INTRODUCTION

Many practitioners who work with children and families will at some point have experienced the difficulty of engaging parents in addressing problems over their troubled children. Defeated, angry, disappointed or puzzled, it is hard for parents to be told that what they do with their children may radically affect how the child behaves. They are sensitive to feelings of being blamed, and often think that professionals place too much responsibility on them for their children’s behaviour, rather than focusing on helping the child to change (Campion 1995). This paper draws on the findings of a small scale pilot process and outcome study in order to demonstrate that play therapy undertaken with individual children, in addition to bringing about improvements in the children’s problems, may improve their parents’ parenting behaviour if they are appropriately involved in the therapy. The paper describes the cases and their outcomes at a 6-month follow-up. It illustrates the finding of changes in parenting behaviour through three case studies, and discusses the kinds of changes, possible reasons for them, and necessary practice requirements if these changes are to take place. The paper concludes that engaging parents in a broadly collaborative effort may be facilitated by a primary initial focus on their children.

PARENTING PROGRAMMES

Parenting programmes have developed over the last two decades either at the primary level of interven-
tion, where they are in principle open to all parents ‘wishing to think about and discuss their own approach to bringing up children’ (Pugh et al. 1994, quoted in Grimshaw & McGuire 1998, p. 1), or at a secondary level, targeting parents whose children have specific problems or difficulties (Smith 1996). The latter programmes have developed out of research on the relationship between parent–child interactions and behavioural problems. This research argued that traditional therapy sessions with individual children alone were ineffective. Long, for example, questioned the appropriateness of a

. . . weekly 50-minute individual therapy session for an 8-year-old child with learning and conduct disorder who is living in a low-income single-parent household where the mother has a history of drug abuse. (Long 1997, p. 502)

He argues for the greater involvement of parents and a greater focus on parent training within child outpatient therapy services.

Much of the parent training literature has focused on families with aggressive or overactive children, or on parents who physically abuse their children, and has emphasized behaviour modification techniques and social learning theory. Programmes such as those developed at the Parenting Clinic in Seattle in the US, which are designed to help families with younger preschool and school-aged children with conduct problems are increasingly being introduced into the UK (Webster-Stratton 1998). These programmes have the dual focus of working with groups of parents on relationship building, communication skills, cognitive techniques and affect management skills, while at the same time helping children, also in a group context, to develop social skills and non-aggressive conflict management strategies. The programmes have been extensively evaluated, and show significant improvements in both children’s behaviour and parents’ self-esteem and emotional well-being (Webster-Stratton 1989; Barlow 1997).

However, parenting programmes are not, as yet, widely available in the UK, and are limited to the extent that the programmes are usually offered on a community-wide basis, which may exclude possible participants from outside the catchment area. They are also run over a particular time period and may, therefore, arguably be less responsive to individual need. Another potential disadvantage is that many parents may be difficult to engage in direct work on their parenting and prefer the focus to remain on their child. Psychodynamic approaches have continued working with deprived and difficult children individually, arguing that child psychotherapy may be a useful intervention when parents themselves are unengaged (e.g. Boston & Szur 1983), or only engaged intermittently in parent guidance sessions (e.g. Slade 1994). It therefore seems useful to highlight possible gains to be achieved from individual child therapy, such as those described in this study, which may in certain situations offer either a valid alternative or a complementary approach alongside parent training.

THE STUDY

Our study considers the process and outcomes of treatment offered to children who were referred for mild behavioural/emotional problems and who received eight individual sessions of non-directive play therapy from trainee play therapists. (Names and some of the details have been altered to protect the children’s and families’ privacy.) These therapeutic interventions were undertaken by the trainees as their second period of clinical practice on the 2-year post-qualifying training programme at the University of York.

During their training, students undertake four periods of clinical work, the first three consisting of eight sessions of play therapy, and the final period consisting of 16 sessions, each with an individual child. The interventions are structured and supervised along tightly specified lines. Trainees must select children according to certain criteria – for example, the children’s problems must be at a level of seriousness that can be addressed in a short intervention by trainees inexperienced in the method, and their circumstances must be stable. The children in the study therefore show relatively mild problems, and probably would not have received statutory help, although all were felt by the families themselves to be experiencing real difficulties.

Treatment in the trainees’ first three shorter interventions consists of the following:

1 A discussion with the referrer.
2 Introductory meeting(s) with the parent(s) or carer(s). (The terms ‘carer’ and ‘parent’ are used interchangeably in this paper.)
3 Introductory meeting with the child, usually at the child’s home (Ryan 2001).
4 Eight-weekly, 1-hour sessions of non-directive play therapy with the child, conducted in a carefully equipped playroom, to which the carer brings the child each week. (Note that an exception is where the child is worked with in a school setting, such as
occurred in Case 1.) The carer is asked to remain in a room nearby during each session, to be emotionally available for their child if needed, and to increase their child’s sense of security overall.

5 A meeting with the carer(s), and in some cases the referrer as well, after the sixth session to discuss the child’s progress in therapy.

6 A follow-up interview, preferably with the child’s carers but occasionally with the referrer only, 6 months after the end of treatment.

The sessions are audio- or video-recorded (exceptions are infrequent and based on strong clinical need). Trainees transcribe or process record from the tapes, and analyse each session for themes embedded in the child’s play and communications, and for their own responses in relation to key features of the non-directive approach. As well as receiving written comments, trainees have five ongoing consultations with their supervisor. (For a fuller account of the non-directive play therapy method, see Wilson et al. 1993 and Ryan & Wilson 2000.)

METHODOLOGY

Our study reviewed and evaluated 11 accounts of play therapy interventions. These were all the cases from the cohort of 12 students which provided full information: the twelfth could not be contacted at the 6-month follow-up. We described the referral problems and contextual features of each case (for example, the family’s economic circumstances or support networks). Themes that the children addressed in therapy (for example, relationship issues, issues of limit testing, the development of autonomy) were described and the extent to which the themes alter and develop during therapy was reviewed, with the two authors working together to develop a classification system for themes. The second author had supervised several of the cases, but was not involved in the 6-month follow-up; the first author was not involved in these interventions at any stage. Finally, the two authors independently of one another ranked the levels of reported progress of the child during and after therapy, and considered the extent to which these (a) reflect referral problems and (b) can reasonably be attributed to the effects of the therapeutic intervention.

Following Kazdin et al. (1990) we define children’s progress during and after therapy broadly in terms of an identifiable decrease in distress, psychological symptoms or maladaptive behaviour, or an identifiable improvement in pro-social functioning. The ranking of progress follows the procedure developed by Malam & Osimo (1992) in their process and outcome study with adults in psychotherapy. The problems described at referral and in the introductory meeting with the carers, the records of play therapy sessions and the 6-month evaluation meeting were considered. The extent of change following therapy was then ranked by the two authors. They worked independently at this juncture and each rated improvements using the broad categories adopted by Malan & Osimo. It was agreed in advance to describe the highest level of change as ‘substantial’ resolution. This seemed better to reflect the children’s and families’ circumstances, and the fact that the problems themselves were relatively mild and the treatment brief (eight as opposed to the approximately 30 sessions received by the adult clients in Malan & Osimo’s study).

RESULTS

Table 1 gives data on the children and their circumstances, with cases classified by epidemiological factors such as age, gender, ethnicity and family composition. (Other descriptive factors, such as cooperation from carers, and the involvement of other professionals, have been collated but are not reproduced here.)

Table 2 provides more detail on the problems identified at referral, describes the outcomes reported at the 6-month follow-up, and ranks these according to the extent of change. As can be seen, six cases were considered to show substantial resolution of referral problems, four to show partial resolution, and one to show deterioration (following the child’s abuse by a close relative). We also worked together to analyse the case protocols to consider whether or not the themes of the child’s sessions seemed to reflect pre- and post-treatment issues (that is, whether or not reported changes could reasonably be linked to the process of therapy), but have not explored this aspect of our findings here.

The finding on which we focus in this paper is that in 10 of the 11 cases the carers were reported to have experienced improvements in their parenting skills or sense of well-being; this was described in nine of the cases by the carers themselves. In the tenth (Case 6) the therapist conducted the 6-month follow-up with the original referrer rather than the mother, because the therapist was unable, due to personal circumstances, to make a home visit and the mother’s limited communication skills made a telephone interview impractical.
CASE ACCOUNTS

We describe three cases in some detail in order to illustrate this finding. We then consider the different dynamics of change, and discuss the features of the individual therapy with children that seem important if families are to experience positive change themselves.

Case 1

Martin, a boy of four and a half years, with poor speech and suffering from cystic fibrosis, was referred for play therapy because of his mother’s over-protective and overly dependent relationship with him. The referrer considered that his mother’s attitude was impairing the development of his independence, and becoming increasingly an issue as he approached the start of school. In addition to the higher level of protectiveness expected in parents whose child has experienced a life-threatening illness, Martin’s mother had suffered sexual abuse as a child. This seemed to affect her marital relationship negatively, and to increase her dependence on Martin. Martin’s father did not involve himself in Martin’s care, and was described by the referrer as holding himself rather apart from family life. His mother was very much in favour of Martin receiving therapy.

In his early play therapy sessions, which were conducted at his specialist nursery school and exception-ally did not entail either parent waiting nearby for him, the therapist was impressed by his general demeanour of quiet confidence and pleasure in ‘feeling big’. But his expression of autonomy seemed hampered by thinking of his mother’s potential dis-approval of his messiness in the playroom. His sym-bolic play also in the beginning seemed to show a need for safety and protection: for example, he repeatedly and methodically placed different farm animals in a field with the fences carefully enclosing them. As the sessions progressed, Martin began tentatively to explore the limits the therapist enforced in the play-room, in particular those related to messiness and to the amount of drink allowed, a key area due to his dietary restrictions.

By his middle sessions, Martin was able to integrate his delight in ‘feeling big’ and ‘being the boss’ (including wanting to leave his sessions when he rather than the therapist felt they had finished!), with his pleasure in at times feeling little and silly. He also sometimes displayed secure attachment and age-appropriate affiliative behaviours, mentioning his mother briefly
### Table 2 Outcomes of therapy

<table>
<thead>
<tr>
<th>Case</th>
<th>Dynamics of problems at referral</th>
<th>Outcome at 6-month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Substantial resolution</strong></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Mother over-protective, depressed; father uninvolved. Difficult medical problems.</td>
<td>Mother no longer protective or depressed, more confident of child’s ability; father more involved. Medical problems remain.</td>
</tr>
<tr>
<td>2</td>
<td>Affected by siblings’ problems and Mum’s worries. Some emotional/physical neglect by both parents.</td>
<td>Wanting to do things for self; more confident/independent.</td>
</tr>
<tr>
<td>3</td>
<td>Sibling of handicapped younger sister. Jealous, teasing and aggressive play. Father unsympathetic, punishing.</td>
<td>Relationship with sibling more positive; cooperative play.</td>
</tr>
<tr>
<td>5</td>
<td>Child suffers from Soto's syndrome but referred for severe problems with faeces retention.</td>
<td>Father now takes child on expeditions, child finding place within the family, seen as more of an individual.</td>
</tr>
<tr>
<td>6</td>
<td>Child has experienced multiple losses. Tearful, demanding, boisterous behaviour.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Partial resolution</strong></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Aggressive, difficult behaviour; excluded from school. Mother unable to control (she has learning difficulties).</td>
<td>Child more settled, less disruptive, although still angry at times.</td>
</tr>
<tr>
<td>8</td>
<td>Extreme temper tantrums at home. Very quiet at school, bullied. Mother depressed because of child.</td>
<td>Mother handling more confidently.</td>
</tr>
<tr>
<td>9</td>
<td>Few friends, insecure after early neglect and abuse from mother.</td>
<td>Tantrums stopped.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not so afraid of strangers, better with other children but still needs professional help.</td>
</tr>
<tr>
<td>10</td>
<td>Aggressive behaviour towards handicapped brother; few friends.</td>
<td>Child more responsive, plays better, makes friends. Less upset when mother doesn’t arrive on time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mother more involved, somewhat more reliable.</td>
</tr>
<tr>
<td></td>
<td><strong>Minimal resolution/no improvement: none</strong></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Child now assertive rather than aggressive. Two new friends.</td>
</tr>
<tr>
<td></td>
<td><strong>Deterioration</strong></td>
<td></td>
</tr>
</tbody>
</table>
and confidently, and greeting familiar nursery staff and children as he entered the building. He was able increasingly to overcome his doubts about messier play, which then allowed him greater scope and initiative, without overwhelming guilty or ‘naughty’ feelings. He exuberantly experimented with large amounts of paint and water, with the therapist’s acceptance and assistance, and painted the (washable) surface of the table in the playroom. His expression of initiative briefly took the form of role-plays, in which Martin placed himself in the role of the powerful doctor and put the therapist in the role of patient. The role-play appeared to reflect his acknowledgment of the seriousness of his medical condition, as well as seeming to be an attempt to master his consequential feelings of helplessness.

The therapist met with both of Martin’s parents after the sixth session, and discussed with them the general themes described earlier in this paper. She also listened to information from them on Martin’s progress and talked through some of their concerns for his welfare. The next, seventh, session had to be cancelled because of Martin’s medical condition. Before the final session could be held, Martin’s parents, evidently encouraged by their discussion with the therapist about his increased confidence and readiness to be independent, started him in the primary school nursery so that the eight sessions could not be completed as intended. Instead, the therapist adapted her practice to Martin’s changed circumstances and held her farewell meeting with him in his home.

In the 6-month follow-up, Martin’s mother reported that she was now confident of his adaptability, and no longer felt such a need to protect him. Martin had begun to attend nursery full-time, and his father was more involved in the care of both Martin and his siblings. There were still, of course, difficult medical problems to contend with, and Martin’s speech was still poor (although said to be much improved by speech therapy).

All of these follow-up results seemed linked both to the referral issues outlined in Table 2, such as Martin’s probable over-protection by his mother, and to the kinds of themes that had emerged in his play therapy sessions. The therapist, as a result of her work with Martin, was able to assure his parents that his emotional development seemed normal for his age, and that indeed, his self-esteem appeared to be a resilient factor over and above his appropriate autonomy and initiative. This reassurance in turn seemed to enable his parents to help him maintain the developmental progress that he had displayed in his therapy sessions.

Note: the ranking of the resolution in this case as ‘substantial’ highlights one of the dilemmas in considering the extent of change, in that there were clearly considerable problems remaining for this family, arising from the serious medical condition from which Martin suffered. However, because there was no expectation that therapy would resolve this, but rather a hope that the emotional difficulties surrounding it would be assuaged, as indeed they were, the raters independently classified the outcome as ‘substantial’ rather than ‘partial’.

Case 2

Angie, who was seven and a half years and the youngest of four children, was referred for play therapy by her teacher because of her mild emotional and physical neglect. This was attributable both to the parenting difficulties of her mother, who had learning difficulties, and also to the lack of involvement in parenting by her father. Caring for Angie’s three older siblings, all of whom had more serious learning and emotional difficulties, further compounded her mother’s relative neglect of Angie. Angie herself seemed to both referrer and therapist to have resilience: for example she was doing quite well academically and socially at school. However, other issues, such as the family’s poverty and Angie’s position as the youngest in the family (and most likely to be overlooked), appeared to be potential risk factors for her.

Angie came with her mother to the community family centre for her first play therapy session. She was initially extremely anxious and unsure of herself. She seemed unable to function independently within the playroom, although she engaged in some rudimentary symbolic play, for example briefly playing at looking after some of the dolls. During the second session, her mother left the building despite an agreement that she would remain in the waiting room in case Angie needed reassurance from her. On discovering this Angie experienced acute anxiety and was unable to continue her session. The therapist contacted her mother to explain that Angie really did need her to stay nearby, and her mother agreed to do so.

After this reminder, Angie began to separate from her mother at the beginning of sessions more easily and to engage in a wide range of playroom activities with less anxiety. A variety of themes then emerged. Caring for dolls and playing out emotions such as tenderness, anger and physical punishment towards
them, and an increasing ability to make use of age-appropriate activities, all became evident in her subsequent sessions. By the progress meeting after the sixth session, the therapist and Angie’s mother had formed a very positive relationship. Her mother was beginning to take an active part in her child’s school life, for example attending events at school, which she had not done hitherto, and beginning to make use of the services and support offered at the family centre, which she had previously avoided. Angie seemed able to value the sessions, value herself and the quiet space provided, and was able to share these feelings with her mother, although sadly not her father, who remained distant and uninvolved. Her mother also began to show more pride in two of her older children.

At the 6-month follow-up these gains had been maintained. Angie had become more independent of her mother and more self-confident, and was maintaining good progress in school and good peer relationships. Her mother was parenting more effectively, for example disciplining through setting clear verbal limits rather than physically chastising her children, and taking part in events both at the child’s school and the family centre.

These changes in Angie and in her mother seemed linked to the process of her play therapy sessions. Angie’s gains in industriousness, a developing valuing of private space, and her growing sense of competence, seemed linked to the problems identified at referral of mild emotional and physical neglect. Her mother’s earlier parenting was addressed by Angie during her sessions in her role-plays with dolls. She seemed then able to elicit positive responses from her mother, with the therapist’s initial help and encouragement. Indirectly, Angie’s mother also benefited by being enabled, with the therapist’s support, to make use of other professional help and becoming increasingly involved in her child’s success at school.

**Case 6**

Gerald, a 5-year-old boy whose mother had moderately severe learning difficulties and mental health problems, was referred because of his disruptive behaviour at school and difficult behaviour at home. His mother seemed overwhelmed by the difficulty of managing him, and alternated between being overly permissive and physically punishing him.

Gerald’s early sessions were characterized by a sense of mistrust, with repeated role-plays depicting a scary world, full of monsters. In later sessions he seemed to develop greater self-control and confidence, and his play became freer and more playful. He also accepted limits from the therapist more readily, and became rather less defiant and more obedient towards his mother. At the meeting after the sixth session, his mother reported that she was finding Gerald easier to manage, and that he seemed less aggressive with her and with neighbours’ children. As we have explained, the trainee therapist conducted the 6-month follow-up with the original referrer rather than the mother, because of the latter’s limited communication skills, especially on the telephone. The follow-up report states:

‘Gerald has been reported to have been more settled with less disruptive behaviour. The referrer used the phrase “no news is good news”, explaining that prior to the intervention there would have been a constant stream of complaints about Gerald’s behaviour from his mother. (He had in the past been excluded from dinnertime at school because of hitting other children.) . . . Gerald’s mother confided to the referrer that she feels more at ease with him, not as concerned with his behaviour as before . . . She is able to try new approaches in parenting [and is] less anxious and therefore more willing to listen.’

The therapist comments in addition:

‘Gerald would appear to have held on to his feelings of self-esteem, which began to develop during play therapy. Clearly his feelings of anger still overwhelm him (for example he threw a spectacular tantrum at school) which demonstrates that not everything has been “cured” by therapy. While the therapy was able to address some of his issues of identity and self-worth, it was unable to alter [all of] the deficiencies in his home situation.’

**DISCUSSION**

The improvements that occurred to a greater or lesser degree in 10 out of the 11 cases reviewed reflect a variety of changes in the parents’ handling of their children, as well as changes in the children themselves. In certain of the cases, as with Martin (Case 1, described under ‘Case Accounts’), or Case 9, the changes involved parenting at a more appropriate level for the child’s age. This seemed due to the parents’ increased confidence in their child’s readiness for independence and/or their child’s capacity for managing their own self-care. In others, parents seemed more engaged and/or less guilt-ridden and anxious about their children, for example, Cases 3, 7 and 10. In yet others, confidence in their ability to parent successfully led to improvements in the parents’ management of difficult behaviour, limit setting and
involvement in their children’s education, as we have seen with Angie and her mother (but not her father) in Case 2. In some cases, for example that of Gerald (Case 6), parental changes seemed to stem from changes in the child’s behaviour, which made the child somewhat easier to handle and to give the carer greater confidence in their parenting. In others (for example, Cases 2, 5, 8 and 9), support and guidance from the therapist towards the carer, in addition to changes in the child’s behaviour, did, we judge, contribute to the carers’ reported increase in parenting skills.

Traditional therapy sessions with individual children alone have, as we have discussed, been criticized as ineffective in addressing the problems facing many children and their families (Hengeller 1994). However, this study suggests that individual therapy may be helpful in bringing about changes in the family system, including changes in the parents’ handling of their children and sometimes in their own sense of well-being. It seems to us likely, although these ideas are speculative because of the limited nature of the study, that a variety of factors may contribute to these positive changes.

First, as we have already suggested, the children’s behaviour will improve if the intervention is successful. They may become more manageable and accept adult control more readily, their self-esteem may increase and with it their social skills. This in turn may make them more amenable to parental discipline. This type of upward spiral, whereby the parents’ increasing success leads to their becoming less stressed and more confident, often seems to produce further improvements in the child’s behaviour (see Landreth 1991, p. 135, for further illustration of this point).

Secondly, our strong impression from considering these cases, is that in very many of them the parents found the process empowering. The trainees took pains to involve the parents in how they were working with the child, but the continuing focus on helping the child seemed to enable the parents to feel less guilty and inadequate, and therefore readier to engage with what was happening. Our numbers are too small to do other than speculate, but it may be that male carers as in Cases 1 and 5, where both fathers became much more involved in their children’s care following therapy, are particularly sensitive to feelings of blame and incompetence and respond better where there is an initial primary focus on the child and more indirect involvement, such as occurred here. The experience of Angie (Case 2), where her father continued to be uninvolved, of course gives a counter example. On the limited information available to us, his circumstances seemed more personally difficult to those of the other ‘detached’ fathers. He had been long-term unemployed, the family lived in deprived circumstances, and he seemed less receptive to changes elsewhere in the family system involving his older children also. Cultural factors that were more resistant to change seemed to contribute to his position. The traditional Irish delineation of parental roles – mother as carer and father as breadwinner – was highly evident to the trainee play therapist during her initial meeting with the mother and father. The father remained aloof during their meeting and did not attend the progress meeting. This cultural difference, along with economic factors and poor living conditions, appears to account for his continued non-involvement during and after his youngest child’s therapy, in contrast to the other fathers involved in the interventions.

Thirdly, parents may also begin to feel more positive about themselves as parents because their children begin to relate to them in a less negative way, leading to an upward spiral in the parent–child interaction. Feeling better about themselves and their capabilities, they may respond with greater confidence and patience to their children, who in turn become more manageable. However, we discuss elsewhere the fact that some children may initially become more difficult, and the need to alert parents to this possibility (Wilson et al. 1993).

Fourthly, we speculate that the kinds of discussions that the therapist is able to have with parents after intense involvement with their children may be particularly acceptable and helpful. The therapist is able to communicate not only concern for the child, but also familiarity with what he or she is like, and as a consequence, without violating the child’s right to privacy, can give detailed suggestions about the most helpful way to manage different behaviours.

Assessing the child’s situation and involving carers

It is, however, essential that child therapists pay proper attention to assessing the child’s circumstances in order to ensure that there is adequate carer support for therapy. Therapists need also to ensure that carers’ own emotional needs do not impede carers in forming an alliance with the therapist in which the primary focus is on their child (O’Connor 1991). It is also essential for a number of reasons that carers are involved by therapists and referrers in the process of intervention with their child. In order for changes to
be maximized and sustained, the carers may need to be helped in how to respond; for example, a child who has been overly 'good' and obedient (perhaps because of the presence of a sibling with a handicap that requires constant parental attention) may in the short term become less easy to control, or less obedient. The parents need to be helped to understand this, and to respond, if necessary firmly, but non-punitively. They may also need to be given clear guidance as to what responses are helpful to the child, and how their involvement affects the child’s behaviour. The experience of Angie, where her mother was initially quite unaware of the effect that her presence, or absence, had on her child, is a case in point. All these possibilities arise from our study and require more intensive research in order to understand parental changes fully.

**CONCLUSION**

The approach described in this study lacks the structured and systematic focus on parenting skills training found in programmes described at the beginning of this paper. However, a systemic approach to non-directive play therapy does have considerable merit in offering a flexible intervention that can be tailored to meet the individual needs of children and their families. More work needs to be carried out to explore which families and which children might benefit from this approach, rather than the parent training approaches discussed at the beginning of the paper. Nonetheless, the findings from this small study suggest that, providing that the therapy with the child is conducted so that parents are fully involved in what is going on, and that they are given where necessary appropriate guidance and help, it can be highly effective in helping both children and their parents with their difficulties.

**REFERENCES**


