Forty Years on from Rogers' APA Address, 'Some New Challenges for the Helping Professions'

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Peter Pearce

SYNOPSIS

In beginning to contemplate what I might write for this invitation to follow Carl Rogers, 40 years on, I initially felt flattered to be asked and daunted to follow such a pioneer and towering figure within psychology as Rogers. In beginning to contemplate what I had to say, I began to feel that the invitation to 'speak to the profession' also felt something of an anathema to my humanistic values. I didn't feel in any position to highlight issues for the profession and to make suggestions to address them; this felt rather too grand. I have therefore chosen to explore what I see as the most immediate challenges for me as a 'helping professional' rather than for all, and hope that others may find that my subjective, perhaps parochial concerns might serve as a catalyst for their own reflection. I am also aware that what have become my pre-occupations arise from my position in the UK (for this I apologise in advance), my position as a parent of five young children (four of them daughters), and from my own history as an isolated person-centred voice striving to hold a place for such humanistic practice, free at the point of delivery, within the UK National Health Service (NHS) system, and as a school counsellor experiencing the waxing and waning of interest in this as an aspect of a school structure.

Challenge 1: Responding to the Evidence-based Culture and Climate

I am beginning with this challenge first, not to represent its importance to me; in fact, it seems in some ways the most self-concerned of my pre-occupations, impacting on my ability to work in the contexts I wish to, as a person-centred therapist. I begin with this particular concern, however, because it impacts my response-ability in both of the other challenges that I will go on to consider, and so must be placed as the ground for each of these more personally engaging concerns that follow.

In the UK the government has an advisory body that provides guidance on what 'treatments' receive funding within the National Health Service and statutory sector,

both for particular physical and mental health issues. The guidelines produced by this body, NICE, the National Institute for Health Care Excellence, are exemplars of this contemporary emphasis on the 'evidence-based paradigm'. They are derived from evidence reviews, with systematic review and randomised controlled trial (RCT) evidence given most weight. Numerous authors have called for a 're-privileging of practitioners' and practice-based evidence, with Alan Kazdin powerfully describing how, by being wedded only to this evidence-based paradigm, 'we are letting knowledge from practice slip away through holes in a colander' (Kazdin, 2008). These differing research paradigms can sometimes, unhelpfully, lead to a dichotomy, being represented as good and bad methodologies. Barkham and Margison (2007) describe how this 'dichotomy' might become 'chiasmus', how practice-based evidence might complement evidence-based practice, with each feeding into the other as an equal partner.

In truth, there is worth and credibility to the evidence from 'trials', but there are significant limitations; and there are worth and credibility to practice-based evidence, but there are significant limitations. Trials are not a panacea and, rightly, there is much continuing debate about the nature of evidence which must be critiqued and broadened. However, NICE is internationally respected, and this research ranking emphasis is likely to continue for the foreseeable future. This focus on 'controlled trials' rather than 'naturalistic' (practice-based) research, on responses to specific issues, and on an evidence ranking system that more easily fits therapist directed, symptom-focused approaches has come to represent a challenge and potential barrier to the future practice of humanistic therapies within the statutory sector in the UK.

Challenge 2: Responding to the Prevalence of the Most Common Mental Health Issues, Depression and Anxiety

The challenge represented by the prevalence of this evidence-based paradigm has been heightened in the UK by the consequences that have followed on from an influential report into the 'cost,' as public health burden, of the most common mental health issues, depression and anxiety.

For me, this is an interesting challenge as it is actually, at least in part, a challenge that arises from an increased political and public interest in mental health and well-being. The Office for National Statistics estimates that between 8 and 12 per cent of the population experience depression in any year, and mixed anxiety and depression is the most common mental disorder in Britain, with almost 9 per cent of people meeting criteria for diagnosis (ONS, 2003). Many authors have highlighted the social and ethical roots of this 'epidemic of depression', with De Graaf (2005) and James (2007) highlighting 'affluenza', arising from constantly chasing material wealth, which can lead to dissatisfaction and depression. A disease metaphor is used to describe affluenza as 'a painful, contagious, socially transmitted condition of overload, debt, anxiety and waste resulting from the dogged pursuit of more' (de Graaf, 2005: 2).

Lawson (2007) describes a 'social recession', asserting that we are less happy and feel more out of control than ever before, despite gaining many individual liberties. Lawson sees the individualism of narcissistic self-absorption as a social evil. This individualism can have damaging consequences, 'fuelling selfishness and greed and leading to isolation and fear, as people struggle to cope and live fulfilling lives'. These ideas have a resonance with the existential malaise which can arise from a 'lack of meaning', as inherent societally imposed meaning structures like religion and family have less influence for many. The 'consumer-fame-me-now' culture that tries to replace this lost meaning can quickly prove very hollow indeed, and the consequence can be depression and addiction.

These authors attempt to look for the roots of the rise of unhappiness in modern societies. In the UK, a health economics argument has led to the inception of a programme to address the end-result of these issues, the experience of depression, and has prompted politicians to begin to talk about 'parity of esteem' between physical and mental health. The Health Economist, Lord (Richard) Layard, highlighted the shocking reality that there were 'more people on incapacity benefits due to mental problems (850,000) than the total numbers of unemployed people on Job Seeker's Allowance' (Layard, 2004). Layard presented a paper to the government, reasoning that funding by the Department of Health to improve provision of psychological therapies in the treatment of depression and anxiety would positively impact the number of people who were fit to work, and the consequent reduction in benefit costs would make this additional spend on the psychological therapies cost effective. Layard highlighted that funding for responding to mental health problems trailed far behind funding for 'physical' health problems, though the 'disease burden' they represented was similar – equivalent to, for example, coronary heart disease.

The report also highlighted the inequitable nature

of current provision for the psychological therapies, and the lack of consistency in implementing recommended guidelines for the treatment of depression and anxiety across the UK. This report was influential, and a large-scale investment in services for people with common mental health problems followed, the Improving Access to Psychological Therapies (IAPT) programme. The success of this report resulted in raising the significance of guidelines for the psychological therapies, from good practice recommendations to determinants of which therapies will be on offer within the UK statutory sector. Paradoxically, although this had the benefit of making psychological therapies much more widely available for people with anxiety and depression (approaching its goal of one million people from a more diverse cultural and socio-economic profile being seen), it has also had the impact of reducing the range of therapies available. Cognitive Behaviour Therapy (CBT) is recommended as the front-line therapy, with counselling and other therapies as 'therapies of last resort', should a service user fail to respond to CBT. Much of the new money going into this programme has been used to fund the training of a new CBT workforce when there is an existing highly skilled and experienced, talking-therapies workforce that has consequently begun to feel deskilled and marginalised, and many established services have been de-commissioned, with counselling jobs lost.

For a number of years I have been part of an informal network of UK person-centred therapists, educators and researchers who have adopted what might be described as a 'strategic engagement' position with the evidence-based paradigm which is at present so prevalent nationally and internationally. I feel that a contemporary challenge to the helping professions is to somehow make space for both critical opposition and critical engagement, if we are to ensure that humanistic voices continue to be represented in this important discourse of what constitutes evidence, who has it and who does not, and what the implications are that follow from this. Coming into therapy for me was an ideological and political action. I am not happy to be consigned to only work with those who can afford it, some of whom might be thought of as less needing of therapy, as they are at least functioning to some degree and maintaining an income.

I find myself increasingly frustrated by the strand of the talking therapies which seems happy to be critical from the outside, purporting to be in 'strategic opposition' to mainstream models of mental health. It seems to me that this principled non-engagement position can itself unintentionally contribute to an undermining of the credibility and consequent lack of representation, particularly of humanistic approaches within statutory sector services.

The unifying tenet of the third force, Humanistic Psychology, was a position of critiquing existing therapies, not as being of no value, but as being incomplete, in missing something of the complexity of the human condition. Following Rogers, humanistic approaches have historically been wary of diagnoses, viewing them as reductionist and objectifying, and highlighting the consequent disempowering and dehumanising effects they might have. However, our not naming it doesn't alter the frequency with which individuals can experience debilitating psychological distress. As Gillon (2007) has pointed out, this critique of the medicalisation of psychological distress (e.g. Bozarth and Motomasa, 2005) has had unintended consequences, giving rise to a 'corresponding critique of the person-centred approach as a model of therapy which is inadequate for working with those with significant or severe psychological difficulties' (p. 119). I feel this critique to be far from true, but it has exerted a powerful impact upon where and with whom I was welcomed to practise, having acquired the 'label' of 'person-centred therapist'. Rogers was more concerned with potentiality than deficiency. However, contemporary person-centred and experiential approaches have developed a range of theoretical and practical approaches to distress that strive to honour the principles of the approach.

I feel that engaging in the 'real' world demands compromise, tolerance of the discomfort that might not sit comfortably with my values, a recognition not just of the limitations of my chosen model, but of all helping models in the face of many people's daily realities: a realistic acknowledgement of just how unimportant and limited a therapeutic response of any kind might be in the face of oppression, deprivation, poverty and prejudice. Though I am hesitant in owning it, I feel that sometimes, such black and white positions of strategic opposition might arise as much from an unwillingness to sit with these discomforting issues as from a principled philosophical position.

Following huge amounts of debate, professional lobbying and engagement with the research evidence ranking system used, the NICE guidelines for depression in the UK were updated in 2009 to include a small number of NICE-approved, 'additional evidence-based' therapies. One of these, Counselling for Depression or CfD, is derived from person-centred and emotion-focused (experiential) therapy. CfD, like all the IAPT recommended therapies, has

been required to be manualised. That is, competencies have had to be developed using therapy manuals from randomised controlled trials and exemplar texts, which have impacted significantly on practice.

The competencies that have become CfD were derived from a broader Humanistic Competency framework devised by Roth, Hill et al. (2009), and were selected by considering which areas of practice have the strongest evidence base and are most common in counselling in primary care research. The reasoning for requiring manualisation is to try to bring everyday practice into line with the existing evidence about what supports beneficial outcomes. Experienced therapists can tend to deviate from the tenets of their initial training, so qualifications and professional title alone are not evidence of proficiency in an evidence-based therapy. Therapies delivered in clinical trials are often manualised, and adherence to the manual is monitored. By contrast, routine practice is non-manualised and carried out by therapists with varying levels of training. So, fulfilling NICE recommendations involves fully qualified and experienced therapists undertaking a post-qualification training in the competencies, along with assessment of their adherence to the model in practice, with the intention of ensuring that practice is as closely aligned to the evidence-base and, hence, might be as predictive of good outcomes for clients as possible.

There is much ongoing and important debate within the person-centred and humanistic community about these issues which cannot be done justice to here. That the IAPT programme began with training and development specifically in Cognitive Behaviour approaches was because they lent themselves to disorder-specific, symptom-focused and manualised responses. I feel strongly that we have to take care not to lose what is unique and human about humanistic approaches in considering how we engage with this debate, but I am interested in whether this reductionism is an inevitable consequence of such an engagement. My experience of the humanistic competence framework – for example, a 'manual', which has felt anathema to the approach for many – is that I can recognise my practice in it and see it as descriptive and indicative, rather than prescriptive, of practice. It has helped me to remain open to the idea of competence frameworks to model Rogers' original 'necessary and sufficient conditions' paper, and also as a sort of 'manual' of research-derived, good practice. My experience of 'adherence monitoring' within the CfD programme, both as an assessor and moderator, has also been that, like anything, it is possible to fulfil this either as an objectifying, tick-box exercise, or to embody it as a principled and respectful offering of collective feedback, given with the intention of prompting the reflection, increased self-awareness and development of another.

I feel that CfD becoming a NICE recommended therapy is a small but significant step in recovering recognition for person-centred and humanistic therapies, free at the point of delivery, within the UK National Health Service. An ongoing challenge for humanistic therapists will be whether we choose to engage with and build on this development. Establishing humanistic approaches further as legitimate 'choices of treatment' will need considerable care, if we are not to lose track of the 'added value' that they try to offer over more symptom-focused approaches. Humanistic therapies strive to attend to the whole person, and are about developing well-being and full functioning, with 'symptom removal' being only a potential 'side effect' of the focus on acceptance of the whole person as they are. Valued colleagues Stephen Joseph and Kate Hayes highlight that, by striving to compete on effectiveness for specific issues – this being the way funding is delivered in the statutory sector – there is a danger that we also remain defensively on the back foot. They encourage us to engage from a more confident position of 'theory consistent measurement', which is more coherent with our intention to support the development of full functioning. As even the UK government is now collecting 'happiness' statistics through the Office of National Statistics, the timing for this may be good.

Challenge 3: The Mental Health and Wellbeing of Children and Young People

The last of the personal pre-occupations I will consider arises from my own painful adolescent and teen years, my long experience as a school counsellor, and my desire to do the best I can to support the ongoing development of my own children.

Figures from the World Health Organisation suggest that levels of mental health problems in children and young people are increasing globally (WHO, 2006). A team of international experts in an influential review presenting the 'grand challenges in global mental health' identify children with mental illness as an urgent priority (Collins et al., 2011). Moreover, in a Unicef review of child and adolescent well-being in rich countries (Unicef, 2007), the UK came bottom overall, and was in the bottom third for 5 of the 6 dimensions measured. The report asserts that,

> The true measure of a nation's standing is how well it attends to its children – their health and safety, their material security, their education and socialisation, and their sense of being loved, valued and included in the families and societies into which they are born. (Unicef, 2007: 1)

Such reports from these prominent bodies make very clear both the scale and urgency of responding to mental health and well-being issues, both globally and nationally. The UK comes out as having some of the unhappiest children and young people among 'developed' countries. The Collins report on global mental health recommends, in the case of young people, 'focusing resources on the earliest definable clinical stage', because 'most mental disorders involve developmental processes' (Collins et al., 2011: 28). The level of crises and the chronic nature of problems, powerlessness and depression which I have encountered over many years working with young people in London would support these concerns, and calls for urgent and appropriate responses.

Nationally, nearly 10 per cent of children aged five to sixteen years of age have a clinically diagnosable mental health problem, which is an estimated one million plus young people (Green, McGinnity et al., 2004) and there is a high probability that these issues, once established, will persist into adult life, seriously impacting life chances (Durlak, 1995) and even life expectancy (Rutter, 2005; Fergusson et al., 2005). This context, then, is the ground for one of the greatest challenges for those of us in the helping professions: the well-being and development of our children and young people. The optimistic view that I hold and work for is that these issues have lifelong ramifications, which may be mediated by proactive early intervention.

Pressures on children and young people are increasing, and they are often trapped between the twin perspectives of being seen as potential victims in need of constant protection who require limits on their freedom, and simultaneously as major causes of social unease, 'feral' gangs roaming the streets, from whom we all most need protection. They are targeted from the early years as potential consumers in ways which can exploit and exacerbate their normal developmental anxieties. A variety of terms have emerged to capture some of these pressures – the concrete child, the clockwork child and the concept of 'natural world deficit', and there is a growing literature exploring the impact of these 'modern life' factors on the development of 'resilience'.

Governments are at last beginning to accept that such pro-active spending on the mental health and well-being of children and young people may be an effective and efficient investment in the longer term. To this end, the coalition government in the UK is beginning to give mental health, and particularly the mental health and well-being of young people, serious consideration. The Report 'No Health without Mental Health' (HM Government and Department of Health, 2011) identifies that 'by promoting good mental health and intervening early, particularly in childhood and teenage years, we can help prevent mental illness from developing and mitigate its effect when it does'.

The Office of National Statistics is now running a 'Measuring National Well-being (MNW) Programme'. The UK government's spend on mental health, the Improving Access to Psychological Therapies (IAPT) programme, is broadening out to include services for children and young people. It can now be said that in the UK, these issues have a higher profile, with the promise of fast-moving development and implementation. I feel strongly that an important challenge for the helping professions is to articulate our practice knowledge to influence the interpretation of guidelines and policies at local levels in ways that are appropriate to the different communities, and to examine what role therapy, and what kind of therapy, can play with young people.

Klinefelter (1994) argues that counselling in school is less stigmatising and less disruptive than offsite specialist services. Bor et al. (2002) support this, describing school as a 'non-pathologising context' (p. 16), and highlighting the potential for school counsellors to play a key role in proactive, preventative work. My experience in schools, as well as within offsite specialist community NHS provision, would support the idea that being sited within a school setting can mean you are more accessible, less stigmatised, and able to offer 'upstream' proactive responses, sometimes being able to begin when young people in distress, who would never choose counselling, just want to have someone to talk to. In the UK, counselling has now been made available in all secondary schools in Northern Ireland and throughout Wales. A commitment to provide school counselling by 2015 has also been made in Scotland (Public Health Institute of Scotland, 2003). A report by the influential Institute for Public Policy Research concluded that there was now 'an excellent case for rolling out a new "school counsellor welfare support role in all schools" (Sodha and Margo, 2008) across the UK'.

Research also indicates that school-based counselling services are feasible to implement, and highly acceptable to young people, pastoral care coordinators and teachers (Cooper, 2009). While referrals to Child and Adolescent Mental Health Services (CAMHS) are currently available

for young people within secondary schools, school-based counselling provisions are perceived by pastoral care staff and related professionals as an important additional resource: highly accessible; capable of responding quickly to young people's mental health needs; and of particular value to emotionally distressed and/or 'troubled' young people who may neither be sufficiently motivated, nor meet the threshold required for referral to educational or clinical psychologists (Cooper, 2009).

In Rogers' original APA address, he highlights the potential role of school psychologists to offer more than just to 'diagnose and remedy the individual ills created by an obsolete education system with an irrelevant curriculum' (p. 361). Rogers suggests the possibility that school-based counselling might play a bigger part in designing opportunities to learn. This challenge seems as current to me now as it was then. My own doctoral research has been about exploring how school-based counselling might play a part in the development of a whole school 'well-being service'. The emphasis of the work, undertaken collaboratively with a long-term colleague, has been on 'out of the counselling room' initiatives, intended to provide therapeutic responses to groups of young people who might ordinarily reject any service involvement, particularly those that bring them into connection with themselves and others, responding to the needs of both the young people and the school and working with staff and students. These have included:

- the setting up of a peer support service
- staff counselling skills courses
- staff support facilitation course leading to peer-led staff support groups
- emotional literacy work with/for a whole year group
- reflexive supervision for staff
- the development of an active use of the waiting list
- staff training on inset days – deepening understanding of a counselling approach and therefore extending access to the service
- workshops for staff to support their learning needs – e.g. 'working with mental health issues'
- off-site provision – offering support to students at the local authority exclusion unit and to the staff working with them – offering bridging sessions to aid the student's return to school
- therapeutic group work
- family therapy – working with interpreters where needed
- 'Laughing Together' – a lunchtime laughter therapy group where students and staff could connect with each other by having fun
- weekly radio broadcasts – recording discussions about sensitive topics on the school radio aimed at promoting discussion among staff and students about difficult issues, deepening understanding about counselling and extending access to the service
- involvement with school behavioural initiatives – offering support to staff and students often isolated from the rest of the school – we were not always welcomed into working with these initiatives, as they were often set up to somehow 'hide' 'problem students'; in this we worked closely with the targeted students, raising their concerns about the damaging psychological effects on the students of such initiatives.

My own experience within schools of being highly valued and then, with a change of leadership, having much of our established work dismissed, mirrors the bigger picture of development and decline that school counselling services in England have experienced, and prompted a change of emphasis within our research interests from a more natural fit for us of qualitative research towards more quantitative, efficacy-focused data collection.

Here again, the current evidence-based culture and climate and the research ranking system used by NICE intervenes. 'Evidence' of the benefits of school-based counselling remains only correlational at present (i.e. counselling is associated with improvements). If the future of such vital provision is to be secured and developed, an emphasis on efficacy studies of school-based counselling which are controlled and randomised will be required. Such efficacy evidence has particular import and relevance in a school, where so much input is constantly on offer for students at all levels, so that attributing change to counselling is extremely complex.

Conclusions

I am aware in reviewing my contribution that it is very localised in its focus, and pragmatic in its perspective. I am also aware that it may not be well received by some, perhaps being seen as representing an 'heretical' position, dismissed as my having abandoned humanistic values or perhaps never having really understood them. Rather, I feel that each of these interests arises from my continuing and deep passion to contribute to an alive and evolving humanistic tradition that is active in the world. These current work and research interests, which are my challenges, also reflect what I think are some of the most pressing issues for the helping professions. First, responding to the now widespread experience of mental

distress, depression and anxiety, and ensuring that these responses are as widely available as possible, free at the point of delivery and accessible to the rich diversity of contemporary society. Secondly, being concerned about how we might play a part in promoting the well-being and development of children and young people. Lastly, I have been acutely aware in writing this article of how the politics surrounding the field of the psychological therapies in the UK and internationally have pervaded my thinking and practice in each of these domains.

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References

Barkham, M. and Margison, F. (2007) 'Practice-based evidence as a complement to evidence-based practice: from dichotomy to chiasmus', in C. Freeman and M. Power (eds), *Handbook of Evidence-based Psychotherapies: A Guide for Research and Practice* (pp. 443–76), Chichester: Wiley-Blackwell

Bor, R., Ebner-Landym J., Gill, S. and Brace, C. (2002) *Counselling in Schools*, London, Sage

Bozarth, J.D. and Motomasa, N. (2005) 'Searching for the core: the interface of client-centred principles with other therapies', in R. Worsley and S. Joseph (eds), *Person-centred Psychopathology: A Positive Psychology of Mental Health* (pp. 293–309), Ross-on-Wye, PCCS Books

Collins, P.Y., Patel, V., Joestl, S.S., March, D., Insel, T.R. and Daar, A.S. (2011) 'Grand challenges in global mental health: a consortium of researchers, advocates and clinicians announces here research priorities for improving the lives of people with mental illness around the world, and calls for urgent action and investment', *Nature*, 475 (7354): 27–30

Cooper, M. (2009) 'Counselling in UK secondary schools: a comprehensive review of audit and evaluation studies', *Counselling and Psychotherapy Research*, 9 (3): 137–50

de Graaf, J., Wann, D. and Naylor, T.H. (2005) *Affluenza: The All-Consuming Epidemic*, San Francisco Calif.: Berrett-Koehler Publishers

Durlak, J. A. (1995) *School-based Prevention Programs for Children and Adolescents*, Thousand Oaks, Calif.: Sage

Fergusson, D.M., Horwood, L.J. and Ridder, E.M. (2005) 'Show me the child at seven: the consequences of conduct problems in childhood for psychosocial functioning in adulthood', *Journal of Child Psychology and Psychiatry*, 46 (8): 837–49

Gillon, E. (2007) *Person-centred Counselling Psychology: An Introduction*, London: Sage

Green, H., McGinnity, A. and others (2004) *Mental Health of Children and Young People in Great Britain*, London: Office of National Statistics

HM Government and Department of Health (2011) *No Health without Mental Health: A Cross-government Mental Health Outcomes Strategy for People of All Ages*, London: Department of Health

James, O. (2007) *Affluenza: How to Be Successful and Stay Sane*, London: Vermilion

Kazdin, A.E. (2008) 'Evidence-based treatment and practice: new opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care', *American Psychologist*, 63 (3): 146–59

Klinefelter, P. (1994) 'A school counselling service', *Counselling*, August: 215–17

Lawson, N. (2007) 'New Labour has presided over a social recession', The *Guardian* newspaper, 22 February; accessible at http://www.theguardian.com/commentisfree/2007/feb/22/comment.politics (accessed 20 November 2013)

Layard, R. (2004) 'Mental Health: Britain's Biggest Social Problem', No. 10 Downing Street Strategy Unit Seminar

ONS (2003) 'Psychiatric morbidity among adults living in private households', *Office of National Statistics*, 15: 65–73

Public Health Institute of Scotland (2003) *Needs Assessment Report on Child and Adolescent Mental Health,* Edinburgh: Public Health Institute of Scotland

Roth, A., Hill, A. and Pilling, S. (2009) 'The competences required to deliver effective Humanistic Psychological Therapies', London: University College London; accessible at http://www.ucl.ac.uk/clinical-psychology/CORE/Humanistic_Competences/clinicians_guide.pdf (accessed 20 November 2013)

Rutter, M. (2005) 'How the environment affects mental health', *British Journal of Psychiatry,* 186: 4–6

Sodha, S. and J. Margo (2008) 'Thursday's Child', London: Institute for Public Policy Research; see http://www.ippr.org/publications/55/1642/thursdays-child

UNICEF (2007) 'Child poverty in perspective: an overview of child well-being in rich countries', UNICEF Innocenti Research Centre, Report Card 7

World Health Organisation (2006) *The World Health Report*, Geneva: WHO