The evaluation of a multi-modal cognitive-behavioural approach to treating an adolescent with Conduct Disorder

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ABSTRACT

Conduct Disorder (CD) is a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated. It is one of the most common problems in South African schools, particularly in those that are poverty-stricken. The child who participated in the study lived in the shelter that was for homeless and disadvantaged children. He attended at Amasango School where the majority of children in the shelter attended. There were many conduct-disordered children in the shelter and the school, particularly in the school. They disrupted classes making in difficult for teachers to carry out their education activities. The aim of this study was to draw on the standard procedures of the CBT in order to design interventions that would be effective in reducing aggressive behaviour in an adolescent who had CD Adolescent-Type and who lived at the shelter. This case study evaluated the effectiveness of a multi-modal CBT programme in a 16 year-old Black male who had been displaying aggressive behaviour for about a year. The treatment consisted of 23 sessions and included teacher counseling, contingency management, self-control and self-instructional training. The treatment was evaluated qualitatively by means of interviews with the child and teacher and quantitatively by means of repeated applications of behaviour checklists completed by the teacher. The results showed a decrease in the client's aggressive behaviour and an increase in prosocial behaviour. The client ultimately ceased from all aggressive behaviour towards his peers and this outcome was sustained during his last two months in therapy.

TABLE OF CONTENTS

1. INTRODUCTION

Conduct Disorder (CD) is among the most frequently occurring child behaviour problems and is difficult to treat. Kazdin cited in Hill & Maughan (2001) states that when treating clients with CD, there is always a high possibility for negative outcomes. CD in children and adolescents can lead to a lifetime of social dysfunction, antisocial behaviour and poor adjustment. Furthermore, CD does not only affect children and adolescents who suffer from it, but also the schools, peers, families and broader society. In schools CD is associated with many problems ranging from annoying and disruptive behaviour such as non-compliance to more serious antisocial and delinquent behaviours (Brunk, 2000). In her study of incarcerated juveniles, Brunk (2000) found that 87-91% had CD. Conduct disordered adolescents can elicit strong feelings of frustration, anger and anxiety within their families. They strain the tolerance limits of those in authority positions through their repeated aggressive behaviour (Feindler & Ecton, 1986). Further, CD is also a very costly form of psychopathology for society (Frick, 2001). Monetary costs include costs of repairing schools damaged through vandalism and social costs include the inadequate and unsafe learning environments created in schools by conduct disordered children.

Considering its negative impact, it is imperative that effective interventions are implemented when rendering psychotherapy to adolescents with CD, particularly as most interventions have had very limited effectiveness (Frick, 2001). The cognitive-behavioural therapists have empirically evaluated many interventions for effectiveness in treating CD. Mpofu & Crystal (2001) reported that the cognitive-behavioural therapies comprise about 50% of treatment studies on CD spanning a period of about two decades. Research findings have shown that a multi-modal cognitive-behavioural treatment approach is among the few effective interventions for this condition as it treats both the individual and the contexts that cause, sustain and escalate CD (Mpofu & Crystal, 2001). Through research, important aspects that need to be taken into consideration to increase the likelihood for positive treatment outcome have been identified. These include the understanding of developmental pathways to CD and the use of a rigorous cognitive-behavioural assessment to which Herbert cited in Graham (1998) referred as the *sine qua non* of an effective intervention.

Conduct Disorder is described as a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated (American Psychiatric Association, 2000). Kazdin (1988) reported that the prevalence of CD is greater for boys than for girls. However, Kann & Hanna (2001) and Friedberg & McClure (2002) in their studies found that after puberty, the rates for CD for boys and girls become equal. They further report that gender somehow shapes symptom expression in CD. Kann & Hanna (2001) stated that, unlike boys, girls express symptoms of CD covertly, such as teen pregnancy. Therefore girls with CD are not easily noticed and referred as compared to boys. This may account for a finding in another study that girls that were referred for CD problems were observed to present with more severe behaviour problems than boys (Kann & Hanna, 2001). Considering gender differences in symptom expression of CD, Lyddon & Jones (2001) suggest that gender specific forms of treatment interventions need to be designed. CD is high in low socioeconomic groups and in single versus two-parent families (Kazdin, 1988).

1.1. DIAGNOSIS

Fifteen criteria of CD are grouped under four subheadings that cover aggression to people and animals, destruction of property, deceitfulness or theft and serious violation of rules. The diagnosis of CD requires the presence of three or more of the fifteen criteria in the past 12 months, with at least one criterion present in the past 6 months (American Psychiatric Association, 2000). CD is categorized into three subtypes, which are:

- Conduct Disorder, Childhood-Onset Type that is characterized by onset of at least one criterion prior to age 10 years.
- Conduct Disorder, Adolescent Type that is characterized by the absence of any criteria characteristic of CD prior to age 10 years.
- Conduct Disorder, Unspecified Onset where the age at onset is not known.

Conduct Disorder is further specified as either mild, moderate or severe, depending upon the number of criteria that are met (American Psychiatric Association, 2000).

1.2. RATIONALE FOR USING COGNITIVE-BEHAVIOURAL THERAPY

Cognitive-behavioural treatment (CBT) has a relatively wide recognition in terms of potential for treatment of CD as compared to the more traditional therapies such as

psychodynamic therapy, client-centred therapy and family therapy (Mpofu & Crystal, 2001). Mpofu & Crystal further reported that CBT comprises about 50% of treatment studies on CD as compared to traditional therapies of which each account for less than 5% of the studies. Through research, a growing number of CBT therapists have acknowledged that individuals who engage in conduct disordered behaviours, particularly aggression, show distortions and deficiencies in various cognitive processes (Hill & Maughan, 2001). Examples include deficiencies in generating alternative solutions to personal problems, deficiencies in making attributions to others of the motivation of their actions, deficiencies in perceiving how others feel and expectations of the effects of one's own actions. Based on research findings, current CBT treatments of choice have been identified. These cognitive-behavioural based interventions for treating CD aim at altering specific perceptions, images, thoughts and beliefs through direct manipulation and restructuring of faulty, maladaptive cognitions (Graham, 1998).

1.3. DEVELOPMENTAL PATHWAYS TO CONDUCT DISORDER

There are different pathways along which children may develop CD. A good insight into the different pathways is vital for the proper assessment as well as for the planning of interventions that are likely to be effective in treating CD. Frick (2001) found that individualized pathways to CD act as guides to assessment and intervention.

1.3.1. Theories on different causal mechanisms operating in the development of CD across the childhood-onset and the adolescent-onset groups

According to the American Psychiatric Association (2000), the two CD developmental pathways are childhood-onset and adolescent-onset. These two developmental pathways differ in the timing at which the symptoms begin to emerge, the correlates associated with the disorder and the long-term outcome of the disorder (Frick, 2001). Mash & Barkley (1998) stated that there are three different but related considerations that must guide assessment and intervention procedures for children with CD. They are developmental, contextual and transactional aspects of CD. By developmental considerations they meant that the behavioural manifestations of CD change over time. The term contextual aspect is used to highlight the fact that the development and maintenance of CD are influenced by genetic or

constitutional characteristics of the child such as temperament, family, peers and broader ecologies that include school, neighbourhood and community (Mash & Barkley, 1998). The transactional aspect means that "the developmental and contextual processes unfold over time and continuously influence each other" (Mash & Barkley, 1998, p.116).

1.3.1.(a) The childhood-onset conduct disorder

Mash & Barkley (1998) found that, as compared to the adolescent-onset CD, the childhood-onset CD seems to have more negative long-term prognosis. They reported that these children are at significant risk for progressing from mild to severe CD over time. The overt behaviours that include defiance and fighting appear earlier than covert behaviours such as lying and stealing. Later conduct behaviour problems expand the children's behaviour repertoire than replacing earlier behaviours. Further, behavioural problems of conduct disordered children expand over time from home to other settings such as the school and the broader community.

According to Mash & Barkley (1998), there are individual, familial and broader contextual factors that may increase the likelihood of a child's entering and progressing along the childhood-onset CD pathway.

- Hyperactivity is a significant risk factor for the childhood-onset CD. Hyperactive conduct-disordered children tend to display more serious and higher levels of CD. They also tend to have poor prognosis.
- Neuropsychological variations in the child's central nervous system increase the likelihood that the child might be temperamentally difficult. The child may display characteristics such as irritability, hyperactivity and impulsivity. Such a child might be predisposed to CD because of the increased likelihood of maladaptive parent-child interactions. The neuropsychological deficits may also affect the development of the child's social cognitive skills. Such children present with a variety of deficits in the processing of social information. Deficits that have been observed include making of more hostile attributional biases, errors in the interpretation of social cues, problems in finding solutions to problems and such children are more likely to engage in aggressive behaviour.

- Coercive parenting practices increase the likelihood of a child's developing childhood-onset CD (Mash & Barkley, 1998). In these families, parents reward children's deviant behaviour. Research has shown that inept parenting practices predict deviant child behaviour and that changing these practices has significant impact on child functioning (Hill & Maughan, 2001).
- There are familial factors that have an impact on the child and that serve to precipitate or maintain CD (Mash & Barkley, 1998). These factors include depressed mothers and parents with maladaptive cognitions who are likely to misperceive a child. Parents with more personal, interpersonal and extra familial distress are more likely to contribute to CD. Parental antisocial behaviour, substance abuse and marital distress have also been shown to be associated with childhood CD.
- Upon school entry the child's coercive style of interaction is likely to extend to interactions with teachers and peers resulting in frequent disciplinary confrontations with teachers and rejection by peers.

1.3.1.(b) The Adolescent-onset conduct disorder

Research on adolescent-onset CD shows that it is less serious as compared to childhood-onset CD. Mash & Barkley (1998) found that children who develop CD at this age usually do not show any evidence of temperamental difficulties and they usually do not have a history of preexisting family adversity. Furthermore, they were less likely to have been convicted of violent criminal offences than children diagnosed with childhood-onset CD. However, there are more children that are diagnosed with adolescent-onset CD than those diagnosed with childhood-onset CD.

Patterson cited in Mash & Barkley (1998) hypothesized that the process leading to the adolescent-onset CD begins in families that have marginally effective family management skills as a result either of significant stressors, such as divorce and unemployment, or of the strain placed on families as children become adolescents. Patterson's hypothesis is consistent with the research findings of Kazdin cited in Hill and Maughan (2001). Kazdin found that CD might either develop because of parent-child influences or of child-parent influences. He then referred to the whole process of the development as bi-directional.

Inadequate parental supervision, particularly at middle and high school increases the likelihood of significant involvement in a deviant peer group (Mash & Barkley, 1998). Mash & Barkley found that children with the adolescent-onset CD are less likely to continue to engage in CD behaviours because they have a higher level of social skills and a longer learning history of employing such skills successfully than do children with childhood-onset CD. However, Hamalainen and Pulkkinen cited in Mash & Barkley (1998) in their study of criminals found that about one third of the criminals were diagnosed with adolescent-onset CD.

1.3.2. Temperament and personality as potential factors in the development of CD

The development of CD in children and adolescents is examined from the perspective of Hans Eysenck's biosocial theory of personality (Kemp & Center, 2003). The findings of this theory have been supported by many large-scale studies across cultures worldwide. The theory views personality as a product of the interaction of temperament, which is a biologically based trait, and socialization experiences. The theory is sometimes called the three-factor model in which the three factors are extroversion, neuroticism and psychoticism. The extroversion is hypothesized to be dependent upon the baseline arousal level in an individual's neocortex and mediated through the ascending reticular activating system (Kemp & Center, 2003). Eysenck found that the neuroticism is dependent upon the individual's emotional arousability due to differences in ease of visceral brain activation which is mediated by the hypothalamus and limbic system (Kemp & Center, 2003). The third factor, the psychoticism, is said to be a polygenic trait in that it is determined by a large number of genes each of whose individual effect is small. Eysenck found that the influence of these 'small effect' genes is additive, so that the total number inherited determines the degree of the psychoticism trait in the personality (Kemp & Center, 2003).

The psychoticism is the factor that has the most direct link to the development of CD. Children and youth that obtain high scores on psychoticism scale are more likely to lack empathy, to be cruel, egocentric and not compliant with rules. This description is congruent with the criteria that are used to diagnose CD (American Psychiatric Association, 2000). Further, research has shown that patients diagnosed with antisocial personality disorder,

schizotypal personality, borderline and schizophrenia also score high on the psychoticism scale. According to Eysenck's theory, individuals who score high on psychoticism and on extroversion traits will be predisposed to developing antisocial, aggressive behaviour. Aggressive behaviour is associated with low cortical arousal (Kemp & Center, 2003). Eysenck cited in Kemp & Center (2003) found that an individual with a relatively under-reactive nervous system does not learn restraints on behaviour or rule-governed behavior, as readily do individuals with a higher basal level of cortical arousal. Eysenck's findings are consistent with those of Frick (2001). Frick found that callous and unemotional traits might designate a subgroup within the children diagnosed with the childhood-onset CD. Frick further stated that the behaviour of these children is more strongly related to a temperament defined by low behavioural inhibition. According to Frick (2001) low behavioural inhibition is characterized physiologically by under activity in the autonomic nervous system and behaviourally by low fearfulness of threatening situations as well as poor response to punishment cues. Further, when an individual scores high on neuroticism as well, this will add an emotional and irrational character to behaviour under some circumstances (Kemp & Center, 2003).

Eysenck cited in Kemp & Center (2003) stressed the role of temperament in the predisposition for antisocial and aggressive behaviour while acknowledging the importance of socialization experiences in interaction with temperament. Frick (2001) found that temperament could be related to the development of callous and unemotional traits in several ways. Examples are that it could place a child at risk for missing early precursors to empathic concern and it could make a child to be relatively insensitive to the prohibitions and sanctions of parents and other socializing agents. It also creates an interpersonal style where a child becomes so focused on the potential rewards of using aggression to solve problems that he/she she ignores the potentially harmful effects of this behaviour on others (Frick, 2001). When discussing the increase of antisocial behaviour due to inadequate or inappropriate socialization, Lykken cited in Kemp & Center (2003) distinguishes between antisocial individuals who have a temperament predisposition for antisocial behaviour (psychopaths) and those that are purely the results of poor socialization (sociopaths). Lykken further stated that sociopaths are reared in environments with little structure and

unpredictable or harsh parenting. According to Lykken, the result of poorly socialized individuals is an individual with a weak, underdeveloped conscience and poorly developed rule-governed behaviour.

Lykken cited in Kemp & Center (2003) discussed three different temperament genotypes and their relationship to socialization. The first genotype is rare. Children with this genotype often achieve good socialization even with socially inadequate parents. The second genotype is the average genotype. Children with this genotype require parents of at least average competence for good socialization. The third genotype is the hard-to-socialize genotype. Children with this genotype are prone to develop antisocial and aggressive behaviour than other children. Such children need highly competent parents to attain adequate socialization and even with such parents, factors such as poor neighbourhood conditions and peer influences may play important roles in the development of antisocial behaviour (Kemp & Center, 2003).

1.3.3. Cognitive processes in aggressive children with CD

A significant amount of empirical evidence has shown how cognitions operate to modify behaviour of aggressive children in social situations. Dodge et al. cited in Tolan & Cohler (1993) formulated a five-step sequential model of social information processing. According to this model, an individual must first encode the social cues, interpret those cues, generate solutions, decide on an optimal response and then enact the response. Research has shown that there is a relationship between biases as well as deficits in processing information at some or all of the steps and problem behaviour, particularly in aggressive children. Tolan & Cohler (1993) stated that one of the most replicated findings is the tendency of elementary school-age aggressive children to attribute hostile intent to peers under conditions of ambiguity. Hostile attributional bias was particularly found to characterize aggressive/ delinquent adolescents.

Huesmann cited in Tolan & Cohler (1993) proposed that social behaviour is to a greater extent controlled by cognitive 'scripts' learned during early developmental stages. By cognitive scripts Huesmann meant a representation in memory of a specific sequence of

actions corresponding to a familiar event. When explaining the sequential steps through which scripts guide the behaviour, Tolan & Cohler (1993) reported that an individual possessing a stable cognitive representation of the script, enters a social interaction that contains elements evoking the script, and retrieves the script from memory. The concept of the script emphasized the role of the content of thought and the process of thinking in mediating behaviour.

Tolan & Cohler (1993) found that beliefs serve to motivate and to inhibit social behaviour. In their study of aggressive adolescents, they found that aggressive boys were more likely than their less aggressive peers to believe that aggression increases status and self esteem. The aggressive boys were also found to be more likely to respond aggressively without considering other non-aggressive responses and the consequences of their behaviour.

When explaining anger and aggression in youth diagnosed with CD, Dykerman (1995) stated that aggressive behaviour is a manifestation of one's personal construct system and the irrational thoughts that emanate from that construct system. Dykerman further explained that these personal constructs and irrational thoughts precede the development of anger and hostility, which ultimately contribute to the onset of aggressive behaviour.

Hill and Maughan (2001) found that children who engage in CD, particularly aggression, show distortions and deficiencies in cognitive processes such as generating alternative solutions to interpersonal problems, identifying the means to obtain particular ends or consequences of one's actions including what would happen after a particular behaviour. More examples include deficiencies and distortions in making attributions to others of the motivation of their actions, perceiving how others feel and expectations of the effects of one's own actions. Hill and Maughan further reported that aggression is not merely triggered by environmental factors but occurs through the way in which the child perceives and processes the events.

1.4. ASSESSMENT

According to Kendall & Hollon (1981, p.227) "assessment plays a central role in child-clinical psychology". A thorough cognitive-behavioural assessment helps a therapist to have a clear picture of the client's problems, particularly as children are referred by adults for therapy. Knowing what is wrong with the client enables therapists to make informed decisions regarding intervention programmes. Zarb (1992, p.190) recommended that "assessment should be ongoing so that fresh information about the client's habitual thought, behavioural patterns, the consequences of the client's adaptive and maladaptive behaviours at home, at school etc. would be evaluated throughout the duration of therapy". As children's behavioural problems could not be separated from the contexts where they live, Kendall & Hollon (1981) recommend that the assessment should involve the peer, family and school systems. Kearney (1999) stated that when assessing children with CD, assessment should focus on behaviours that are most problematic, such as aggression. It is important to state the severity of problematic behaviours, whether they are covert or overt in nature, comorbid conditions and variables, which maintain them. There are many reasons that may prevent the use of assessment techniques with every child such as time constraints and unavailable or uncooperative parents. However, attempts should be made to secure data from as many sources as possible. Therapists use various assessment methods to assess clients' behaviour, beliefs and emotions. They include clinical interviews, behavioural observations, role-plays, imagery, dysfunctional thought records and psychometric testing.

1.4.1. Clinical Interviews

In order to obtain an accurate representation of the client's problems, the therapist conducts interviews with the conduct-disordered child, parents and other relevant parties such as teachers and the child's peers. Therapists differ with respect to whom they prefer to meet during the initial interview. Some prefer to have an initial interview with the family and others prefer to interview the client first. Kann & Hanna (2001) noted that an adult informant is necessary for a reasonable assessment of clients with CD because it requires reporting on the client's negative impact on the social environment. Kendall (2000) recommended that, if possible, the initial interview should be held with the entire family. Furthermore, the therapist can obtain information about how angry the parents are with the

child, and with each other and about the problem. Such information can be very useful during treatment implementation. Meeting with the family during the initial interview also helps to prevent the child from suspecting that something secretive is being planned. Further, aggressive children generally have a history of conflict with authority figures and are quick to think that they are in trouble again (Kendall, 2000). Therefore meeting with the parents during an initial interview might result in a negative perception by a child.

As parent-child interactions are an important aetiological factor in CD, Mash & Barkley (1998) emphasized the importance of conducting clinical interviews with the client's parents. The primary purpose of the interview is to determine the nature of the typical parent-child interactions that are problematic, the antecedent conditions under which conduct-disordered behaviour occur and the consequences that accompany such behaviours (Mash & Barkley, 1998). The information obtained during an interview is recorded. The use of structured interview formats helps in ensuring that the required information was obtained and recorded.

Mash & Barkley (1998) further stated that, depending on the age or developmental level of a child, individual interviews with children might or might not provide useful content-oriented information. Young children aged below ten years old are usually not reliable reporters of their own behavioural symptoms (Kann & Hanna, 2000). Mash & Barkley (1998) suggested that the use of parents and teacher reports might be of assistance particularly in reporting overt types of conduct-disordered behaviours such as fighting and bullying. However, Ross (1980) emphasized that no matter how young the child, conducting interviews with him/her is necessary for the clinician to have a firsthand knowledge of the one who is the main target of assessment. Further, Ross states that clinicians need to acquire necessary skills for conducting interviews with young children such as conducting interviews while taking a walk or using play. Kendall (2000) found that conduct-disordered children tend to present themselves in the best light or minimize their own aggressive behaviour. When the presenting problems include the classroom behaviour or underachievement, interviewing teachers seems appropriate. Different scales may be used for this purpose such as Conner's Teacher Rating Scales and Barkley's School Situation Questionnaire (Mash & Barkley, 1998). However, research has shown that when assessing covert types of conduct-disordered

behaviours, such as stealing and lying, more valid reports were obtained after individual interviews with conduct-disordered children than with significant others (Mash & Barkley, 1998). Another advantage of individual interviews with children with CD is that they provide the therapist with an opportunity to assess their perception of why they have been referred for therapy (Kendall, 2000). Further, information about the child's cognitive, affective and behavioural characteristics are assessed during individual interviews (Mash & Barkley, 1998).

Kendall (2000) emphasized the importance of the maintenance of a good rapport between the client and the clinician throughout the interview and treatment implementation. The clinician needs to be patient and be supportive of the child as…" by the time the child meets with the therapist, he or she has been lectured, scolded, punished by many adults, and often feels guilty and defensive" (Kendall, 2000, p. 144). According to Kendall aggressive clients often respond with single word responses to open-ended questions, or simple shrug, or they simple withdraw and remain silent. The client must always be made to feel that the aim of the interview is to help and confrontations must be avoided, as they are likely to make children defensive.

1.4.2. The use of imagery

Imagery has been found to be particularly useful during interviews with aggressive children. The clinician simply asks the client to close his or her eyes and visualize the event. Thereafter the client is asked to play the scene and to give a description of what is being played or to make drawings about the scene. The clinician can help the child focus attention by asking specific questions about internal dialogue, visual images, physiological sensations and about other details that are seen as potentially relevant. It is important to record all the details while the child is providing the description (Kendall, 2000).

Kendall (2000) found that children below the age of 10 frequently have difficulties in using imagery as their attention drifts and a more concrete approach is more helpful. The use of action figure drawings has yielded positive results. Children tend to enjoy this type of task and this helps to develop a sense of collaboration that becomes helpful during therapy. When

this approach is used the client is asked to describe the scene and the therapist makes a stick drawing of the described scene. The clinician asks questions to help make the drawing and at the same time asks information about the client's feelings, thoughts and physical sensations. Bubbles, as utilized in cartoons, could be used to refer to the internal dialogue while continuous lines could be used to indicate the external speech.

1.4.3. Role-Plays

For role-plays to yield the required response, a good relationship between the client and the therapist should have been well established. The therapist should also set the limits clearly indicating what behaviours are not allowed during role-playing. Kendall (2000) noted that it does not take a long time for children to be comfortable with role-plays and during role-plays they actually play the behaviours that have led to their being referred. Reinecke, Dattilio & Freeman (1993) stated that using dolls or puppets during plays helps to remove the focus on the child who is assessed. This is important as, "feelings most defended against and defenses hardest to point out can thus be visualized and verbalized in an unobstrusive way" (Reinecke, et al., 1993, p. 234).

1.4.4. Dysfunctional Thought Record

Freeman, Pretzer, Fleming and Simon (1990) recommend the implementation of the dysfunctional thought record to assess adolescent's emotions and cognitions outside the therapist's office. When used properly, the thought record may yield complete and accurate information, as the client does not need to wait for the session to report about his/her emotional and thought responses to a particular situation. It allows the therapist to have a clear description of the client's emotions and cognitions, particularly as adolescents often fail to name what they feel (Graham, 1998). However, adolescents need thorough training on its utilization.

1.4.5. Behavioural Rating Scales

Kann & Hanna (2000) noted that behaviour-rating scales are among the most popular behaviour measures for children with CD. The behaviour-rating scales could be completed by the client's significant others such as parents and teachers or by the client. Kendall (2000)

referred to the behavioural rating scales that are completed by the client as self-reporting measures. When used as self-reporting measures, behaviour rating scales are helpful in assessing covert behaviours that could not be accurately identified by the client's significant others. However, Ross (1980) warned that when interpreting what teachers or parents report on child behaviour, therapists should also take into consideration data that was obtained through other assessment methods such as observation. This is so because research findings indicated that reports on child behaviour using behaviour rating scales sometimes bear little relationship to the child behaviour when others observed it. Ross further stated that reports on child behaviour might be biased as after all parental/ teacher complaints are the main reason for the referral of a child.

Mash & Barkley (1998) stated that the advantages of using behavioural rating scales during assessment are that they are excellent measures of parental and teacher perceptions of the child. Further, as different informants complete the behavioural rating scales, more information is gathered about the child's behaviour and this allows comparisons across informants and situations. Conner's Teacher Rating Scale is recommended.

1.4.6. Behavioural observations

Ross (1980) emphasizes the importance of behaviour observations in child clinical psychology research. He further stresses that for behavioural observations to be successful, the clinician needs to know explicitly what behaviour he/she is looking for. To accomplish this, the clinician has to rephrase the complaints about the child in an objective form so that they become observable and measurable. Ross recommended the use of observational codes that explicitly label the behaviour that should be observed. A child's behaviour should be observed in the setting where it is deemed to be a problem. The information that is gathered through behavioural observation procedures is compared with data obtained via other methods to assist the clinician in determining whether the treatment focus should be on the parent-child/ teacher-child interaction or on the client. Kendall & Hollon (1981) warned that the very act of observation changes the actual behaviour being observed. They suggested that it sometimes helps when the researcher starts by visiting the place where observations

would take place and starts the actual observations later when the participants are used to his/her presence.

1.4.7. Psychological Testing

Psychometric testing might be necessary, particularly if there is a history of neurological injury or diseases and/ or evidence of learning problems since some CBT techniques need to be stored in memory, accessed and implemented when necessary. All this requires cognitive abilities in the average intellectual range (Feindler & Ecton, 1988).

1.5. KEY CHARACTERISTICS TO CONSIDER IN RELATION TO TREATMENT

Hill and Maughan (2001) stated that CD encompasses heterogeneous and multifaceted problems that increase the challenge for the therapists who are involved in treating clients with CD. Further, since a diagnosis of CD depends on the child presenting with at least three of the 15 criteria specified in the DSM, children diagnosed with CD vary greatly in the specific symptom combinations they present. Even where children present similar symptoms, pathway patterns that led to that point may be quite different. Furthermore, children who meet criteria for CD are likely to meet criteria for other disorders as well (Mash & Barkley, 1998). They are likely to show academic deficiencies, to be diagnosed with ADHD, anxiety and depressive disorders. Therefore for treatment to be effective, more will need to be addressed within the child's repertoire than the core symptoms of CD (Hill & Maughan, 2001).

Kemp & Center (2003) stated that sometimes children diagnosed with CD show significant improvement following time-limited intervention but soon revert to displaying behavioural problems after treatment interventions have been stopped. Thus Kemp & Center recommended that children with CD might need some form of monitoring and treatment follow up at least every six months. If there are indications of relapse, these should be followed with booster treatments.

1.6. CURRENT TREATMENTS OF CHOICE FOR CONDUCT DISORDER

There are many different types of interventions that have been used in treating children and adolescents with CD. Unfortunately many of these have not been effective. A few current treatment interventions that have been empirically evaluated as effective in treating CD are highlighted below.

1.6.1. Parent Management Training

Kazdin (2000) stated that Parent Management Training (PMT) is among the most well researched and is one of the most promising treatment interventions in treating behavioural problems in children with CD. PMT aims at altering the pattern of interaction between the parent and the child by reinforcing and supporting a prosocial rather than coercive pattern of interaction within the family. It is based on the general view that the behavioural problems of a child are developed and maintained in the home by, for example, harsh punishment and directly reinforcement of deviant behaviour. During therapy sessions, the therapist adopts a relatively directive stance. He/she teaches parents to use specific procedures to alter their interaction with their children. Parents are also trained to identify, define and observe behavioural problems of their children in new ways.

Friedburg and McClure (2002) have found it helpful for a therapist to train both the parent and the child to learn to hear problems from each other's perspective. This process had been found to soften rigid patterns and pave the way for more productive problem solving. Further, the therapist teaches parents how to implement PMT procedures. Parents are also given a chance to practice and to refine the use of the procedures through extensive role-playing. Friedberg and McClure warned that attention must not only be paid to what parents say during sessions but to how they say it. The non-verbal communication, such as body posture and facial expressions, should be watched as "disingenuous commands sabotage PMT effectiveness" (Friedberg & McClure, 2002, p. 272). The use of positive reinforcement and punishment to extinguish deviant behaviour are also practiced. Friedberg & McClure reported that equipping parents with such skills has many advantages. It helps to decrease the parents' all-or-none thinking. This is so because as parents try to catch the child when he/ she is on his/ her better behaviour, parents are shifting their attentional set. Such skills help to

shape the behaviour of a conduct-disordered child. They also replace ineffective methods being used within the family such as the overuse of punishment techniques, coercion and calling of insulting names, to which the child is unlikely to listen. The therapist may use video-based lecture demonstrations and manuals. Usually only one parent is directly involved in PMT programmes. The duration of treatment varies according to the severity of the child dysfunction. Kazdin (2000) stated that programmes for clinically conduct-disordered children usually last for 12 to 25 weeks.

The effects of PMT have led to the marked improvement of children's deviant behaviour on a wide range. Positive reports on the behaviour of children have been received from parents, teachers and institutions such as prisons. Through PMT conduct problem behaviours have been changed to be within non-clinical levels of functioning at home and at school and treatment gains have been maintained to one to three years. Long et al. cited in Kazdin (1995) reported treatment gains that lasted for 10 to 14 years later. Kazdin further found that the impact of PMT is relatively broad. It led to the improvement in the behaviour of the siblings of children referred for treatment. In addition, maternal psychopathology, particularly depression, has been observed to decrease systematically following PMT (Kazdin, 1995).

The PMT effectiveness depends on the various family, child, therapist and treatment characteristics (Kazdin, 2000). Socioeconomic disadvantage, marital discord, parent psychopathology and poor social support tend to be associated with fewer gains in treatment and poorer maintain of gains. Among the child characteristics, more severe and chronic antisocial behaviour as well as comorbidity predict reduced response to treatment (Hill & Maughan, 2002). Kazdin (2000) found that there is some evidence that therapist's training skills are associated with the magnitude and durability of therapeutic changes. The duration of treatment influences the outcome of PMT. Therapy sessions that last for less than 10 hours are less likely to show benefits. More durable PMT effects have been achieved with PMT programmes that lasted for up to 50 to 60 hours (Kazdin, 1995). Hill & Maughan (2001) also noted that providing the parents with in-depth knowledge of social learning principles in addition to teaching PMT techniques is associated with improved outcome.

According to Kazdin (2000), PMT has several limitations as well. It makes several demands on parents as they are expected to master educational materials that convey major principles underlying the programme. Further demands made on parents include systematic observing deviant child's behaviour and implementing specific procedures at home and attending weekly sessions with the therapist. In addition, Kazdin (2000) found that PMT is less effective with adolescents. Brunk (2000) found that the optimal affects of PMT are achieved before conduct-disordered children finish the fourth grade and before conduct behavioural problems become firmly entrenched through association with deviant peers.

1.6.2. Cognitive problem- solving skills training

Problem solving skills training (PSST) focuses on developing and improving the children's approaches in interpersonal interactions (Hill & Maughan, 2001). The emphasis is on thought processes that the child engages to guide responses to interpersonal situations. Friedberg and McClure (2002) noted that problem solving with conduct-disordered children requires considerable flexibility as the maladaptive problem solving can be quite reinforcing. An example is that of a youth whose immediate cash benefits of drug dealing outweighs the consequences of criminal activity. To succeed in developing more productive alternatives and in obtaining the cooperation of children with CD, each option's reinforcing value has to be considered. Thereafter different approaches could be implemented to substitute maladaptive strategies with productive ones. Furthermore, Friedberg and McClure warned that working too abstractly should be avoided as conduct-disordered children live in the now. The therapist has to help the child to realize how better problem solving can serve their immediate needs. They formulated a problem solving strategy that has five basic steps and to which they referred as 'COPER'. 'C' stands for catching the problem, 'O' refers to listing the options, 'P' denotes predicting short and long-term consequences, 'E' stands for evaluating the anticipated outcome and the taking action based on this review. 'R' is for self-reward for following the steps and for attempting productive action.

Various programmes are implemented in the training of adolescents in problem solving skills. They include relaxation coping skills, anger control training, social skill training,

empathy training, self-instructional approaches and cognitive restructuring. Relaxation-based interventions are commonly used with adolescents who present with heightened emotional and physiological arousal that often characterizes the experience of anger (Lyddon & Jones, 2001). Relaxation-based interventions include training clients on deep breathing exercises and on how to do progressive relaxation of different muscles in order to lower their anger. Research has shown that when implemented properly, relaxation techniques have led to significant reductions in trait anger and anger from a variety of common provocations. They are also easy to integrate with other treatment components. Anger control training involves helping adolescents to identify their aggressive behaviour and to recognize the conditions that maintain it (Graham, 1998).

Friedberg and McClure (2002) noted that training adolescents in social skills helps to decrease their aggressive behaviour, inappropriate intrusions or interruptions and this in turn increases prosocial behaviour and friend-making skills. To enhance the client's understanding of social skill training, Zarb (1992) suggested that the therapist could ask the client to describe several actual situations in which the client behaved aggressively towards peers. Then the therapist models more appropriate, non-aggressive responses to these situations. Role-plays could be used to help clients to rehearse. Further, Zarb stated that therapist needs to provide feedback on the clients' performance and praising of adaptive non-aggressive behaviour should be done. Pointing out of the aspects of the client that still contain aggressive components is also important. Social skill training could be done during the individual sessions with the client or in group therapy sessions. Friedberg and McClure (2002) stated that a group could be given a social skill exercise such as planting a garden, building a sandcastle or acting out a story. The exercise is then divided among the group members who are expected to work in collaboration with the rest of the group.

Training adolescents in empathy is based on the notion that aggressive and violent children lack empathy. Freidberg and McClure (2002) argued that if the adolescents had empathy for the target of their aggression, they would be less likely to attack. The therapist might begin empathy training by playing a movie for the client or by reading him/ her a book with characters who experience different feelings and stressors such as being bullied or teased.

Group therapy is well suited to empathy training as it allows opportunities for real life practice (Friedberg & McClure, 2002).

Training clients on self-instruction techniques is based on the notion that aggressive behaviour is maintained by negative self statements that an individual uses in situations of provocation (Zarb, 1992). Clients are trained to develop internalized speech that they would use to control their anger or aggressive behaviour (Meyers & Craighead, 1984). Clients are initially trained to self-instruct aloud, then to fade self-instructions to a whisper and finally to covert speech. Meyers & Craighead further emphasized that the client should be trained to self-reinforce themselves for successfully completing the task. Examples of self-instructions include "I will not hit him, I'll ignore him and I'll stay calm". Zarb (1992) found that best results in controlling aggressive behaviour were obtained where self-instruction techniques were used in conjunction with deep breathing exercises. Friedberg and McClure (2002) found the 'ON Purpose or By Accident' tool useful in self- instruction training. The tool is composed of ten items. The client is expected to read each item and to determine if each item happened on purpose or by accident. The therapist's task is to engage the client in a discussion regarding his/ her choice. Such discussions help the adolescent to think before making a decision about another person's actions. The therapist also asks the client to list about five ways he/ she can tell if someone does something on purpose or by accident. The use of metaphors has been found helpful in improving self-instructional techniques. Cognitive restructuring is done to help clients to replace anger-related cognitions with more calming thoughts (Lyddon & Jones, 2001). Clients are trained in questioning the evidence for particular beliefs and in replacing irrational thoughts with rational ones.

Problem solving skill training has significantly reduced aggressive and antisocial behaviour at home, school and in the community. Hill & Maughan (2001) found that adolescents gain more from problem solving skill training than young children and this might be because of their cognitive development. They also found that conduct-disordered children that present with comorbid diagnoses such as academic delays and also those whose families have high levels of impairment respond less well to treatment than children with less dysfunction in these domains.

1.6.3. Contingency Management

Frick (2001) stated that the use of contingency management treatment approach in CD has led to increased treatment gains, particularly as the majority of children with CD come from families in which they have not been exposed to a consistent environment. They had poor socialization experiences that play a major role in their deficient ability to modulate behaviour. Some of children with CD tend to focus more on the potential positive consequences of their behaviour than on the potential negative consequences.

Frick (2001) stated that contingency management programmes involve

- Establishing clear behavioural goals that gradually shape a child's behaviour in areas of specific concern.
- Developing a system to monitor whether the child is reaching these goals.
- Developing a system to reinforce appropriate behaviour toward reaching stipulated goals. Examples include gaining of points when an aggressive child has expressed anger appropriately and has displayed increased prosocial interactions with peers and with adults.
- Providing negative consequences for inappropriate behaviour. Examples involve losing of points for misbehaving and explaining to the child that fighting results in isolation.

Frick (2001) further stated that for the contingency management programmes to be effective they need to be individualized in terms of selecting appropriate goals for the child as well as the behaviour reinforcements and punishments that are likely to motivate good behaviour. The implementation of the contingency management programmes in a classroom situation helps to make teachers pay attention to both the problematic and the prosocial behaviour. Research shows that the rates of positive teacher attention to prosocial behaviour are very low and are insufficient for increasing and maintaining the prosocial classroom behaviour of children with CD. Mash & Barkley (1998) further stated that praise alone can have a neutral or negative effect on children engaging in aggressive behaviours.

1.6.4. Play Therapy

Research has shown that using play therapy in treating children with CD has yielded positive results. The therapist starts by setting therapy goals with the client and the client's family (Knell, 1993). Thereafter play activities are structured to support progress towards the goals. Dolls and puppets are usually used in directive plays but a child is allowed to select the types of toys he/she prefers. The relaxed circumstances during play help in the development of rapport and in creating an environment where even guarded, suspicious and aggressive children would engage (Reinecke, et al., 1993). The client feels relaxed and accepted. The therapist manages to access the child's emotions and cognitions which helps in replacing the maladaptive ways of coping with more adaptive approaches (Knell, 1993).

Therapy is implemented through modeling, such as using a puppet to model non-aggressive problem solving. The therapist uses toys to teach a child new strategies for coping in different situations, such as teaching positive self-statements. Knell (1993) found that play therapy could also be the means through which the client and the therapist communicate. As the child plays, the therapist could depict how he/she views his/her world and could also understand better the child's problems, thoughts and feelings. Play therapy could be educative. Education is accomplished by using toys to model the skill that the child has been found lacking and the child is further allowed to practice such skills during play therapy until he/she could apply it in real life settings.

1.6.5. The multi-modal treatment approach

Research has shown that there is no single treatment approach that could effectively treat CD. A multi-modal treatment approach is recommended in which several therapeutic strategies are included to address the many-sided problems that manifest in adolescents with CD (Graham, 1998). Kazdin (2000), for example, combined cognitive behavioural treatment and the family therapy to treat youth with CD. Friedberg and McClure (2002) emphasized that the implementation of the multi-modal treatment approach should be done sequentially. The first stage of the treatment includes the education of the adolescent about the treatment model, as disruptive adolescents do not generally enter treatment with motivation to change their behaviour. Rather, they usually want others to change. It is important to explain the

treatment rationale to the adolescent undergoing treatment as adolescents with CD have a tendency to see therapists more as adversaries than allies and have a tendency to blame others for their problems. The following treatment phase involves teaching the adolescent with CD and his/ her caregivers basic behavioural skills. The therapist uses as many techniques as needed to address problems at the level of the client, family and contexts outside the immediate family. These might include relaxation training, problem solving skill training, parent management training and marital therapy.

The next treatment phase involves teaching the client sophisticated techniques such as self-instructional skills to help the client to rethink situations and to replace provocative internal dialogues with soothing self-talk (Friedberg & McClure, 2002). Meyers & Craighead (1984) recommended the use of thought stopping which is a form of self-instruction. It helps the client to rethink about how to respond and by so doing preventing him/ her from entering a situation that eventually would lead to overt aggressive behaviour. Other skills such as empathy training and social skills training could be taught at this level of treatment phase. The last level of the multi-modal treatment approach involves the complex cognitive procedures such as rational analysis procedures and teaching aggressive children moral reasoning (Friedberg & McClure, 2002). Education of youth at this treatment phase is generally accomplished by using the ABC strategies of the CBT. 'A', stands for the antecedents to behaviour, 'B' denotes the behaviour and 'C' stands for consequences. In addition to the use of the ABC strategies, Friedberg & McClure (2002) stressed that the therapist should be creative in devising simple experiential exercises that are useful in educating aggressive adolescents about the fact that there is always a choice. Friedberg & McClure further noted that aggressive clients should be educated about the ways impulsivity overrides reason.

Many investigations have shown the effectiveness of the multi-modal treatment approach in treating aggressive adolescents with CD. It has been observed to produce more positive and lasting treatment effects as compared to treatment approaches that only focus on the child's problematic behaviour and, in so doing, neglect the contexts in which a child lives (Hill & Maughan, 2001). Dykerman (2000) conducted a school-based multi-modal treatment

approach on adolescents with problems of inability to control anger and found a significant difference between pre-test and post-test anger control in the majority of adolescents. Similarly, Slabby and Guerra cited in Graham (1998), used the multi-modal treatment approach on aggressive youth. They were able to increase clients' problem solving skills, reduce their beliefs in the legitimacy of aggression and lessen aggressiveness.

1.7. Conclusions

Reviewing literature on CD shows that through research, cognitive behavioural therapists have made valuable contributions on this condition. Enriching contributions have been made on different aspects of this condition such as its developmental pathways, assessment and treatment approaches that have been effective in treating the multifaceted problems in CD. However, there is scarcity of literature on the treatment of CD for street children who live at the shelter where there is no parental involvement. Guidance on how conditions at the shelter could be modified to promote prosocial behaviour is needed.

2. METHODOLOGY

2.1. THE AIM OF THE STUDY

The aim of this study is to draw on the standard procedures of the CBT in order to

- Design interventions that are effective in reducing conduct disorder behaviour at Eluxolweni Shelter and at Amasango School
- implement the interventions
- assess the practical aspects of the implementation of the interventions
- evaluate the impact of the intervention on the specific child.

2.2. THE CASE STUDY RESEARCH METHOD

An embedded case study was used as it allowed for the study of more than one unit in one study (Yin, 1994). The study focused on the child with conduct disorder and also involved an institutional case study. The institutions that were studied were Eluxolweni Shelter where the target child lived and the Amasango School, which was his school. Such an approach was necessary, as conditions at the shelter and at the school might have contributed to the development, maintenance and the course of the child's conduct disorder. An embedded case study made it possible for the CBT multi-modal treatment approach to be implemented, as this treatment approach treated both the individual and the contexts that caused, sustained and escalated conduct disorder (Mpofu & Crystal, 2001).

2.3. THE INSTITUTIONAL CASE STUDY

2.3.1. Aim

To obtain insight into the organizational structure of Eluxolweni Shelter and Amasango School as well as existing behavioural problems and current management strategies. Information obtained assisted in the planning and implementation of treatment interventions that were designed for the participant with conduct disorder.

2.3.2. Participants

The school principal, teachers, shelter manager, house parents, volunteers and other relevant informants.

2.3.3. Data Collection

Observations of the behaviour of the children and teachers in the classroom were done weekly during the first month of the study. Behavioural observations were also done at the shelter. Semi-structured interviews with teachers and the shelter staff were conducted as well. Monthly interviews with teachers and shelter staff were conducted to evaluate the effectiveness of the interventions that were implemented. Written notes were taken during behavioural observations. Interview sessions with teachers and the shelter staff were tape-recorded.

2.3.4. Data Reduction

Data reduction (Edwards, 1996) took the form of the synoptic summary of the information obtained which provided an account of relevant aspects of the organization of the school and the shelter as well as the disciplinary situation in the classroom and at the shelter.

2.4. THE CHILD CASE STUDY

2.4.1. The selection of the client

The school principal and the teachers were involved in the selection of a child who displayed serious behavioural problems and who lived at the shelter. The selected client, according to the DSM-IV, met the full criteria for the diagnosis of the conduct disorder. The client's name was Bongani. He was a 16 year-old boy. He was in Grade 7 at Amasango Career School and he lived at Eluxolweni Shelter.

2.4.2. Participants

The participants were the school principal, teachers, the shelter staff and the client.

2.4.3. Data Collection: Assessment phase

The initial assessment was done with the client and his school principal. The assessment of the client's behaviour, emotions and cognitions was done over two sessions, which involved the client and the therapist. Each session lasted for 50 minutes. Different data collection methods were used. Such a comprehensive understanding of the client's behavioural problems helped in planning of treatment interventions.

2.4.3.(a) An initial meeting with the client and the school principal

An initial meeting with the client and his school principal was held at the therapist's office. The history of the presenting problem was collected from the school principal and from the client. As the school principal had some details about the social background of children in her school, she was asked during the meeting to assist the client with the giving of his family and personal history. This was necessary, as the client might have not been aware of some of the details in his history. The client could also distort information, particularly the information that would bring a bad reflection on him (Kendall, 2000). Other important aspects that were asked included the client's past medical and psychiatric history as well as the history of substance abuse. Such details were needed to form the foundation for further assessment and for treatment planning.

The rest of the session was spent with the client alone. The school principal was excluded. This was done to give the client a chance to talk about any relevant issues he could not report in the presence of his school principal such as his habits. Confidentiality was ensured during history taking. He was also given a chance to state what he thought were his problems. This was done to make him realize that his contributions in his therapy were important. Another reason was that the therapist wanted to assess his perception of the reason for his referral and, if possible, to obtain information on his covert behavioural problems, which his teachers could not report (Mash & Barkley, 1998).

2.4.3.(b) Motivational interview

It was done to motivate the client so that he could realize the need for therapy and by so doing encouraging him to cooperate during assessment and therapy, particularly, as the decision to come for therapy was imposed onto him by his school principal (Graham, 1998). Different strategies were adopted to motivate him, such as giving him facts about the effects of his behavioural problems to his current life and to his future. Different efforts were made to make him realize that his behaviour was a problem that needed to be solved. His response to these interventions assisted in planning his treatment interventions.

2.4.3.(c) Clinical interviews

With the client: The client was given time during therapy to talk about his interactions, with teachers, peers and the shelter staff, that was viewed by his teachers as problematic. Open-ended questions were asked (Freeman et al., 1990).

With the client's class teacher

The therapist held a meeting with the client's class teacher at Amasango School so as to obtain more details on his behavioural problems. To plan the treatment interventions for CD, it was important to collect data from as many sources as possible, particularly as the client could have presented himself in the best light or minimized his aggressive behaviour (Kendall, 2000).

2.4.3.(d) Role-plays

To further assess the client's behaviour, cognitions and emotions in different situations, the therapist involved the client in role-plays. Role-plays helped to remove the focus from the client, as the focus was on the play. The client became relaxed and expressed his emotions freely without feeling monitored (Reineke, el al., 1993). This allowed the therapist a chance to assist the client in naming the type of emotions instead of relying on the client. Expressed emotions made it possible for the therapist to assess the client's cognitions (Freeman, et al., 1990). Sessions were tape-recorded.

2.4.3.(e) Projective Drawings

Projective drawings were used as another strategy to assess his emotions. He was asked to draw his feelings in different situations, particularly where he displayed behavioural problems. This helped to give the precise description of his feelings that were difficult to describe verbally. Distorted cognitions that accompanied his emotions were discussed (Keineke, et al., 1993). Data collected was compared with data obtained through other assessment methods. Sessions were tape-recorded and written notes were taken.

2.4.3.(f) Behavioural Observations

During the first month the therapist did weekly behavioural observations in the client's classroom as well as at the shelter. The aim was to know the client better and to observe how

he interacted with his class teacher, peers and with the shelter staff. The type of behavioural problems that he displayed and their frequency were also observed. His performance during lessons was observed as well. Further observations were done during school breaks, as the client was often well behaved in the presence of the therapist in the classroom (Kendall & Hollon, 1981).

2.4.3.(f) Behaviour Checklists

The client's classroom behavioural problems were observed daily by using the behaviour checklists for 7 months. The therapist used the Conner's Teacher Rating Scale as a guide to design the behaviour checklists. The Conner's Teacher rating Scale is one of the behaviour checklists that research recommends (Mash & Barkley, 1998). The designed scale had 13 items that were easy for the teacher to complete (see Appendix A). The designed scale focused on his aggressive behaviour in the classroom and his attitude towards authority. The client was made aware that his class teacher would monitor his behaviour.

2.4.4. Case Formulation and treatment plan

The multi-faceted formulation was made of what were the predisposing, precipitating and maintaining factors for the behavioural problems that were displayed by a child. Case formulation helped in treatment planning thus guiding and focusing therapy (Leahy, 1996). A treatment plan based on the identified problems was made (Tompkins, 1999). It included individual treatment interventions that were directed at the client as well as classroom interventions.

2.4.5. Data collection: treatment phase

Assessment was continued during therapy and this helped to furnish the therapist with fresh information on the client's problems (Zarb, 1992). Identified problems were taken into consideration when planning treatment interventions for subsequent interviews.

2.4.5.(a) Clinical interviews

With client: As therapy progressed, his motivation increased gradually and eventually he co-operated. Clinical interviews yielded valuable information on the antecedents, contextual factors and details of the aggressive episode.

With the client's class teacher: Interviews with his class teacher were conducted monthly from March to September 2003. The aim was to evaluate if were there any improvements in his behaviour in the classroom after the implementation of treatment interventions and to ensure that the child was not displaying new behavioural problems other than those at which treatment interventions were directed. Interviews also focused on issues around the correct use of the behaviour checklists and the use of contingency management in discouraging behavioural problems. Sessions were tape-recorded.

2.4.5.(b) Role-plays, behaviour checklists and behaviour observations

As role-plays were implemented in therapy to teach him new skills, more problems were identified, particularly cognitive problems. Behaviour checklists were used to continuously assess his behavioural problems. Using behaviour checklists helped in the evaluation of the effectiveness of therapy and also in the planning of treatment interventions for the subsequent sessions. Monthly behavioural observations of the client were done throughout therapy.

2.4.5.(c) Use of imagery and dysfunctional thought record

The use of imagery and the dysfunctional thought record was attempted but could not be used, as the client did not understand how to apply them.

2.4.5.(d) Cognitive Testing

Cognitive assessment was done as the client was observed to be experiencing difficulties in grasping some of the CBT interventions. It helped in further planning of treatment interventions that were at his level of understanding. It was also done so that the expectations of people around him would be appropriate, particularly with his school performance. The following tests were used:

- Goodenough Draw A Person Test

This test was used to estimate intellectual functioning in that the quality of and detail in the drawing provides a measure of mental age.

- Bender-Gestalt Test

The Koppitz score on this test was used to estimate intellectual functioning based on visual motor, visual perceptual and visual integration abilities (Groth-Marnat, 2000).

- Raven's Coloured Progressive Matrices.

The score on this test was used to estimate intellectual functioning in terms of visuo-perceptual ability, particularly with regard to the capacity to reason non-verbally in terms of pattern matching, gestalt completion and abstract visual reasoning. This test is regarded as culture fair in that it is minimally influenced by education (Groth-Marnat, 2000).

2.4.6. Data Reduction

2.4.6. (a) History of the presenting problem, family and personal history

The client's presenting problem was clearly described. Problems that were identified during family and personal history taking were also described. Further, a summary of his problems that were obtained through cognitive-behavioural assessment was also made. Quantitative data from behavioural checklists were summarized and tabulated.

2.4.6.(b) Case formulation and treatment plan

A clear description of predisposing, maintaining and precipitating factors of his behavioural problems that were discussed in case formulation was done. Problems for which treatment was planned were considered in the data reduction. Problems that were identified during therapy were also clearly described.

2.4.6.(c) Treatment narrative

Information on the implementation of treatment interventions and the client's responses were included in the treatment narrative (Edwards, 1998).

2.4.7. Data collection post treatment

To check the effects of the multi-modal CBT approach post treatment, it had been planned that the client's behaviour would be assessed fortnightly for a month and monthly for three

months. The behaviour checklists, semi-structured interviews with his class teacher and the shelter manager would be done post treatment. A behaviour checklist for use in the shelter was designed to assist the shelter manager in the evaluation of the client's behaviour (see Appendix B). It was written in English and Xhosa. It was to be completed weekly. Booster treatment interventions would have been given should there be any signs of relapse (Center & Kemp, 2003).

However, post treatment behaviour assessment was done only once. Further post treatment assessment could not be done as the child was expelled from the shelter. This took place on the 25th September after the client was caught by one of the shelter parents in town selling clocks that he and other two children had stolen from the shelter.

2.5. Data Interpretation

The reading guide method will be used to interpret the collected data (Edwards, 1998). Reading questions will include:

- How did the child respond to specific interventions at specific times?
- To what extent was the client's behaviour effectively modified?
- Was this approach appropriate in this setting?
- Was the treatment effective given that he still ended up being expelled?
- Recommendations for the modification of CBT in this setting.

3. BEHAVIOUR MANAGEMENT IN THE ELUXOLWENI SHELTER AND AMASANGO SCHOOL

3.1. INTRODUCTION

Bongani lived at Eluxolweni Shelter and attended Amasango Career School where he was observed to be displaying behavioural problems. The following discussion involves the organizational structure of the shelter and the school as well as the existing behavioural problems and management strategies in these institutions. It also includes observations and semi-structured interviews that were conducted by the therapist.

3.2. THE ELUXOLWENI SHELTER

3.2.1. The organizational structure of the shelter

The shelter started to operate in 1994. It accommodated 37 children, with boys outnumbering girls. Children with ages ranging between 9 and 17 have been admitted into the shelter since 1994. Staffing of the shelter was as follows: 1 Shelter manager, 1 assistant manager, 2 housemothers and 2 housefathers. It accommodated socially marginalized children who, because of different domestic problems, referred themselves to the shelter. Concerned citizens brought some of the children to the shelter and the Department of Welfare referred others. Children who were referred by their parents were rarely accepted into the shelter, as it was first necessary to conduct investigations to exclude poor parental involvement. Life in the shelter was more or less similar to life at boarding school. All children attended school and the majority attended Amasango Career School. There were a few children who attended the local high schools. Children were encouraged to participate in domestic chores. They were allowed leisure times which they used as they liked. Children were allowed to go out whenever it was convenient as the shelter gates were only closed at night. However, they were expected to obtain permission to do so.

3.2.2 Behavioural problems at the shelter

Some of the children are aggressive and they usually bully their peers. Swearing is common during their fights or it could be the cause of fighting. However, there has never been any fighting with authority figures since the shelter started to operate. Stealing is another common problem in the shelter. Staff coped with it by keeping cupboards, offices and

storerooms under lock and key. It was usually difficult to find the culprit as children covered for each other. Some of the problems occurred less frequently. Examples are leaving the shelter overnight without obtaining the permission to do so, drinking of alcohol and cigarette smoking as well as sodomization of small boys. Sodomization of one small boy occurred once in 2002. This was the first time this had happened and the culprits were incarcerated.

3.2.3 Observations

Weekly observations of the behaviour of children and their interaction with the shelter staff were done during the first month. Children generally spent most of the day playing outside and their playing was mostly characterized by fight-like games. Playing as boxers was not uncommon and defeated children would sometimes weep quietly without any member of the shelter staff noticing it. Frequently, screaming children would run to the shelter manager after being bullied. The bullies were frequently called to the shelter manager's office where they would either be warned or be punished. It was also observed that children were only punished after displaying the more severe forms of aggression resulting in bruising another one. Other forms of behavioural problems, such as swearing at each other, were as good as the norm at the shelter.

It was also observed that punishment methods were not graded according to the severity or frequency of the delinquent behaviour. The methods of punishment that were used to discourage behavioural problems were not effective. 'Grounded' children were leaving the shelter whenever they felt like doing so, as they were not supervised. Even when they did not leave the shelter as was expected of children who were grounded, it appeared as if they did not feel punished, as they played happily with other children. Cleaning of the shelter windows and gardening were the popular forms of punishment but the windows were not as clean as would be expected. The garden had weed and grass and there was nothing planted on it.

Interaction between children and the shelter staff was mostly work-related, such as when meals were served to the children and when household chores were done. There were no programmes that aimed at promoting a family-like life style where children would spend

some time with the shelter parents and feel loved. Children needed parental love, particularly as most of them came from disorganized families. Some of the problems that children sometimes reported to the shelter staff were ignored. The shelter staff generally felt incapacitated by the whole situation, which helped to maintain the behavioural problems.

3.2.4 Semi-structured interviews with the shelter staff

Semi-structured individual interviews were conducted with the shelter manager and the rest of the shelter staff at different times. Regular visits to the shelter had to be done by the clinician to establish rapport, trust and by so doing obtaining their cooperation. The aim of the study was explained to them. Initially the presence of the clinician in the shelter made the shelter staff feel watched and they were less relaxed and guarded. It appeared as if they anticipated that they might be blamed for the behavioural problems that were displayed by some of the children.

The participants, particularly the shelter parents, reported that most of the children were unruly. They also reported that the aggressive children were not respectful towards them, as they often obeyed instructions only when the shelter manager was physically present in the shelter. Some of the participants were not satisfied with the methods of punishment that were currently implemented in the shelter. They were of the opinion that using corporal punishment could be a better solution. It also came out that sometimes participants simply ignored the behavioural problems that were displayed by the children that were not compliant. Some of the responses from the participants indicated that communication between the shelter staff working on day and night duty shifts was poor as well as that between the shelter manager and the rest of the staff. Because of this problem, there had been a lack of consistency when punishing children who misbehaved. For example, one adolescent stabbed another one with a kitchen knife during the night and was not punished as the only staff member who was aware of this incident went off duty for two days.

3.3. THE AMASANGO SCHOOL

3.3.1 The organizational structure of the school

The school started to operate in 1995. There were 87 pupils. It had four classes of which two were 'not formal educational' classes. Classes I and II were classes that were specially designed for street and marginalized children. Grades 6 and 7 were the only 'formal educational Grades' at Amasango Career School. Pupils' ages were ranging between 8 and 18. The staffing of the school was as follows: 1 Principal (a qualified high school teacher), 3 Teachers (qualified with primary teacher's diploma), 1 unqualified teacher. Students from Rhodes Centre for Social Development rendered volunteer services yearly at the school by helping children with English.

The school admitted children from Eluxolweni Shelter, street children and severely socially marginalized children who had previously spent their days on the township streets. Some of the children had never been to school before. The vast majority was dropouts from mainstream education. Children tended to have at 3 to 4 year's educational disparity between their ages and their grades. About 25% of the pupils were girls. Many of the children had experienced gross malnutrition and were very small for their ages. For example there was a 17-year old boy who was in Grade 4 who weighed 39kg.

3.3.2. The existing behavioural problems

Some of the children were aggressive, poorly disciplined, had anger outbursts and frequently fought with each other. Forms of aggression included: swearing at each other and sometimes at teachers, being cheeky and rude, arguing with teachers and throwing stones at the closed classroom or office doors or at the roofing. When fighting, some of the children could only be separated by Hi-Tech Security Guards. They kicked, boxed and pushed each other against the wall. It was common for them to stab each other with pencils, sharpened pieces of wire, sticks or metal rods. There were a few occasions where screwdrivers and knives were used to stab other pupils. On one occasion a boy was stabbed by another one within school premises and was taken to hospital for suturing. Such cases were reported to the police. The school principal had some of the weapons that she confiscated from pupils in her office. She was at some stage kicked and nearly bitten when trying to separate children who were

fighting. Stealing was another behavioural problem at Amasango School. Pupils stole money, bread and sometimes property from the community. There were a few pupils who smoked cannabis after school hours. Some children were selling it. Many pupils were performing poorly at school. They tended to have a short concentration span. Wandering about inside classes during lessons and poor co-operation of pupils with teachers were common problems that disrupted classes. Classrooms were locked during lessons to prevent pupils from leaving classes. The school gate was also kept locked during school hours to keep children within the school premises.

3.3.3 Observations

Weekly observations of the behaviour of children and their interaction with teachers or volunteers in the classroom were done during the first month. Classes were chaotic, as children walked around inside the locked classrooms. They sometimes fought and swore at each other. Teacher's warnings were disregarded. About one quarter of the class would not pay attention to what was taught. Teachers usually continued teaching and they tried to ignore any disturbances caused by disruptive children. There would always be children who would be standing outside their classrooms after being punished. Sometimes children who were punished by being asked to leave the class would continue disturbing classes from outside. They would sometimes press their faces against the windowpanes, making funny faces that would cause other pupils inside the classroom to laugh. Some would threaten to hit other children during the school break or after school and they would subsequently do that. Teachers could not give lessons smoothly. They would go in and out of the classroom to attend to the disturbances that were made by the children with behavioural problems. If the teacher happened to leave the door unlocked, some of the children would walk out of the classroom and would go to the toilets where they would take a long time to return to the classroom. There were only a few pupils who obeyed the rules of the school.

3.3.4. Interviews

Teachers also expressed difficulties they experienced when teaching severely marginalized pupils. Many pupils had a short concentration span. Some of the pupils only had something to eat whilst at school as breakfast and lunch were served at school. The majority of the

pupils were from neglectful or very poor families. Some of the pupils appeared very exhausted during lessons to the extent that they fell asleep. Teachers were uncertain if such behaviours occurred as a result of adverse familial conditions, substance abuse or were caused by mental problems such as mental retardation. Communication between the teachers and the parents was extremely rare. Teachers were experiencing problems in trying to solve the learners' problems without the assistance of their parents. Teachers stated that they usually coped with behavioural problems by asking the 'problematic' children to leave the class or by reporting them to the school principal. Pupils displaying behavioural problems were also punished. They were aware that punishment methods that they used were not effective but they could not come up with the alternative methods that could be more effective. Some of the participants had accepted the whole situation and they felt nothing could be done.

3.4. Management strategies at Amasango School and Eluxolweni Shelter

Teachers at Amasango School used gold stars to reinforce good behaviour. When a child's performance at school was satisfactory and he/ she did not disrupt classes, one gold star was given to him/ her. The number of stars went up to three if good behaviour persisted and thereafter the child would be given a prize during the school prize giving day, which was held every quarter. A slab of chocolate was also given to children whose behaviour was satisfactory. Red stars were given to discourage behaviour problems. A child would be given up to three red stars and thereafter would be punished by being sent to the shelter or would be allocated duties which he/she would do during school breaks.

To cope with the child's anger and aggression, teachers either threw cold water at the child's face to cool him/ her down or the child was secluded. Seclusion was done by locking the child into the principal's office and letting him/ her to remain there until he/ she had cooled down. Alternatively, they pressed the Hi-Tech button and the security guards would come and take the child to the shelter or to where he/she lived. Further, individual children were referred either to Fort England Hospital or to Rhodes University Psychology Clinic for psychotherapy. Groups of children were assigned either to Rhodes clinical psychology

students for art therapy that was conducted at the school or to volunteers who did art with them.

The school worked hand-in-hand with the shelter in as far as punishment of behavioural problems was concerned. Some of the children who deserved to be punished at Amasango School were sent to the shelter as part of punishment. Punished children were instructed to leave the school and to go to the shelter on their own. The shelter manager or staff would be informed telephonically about these children. On arrival at the shelter, punished children would be assigned duties, such as gardening and cleaning of windows. Children who did not stay at the shelter were punished by being made to pick up refuse from within the school premises or in the street and this was done under supervision. They were also allocated to do gardening and to scrub classroom floors during school breaks. Children who lived at the shelter and who were involved in any form of wrongdoing after school hours and during weekends were punished at the shelter. However, the staff noted that children generally displayed less behavioural problems when they were at the shelter than when they were at school. The forms of punishment involved grounding whereby punished children were not allowed to leave the shelter premises. Other forms of punishment included allocation of extra duties, such as gardening and cleaning of windows during leisure times.

If a child displayed more severe forms of behavioural problems and did not respond to any form of punishment, he/ she would be transferred to 'more strict, safe and well-staffed' homes, such as Erica House and Protea Home in Port Elizabeth. The transfer was made through the Children's Court and was authorized by the Magistrate. Children did not like to be transferred to such places, as they were scared of being bullied. For example, there were two boys who were once transferred to Erica House. They absconded and they returned to the shelter claiming that they were bullied. However, it was emphasized that such measures were only taken in extreme cases, which included instances where a child wanted to escape from the shelter and the feeling would be that his/ her life would be at stake in the street.

3.5. Conclusions

Aggressiveness and anger were the major behavioural problems at Amasango School and at the shelter. Such problems led to the disruption of classes, which made it difficult for the teachers to manage classes effectively. Poor school performance was another problem and the predisposing factors included malnutrition and mental retardation. The shelter staff did not have any programmes to reinforce good behaviour. Children who were bullies were not given any rewards when they had not displayed any behavioural problems. Punishment methods were not effective in discouraging misbehaviour and there was a lack of consistency when meting out punishment. Teachers needed assistance with structuring the punishment of children who lived at the shelter.

Teachers and the shelter staff needed assistance with their problem solving skills, as sometimes problems that were displayed by pupils were ignored. Some of the teachers had given up, as they were of the impression that nothing could be done to improve the situation at the school. The staff had difficulties in selecting possible solutions to behavioural problems as children with behavioural problems were regarded as unruly. There were patterns that unintentionally promoted the display of behavioural problems in the shelter. Such patterns include allowing children too much autonomy and ignoring behavioural problems that were displayed by non-compliant children. Children with behavioural problems received more attention from the shelter staff as compared to children who did not display any problematic behaviour. The school and the shelter were understaffed. Classes were too big for teachers, particularly as the majority of children displayed behavioral problems. At the shelter, the staff on duty could not spend time with children, as there was a lot to do. The shelter had a shortage of resources such as toys as well as equipment for games such as table tennis. It was difficult to keep children busy in a constructive way during leisure times.

4. THE TREATMENT OF CONDUCT DISORDER: THE CASE OF BONGANI

Bongani Goga was a 16-year old Xhosa speaking male referred by his school principal for behavioural problems. At the time of the initial assessment, Bongani was in Grade 7 at Amasango School. He lived at Eluxolweni Shelter where he had lived since the age of 8 in 1995. His school principal contacted the therapist insisting that an immediate appointment be made, as Bongani had been very aggressive and was not responding to punishment. An initial assessment appointment was scheduled for 4 days later.

4.1. PRACTICAL PROBLEMS IN ASSESSING AND WORKING WITH BONGANI

Assessment was difficult, as Bongani was not co-operative. He was defensive and was not motivated for therapy. He laughed and shook his head when the therapist attempted to engage him in role-plays. To him role-plays were 'kids' staff'. He was not very verbal, as he responded to open-ended questions with one-word sentences. To engage him in therapy, it was explained that therapy would provide him with a space to talk about his reasons, particularly those that caused him to be short-tempered and hit other children. It was further explained that, as some of the reasons for his aggressive behaviour were not readily available to his awareness, the therapist would use different assessment strategies to further identify why he often became aggressive. It appeared as if not judging him as being problematic and listening attentively to his side of the story encouraged him to talk freely. He realized that he was accepted and that therapy was not about finding him guilty or not. He then started to talk freely about his interactions with his peers and his teachers. Episodes where he became aggressive, such as hitting other children and disrupting classes, were highlighted through role-plays. The aim was to make him realize that his behaviour was a problem that needed to be solved.

Another problem was that Bongani's cognitive functioning was below average. It was difficult for him to participate in assessment strategies that required an abstract approach, such as using imagery and dysfunctional thought record. Inability to utilize such assessment strategies restricted the therapist to the use of role-plays and clinical interviews for monitoring his distorted cognitions. He also took a long time to understand new skills that were taught to him in therapy. New skills had to be role-played repeatedly for him to

understand. Sometimes he failed to use his discretion as to when to apply new skills that he had learnt from therapy. An example is when he would successfully apply relaxation techniques to control his aggressive behaviour while in class but hit other children in the shelter and claimed that he was not aware that he had to apply such skills after school hours. Therapy with Bongani was quite challenging, as he had many models for aggressive behaviour in the shelter and in school. There were many children who displayed behavioural problems. The fact that he lived in the shelter meant that it was not possible to work with his parents, which made it demanding for the therapist.

4.2. ASSESSMENT RESULTS

4.2.1. Clinical Interviews with Bongani

As Bongani was always allowed time to report about his behavioural problems with his peers, teachers and shelter staff, it was observed that sometimes it would be difficult for him to recall details of some of the events. He was then encouraged to write incidents immediately after they had occurred. Since it was difficult for him to write Xhosa sentences, he was encouraged to write them in any way that would make it easier for him to recall, such as words, fragmented sentences or making drawings. As therapy progressed, he was very co-operative and he talked freely about his problematic behaviours. On his own he reported about incidents where he was very angry and thereafter became aggressive. An example is when he reported that he once had a fight with one of the shelter fathers and Bongani became so angry that he organized a knife to stab the house father. In another incident he became very angry after discovering that Vuyo, one of his mates in the shelter, had stolen his clothing and had sold them to somebody who lived in the township. He actually stabbed Vuyo on the hand with a kitchen knife. He also clapped one girl on the face after she had insulted him by saying bad things about his mother. These incidents took place during his first month in therapy and he reported about them in the third month.

Cognitive distortions such as overgeneralization and anticipation that something bad would occur if he did not defend himself were observed during interviews. He said during the first week after he had been accepted to stay in the shelter, some of his clothes were stolen. Because of this single incident, he referred to himself as a person who has bad luck. He

stated that he would 'act first to save his life'. When asked to clarify his statement, he said whenever he anticipated that another child might do him wrong, he would hit that child to protect himself. His distorted thoughts contributed in making him generate aggressive solutions.

4.2.2. Clinical interviews with his class teacher

As one could not rely on data that one collects from adolescents with CD, monthly interviews with Bongani's class teacher helped to confirm some of the information that was collected from Bongani in therapy. It came out that he also had a problem with telling lies, as sometimes he would hide from the therapist that he had been punished. Sometimes he would tell lies saying that he managed to stop himself from hitting another pupil after practicing relaxation exercises, only to find that it did not happen. Sometimes he would attempt to practice skills taught to him in therapy but would do them incorrectly. This information helped the therapist to be aware that each new skill had to be role-played several few times before he could master it.

4.2.3. Projective Drawings

Projective drawings were used during the initial sessions to assess his emotions, as he was nonverbal and at some stage he could not describe his feelings. After giving a history of many deaths in his family, he appeared very sad but was unable to put his feelings into words. Considering his social background that was characterized by a lack of social support and many stressful life events, it was anticipated that he might have suppressed or postponed the grief. Projective drawings were used to gradually expose his emotions about the loss (Vallis, Howes & Miller, 1990). When asked to draw how he felt, he used red and blue paints which could have indicated anger and sadness (Burns, 1987). From the projective drawings, it appeared as if he was angry and also that he felt left alone without any close family member.

4.2.4. Role-plays

More insight into his feelings and the cognitive distortions behind his aggressiveness was gained after role-playing different situations where he became aggressive. One of the role-

plays was an incident that took place in his classroom where he hit one boy, Themba, on the face when his class teacher had gone to fetch something from the principal's office. Their class teacher had allocated Themba to issue extra pens to other pupils in his class. Each pupil was allowed one new pen at least once in two weeks. Puppets were used. The therapist role-played as Themba as follows:

Bongani: *Ek se: Give me a new pen, now!*

Therapist: *I am still busy with my schoolwork.*

Bongani: *Swore at Themba*

Therapist: (After Themba had reported the incident to the class teacher) *Miss Nala said you should stop swearing at me or she would give you a red star.*

Bongani: *slappped Themba on the face.*

After the role-play the therapist made a remark that Bongani became annoyed when Themba said he was still busy with his schoolwork. Bongani said, "yeah, Themba was cheeky". The therapist further said to Bongani, "After Themba had gone to report you to your class teacher, you decided to clap him on the face". Bongani responded by saying that, "I wanted to prove to Themba that Ms Nala could not stop me from hurting him". His response explained his class teacher's statement that "no one could stop him". From the above role-play, the therapist observed that Bongani wanted immediate attention. He was not concerned about the effects of his actions towards Themba. Bongani reacted to Themba's explanation in a hostile manner. Bongani believed that it was in his interests to show that no one could thwart him and get away with it. A similar pattern of behaviour was observed in subsequent role-plays. The only means he had for solving his problems was to be aggressive.

4.2.5. Behaviour Rating Scales

The behaviour checklists were given to his class teacher to fill in daily and were collected on Fridays every week (see Appendix A). He was still hitting and hurting pupils for about a month after therapy had commenced. Classes were disrupted because of his aggressive behaviour. In one of the behaviour checklists, his class teacher made remarks that while chasing his victim inside the classroom, Bongani walked on the desks, disturbing and hurting other pupils. This incident took place in the presence of his class teacher. As will be shown

in Figure 1 in section 4.3.2, during his third month in therapy, a gradual drop in his rate of hitting other pupils was observed. Such positive changes in his behaviour guided planning of his treatment interventions. For example after it was observed that his rate of hitting other children was dropping, the therapist stopped teaching him new skills but ensured his competency in applying taught skills in real life situation. When it was observed that he was no longer aggressive towards other children, the focus of treatment was to prevent him from relapsing.

4.2.6. Behaviour observations

Behavioural observations were done monthly. Classroom behavioural observations did not yield much information on his behavioural problems. It was observed that the presence of the therapist in his classroom made him modify his behavioural pattern. The same thing happened when observations were done in the shelter. He would avoid interacting with other children by watching television or by listening to the music from his radio cassette. On one occasion the therapist decided to do behaviour observations during the school break. The therapist joined the teachers who were seated outside in front of the classes. The focus of the observations was on the target child's interaction with other pupils during the school breaks and on how teachers', particularly his class teacher, perceive his behavioural problems. Children came to complain to different teachers about being bullied. One girl reported that Bongani had thrown her ball out of the schoolyard. Whilst the teacher was organizing for the girl's ball to be fetched, another little boy who was crying loudly went past the teachers to the principal's office. One of the teachers asked him what was wrong and he responded by saying that Bongani had clapped him on the face after an argument. The principal called him into her office where he was subsequently punished by being sent to the shelter. It was also observed that bullying was a common problem in the school.

4.2.7. Cognitive Testing

History of poor scholastic performance and his difficulties in implementing some of the CBT strategies necessitated the assessment of his cognitive functioning. Tests administered and the results were as follows: Goodenough Draw A Person - **Score**: 30; **Estimated IQ:** 67;

Bender-Gestalt Test - **Score**: 3; **Estimated IQ:** 55; Raven's Coloured Progressive Matrices - **Score:** 19; **Estimated IQ:** 60-70. Performance on all these tests indicated intellectual functioning in the mild mental retardation range. However, clinical impressions placed his intellectual functioning in the borderline retarded range.

4.3. DATA REDUCTION

4.3.1. The case narrative: Assessment and formulation

(a) Presenting problem and history of the presenting problem

Bongani's school principal became aware of Bongani's behavioural problems in February 2002. He was interviewed with his school principal. He had had an ongoing problem of violent outbursts over the past two years. He hit children for no apparent reason in front of his teachers. Bongani had been warned several times that he would be expelled from the school and the shelter if he continued with his problematic behaviour but he continued to be aggressive in spite of his promises that he would change his behaviour. Although his school principal wanted him to be helped with his problems, she could not hide her anger when she stressed that referring him for psychotherapy was her last resort before he would be taken out of the school and the shelter.

Various measures had been taken by the school principal to curb Bongani's aggressive behaviour. From February to March 2002 he underwent weekly individual counselling sessions for his behavioural problems at the school. A volunteer who was finishing his Clinical Psychology thesis at Rhodes University volunteered to give him counselling sessions. From April to the end of September 2002, Bongani underwent art therapy that was done weekly at Amasango School by the Rhodes Clinical Psychology Master's students. As his behavioural problems were escalating, in January 2003 the school principal referred him to Fort England Hospital where a medical officer prescribed Carbamazepine, which he took twice a day. In spite of all that was done for him, he continued to be aggressive.

Further, the school principal sometimes punished him by sending him to the shelter. This also did not help, as sometimes he would go to the township or would loiter in the streets instead of going to the shelter as was expected. His behaviour became so problematic that

sometimes he would be sent to the shelter to cool down and would be told to come back after a week. It looked as if there were times when his absence from school was a relief for the pupils and teachers.

During the last part of the session, the school principal was excused. Bongani, who appeared untouched by what the principal had been saying about him, was asked to tell the therapist about what he considered were his problems. He responded by phrasing his problem by using the local gospel song, which says "Devil does wrong things and thereafter jumps over the fence". He said, with a smile, that 'devil told him to do wrong things and to thereafter jump over the fence' which he subsequently did. Questioning him further revealed that he was not hearing voices. He admitted that sometimes he, without any apparent reason, felt like disrupting other children's play so that they could feel provoked and eventually fought with him. According to him, although fighting relieved his anger, he sometimes regretted it and felt guilty about his aggressive behaviour towards other pupils. His main worry was the school principal's threats that he might be expelled from the shelter. He wanted to be helped with his aggression, as he would like to continue living at the shelter. On the other hand he blamed other children for provoking him in several of the instances that were reported by the school principal. It was clear that when he was of the opinion that he had been provoked, he saw nothing wrong with retaliating. He said, "he would not allow children to do as they like with him, as he was not a ball ". When asked about his future goals, he scratched his head as he was trying to think for an answer. After a few minutes he responded by saying that he would like to leave the shelter at the age of 18 and then would go to the initiation school. He continued saying that, thereafter, as a young man he would see what to do. From his responses it became clear that he was living in the now and he was not that much concerned about what would happen in the future.

With respect to his behaviour in the classroom, his class teacher said Bongani on the average hits at least two pupils a day or hit one pupil more than once a day until he would be sent out of the class. He held a grudge as, if he wanted to hit another child, he would make it sure that he hit him or her even if it meant following that child to the township. Nobody could stop him and his class teacher described his fighting as 'ongoing'. His class teacher had fears

that 'one stupid day' Bongani would severely injure one child, as he could be dangerous. He was short tempered. Pertaining to class activities, he was a 'slow learner'. He was very passive during class activities. At times he would leave classes and would loiter in the streets.

As during the initial assessment phase Bongani was still taking carbamazepine, the therapist decided to find out from his medical doctor about its expected effects on his aggressive behaviour. His doctor responded by saying, "it was just a decoration". His doctor thereafter recommended behaviour modification and psychotherapy. To obtain more information about his past behavioural problems, the intern clinical psychologist was contacted in whose art therapy group Bongani had been in 2002. It came out that Bongani missed many group sessions and dropped out of the therapy before the programme ended. She could only remember that Bongani was very quiet in the group. On the basis of all these reports, it was established that Bongani met DSM-IV criteria for conduct disorder, adolescent type, moderate.

(b) Family and personal history

Questioning in the subsequent sessions revealed that Bongani had had painful experiences as a child. At age 5, his mother, Nomvula, died aged 42 in 1992. Bongani could not tell what was the cause of his mother's death. But he could remember that there were times when she would be very drunk to the extent that she would fall asleep. Nevertheless, the pain of losing his mother was visible in his face. He held back tears from his eyes when he related some good memories of his mother. He said, his mother used to give him pocket money and she referred to him as Yanda. Bongani's life was difficult after the death of his mother, as she was not married and she owned no house. She had stayed with Bongani in a farmhouse where she worked as a domestic worker. After her death, Bongani stayed at his maternal uncle's house for a few months. He also stayed with some of his mother's friends and eventually was taken to the shelter in 1995 when he was 8 years old. Another painful experience was that his two sisters died in their early twenties within two years. His eldest sister, Phelisa died in 2002 and his other sister, Fundiswa died in 2001. They died of AIDS related illnesses. He was close to Fundiswa and he said she was kind to him.

At the time of the study, Bongani's only family member was his half-brother, Lulama (20) who stayed at their maternal uncle's house. Lulama also lived at the shelter from 1995 to 2000. He left the shelter, as he was 18 years old. He was well behaved. Bongani's father was Sam. Sam was renting a room at Kwaloki Township near Grahamstown. His father did part-time jobs and was abusing alcohol. Bongani said his father would sometimes visit him at the shelter and he would be drunk. His father sometimes gave him some pocket money. However, Bongani did not know his father's address and his father could not be contacted for an interview. Bongani's birth and early developmental history could not be obtained, as he was not aware of it. He could only recall that at about age of 4 to 6 he attended crèche at Nkqubela Day Care Centre. He started school at age 7 in 1994 at Glenview Farm Primary School near Somerset East, where he did Grade 1.

(c) Case formulation

Predisposing factors

Bongani's parents did not marry. They abused alcohol. He did not have a home, as he stayed in different places where his mother was employed as a domestic worker. Poverty and neglectful circumstances under which he was brought up predisposed him to behavioural problems. He was not properly socialized. From an early age, his emotional and physical basic needs could not be satisfied. He learnt from an early age to protect himself, as his parents could not be there for him all the time. He also learnt to organize his life and to be aggressive if that was the only way he could get things done his way. Repeated exposure to the aversive physical and social environment encouraged him to continue being aggressive. The death of his mother when he was 5 years old worsened his life situation. He had to adjust to different unfamiliar places, where he stayed before he was taken to the shelter. He was frequently exposed to aversive emotional stimulation to which he frequently responded with aggressive behaviour.

Maintaining factors

At age 8 he started to live at the shelter where bullying was common. This helped to maintain his aggressive behaviour. Living circumstances at the shelter were different from those at

home, within the family situation. He interacted with peers at a higher frequency than would be the situation at home. As the majority of children in the shelter displayed behavioural problem, frequent interaction with his peers reinforced his behavioural problems. The shelter was short-staffed and interaction between staff and children was mainly work-related. Children were not supervised. Bullying was common and the staff often ignored the complaints of the victims. Such circumstances reinforced his aggression. He had to defend himself against being bullied. His belief that he had bad luck and his anticipation that something bad would occur if he did not protect himself led him to see aggression as the best way to deal with everyday problems. Life at Amasango School was not different from life in the shelter. Actually, at school children displayed more behavioural problems than in the shelter. Means to discourage aggression through punishment and reinforcement were not effective. He was often scolded for his behavioural problems, which reinforced his aggression. The crying of the children that he bullied also helped to reinforce his aggressive behaviour. Teachers were aware that it was difficult to control behavioural problems but could not suggest alternative methods that could be used. Some of the teachers were of the opinion that nothing could be done which, helped to maintain behavioural problems.

Bongani's aggressive behaviour had been reinforced for a long time in so much that, to him, it had been the only way things could be done. He only used aggression to solve his problems. There were many models for aggressive behaviour at the shelter and at school. The regularity of his deviant behaviour and the fact that he was an adolescent led to the teachers becoming intolerant of his behaviour. He disrupted classes and his behavioural problems could no longer be ignored. No form of punishment could stop him from being aggressive. He was referred for different types of therapy and for medical treatment but he continued to be aggressive. The school principal referred him for therapy as a last resort before expelling him from the school and the shelter.

(d) Treatment plan

Treatment goals included decreasing Bongani's rate of hitting other pupils and his rate of hurting other children in different ways such as pushing them hard. His treatment also aimed at decrease his aggressive behaviours that disrupted classes, such as chasing his victims

during lessons. Increasing his respect towards teachers and improving his class teacher's skills in reinforcing good behaviour as well as discouraging problematic behaviours were part of his treatment plan.

To accomplish treatment goals, role-playing of treatment interventions that would address his aggressive behaviour was to be done. Interpersonal skill training, relaxation techniques, self-instruction techniques and empathy training were some of the interventions that were to be role-played with an intention of teaching him new skills. Contingency management was another intervention that was planned to address the child's problems and his contextual problems. Motivating him for therapy was also planned. Interventions to facilitate mourning were also included in the treatment plan.

4.3.2. The case narrative: The treatment

Bongani underwent therapy from March to September 2003. He missed seven sessions, three of which were during school vacations. He was seen for 23 sessions. The shelter manager was responsible for organizing transport for taking him to therapy.

i) Sessions 1-2: Motivation and orientation to therapy

During Bongani's interviews, it was observed that he would not like to be expelled from the shelter. His concern in this respect was used to motivate him for therapy. He was made to understand that, as he was in therapy, he had a chance to prevent his removal from the shelter from occurring. As he was keen to know more about it, therapy was explained to him and the need for his active participation was stressed. Further motivation was done by role-playing different situations where he hit other children. The aim was to make him realize that his aggressive behaviour was a problem that needed to be solved. Using role-plays made it possible for the therapist to form collaborative relationships with the child. Such relationships were necessary for the formation of the therapist-client team that would work against the common opponent, which was the client's aggression. Identifying ambivalence in his statements also helped as he felt understood and gradually he started to co-operate. An example is when he said that he sometimes felt regret after hitting other children or when he blamed other children for provoking him. The therapist's reflection of his ambivalence was

that being aggressive works for him but he sometimes dislikes the fact that he is unpopular because of his behaviour.

ii) Sessions 3 and 4: Allowing him to mourn the death of his mother and his two sisters

Using projective drawings helped in opening an outlet for the expression of his pain, fear, sadness and anger of being left alone. He became tearful when he talked about good times he spent with his mother to whom he was close. At some stage while talking about the death of his mother and Fundiswa, his second sibling, he wanted to know why all this had happened to him. At this juncture, he was asked to write them letters and to tell them how he felt. Later, he was asked to talk to them as he experienced difficulties in writing down his messages. He said "Mama, because you died, I was taken to the shelter as there was no one to live with me". Thereafter he became tearful and time was allowed for him to cry. As it was observed that he might have been blaming his mother for his current life situation, we talked about the pains that his mother could have been experiencing before she died. The aim was to stimulate his emotions that were associated with the deceased to the point of accepting the loss. Providing him with space to talk about his losses during therapy helped to allow him expressed his feelings. It was observed that, in subsequent sessions, he could talk about his mother without becoming worried or tearful.

iii) Sessions 5 to 17: Decreasing anger and aggressive behaviour

Relaxation skills (Sessions 5 to 6): In one session in which he spoke about the situations where he became angry, the therapist asked him to describe the physical sensations that he usually experienced before hitting other children. Bongani said that his body usually felt warm, light and his muscles became tight, particularly those of the arms. The therapist then taught him to do deep breathing exercises, which helped to relax his muscles and eventually calm down. Further, the therapist demonstrated how deep breathing exercises were done. Role-plays were used to emphasize the fact that deep breathing exercises were to be performed to reduce his anger and by so doing helping to stop him from hitting other children. He was then given homework to go and apply the exercises whenever he felt angry and felt like hitting somebody. Initially, according to his class teacher, he would hit the child and thereafter do the relaxation exercises and he was not doing them correctly. Such reports

necessitated further demonstrations and role-playing in subsequent sessions. A few weeks later, his classroom behaviour checklists indicated that there was a slight drop in his aggressive behaviour.

Self-instructional techniques (Sessions 7 to 9): As it was presumed that he had mastered the initial step in reducing his anger, he was trained in making self-instructions while doing deep breathing exercises. This was done to develop internalized speech that he would use to control overt aggressive behaviour and to promote prosocial behaviour. Initially, he was trained to say self-instructions aloud. For example, he was trained to do deep breathing exercises three times and thereafter to say loudly that "I will stay calm, I will not give in to angry feelings". He was allowed to practice and to role-play new behaviours during a session. Thereafter he was asked to apply what he learnt in the session in vivo. In the following sessions he was trained to fade self-instructions to a whisper and finally, to use covert speech to guide overt behaviour.

Despite learning these techniques in therapy he did not display any changes in his classroom behaviour as was monitored per daily behaviour checklists. He continued to hit other children to the extent that the girl with whom he shared the desk was organized another place. He was frequently sent to the shelter after being punished. At some stage he would jump over the school fence after hitting other pupils during school breaks. He was observed to be aggressive by the therapist during his behavioural observations that were done during the school break. He also missed one therapy session.

The following therapy sessions focused on strengthening his commitment to change by motivating him for therapy. Contingency management was also implemented. The antecedents of the incidents for which he was punished were asked. It came out that one of the reasons was that he found class activities difficult. He was encouraged to report to his class teacher about his problems. The therapist asked for his permission to discuss his problems with his class teacher. The other problem was that it was difficult for him not to fight with other children, as many children displayed behavioural problems in his school. He was also interpreting other children's actions in a hostile manner.

A meeting was held with his class teacher. There was a discussion about how methods that were used to discourage behavioural problems and to encourage prosocial behaviour could be implemented effectively. It was agreed that his class teacher would be consistent in punishing behavioural problems and in rewarding good behaviour. It was further stressed that this would apply to all children in her class. His class teacher also promised to assist Bongani with his problems in class. Further, the therapist held discussions with the shelter manager where the effectiveness of the duties that were allocated to children who were punished was explored. The importance of supervising punished children was stressed. Refusing punished children permission to watch certain television programmes was added to the routine punishment methods. This was also to apply to all children who were punished by being sent to the shelter.

Cognitive Restructuring (Sessions 10 to 17): A good working relationship between Bongani and the therapist were well established at this stage. He could trust the therapist and his cooperation was good. However, the therapist was always cautious that therapy did not lose focus, as Bongani would sometimes not show commitment to achieving therapy goals and would try to convince the therapist to understand his reasons. On his own he related incidents where he could not control his anger. In one of these **events,** Bongani discovered that one boy, Vuyo, who also lived at the shelter, had stolen his clothing and had sold them to somebody in the township. He retaliated by stabbing Vuyo on the hand with a kitchen knife.

To decrease Bongani's attributional biases and to explore various alternatives, cognitive interventions were implemented. A few passages from a CBT manual on 'bad stuff that happened when one becomes angry' were read slowly in order for him to understand. This was done to highlight the fact that when one is angry, one is likely to act without having thought properly (Wilde, 1997, p.11). Drawings were made to illustrate his behaviour in different situations where he was angry. He also made a drawing of a lion and he said there were times when he would feel as if he was a lion. It took about two sessions for him to understand his 'faulty thinking ' when he was angry. Role-plays were also used to further highlight his 'faulty thinking' in different situations. With the assistance of the therapist, he

could identify his 'faulty **thoughts**' that were related to the **event** where he stabbed Vuyo. They were:

“Vuyo thinks I am scared of him.”

“Vuyo thinks I am a coward”

“People like messing me up.”

“I have bad luck.”

To illustrate the connections between **thoughts and feelings**, the therapist used the list of thoughts that Bongani had identified earlier and he was asked to indicate how did he feel. His responses were that he felt angry and that he had no alternative but to hit Vuyo. It took another two more sessions to make him understand how the 'demanding words' such as **'had to'** contribute in making him feel compelled to hit Vuyo. Demanding words and their effects were further identified in other situations where he became aggressive. He was trained in identifying such words.

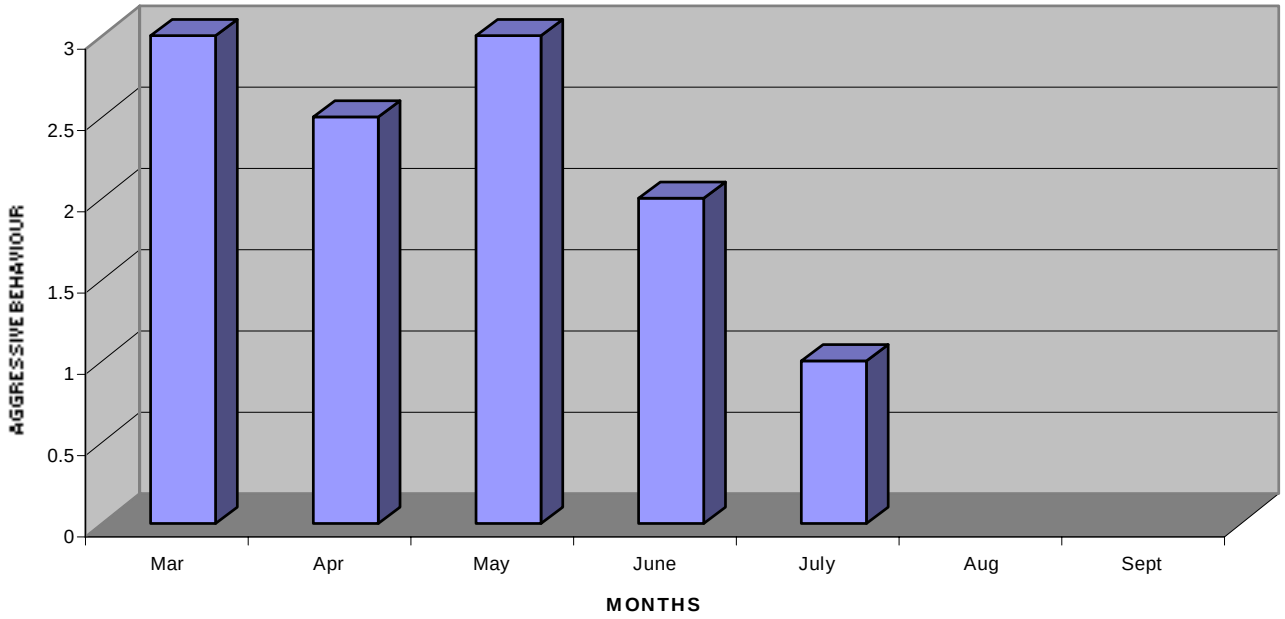
This took us to the following step, where we checked if there was any evidence for the identified thoughts. For example, the therapist challenged Bongani's distorted thoughts by asking if were there any proof that Vuyo was of the opinion that Bongani was a coward. Gradually, he understood that it was not possible to be sure of what another person thinks about you and also that it was wrong to hit other children for things of which one has no proof.

The next step focused on changing his thoughts from irrational to rational. With the assistance of the therapist, he realized that there could be other reasons for Vuyo's behaviour. He realized that it might be that Vuyo wanted some money and was not aware that he would be caught. He also realized that he was actually lucky as he recovered some of his clothing that was stolen. He also realized that the 'new way' of thinking did not make him feel angry and compelled to hit Vuyo. As his hitting of other children was still rating 2 in the behavioural checklists (see Appendix A), he was given homework to practice all the skills he had been taught to control his anger. Challenging of his irrational thoughts was done repeatedly in subsequent sessions after analyzing the real situations where he was involved in bullying of other children.

To decrease his aggressive hostile perceptual biases, the therapist also used a cognitive restructuring approach called 'On Purpose or By Accident' (Friedberg & McClure, 2002: see Appendix C). The tool had six events. The therapist read each event. Bongani had to indicate if the events happened on purpose or by accident. Thereafter discussions were made about the choices that he made. The aim was to assist him to be more accurate in determining whether someone's behaviour was done on purpose or by accident. He was given homework to go and practice what he had been taught in real life settings.

The continuous analysis of his behaviour in the real situations where he displayed behavioural problems and repeated education on the implementation of anger coping skills, particularly cognitive interventions, helped to gradually drop Bongani's aggressive behaviour (see Graph). Continuous monitoring of the implementation of contingency management in his school further helped in improving his behavioural problems. Behaviour checklists gradually indicated a drop in his rate of hitting other children. An example, the behaviour checklists indicated that he hit one or two children once a month and his class teacher's remarks indicated that he was involved in an argument or rough game with his peers once in two weeks. He hit one child once on the 3rd July and no one in August and September. To evaluate the effectiveness of the interventions, the therapist did not only rely on the behaviour checklists but also on monthly behavioural observations as well as on monthly interviews with his class teacher. In one of the regular meetings that were held in the first week of June, his class teacher reported that his behaviour was generally good. She further said that he was 'just like other children in class' in that he would sometimes pass a joke and would share with other pupils in the class. This was not the case before. However, his class teacher also indicated that sometimes, very rarely, he surprised her by displaying anger episodes.

A Graph Showing the Relationship between the amount of Therapy and Reduction of Agressive Behaviour



Key:

Months in therapy: March to September

Therapy sessions: 23 sessions

iv) Sessions 18 to 23: Prevention of relapse and follow-up

To prevent relapse, Bongani was equipped with more skills that would assist in controlling his aggressive behaviour, particularly as behavioural problems were common at Amasango School as well in the shelter.

Behavioural coping/ social skills training (Sessions 18 to 20): Sequential training on interpersonal communication skills, negotiation and feedback skills were taught in therapy by making use of the incidents that he related in therapy. He was given homework to go and apply the skills he learnt in therapy in real life situation. Problems that he encountered were addressed in therapy. An example, he once reported that in one incident one boy referred to him as a coward after he had responded calmly after being mocked. Coping skills were

continuously role-played. In some of the role-plays, the therapist role-played the part of young boys who usually 'provoked ' him and he would be coached to express himself calmly as a grown up boy, as he turned 17 in August. Continuous rehearsal of coping/ social skills was done to allow him to identify and explore effective behaviours for coping with aggressive behaviour.

Empathy Training (Sessions 21 to 22): Different events where Bongani hit or stabbed another child were used to make him understand how his victims feel. Initially, it was difficult for him to give responses about how his victims could have been feeling. He would respond by saying, "I don't know". Gradually, after involving him in role-plays, his understanding of his victims' feelings increased. Changing roles during role-plays helped in making him empathic. He was made to role-play the part of his victims and the therapist, role-playing the child's part, behaved aggressively towards him. He became aware that his aggressive behaviour makes his victims to experience pain, to be frightened and it disrupts them during lessons as well as when they are playing their games. Using role-plays, he was then taught new social skills which would caused him not to hurt other children.

Follow-up (Session 23):

At this juncture, positive changes in Bongani's behaviour had been observed by the therapist and by his class teacher. He also could feel that he was behaving differently and he was happy about the positive changes in his behaviour. Because of these reasons, the therapist decreased the frequency of his therapy sessions from weekly to fortnightly. Behaviour checklists were used to monitor his classroom behaviour as well as his behaviour in the shelter. He continued to display good behaviour. However, he could not come for his second fortnightly session, as he was expelled from the shelter and the school.

4.3.3. Bongani's expulsion from the shelter and the school

This occurred after one of the shelter fathers had caught Bongani and other two children, who also lived at the shelter, selling clocks in town. It was alleged that they had stolen the clocks from the shelter storeroom. The shelter father confiscated the clocks and returned them to the shelter storeroom. Thereafter he reported the case to the police. Eventually Bongani and

the other two children were taken to the police charge office. The magistrate released them after giving them a warning. The shelter governing body, whose chairperson was the Amasango School Principal, decided to expel Bongani and the other two children from the shelter and the school. The school principal told the therapist that they wanted 'to give a lesson' to other children that the shelter governing body was no longer going to tolerate any wrongdoing.

According to the shelter manager and his class teacher, Bongani had never been involved in stealing before. This was the first incident in this respect. It could have happened that the positive changes in his behaviour that occurred after he had been undergoing therapy helped him to have friends, as he was unpopular before. Unfortunately he became friends with children who still had behavioural problems, as there were many children who displayed behavioural problems in the shelter. It was also a pity that the therapist was not given a chance to incorporate his newly observed behavioural problems in his treatment plan. His class teacher, who was impressed with positive changes in Bongani's behaviour, was also not involved when the decision was made to expel him from the shelter and the school.

4.3.4. Effects of treatment on his classroom behaviour and other feedback from the staff

Interventions were effective in controlling his aggressive behaviour. A gradual decrease in his behavioural problems was observed from June (see Figure 1). In August and September no aggressive behaviour was observed. The decrease in his aggressive behaviour was accompanied by an increase in prosocial behaviour. He stopped hitting other children but reported them to his class teacher where he felt they had done him wrong. He stopped disrupting classes and he became respectful towards his teachers. He received gold stars for displaying good behaviour and this had never happened before. Unlike before, he indicated to his class teacher where he encountered problems with his class activities. For example, when schools reopened in July, Bongani told his class teacher that he found Grade 7 very difficult. He suggested that he be allowed to repeat Grade 6, which subsequently occurred. His class teacher and the school principal appreciated his assertiveness. On the 15th session, he told the therapist that he could control his anger and that he no longer needed any

assistance in this respect. His report was consistent with behavioural observations and feedback from his class teacher.

5. DATA INTERPRETATION

5.1. INTRODUCTION

In this chapter, the case narrative is investigated in terms of a series of questions in the form of a reading guide. The reading questions were designed to clarify aspects of the case which were of interest for clinicians faced with the task of modifying disruptive behaviours and to provide the basis for making recommendations with respect to the development of suitable CBT models for the future treatment of street children in similar South African settings.

5.2. How did the child respond to specific treatment interventions at specific times?

Interventions that were implemented to control his behavioural problems included relaxation training, problem solving skill training, cognitive restructuring and contingency management. New skills had to be taught repeatedly for him to understand. His borderline cognitive functioning and his poor social background contributed to his slow learning of new skills. He was brought up in a disorganized family and he had lived in the shelter for many years where wrongdoing was common. He was also poorly motivated for therapy, as he was referred by his school principal.

Initially, his response to interventions was very poor. Motivating him and teaching him new skills caused positive changes that were only noticed during therapy. He continued to be aggressive towards other children and to disrupt classes. Emphasizing the fact that if he continued with his behavioural problems, his school principal would have no alternative but to expel him from the school and the shelter helped to motivate him to cooperate. A slight decrease in his aggressive behaviour was observed from the behaviour checklists by the 6th therapy session but it did not last, as he reverted to his tendency of solving his problems by being aggressive.

After regular rehearsal of new skills during therapy sessions his understanding of what was taught increased. By the 12th session, he had learnt to use the new skills to change his behaviour. His commitment to therapy had also increased. From the 13th session a drop in his rate of hitting other children was observed from his behaviour checklists. His class

teacher was also happy about the positive changes in his classroom behaviour. Eventually, he stopped hitting other children. The last incident where he hit another child was before the 13th session and that was on the 3rd of July. He did not hit any child for the rest of July or in August and September. The decrease in his aggressive behaviour was accompanied by other positive changes in his behaviour, which helped to reinforce his display of good behaviour. For example, his class teacher praised him and gave him gold stars for displaying good behaviour, which he found encouraging.

5.3. Why were there sudden changes in his behaviour from July?

Several factors contributed in the modification of the child's behaviour that was observed from July. His class teacher was trained in some of the new skills that were taught to the child, for example, relaxation training. This was done after it was realized that he sometimes encountered problems in implementing such skills correctly. Training of his class teacher helped, as she could assist the child to implement new skills that were taught in therapy correctly. His class teacher was also regularly coached on how to implement the contingency management to the child and to the rest of the class. Keeping his class teacher well informed about therapy issues encouraged teamwork whereby she could be of assistance to the child when necessary. It also helped to keep clear communication, which prevented any form of resistance from occurring. Graham (1998) stressed that, to be effective, programmes must attend to the sources of resistance. Similarly, Howells (2000) emphasized that it is important that staff looking after aggressive clients outside therapeutic sessions be informed and educated about therapy goals.

The implementation of contingency management equipped the child's class teacher with skills to effectively manage behavioural problems, which were rife in the school. The effective implementation of contingency management helped to decrease the contextual factors that maintained the child's behavioural problems. For example, it decreased the reinforcing of his aggressive behaviour by his peers, as behavioural problems were properly punished. His class teacher's problem solving skills were enhanced. She also stopped reinforcing the child's aggressive behaviour by shouting and being angry towards him. Kazdin (2000) warned that for effective treatment of CD, the child's context must not be

neglected. Having controlled the contextual maintaining factors of his aggressive behaviour, the therapist could effectively teach him new skills in which he was found lacking. He was then allowed to practice the learnt skills in school and in the real life settings.

Enough practicing of the new skills, which he was taught during therapy contributed to the sudden decrease in his aggressive behaviour from July. By this time he had understood and could apply the learnt skills. He could generate more adaptive solutions to addressing problem situations than being aggressive. Positive changes in his life that accompanied the modification of his behaviour made him feel happy. Being happy about his success in decreasing his aggressive behaviour was reinforcing, making him more likely to apply the new skills to other settings.

5.4. Could any observed changes in his behaviour be linked to specific components of the intervention programme?

The positive changes in his behaviour could be linked to the comprehensive treatment that was implemented to treat the myriad factors within the child and within his social context that caused and maintained CD symptoms. Research has discovered that no one treatment could be used to treat CD (Hill & Maughan, 2001; Frick, 2001; Howells, 2000). Treatment interventions were tailored according to the individual needs of the child. Different treatment components had effects on different aspects of his aggressive behaviour. In the present case it seems probable that all the interventions that were implemented were helpful for the positive treatment outcomes.

5.5. To what extent was the child's behaviour effectively modified?

The multi-modal treatment approach was effective in modifying his aggressive behavioural problems. He stopped hitting other children, which was the reason for his referral. He also stopped disrupting classes. His participation during lessons improved although he was still performing poorly. His respect for his class teacher was increased. He also could express his problems in a non-aggressive way. His assertiveness was increased. For example, after realizing that Grade 7 class activities were difficult for him, he reported his problems to his

class teacher and suggested that he be made to repeat Grade 6. During the last meeting with his class teacher, she described his behaviour as 'like that of any normal child'.

His interpersonal skills had positively changed. He was cooperative. At school he could play peacefully with other children, which was not the case when he was aggressive. He even shared a desk with another pupil. He showed initiative in carrying out tasks such as cleaning the blackboard in class and helping house parents with lifting up of heavy objects during spring cleaning. At the end of the treatment, his functioning was at normal level. He no longer met criteria for a diagnosis of CD.

Besides treatment, his behaviour was also modified by his success in implementing new skills. He was reinforced by positive outcomes to continue displaying good behaviour.

5.6. Was this approach appropriate in this setting?

The multi-modal treatment approach was the appropriate treatment strategy in treating CD in this setting. Before the intervention, Bongani's aggressive behaviour was being reinforced in the school and in the shelter where behavioural problems were common. Focusing treatment interventions on the child alone would have not yielded any positive outcome. This treatment approach focused on the client's problems and on the institutional problems that were identified during assessment. It allowed the implementation of more that one treatment intervention in treating the child's behavioural problems. The comprehensiveness of this treatment approach made it possible for the many-sided problems of the client to be addressed sequentially. It yielded positive treatment outcome without any support from the client's family, as he lived in the shelter. Using this treatment approach made it possible for the client's aggressive behaviour to be modified although his cognitive functioning was in the borderline range. It also assisted teachers in managing behavioural problems, as contingency management was applied to all children. The shelter staff were also indirectly helped with behavioural problems as the majority of children who lived at the shelter attended school at Amasango School.

5.7. Was the treatment effective given that he still ended up being expelled?

Treatment was effective in that it controlled his aggressive behaviour. He was expelled from the shelter for stealing, which had never been reported as one of his problems. According to sources of collateral, this was the first episode. It could be an indication that therapy was successful in increasing his social skills to the extent that he could make friends, which was not the case before. Unfortunately he got into bad company.

5.8. Recommendations for the application of CBT in South African schools for homeless and deprived children and similar settings

When treating the child with CD who lived in the shelter, it was helpful to do the institutional case study. The institutional case study involved studying the shelter and the school for the homeless and the deprived children where the child attended. Studying the two institutions helped in that the roles they played in maintaining the child's behavioural problems became known. They perpetuated the child's aggression by reinforcing it. There were many role models for aggressive behaviour, as behavioural problems were common in these institutions. It then became clear that for effective treatment of the child's behavioural problems, identified institutional problems needed attention. Research has shown that assessing what factors might cause, maintain or escalate the child's conduct problems within the child's family has yielded positive treatment outcomes (Kazdin, 2000) but with homeless children, attending to the problems of the institutions is appropriate.

Involving adults who live with the child is very important for effective treatment of CD in this setting. This is so because they are the people with whom to liaise during the course of the treatment of the child. However, Mash & Barkley (1998) warned that while doing so, caution must be taken not to make them feel blamed for the child's behavioural problems. In this study, semi-structured interviews and monthly meetings were held with the child's class teacher and the shelter manager. His class teacher was informed about the child progress in therapy and regular feed backs on the progress in the child's classroom behaviour was obtained from her in the form of behaviour checklists that she completed daily. It was

helpful to educate his class teacher on some of the new skills that were taught to the child. The aim was to obtain her assistance, when necessary, in monitoring that the child practiced the new skills he was taught in therapy. To be able to do this, she was trained regularly on the roles she was expected to play. On the basis of research findings, it is widely recommended that is thorough training of the staff or adults who take part in the child's therapy, as failure to do this might make therapy ineffective (Howells, 2000; Frick, 2001).

To attend to the child's problems in his social environment and to his individual problems, the comprehensive multi-modal CBT approach was used. This was done by implementing the contingency management in the child's class and also by teaching the child, during individual therapy sessions, skills in which he was found lacking. Classroom interventions in the form of contingency management helped to decrease classroom behavioural problems in all pupils including the child. They also helped to socialize children by so doing making them learn to practice behaviours that were socially acceptable. Frick (2001) found that the majority of children with CD have been poorly socialized and they lacked the ability to delay gratification and to conform to societal norms. Contingency management helped to decrease the environmental causes of the child's problems but cognitive interventions equipped the child with skills in which he was found lacking. This was done by teaching him new skills, for example, replacing of irrational beliefs with rational ones. Further, he was allowed enough time to rehearse the new skills to the point where he understood them and could practice them in real life situations. The skills that he learnt helped him to generate adaptive solutions for problems that he encountered in his life. Being successful in solving his problems in a non-aggressive way reinforced him to continue applying the learnt skills to other situations. The combined effort that characterized his treatment was effective in increasing his prosocial behaviour to the normative level. Research has shown that no single treatment could effectively treat CD (Hill & Maughan, 2001).

Seeing the child for 23 sessions was important for treatment to be effective. The majority of homeless and disadvantaged children had been poorly socialized and, by the time they are referred for therapy, they had been interacting with adults and peers who had been modelling problematic behaviours for a long time. More time is needed to teach such children new

skills to the point where they would be able to practice learnt skills to change their behaviour. In this study, it was encouraging to observe that allowing the child to learn and rehearse the learnt skills yielded positive outcomes despite his poor social background and his cognitive functioning that was below average. Although it was not possible to do post treatment follow up as it had been planned, he did not display any form of aggressive behaviour for three months whilst he was in therapy. Research has shown that where many therapy sessions were spent in treating children with CD, the prosocial behaviour that was yielded lasted longer than where positive treatment outcomes were attained over a fewer sessions (Hutchings, Lane & Kelly, 2004).

5.9. Conclusions

Conduct-disordered children in South African schools present with myriad problems that far exceed the resources to deal with them. Moreover, research findings have shown that such children are at a high risk for developing adult psychological problems (Webster-Stratton, 1983). Effective treatment interventions are urgently needed to reduce the effects of CD and its associated problems within the family or institutions where children live. The multi-modal cognitive-behaviour programme has yielded positive treatment outcomes when treating children with this condition.

6. REFERENCES

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Brunk, M. (2000). *Effective treatment of conduct disorder*. Charlottesville, VA: Institute of Law, Psychiatry & Public Policy, University of Virginia.

Burns, R. C. (1987). *Kinetic-House-Tree-Person Drawings: An interpretative manual*. New York: Brunner/Mazel.

Dykerman, B. F. (1995). The social cognitive treatment of anger and aggression in four adolescents with conduct disorder. *Journal of Instruction Psychology, 22*, 194-211.

Edwards, D. J. A. (1996). Case study research method: The cornerstone of theory and practice. In, M. Reinecke. F. Dattilio & A. Freeman (Eds.). *Cognitive therapy with children and adolescents: A casebook for clinical practice* (pp.10-37). New York: Guilford.

Edwards, D. J. A. (1998). Types of case study work: A conceptual framework for case-based research. *Journal of Humanistic Psychology, 38*, 36-70.

Feindler, E. L. & Ecton, R. B. (1988*). Adolescent anger control*. New York: Pergamon.

Freeman, A., Pretzer, P., Fleming, B., & Simon, K.M. (1990). *Clinical applications of Cognitive Therapy.* New York: Plenum.

Frick, P. J. (2001). Effective interventions for children and adolescents with conduct disorder. *Canadian Journal of Psychiatry, 46*, 597-609.

Friedberg, R. D. & McClure, J. M. (2002). *Clinical practice of cognitive therapy with children and adolescents.* New York: Guilford.

Gabel, S., & Shindledecker, R. (1991). Aggressive behaviour in youth: characteristics, outcome and psychiatric prognoses. *Journal of Child and Adolescent Psychiatry, 6,* 932-8.

Graham, P. (1998). *Cognitive behavioural therapy for children and families*. Cambridge: Cambridge University.

Groth-Manart, G. (2000). *Handbook of psychological assessment* (3rd ed.). New York: John Wiley.

Herbert, M. (1978). *Conduct disorders of childhood and adolescence*. New York: Wiley.

Hill, J., & Maughan, B. (2001*). Conduct disorders in childhood and* a*dolescence*. New York: Cambridge University.

Howells, K. (2000). *Treating complex cases: The cognitive therapy approach*. South Australia: University.

Hutchings, J., Lane, E., & Kelly, J. (2004). Comparison of two treatments for children with severely disruptive behaviours: A four-year follow-up. *Behavioural and Cognitive Psychotherapy, 32*, 15-30.

Kann, R., & Hanna, F. J. (2000). Disruptive behaviour disorders in children and adolescents: How girls differ from boys. *Journal of Counselling and Development, 3,* 267-290.

Kazdin, A. E. (1988*). Child psychotherapy.* Needham Height: Allan and Bacon.

Kazdin, A. E. (1995). *Conduct disorders in children and adolescence* (2nd ed.). New Delhi: SAGE.

Kazdin, A. E. (2000). *Psychotherapy for children and adolescents*. New York: Oxford University.

Kearney, C. A. (1990). *Casebook in child behaviour disorders*. Wadsworth: Brooks/ Cole.

Kemp D., & Center, D. (2003). Temperament and personality as potential factors in the development and treatment of conduct disorders. *Education and Treatment of Children, 1*, 75-88.

Kendall, P. C. (2000). *Child & adolescent therapy* (2nd ed.). New York: Guilford.

Kendall, P. C. & Hollon, S. D. (1981). *Assessment strategies for cognitive-behavioural interventions.* New York: Academic Press.

Knell, S. M. (1993*). Cognitive-behavioural play therapy*. New Jersey: Jason Aronson.

Leahy, R. L. (1996). *Practicing cognitive therapy*. New Jersey: Jason Aronson.

Lyddon, W. J. & Jones, J. V. (2001). *Empirically supported cognitive therapies*. New York: Spinger.

Mash, E. J., & Barkley, R. A. (1998). *Treatment of childhood Disorders* (2nd ed.). New York: Guilford.

Meichenbaum, D. (2001). *Treatment of individuals with anger-control problems and aggressive behaviours: A clinical handbook*. Florida: Institute.

Meyers, A. W., & Craighead, E. W. (1984). *Cognitive behaviour therapy with children.* New York: Plenum.

Mpofu, E., & Crystal, R. (2001). Conduct Disorders in Children: Challenges and Prospective Cognitive Behavioural Treatments. *Counselling Psychology Quarterly, 14*, 21-33.

Reinecke, M., Dattilio, F. & Freeman, A. (Eds.) (1993). *Cognitive therapy with children and adolescents: A casebook for clinical practice.* New York: Guilford.

Ronen, T. (1997). *Cognitive development therapy with children*. New York: John Wiley.

Ross, A. O. (1980). *Psychological disorders of children* (2nd ed.). Kogasha: McGraw-Hill.

Tolan, P. H., & Cohler, B. J. (1993). *Clinical research & practice with adolescents*. New York: John Wiley.

Tompkins, M. A. (1996). Cognitive-Behavioural Case Formulation: The case of Jim. *Journal of Psychotherapy Integration, 2*, 97-105.

Vallis, T. M., Howes, T. L., & Miller, P. C. (1994). *The challenge of cognitive-behavioural therapy*. New York: Plenum.

Webster-Stratton, C. (1983). Intervention approaches to conduct disorders in young children. *Nurse Practitioner, 8, 29*, 33-34.

Wilde, J. (1997). *Hot stuff to help kids chill out: The anger management book.* New York: LGR.

Yin, R. K. (1994). *Case study research* (2nd ed.). London: SAGE.

Zarb, J. M. (1992). *Cognitive-behavioural assessment and therapy with adolescents*. New York: Brunner/ Mazel.

APPENDICES: APPENDIX A

TEACHER'S RATING SCALE

NAME :

AGE :

GRADE :

DATE :

LISTED BELOW ARE DESCRIPTIVE TERMS OF BEHAVIOUR. PLEASE USE THE SCALE AS INDICATED TO MARK THE COLUMN WHICH BEST DESCRIBES THE PUPIL

ANSWER ALL ITEMS.

Not at all	0	Just a little	1	Pretty much	2	Very much	3

	Degree of activity			
OBSERVATION	**0**	**1**	**2**	**3**
CLASSROOM BEHAVIOUR				
1. Hits another pupil(s)				
2. Stabs another pupil (with a pen or other - specify)				
3. Hurts another pupil – specify				
4. Quarrelsome				
5. Lies				
6. Temper outbursts, explosive & unpredictable behaviour				
7. Steals				
8. Intolerable of other's mistakes				
9. Teases other children or interfere with their activities				
ATTITUDE TOWARD AUTHORITY				
10. Defiant				
11. Cheeky and rude				
12. Excessive demands for teacher's attention				
13. Stubborn				

REMARKS

APPENDIX B

Date	Time	Type of behaviour problem	Punishment	Observed by

APPENDIX C

On Purpose or By Accident

Someone cuts ahead of you in line. On purpose By accident

Someone bumps into your desk when he/she is not looking where he/she is going. On purpose By accident

Someone takes your pencil and won't give it back. On purpose By accident

Someone gives you a strange look. On purpose By accident

A classmate makes fun of you and calls you names. On purpose By accident

Someone bumps against you whilst playing a game during break time. On purpose By accident

State two ways you can tell if someone does something on purpose or by accident.

1.

2.

What is important about learning to decide whether somebody does something on purpose or by accident?