The power of the therapeutic relationship: Bringing balance to evidence-based practice

Grant Thomas

Grant Thomas works as a Psychiatric Social Worker for the Community Mental Health Service in Palmerston North. He works as a keyworker and specialises in psychotherapy.

Abstract

The inspiration for the article comes from working with a woman for 2.5 years, who was diagnosed with Borderline Personality Disorder. Over the period, structured therapy and a skills approach had been utilised but had not been particularly successful. As we explored the last 2.5 years' work it became increasingly obvious something had brought change. I became interested in the idea of what that something was. Exploring this during supervision sessions it appeared to be related to the power of the therapeutic relationship and the relational tools used at the time out of necessity.

Introduction

The main purpose of this article is to suggest that a better balance is needed between the therapeutic relationship factors and those factors that enjoy empirically supported research in what is in a broad sense termed evidence-based practice. It is suggested that the therapeutic relationship factors are difficult to develop into constructs and even more difficult to measure and have thus remained relatively unacknowledged from an evidence-based perspective. A concern is that over time a subtle shift in emphasis as regards the importance of those components that are easily measurable has occurred. Yet if we view meta-analytic studies of outcome research over the past five decades we understand that therapeutic relationship factors actually account for as much as 75% of success in therapy while models and techniques used account for 25% of success in therapy.

The position taken in this article challenges the current emphasis in treatment toward those factors that are more easily measurable. It is suggested that a greater emphasis on the power of the therapeutic relationship in the practical field of therapy is needed. It is believed this would bring an improved balance to evidence-based practice and thus contribute toward providing greater overall efficacy to therapy and an improved outcome for clients.

The therapeutic relationship is introduced, reflecting first on what is needed within that relationship and then on what may go wrong from both an agency and client perspective. A

process within the framework of therapy is next discussed before introducing what may be 'surfaced' and then the relational tools that may assist surfacing those things are discussed. Finally, a case study is examined in order to put the ideas together in practical terms.

The therapeutic relationship

Evidence-based practice is that which is empirically supported by research. The therapeutic relationship is viewed here as that part which may be termed the more silent or invisible component of what is in broad terms called evidence-based practice.

As discussed in the introduction the relationship factors are difficult to develop into constructs and often prove difficult to measure so that they have remained relatively unacknowledged from an evidence-based perspective.

Beyond difficulties with measurement there is a further problem. Even if one were to gain evidence for many of the relational constructs, every client is an individual and what may in simple terms be protective for one person may not be for another. Thus the dynamics within the therapeutic relationship can never be the same. The principle of 'coming from where the client is' becomes paramount.

Two useful concepts assist in providing a foundation for the power of the therapeutic relationship. They are 'self evident principles' and 'disparity'. Self evident principles (Covey, 2005) are similar to life laws. They are timeless and do not change. They also have universal meaning, they transcend culture and are embodied in all major world religions and enduring philosophies. Being trustworthy, consistent, understanding, respectful, patient, kind, accepting and honest are some.

Disparity (Briere, 2002) is a technical term for the absence of things that could reinforce negative conditioned emotional responses, for example the absence of criticism, judgment or absence of expectations of rejection or abandonment. It is also the provision and presence of the opposite, for example the provision of attention, warmth, empathy, understanding, listening and strength, direction and guidance from another. The therapeutic relationship must also have credibility and is influenced by such characteristics as reliability, dependability, predictability and consistency (Linehan, 1993).

The provision of disparity provides one way of counter-conditioning. Covey (2005) suggests that people need to turn 'love' and 'trust' into verbs as a further way of counter- conditioning. Trust becomes a verb when you communicate to others their worth and potential so clearly that they are inspired to see it in themselves. Love (in its many forms) becomes a verb in the same way. It is something you do, protecting, trusting, believing, persevering, hoping in another, and providing opportunity and encouragement.

Meta-analytic studies of outcome research over the past five decades show it is the relationship of the therapist and client in combination with the resources of the client that account for at least 75% of success in therapy, (Asay & Lambert, 1999; Duncan, Miller & Sparks 2004 and Wampold 2001, cited Drury, 2006: 178). Duncan, Miller & Sparks (2004) view four aspects of the therapeutic relationship. Their viewpoint understands the client and the resources they bring as the most potent contributor to successful outcomes and accounting

for 40% of total contribution. Relationship factors (alliance and partnership) account for a further 30% contribution. Placebo, the knowledge of being helped and client perceptions of the therapist's credibility as regards rationale, all bring a sense of hopeful expectation and account for a further 15% contribution, while model and technique account for 15% of total contribution. According to this viewpoint 85% of success in therapy is accounted for by what the client brings to therapy, coupled with major therapeutic aspects other than the model and techniques used. Frank (cited in Niolan 12/99) has argued that the relationship is the most important part of therapy stating it is through the relationship that the therapist provides the critical elements of therapy. In fact some would argue that all therapy gains its effectiveness through the relationship (Strupp, 1992, cited Niolan 12/99). While speaking at the Brain Wave Seminars in New Zealand in 2005, Dr Bruce Perry, child psychologist and current senior consultant to the Ministry of Children's service in Alberta Canada argued that 'Relationship is the greatest therapy'.

It has become fashionable to place an emphasis on locating professional accountability in adherence to the medical equation of 'diagnosis + empirically validated treatment = cure' (Drury, 2006, p184). The position taken in this article challenges that emphasis and suggests a greater focus on the therapeutic relationship, that relatively silent partner in what is called evidence-based practice. If we take note of the outcome study percentages discussed it would appear there is a need to bring balance to evidence-based practice by acknowledging and paying more attention to the therapeutic relationship part within the context of the broader therapy.

What is needed within the therapeutic relationship

While the emphasis in this section is towards what the therapist brings it also includes those things that form the dynamic between the client and the therapist and thus constitute the complete therapeutic relationship. However the list is by no means exhaustive.

The therapist needs to have done their own self work. Understanding one's personal values, standards and preferences and how these relate to the overall goals of therapy is important. As well, understanding one's stress triggers and one's own style of managing stress are important. Lastly understanding how the above factors 'fit' with the client's own system is important.

Deep emotional engagement is necessary for one to know at a deep level what another needs and this is at the heart of what the therapist brings to the therapeutic relationship. Empathy best describes this. Covey (1990) suggests empathic listening is listening to get inside another person's frame of reference. Understanding how they see the world and how they feel, the therapist is then able to deal with the reality inside the client's mind and heart. Understanding the other at a deep level is also a catalyst for the development of a trusting relationship. To be trusted one first must be trustworthy. Trust is a feeling that grows from experiencing another as understanding, dependable and trustworthy.

The therapist needs to be a good model. Modelling the non-specific factors of effective therapy identified by Rogers (1951), warmth, genuiness, non judgmental attitude as well as empathy assist to create an environment that is accepting and safe and in which the client can form an emotional bond with the therapist (Young, Klosko & Weishaar 2003). Linehan,

(1993) also makes the point that if one models validation they may teach the client to validate themselves.

In my experience, patience and perseverance are also important and are at risk of being sidelined by the therapist due to the business of the modern environment and the imperatives of economic agendas. For the client, wanting quick change and not understanding the process of therapy from an internal system perspective and not understanding that slow change is good change are barriers to both patience and perseverance.

Yet for both the therapist and the client, if patience can only be exercised the rewards will be immense. The real catalyst for change only emerges as time does its own work. For the therapist explaining carefully the rationale for slower work and why slow change is good change is valuable.

Flexibility is also a key factor in therapy. Within any system the more flexible it is the more successful it is. Flexibility is a further factor one may model as it is equally important for therapist and client. The therapist needs to be flexible enough in their approach to cater for the widely differing needs of the client, while for the client, a rigid thinking style and inability to work from more than a limited source of information will form a barrier to change.

The 'use of self' utilising a holistic approach is also valuable. Again it is something the therapist can model. If, when engaging with the client the therapist is using all of the self, then they are likely to connect with all dimensions of the other, the body, mind, emotions and spirit. By practising a holistic approach to therapy the therapist brings to the therapeutic relationship the physical, mental/emotional, social and spiritual dimensions of health, wellbeing and healing.

If working with tangata whenua, Durie's (2001) Whare Tapa Wha model adds the further dimension of taha whanau (extended family). In Aotearoa New Zealand, the Whare Tapa Wha model is now a widely accepted cultural model used across a wide variety of settings.

What may go wrong

Firstly an absence of those aspects that were discussed in the previous section would obviously be detrimental to the therapeutic relationship.

Secondly there are some potential aspects within the agency setting itself that are not conducive to the power of the therapeutic relationship.

Lastly for the client some factors typically maintain problems and are in themselves barriers to 'moving on' in therapy thus blocking the power of the therapeutic relationship.

Briefly it is suggested the agency factors are:

- Basic assessments that are often not comprehensive in nature.
- Time limited therapies with a main focus on the medical model.
- Emphasis on treating symptoms rather than a preventative or causal focus.
- Group work or therapy.

- Manualised treatment plans (one size fits all).
- The tendency toward quantitative rather than qualitative measures.

Three factors that typically maintain problems for the client thus acting as a barrier to moving on in therapy are discussed. They are the concept of negative payback, aspects of responsibility and 'rules for living'.

The concept of negative payback suggests that the cost of giving up something is often greater than the benefit of change. What may be considered one of the world's greatest problems, that of competing values, is relevant here. People value the powerful payback or reinforcement from a partially met need, for example getting attention or being loved for a moment through pleasing another, yet at the same time they may really value changing in an adaptive way. However if there is more advantage associated to the old way than the new, change will be resisted and the old way will persist.

Clients tend to either (1) take too much responsibility and believe everything is their fault or (2) take no responsibility and blame others or external factors for everything. Either is a barrier to change and moving on in therapy. With the former the punitive and demanding parental modes (Young, Klosko & Weishaar, 2003) are evident. This is when the client 'parents' their own emotional self in these punishing and demanding ways. With the latter the client simply blames something or someone else, in this way taking no responsibility.

The subtle everyday rules the client lives by are better known as the 'shoulds' or those things that need to happen for the person to be successful or okay. If the mind is very attached to the idea they must happen, however they are not happening, then distress is likely due to the person rating themselves and often everything around them in a negative way. The distress acts as the barrier to moving on thus blocking the power of the therapeutic relationship.

A process

As discussed the therapeutic relationship is viewed as the more silent or invisible part of therapy. It is however the part that provides the foundation for therapy. It includes those aspects discussed in the section 'what is needed within the therapeutic relationship' which as mentioned was not exhaustive. If we study those more silent parts of therapy we can frequently observe a process taking place.

It is acknowledged the process discussed here is the process observed in more complex cases. The process may not always happen in the same way or at the same stage of therapy or with the same intensity and with clients that are not ready to 'move on' or where basic acceptance has been blocked for some reason it may not happen at all.

As deeper emotional engagement within the dynamics of the therapeutic relationship slowly takes place several types of 'surfacing' may be observed. From a process perspective deep psychological pain is again connected with and surfaced to an extent within the client system. Sometimes just the increased awareness or consciousness may provide a catalyst for change while at other times the externalising of this pain through sharing it with another may be the catalyst for change. As well, the more causal or maintaining factors are

surfaced and in the first instance made more evident to the therapist who can then gently share them with the client and assist them in being more aware of them and in being able to observe them. To see one's predicament clearly is a first step in going beyond it. The factors discussed in the previous section are relevant. Also the actual sharing of the person's story frequently surfaces a sense of reality of 'what was' and 'what is', bringing with it a basic level of acceptance regarding present reality.

The different 'surfacings' all individually act as a catalyst for change and then act together as a powerful catalyst for further change and assist in surfacing those things that have lain dormant or latent within the person's being. In the following section we will discuss some of those aspects that may be surfaced.

Where the relational tools come into play is in assisting those latent aspects to be surfaced. They will be discussed following the next section.

What may be surfaced

In this section I discuss key elements in the therapeutic process which may be surfaced. These are: vision; beliefs; perceptions; valued things; courage, passion and enthusiasm; and hope, trust and integrity for the self.

Vision. Many clients adapt to living day by day as a way of protecting themselves from failure in the future. Yet vision is essential. For the client vision acts as both an anchor and a magnet and releases hope. It anchors a person to a specific idea and at the same time draws them towards it. Vision is also relatively painless. The pain if any is in the journey or short-term goal required to get to the vision. Vision agrees with Covey's (1991) principle 'begin with the end in mind'. In the case study the surfacing of vision played a major role.

Belief. Harrold (2006) states both fate and destiny exist within one's belief system. Here we are hoping to surface destiny and other positive beliefs that will give the client wings to fly again. Structured therapy may be further planned to address cognitive limitations if necessary. Linked to belief is hope.

Hope. Hope is related to the concept of hopeful expectation. I read somewhere once that we need hope the day we are born, the day we die and every day in between. It appears to surface slowly over the course of therapy and I believe that it plays a role in every aspect of therapy.

Perception. Perception is often associated with major paradigms in thinking, for example win/lose thinking. Similar to rigid internalised beliefs perceptions are often totally accepted as 'the way' and are not readily negotiable. They are more what someone 'sees' than what they believe. The 'bad has happened so I am bad' discussed in the later case study is another example. Here we hope to surface perceptions that are creative in nature and that will assist in creating new experience and in bringing positive change to the client's life.

Valued things. Valued things have a means and an end (Robbins 1992). In simple terms the means needs to always reconcile with the end which is the desired emotion, for example enjoyment. As can be imagined this is not necessarily common practice. Competing values,

previously discussed are the relevant factor. If a life value is getting one's own way or perhaps retail therapy then the means may not reconcile with a happy emotion (the end). Here we are not only trying to surface the person's most valued things but also ensure they reconcile to the most valued emotion. Using an acknowledged value hierarchy is also useful.

Courage, passion and enthusiasm. These are the real motivators for the client. Once new goals are able to be set enthusiasm especially is necessary to maintain momentum. It appears they frequently surface later in therapy. They cannot be demanded and it can only be hoped that they surface as part of the therapeutic process. The basic N.L.P. skills discussed in the case study were particularly useful in surfacing them.

Trust and integrity for the self. Trust is a fragile thing and is commonly lost when people have traumatic histories or are unwell. Trust in the self is related to belief and both are related to integrity for the self. Trusting in the self generally comes before trusting others. For the client, being able to first trust in themselves will assist with the trust that is essential within the therapeutic relationship. However, trust always involves a two-way dynamic. If trust is modeled and trustworthiness is exhibited then trust within the dynamic of the relationship is more easily attainable. Trust is a foundational aspect and provides a solid base for the client and therapist to work from.

The relational tools the therapist may use

Included here is a range of therapeutic tools that I believe are relational in nature. Some would be considered to have partial empirical support as they are derived from evidence-based therapies. Some are self evident in nature.

The purpose of relational tools is to provide assistance to that more silent part of therapy, the therapeutic relationship. They are used in conjunction with the therapeutic relationship to assist in surfacing and releasing those aspects discussed in the previous section. They may be used in two ways as an adjunct to therapy. Firstly they may be used in the early stages of therapy to provide the early motivation and secondly they may be used in later stages of therapy to keep it alive and moving on particularly when the therapy may have stalled for some reason.

Validation. Validation and affirming the person are critical elements. Understanding the client at a deep level and affirming their experience and feelings are important. Acknowledging and honoring the specialness and sacred quality of the client's story and thanking them for sharing it is particularly validating for a client from my experience. Kiwi Tamasese's (1994) ideas of the therapeutic conversation being a sacred encounter, the story being a gift and having a spiritual quality resonate here (Waldegrave & Tamasese 1994).

Enquiring conversations. Enquiring conversations do not demand outcomes. Rather they are about exploration and discovery, about making that which is invisible, visible. The conversation provides a therapeutic framework, however it is for the client to make the meaningful links, to know something new from within.

Questions. Questions, as discussed by Robbins (1992) may also form part of our conversations with clients. Questions not only lend new ideas but change a person's focus and in

doing so they change a person's emotional state. Robbins (ibid) suggests 'could' questions. When framed in the right way they can be both empowering and enabling, for example 'what could you do in the moment to help yourself emotionally' or 'what could you do to have fun today?'. It is believed the brain will always find an answer for what we ask so many new distinctions or reference points can be found. 'Could' questions also leave a person free to choose. From a strength based perspective they also tap into the resources of the person themselves. It is believed that successful people merely ask better and more questions.

Reframes. Simply speaking, reframing gives new representations about something that puts the person in a state that causes then to feel or act differently. Reframing is finding the most useful frame for any experience so it turns something that is working against you into something that is working for you. Harrold (2006, p54) introduces a useful exercise called 'use your advantage'. In practice one's 'advantage' is concealed in disappointment and regret. The exercise enables one to spot the 'advantage' in past experience and then put it to good use for one's own personal refinement and happiness. A similar exercise is called 'what's the mistake; what's the discovery'. Here you need a mistake to make a discovery. The use of simple four-part contrasting pie charts can assist this exercise. By acknowledging the 'mistakes' on one pie chart 'discoveries' can then be mapped on the contrasting pie chart.

Use of contrasting pie charts. These may also be used in taking the client from a negative position to a positive one, from an old idea to a new one, from avoid to approach or similar. Similar to questions, the change in focus changes the emotional state. Firstly the 'old' ideas are acknowledged on the left-hand chart then by changing focus a number of opposite ideas are put on the right-hand chart. A key idea is then developed. The key idea can be termed a positive anchor and further ideas are then fashioned to nurture it. The positive anchor can be further developed by using the strategies discussed next. They are being very specific, using graphic imagery, and using repetition.

Use of basic N.L.P. strategies. These strategies technically form part of what is known as Neuro-Linguistic Programming (N.L.P.), however the few I have adapted for use are better recognised as the common strategies that all high powered advertising seen on our television sets utilise (Robbins, 1989). As above they are being very specific, using graphic imagery and imagination, followed by repetition. These strategies are further expounded in the case study where they were particularly useful in developing vision and in keeping it 'alive'.

The first step is in getting very specific about a certain idea, then using the imagination to create graphic imagery, particularly in regards to detail about the context, the person being there and part of it in the future. Repetition is then used to keep it foremost in the person's mind. Homework exercises are useful in this regard.

The brain is particularly responsive to the use of sensory modes, particularly in what is seen, felt and heard regarding a future positive context. This responsiveness is probably better understood regarding past negative experience, trauma being a good example.

Perception exercises. For bigger perception or paradigm shifts the well known old women/young women perception exercises provide a powerful tool for change. The imagery of the three pictures, first the old women, second the young women and third both in the same picture (cited Covey, 1990) lends something special of its own. The client firstly sees their old

self represented in a singular way in one of the first pictures and a contrasting self existing in the other. Secondly they see a new self as being able to exist within the old self as both forms are revealed together in the third picture. This new perception provides a powerful catalyst for change. The case study provides an example. Unlike N.L.P. strategies they can be effectively used once but not in a repetitive way.

Externalisation. The idea of externalisation is for the client to understand they are neither their conditions nor their behaviours. Froggatt (1993) suggests people should rate their behaviours not themselves. The common idea of 'bad has happened so I am bad' leads people to not differentiate themselves from their conditions. Integrity for the self is the goal.

I use the story of the daffodil to illustrate. The daffodil was 'born' with a wonderful blueprint, it had the potential to be a beautiful flower with beautiful blooms but alas along came the wind, the rain, the dog, the workmen with the big boots who all 'trod' on its fragile beauty. Years went by and the daffodil never bloomed, living an existence of pain and suffering as each new assault came its way. However, one day the sun came out and the daffodil remained true to itself, blooming in its own beautiful fashion. Clients appear to understand and identify with the story and are frequently touched by it.

Case example

My practice experience with several clients has inspired this article and one in particular has inspired the case study example presented here. Names, places and other relevant potentially identifying details have been changed to protect confidentiality.

Lucinda is 33 years old. She has a diagnosis of Borderline Personality Disorder. She suffered from low mood, was not able to let the past go easily and was passive in nature. Impulsivity was a problem with overdosing, substance use and self harming all problematic. Relational aspects however were good. Her husband who was 20 years older was very supportive and attended appointments. He provided much home support for ideas introduced in therapy. Lucinda has two young children.

Structured therapy with a cognitive emphasis was trialed early in therapy, however was not found to be useful by Lucinda. Skill learning from a Dialectical Behaviour Therapy approach was also trialed, however Lucinda was not willing at the time to experiment with new skills and frequently returned to her own maladaptive ways of coping. Being passive in nature was at times a barrier to motivation. Being obsessive in nature supported her focus on the idea 'that bad had happened and she was bad'. Lucinda found it difficult early in therapy to believe she was deserving in any way and this was a barrier to the early basic acceptance needed to move forward.

Just knowing someone was there for her in a consistent way was very important for Lucinda. She had a big fear of being abandoned in some way. Knowing she had control over the therapy and that she did not have to share all the details was equally important. However, the number one thing Lucinda found important was having someone actually listen and believe her story. Her previous experience had been of having people focusing on assisting the social aspects that were external to her and of the focus been away from the importance of her story. She spoke frequently about the deep importance of being listened

to, understood and believed. For her it was the most validating thing that could happen and an early catalyst for change.

For myself, in the early stages a lot of patience, extra time and flexibility was necessary. Extra time was needed to listen and understand. Needs were often quite different from one appointment to another, meaning my own goals for therapy were frequently put aside.

The major problem was emerging, that of Lucinda's focus on the past and the idea that because bad had happened she was bad. This was maintaining maladaptive coping responses.

The story of the daffodil was utilised at this time to try and show Lucinda she was not bad like her previous conditions, but was separate from them. Though usually not needing a lot of repetition the story certainly did with Lucinda. However, over the whole period of therapy the story became more real to Lucinda.

As Lucinda continued to look back and dwell on the idea that she was bad, an approach was required that could assist her in looking forward to see a new her.

Questions rather than enquiring conversations were initially used. The 'could' questions assisted in changing focus and emotional state which was quite evident at appointment times. Lucinda surprised by having many references for the 'could' questions and early ideas for behavioral change were tapped into in this way.

A single session using the old lady, young lady perception exercises was highly successful and provided a major catalyst for change in therapy. For Lucinda the idea that there could be another part of her existing within the only part she herself knew was something new and fascinating to her. The major perception shift, from 'the old' to 'the new', surfaced ideas as to where the new Lucinda could be in the future and what she could do there. Early ideas were to shift to Northland where Lucinda would be free of the past and the ideas as to what she could do and be in the future could become reality in the new environment.

The next problem to overcome was to maintain the focus. Perception exercises can change perception and focus but do not necessarily maintain it. Invariably Lucinda would return to the old focus. The contrasting pie charts were very useful for quickly changing ideas and focus from the old back to the new and were frequently used in session. Taking key ideas from the right-hand chart and developing homework exercises with Lucinda and her husband assisted in maintaining focus in the short-term, however we needed something in the longer term to bring a sense of excitement and passion to the evolving ideas.

We were experimenting at getting excited about something at one particular appointment and in a fun way we tried out the basic N.L.P. strategies around having a cup of coffee. It worked so well and was so much fun we tried it out with the longer-vision ideas that the strategies are actually more suited to. Again they were highly successful and over the ensuing months we used them to maintain a focus on the key ideas that were being developed. These ideas were the new ideas that Lucinda was 'seeing' for herself in the future.

Getting specific is not a difficult task and is the first key. Using imagination and graphic imagery is the second key and takes time and creativity. Imagining being in the future situation with a lot of specific detail, then utilising sensory input, that is graphic imagery as well as the thoughts and feelings that accompany it is very important. Repetition, the last key, also takes time and creativity and assists in maintaining the focus. Homework exercises assist repetition. For example downloading travel pictures from the internet and getting travel brochures from a travel centre were ideas used. Lucinda's husband assisted in supporting these and other repetition ideas at home.

To summarise, a major perception shift from 'the old' to 'the new' was made, vision was surfaced along with destiny beliefs and a new valued thing was discovered that reconciled with a positive emotion. Hope was again evident and some passion and enthusiasm were released to provide motivation. The outcome was the client moved to Northland.

Summary/future directions

The position taken in this article challenged the current emphasis in treatment towards those aspects that are more easily measurable and suggested a better balance is needed between the therapeutic relationship factors, those more silent and invisible parts of therapy, and those factors that enjoy empirically supported research. The article brought a greater emphasis toward the therapeutic relationship factors and those things within the dynamic of the therapeutic relationship.

The subtle agency perspectives that may not be conducive to the power of the therapeutic relationship were briefly discussed along with some relevant things that may go wrong within the client system itself.

A process was introduced and aspects of that process considered before discussing what could be surfaced within the client system.

Relational tools that could be used as an adjunct to therapy were next introduced as ways to assist the therapeutic relationship either in the early stages of therapy or in the later stages to keep it alive and moving on.

The case study provided an example of a client who was not particularly suited to structured therapy or a skills development approach. It showed how the relational tools were used in conjunction with the power of the therapeutic relationship. It is intended that this article will in some way inspire others to explore, debate and research the subject in more depth. Overall efficacy for therapy and an improved outcome for clients is the greater goal.

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