

6

Newcastle Community Based Prevention and Intervention Studies

I. Kolvin

*Nuffield Child Psychiatric Unit, The Hospital for Sick
Children, Great North Road, Newcastle Upon Tyne, NE2 AX,
England.*

Clinicians who conduct psychotherapy with children and adolescents have for long done so without the evidence that their activities are validated by sound confirmatory research. The doubts and uncertainties surrounding psychotherapy were thrown into sharp relief in the 50's with Eysenck's (1952) controversial claims that patients receiving psychotherapy were no better off than those receiving no treatment at all. Since then, the claims and counter-claims have resounded through the therapy evaluation literature. Yet clinicians continue to practice psychotherapy, guided presumably by their own experiences within the context of therapy. But is it possible to provide evidence at the research level also for the clinician's assumptions? It will be argued in this chapter that positive evidence *does* exist – drawing on recent work conducted in Newcastle upon Tyne – and, additionally, that pessimistic conclusions have in the past been based on inadequate and misleading data. In arguing this position it is essential to address some fundamental issues in what constitutes good research evidence.

Criteria for good outcome research

There is considerable variability in methodological criteria across psychotherapy research studies. In a recent review, Epstein and Vlok² presented a list of accepted criteria so as to provide a framework for their own evaluation. The main criteria include:

1. Rigorous and clearly thought out assumptions, questions and procedures.
2. Adequate size of research sample.
3. Random assignment to experimental and control group.
4. Clear description of patient sample to allow generalization.
5. Post-treatment evaluation and long-term follow-up.
6. Multiple and valid measurement, and sources of assessment.

We can address only some of these themes here: a fuller account of methodological issues is available in Hartmann et al.³

The nature of the control group

One of the basic assumptions in psychotherapy research is that the control group will allow systematic investigation of the degree of spontaneous change in untreated patients. Given the possibility that even one diagnostic interview may be of therapeutic benefit in conveying support and reassurance⁴ with supposedly 'untreated' controls, in community based research it is clearly difficult to maintain a rigorous separation between subjects who are 'treated' and those who are not. Bias may be minimized with *no-contact* control groups, where subjects have no knowledge of their inclusion. Next the notion that patients who do not receive formal psychotherapy such as *no treatment* or *waiting list* controls, remain without help from other sources has not been substantiated. Many people in search of psychological help do not choose mental health professionals but obtain help from other sources.⁵ A more accurate representation of psychotherapy evaluation research is that, frequently, formal therapy is being compared with other forms of help of an unknown kind. Finally, *treatment drop-outs* do not constitute adequate controls because selective factors such as motivation may determine continuation, and

a variety of negative factors may precipitate termination as may positive factors such as seeing themselves as sufficiently well so as to no longer need help.

The controversy about the effects of psychotherapy

The basis of the controversy was Eysenck's¹ contention that two-thirds of adult neurotic patient showed spontaneous remission, a rate of improvement that was not bettered by psychotherapy. This conclusion was based on a review of studies considered to be methodologically sound. In a re-examination of the evidence two decades later, Bergin⁶ concluded that Eysenck's remission figures were an over-estimate and cited a median remission rate of only 30 per cent. Rachman⁷ countered with support for Eysenck's original estimate. A further review by Bergin⁸ and his colleagues argued again for a more conservative spontaneous remission rate of 43 per cent with the caution that "this is an average figure which obscures considerable variation". The original position, however, has been vigorously re-stated.⁹

The early reviews which appeared to lead to a discrediting of psychotherapy with adult patients were soon paralleled by review of child psychotherapy.^{10,11} In a series of reviews starting twentyfive years ago, Levitt cites an outcome in child guidance cases at the end of treatment of one third improved, one third partly improved, and one third not improved with similar rates for both treated and untreated cases. Somewhat better rates of improvement were observed at follow-up than at termination (three quarter of cases as against two thirds).¹² Serious questions have been raised about Levitt's conclusions. There are so many deficiencies which have resulted in Levitt's baseline improvement rate coming to regarded as unreliable. Furthermore, some of the studies included in Levitt's survey were overloaded with problems with known high spontaneous improvement rates are excluded, the 'much improved' rate falls to about 25 per cent. Levitt's evidence is seriously flawed and his conclusions therefore be seriously questioned, yet his contention of one third 'improved', one third 'partly improved' and one third 'not improved' became the hallmark against which other child therapies were judged.

The Newcastle School Based Studies (Help Starts Here)

We have seen that the argument which psychotherapy researchers have to confront is that there is essentially no difference in outcome between treated and untreated groups – some 66 per cent of both tend to show improvement. It has been suggested that the base rate for spontaneous recovery is so impressive that psychotherapy is not worthwhile since children will improve irrespective of therapy. Thus a reliable baseline for spontaneous recovery is crucial. We consider the Newcastle research makes a useful contribution towards a resolution of this complex area.

In the Newcastle studies described fully elsewhere,¹⁴ two control groups of disturbed children were identified, for which base rates could be calculated, with categories of 'good', 'moderate' and 'poor' outcome:

a) A random sample of 'maladjusted' controls (N = 83) in ordinary schools aged 11 - 12 years, identified by a multiple criterion screen. These were drawn from a school-based intervention study.¹⁴

b) A random sample of 'at risk' controls (N = 61) aged 7 - 8 years, in ordinary schools. These somewhat less disturbed children were drawn from the same study as (a) and were identified using a multiple criterion screen; they were considered as 'maladjusted' or 'at risk' for maladjustment.

The outcome pattern for the younger group proved similar to that shown by the other groups, and the greater numbers increases the robustness of the results. The combination of groups yields a sizeable sample of 144 untreated controls. (Another control group has been studied and is reported on elsewhere and the inclusion of this group gives rise to a modest variation of the proportions of good and poor outcome listed below).¹³

Outcome - the Newcastle control group (See figure 1)

The rate of good outcome after three years proved to be only 41 per cent. For a number of other reasons these results probably constitute an optimistic estimate of spontaneous improvement. For example, there may have been possible thera-

peutic contamination of the controls within schools, through the numerous contacts with the controls or their families by research workers. In addition, certain controls may have obtained help elsewhere.

However, against the background of results of the early reviews on spontaneous remission, these are unexpected findings. Are these findings consistent with more recent reports?

Recent evaluations of psychotherapy outcome

A relevant review of outcome data is that by Tramontana (1980)¹⁵ in his ten-year survey of clinical and experimental studies of psychotherapy for adolescents (between 1967 and 1977). A scan of the studies he selected for inclusion reveals only four studies with a reasonably sound methodology, with sample size sufficiently large to encourage confidence in results, and which also had follow-up data. Two of these studies concerned were of institutionalized delinquents receiving individual psychotherapy or some form of group therapy or counselling.^{16,17} The other two studies concerned discharged hospital psychiatric patients who continued in psychodynamic psychotherapy¹⁸ and a mixed psychiatric outpatient sample.¹⁹ The controls in the latter studies were patients who had terminated treatment and cases where it is reported that therapy was not indicated or refused.

When we combine the outcome in these four studies we obtain a 63 per cent rate of good outcome for the treated cases and 42 per cent for the controls. Tramontana¹⁵ adds that these results are not really comparable as there are vast differences in method and way of rating improvement in the studies surveyed.

Finally, Tramontana suggests that the change process in spontaneous remission is not random, but rather there are complex, but systematic, factors operating to produce changes in the absence of formal psychotherapy. He argues that describing it as spontaneous remission merely reflects our ignorance about such factors.

A study, comparable in methodology to the Newcastle treatment-comparison study, was that of Miller et al.²⁰ Two treatments, namely psychotherapy and systematic desensitization

were evaluated with phobic children. Treatment was time-limited, multiple measures were employed, and assessments were also available at follow-up. While both treatments did better than controls, they did not differ from each other. Most importantly, from the point of view of the present discussion, only 34 per cent of untreated cases had a successful outcome.

The findings examined in this section point consistently to the need for a downward revision of the traditional two-thirds estimate for spontaneous improvement of untreated cases. This represents an important shift in the standpoint of comparison for treatment studies. But what of treatment itself? Can it be shown to be effective?

Is therapy effective?

The central theme of this chapter relates to the question of whether therapy is effective. The Newcastle studies (Kolvin et al 1981; 1985) go some way towards providing a positive answer. The school-based study was undertaken with 547 children identified by screen procedures, and on whom individual information was gathered from parents, teachers and individual and group assessments. The children were randomly allocated by school class to the various treatment regimes, including a non-treatment regime. Major follow-ups were undertaken 18 and 36 months after the baseline assessments. The treatment regimes, with their principal characteristics, were as follows:

Behaviour modification

This programme was applied in secondary schools, with the main strategy being social reinforcement by teachers. Problem behaviours and goals were defined in behavioural terms and individual prescriptions were prepared for each child. Ongoing consultation with the teachers were provided by a psychologist.

Group therapy

Applied in both primary and secondary schools and conducted by social workers with small groups, with an emphasis on non-directive principles derived from Axline²¹ and Rogers.²²

Parent counselling - teacher consultation

This was applied in primary and secondary schools. Interventions consisted of consultation by social workers with teachers of identified children, casework with the parents, and attempts to link the home and school.

Nurture work

This was applied in primary schools and consisted of a compensatory and enrichment programme focussing on health interactional experiences. Teacher-aides were the principal mediators of the procedures.

Examining the results some 30 - 36 months after the start of treatment programmes, the following pattern emerged (see Figure 1). Combining the untreated control groups, the base rate of good plus moderate outcome is 41 per cent; the pattern for parent counselling - teacher consultation is similar to that of the controls; this base rate is exceeded by some 25 per cent in the case of the nurture work, by 32 per cent in the case of behaviour modification, and by 35 per cent in the case of group therapy.

It is important to try to locate such beneficial changes on the dimension of time. It is commonly believed that patients respond gradually to psychotherapeutic help, with the maximum response being achieved by the end of treatment. Thereafter, patients may reach a plateau, or, with the cessation of therapeutic support, the effects of treatment may begin to dissipate. Examining outcome across assessment points, it was intriguing to find that treatment effects continued to increase for some eighteen months or so after the end of treatment. The failure of the controls to 'catch up' by the end of our follow-up period also suggests that positive processes had been set in motion. This is well demonstrated in Figure 1.

One of the most attractive ideas to emerge from recent psychotherapy research is whether different types of disorders respond to different kinds of treatment. These concepts of specificity, which are so important in adult disorders, do not appear to be supported by our work with children and adolescents. We found no consistent evidence of specificity, namely a better response of conduct or neurotic disorders to different treatment or management programmes. Where treatment was

effective, it proved to be more so for neurotic and less so for conduct disorders, but there was no particular treatment which was more effective for one or the other.

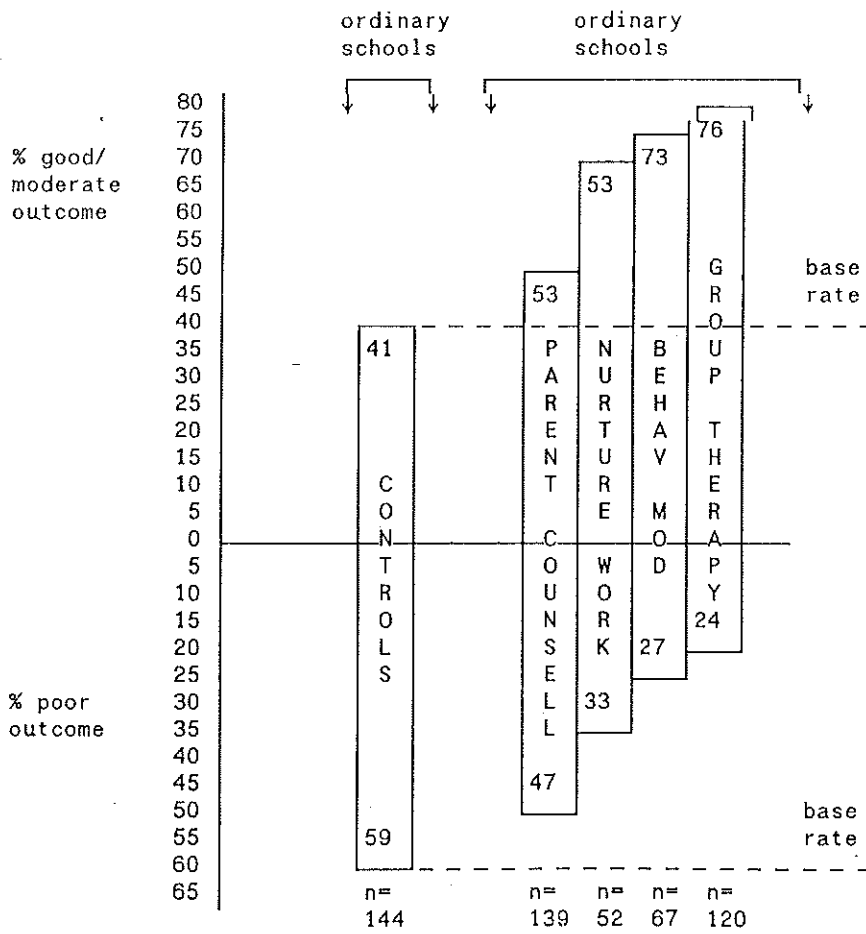
Discussion

The data presented here suggest that treatment can be effective and that some forms are more effective than others. Thus, nurture work, group therapy and behaviour modification show significantly better outcome than controls. Parent counselling - teacher consultation, in the form in which we applied it, proved ineffective, and children in this regime did no better than untreated controls. It should be noted that this pattern of results is essentially the same as revealed by multivariate analyses.¹⁴ (Maladjusted children in E.S.N. settings tend to do poorly, unlike counterparts in schools for the maladjusted. The greater availability of therapeutic input in the latter setting may explain some of this difference. With the hospital it is likely that the varied and multiple forms of psychotherapeutic input contributed to the good outcome with these cases.)

A major theme of this chapter has been the crucial status of information on untreated controls in evaluating therapy outcome. The results of the Newcastle studies and other recent work suggest that therapy researchers have for too long been misled by inflated spontaneous remission rates, against which the impact of their own helping efforts seemed almost inevitably trivial. The optimism of earlier estimates seems strangely at odds with clinical experience and findings from longitudinal research that a significant proportion of difficulties in childhood and adolescence do persist. In the Isle of Wight follow-up study²³ of children with psychiatric disorder at ten years, three-quarters of those with conduct disorders and nearly half (46 per cent) of those with emotional disorders still had handicapping psychiatric disorders in adolescence. There is much other evidence that disorders involving aggressive and anti-social behaviour are likely to persist to a greater extent than emotional disorders.²⁴ Other workers have also demonstrated persistence of widespread pervasive conduct disorder from the junior school years into adolescence.

Against such a background of evidence, our own findings

Figure 1: Experimental studies: good and poor outcome (%).



Based on data from 'Help Starts Here' (1985)

that some of 54 per cent of maladjusted children are the same or worse 30 - 36 months after identification, are not at all surprising and must erode confidence in the notion of transiency of psychiatric disorders in childhood and adolescence, especially those that are severe.

Another theme that the Newcastle studies help to highlight is the importance of follow-up assessments once treatment has ended. Our findings suggest that therapy may set in motion processes which have effects long after termination and these may go undetected if provision is not made for long-term follow-up. This has been a particular weakness of behaviour modification research where the often unwarranted assumption has been made that withdrawal of reinforcement procedures will lead to the loss of treatment gains, in the absence of programming for generalization.²⁶ The positive follow-up results reported here are not new: they are consistent with those of Wright et al.²⁷

As well as considering the notion of the trajectory of change, it is also important to consider other ways in which time is a relevant factor in therapy. Duration of treatment is an important element. For many reasons it is essential to identify forms of therapy that give rise to good outcome in the briefest possible time and hence are most economic.²⁸ Our work has shown that shorter term treatment has the best outcome, which is consistent with the findings of others^{29,30} who have indicated that the majority of patients respond positively with brief intervention.

Another question is the importance of frequency of sessions of psychotherapy. However, in our school-based treatment studies, it seemed that it was *type* rather than *intensity* of treatment that was the critical factor in intervention.

Community based early secondary prevention: some relevant findings

The classical approach to prevention has been based on the work of Caplan (1964).³¹ Such phrases have been coined as 'Cure is costly - prevention priceless'. The most influential ideas developed in the sixties and seventies stated that primary preventive activities are important because they attempt to

prevent the development of subsequent disorder by attacking its presumed origins, and simultaneously promote psychological adjustment (Sandford 1965).³² Such primary preventive approaches do not focus directly on individual distress. In Newcastle there has been particular interest in early secondary preventive activities which try to identify children who are considered to be at grave risk of developing abnormally and to prevent dysfunction becoming severe or overt. A prominent example of early prevention were the *Head Start* programmes which were designed to facilitate educational progress by providing deprived children with compensatory stimulation. The projects were reviewed by Bronfenbrenner (1974).³³ He concluded that compensatory stimulation provided in the preschool-years gives rise to substantial I.Q. gains while the programme lasts but that this trend reaches a plateau and gains are rapidly eroded once help ends. There have been some recent reviews which suggest that these programmes were not without useful long term effects.

In contradistinction to these findings Newcastle research outlined in *Help Starts Here* indicated that short term duration (ten sessions) group therapy with maladjusted older children or play-group therapy with younger children who were at risk for maladjustment had impressive long term outcome with widespread improvement in adjustment. The crucial difference between the above and the *Head Start* compensatory enrichment programme was that in Newcastle a therapeutic component was added. Traditionally enrichment is geared to cognitive and social development of the child. Play-group therapy includes this but in addition it attempts to promote emotional maturation and modify any associated behavioural and emotional problems.

The *Help Start Here* project included a number of deprived infant school children merely because maladjustment was so often inextricably interwoven with deprivation. However, the numbers of deprived children were not sufficient to enable a specific check of efficacy to be undertaken. If such efficacy can be demonstrated then play-group therapy has the potential for making a major contribution to counteracting the medium to long term effects of deprivation which is so widespread in our inner cities.

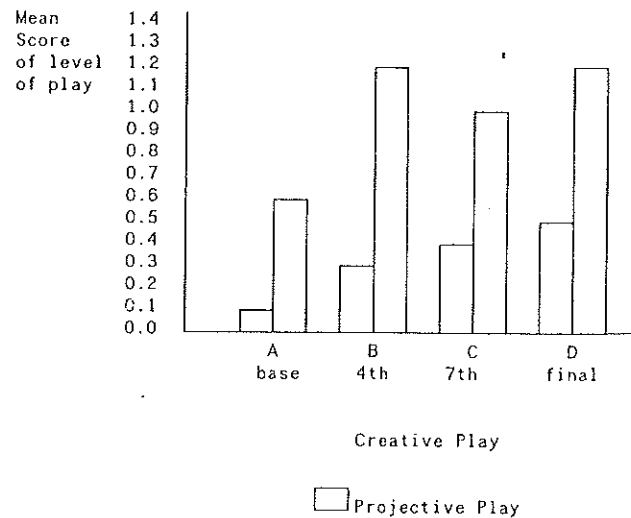
The intention of this most recent project was to evaluate the impact of play-group therapy on deprived infant school children. Inevitably the deprived group will include a high proportion of children who are 'at risk' for maladjustment. The treated group will be compared with a control group of deprived children not receiving this form of help.

Results

At the present time follow-up data are incomplete. However from monitoring of play and behaviour there are indications of some short term fluctuations occurring during therapy. Whilst we are not relying on these as indicators of long term outcome it is important to be aware of processes that have taken place during therapy. And indeed they may be predictors of outcome.

The patterns are summarized in figures 2, 3 and 4. Figure 2 shows an upward trend in creative and projective play. This upward trend suggests to us a growth of self esteem and increases in imaginativeness. We interpret this as an improvement in the ability to us play at a more advanced level.

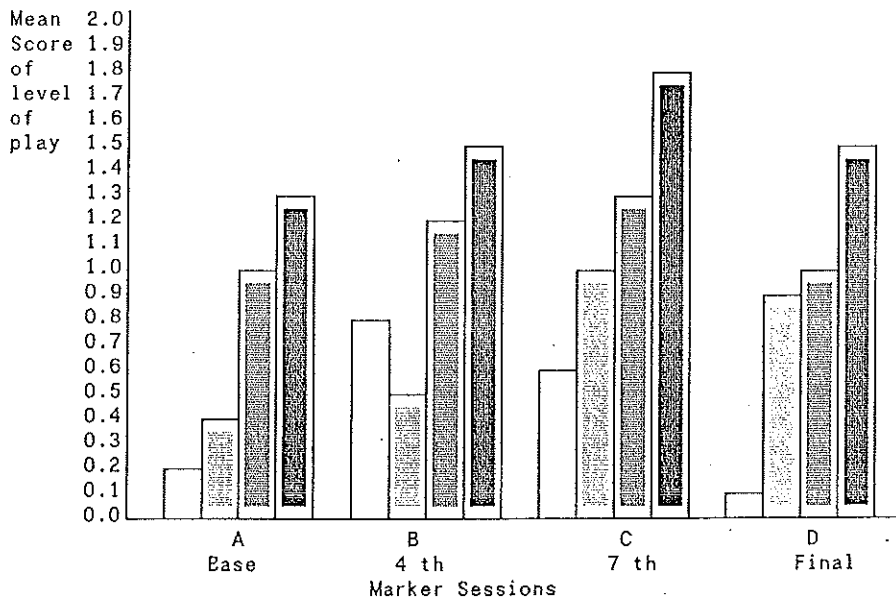
Figure 2: Changes in play: increases.



Note: Play was rated on an ordinal scale
(0 = none; 1 = little; 2 = some; 3 = much)

Figure 3 shows a pattern of increase followed by decrease and these are represented by regressive, aggressive and fantasy forms of play. The regressive scale possibly demonstrates the needs of some children to re-explore and meet early developmental needs at the sensory/tactile and motor levels. The aggressive scale perhaps indicates some of the emotional and physical tension released by these children in an environment that promotes health growth e.g. Klein (1955),³⁴ Ginott (1961),³⁵ Woltmann (1955),³⁶ and Slavson (1975).³⁶ We suggest that other reasons for the rise in aggressive play were its use in challenging the boundaries of the play setting and in some cases may represent increased assertiveness in previously passive children.

Figure 3: Changes in play: increases followed by decreases.



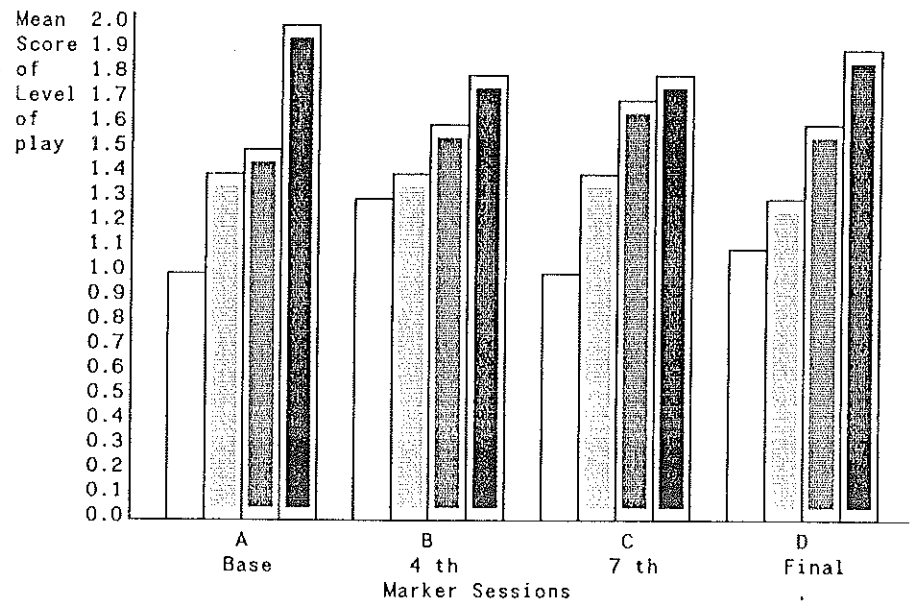
Note: Play was rated on an ordinal scale (0 = none; 1 = little; 2 = same; 3 = much)

Fantasy Play
 Regressive Play
 Aggressive Play
 Directed Play

In figure 4 we have the type of play that remained constant. Constructive play proved to be common. It reflects the children's level of active involvement in the play materials and the novelty of their unrestricted availability.

We would suspect that imitative and social play, which are less common but constant will increase with the child's improved ability to socialise and identify with the alternative adult models in their educational and play environment. However, there are some minor fluctuations which tend to obscure major changes in a small percentage of cases. For instance, looking at the curve of social play, little change occurs, but looking at individuals starting with problems in cooperative play one in four improve substantially.

Figure 4: Changes in play; play which remains constant.



Note: Play was rated on an ordinal scale
(0 = none; 1 = little; 2 = some; 3 = much)

□ Imitative Play

▨ Social Play

▩ Neutral Play

■ Constructive Play

Is Play-Group Therapy Helpful? There appear to be some immediate effects, as reflected in changes in creative and projective play and facilitory changes as seen in aggressive and regressive play. The medium and long term effects of the therapy is not yet available .

Another important question is what are the advantages of this type of intervention. Firstly, it is community rather than clinic based, so has the potential of being available to a larger number of children in need. It is also a relatively inexpensive form of short term group therapy. Lastly, parents in deprived circumstances may not have the resources, enthusiasm or motivation for participating in a therapeutic programme. Our programme is dependent on parental permission but not their participation. Therapy is given directly to the children in their everyday environment. However, whenever possible, complementary parent programmes should be encouraged.

There is now substantial evidence that community based prevention and intervention approaches help both children who are psychiatrically disturbed and those at risk for disturbance. We anticipate that in the future research workers will be addressing themselves to ascertaining what other forms of intervention might be helpful. And also studying the processes of therapy in endeavours to demonstrate predictive utility.

References

1. Eysenck, H.J. The Effects of Psychotherapy. An Evaluation. *Journal of Consulting Psychology* 1952; 16: 319-24.
2. Epstein, N.D. and Vlok, L.A. Research on the Results of Psychotherapy: A Summary of Evidence. *American Journal of Psychiatry* 1981; 1027-35.
3. Hartmann, D.P. Considerations in the Choice of Inter-observer Reliability Estimates. *Journal Applied Behaviour Analysis* 1977; 10: 103-116.
4. Meltzoff, J., Kornreich, M. Research in Psychology. New York: Atherton Press, 1970.
5. Gurin, G., Veroff, J., Feld, S. *Americans View Their Mental Health: A nationwide Survey*. New York: Basic Books, 1960.
6. Bergin, A.E. The Evaluation of Therapeutic Outcomes. In Bergin, A.E. and Garfield, S.L. (eds) *Handbook of Psychotherapy and Behaviour Change (1st edn)*. New York: Wiley, 1971.
7. Rachman, S. The Effects of Psychological Treatment. In Eysenck, H.J. (ed.) *Handbook of Abnormal Psychology*, New York: Basic Books, 1973.
8. Bergin, A.E. and Lambert, M.J. The Evaluation of Therapeutic Outcomes. In Garfield, S.L. and Bergin, A.E. (eds) *Handbook of Psychotherapy and Behaviour Change (2nd edn)*, New York: Wiley, 1978.
9. Rachman, S., Wilson, G.T. *The Effects of Psychological Therapy*. Oxford: Pergamon Press, 1980.
10. Levitt, E.E. Psychotherapy with Children; A Further Evaluation. *Behaviour Research and Therapy*, 1963; 60: 326-29.
11. Levitt, E.E., Beiser, H.R., Robertson, R.E. A Follow-up Evaluation of Cases Treated at a Community Child Guidance Clinic. *American Journal of Psychiatry* 1959; 29: 337-47.
12. Levitt, E.E. The Results of Psychotherapy with Children; An Evaluation. *Journal of Consulting Psychology* 1957; 21: 189-96.
13. Kolvin, I., MacMillan, A., Nicol, A.R. and Wrate, R.M. Psychotherapy is Effective. *Journal of the Royal Society of Medicine*, April 1988.

14. Kolvin, I., Garside, R.F., Nicol, A.R., Macmillan, A., Wolstenholme, F., Leitch, I.M. *Help Starts Here: The Maladjusted Child in the Ordinary School*. London and New York: Tavistock Publications, 1981, 1985.
15. Tramontana, M.G. Critical Review of Research on Psychotherapy Outcome with Adolescents 1967-1977. *Psychological Bulletin* 1980; 2: 429-50.
16. Redferring, D.L. Durability of Effects of Group Counselling with Institutionalized Delinquent Females. *Journal of Abnormal Psychology* 1973; 82: 85-86.
17. Persons, R. Relationship between psychotherapy with Institutionalized Boys and Subsequent Community Adjustment. *Journal of Consulting Psychology* 1967; 31: 137-41.
18. Gosset, J., Barnhart, D., Lewis, J., Phillips, V. Follow-up of Adolescents Treated in a Psychiatric Hospital: Predictors of Outcome. *Archives of General Psychiatry* 1977; 34: 1037-42.
19. Pichel, J.A. A Longterm Follow-up of 60 Adolescent Psychiatric Outpatients. *American Journal of Psychiatry* 1974; 131: 140-44.
20. Miller, L.C., Barrett, C.I., Hampe, E., Noble, H. Comparison of Reciprocal Inhibition, Psychotherapy and Waiting List Controls for Phobic Children. *JK. Abnormal Psychology* 1972; 79(3): 269-79.
21. Axline, V.M. *Play Therapy*. Boston: Houghton Mifflin, 1947.
22. Rogers, C.R. *Client-Centred Therapy*. Boston: Houghton Mifflin, 1952.
23. Graham, P., Rutter, M. Psychiatric Disorder in the Young Adolescent: A Follow-up Study. *Proceedings Royal Society of Medicine* 1973; 66: 1226-29.
24. Robins, L.N. Follow-up Studies of Behaviour Disorders in Children. In Quay, H.C., Werry, J.S. (eds) *Psychopathological Disorders of Childhood*. New York, 1972.
25. West, D.J., Farrington, D.P. *Who becomes Delinquent?* London: Heinemann, 1973.
26. Macmillan, A. *The Effectiveness of Behaviour Modification Procedures in Secondary Schools with Limited Teacher Training and Consultation Time*. University of Newcastle upon Tyne: PLO /Thesis, 1983.

27. Wright, D.M., Moelis, I., Pollak, L.J. The Outcome of Individual Psychotherapy Increments at Follow-up 1976. *Journal of Child Psychology and Psychiatry* 1976; 17: 275-85.

28. Strupp, H.H. Psychotherapy Research and Practice: An Overview 1978. In Garfield, S.L., Bergin, A.E. (eds). *Handbook of Psychotherapy and Behaviour Change (2nd edn)*. New York: Wiley, 1978.

29. Luborsky, L., Spence, D.P. Quantitative Research and Psychoanalytic Therapy. In Garfield, S.L. and Bergin, A.E. (eds) *Handbook of Psychotherapy and Behaviour Change (2nd edn)* New York: Wiley, 1978.

30. Garfield, S.L. In Strupp, H. (Chair) *Short-term Psychotherapy for Whom?* Symposium presented at the Annual Meeting of the Society for Psychotherapy 1977; Madison, Wis.

31. Caplan, G. *Principles of Preventive Psychiatry*. London: Tavistock, 1964.

32. Sandford, N. The Prevention of Mental Illness. In Wolman, B. (ed.) *Handbook of Clinical Psychology*. New York: McGraw-Hill, 1965.

33. Bronfenbrenner, U. *A Report on Longitudinal Evaluation of Preschool Programs*. Washington DC: US Department of Health, Education and Welfare; Office of Child Development, 1974.

34. Klein, M. The Psychoanalytic Play Technique. *American Journal of Orthopsychiatry* 1955; XXV: 223-237.

35. Ginott, H. *Group Psychiatry with Children*. New York: McGraw-Hill, 1961.

36. Woltmann, A.G. Concepts of Play Therapy Techniques. *American Journal of Orthopsychiatry* 1955; XXV: 771-783.

37. Slavson, S.R. and Schiffer, M. *Group Psychotherapies for Children*. New York: International Universities Press, 1975.