

CHAPTER

1 PSYCHOTHERAPY AND COUNSELLING: CONTEXT AND CONTENT

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Psychotherapy and counselling will have touched everybody at some time in their lives, just as mental anguish, alienation, ennui, crises or other specific types of suffering can touch us. We will have directly sought therapy for ourselves, recommended therapy to a loved one, or know someone else who has done so, given the now axiomatic assertion that one in five people are affected by mental illness, including anxiety and depression. What is involved and how this discipline conducts itself is explored in this chapter, which includes an introduction to the book's content and to the contribution to the field of psychotherapy and counselling practice from those who know it best: the therapists and their clients.

WHAT DO PSYCHOTHERAPISTS AND COUNSELLORS DO?

The healing art and science of therapy has been practised in one form or another for at least a century. The plurality of forms that it takes, the wide range of contexts for its practice, and the different professional roles within which it is practised, lead to confusion about what exactly it is. A short answer to the question 'what do psychotherapists and counsellors do?' is provided by the peak body for the profession in Australia, the Psychotherapy and Counselling Federation of Australia:

Psychotherapy and counselling are professional activities that utilise an interpersonal relationship to enable people to develop self-understanding and to make changes in their lives. Professional counsellors and psychotherapists work within a clearly contracted, principled relationship that enables individuals to obtain assistance in exploring and resolving issues of an interpersonal, intrapsychic, or personal nature. Professional Counselling and Psychotherapy are explicitly contracted and require in-depth training to utilise a range of therapeutic interventions, and should be differentiated from the use of counselling skills by other professionals. (PACFA, n.d.)

Therapeutic work is conducted in various physical and temporal contexts. It takes place in the public and private sectors, with individuals, couples, families and groups. The work may involve short-term intervention into problems or crises—lasting anywhere from one session to around twelve—or it may involve restructuring of the client's persona, worldview or spiritual understanding, and endure in the longer term, perhaps across years. This is determined by factors such as the scope of the presenting

issues, the therapeutic modality, and the client's interest in and resources for extending the enquiry to other reaches of their subjective experience.

According to PACFA, in order to facilitate an effective therapeutic change process for clients, psychotherapy and counselling professionals are required to: develop advanced interpersonal skills and pursue in-depth training in the application of psychotherapeutic, and/or counselling, and psychological theories; undergo professional supervision of their practice; meet the qualification requirements of some modalities; and undergo their own personal therapy or analysis. Qualified and registered therapists are obliged to meet annual requirements for ongoing clinical supervision and professional development, and to work within ethical and legal frameworks, because 'such practices lead to enhanced capacity to utilise the self of the practitioner effectively in the therapeutic relationship' (PACFA, n.d.).

The work of psychotherapists and counsellors is 'based on an ethos of respect for clients, their values, their beliefs, their uniqueness and their right to self-determination' and it factors into the therapeutic enquiry the cultural and socio-political context of the client:

This includes awareness and assessment of social and cultural influences such as age, development, (dis)ability, religion, cultural identity, Indigenous identity, sexual orientation, socioeconomic status, nationality and gender. Professional Psychotherapists and Counsellors value such differences and avoid discrimination on the basis of these aspects of identity. (PACFA, n.d.)

In order for a therapist to sit with a client through their distress, listen intelligently and facilitate transformative and integrated change in a life, they must be conversant with philosophical frameworks that understand the workings of human subjectivity (cognitive, emotional, embodied, subjective experience), diligently apply these to specific circumstances, and develop self-awareness (through personal therapeutic process and related practices) as well as social awareness and critical analysis (through engagement with socio-political discourses of subjectivity and power relations).

Therapy is therefore not a simple process of advice-giving, problem-solving or diagnosis; it is not about befriending the client; and it does not exist solely within the enclosed space of a consultation room. At its fullest and most effective it considers the world of the client in relationship to the broader social context of their life, and uses the self of the therapist in co-constructed engagement with the client towards a supported enquiry into the client's current condition. Rather than the disinterested stance of an expert, applying manualised techniques to fix the externalised problems of a client, effective therapy calls the whole of the therapist into the endeavour.

Psychotherapists and counsellors are supported and regulated by their peak professional body. The profession in Australia is self-regulating, setting and monitoring minimum training standards and minimum practice standards, such as clinical hours, supervision and professional development; and establishing registration pathways from intern to full clinical registrant.

Although the profession designates qualifications and training specific to psychotherapy and counselling, the terms 'psychotherapy' and 'counselling' are not protected. Whereas a protected term is unique to a single profession, 'counselling',

in particular, currently remains a broadly defined term to describe work that can be carried out by teachers, case managers, psychologists and social workers, who may not meet the minimum standards set by PACFA, as well as by fully trained and qualified psychotherapists and counsellors.

There continues to be a growing number of new and renewed modalities of practice in psychotherapy and counselling across various disciplinary fields. These include, but are not limited to, the classic and renewed variations of psychodynamic therapy originating with Freud, Jung and their students; the manualised approaches of cognitive-behavioural therapy (CBT) and dialectic behavioural therapy (DBT); the intersubjective and philosophically informed practices of existential, person-centred, and Gestalt psychotherapies; emotionally focused therapy, family therapies, expressive arts therapies, narrative therapy; and the socio-politically informed practices of feminist, First Nations and cross-cultural therapies.

The diversity of range arises for many reasons: historical, disciplinary and political.

THE DISCIPLINARY BASES OF PSYCHOTHERAPY AND COUNSELLING

There is no single discipline or research method that informs the work of psychotherapists and counsellors. Therapeutic approaches continue to develop across a spectrum of disciplines from the philosophically informed to the science-practitioner approaches, with influences from social theory, sociology and neuroscience among others.

The philosophical influences are based in enquiry about the experience of *being* and what can be known about *being*, as such. This is a good fit for professionals working in the uncertain space of human subjectivity. Rather than attempting to set subjectivity aside in a pursuit for objective truths about human subjective experience, phenomenology—a modern branch of philosophy—recognises its inherent subjectivity and has developed systems for working rigorously with that reality. This philosophical influence has generated a capacity for therapists to maintain competence and steadiness in the face of the genuine uncertainties of working intersubjectively with other human beings. The influence is most evidently present where a therapist works intentionally and skilfully with the therapeutic relationship, attuned to the present reality—to the ‘in between’—of the exchange flowing between them and their client.

The medical model of health and science-practitioner influences on the practices of psychotherapy and counselling have been in the area of empirical research: on what can be measured and objectified in the client’s experience. This has tended towards assessment for diagnostic purposes, and the application of manualised treatments based on diagnosis which exclude the role of the practitioner from the technique/s they deploy. While there are benefits in this influence, it has been inflated at the cost of other important influences because the regulatory climate in Australia favours measurable and quantifiable factors. Governments are more swayed to fund practices that are subject to predictability and repeatability, with quantifiable outcomes. This is misleadingly referred to as evidence-based practice, as though practices that do not readily submit to

measurability are not evidence-based and implicitly lack effectiveness. Although many modalities can meet requirements for quantifiable outcomes, those that tend towards manualisation—that is, to a focus on technique using a standardised protocol set out in a treatment manual—are more readily measurable and conform to the narrow frame of evidence-based practice. This may in part explain the overrepresentation of cognitive-behavioural therapy in mainstream discussions on therapeutic effectiveness. This approach to evaluating therapeutic effectiveness has been significantly challenged by the Common Factors meta-research, discussed below.

All the politics and differences that have emerged in the great disciplines of the humanities and the sciences are replicated in the disciplinary domains of the psychotherapy and counselling profession, each with the hubris that their disciplinary methods provide the surest access to truth. Yet the family tree of psychotherapy has over the century from Freud developed multiple branches that include these main influences alongside input from sociology, social theory, anthropology, literary and critical theory, gender and sexuality politics, and postcolonialism. More or less recently, we can see the rise and rise of the relational orientation that sits astride many modalities (relational Gestalt psychotherapy, Hakomi, psychodynamic psychotherapy, psychoanalytic psychotherapy, for example).

Another key influence on professional practice is the World Health Organization's (WHO) social model of health with its emphasis on the broader social, economic and ecological determinants of health, rather than those that are simply intrapsychic and biological. As the leading international organisation dedicated to global health and well-being, the WHO auspiced the First International Conference on Health Promotion in 1986, producing the Ottawa Charter for action to achieve health for all. The Charter defined the prerequisites for health as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity, and asserted that 'improvement in health requires a secure foundation in these basic prerequisites' (WHO, 1986).

This approach was reiterated at the WHO World Conference on the Social Determinants of Health in Rio in 2011:

Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health. We are convinced that action on these determinants, both for vulnerable groups and the entire population, is essential to create inclusive, equitable, economically productive and healthy societies. Positioning human health and well-being as one of the key features of what constitutes a successful, inclusive and fair society in the 21st century is consistent with our commitment to human rights at national and international levels. (WHO, 2011)

The metaphor commonly used to emphasise the social and economic benefits of health promotion is of servicing 'upstream'. This refers to the priority of addressing the causes and conditions of ill health, upstream, before people fall into ill health, to avoid having to focus all resources on pulling people out when they are drowning downstream. By situating it within a broader context of lives as they are lived and experienced, this model has strong explanatory force regarding health and well-being.

Such an understanding aligns well with the more philosophically and socially informed practices in the profession.

Clinical work within the psychotherapy and counselling profession can best be designated as the reflective practitioner model, informed by philosophical and empirical understandings of the human subject, the social model of health, and an emphasis on the interpersonal therapeutic relationship. These areas can overlap in their clinical application, based on the range of training and skill of the clinician.

Definitions based on these different approaches are as much political and contextually based as they are about specific methodologies. Foucault's (1969) notion of technologies of knowledge is useful to recall here because it reminds us that our ways of knowing are derived from the broader socio-political context in which they arise and are deployed. They are not neutral or unaffected by the swirls of cultural and economic relations of their context. Foucault's argument is reiterated in contemporary discussions about the evidence base for psychotherapy and counselling: 'defining evidence, deciding what qualifies as evidence, and applying what is privileged as evidence are all complicated matters with deep philosophical and huge practical consequences' (Norcross, Beutler & Levant, 2006, cited in Sparks & Duncan, 2010, p. 357).

DEFINING PSYCHOTHERAPY AND COUNSELLING

From the perspective of the psychotherapy and counselling profession it is straightforward to distinguish between professional psychotherapists and counsellors on the one hand, and allied health practitioners who practise counselling skills on the other. This is based on the minimum requirements for training and practice set by PACFA: technologies of knowledge negotiated within the profession itself. While registered psychotherapists and counsellors meet these requirements, allied health practitioners will not, unless they have undergone additional training that meets PACFA's training standards.

Psychiatrists are trained under the medical model of health, with practice largely focused on diagnosis of mental disorders—using the *Diagnostic and Statistical Manual* (DSM) produced by the American Psychiatry Association—and treatment driven by medication, although some psychiatrists are trained in models of psychotherapy or counselling. Psychologists are trained in the scientific study of mind and mental processes, and apply a science-practitioner model, again with relative emphasis on diagnosis and assessment and manualised treatment. Counselling psychologists undergo counselling training, and clinical psychologists may also train in models of counselling and psychotherapy.

Differentiating psychotherapy and counselling, however, is a more challenging and contentious endeavour within the profession. The PACFA definition of psychotherapy and counselling indicates that there is overlap between the two, alongside 'recognised differences' pertaining mainly to the goals and depth of the work:

[T]he focus of Counselling is more likely to be on specific problems, changes in life adjustments and fostering clients' well-being. Psychotherapy is more concerned with the restructuring of the personality or self and the development of insight. At advanced levels

of training, Counselling has a greater overlap with Psychotherapy than at foundation levels. (PACFA, n.d.)

Because registered psychotherapists and counsellors meet the PACFA requirements for training and practice they have equal weight in the profession and their practice may be most unproblematically summarised, as we do in this chapter, as therapy.

WHO COMES TO THERAPY AND WHY?

Traditional assumptions influenced by popular media were that wealthy European clients paid exorbitant rates for interminable psychoanalytic therapy. When therapy became more medicalised, mainstream assumptions have been that therapy was for those with serious mental illness, not for the 'worried well'. A century after Freud, with increased research on the relationship of body and mind, and a broader understanding of therapeutic work and its benefits, popular conceptions of therapy have changed. Clients of therapy come from a much broader base of social, economic and multicultural contexts. Many therapies are subsidised by government and/or a third party payer. Longer-term therapies remain available for those who wish to invest in that level of work on themselves; and most therapeutic modalities have adapted to provide shorter-term work in recognition of the complex and busy lives of citizens of the 21st century.

There are no indications that therapeutic services will decline; on the contrary, the indications are that the profession will grow alongside current growth in demand. When in 2013 the Australian Council of Social Services (ACOSS) surveyed 500 not-for-profit service providers nationally, it found services under strain and unable to meet growing demand. Specifically, 47% of mental health services and 46% of domestic violence and sexual assault services were unable to meet demand for services (ACOSS, 2013). With increasing pressure from the currently unbalanced economic, geopolitical and ecological conditions, the professional services of psychotherapists and counsellors are likely to continue to be called upon in increasing numbers.

Clients bring a multitude of enquiries to therapy. These include but are not limited to:

- managing stress, depression and anxiety, compulsions and addictions, family and relationship difficulties, concerns about work, life transitions (moving to a new school, job or house, coming out about sexuality or gender identity, pregnancy and birth, retirement, ageing, illness, and other endings and beginnings)
- domestic violence, sexual assault and other current or early life traumatic experiences; incarceration; dealing with physical or mental limitations
- coping as a recipient of prejudice, and the impacts of cultural, social, racial and economic inequity, including colonisation
- processing grief
- concerns about loneliness, meaninglessness and questions about the subjective experience of existence, expressed by the French word *ennui*.

Any painful subjective experience can be the prompt for seeking therapeutic services and support. Experiences that are subjectively felt can be supported in a wide

range of ways. Consider a client presenting to therapy with stress-related concerns. Enquiry over several sessions reveals that the client is living in an unsafe situation and has been subject to verbal harassment. The therapist will be guided in the work, in this as in all cases, by the combined weight of their training and supervised experience, by professional codes of conduct and ethics, and by broader legal frameworks. A therapist practising within a medical framework may work on a diagnostic basis, which may include prescribing medication for symptom management; a therapist practising within an experiential framework may be led by the physical or emotional expressions of the client to explore the client's subjective world as a whole, and work on building the agency or self-functions of the client so that they are empowered to address their situation; a therapist working with the technique of cognitive-behavioural therapy may assign exercises to the client for retraining thought processes in order to build the client's coping capacity; a therapist with an integrative orientation may include some or all of these approaches.

Any or all of these therapists will as a matter of urgency address the unsafe living situation of the client—linking the client to relevant authorities or services—and those practising within a social model of health will engage a contextual approach, making connections between the client's presentation and wider social factors. In some cases, a client with a presentation of this kind may have most of the DSM markers for severe anxiety or depression, or both, and could benefit from a diagnosis of mental illness, and related treatment. In other cases such a diagnosis may alienate a client with this presentation, and distract from attention to the external factors that have conditioned the stress.

Most importantly, if the therapy is to be effective, the therapist will be guided by the client's express needs and by the dynamics of the therapeutic relationship they co-create with the client.

THE COMMON FACTORS OF THERAPEUTIC EFFECTIVENESS

Psychotherapy and counselling are relatively recent players in the higher education and professional regulatory context. A number of factors have brought significant pressure to bear on the emergence of psychotherapy and counselling as a distinct profession in the mental health and well-being space. These include the earlier effective lobbying of government by the profession of psychology for the science-practitioner model, and the pressure of pharmaceutical companies for modes of research that support their interests. These have contributed to the trend in which empirical research is coming to stand in for all forms of research, notwithstanding the compelling case from the Common Factors meta-research that evidence-based techniques turn out to be peripheral to therapeutic effectiveness.

The Common Factors meta-research involved analysis of 40 years of outcomes data and found that the client's own life space and the quality of the therapeutic relationship together constitute the most significant, or common, factors of therapeutic

effectiveness (Duncan, Miller, Wampold & Hubble, 2010). The research identified four factors consistent with therapeutic effectiveness. In order of significance they are:

1. the client's life-space (40%)
2. the therapeutic relationship (30%)
3. the element of hope held by client and therapist in the usefulness of therapy (15%)
4. the technique/s employed in the therapeutic encounter (15%). (Asay & Lambert, 1999)

According to Wampold (2010), this research signifies that particular therapeutic treatments ought no longer to be mandated. This is because all are effective on the basis of the therapeutic alliance between client and therapist, and because there is no evidence that a given technique or approach is more effective than another (when researcher allegiance to the model being researched is accounted for): 'the notion of requiring clinicians to use empirically supported treatment or evidence-based treatments simply is not supported by the research evidence' (Wampold, 2010, p. 72.). By this logic it no longer makes sense to use documentation of a specific evidence-based treatment as a measure of accountability; rather, the therapist themselves becomes accountable for the outcomes and is the measure of effectiveness based on client feedback.

This quietly radical research provides opportunities for psychotherapy and counselling professionals to clarify the profile of the profession in the health space, especially in reference to the continued rise of relational therapeutic orientations. The renewed emphasis on the therapeutic alliance is a prompt for relational psychotherapists and counsellors to join the conversation more actively about how the therapeutic relationship works and to foreground the philosophical and phenomenological bases for relational intersubjective therapy.

The centrality of the therapeutic relationship to effective therapeutic outcomes subordinates the definitional politics of psychotherapy and counselling to the skills and capacity of a given therapist—psychotherapist or counsellor—to establish, maintain and work intentionally within the therapeutic relationship. This research is quite possibly changing how therapy is practised in Australia; or at least changing the terms in which the stories of psychotherapy and counselling are told.

What the therapeutic relationship and therapeutic interventions actually look like in and across sessions of therapy necessarily remains shielded because confidentiality and privacy for the client are paramount in professional practice. However, with permission from clients to publish elements of their therapeutic experiences and, in some cases, co-authorship with their therapist to write the story of their experience of therapy, readers can glimpse therapy sessions in real time across a range of approaches. This provides readers with what we hope is a compelling and insightful way of exploring and exposing therapy in context.

Having laid out the professional, disciplinary and socio-political context of the book, we introduce its aims and contents.

THE AIMS AND CONTENTS OF THE BOOK

Each of the stories in this book has been written either to highlight the process of the therapeutic relationship, to detail the application and experience of effective interventions, to represent various modalities under the PACFA banner as they are

practised, or to present new initiatives and directions in the field. Most of these stories have been written with some form of collaboration between practitioners and clients. While not all modalities can be covered in any single book, enough stories have been selected here to showcase the diversity of modalities in the field of psychotherapy and counselling, how they work in detail, and what can be expected from a particular therapeutic experience.

Therapists employ a range of skills from their specific modality or approach, but all will have trained in the core micro-skills. These are the bread and butter of therapeutic practice. They include skills such as:

- encouraging and attending to the client's story and listening reflectively
- gathering information
- questioning and probing, where appropriate
- restating and paraphrasing prominent elements of the dialogue; reflecting content, emotions, and other phenomenological material such as body movement, choice of metaphor, or tone of voice
- clarifying and checking perceptions
- summarising content and process
- self-disclosure, where it adds value to the client's exploration.

Self-disclosure involves the therapist sharing with the client specific feelings, thoughts and experiences relevant to the context in the hope of strengthening the therapeutic alliance. When executed well, this phenomenological practice can deepen trust, or insight, and render the relationship more real and less unequal. Psychotherapists and counsellors place emphasis on the therapeutic power of these interpersonal skills which, when deployed effectively within the context of the therapeutic relationship, require a higher order of competence than in mundane communication. This higher order of skills includes more subtle, probing, accurate, insightful and theoretically informed explorations than are found in typical conversational responses. The capacity to work in this way develops from the combination of training in general and modality-specific therapeutic frameworks, the personal development of the therapist, and supervised practice. Examples of the application of these skills are to be found in many of the stories in this book.

Through this presentation of varied perspectives on how practitioners and clients co-create therapy across many modalities, we aim to amplify awareness of the manifold therapeutic options for equipping people with the agency to achieve personal growth and change, individual and social well-being. Further, we hope to inspire in students, practitioners and a general readership an active engagement with the diversity, integrity and range of modalities available in the profession of psychotherapy and counselling in Australia.

The book's 23 chapters are divided into the following five parts:

Part 1 *Contemporary Horizons of Practice*, sampling practices that are overtly oriented to cultural context, are ethically contentious, or work with a new medium.

Part 2 *Relational Therapies*, sampling practices that place the therapeutic relationship at their heart or, in some related way, reference the Common Factors meta-research that is reorienting practice from a more limited focus on evidence-based practice to a more expansive and inclusive client focus.

Part 3 *Expressive Therapies*, sampling therapeutic modalities that emphasise creative forms of expression through language, play, dance, and work with animals, to promote change, growth and agency in clients.

Part 4 *Integrative Therapies*, sampling approaches that incorporate metaphor and narrative, hypnotherapy, and other forms of awareness into counselling sessions.

Part 5 *Psychodynamic Therapies*, sampling approaches that work with dreams, metaphor and the imagination to access unconscious process and to facilitate insight.

These sections aim to give shape to the reading experience and elucidate key components of psychotherapy and counselling as it is practised by professionals under the banner of the profession's peak body, PACFA. Parts 1 and 2 in different ways represent examples of some of what is trending or responsive to developments in the profession currently. Parts 3, 4 and 5—expressive, integrative and psychodynamic therapies—while also representing current practice, are arranged according to strands of practice specific to psychotherapy, counselling and psychodynamic therapy. Although the definitions and practices of each of these therapeutic domains are blurring, nevertheless the distinct histories of psychotherapy, counselling and psychodynamic therapy can be traced in these contributions. Part 3, *Expressive Therapies*, comprises stories from practitioners trained in a specific psychotherapeutic modality; Part 4, *Integrative Therapies*, comprises stories from practitioners trained in counselling, with additional qualifications or practice experience; and Part 5, *Psychodynamic Therapies*, comprises stories from practitioners trained in the psychodynamic approach based in analytic processes that have their roots in Freudian or Jungian psychoanalysis.

The five parts are not intended to be categorically fixed, mutually exclusive or exhaustive. They are not categorically fixed or mutually exclusive in the sense that elements of each section could arguably belong in any of the other sections; and the 23 chapters could be classified differently. A primarily psychodynamic therapist, for example, might also work integratively, or use interventions drawing on expressive therapies; a primarily relational therapist may in some instances of therapy deploy the techniques of cognitive-behavioural therapy; a primarily expressive therapist may work with psychodynamic notions of the unconscious as part of their process. The therapeutic reach of a given practitioner will depend on their training qualifications, level of personal therapy work, and the extent of their supervised practice, as well as on the expressed needs of the client. Nevertheless, this choice of structure has been made in order to provide a big-picture sketch of practice in Australia—as well as globally—within the profession of psychotherapy and counselling.

The five parts are not categorically exhaustive either, in the sense that there are many untold stories from each of these sections, and what is presented here is a select sample in order to reveal the workings from the inside of a given type of therapy. Each part is prefaced with a brief introduction to further elucidate the rationale for the section, and to introduce each chapter within it.

This book expands on answers to the question of what it is that psychotherapists and counsellors do, illustrating it with stories by researcher-practitioners—those, that is, who meet the PACFA training and practice standards—and their clients, from the coalface of therapy.

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