Whiston, Brecheisen, and Stephens (2003) found that limited empirical studies were to the clinical significant change in therapeutic assessment. While, some empirical analyses on psychological assessment were published (cf. Meyer et al., 2001; Whiston, Sexton, & Lasoff, 1998), most of them are less theoretical or descriptive oriented (Claiborn, Goodyear, & Horner, 2001; Finn & Tonsager, 1997; Riddle et al., 2002; Tinsley & Chu, 1999). Therefore, there is a need for a therapeutic assessment that generates constructing and significant impact on treatment than the medical tests (Meyer et al., 2001).

Discussion

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, distrust of theoretical research methods may have hindered its 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 debate about attaining clinical significance change in therapeutic assessment continues to take a centre stage in psychotherapy research. Though, theoretical approach to psychological assessment are facing crucial challenges critical to their history, these problems will definitely reduce if clinicians and researchers embraced empirically treatment validity and work toward attaining clinical significance change in their dealing. There is no doubt that recent debate on the issue has 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). Therefore, the conclusions of this review are consistent with and bring up to date those of other reviews on clinical significant change in therapeutic assessment.

Surprisingly, one of the empirical challenges in attaining significant change in therapeutic assessment is how to isolate and control variables. Many of the 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.

In addition to the body of research confirming therapeutic model as clinically significant to clients’ treatment (e.g., Finn, 2007), some of the literatures on the subject specifically mentioned and pointed towards its long-term survival in clinical practice.. Overall, it was found that clients who received therapeutic treatment were statistically improved (treatment effect size of .8 or approximately 80% get better) in clinical symptoms compared to those with no treatment irrespective of the approach (Grossman & Hughes, 1992; Kazdin et al. 1990; Shadish et al. 1993; Weisz et al. 1995).

According to the findings, therapeutic assessment improved treatment, and helped clinical professionals to achieved constructive and clinical significant change. To sum up, methods such as the SWAP could be integrated in future research to gauge the clinical significance change in therapeutic assessment. Though methodological boundaries prevent drawing causal conclusions from the reviewed studies, 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 clinical significant change to measure therapeutic outcomes 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

Research on clinical significance of therapeutic intervention in treatment planning is particularly important. In fact, the subject has a long way to go to provide evidence that support therapeutic effect on treatment. This idea did not come out of the blue but was part of the debate for a more effective and clinically means of documenting therapeutic outcome (Kendall & Norton-Ford, 1982). Though the proponent of clinical significance have long canvassing its importance to treatment outcome, nonetheless there are still preponderance of assumptions based on minor numerical effects of little practical meaning and an 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. Therefore, the future research should focus on the usage of clinical significant change as a criteria for measure the effectiveness of therapeutic approach to treatment, 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 consumer relevant.

2. Psychology professional body should embraced professional development training that focus on therapeutic models. This will go a long way to effect client policy 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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