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DISRUPTIVE, IMPULSE CONTROL AND CONDUCT DISORDERED BEHAVIOURS IN SCHOOLS: A MULTISYSTEMIC INTERVENTION USING RATIONAL EMOTIVE BEHAVIOUR THERAPY

By

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Declaration

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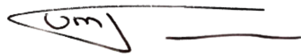
I, Victoria Margaret Timm, declare that **DISRUPTIVE, IMPULSE CONTROL AND CONDUCT DISORDERED BEHAVIOURS IN SCHOOLS: A MULTISYSTEMIC INTERVENTION USING RATIONAL EMOTIVE BEHAVIOUR THERAPY**, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.



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Ethics Statement

I, Victoria Margaret Timm, obtained for the research described in this work the applicable research ethics approval.

I declare that I observed the ethical standards required in terms of the University of Pretoria's Code of ethics for researchers and the Policy guidelines for responsible research.

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Abstract

Disruptive impulse control and conduct disordered behaviours present an ever-increasing problem in South Africa. This study aims to design an intervention for this based on a multisystemic approach within which framework, evidence-based Rational Emotive Behaviour Therapy (REBT) and contingency management are applied.

Any such approach should include the environmental factors that influence and maintain the problem. The strength of this research is the utilisation of an embedded, pragmatic case study research design applied to four children, and one of each child's parents and teachers. The embedded approach of studying more than one unit of analysis, includes environmental factors such as the home (represented by the parent) and the school (represented by the teacher) which may contribute to the development and maintenance of the problem behaviours. The children (11 – 14), vary in terms of race, culture, socio-economic status, and severity of symptoms. The case studies are used to examine the application, process, and effectiveness of a multisystemic intervention in South African schools.

The commonalities and idiosyncrasies of the case studies, regarding the process of treatment and techniques, are noted. The children's characteristics that influence the therapeutic process are discussed alongside the influence of the family and school contexts. The influence of the wider South African context on the problem is also considered. The efficacy of the process and theory are considered. The intervention was successful to varying degrees across most participants. These results are discussed along with the methods and techniques that were successful. Recommendations for future therapy are considered.

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Thank you to all the participants in this study for allowing me the opportunity to work with each one of you.

I acknowledge the supervisor and co-supervisor of this study for their contribution.

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Dedication

I dedicate this thesis to Adri Prinsloo. A couple weeks before you left this world you told me that you had put your PhD away and that it was now up to me. Well, here it is, for both of us. Your support in this process, even when your situation was so dire, was invaluable. Your friendship, love, laughter, camaraderie, quirkiness, and everything that made you 'you' will always be missed.

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Chapter 1: The Context

The aim of this study is to design, implement, and explore the process and value of a multisystemic treatment intervention (MST) (Swenson et al., 2005) for addressing children's disruptive, impulse control and conduct behaviours in South African schools. The definition of disruptive, impulse control and conduct disorders are many and varied as are the contributing contextual factors to its development and maintenance (American Psychiatric Association, 2013). The context in which this cluster of behaviours occur therefore forms an important part of both the understanding and treatment of it.

Disruptive behaviours are considered to present an ever-increasing problem in South African schools (Burton & Leoschut, 2013; Jordaan, 2017; Marais & Meier, 2010; Mncube & Madikizela-Madiya, 2014; Pienaar, 2003; Wolhuter & Steyn, 2003). Violence and anti-social behaviour in schools has been prominent in the news and media in South Africa, and some of these incidents have proved fatal (Burton & Leoschut, 2013; Jordaan, 2017). Unsurprisingly therefore, there is a widely held perception that school violence and disciplinary problems is growing in this country (Burton & Leoschut, 2013; Hendricks, 2019; Jordaan, 2017) and intervention is necessary (Burton & Leoschut, 2013; Steyn & Singh, 2018). Difficulties in discipline to address these behavioural problems and others are almost ubiquitous in South African schools (Reyneke, 2015). Mabeba and Prinsloo (2000) state that learner discipline is one of the major concerns expressed by all stakeholders in education. A South African study conducted by Rossouw (2003) revealed that there has been a decline in the level of discipline in schools and that this impedes the teaching and learning process as behavioural problems go unchecked. Thompson (2002) carried out a study into discipline in primary and secondary education in South Africa and confirmed a breakdown in discipline in schools. Many educators in rural secondary schools acknowledge that they have serious problems disciplining learners and are disempowered to deal with learners' disruptive behaviour (Van

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Wyk, 2001). The issue of safety and security of learners in South African schools has therefore become a major focus (Mncube & Harber, 2013). Despite several intervention strategies that have been developed in response to these issues, the violence in South African schools remains unabated (Ncontsa & Shumba, 2013).

The legal and theoretical framework for a code of conduct to guide behaviour in schools, are contained in the Constitution of the Republic of South Africa (1996) and the South African Schools Act (1996). The code of conduct defines rules pertaining to learner behaviour and the disciplinary process that should follow school children's transgressions. Although the principal, the school management team, and educators are usually the front of disciplinary process, the school governing bodies (SGBs) have been given statutory duty to ensure that correct structures and procedures are in place so that any disciplinary measures contained in the school's code of conduct are implemented fairly and in line with the laws above. Although the South African Schools Act (1996) decrees that school governing bodies (SGBs) should be responsible for the enforcement of a learner code of conduct to maintain effective discipline, many rural school governors lack the relevant knowledge and skills to design and enforce an effective learner code of conduct. The low literacy levels of some SGB members (constituting parents) contributes to this lack of efficacy. Parent-governors are also not part of the day-to-day operations of the school and therefore cannot contextualise the seriousness of discipline problems or how to enforce any disciplinary code effectively (Mestry & Khumalo, 2012). Most SGBs tend to overlook the enactment and enforcement of a code of conduct for learners because they are not empowered to perform these functions (Bray, 2005; Xaba, 2011). Rossouw (2007) states that the code of conduct is a consensus document, and its drafting process should involve the input of parents, learners, educators, and non-educators at the school. There is however lack of collaboration between the principal and other SGB members (Mestry & Khumalo, 2012). Teachers seem to doubt the

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effectiveness of their schools' codes of conduct and their ability to enforce the strategies stipulated to deal with learner discipline. Effective design and enforcement of a code of conduct however may address learner discipline problems and make the school an environment that facilitates teaching and learning (Mestry & Khumalo, 2012).

Furthermore, there is a paucity of research on what works, practically in the South African context, as an effective evidence-based treatment to address the issue of behavioural problems, making such research even more important (Burton & Leoschut, 2013). While several studies have been conducted on the issue of safety and security in schools in South Africa, interventions have been focused on the physical aspects of safety such as electric fences or signs declaring what items the children attending can bring into the schools (Mabasa & Mafumo, 2017). This current study will thus seek to address this gap in research as to what an intervention for children presenting with behavioural problems could look like and what about this process could work, as a therapeutic intervention, within South African schools.

1.1. The South African School Context: Private Schools Versus Public Schools in South Africa

South African Schools Act (1996) created a national schooling system and established two categories of schools: public and independent (private). The act regulates both these categories of schools. Public schools are state controlled, while independent schools are privately controlled.

In terms of Section 29 of the Constitution of South Africa, anyone can establish a private school at their own expense (Constitution of the Republic of South Africa, 1996). This could explain the great variety of private schools that exist in the country. Private schools are no longer exclusively for the wealthy. Several private schools now have a low-fee structure, serving relatively poor families (Van der Berg et al., 2017).

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The types of behavioural problems encountered in private schools are similar to those experienced in public schools but tend to occur less frequently and are somewhat less severe in intensity. Sometimes they do differ in presentation. Pells (2017) cites recent research that indicates that children attending private schools are more likely to have alcohol and other substance-related addictions when compared to public schools. Although behaviour in private schools is usually not severe enough to make news headlines, it is still sufficiently severe to cause stress and disruption in the classroom (Charles, 2017). To curb this behaviour and to ensure the functionality of education, discipline is necessary in both public and private schools (Segalo & Rambuda, 2018).

Although there is less literature published on behavioural problems specifically in private schools, the research published on this problem in public schools is deemed to be relevant to both contexts. Researchers often do not distinguish between the two types of schools. Private schools, some of which were low-fee schools, were chosen for this study due to the difficulty and time-consuming process of attaining permission to work in government schools. It was also envisaged that the less serious behaviours found in private schools would be more responsive to initial intervention, as the converse, severity of condition, is related to less successful outcomes in literature (American Psychiatric Association, 2013; Lambert & Cattani-Thompson,1996; Werba et al., 2006). Although the private schools have generally less severe behaviours, the sample in this current study were severe enough to warrant a DSM-5 diagnoses of one of the disruptive, impulse control and conduct disordered behavioural clusters.

1.2. The Research Problem

There are several studies and opinion pieces commenting on child/youth behaviour in South African schools. From older writings, such as Dugmore (2005), through to more current writings, such as Burton and Leoschut (2013), Hendricks (2019), Jordaan (2017), and Steyn

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and Singh (2018), the findings are much the same in that behavioural problems are prevalent. The research of Wolhuter and Steyn (2003), and Wolhuter and Russo (2012) shows that poor child/youth discipline is an acute problem in South Africa. Similarly, Pienaar (2003) says that discipline has collapsed in many South African schools.

The escalating level of behavioural and discipline problems impact negatively on the culture of learning. In 2005 the Human Sciences Research Council (Dugmore, 2005) reported findings that 55% of teachers considered leaving the profession, and many of these teachers cited fear of violence as one of the reasons. According to Dugmore (2005) teachers complained that it is difficult to attend to disciplinary issues whilst trying to deliver a lesson. In the Western Cape, a teacher reported spending the first fifteen minutes of each lesson trying to bring the class to order (Dugmore, 2005). There seems to be a perception that since the abolition of corporal punishment, teachers have become powerless in the face of behavioural issues and the children/youth are taking advantage of this powerlessness (Marais & Meier, 2010).

The Centre for Justice and Crime Prevention's (CJCP) National School Violence Study (Burton, 2008) involved 12 794 children/youth from primary and secondary schools, 264 school principals, and 521 educators. The results indicated that 15.3% of children at primary and secondary schools have experienced some form of violence whilst at school, mostly in the form of robbery or threats of violence. The school principals corroborated this report. Both children/youth and principals indicated that drugs, alcohol, and weapons are easily accessible. Half of the secondary school principals reported incidents involving weapons, and three quarters reported incidents involving drugs and alcohol at school. One in three learners report having observed fellow children/youth under the influence of alcohol (Burton, 2008). A follow up study in 2012 (Burton & Leoschut, 2013) indicates that little has changed. Although bullying is cited as a global phenomenon in all schools (Laas & Boezaart,

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2014), it is particularly prevalent in South African schools (Steyn & Singh, 2018), and conduct disorder specifically has been recognised as being widespread (Mashalaba & Edwards, 2005).

According to reports in the media the problem has remained prevalent to date. In 2013 a South African Press Association (2013) news article cited the following research by the company Pondering Panda:

- The company interviewed 5314 pupils, teachers, and family members between the ages of 13 and 34 countrywide.
- Thirty-six per cent of respondents identified bullying as one of the biggest problems at school, compared to 28% the previous year. The prevalence of bullying was reported across age groups. According to demographics, bullying was prominent in all groups:
    - 34% of black respondents reported school bullying as a major issue, compared to 41% of white respondents, and 43% of coloured respondents.
    - The incidence of bullying was reported as being prominent in all provinces
        - Western Cape (44%)
        - North West (41%)
        - Gauteng (40%).

An article in the Cape Argus (Charles, 2017) cited statistics from the Western Cape Education Department (WCED), claiming 81 reported cases of bullying the previous year in the Western Cape area. The problem is countrywide and occurs across race and age groups.

Africa Check, reporting on a study carried out by Trends in International Mathematics and Science Study (TIMSS), stated that out of the 49 countries involved in the study, South African Grade 5 pupils reported the highest incidents of bullying. Africa Check said that only Thailand and Botswana’s pupils reported more bullying incidents generally than South

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African pupils (Charles, 2017). Forty-four per cent of respondents reported being bullied on a weekly basis, while 34% reported monthly bullying. Boys reported being bullied more than girls. Children/youth in South Africa's public schools reported more bullying than those in private schools. Approximately 48% of children in schools in lower socio-economic areas reported being bullied on a weekly basis, compared to approximately 25% of private school children/youth who are generally from a more affluent background (Charles, 2017). Many factors such as economic status, geographical location, and gender influence the occurrence of conduct problems. These are discussed in the following chapter.

Jordaan (2017) quoted Gauteng Education MEC, Panyaza Lesufi, who said: 'the recent spate of violence makes it seem as though school institutions are under siege.' He refers to acts of violence ranging from corporal punishment, to bullying, killing of scholar patrollers, and cases of assault between learners.

Media reports over the years indicate that the situation regarding disruptive and aggressive behaviours in schools has remained a serious problem with insufficient disciplinary structures to contain it. Although there is awareness of the issue, it seems to have worsened over time (South African Press Association, 2013) and there are ineffective disciplinary structures to contain it. An effective intervention programme for this problem is therefore needed.

1.3. Definition of Disruptive Impulse Control and Conduct Disorder

As stated, there are a wide range of behavioural problems in the South African schools ranging from rape, murder, and theft to less serious offences such as disruptions, rudeness, and lack of commitment to schoolwork (Reyneke, 2013).

The forms of aggressive and disruptive behaviours are thus varied and as such the behaviours are difficult to define and thereby target. The description of the target behaviours for this study are taken from the American Psychiatric Association's Diagnostic and

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Statistical Manual of Mental Disorders (DSM-5) (American Psychialtirc Association, 2013). Specifically, the target behaviours are summarised by the descriptive term of disruptive, impulse control and conduct disorders (American Psychiatric Association, 2013). The chapter in the DSM-5 entitled disruptive, impulse control, and conduct disorders includes oppositional defiant disorder (ODD); conduct disorder (CD); other specified and unspecified disruptive, impulse-control and conduct disorders; or impulse-control disorders not otherwise specified, all of which were utilised for the descriptive definition of the behaviours. Intermittent explosive disorder, kleptomania, and pyromania (American Psychiatric Association, 2013) are included in this DSM chapter; but did not occur in the participants in this current study. The two most common diagnoses here are ODD and CD (Kaminski & Claussen, 2017). The DSM-5 (American Psychiatric Association, 2013) was thus used as a reference to describe the target behaviours and they did not necessarily have to meet all the criteria for a DSM diagnosis as the behaviour was considered problematic if it was defined as such by the context. However, the children in this current sample all met the criteria for a DSM diagnosis.

Behavioural problems often occur in clusters, meaning that one child will present with multiple problematic behaviours concurrently (Bruce & Jongsma, 2011). This is certainly true of the category of behaviour described as disruptive, impulse and conduct disorders (American Psychiatric Asscociation, 2013), which again makes it difficult to clarify and define. The behaviours are complex, pervasive, and treatment resistant (Van de Wiel et al., 2002). These challenges around variability in behaviour makes comparison across studies difficult and numerical averages attained through quantitative data sometimes difficult to interpret. While these behaviours take on many forms, they have impulse and emotional regulation problems in common. The defining commonality is that they bring the child or youth into conflict with authority, parents, and peers (American Psychiatric Association,

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2013). Although the four children participating in this current study did meet the DSM-5 (American Psychiatric Association, 2013) criteria for disruptive, impulse control and conduct disorders (American Psychiatric Association, 2013), the criteria for inclusion was that their behaviour involved impulse and emotional regulation problems which put them at odds with peers, parents, and authority (American Psychiatric Association, 2013; Iliades, 2014; Kaminski & Claussen, 2017). The symptoms of disruptive, impulse control and conduct disordered behaviours are therefore part of the problematic interactional patterns with others. Those displaying the symptoms do not see their actions as problematic and they blame others for their behaviour.

The bi-directional and relational influences in the behaviours are recognised. It becomes difficult to disentangle the contributions of various role-players in the interaction patterns and in the origin and maintenance of the problems (American Psychiatric Association, 2013). Despite the variety of contributing factors, the diagnosis of the child is still made if their symptoms warrant it (American Psychiatric Association, 2013). The contributions of the role players and various contexts of the youth/child are reviewed in the following chapter.

Gordon and Browne's (2004) criteria were used in this study to qualify the descriptions of the behaviours found in the DSM-5 (American Psychiatric Association, 2013), stating that the described disruptive, impulse control and conduct disordered behaviours are those that are considered inappropriate behaviour for the given context in which they occur. If the number or duration of described behaviours in the DSM-5 (American Ppsychiatric Association, 2013) were not met, it did not result in the exclusion of the participant from this study. The context (the school) therefore identified the children's behavioural traits that were considered as inappropriate (American Psychiatric Association , 2013; Gordon & Browne, 2004). The participants in this current study were referred by their teachers, who considered

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the behaviour to be inappropriate for the context, and thus standing out from that of their peers. This fits with the DSM-5's directions that others in the individual's context, such as parents and teachers, should verify the interpersonal interaction as problematic. This is particularly important for these disorders, as the child displaying the traits, will likely not recognise this (American Psychiatric Association, 2013). It likewise fits with the multisystemic framework (Swenson et al., 2005) used in this study which incorporates the system in which the problem occurs. Budd and Hughes (2009) state that a psychiatric diagnosis can present differentially, as it is not a pure concept (Budd & Hughes, 2009). It is not pure in the sense that the individual's context influences how any diagnoses are applied, as it depends on how the individual fits with this context. Diagnosis is therefore not a static, clear-cut black and white concept as it is systemically influenced.

The criteria for conduct disorder and oppositional defiant disorder will be outlined below as descriptions for the kinds of behaviours included as target behaviours in this study. The children in this current study presented with these two disorders that fall under opposition, defiant and conduct disordered behaviour:

1.3.1. The criteria for conduct disorder

The criteria for CD include repetitive and consistent behaviour in which the rights of others, or major age-appropriate societal rules and norms, are violated. For the DSM-5 diagnosis, there must be at least three of the following 15 criteria (henceforth referred to as CD-indicative criteria) from any of categories listed below, within the last 12 months, and at least one being present for the last six months:

Aggression to people and animals:

- Bullies or threatens others.
- Initiates physical fights.
- Uses a weapon that can inflict harm on others.

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- Has been physically cruel to people.
- Has been physically cruel to animals.
- Has stolen while confronting someone.
- Has forced someone into sexual activities.

Destruction of property:

- Setting a fire deliberately with the intent of causing damage.
- Damaged property in some other way.
- Serious violation of rules:
- Stays out at night despite parents' prohibitions, beginning at age 13.
- Has run away from home whilst staying in parental or guardian home at least twice or once for a lengthy period.
- Often truant from school before age 13.

The disturbance in behaviour causes clinical disturbance in social, educational, or occupational contexts.

If the individual is 18 years or older, criteria are not met for anti-social personality disorder.

Deceitfulness or theft:

- Has broken into someone's building, house, or car.
- Has stolen items of non-trivial value, without confronting a person.
- Often lies to obtain goods or services, or to avoid obligations (American Psychiatric Association, 2013).

CD can occur with lack of pro-social emotions. To qualify for this two of the following traits must be present for at least 12 months across different settings:

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- **Lack of remorse or guilt:** there is no sign of remorse or guilt for an action that has caused harm to others unless they are caught; and even then, they do not care about the consequences of their actions.
- **Lack of empathy:** there is little concern about the feelings of others, and they are more concerned about themselves after they have caused hurt to someone else, than they are about the one on whom they inflicted harm.
- **Lack of concern over performance:** there is a lack of concern over performance at school, and others are blamed for their poor performance.
- **Shallow or deficient affect:** little emotion is shown towards others. Emotions are used rather to manipulate or intimidate others (American Psychiatric Association, 2013).

These traits must represent a pattern of interpersonal interactions. Others in the individual's context such as parents and teachers should verify the interpersonal interaction as problematic, as the person displaying the traits will not likely recognise them (Amerrican Psychiatric Association, 2013).

The disorder varies in severity:

- It is mild when there are only exactly three of the CD-indicative traits (the minimum number necessary for the diagnosis) present, and also when harm to others is minimal.
- It is moderate when the CD-indicative traits present are between mild and severe e.g., stealing without confronting the victim or vandalism.
- It is severe when there are more CD-indicative traits present than the minimum necessary for the diagnosis, and severe harm towards others is noted.

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Behaviour associated with CD may lead to expulsion from school or dismissal from work, legal difficulties, sexually transmitted diseases, unwanted pregnancies, and physical injuries from fights. The symptoms could preclude living in a home or foster home. Substance abuse and cigarette smoking are often present in CD, as well as reckless risk-taking behaviour. Problems with the criminal justice system are not uncommon, due to illegal behaviour. CD is one of the most common reasons for referral to mental health facilities for children, and it is more commonly associated with chronic and severe symptoms than other childhood disorders (American Psychiatric Association, 2013).

1.3.2. Oppositional defiant disorder

ODD is defined as a pattern of irritable mood, vindictiveness, and argumentative/defiant behaviours that last for at least six months. For a DSM-5 (American Psychiatric Association, 2013), diagnosis at least four of the following ODD-indicative behaviours, regardless of category, must be present in interaction with at least one other person that is not a sibling (American psychiatric Association, 2013):

- Angry/irritable mood.
- Often loses temper.
- Often touchy and easily annoyed.
- Often angry and resentful.
- Argumentative/defiant behaviour.
- Often argues with authority figures (for children and adolescents, this includes with adults generally).
- Often actively defies or refuses to comply with requests from authority figures or rules.
- Often deliberately annoys others.

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- Often blames others for their own mistakes or behaviour.
- Vindictiveness.
- Has been spiteful or vindictive at least twice in the last six months (American Psychiatric Association, 2013).

The frequency or persistence of these behaviours is used to distinguish it from that within normal limits. For children under five years of age, the behaviour should occur on most days to be considered problematic. For those over the age of five, the behaviour should occur at least once a week. The intensity of the behaviour should also be considered to ascertain if it is within normal range for the age, gender, and culture (American Ppsychiatric Association, 2013). The behavioural problems should be severe enough to cause distress in the individual or their social context i.e., parents, authority figures or peers. To meet the DSM-5 criteria (American Psychiatric Association, 2013) the behaviour must normally impact negatively on social, educational, occupational, or other important areas of functioning (American Psychiatric Association, 2013). It should not occur exclusively in depressive, substance use, psychosis, or bipolar episodes (American Psychiatric Association, 2013).

The severity of the disorder is measured by how pervasive it is:

- Mild – occurs in one setting (home, school, work or with peers).
- Moderate – occurs in two settings (home, school, work or with peers).
- Severe – occurs in three different settings (home, school, work or with peers).

As with CD, the individuals exhibiting these symptoms do not see themselves as exhibiting oppositional, defiant, or angry behaviour but often justify themselves as responding to unreasonable demands from the context.

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ODD is not as severe as CD. ODD has emotional dysregulation (poorly controlled emotion), which is not necessary for a CD diagnosis. ODD does not involve aggression towards animals and people or patterns of theft or deceit (American Psychiatric Association, 2013).

1.3.3. Relational/interactional definition of disruptive behaviours

Moving from these descriptions to a more relational/interactional definition, Levin, and Nolan (1996) state that disruptive behaviour is that which sabotages the teacher in attaining his or her goals, and that which disturbs the classroom learning experience on a regular basis. This behaviour takes up considerable time on the teachers' part and can contribute to teacher stress and burnout (Ghazi, et al, 2013). It puts the child into conflict with teachers, which is a defining characteristic in the DSM-5 for these disorders (American Psychiatric Association, 2013) and a defining characteristic for this study. Mabeba and Prinsloo (2000) define disruptive and conduct disorder as behaviour that affects other children's rights to feel safe and respected while at school. Four types of behaviours are described by Levin and Nolan (1996) as disruptive behaviour in the classroom:

- **Behaviour that interferes with the teaching and learning process:** such as distracting other children in class, being aggressive, or not following directions.
- **Behaviour that interferes with other children's rights to learn:** such as disrupting lessons by calling out or making noise.
- **Behaviour that is psychologically or physically unsafe:** such as teasing and harassing classmates or using equipment in an unsafe manner.
- **Behaviour that causes the destruction of property:** for example, vandalism in the classroom.

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Conduct problems in children and youths have a strong effect on others and, as a result, other conditions can easily be missed. In clinical referrals, comorbidity is common. The most common accompaniments are depression and attention-deficit hyperactivity disorder (ADHD); some may present with post-traumatic stress disorder (PTSD), for example having been physically abused at home or witnessing family or community violence (Scott, 2008).

1.3.4. Definition of disruptive, impulse and conduct disordered behaviour for this current study

In summary, in this current study disruptive, impulse and conduct disordered behaviour is that which involves impulse control and emotional regulation disorders that put the child and youth in conflict with their peers, parents and authority in a way which is experienced as inappropriate for the contexts in which they find themselves (American Psychiatric Association, 2013; Gordon & Browne, 2004). The DSM (American Psychiatric Association, 2013) descriptions, described above, are used as a reference of the types of behaviours that can occur. Others in the individual's context, such as parents and teachers, verify the interpersonal interaction as problematic (American Psychiatric Association, 2013; Gordon & Browne, 2004). I, the therapist/researcher, also assessed whether the children, referred by their teachers, met the definition of disruptive, impulse control and conduct disorders according to the above literature sources and/or as defined for this current study. Elements of the relational definition of Levin and Nolan (1996) can be seen in the behaviour prevalent in the children in this current study. There is also a need to distinguish disruptive behaviour from general naughty or inappropriate behaviour in the classroom. This was achieved by enabling the teachers to define the behaviour as problematic for the school context. In this way, there is a fluidity of diagnosis, as it is also determined by context (Budd & Hughes, 2009).

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1.4. Research Objectives

The aim of this study is to design, implement, and explore the value and process of a multisystemic treatment intervention (MST) (Swenson et al., 2005) for addressing children's disruptive behaviours in South African schools.

To achieve the above aim, this study has the following objectives:

- Design an intervention based on an integrative, multisystemic approach within which framework evidence-based rational emotive behaviour therapies (REBT) and contingency management are applied.
- Implement and document the application of this applied intervention to four case studies to document the process including such elements as:
  - Identify the therapeutic processes that are successful in the above therapeutic interventions.
  - Identify challenges and obstacles to effectiveness in the therapeutic intervention.
  - Identify client-related aspects and contextual factors that influence the therapeutic process.
  - Note the difficulties experienced by the therapist/researcher and identify any therapist-related factors that could influence the therapeutic process.
- Add to the body of evidence-based case studies that will contribute to case-based research for the reference of other professionals working in this field in South Africa.
- Evaluate the success of the process through feedback from relevant people (teachers and parents) and by using psychometric tests and statistical evaluation thereof.

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1.5. Approach to the Study

Any approach that addresses disruptive, impulse control and conduct problems should not be aimed at the child's attributes alone, or indeed at any standalone measure. Instead, the approach should include environmental factors that influence and maintain the problem. This is supported by the recommendations found in the literature review in this study and the diverse nature and findings around the problem of disruptive, impulse control and conduct disorder (Bruce & Jongsma, 2011).

Several authors have suggested including strategies directed at different systems or different levels of a system (Burton & Leoschut, 2013; Ghazi et al., 2013; Pelser, 2008; Timm, 2007), those being: stakeholders (Burton, 2008; Leoschut, 2008), parents, (Burton, 2008; Burton & Leoschut, 2013; Leoschut, 2008; Ndinga-Kanga, 2015; Swenson et al., 2005), and the school community (Burton, 2008; Burton & Leoschut, 2013; Brion-Meisels & Selman 1996; Coetzee, 2005; Khan, 2008; Leoschut, 2008; Swenson et al., 2005; Timm, 2007; Yeo & Cho, 2011). Considering this, a multisystemic (Swenson et al., 2005) approach was utilised as a heuristic framework to integrate these various levels and treatments.

There are two components of the methodological approach to this study, the clinical methodology and the research methodology.

1.5.1. Clinical methodology

The clinical methodology is informed by the multisystemic (MST) (Swenson et al., 2005) approach. MST is rooted in Systems Theory and ecological approaches. From the perspective of these theories, behaviour is seen as multi-determined and influenced by reciprocal and bi-directional relationships between the youth and others in their environment (Swenson et al., 2005). It is based primarily on the works of Bronfenbrenner (1979, 1997), Haley (1976) and Minuchin (1974).

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A system is seen as several interrelated and interdependent parts that form a coherent whole. The parts are not seen as independent elements. Families, schools, and society are conceptualised as interrelated parts of a system. To understand the parts, you must understand the interrelationships (Laszlo, 1972).

In this study, interventions are implemented across the individual (child), family (parent/mother), and school (teacher) levels of the system, because the behaviour of the child/youth is influenced by all these (and many more) levels of interaction. In addition to targeting various levels of the system, the interventions used in an MST approach are adapted from evidence-based therapies such as behavioural and cognitive therapies (Swenson et al., 2005).

There is evidence that Cognitive Behaviour Therapies (CBT) and interventions can be successful in the treatment of disruptive behaviours (Iliades, 2014; Kazdin, 2007; Mashalaba & Edwards, 2005). In practice, therapies belonging to the CBT family are integrative in that they incorporate many techniques and principles of other therapies. CBT interventions are usually multi-faceted and are directed at the development of the problem, the environmental and individual factors that maintain the problem, as well as the restructuring of maladaptive cognitions that likewise maintain the problem (Mashalaba & Edwards, 2005). Rational Emotive Behaviour Therapy (REBT) is one of the many forms of CBT. These REBT interventions consist of both cognitive and behavioural interventions (DiGiuseppe et al., 2014). The evidence-based therapy used in this current study is REBT. REBT was chosen as in practice I, the therapist/researcher, experienced that teaching clients the concepts was easier compared to other approaches that described many more irrational belief categories compared to that of REBT. Albert Ellis pioneered the application of rational-emotive behaviour therapy (REBT) to the treatment of children and adolescents in the mid-1950s, and it has a long-standing history of application in schools (Vernon & Bernard, 2019). Meta-

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anaysis across REBT research indicates success with disruptive, impulse control and coduct disordered behavior (Engels, et al., 1993; Gonzalez et al., 2004; Lyons & Woods, 1991; Trip, et al., 2007). It has also been used successfully in the South African context (Edwards, et al., 2012). I, the therapist/researcher, have further training in this approach as both the primary and advanced practicums have been completed through the Ellis Institute in New York.

Along with the concept of responsiveness, which draws attention to bi-directional interactions (Kramer & Stiles, 2015), the multisystemic (Swenson et al., 2005) framework provides an integrative conceptual framework for the application of REBT therapeutic techniques and contingency management within the case studies across the different levels of the child/youth's system. The MST framework and the concept of responsiveness (Kramer & Stiles, 2015), covered in Chapter 2, also provides an integrative framework for the catalogue of findings and ad hoc application of treatments prevalent in the field of disruptive, impulse control and conduct disordered behaviour (Van der Walt & Potgieter, 2012).

1.5.2. Research methodology

To study the development, implementation and value of the intervention, an embedded, pragmatic case study method was used. Allport (1937) differentiates between idiographic research, which examines the specifics of individual cases, and a nomothetic approach, which examines general laws and concepts. According to Edwards (2018) nomothetic research on interventions ignores the kind of process knowledge that the therapy practitioners require. Pragmatic case studies provide a means for investigating what works in the therapeutic process. Therapy practitioners can draw on and utilise the knowledge gleaned from a case study (Fishman, 2013).

An embedded case study describes the study of more than one unit (or level of analysis) in one participant or case study (Yin, 1994). In this current study, the children represent one level of analysis and the parents and teachers of the children the other levels.

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The embedded approach of studying more than one unit of analysis for each participant is necessary, as elements in the home (represented by the mother) and school (represented by the teacher) may contribute to the development and course of the child's conduct problems (Mpofu & Crystal, 2001).

The complexities of the case studies are analysed using both qualitative and quantitative data. The embedded aspect of the case study mirrors the MST (Swenson et al., 2005) approach allowing analysis across different levels of the system and the pragmatic element allows research into the process of the treatment approach. This approach is thus suited to address the research aims of this study.

1.6. Definition of Key Terms

- **Rational Emotive Behaviour Therapy (REBT):** is one of the many forms of Cognitive Behaviour Therapy (Diguiseppe et al., 2014). The approach promotes a scientific philosophy and methods as the way to attain knowledge and truth about the self, others, and the world (Walen et al., 1992). From an REBT perspective disturbance in behaviour and emotion is perceived to be largely, but not totally, a result of the individual's perceptions, evaluations and value systems which comprise our philosophies (Walen et al., 1992). Ellis, the father of REBT, claims that REBT is a multimodal therapy in that it focuses on behaviour, cognitions, and emotions.
- **Multisystemic Therapy:** the approach is rooted in Systems Theory and ecological approaches. From the perspective of this theoretical framework, behaviour is seen as multi-determined and influenced by reciprocal and bi-directional relationships between the youth/adult and others in the environment (Henggeler et al., 1996; Swenson et al., 2005). The child/adult is seen as embedded within multiple systems. The approach suggests potential target areas and interventions across these different

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systems, or across different levels of a system (Henggeler et al.,1996; Scott, 2008; Swenson et al., 2005).

- **Pragmatic case study:** case study methodology provides a vehicle to analyse the complexity of knowledge discovered in context (McLeod, 2010), and it is a tool for understanding the practical process of therapy in action. The process builds narrative knowledge, which is the story of the sequence of events of the therapeutic process in chronological order (Fishman, 2013). The focus of pragmatism is on acquiring knowledge of how to deal with a specific social problem within a specific context, at a certain time, as opposed to proving timeless laws and principles. The goal is not primarily to prove a theory, it is to establish what works and what does not work in the therapeutic process (McLeod, 2010).
- **Embedded case study:** refers to the study of more than one unit (or level of analysis) in one participant or case study (Yin, 1994). In this current study, the multiple units of analysis are represented by the child, parent (family), and teacher (school). The identification of these different levels of analysis or sub-units allows for a detailed inquiry across these levels and the bidirectional influence they have. It is this embedded element of the case study that is influenced by Systems Theory (Anaf et al., 2007).
- **Responsiveness:** this concept sees human interaction as a system and the therapeutic process is no exception (Kramer & Stiles, 2015; Stiles et al., 1998). This concept carries through the focus on the interactions between various combinations of the system facilitated by the MST (Swenson et al., 2005) approach to the interpersonal interactions between therapist and the clients. In this study responsiveness was used in a different sense. Each participants irrational beliefs existing in the different layers

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of the system were themselves seen as a system that influenced each other in dynamic interaction.

- **Mixed methods:** The pragmatic case study provides a means of integrating both quantitative and qualitative research methodology (Scholz & Tietje, 2002; Yin, 2003).

The strength of the positivistic approach lies in the properties of numerical data that brings stable meaning across time, the quality control achieved by psychometric procedures, the ability to reduce large quantities of data, the provision of a normative context for the comparison of many individuals (Stiles et al., 2006). The strength of the qualitative paradigm is that it sees the data as context dependent and thus addresses context and client experience (Creswell, 1998). It provides a means of gathering rich descriptions of contextual information (Fishman, 2013). The methodology and mixed method approach lend further rigour and thoroughness to the process. Although this doctoral study is heavier in qualitative data, the psychometric tests and analysis brings in a quantitative element and is thus described on this basis as mixed methods.

1.7. Conclusion and Layout of the Thesis

This chapter discusses the prevalence of the problem of disruptive, impulse control and conduct disordered behaviour by exploring literature on disruptive, aggressive, and other problem behaviours in the context of South African schools. The associated motivation for the necessity of the current study that explores the development of an appropriate intervention is likewise discussed. The multi-faceted description and definition of disruptive, impulse and conduct disorder behaviours for this current study is outlined. The research aims and questions to be answered in this current study and the approach used are likewise elucidated. The therapeutic approach, and the research methodology are introduced and motivated.

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In Chapter 2, literature regarding disruptive, impulse and conduct disordered behaviour, prevalence, research findings, and contribution of context, school, family, and child factors are discussed. Different treatment approaches to the problem and the therapeutic theoretical frameworks utilised in the intervention are discussed.

In Chapter 3, the research and clinical methodology underlying this current study is presented, motivated and integrated. How the approach fits with the aims of the study are elucidated. The ethical considerations, and how rigour was achieved in this current study are discussed.

In chapters four through seven, the presented methodologies are applied to four, pragmatic, embedded case studies. These are written up according to the format described in Chapter 3.

Chapter 4 presents the pragmatic, embed case study of Neo.

Chapter 5 presents the pragmatic, embed case study of Moses.

Chapter 6 presents the pragmatic, embed case study of Jonathan.

Chapter 7 presents the pragmatic, embed case study of Thabo.

In Chapter 8 the findings of the study are discussed. The children's characteristics that influenced the therapeutic process are discussed along with the influence of the school context (teachers), and the influence of the family context (parents/mothers). The influence of the wider South African context on the problem of disruptive, impulse control and conduct disordered behaviours of South African school children are also considered. The therapeutic process regarding commonalities across different cases are discussed, thereby carrying out phase two of the analysis described in Chapter 3. The efficacy of the process and theory, applied in this South African context, are considered. The concept of responsiveness (Kramer & Stiles, 2015) is reviewed between therapist and clients. Responsiveness in a different sense, regarding the interaction of the different irrational beliefs, within the case studies across

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teacher, parent and child are also explored. The influence of contingency management on the child's behaviour are discussed. Recommendations for future therapy including reaching a wider number of prospective clients are considered as well as the strengths and weaknesses of the study. The research questions in relation to the results of the study are briefly summarised.

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Chapter 2: Literature Review

2.1. The Multi-dimensional Problem and Influences

In this chapter literature around the multifaceted problem of disruptive, impulse-control, and conduct disorders in children and young adolescents in schools is reviewed, along with the many contributing contexts, treatment approaches and specific treatments used in this current study. Disruptive, impulse control and conduct disordered behaviours also often occur in clusters, meaning that one child will present with multiple problematic behaviours concurrently (American Psychiatric Association, 2013; Bruce & Jongsma, 2011). The links between these disruptive behaviours are not found in their cause, as these are largely unknown and varied. The common element is emotional and behavioural dysregulation and the breaking of societal norms, which puts these children or adolescents at odds with authority, peers, and family; and can involve harm to others (American Psychiatric Association, 2013; Iliades, 2014). The underlying causes for and influences on these behaviours may vary across different types of disruptive and aggressive behaviours and even across individuals exhibiting the same type of disruptive behaviour. Research has shown that both environmental and genetic factors influence the development and maintenance of conduct disorder (CD) and other disruptive and impulse-control behaviours (American Psychiatric Association, 2013; Frick, 2001). Interventions for CD often fail, as these do not consider the myriad factors that contribute to both causation and maintenance of the associated behavioural problems (American Psychiatric Association, 2013; Frick, 2001; Iliades, 2014). This is a multi-dimensional problem that is influenced by social, cultural, family, neurological and biological factors (Benbenishty & Astor, 2005) some of which are included in this chapter.

According to the literature review carried out by Kourkoutas and Wolhunter (2013) there are correspondingly a variety of ways to address behavioural problems and associated

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disciplinary issues in schools. These techniques and treatments are often applied in a piecemeal fashion (Grauerholz, 2000). Research provides insight into the resulting problems and ramifications of the issue, but the results read like a catalogue of findings (Van der Walt & Potgieter, 2012) as opposed to an integrated approach. The experience of reviewing the literature for this study likewise resembles a catalogue of findings as opposed to a holistic framework. However, due to the nature of this problem and the multiplicity of influential factors, a holistic approach is recommended for both understanding and treatment of conduct problems (Burton, 2008; Burton & Leoschut, 2013; Frick, 2001; Ghazi et al., 2013; Khan, 2008; Kourkoutas & Wolhunter, 2013; Pelser, 2008).

2.2. The Organisational MST Framework and Systemic Bi-directional Interaction

Despite this above recommendation, not much of an attempt has been made to integrate these theories, findings, technical elements, and treatments into a holistic approach regarding disruptive, impulse control and conduct disordered behaviour. The systemic, ecological, and likewise Multisystemic Therapy (MST) approaches provide a framework to integrate the myriad of findings and contributing factors (Grauerholz, 2000). Although the MST (Swenson et al., 2005) framework cannot cover all the factors relating to disruptive, impulse control and conduct disordered behaviour, it can be useful as a heuristic framework to organise the large amount of divergent literature and piecemeal applications of techniques. The MST (Swenson et al., 2005) approach is used for such purposes; to integrate multiple contextual and individual factors that influence this problem reviewed in this literary chapter, as well as the application of treatment that is reviewed later. From this perspective, behaviour is seen as multi-determined and influenced by reciprocal and bi-directional relationships between the child/youth and others in their environment (Swenson et al., 2005). Harpell and Andrews (2006) state that conduct problems are multilevel and multidimensional in nature. Because of this the MST (Swenson et al., 2005) approach, derived from the socio-ecological framework,

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is the best way to describe how the various conduct disorders develop and how they in turn impact the different facets of life in a bidirectional fashion. Different socio-ecological facets such as family, school and community are interconnected and dynamic, and the various conduct disorders are maintained by problematic transactions between various combinations of these systems. Treatment often focuses on the problematic dynamics and interactions between these facets of the child's life rather than standalone problems in isolation. The MST (Swenson et al., 2005) framework was thus used to organise this divergent and interactional information.

2.3. The Concept of Responsiveness and the Recognition of Bi-directionality in Micro-interactions

The concept of responsiveness sees human interaction as a system and the therapeutic process is no exception (Kramer & Stiles, 2015; Stiles et al., 1998). This concept carries through the focus on the interactions between various combinations of the system facilitated by the MST (Swenson et al., 2005) approach to the interpersonal interactions between therapist and the clients. Responsiveness (Kramer & Stiles, 2015) is thus used as a means of carrying through the concept of bi-directionality, evident in MST (Swenson et al., 2005), from the wider contextual influences to the micro-interpersonal interactions within the therapy process. Within the therapeutic system, therapist, client, treatment, and context partly depend on each other (Stiles, 2009). Both the client's and the therapist's behaviour are affected by the emerging context which includes perceptions of each other's behaviours and characteristics (Kramer & Stiles, 2015; Stiles et al., 1998). The therapist and client both use feedback from their interaction to alter activity in therapy to optimise the outcome in line with their goals (Stiles, 2009). The concept of responsiveness (Kramer & Stiles, 2015) is adapted in this study and applied not only to the therapist and client but also to interactions between clients and

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their irrational beliefs across the system. This concept, in line with MST (Swenson et al., 2005), forms part of the integrative framework of the study.

Appropriate responsiveness refers to the therapists' reactions being carried out at the right time and in the right way in relation to the emerging context of therapy. In this way, therapists adapt their approach to the needs of the client (Kramer & Stiles, 2015). Stiles (2009) claims that responsiveness explains why most therapeutic orientations are seen to be equally effective in randomised control trial studies (RCTs). In other words, the appropriate, responsive application of therapeutic orientations may be more important pertaining to successful outcome than the approach itself.

Due to the process of responsiveness, clients receive different types of therapy within the same model (Stiles, 2009). Each therapist administers a particular treatment differently and the same therapist will administer the same treatment differently across different clients. Clients likewise behave differently with different therapists within the same treatment approach. This process is recursive (Krause & Lutz, 2009) and these reciprocal feedback loops can be chaotic and dependent on contextual and interactional conditions, making the therapeutic system unpredictable and even possibly inconsistent (Barton, 1994).

Therapist responsiveness involves more than just adapting techniques to make them meaningful and acceptable to clients (Edwards, 2010). Responsiveness is also used in strategic decision making, this is referred to as meta-competences (Roth & Pilling, 2008). These are skills used in applying general principles of case formulation and treatment planning in a strategic decision-making process about where to focus as the therapy proceeds. This enables the delivery of therapy in a coherent and responsive manner. These skills do not address the implementation of specific techniques, but the way in which the therapist monitors broader aspects of the relationship with the client and the ongoing therapy process (Edwards, 2010).

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Responsiveness also happens in moment-to-moment instances of micro-interactions during therapy (Stiles et al., 1998). Thus, it involves the therapist's application of specific technical interventions appropriate for the client's problems and stage of the therapeutic process. Responsiveness therefore is appropriate for the desired outcomes of the practitioner's therapeutic approach (Kramer & Stiles, 2015; Stiles, 2009;). The appropriate responsive application of the therapeutic framework is referred to as competences by Roth and Pilling (2008). Competencies involves working within the structure of the session, such as agenda setting or selection of focus for the session (Edwards, 2010). Within the REBT framework the case conceptualisations, treatment intervention, homework assignments etc. provided by the therapist are all types of responsiveness (Kramer & Stiles, 2015) on the part of the therapist. For example, homework assignments are given in response to the client's level of ability or if the client cannot create their own alternate belief, the therapist suggests one thereby using inductive interpretation as opposed to induction (Diguiseppe et al., 2014).

Despite the importance of responsiveness in therapy, there is a paucity of research in the area (Stiles, 2009), most likely due to lack of expertise and resources. The case study design used in this study enables the analysis of responsiveness in the therapeutic process (Fishman, 2013) and is used to continue the conceptualisation of bi-directionality down to the interpersonal and micro-interactions.

2.4. Summary of the Review to Follow

In this chapter, the MST (Swenson et al., 2005) approach is used to organise existing knowledge about contributing influences on disruptive, impulse control and conduct disordered behaviour into different levels of the system (wider community, school, family, and individual factors). The bi-directional nature of the influence of these various contexts and the youth with the conduct problem are recognised. Research regarding statistics and prevalence of disruptive, impulse-control, and conduct disorders are discussed within these

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various levels of the system. Treatment orientations and therapeutic modalities used in the remediation of the disorder are discussed according to their ability to incorporate various levels of the system; the contextual factors pertaining to conduct problems.

Finally, the theoretical and clinical models and theories chosen for this study are discussed, and how they are applied to the chosen levels of the system. The concept of responsiveness (Kramer & Stiles, 2015) is used to conceptualise the bi-directional interactions in the therapeutic process and, in the following chapters, between the different members of the ecological case studies. In this way an attempt is made to represent the fluid and bi-directional influences and processes that are difficult to capture in the static snapshots taken in a research process.

2.5. Contextual Factors Contributing to Disruptive, Impulse-Control and Conduct Disorders

The variety of influences on behavioural problems vary in severity and weight. Such influences include the personal, familial, scholastic, and societal (Kourkoutas & Wolhuter, 2013) which represent different levels of the system to which the child belongs.

2.5.1. Wider society's influence

Using Bronfenbrenner's (1979) model, school violence and responses to it are the product of the interplay between several, interconnected influences, or sub-systems. Through this theoretical viewpoint violence and other behavioural problems in school, as well as its causes, incidence, impact, and the resulting interventions, cannot be viewed in isolation. Maree (2005), writing specifically on bullying in South African schools, regards the current behavioural problems in schools as part of the broader picture of spiralling levels of violence and crime which dominate South African society. Pelser (2008) notes that the youth make up approximately half of the population of South Africa. He claims that the youth crime rate is a

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function of the development and replication of the culture of violence that has been normalized in South Africa, and that the youth have been socialized through it. Due to the riots and violence since 1976, the authority of schools and families were undermined in the perceptions of the youth and these institutions have still not yet recovered (Pelser, 2008).

Children reflect the culture and society from which they come. In turn, the resultant destructive behaviours of the children have a negative effect on and implications for wider society (Bronfenbrenner, 1979). Substantiating this, the DSM-5 (American Psychiatric Association, 2013) claims that communities high in crime and violence report an increased risk of disruptive, impulse-control, and conduct disorder (American Psychiatric Association, 2013). Noddings (1996) states that a decline in the morals of society in general are associated with violence and behavioural problems in schools. The DSM-5 (American Psychiatric Association , 2013) however, cautions against this diagnosis where conduct problems are normative for the context. Those in war-torn areas, for instance, have been misdiagnosed with conduct disorder. Care should be taken to consider the context in which the behaviour occurs before this diagnosis is given. If it is a normative behaviour for that context, the diagnosis should not be applied (American Psychiatric Association, 2013). This seems to be in accord with Gordon and Browne (2004) and the definition of the target behaviours in this study, in that the problem behaviours are those that are out of keeping with the child or youth's context. In this way the context is considered in the diagnosis thereby differentiating naughty behaviour from disruptive behaviours.

2.5.1.1. A catalogue of findings

According to Mpofu (2003) there was no systematic epidemiological research in South Africa to document the prevalence of disruptive behaviour disorders at the time of writing, yet health professionals recognised that the issue posed a serious problem (Mpofu, 2003). The Centre for Justice and Crime Prevention's (CJCP) National School of Violence carried out two

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nationwide studies, one in 2008 (Burton, 2008) and a follow up in 2012 (Burton & Leoschut, 2013), to address this gap in the South African context (Burton & Leoschut, 2013). The initial study carried out in 2008 (Burton, 2008), sampled both primary and high schools, whilst the follow-up involved only high schools (Burton & Leoschut, 2013). In the literature search for this doctoral study, these studies were the most comprehensive research found with regards to the prevalence and nature of violence and anti-social behaviour in South African schools. Violence in this research (Burton & Leoschut, 2013) is defined as the use of force against another, threatened or actual, that results in physical or psychological harm, injury, death, or deprivation. Operationally the definition includes assault, threats of violence, robbery, sexual assault, and non-violent crimes such as theft (Burton & Leoschut, 2013),which overlap with the definition of target behaviours in the doctoral study. These studies confirmed that several community-based risk factors increase the susceptibility to violence in schools. These risk factors include community disorganisation, exposure to adults involved in drugs, alcohol, criminal or violent behaviour, exposure to crime and violence, and the presence of weapons in the community in general. The exposure and easy access to weapons, alcohol, and drugs facilitates bringing these items onto the school premises. Physical factors that were seen to affect crime in the community are the presence of open and un-kept spaces, including abandoned buildings (Burton, 2008; Burton & Leoschut, 2013).

Burton (2008) states that the CJCP study involving 12 794 learner participants, determined that one in three primary school, and two in three secondary school learners reported that it is easy to get alcohol in their communities, while two in three secondary school learners think that it is easy to access guns in their community. Liberante (2012) likewise relates violence and other behavioural problems in schools with involvement with drugs and alcohol accessible in the community.

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Other authors have linked poverty to disruptive, impulse-control, and conduct disorders (American Psychiatric Association, 2013; Barnes et al., 2006; Ndinga-Kanga, 2015), as well as related structural issues such as the absence of amenities or housing (Anderson et al., 2001). Poverty-stricken backgrounds are also often associated with neglect or even mistreatment that can result in behaviour related to conduct disorder (American Psychiatric Association, 2013). There was no mention of the economic status of the communities in the CJCP research (Burton & Leoschut, 2013), though the research did differentiate results according to province. The various communities in this study would be described as affluent, middle class, and underprivileged. Irrespective of economic status or geographical area of the children in this study's sample, all children involved were exposed to drugs, alcohol abuse, and violence within their communities.

Regarding the modelling of violence, exposure of children to examples of violence in both the home and community is a contributing factor to violent behaviour in schools (Herrenkohl et al., 2008). Violent behaviour is more likely to be modelled if the perpetrator is known to the child (Burton & Leoschut, 2013). Excessive TV-watching and gaming are associated with behavioural problems (Wolhuter & Steyn, 2003). Violent images on the media generally have been associated with violence and other behavioural problems (Maree, 2005).

The above findings emphasise how the community context influences the life experiences of children and adolescents, as well as their vulnerability and exposure to violence. Again, confirming the influence of community context, the CJCP found that the province with the highest perceived rate of crime is the Free State, and that the schools in this area report the highest levels of violence (Burton & Leoschut, 2013).

If social attitudes and behaviours are learned through observations and societies' narratives present in the world, this would include narratives and behaviours associated with

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anti-social behaviours such as drug-taking or domestic violence (Ndinga-Kanga, 2015). Through exposure to violence in the media and community in general, violent narratives are perpetuated further (Maree, 2005). In short, schools are microcosms of the wider community, and the social issues in the community permeate the school context (Burton & Leoschut, 2013; Leoschut, 2008).

2.5.1.2. Sense of belonging

Youth anti-social and violent behaviour are attributed to the interference of the fulfilment of the need for a sense of hope, agency, connections, inter-generational relationships, and coherence. People require these five elements to make sense of the world. If these needs are not attained through positive means in society, then people turn to negative means, such as belonging to a gang, to attain them (Gunderson & Cochrane, 2012). Furthermore, the risk of disruptive, impulse-control, and conduct disorders has been found to be associated with rejection by peers and association with undesirable peer groups (American Psychiatric Association, 2013). This finding seems to support this claim that the need for belonging influences the development of disruptive, impulse control and conduct disordered behaviour.

2.5.1.3. Requirements to address the problem

Accordingly, wider community aspects seem to be involved in the influence and maintenance of disruptive, impulse-control, and conduct disorders. The KwaZulu-Natal Department of Education's appeal to parents, communities, and all other stakeholders to come together to combat school bullying, appears to reflect a public recognition of the community influence on conduct disorders at school. Department spokesperson, Muzi Mahlambi, was reported as saying "We are very much disturbed by this kind of continued violence that we see happening in our schools. As the department of education, it is not a matter we can address alone" (Singh, 2017).

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In treatment, incorporation of the wider contextual influences is generally considered to be important (Burton, 2008; Burton & Leoschut, 2013). Both short and long-term goals are advocated. Immediate measures such as prevention of access to weapons, drugs, and alcohol on school grounds; as well as making schools generally safer, are suggested to decrease violence. However, longer term goals such as intensified and expanded early childhood programmes are also called for. Programmes such as these can offer support to children as well as their parents. Concomitantly, local government have a responsibility for cleaning up neighbourhoods around schools, freeing them of illegal liquor outlets and drug merchants, many of whom reportedly sit directly outside school grounds (Burton & Leoschut, 2013).

The findings and recommendations of the 2012 study of the CJCP (Burton & Leoschut, 2013) are substantially like those of the 2008 study (Burton, 2008). It is concluded that school behavioural problems can be addressed effectively only through the combined efforts of school authorities, parents, community leaders, and government. These efforts must be located within a broader framework of an intensive social crime prevention strategy that addresses much of the violence that is beyond the reach of police and which occurs within the home environment (Burton, 2008; Burton & Leoschut, 2013). Pelser (2008), Ghazi et al. (2013) and Khan (2008) also claim that a wide approach to combat behavioural problems in schools must include policy choices that address the issues of children and youth in this regard.

2.5.1.4. Conclusion

The co-ordination of such an inclusive approach that incorporates community intervention seems to remain theoretical only. The current practical interventions in South Africa seem to involve small interventions targeting elements of this problem. This is possibly the reason why not much change is evident in problem behaviour indicators noted in the two cited CJCP studies (Burton, 2008; Burton & Leoschut, 2013) conducted four years apart.

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To address disruptive, impulse control and conduct disordered behaviour which includes such problems as violence and anti-social behaviour, on a wide scale, the psycho-social aspects mentioned above would need to be addressed. This doctoral study is likewise a small-scale intervention that could not address wider psycho-social problems, but on a small scale it did try to target a system, as opposed to mere stand-alone elements due to its MST (Swenson et al., 2005) framework and application thereof.

It is extremely difficult, if not impossible, for isolated, individual researchers to incorporate and address wider social issues on a practical level. The influence of factors impacting behavioural problems such as excessive TV-watching and gaming are emphasised if the society is in a state of flux (Wolhuter & Steyn, 2003). It is argued by Eagle (2015) that in South Africa high levels of crime entailing interpersonal violation reflects the ruptures in the social fabric, and likewise this interpersonal violation in turn contributes to social disorganization. Eagle, (2015) lists a broad range of social formations such as the trade unions, political constituencies, and civil society groupings (including those exclusively incorporating national or non-national citizens), pervasive service delivery protests, labour unrest, student demonstrations, racial polarisation, and the legal battles that are taking place in response to allegations of corruption and abuses of power, directed at government figures and agencies, as evidence of these post-Apartheid social ruptures in the South African society. The South African economy is weakening, unemployment is severe, and wealth disparity remains amongst one of the highest in the world. These conditions reflect a lack of social cohesion, and likewise threatens any project designed to address any aspect of social relationship. South Africa needs to work towards social cohesion if it is to attempt to address the conditions and states of mind that stem from the current high levels of criminality and alter the kind of climate that perpetuates such criminal potentiality (Eagle, 2015), such as the current state of the school system. If the lack of wider social cohesion manifest in the above

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social issues and turmoil is not addressed, projects aimed at remediating such things as school violence are likely to have limited success. The state of research in South Africa, being largely limited to small university-based studies, likewise reflects this lack of cohesion.

2.5.2. Contribution of the school context

Schools function as an integral part of communities, and their problems, like disruptive, conduct disordered and impulse control behavioural disorders, must be addressed as such (Benbenishty & Astor, 2005; 2008). School systems are important socialising agents for children (Khan, 2008). Experiences of violence and conduct problems attached to schools have a profound impact on children and their development. They are likely to impact on: a child's attachment to school; increased drop-out and truancy rates; self-confidence; levels of academic performance; the young person's later vulnerability to violence; and the likelihood of their own turning to violence (Burton, 2008; Burton & Leoschut, 2013). Violence in schools can affect the child’s sense of hope and optimism in the future, and this can lead to less resilience when faced with contextual stressors in society (Burton & Leoschut, 2013). According to the CJCP study (Burton, 2008), the experience of violence and other conduct problems in the school context was common in both primary and secondary school contexts. The most common types of conduct problems experienced were threats of violence, assaults, and robbery. Although the threats may not result in physical harm being done, they are still detrimental to the child’s trust of others, fear of school and classmates, concentration, and overall social experience (Burton, 2008).

Classrooms are the most common location where these threats and acts of violence happen (Burton, 2008; Burton & Leoschut, 2013). Classroom incidents are attributed to the absence of teachers or due to teachers being unable to manage classroom behaviour (Burton & Leoschut, 2013). These acts also tend to take place in toilets, and open grounds, such as playing fields (Burton, 2008).

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Within the school system there is a clear bi-directional, interactional effect between the behaviour of children and teachers. For example, teacher behaviours such as classroom management and competence can affect the behaviour of the children (Burton & Leoschut, 2013; Wolhuter & Steyn, 2003) and the behaviour of children, in turn, affects the behaviour of teachers. Classroom discipline in general has been cited as one of the biggest contributors to new teachers' stress. Disruptive behaviour takes up considerable time of the teachers and can contribute to teacher stress and burnout. It is difficult to organise classrooms and to deal simultaneously with disruptive behaviour (Ghazi et al., 2013). The school context often introduces new rules at the beginning of the year and the expectation is that when the rules are implemented, and the contingencies consistently adhered to, behaviour will then improve. When these expectations are not met, it leads to teacher stress (Ghazi et al., 2013). Educators need strategies to deal effectively with challenging behaviour. Different approaches are needed to address the way in which troubled young people are dealt with and perceived (Coetzee, 2005).

Discipline in South African schools has deteriorated over the years and the abolition of corporal punishment was one of the contributing factors (Mabeba & Prinsloo, 2000). Marais and Meier (2010), claim that no disciplinary alternatives have been implemented. Moyo et al. (2014) still found a strong support amongst teachers and principals for corporal punishment, and no evidence that they believed in alternatives to this method of discipline. This belief revealed ambivalence and lack of understanding. It is suggested that principals and stakeholders focus on cultivating a new school culture guided by values such as self-discipline, to lessen the need for extrinsic punitive control. Zondi (1997) claims a lack of South African literature and research on the topic of classroom management, which means there is little knowledge to guide teachers in managing behaviour problems in the classroom. According to Marais and Meier (2010), over a decade after Zondi's (1997) research, the

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situation had not changed and is long standing. In 2010 the National Department of Education recognised this need and developed a booklet with guidelines to alternative forms of discipline. However, despite this intervention, media headlines claimed that the book was of little value (Marais & Meyer, 2010). Disruptive behaviour and other behavioural problems remain widespread over the decades and is a prevalent part of teachers' experiences in South African schools (Jordaan, 2017; Marais & Meier, 2010).

Reviewing overseas literature and research with regards to teacher-related factors, Wolhunter and Steyn (2003), identified teacher competence, effective knowledge of a subject, presentation of lessons, classroom techniques, and management skills as influencing classroom behaviour. There are common themes of causation and correlates of behavioural problems in schools in both overseas and local South African research.

2.5.2.1. Catalogue of findings

Olweus (1995), a prominent researcher on the topic of bullying, claims that the teacher's attitudes, behaviours, and routines in the classroom influence how bullying manifests. For instance, when the academic expectations of one student are below that of the rest of their peers, the student can become frustrated, and this can alienate the child from the school context. This frustration can be expressed through anger and violence (Cullinan, 2007). Marciniak (2015) cites inappropriate curriculum which does not reflect the needs of the scholar, as being associated with general disciplinary problems. This is particularly so if this curriculum is presented in such a way that it is seen as a waste of time. Slee (2020) states that differing sets of attitudes and values of teachers on the one hand, and school children on the other, can add to this issue. The teachers may value learning whereas students can be bored in the learning context. Stewart (2004) points to the different kind of life that the child experiences in the classroom compared to that of outside. This leads to the experience of

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dissonance, and this is proffered as a possible contributor to behavioural problems in the classroom.

Various other factors in the school are also correlated with higher incidence of violence at those schools, including when the quality of education is poor (Futrell, 1996); there is inadequate management and poor organization of schools (Mncube & Madikizela-Madiya, 2014), there are too many pupils in a class; or parents are not involved enough (South African Press Association, 2013). The location of and condition of ablution facilities have been reported to impact the level of school bullying as well (South African Press Association, 2013).

Gender appears to influence the experience of violence. In high school, girls are more likely than boys to experience sexual assault while males were three times more likely than females to be physically assaulted. These offenses were committed more than once on some of these children. Age seems to be a variable that impacts the experience of violence, more secondary school children reported violence than primary school children. In primary school 70% of children reported being caned, spanked, or beaten by educators when they did something wrong, compared with almost 50% of high school children. More than half of the secondary school children report weapons-related incidents at school, while two-thirds report drugs and alcohol incidents (Burton, 2008). In 2012, exposure to schoolmates taking drugs, buying, and selling drugs, and involvement in illegal activities, were reported by children; confirming that young people are exposed to anti-social behaviour in the school context (Burton & Leoschut, 2013). Children usually report these incidents to friends and not parents or educators. This finding emphasises the possible importance of peers in the prevention of violence and treatment programmes (Burton & Leoschut, 2013). It is suspected that there is still a large percentage of such incidents that go unreported.

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The Centre for Justice and Crime Prevention (CJCP) studies (Burton, 2008; Burton & Leoschut, 2013) concluded that not much had changed between 2008 and 2012 with respect to the statistics regarding widespread violence experienced in schools. The percentage of overall violence experienced was generally no different. The number of incidents of theft, assault, and sexual assault, however, were higher in 2012 compared to 2008; while threats of violence were lower in 2012 compared to 2008, as was robbery (the use of violence in theft). The overall picture remains much the same (Burton & Leoschut, 2013). Despite these statistics, most of the children reported feeling safe at school, but more so in primary school than in high school. This suggests the normalisation of violence in the South African schools and the wider community (Burton, 2008).

2.5.2.2. Intervention strategies

The South African National Department of Basic Education and the Open Society Foundation of Southern Africa carried out a study in 2004, including 100 schools in the Limpopo and Eastern Cape provinces (Khan, 2008). The study concluded that schools are an integral part of the community and that all the stakeholders are required to participate in any intervention if it is to be successful. This recommendation confirms the need for a wide approach to treating conduct disorders in schools in South Africa. Clustering schools (placing them in groups according to area) as a strategy to provide support in a wide intervention was suggested (Khan, 2008). This is supported by other studies that claim that a community approach involving educators, children, administrators, and management is needed for effectiveness (Burton & Leoschut, 2013).

The school context can be an ideal setting to develop a culture within which children can learn to redirect destructive behaviours (Coetzee, 2005). They could also help to promote pro-social behaviour and positive emotions (Burton, 2008). If schools were safe places for children, schools could act as a buffer against the violence experienced by children in their

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wider communities. Based on a review of international literature, Wolhuter and Steyn (2003) claim that school-related factors can contribute to developing a sense of community, shared values, and a positive relationship with parents. Factors fostering this sense of community are the physical appearance of the school, classroom management and style, teacher responsibility, and content of the curriculum (Wolhuter & Steyn, 2003). According to Khan (2008), children who change schools often are more prone to violence than those who experience stability (Khan, 2008). This could be related to the sense of belonging and community spoken of by Gunderson and Cochrane, (2012). Many risk factors related to violence can be addressed at school level, including truancy, drop-out, poor educator-learner bonds and relationships, disorderly school environments, association with delinquent peers, and generally a negative or harmful school context. Conversely, the school context can lend protective factors such as positive educator-learner bonds, academic motivation and success, positive peer relationship, clear disciplinary structures and rules, and opportunities for pro-social activities (Burton & Leoschut, 2013).

In turn, early detection of crime and violence in schools can help to prevent violence in the communities. Educators can be trained to detect warning signs in children regarding behavioural problems. Schools also need to adhere to policies and legislation to ensure democratic management and decision-making and instilling a culture of respect for human rights (Khan, 2008). It is recognised that it is easier to note this theoretically than it is to practically implement such a recommendation and to engage all the necessary stakeholders. Due to this difficulty, interventions implemented are undermined.

2.5.2.3. Conclusion

Recommendations emerging from the reviewed literature emphasise a need for a wide approach to treatment. The school is an integral part of the community, and all stakeholders are required to participate in any intervention if it is to be successful (Khan, 2008). This

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requires a high level of organisation and collaboration which does not yet exist in the context of South African schools (Eagle, 2015). This current study included the school context as one of the layers of the system in the ecological case study, even though this was done on a small scale. The teacher represented this layer of the system.

2.5.3. Contribution of family (parents)

Schools in most countries rely on interaction with the families of children to enhance the learning and social development of children. Sometimes, however, stressors within families can result in violence involving their children (Oostdam & Hooge, 2013). According to Social Learning Theory, the acquisition of any complex social behaviours such as the expression of aggression, are acquired through social learning; that is, as children develop, they are exposed to several socialising agents which impacts on the development of their own moral standards. The home and parents are the first of these socialising agents. Through the means of direct teaching, evaluative reactions to their behaviour and exposure to the standards by which others evaluate themselves, children are socialised. In turn the child's behaviour affects the social context to which they are exposed, and the social context, in turn, affects the child's behaviour. In short, exposure to violence, harsh and inconsistent discipline, and poor role models socialise the child into several anti-social behaviours. This may include behaviour such as the use of aggression as a way of solving conflict and dealing with difficult situations. Through social interaction with parents, inconsistent disciplinary action and certain parenting styles, negative and positive reinforcement of anti-social behaviours occurs within the family contexts which determines its expression (Khan, 2008). The child may have experienced hostile parenting, or the child's behaviour may have contributed to hostile parenting, or there could be contributing elements from both parties (Lengua & Kovacs, 2005). Generally, according to Gunderson and Cochrane (2012), unless there is an intervention, children observe how their parents respond to conflict and life in general and imitate their behaviour.

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2.5.3.1. Parenting styles

Following on from the above theoretical understanding, parenting practices are considered important in contributing to ODD, particularly neglectful, harsh, or inconsistent parenting practices (American Psychiatric Association, 2013). Likewise, Khaleque (2014) and Palmer (2009), states that certain kinds of parenting such as lack of supervision at home are risk factors for behavioural problems.

Olweus (1995) identified four child-rearing factors that were likely to contribute to the development of aggressive reaction patterns in children: a predominantly indifferent attitude of the primary caregiver in the child's early years; lack of parental warmth and involvement; permissiveness for aggressive behaviour in the child, and inadequate limit setting; and use of power by the primary caregiver, such as physical discipline.

In the culturally diverse South African context, parenting style is an emerging topic of research (Roman et al., 2016). The study by Roman, et al, (2016) based its research on the parenting styles described by Baumrind (1967; 1991; 1978). Baumrind (1967) identified three different parenting styles and the effects that these parenting styles have on child behaviour, well-being, and adult adjustment. Parenting styles known as authoritative, authoritarian, and permissive were identified. These styles are characterised by different combinations of warmth and control. Warmth fosters self-reliance, individuality, and assertiveness in a child (Hart et al., 2003). Control integrates the child into the family, through discipline and parental supervision (Baumrind, 1991). Authoritarian parents are low on warmth and high on control. Obedience is most important and instilled through punishment (Baumrind, 1967). Authoritative parents are high on control, but also high on warmth. They foster autonomy and self-will, but also discipline their children using both power and reason in this pursuit (Baumrind, 1967; 1991). Authoritative parents are deemed the most optimal, and they foster social responsibility, independence, self-confidence, higher self-esteem, and adaptive

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behaviour (Baumrind, 1991). Permissive parents show more warmth and less control. This form of parenting lacks structure for children, in that the parents indulge the children's needs and whims and do not set proper boundaries. Outcomes for children include high self-esteem, but the style is correlated with drugs and alcohol use, as well as problem behaviours (Scaramella & Leve, 2004). Children raised by permissive parents can show; a lack of self-control, egocentrism, and demandingness, and may have difficulty in forming relationships (Baumrind, 1997).

Based on the parenting styles of Baumrind, South African researchers Roman et al., (2016) found maternal authoritative parenting style to be the most prevalent across and within the ethnic groups involved which were black African, coloured (a specific cultural grouping in South Africa), and white, and there was no significant variation across groups. Fathers' parenting styles were perceived as significantly different across the three ethnic groups. The permissive and authoritarian were the most represented, particularly in the black and coloured groupings. Mothers were generally more involved than fathers across all groups (Roman et al., 2016). That the approach of parenting influences the child, is further corroborated by a recent systematic review conducted by Davids et al., (2015) in South Africa, who established that negative parenting styles were associated with maladaptive behaviours in both children and adolescents.

2.5.3.2. A catalogue of findings regarding parental influence on behavioural problems

An analysis of the research findings of the CJCP studies (Burton, 2008; Burton & Leoschut, 2013) show a strong association between dysfunction in the home environment and violence at school. The general prevalence of dysfunction of the home context reported in these two studies is as follows: one in 10 primary school learners report parental use of illegal drugs, a similar percentage report that their caregiver/parent had been in jail, and one in five secondary school learners report siblings who had been in jail. These factors, together with

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children's experience of corporal punishment at both home and school, all impact significantly on the likelihood of them engaging in violence at school (Burton, 2008; Burton & Leoschut, 2013). Similarly, the DSM-5 (American Psychiatric Association, 2013) lists familial risk factors for disruptive, impulse-control, and conduct disorders to include: criminality of parents, psychopathology such as substance abuse disorders, neglect, parental rejection, inconsistency in child-rearing, physical or sexual abuse, harsh punishment, lack of supervision, frequent changes in caregivers, and large family size. In research done in South Africa, Timm (2007) confirmed that family discord was prevalent in the family context of the children exhibiting general behavioural problems.

Families of children with behavioural problems are characterised generally as disorganised, disadvantaged, and experiencing high levels of conflict with officialdom such as the child's school institutions (Kazdin, 1996). Parents who are conflicted with the school over discipline of their child, send mixed messages to their children. These children can learn to play off their parents against the school, and vice versa, and this further undermines discipline (Ndamani, 2008). A review of overseas literature determined that family-related factors such as lack of parental guidance, lack of parental school involvement, family stress such as marital problems, financial difficulties, poverty, and poor housing are all associated with disciplinary problems of the children in the school context (Wolhunter & Steyn, 2003). Khan (2008) corroborates that families in the lower economic strata are more likely to have children who exhibit behavioural problems, as they are exposed to the stressors associated with poor housing and poverty. This again exemplifies the interrelation and bi-directionality of the different layers of the system on the problem of all disruptive, impulse control and conduct disordered behavioural problems. This again confirms the need for an integrative approach which can be facilitated by the heuristic value of the multisystemic (Swenson et al., 2005) approach.

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2.5.3.3. Genetics

The contribution of genetics to disruptive, impulse control, and conduct disorder has also been considered. Those children with biological parents or siblings that exhibit conduct disorder are more likely to develop these symptoms themselves. Those with parents displaying bipolar, depressive, or substance abuse, and schizophrenia or ADHD diagnoses are more at risk for behavioural problems (American Psychiatric Association, 2013). These parents would however be more likely to exhibit the detrimental parenting styles and the subsequent problematic behaviours stated above that could be modelled by their children. Accordingly, it is difficult to disentangle genetic predisposition from problematic parental behaviour as an influencer on the child's behaviour. This again indicated the bi-directional nature of the various influences.

2.5.3.4. Conclusion

From the above it is established that parents form part of the context that can contribute to the origin and maintenance of disruptive, impulse control, and conduct disordered behaviour. It is therefore important for any intervention to include the parents to enhance the possibility of success. This current study included the mother as representative of the family layer of the system in the ecological case study. It was not stipulated that it should be the mother but only the mothers volunteered.

2.5.4. Contribution of the child's temperament and idiosyncrasies

As with other levels of the system, a reciprocal influence is noted between child and context (Burton, 2008; Burton & Leoschut, 2013). The child affects those around him/her due to aspects pertaining to the child. The same interplay noted from context to child likewise works in reverse from child to context.

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2.5.4.1. Neurological and biological factors

Neurological and biological factors within the child influence anti-social behaviour (Benbenishty & Astor, 2005). Lower heart rates have been noted in children displaying behavioural problems along with reduced autonomic fear conditioning, particularly low skin conductance. Reduced cortisol activity has also been noted. These conditions have been documented but they are not diagnostic requirements of the condition according to the DSM-5 (American Psychiatric Association, 2013).

Structural functional differences in the brain areas associated with affect regulation and affect processing have been noted in children with conduct disorder, particularly differences in the frontotemporal limbic connections, have been noted as well as in the ventral prefrontal cortex and the amygdala. Again, these noted differences are not used as diagnostic indicators (American Psychiatric Association, 2013). The frontal cortex and the limbic system are the areas most likely to be associated with impulsivity in these disorders (Iliades, 2014).

The amygdala and insula regions of the brain that contribute to emotion perception, empathy, and the ability to recognise when others are distressed were found to be smaller in teenagers with antisocial behaviour. The changes were present in childhood-onset CD and in adolescence-onset CD, and the greater the severity of the behaviour problems, the smaller the size of the insula. Smaller size in structures of the brain involved in emotional behaviour have been linked to childhood-onset CD. Adolescence-onset CD was previously thought to be linked to other contextual issues such as associating with badly behaved peers, but more recent findings suggest a potential neurological basis for these behavioural problems despite age of onset (Fairchild et al., 2011). According to the MST (Swenson et al., 2005) approach and literature reviewed for this study these findings would be indicative of a possible biological predisposition as opposed to a biological basis for the disorder.

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Furthermore, impulse control, disruptive and conduct disorders are more prevalent in males than in females although this proportion can vary across different age categories. The way in which conduct disorder manifests across genders also differs. In males, both physical and interpersonal aggression are displayed, whereas females are more likely to display interpersonal aggression. Females display more frequently manifest symptoms such as prostitution, substance abuse, truancy, running away, and lying; whereas males are more likely to manifest symptoms such as fighting, stealing, vandalism, and school disciplinary problems (American Psychiatric Association, 2013). Males are more prone to overt bullying behaviour at school than females, while females engage in more indirect and subtle bullying behaviour. Males are also more likely to be the victims of bullying. There is a pattern that males bully females and older students bully younger students (Olweus, 1995; Olweus, 2003). This gender difference could be due to either biological or socialization factors, or a combination of the two.

2.5.4.2. Developmental stage of the child

The developmental stage of the child is also a mediating factor regarding the frequency of aggression and the way in which this behaviour is expressed. The differences between high school and primary school children were noted in the statistics of the CJCP studies of 2008 and 2012 (Burton, 2008; Burton & Leoschut, 2013). Although the kinds of aggressive behaviours such as threats of violence, physical assault, sexual assault, robbery, and theft of goods was experienced with both high and primary school children, the prevalence across the developmental stages can differ. Primary school boys (2.5%) are more likely than primary school girls (0.2%) to experience sexual assault; while in high school, girls (4.8%) are targeted more than boys (1.4%). Seventy percent of primary school children were spanked or caned by teachers compared to 50% in high school (Burton, 2008).

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Regarding exhibiting behavioural problems, children entering high school are generally at the teenage stage of development, and are thus more likely to engage in grandstanding, to attract attention, in the classroom. Disruptive behaviour could be used as a form of grandstanding. Any kind of psychological or biological deficiency may appear more exaggerated at this stage. The presence of such disorders as attention deficit disorder (ADD) and Attention Deficit and Hyperactivity Disorder (ADHD) can lead to an elevation of associated disruptive behaviours (Ghazi et al., 2013). These comorbid conditions can also affect prognosis of therapy. As a result of the above disruptive, impulse control and conduct disorder tends to be more severe and prevalent in adolescence (American Psychiatric Association, 2013).

Further research findings (Schäfer et al., 2005) note a difference in the reaction of peers with regard to bullies. Primary school children are rejected by peers for bullying behaviour, but despite this rejection the role is not destabilised. The bully role usually remains constant through to high school. In contrast to primary school, high school children who bully are encouraged in their behaviour in that they are more accepted by peers because of it (Schäfer et al., 2005). Despite the difference in peer reaction, bullying can remain a constant over the development of the child. Olweus (1995), who did extensive research on bullying, likewise claims that this behaviour is part of an anti-social behaviour pattern which is largely constant over time. To verify this, Olweus (1995) cited that, in follow up studies, 35-40% of boys who bully in grades 6-9 go on to be convicted of three registered crimes by the age of 24, compared to 10% who were not classified as bullies. This is contrary to other theories such as ecological (Auerswald, 1992) and Systems Theory (Swenson et al., 2005) that advocate that the child and their behaviour is related to context and therefore subject to change. Despite the consistency of the role of bullying, Wolhuter and Steyn (2003), reviewing overseas literature, also list the developmental stage of the child as a mitigating

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factor in bullying and aggressive behaviour, as it affects the way that the role is perceived by peers and how the bullying behaviour is expressed.

2.5.4.3. Personality factors

The personality features noted in children with disruptive, impulse-control, and conduct disorders are emotional negativity, poor self-control (including poor frustration tolerance), suspiciousness, temper-outbursts, toleration of punishment, and thrill-seeking and recklessness (American Psychiatric Association, 2013). According to Olweus (1995) bullying is linked to personality factors with respect to children of both genders: they have a need for control, power, and to dominate; they are impulsive; and they are described as having low levels of empathy (Harris & Petrie, 2003; Olweus, 1995). Olweus (1995) claims that children who bully are low in anxiety and insecurity compared to their peers. This is in keeping with the biological finding of low cortisol levels noted above (American Psychiatric Association , 2013). As infants, the temperament of these children was reported to be difficult regarding emotional regulation, suggesting a possible biological predisposition to dysregulation (American Psychiatric Association, 2013).

2.5.4.4. Information processing

According to this theory, distorted information processing is prevalent in these children in that they perceive limited cues from a specific social situation and interpret the situations as intentionally negative, especially if the situation is ambiguous (American Psychiatric Association, 2013; Dodge, 2011). Due to this distorted processing, they respond with aggression to the situation (American Psychiatric Association, 2013). The aggressive response is perceived to give them power, which is thought to be to their advantage (American Psychiatric Association, 2013; Dodge, 2011). The consequences of aggression however are usually not in their favour, and this leaves them feeling anxious, angry, and

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helpless. This is contrary to the above findings that these children are punishment resistant (American Psychiatric Association, 2013) and low in anxiety (APA, 2013; Olweus, 1995). Mainly cognitive treatments are used to alter the perceptions of the children and alter the way they interpret the social situations that they experience (Kazdin, 2007).

2.5.4.5. Cognitive factors

Children who perform poorly academically are more prone to violent behaviour (Khan, 2008). A child with a lower-than-average IQ, particularly in the verbal category (which suggests problems with verbal and communication skills), are at risk for conduct problems (American Psychiatric Association, 2013). Conversely, some literature shows that it is not only those with poor academic performance that exhibit problematic behaviour.

Webb, et al. (2005) states that a major cause of conduct problems in gifted children can be attributed to asynchronous development. This term refers to an uneven development across sensory, emotional, physical, and executive function skills. Some skills are superior while others lag. The skills that usually lag behind are fine motor (difficulty with the execution of what the mind's eye sees, difficulty writing letters and numbers, and pencil grip); gross motor (clumsiness, poor performance in sport); language (language articulation, pressured speech or racing thoughts); sensory (light, sound, or smell sensitivity, or sensitivity to large crowds, or intense and/or numerous stimuli); and emotional skills (low frustration tolerance, perfectionism, rigidity and a black-and-white way of thinking, or hyper-sensitivity). These developmental asynchronies can leave the child feeling highly frustrated; and this, coupled with high sensitivity usually present in gifted children, can lead to them being diagnosed with psychiatric disorders (Webb et al., 2005). The asynchronous development could possibly be the common element across both high and low performing groups.

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2.5.4.6. Conclusion

Again, as with other levels of the system, a reciprocal influence is noted between child and context (Burton & Leoschut, 2013). The child is another level of the system that forms part of the pragmatic, embedded case study in this current study and is included in the treatment. There is no consensus on the causality of disruptive, impulse control and conduct disorder. For now, the only consensus is that physical, biological, psychological, emotional, and even cultural factors may all play a role in causality (Iliades, 2014).

The treatment approaches below are discussed according to how each one is inclusive of the various contextual elements contributing to disruptive behaviour, in other words, with reference to the MST (Swenson et al., 2005) framework.

2.6. Approaches to the Treatment of Disruptive, Impulse Control and Conduct Disorder

Various treatment strategies with various degrees of effectiveness have been developed through the years for children with disruptive, impulse control and conduct disordered behaviours. Swenson (et al., 2005) and others concluded that ‘the intervention programmes that work are: family based; remove barriers to service access; use behavioural intervention strategies; include rigorous quality assurance policies; include well-supervised, well-structured, neighbourhood-based interventions and approaches and provide pro-social recreational activities for youth, such as the development of community centres with, for example sporting activities, at times when supervision is low’ (Swenson et al., 2005, p.29). This would lend credence to the above literature review of South African authors who suggested across the years that interventions should be integrated and include different stake holders from the wider community context (Brion-Meisels & Selman, 1996; Burton 2008; Burton & Leoschut, 2013; Pelser, 2008). These wider interventions require substantial resources, time, and effort (Swenson et al., 2005).

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Despite the indicated success of evidence-based therapies in the UK and USA, few children with conduct problems receive treatment for the disorder. The challenge regarding treatment is how to make it available on a large enough scale and how to provide early intervention to increase the possibility of success (Scott, 2008). There is generally a high drop-out rate from treatment: sometimes as high as 60% (Luk et al., 2001; Prinz & Miller, 1994). Attempts to reduce drop-out rates of clients/children and increase the accessibility of treatment to families include providing evening sessions and arranging transport to these sessions (Prinz & Miller, 1994; Swenson et al., 2005). This puts a greater demand on the therapist. It is also beneficial for retaining the client in therapy if the therapist can form an alliance with the client (Prinz & Miller, 1994). A meta-analysis of the results of therapy programmes claims that the ability to engage the family accounted for 15% of the variance in treatment outcome (Shirk & Karver, 2003).

Conversely, according to Scott (2008), community-based interventions are less effective than those therapies conducted outside of real-life situations and reported in control studies (Scott, 2008). The contradictory views could be explained as follows. The real-life situation is more arduous to intervene. The wider the sphere of influence of the treatment intervention, the greater the chance that it has of being successful (Swenson et al., 2005), but these wider influences necessitate a co-ordinated effort reaching from policy level (Timm, 2007) through to the communities, school context, families, and individuals. This necessitates many resources including financial, manpower, and co-ordination that are difficult to attain and rarely exist abundantly in the South African context. This is evidenced in that South Africa produces mostly small, university-based studies. There is no blanket treatment approach that addresses school violence across South Africa as needs are diverse from province to province (Khan, 2008).

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The reviews below cover some of the catalogue of treatments available for the behaviours comprising disruptive, impulse control and conduct disorders. Approaches were chosen that addressed different elements of the child's system. They included approaches aimed at the individual through to wider approaches that target family and school contexts. As such they all comment on an element of the system included in this study. The MST (Swenson et al., 2005) framework is again utilised heuristically to organise the treatments according to how widely they include the different levels of the child/youth's system.

2.6.1. Interventions that target the individual

The interventions below are directed at the individual level of the system, the child.

2.6.1.1. Interventions that remove the child from the system in which the behaviour occurs

According to Swenson et al. (2005), research has shown that less effective interventions in dealing with behavioural problems include: zero-tolerance policies; involving severe punishment; boot camps involving tough discipline and scared straight programmes where children are shocked into behaving; residential treatment and hospitalisation; and wilderness programmes. The latter three programmes remove children from society and treat them outside of the context in which the problematic behaviour occurs (Swenson et al., 2005). Scared straight programmes utilize prison visits to decrease delinquent behaviour. A meta-analysis of nine controlled studies established that this technique is more harmful than helpful (Petrosino et al., 2003). The approaches that do not work usually occur in settings that do little to impact the natural environment of the youth (Swenson et al., 2005). Scott (2008), in support of this, claims no positive improvements for what he calls "harsh" and "outdoor" interventions. Randomised controlled studies, carried out by the California Youth Authority, gathered long-term data regarding youth arrests. They found no difference in occurrence of arrests between boot camp treatments versus standard custody and parole interventions

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(Bottcher & Ezell, 2005). Conversely, a meta-analysis of 28 studies involving wilderness programmes, combining therapy with challenge experiences in an outdoor, wilderness environment, showed small positive effects sizes (Wilson & Lipsey, 2000). Of this group of therapies that remove the child from the system, programmes involving both therapy and intense physical activity were the most effective (Scott, 2008).

These therapies in which the child/youth is removed from their context have been reported to be unsuccessful by many sources (Brion-Meisels & Selman, 1996; Burton, 2008; Burton & Leoschut, 2013; Coetzee, 2005; Frick, 2001; Khan, 2008; Leoschut, 2008; Ndinga-Kanga, 2015; Swenson et al., 2005; Timm, 2007; Yeo & Cho, 2011). The likely reason for this, is that aetiology causes, and maintenance of the problem behaviour is found in the context which needs to be addressed if treatment is to be successful. As a result, in the research for this current study, the child/youth was not removed from the context in which the behaviour occurred. The therapy was given in the school context.

2.6.1.2. Medication

No medication has been approved for conduct disorder. Despite this, medication is frequently used to treat conduct problems in the USA (Turgay, 2004). In the UK prescribing medication for conduct disorder is not seen as good practice. There is evidence that, where ADHD is co-morbid, a reduction in impulsivity and hyperactivity is noted with the use of stimulants as well as a general decrease in accompanying conduct disordered behaviours (Connor et al., 2000). There is insufficient evidence to establish whether stimulants reduce aggressive behaviour without co-morbid ADHD.

Mood stabilisers such as lithium and carbamazepine and drugs that target emotional dysregulation such as clonidine have been reported in some studies to reduce aggression and hostility in adolescents in psychiatric institutions (Campbell et al., 1995; Malone et al., 2000); but conversely, other studies have failed to establish effectiveness in out-patient samples

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(Klein, 1991). Other studies have indicated some success with the use of anti-psychotic drugs, such as risperidone, which have produced moderate effects in conduct disordered patients with average intelligence and without co-morbid ADHD (Scott, 2008). The review by Pappadopulos et al., (2006) found risperidone to be effective when low intelligence and ADHD were co-morbid with conduct disorder in patients.

Research trials have indicated that the effectiveness of medication on disruptive, impulse control and conduct disordered behaviours in South Africa has been limited, especially for those cases in which ADHD is not co-morbid (Scott, 2008). In South Africa stimulants are used in the treatment of conduct disorder when ADHD is co-morbid. The mood stabilizer clonidine has also been used when ADHD is co-morbid. The mood stabiliser lithium has been used to treat aggression in conduct disorder. Anti-psychotics have also been utilised (Hawkridge et al., 2005). However, no local research was found as to the effectiveness of such medication on conduct problems in children in the South African context.

Scott (2008) cautions that all medications are subject to side effects and that medication appears largely ineffective (Scott, 2008). Again, this treatment focuses on the biological components of the individual alone and does not address the myriad of factors impacting behavioural problems (Frick, 2001). This is likely why it is unsuccessful as a standalone treatment. Generally, as noted in the literature reviewed here, medication is focused on symptoms rather than the specific diagnoses found in the cluster of oppositiona, defirant and conduct disordered behaviour.

2.6.2. Family-based therapies

Family-based interventions are used as effective therapy for teenage children with conduct problems (Diamond, 2005). Supporting this, Swenson et al. (2005) listed family therapy as one of the most effective therapies for juvenile offenders. There are different kinds of family

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therapy, and they differ in effectiveness for treating behavioural problems in children/youth. The emphasis of this approach is on improving family relationships for distressed adolescents (Steinberg, 1990).

2.6.2.1. Attachment based family therapy

Attachment theory, upon which some family therapies are based, focuses on interaction between family members (Bowlby, 1969). It provides an alternative to systems and cybernetic theory as a framework to explore the interpersonal dynamics of family life. When the parent responds appropriately to the needs of the child, a secure attachment develops. The child's sense of security is dependent on attachment which develops if the parent is both available and protective. Attachment is necessary for survival and so it is thought to be biologically hardwired (Bowlby, 1969).

The challenge in the family-based attachment approach is to build this form of security-promoting parenting. When parents are unresponsive at crucial times, they become a source of hurt as opposed to a foundation of support (Kobak & Mandelbaum, 2003). Despite the emphasis on individuation and separation as part of the developmental stage of adolescence, it is recognised that continuity in connection and attachment to parents is essential (Steinberg, 1990). Although attention has been mainly on attachment of young children, the importance of attachment throughout life has been well documented (Ainsworth, 1989; Steinberg, 1990). One of the developmental tasks of adolescence is seen as transforming the parent-child relationship so that it is characterised by the correct balance between autonomy and attachment. Adolescents in therapy usually have problems with this balance. If adolescents are not provided with safe interpersonal relationships, they become preoccupied with preserving dysfunctional relationships and fear that honest communication will lead to further rejection (Diamond & Siqueland, 1998). Bowlby claimed that although the

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internal models created from attachment experiences are persistent, they are still subject to change throughout life (Bowlby, 1969).

The focus of this therapy is to restore or build secure family relationships. Three interpersonal elements need to be present to promote attachment. The child must: feel that they have access to their caregivers; be able to communicate without being rejected or judged; and feel that caregivers are able to protect them both physically and emotionally (Kobak et al., 1991). To achieve this, parents must learn to listen better, promote emotional expression, and provide a haven. In such a haven, the adolescent can learn emotional expression without dire consequences, tolerate difficult emotions, and problem solve. Attachment based family therapy provides a map to accomplish these goals (Steinberg, 1990).

The parents of children with behavioural problems often have their own issues with attachment and abandonment (Diamond, 2005). It is easier to have conversations around behavioural problems, chores, and homework than it is around feelings of abandonment, attachment, and abuse that are relevant to both child and parent alike (Diamond, 2005). Conversations around relational rifts and the painful emotions associated with them can foster attachment and fulfil the need for it. Conversations between the child and parents around attachment failure can rekindle trust and foster forgiveness (Diamond, 2005).

Good parenting, a positive marital relationship between parents, or a positive therapeutic experience can help to remediate previous negative experiences (Pearson et al., 1994). Adults with insecure attachment are likely to be prone to depression and continued insecure attachments but they can alter their own parenting style. In this way adolescents and adults who have experienced insecure attachments can promote healthier living (Cicchetti & Greenberg, 1991) and foster the change alluded to by Bowlby (1969).

There are similarities between REBT (Diguiseppe et al., 2014), the approach chosen for this current study, and the attachment-based family therapy approach. In both approaches,

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cognitions are linked to emotions. Schemas are internalised models of experience. The 'hot cognitions' (Diamond, 2005, p. 22) are seen to originate from core conflicts. The difference between REBT (Diguiseppe et al., 2014) and attachment-based family therapy is that in family-based therapy the emphasis is on interpersonal trauma emanating from the family. Reframing is one of the main techniques utilised in the therapy process of attachment-based family therapy. For example, a child who frequently offends without getting caught may be labelled as bright; a mother who nags may be described as caring and involved. The treatment includes addressing core traumas, if these are not addressed, it can stall behavioural change in adolescents. The adolescent can use the behavioural problems as a means of punishment of parents regarding past trauma. In treatment at the skills level, parents can learn to speak about the traumas and provide empathy, compassion, understanding and reassurance, and these skills are the basis for secure attachment. In turn the adolescent learns to express and tolerate difficult emotions. These therapeutic conversations can lead to a corrective emotional experience regarding relational trauma (Diamond, 2005).

This approach is considered practical and inexpensive. Empirical support exists for attachment-based family therapy demonstrating the efficacy of the model, as well as preliminary data regarding the effectiveness across various problems. In a randomized control study (Diamond et al., 2002) with 16 treatment cases, 81% of those treated for major depressive disorder no longer met the criteria for depression, compared to 56% on the wait list. Improvement in the patient's anxiety, increased attachment of the patient to their mother, and a decrease in family conflict and suicidal ideation were also noted. These improvements were noted as retained six months after treatment. Specifically, regarding behaviours that comprise disruptive, impulse control and conduct disorders, research has indicated significant decreases in unresolved anger and state anger (temporary, short-lasting outbursts of anger), (Diamond et al., 2016).

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Common elements exist between attachment-based family therapy and the processes involved in the research for this current study. For instance, alliance-building was part of the therapeutic process. The pragmatic case study structure identifies alliance-building as a common element in all therapies. This alliance was built with all participants in this study, teachers, parents, and children. Due to the utilisation of the REBT (Diguiseppe et al., 2014) framework, cognitive reframing was also utilised in this process. Reframing was used to alter perceptions of each other, referring to the parent, teacher and child, and the various relationships. The tasks built around contingency management helped to restructure the relational interactions. Due to the REBT (Diguiseppe et al., 2014) therapeutic framework the intervention focussed on cognitive and behavioural interventions as opposed to being attachment focused. Although useful, further intensive family sessions would have further taxed the therapist's resources. However, interpersonal trauma was noted in some of the case studies presented.

2.6.2.2. Functional family therapy

This approach is one of the most widely utilised methods for the treatment of adolescents with serious anti-social behaviour (Alexander et al., 2000; Scott, 2008). The therapy is given at home to remove barriers from treatment. A convenient time for the family is arranged for the same reason, even if the sessions are given in the evenings. The target population is aged between 11 and 18 years of age. Usually eight to 12 sessions (or 16 sessions in more serious cases) are given over a three-month period (Scott, 2008). The focus of this approach is relational. Usually, three to eight therapists are involved with a case load of 12-15 families. This is due to the intensive nature of the work so that it does not overburden one therapist (Henggeler & Sheidow, 2012; Scott, 2008).

There are four stages to treatment. Engagement and motivation are the first two stages. In these stages, the therapist enhances the perception that change is possible and that

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the therapeutic process can help the client to attain this change (Henggeler & Sheidow, 2012; Scott, 2008). Negative perceptions of therapy are managed. The aim is to engage the family and thereby keep them in therapy, and only then to establish goals. Treatment begins after motivation is established, negativity decreased, and alliances built. Attempts are made to avert negative spirals and blaming language. Reframing of the family's behaviour is used as a technique but at the same time the severity of the effects that conduct disordered behaviour has, is not undermined. These phases seek to establish the following:

- the child is not inherently bad, it is the way they have done things that has not worked.
- even though the child made mistakes the therapist took their side as much as everybody else's.
- even though each family member experiences things differently, they must all contribute to the solution.
- even though there is a lot to change, the therapist will protect the child and other family members in the process.
- there is motivation to attend the next session as hope is established that things may improve (Scott, 2008).

The third phase targets behavioural change, particularly through communication training and parent management training (Henggeler & Sheidow, 2012; Scott, 2008). This stage is dependent on the success of the first two stages. The behavioural change stage is flexible and addresses the families' needs. For instance, if marital strife is causing stress in the family, then marital problems are addressed. The parent management element includes standard procedures such as praise and reward, contingency management, limit setting, consequences, and response cost.

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Generalisation is the final stage. In this stage, the family is taught to generalise what they have learnt from specific situations to other similar situations (Henggeler & Sheidow, 2012; Scott, 2008). They are also taught to negotiate within their other contexts, such as schools, to attain the necessary resources that they require. This requires knowledge, on the therapist's part, of the resources available in the specific community (Scott, 2008).

The effectiveness of this approach is well-established in randomised controlled studies (Scott, 2008). Alexander et al. (2000) cited 10 replication studies, of which the trials published so far have all been positive; reduction rates in anti-social behaviour are between 20–30% lower than in control groups. Scott (2008) states that all results to date have been positive showing a reduction in anti-social behaviour by 30% to 40% compared to that of control groups. In the literature search done for this study, no efficacy studies of this approach were found in the South African context. In the South African context only small-scale efficiency and exploratory university-based studies about different kinds of family therapy seem to exist (Engelbrecht & Kasiram, 2007; Kasiram & Thaver, 2013). This is far from the research needed to transport family therapy into community settings in a way that would impact public health (Henggel & Sheidow, 2012).

2.6.2.3. Conclusion

As with attachment-based family therapy, some elements of this approach overlap with the process of the therapy presented in this current study. Alliance-building and cognitive restructuring overlap in both the family therapies presented above and in the therapy process for this thesis. The core conceptual elements of attachment-based, and functional family therapy are relationship and the remediation thereof. The focus of REBT (Diguiseppe et al., 2014). used in this current study, is on the cognitive restructuring or challenging of irrational beliefs. This process does impact relationships as the irrational beliefs impacting them are disputed with the aim of replacing them with rational beliefs. While this current study

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included the parents in the therapy, this process was carried out in the school context as the focus was on disruptive, impulse control and conduct disordered behaviours in the classroom.

2.6.3. Whole school approach

As discussed, any effective approach must account of the diversity of influences on behavioural problems (Khan, 2008). The whole-school approach is such an approach as it is of a wide scope and inclusive to maximise the potential success of the intervention (Kourkoutas & Wolhunter, 2013).

In this approach, children are seen in a holistic manner; for example: a hungry child cannot achieve; a frightened child cannot concentrate (Khan, 2008). The approach is based on the premise that bullying, or other problematic behaviour, is a systemic problem not an individual problem. As such, the programmes have different components that operate across different levels of the school system. These programmes have certain core features in common. The whole school is involved: staff, parents, and children. Directions to deal with behavioural problems are written into school policy and staff are to act as a unit when responding in accordance with such policy. Curricular activities are initiated that include relevant topics to address disciplinary issues such as conflict resolution. The programmes are usually directed at bullying or violence, and not general issues like communication, relationships, or academics (Smith et al., 2004). Conversely, Ortega-Ruiz and Lera (2000) claim that these general issues also impact on bullying and other behavioural problems. Disciplinary problems in turn affect teacher/learner dynamics but influence on disciplinary problems is wider than these dynamics alone (Kourkoutas & Wolhunter, 2013). There is a bidirectional and wide influence. Additionally, the children, both perpetrators and victims, are engaged in individual treatment in whole school approaches (Smith et al., 2004).

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2.6.3.1. The Hlayiseka Early Warning System

In South Africa, The Hlayiseka Early Warning System, developed by the CJCP (Khan, 2008) is an example of such an approach. It was developed from a combined study by the National Department of Education and the Open Society foundation in 2005 (Khan, 2008). The study gathered baseline data about the types of behaviours and incidents occurring in 100 schools in the Limpopo and Eastern Cape regions. Recommendations as to possible interventions for these problems were also gathered and an intervention developed from the data. The resultant intervention targets the school management team in addressing crime and violence through consultation, and effective reporting and feedback systems. Teachers, parents and children are included in the programme (Khan, 2008). This model is explained below but it appears that although it offers a practical approach, it is as yet only at a theoretical stage of development. No official research results on the implementation could be sourced.

A central premise of this model is to break the authoritarian approach to school management. This is based on the idea that if the scholars are given a voice in the type of discipline implemented, then conduct problems will decrease. This model is based on a study conducted in France where violence in schools dropped by 60% and verbal abuse by 50% when community stakeholders, school management, educators, parents, and scholars came together to negotiate a disciplinary policy. The results were attributed to giving the scholars a voice (Khan, 2008).

The different components of this particular model are the early warning system; the broad objective; the toolkit; the diagnostic tool; learner and educator surveys; developing safety plans and the importance of partnership; reporting and recording incidents of violence; and mechanisms for reporting; monitoring and evaluation. Each component is discussed briefly below (Khan, 2008).

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2.6.3.1.1. The early warning system

The early warning system is built on four building blocks:

- be prepared to prevent and manage problems.
- be aware of what is happening at school.
- act when something happens; and
- take care to build a caring school (Khan, 2008).

With such a system, the building blocks are in place to provide systematic steps towards building school safety.

2.6.3.1.2. The broad objective

The broad objectives are:

- to help the school to understand threats that it is exposed to.
- to guide schools to respond effectively to these threats.
- establish a framework for reporting these incidents, and to manage these incidents appropriately.
- monitor the school's performance in reducing these incidents over time; and
- integrate the school's legislation and policy so that the school safety initiative is not merely an add on (Khan, 2008).

2.6.3.1.3. The toolkit

A toolkit, which comprises four booklets and interactive charts provide step-by-step guidelines as to how to manage school safety. The approach is broad enough to be applied to schools of varying resources and capacity (Khan, 2008).

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2.6.3.1.4. The diagnostic tool

The diagnostic tool is the assessment of the education department's, and the school's legislation and policy regarding the protocol around safety, educators, and learners. A democratic approach is established in which both educators and learners have a voice in the construction of this policy (Khan, 2008).

2.6.3.1.5. Learner and educator surveys

A set of surveys targeting both educators and learners, along with a template, helps to identify the issues facing the school. The template assists in the interpretation of the data. The various surveys focus on the nature of violence experienced at the school by both learners and educators, and where the incidents are likely to occur (Khan, 2008).

2.6.3.1.6. Developing safety plans and the importance of partnership

From the data derived from the surveys, a step-by-step safety plan is developed. As the school is embedded in the community, this plan necessitates building partnerships with other organisations and other stakeholders in the same community. In this way the school establishes referral sources in the community to provide specialised interventions which deal with various problems as they occur. Initiatives by the schools are augmented by this referral network. The parents are involved to support the work done or to follow through with the treatment in the home context. The school's main function remains that of education and the referral process supplies the other needed specialisations (Khan, 2008). During the referral process, individual therapy is sometimes suggested. This should promote partnership in the community between the various practitioners and the schools (Kourkoutas & Wolhunter, 2013).

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2.6.3.1.7. Reporting and recording incidents of violence

The reporting system must be emphasised and implemented. Children who report incidents are given feedback regarding their complaint and what was done. The school is encouraged to record all incidents from petty misdemeanours to more serious offences as this gives an indication of the types and patterns of incidences. This provides a way of monitoring, organising, and categorising ongoing incidents (Khan, 2008).

2.6.3.1.8. Mechanisms for reporting

Confidentiality is also prioritised. Systems for reporting are established so that individuals reporting incidents do not get victimised. Those that do report, are given feedback, so that they know that the school is taking them seriously (Khan, 2008).

2.6.3.1.9. Monitoring and evaluation

The toolkit provides a way of getting a baseline for behaviour and measuring any subsequent changes. The success of the various interventions can be measured and continued or changed, depending on the data gathered (Khan, 2008).

2.6.3.2. Research and opinion pieces on the success of the whole-school approach

There is no quick fix to conduct disorders in schools, however the more systematically the management programme is followed, the greater the chance of success. The systems approach provides a way of organising an intervention (Khan, 2008). The interventions that are monitored are more successful than those that are not (Smith et al., 2004). Long-term treatments that stretch over years are reported to be more effective than short-term treatments (Kourkoutas & Wolhunter, 2013).

Smith et al. (2004) carried out a synthesis of existing research on the evaluation of the whole school approach efficacy in addressing various behavioural issues. The studies were taken from the USA, England, Europe, Canada, and Australia. Many of the results proved to

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show small, negligible, or even negative effects size. Only seven percent of the studies attained change of a medium effect size. It was concluded that the empirical support for the whole school intervention programme is not strong. It is however difficult to compare these studies as, although there are basic similarities, the approaches varied in their application and the contexts to which they are applied, are likewise varied. This is a common problem across the comparison of results of inclusive models. Self-reporting of victimisation was used as the means of measuring the success of the programme and this could likewise have also confounded positive results. The implementation of the programme itself could have led to the increase in the report of incidents due to increased awareness thereof, which would have skewed results. The only large effect sizes were attained from the original prototype of the model, the Olweus bullying programme (Olweus, 1993).

The Olweus programme (Olweus, 1995) was originally implemented in Scandinavia and applied on a national scale in response to a high level of suicides in schools. There was a high investment of resources in this programme. The positive results of the application of this model could also be attributed to the high functioning Scandinavian schools where classes are small, teachers are well-trained, and there is state intervention in social welfare. It is difficult to replicate this approach with fidelity across different contexts. Results of this programme, when applied in Finland and Italy, had smaller effect sizes; but nevertheless, they were still significantly positive. This result can also be attributed to the context in which it was applied, as Finish and Italian schools are reported to be of a similar quality to those in Scandinavia (Smith et al., 2004).

Conversely, despite the minimal empirical support for the whole school approach, there is no evidence to claim that other approaches are more effective. More studies are required to determine when it works and how. The evidence thus far does not, however, warrant the application of the whole-school approach to the exclusion of other approaches

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(Smith et al., 2004). This limited success could be related to the research being in the naturally occurring situation as opposed to a controlled setting.

In the South African context, the research cited by Khan (2008) seems to be the biggest project undertaken, however the implementation of this project has not yet resulted in research data. Other studies, such as that of Bertram (1999) appear to be theoretically orientated and others small-scale university-based studies.

2.6.3.3. Conclusion

The practical application of the whole-school approach is difficult to implement and maintain consistently. It seems that it works best in high-functioning schools such as the one mentioned in France (Khan, 2008), and in Scandinavia where the Olweus Programme (Olweus, 1993) was originally implemented. For the application of such an approach to be successful, the American institute for researchers' criteria must be met: there is a need for teachers to be present at school, and to believe that they can make an effective difference; there needs to be a belief that the teachers as a collective group are responsible for the success of learning, and that success is possible; and instead of a culture of blame, attributing wider social ills or parents as being responsible for disciplinary problems, there is rather a culture of problem-solving within the school context itself (Khan, 2008). There is emphasis on building a caring school. This is thought to build a sense of belonging for the learners, which is associated with a reduction in problematic behaviours such as bullying (Khan, 2008; Ndinga-Kanga, 2015).

The success of the whole-school approach in France was attributed to giving the scholars a voice (Khan, 2008). In this current study the voices of the children were heard in the application of the contingency management programmes, as this was a collaborative process with the children helping to identify what rewards and punishments, they thought to be appropriate and effective. Although these programmes were not always implemented, the

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children assisted in the design of them. In Case Study four (Chapter 7) of this thesis, the child/youth was brought into the discussion of a prospective change in the disciplinary code of the school. Some of his ideas as to what would work were implemented.

A teacher, as a representative of the school system, was involved in each of the case studies written in this thesis. However, the school context was not brought into the intervention as widely as is suggested by the whole-school approach. A wider involvement of the school system was not possible in this thesis due to lack of resources, and due to the focus on the therapy process itself. Such approaches require unified and community participation and organisation which in the socialy ruptured South African context (Eagle, 2015) could be difficult.

2.6.4. Cognitive behavioural therapies approach

The following approaches are typically considered to be intrapsychic approaches, however the context as the origin and maintenance of the intrapsychic processes is acknowledged and accounted for.

Cognitive Behaviour Therapy (CBT) is a popular therapeutic approach, used in a wide range of mental health problems exhibited by children, young people, and adults alike (Diguiseppe, et al, 2014). There are many resources available to clinicians for the adaptation of CBT theories and techniques for application with children and young people (Stallard, 2005).

While CBT was developed out of disillusionment with strictly behavioural therapies, most approaches now advocate integration of CBT with behavioural therapies (Diguiseppe et al., 2014). According to Kendall (2006), CBT brings about change via two levels: cognitive (through cognitive restructuring); and behavioural (through changing antecedents and consequences of behaviour). Accordingly, CBT uses both behavioural-based interventions and cognitive restructuring to change thinking, feeling, and behaviour in children and

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adolescents (Kendall, 2006). The link between behaviour, cognitions, and feelings are acknowledged and explained to the client (Fenn & Byrne, 2013). The cognitive restructuring element of the treatment enables clients to identify cognitive distortions, and to change these negative cognitive responses into more positive, realistic responses. After core irrational beliefs are challenged, rehearsal of the more adaptive thinking encourages replacement of the old irrational way of thinking (Fenn & Byrne, 2013). Generally, treatments used in CBT include cognitive restructuring, role-playing, self-monitoring to improve self-awareness and recognise arousal states, self-instruction to initiate inhibitory self-directedness, and problem-solving skills to widen options and solutions to problematic situations (Kendall, 1993).

Yeo and Cho (2011) investigated the efficacy of CBT groups for children with behavioural difficulties in Singapore elementary school classrooms. The therapy was delivered by a school psychologist. Children attending the CBT groups improved significantly in school and home behaviours, self-control, social skills, and self-esteem compared to control groups (Yeo & Cho, 2011).

Over the last 10 years, several meta-analytic treatment outcome studies examining CBT's impact on anger and aggression, anti-social, and anger-related behavioural difficulties in a variety of settings have reported positive outcomes with moderate effect sizes for adolescents (Sukhodolsky et al., 2004), and for children (Bennett & Gibbons, 2000). Earlier meta-analytic research in school settings showed moderate effects for CBT methods (for instance, the use of self-statement modification) on childhood behavioural disorders (Dush et al., 1989), and reduction of hyperactivity/impulsivity and/or aggression (Robinson et al., 1999). Effects were largest when techniques addressed rebellious and aggressive behaviours in school children (Wilson et al., 2001).

In her review of 20 peer-reviewed journal articles Gansle (2005) reported a moderate effect size for school-based CBT interventions focusing on anger and externalizing

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behaviours. In the UK, Humphrey and Brooks (2006) reported a six-session school-based CBT intervention that reduced adolescent problem behaviours. In Scotland, educational psychologists successfully employed cognitive behavioural approaches in attributional retraining for children who had learning difficulties and/or poor self-esteem (Toland & Boyle, 2008).

In a study in the USA, CBT was applied to a difficult school context where expectations were low, school settings were disorganised, and teachers arrived late. Despite these factors, CBT interventions produced changes in children displaying difficult behaviours (Gottfredson et al., 2002). Considering the above findings, Yeo and Cho (2011) state that CBT interventions have excellent potential when applied to school settings.

The research base for the effectiveness of CBT is more substantive than for other therapies and therefore it is considered an evidence-based approach. Despite this, there are many gaps in the research on the effectiveness of CBT (Stallard, 2005).The results of random control trials indicate considerable post-treatment and short-term gains in child-focused CBT compared to placebo effects and wait periods. Not as much focus has been given to long-term effects of CBT in this context. It has not been established which of the various components of CBT are most effective and what differentiates its success from behaviour therapy. Little is known about treatment components and sequencing, or the most effective way of involving parents (Stallard, 2005).

Additionally, there is a paucity of research focusing on the process of CBT, as opposed to effectiveness. Greater knowledge of process would enable clinicians to ensure that the core principles underpinning the theoretical model are adhered to. Being process-focused enables the clinician to apply CBT in a theoretically coherent way, as opposed to applying a simplistic approach that dips into disconnected strategies (Stallard, 2005). The goal of therapy research is to explore how treatment leads to change, and how the various components

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contribute to this change. We need to know both if and why it works so that the magnitude of its effect can be influenced. There has been a particular paucity of research into child and adolescent therapy as to what should be applied to whom under what circumstances (Kazdin, 2000).

Nonetheless, CBT study outcomes provide evidence that cognitive-behavioural interventions are most effective for the management of externalizing behaviour problems such as conduct problems. It constitutes an empirically validated treatment that school psychologists can add to their arsenal of intervention tools (Yeo & Cho, 2011).

Different kinds of CBT therapies exist. Rational Emotive Behaviour Therapy (REBT) is one specific therapy. From the small number of published research articles on CBT and REBT in South Africa, Edwards, et al., (2012) conclude that CBT and REBT can be used as easily in the South African context as it can in the European and North American contexts where the approach originated. Both approaches are widely used in clinics and private practice to treat depression, anxiety, post-traumatic stress disorder, and disruptive behaviours. Tshabalala and Visser (2011) utilised a CBT therapeutic approach with HIV-positive women. Eight sessions were applied, and it was noted that the cognitive techniques that were most effective were positive reframe and de-catastrophising. The more complex cognitive techniques such as identifying underlying automatic thoughts and thus managing their own thoughts outside of the therapy situation, was less successful. The therapist had to identify the thoughts for the clients in the therapy session. The use of Socratic questioning did not assist in the development of self-reflection. The authors suggest that the use of the more complexed techniques and self-reflection may have developed over more sessions. Assertiveness training described by the authors as a behavioural technique, was seen to be successful.

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2.6.4.1. Conclusion

There is evidence for both the effectiveness of REBT and CBT techniques, and the application of these in SA for disruptive, impulse control and conduct disordered behaviours. The REBT (Diguiseppe et al., 2014) approach was utilised in this current study. There are only four categories of irrational beliefs in this particular theory, so it seemed, to the therapist/researcher, to be the easiest to explain to participants/clients and use in this current study. The ecological case study incorporated layers of the school system to which the child belonged in the form of a parent, a teacher, and a child/youth. The approach was applied to the chosen levels of the system. As this was the therapeutic approach used in this research, it is expanded upon in detail below.

2.7. Theoretical Models Used in this Current Study for the Intervention of Disruptive Behaviours

It can be seen from the above literature review that there are many factors influencing disruptive, impulse control and conduct disordered behaviour patterns in the classroom. An integrative approach that includes as many of the components as possible should therefore be applied to address the problem. Whatever therapeutic approach is used; the approach must be applied to different elements of the system. For this reason, a multisystemic (MST) (Swenson et al., 2005) approach is adopted to organise and integrate the intervention in this current study. REBT evidence-based therapies and techniques are incorporated and applied across the different elements of the system, specifically with the child/youth, teacher, and parent. Within the REBT (Diguiseppe et al., 2014) therapeutic framework, both cognitive and behavioural techniques and strategies are utilised.

Micro moments of human interaction can likewise be conceptualised as a system, and the therapeutic process is no exception. This is recognised and described in the concept of responsiveness described earlier in the chapter (Kramer & Stiles, 2015; Stiles et al.., 1998).

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Through this concept, the MST (Swenson et al., 2005) framework is carried through to the human micro-interactions that take place in therapy between the clients and the therapist and likewise between the clients; (members of the school system) the teacher, the parents, and the children. As the REBT (Diguiseppe et al., 2014) therapeutic framework is chosen for this study, the bi-directionality of the irrational beliefs across the members of the school system is explored and applied in the chapters to follow.

Regarding this interaction, Ellis (1986) focuses on helping partners and family members and people in all relationships to accept responsibility for their own disturbed emotions and failings. Rational-emotive relationship therapy is a form of Cognitive Behaviour Therapy that emphasises the cognitive disturbance related to any disruption in relationship. It teaches that people largely disturb themselves and that they can stop doing this. It employs several cognitive, emotive, and behavioural techniques not just aimed at relieving symptoms but at achieving a philosophic reconstruction of beliefs aimed to bring about permanent change. Its active and directive methods aim to alter the strongly held irrational beliefs that people hold about relationship. Thus, the approach addresses relationship but does so as an intra-psychic approach to change family situations and interactions. So, although this model is intra-psychic it can be applied systemically. This was the approach taken in this current study and the concept of responsiveness was used to look at the relationship across the irrational beliefs of the different participants of the ecological case study. Thus, it was applied inter-psychically to address the bidirectional influences acknowledged by the MST (Swenson et al., 2005) approach. This was done theoretically by myself, the therapist, and used in my own case conceptualisation as thought records were not shared across the different participants.

REBT therapies are integrative in that they utilise many different techniques and in that they are multimodal as they focus on cognitions, behaviour, and emotion (Diguiseppe et

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al., 2014; Walen et al., 1992). The approach is seen to have worked in the South African context for disruptive, impulse control and conduct disordered behaviour (Edwards et al., 2012). This current study's focus was on the school context and not just the family context.

The goal of therapy research is to explore how this treatment leads to change and how the various components contribute to this change. We need to know both if and why it works so that the magnitude of its effect can be influenced (Kazdin, 2000). In other words, the focus is on the process of therapy as opposed to effectiveness.

2.7.1. Conceptual theoretical and clinical framework

The above literature review indicates that the MST (Swenson et al., 2005) framework within which REBT (Diguiseppe et al., 2014) therapeutic concepts and techniques are applied, should be a useful approach to address disruptive, impulse control and conduct disordered behaviours in children within the South African school system.

2.7.1.1. Multisystemic Therapy (MST)

The MST (Swenson et al., 2005) approach is a well-documented, community-based approach that was originally developed to assist juvenile offenders. The aim was to keep these youths out of institutional care. Interventions in this approach are still currently often family-based and include peers, schools, neighbourhoods, and the wider community. Caregivers are involved in the treatment plan and implement the techniques with the help of the therapist. The barriers to therapy (like transport problems) are removed to make it easier for the youth and their various contexts to access treatment. The therapies and therapeutic techniques are chosen from evidence-based therapies such as CBT, behavioural therapy, and pragmatic family therapy (Schoenwald et al., 2008). In this current study the MST (Swenson et al., 2005) approach provides a heuristic framework that organises the conceptualisation and integration of the application of the therapies.

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MST is one of the best developed therapies of its time (Scott, 2008). The approach is rooted in Systems Theory and Ecological Approaches. It is based primarily on the works of Bronfenbrenner (1979, 1997), Haley (1976) and Minuchin (1974). From the perspective of this theoretical framework, behaviour is seen as multi-determined and influenced by reciprocal and bi-directional relationships between the youth/child and others in the environment (Henggeler et al., 1996; Swenson et al., 2005). The child is seen as embedded within multiple systems. The approach suggests potential target areas and interventions across these different systems, or across different levels of a system (Henggeler et al.,1996; Scott, 2008; Swenson et al., 2005).

In this current study, interventions are implemented simultaneously at different levels, including the child/youth with the behavioural problems, the family of the child (one parent) and the child's school (one teacher). REBT (Diguiseppe et al., 2014) is applied across child/youth, parent, and teacher. Multiple systems, such as family, school, and community, can all be involved in the development and maintenance of behavioural problems in children and adolescents, so they need to be included in the intervention. As it perceives behaviour as bidirectional, the multisystemic (Swenson et al., 2005) approach also focuses on the behaviour of the identified patient (the child/youth) and how it, in turn, affects others (Kazdin, 2000). Again, the MST (Swenson et al., 2005) framework organises and integrates this complexed array of bi-directional, influential factors.

MST therapies usually involve the wider community in intervention (Harpell & Andrews, 2006; Henggeler et al., 1996). Some authors suggest including community resources to occupy children after school as opposed to extended unsupervised hours where they are idle (Scott, 2008; Swenson et al., 2005). Finding the child's strengths (such as sporting ability) helps to engage the child in prosocial activities (Scott, 2008), and community facilities can assist in providing such outlets. This echoes the whole-school approach where

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networking to involve other community specialists, forms part of the intervention (Khan, 2008). The systemic approach can move this concept even wider into general community facilities if resources and networks are available.

The nine primary principles of MST (Swenson et al., 2005) are as follows:

- The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
- Therapeutic contacts emphasise the positive and use systemic strengths as levers for change.
- Interventions are designed to promote responsible behaviour and decrease irresponsible behaviour among family members.
- Interventions are present-focused and action-oriented, targeting specific problems that are well-defined.
- Interventions target sequences of behaviour within and between multiple systems that maintain the identified problems.
- Interventions are developmentally appropriate and fit the developmental needs of the youth.
- Interventions are designed to require daily or weekly effort by family members.
- Intervention effectiveness is evaluated continuously from multiple perspectives with providers (therapists) who assume accountability for overcoming barriers to successful outcomes; and
- Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts (Harpell & Andrews, 2006; Scott, 2008; Swenson et al., 2005).

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MST therapies provide a supportive supervision process during the therapeutic intervention. The regular supervision, usually occurring weekly, helps therapists to achieve the desired outcome with the families and other systems within which they work. Often therapeutic sessions are recorded to enhance the rigour of the supervision (Swenson et al., 2005). Supervision more specifically aims to:

- Understand the MST model.
- Ensure adherence to the treatment principles.
- Assist in learning and implementing (in this study REBT) therapies and techniques; and
- Identify barriers to successful intervention (Scott, 2008; Swenson et al., 2005 p. 51).

2.7.1.2. Research results

The effectiveness of MST was established in a meta-analysis carried out on seven studies involving 708 youths and 35 therapists (Curtis et al., 2004). The results of this meta-analysis indicated that Multisystemic Therapy produced generally moderate effect sizes across different systemic domains. The different domains include peer relationships (small effect sizes), family relationships (large effect sizes), individual psychopathology symptoms of both youth and parents (moderate effect sizes), and target behaviours (drug use, criminal behaviour, arrests etc.) (moderate effects size). The therapists in the study included student graduates who conducted their studies under the developers of MST (Swenson et al., 2005) therapies on the one hand, and community therapists who were only supervised by these developers on the other. Larger effect sizes were noted when the therapy was conducted by therapists from the former group, while effects were much smaller with the community group. This could be because the developers of the therapies had greater specific expertise and motivation than those therapists found in the community.

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MST has been successful across different clinical problems that have been resistant to other therapies. According to Swenson et al. (2005), multisystemic interventions have had favourable results for juvenile offenders. Henggeler et al. (1996) support this, stating that MST has been shown to be effective in the long-term reduction of criminal activity and violence in youth (Henggeler et al., 1996). Previously, the effectiveness of MST was supported by clinical trials involving juvenile offenders from impoverished inner-city areas (Henggeler et al., 1996). Limitations in meta-analysis studies include the lack of specificity, as well as variability in the application of the MST approach, as well as the contexts to which it is applied. This makes comparability across studies difficult (Scott, 2008). This is the same problem as that encountered in the meta-analysis applied to the whole-school approach discussed above.

Originally developed in the USA, there have been limited studies as to how the MST approach translates to international contexts. Difference in international context does influence application. For instance, the number of cases seen in the MST therapy approach is generally small (due to intensity of the work), but this number fluctuates by national context. A review of international studies by Schoenwald et al. (2008) noted that the case load seen in Europe compared to that of the USA was smaller due to reduced working hours in Europe. In Europe, a case load of three to five cases per therapist at any one time is usual, compared to four to six in the USA. Cultural differences often necessitate consultation of experts within a certain culture to explore how to apply the process in a culturally relevant way (Schoenwald et al., 2008). In the South African context this becomes difficult due to the diversity of cultures that are also integrated. Edwards et al. (2012) refer to dual belief systems in South African individuals which creates a range of idiosyncratic beliefs. Difference in national policy across countries also influences the implementation and growth of MST therapeutic interventions (Schoenwald et al., 2008). In South Africa, research efforts are not co-ordinated

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and tend to be carried out by individuals completing masters' dissertations and PhD doctoral studies as opposed to largescale co-ordinated efforts. Research tends to be generally limited to small university-based studies. Markham (2018) listed several outcome implementation and benchmarking studies, but none from South Africa were listed.

2.7.1.3. Rational Emotive Behaviour Therapy (REBT)

REBT is one of the many forms of CBT (Diguiseppe et al., 2014). The approach promotes a scientific philosophy and methods as the way to attain knowledge and truth about the self, others, and the world (Walen et al., 1992). Ellis, the father of REBT, considers a quotation by Epictetus, a stoic philosopher from first century AD, as a benchmark of REBT: 'Men are disturbed not by things but by views which they take of them' (Walen et al., 1992, p.3). From an REBT perspective disturbance in behaviour and emotion is perceived to be largely, but not totally, a result of the individual's perceptions, evaluations and value systems which comprise our philosophies (Walen et al., 1992). Ellis claims that REBT is a multimodal therapy in that it focuses on behaviour, cognitions, and emotions (Diguiseppe et al., 2014).

REBT follows the same format as CBT in that a comprehensive assessment furnishes an understanding of the developmental history of the client and the presenting problem, as well as environmental elements that maintain it (Mashalaba & Edwards, 2005). The model's conceptualisation of the connection between thoughts, emotions, and behaviour forms part of the overall case conceptualisation (Diguiseppe et al., 2014). Some interventions are directed at the environmental factors that maintain the problem, and others at the individual client and the irrational beliefs that likewise maintain the problems (Mashalaba & Edwards, 2005)**.** This inclusion of environment or context fits with the MST theoretical conceptions. REBT is an evidenced-based therapy (Walen et al., 1992) which likewise allows it to fit within the MST framework as a therapeutic treatment (Swenson et al., 2005).

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Ellis claims a constructivist element to REBT, in that clients are thought to disturb themselves through irrational beliefs and thoughts (Walen et al., 1992). Most of people's thoughts, goals, emotions, and values are learnt from previous experience and from parents and culture. These aspects of people are considered enmeshed with their sociality. People are therefore both individual and social in that they do not just blindly accept what is taught to them but are active in constructing and re-constructing ideas and behaviours. The constructivist element found in REBT is recognised in this research in that it is acknowledged that the individuals influence the construction of their own thoughts (Ellis, 1994). Thoughts are also influenced by the norms, beliefs, and philosophies of society (the environment). This acknowledges a bi-directional influence on thinking, flexibility, and fluidity in thought that allows for practical therapeutic intervention and success (Ellis, 1994).

According to the conceptualised model of REBT, beliefs (B) are categorised into irrational beliefs (IB) and rational beliefs (RB). Generally, the therapeutic process involves distinguishing between IBs and RBs and decreasing the IBs and increasing RBs by challenging, through the process of disputation, the IBs. The resulting more rational beliefs (RBs) are then practiced as a new and alternative way of thinking (Diguiseppe et al., 2014). The core irrational beliefs of the REBT model are generally placed into four categories: demands, awfulizing, frustration intolerance, and global evaluations of human worth (Terjesen & Kurasaki, 2009).

2.7.1.3.1. The ABCDE model

A basic theoretical foundation in REBT is that emotions, cognitions, and behaviours are inseparably interlinked and overlap (Walen et al., 1992). This link is elucidated in what is referred to as the ABCDE model. A is an activating event which is usually the occurrence of a negative event in the environment but can also be a thought. B stands for the beliefs that consist of the rational and irrational beliefs about the event. C is the emotional and

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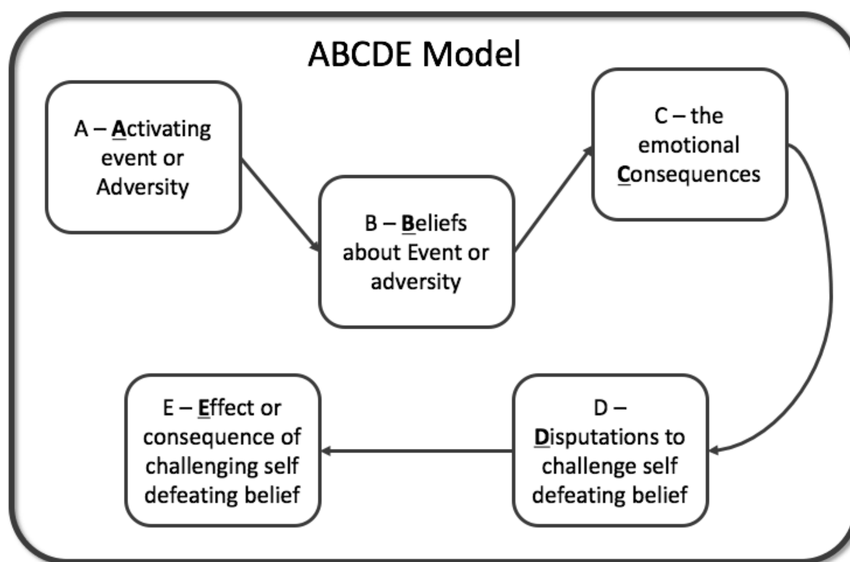
inappropriate behavioural response. Irrational beliefs are associated with uncomfortable emotional responses and inappropriate behaviour, while rational thoughts are followed by appropriate emotional response and behaviours. Appropriate emotions are not just positive emotions. When the model is expanded to include treatment elements, D stands for disputation that challenges the irrational belief and E stands for a new effective (rational) belief that culminates from the disputation (Diguiseppe et al., 2014) depiction of this model appears in figure 1.

Figure 1

Graphical Depiction of the ABCDE Model



Diguiseppe et al. (2014, p. 37)

Regarding the emotional disturbance that results from cognitions, REBT distinguishes between functional and dysfunctional negative emotions. If there is an activating event (A) and the person thinks irrationally (B) they will experience disturbed emotions such as anxiety, anger, guilt, and depression (C). If the IBs are challenged and replaced with a new RB (new B) then a new emotional response will occur (C). Rational thinking leads to functional

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emotions of sadness, concern, annoyance, regret, or remorse. If an unpleasant activating event is still in place, it would be unrealistic for the person to feel good. The rational thinking will instead result in a functional negative but motivating emotion. Most psychotherapies in this family of therapies (CBT) rate emotions along a continuum and use a quantitative measurement to rate success. For example, subjective units of distress (suds) rating scale are used and if the person demonstrates a lower rating, then therapy is considered effective. Contrary to this, Ellis claimed that emotions derived from rational thinking are qualitatively different to those of disturbed emotions that emanate from irrational thinking. In this approach they differ according to phenomenological experience, social expression, problem solving, flexibility, and types of behaviours generated. The therapist will use words carefully to describe functional emotions so that the client can choose what emotion they can feel in place of a maladaptive emotion (Diguiseppe et al., 2014).

Those that seek therapy seem to have a higher proportion of irrational beliefs along with a lower incidence of counterbalancing rational thoughts. REBT advocates different levels of cognitions. Some thoughts are in the stream of consciousness, and others are tacit, undeclared, elusive and could even be pre-conscious (Diguiseppe et al., 2014).

2.7.1.3.2. Levels of cognitions

REBT distinguishes between three different levels of cognition: first, inferential beliefs; second, evaluative beliefs; and third, demand schemas.

The first level cognitions are conscious and inferential in nature. They represent perceptions of reality and the inferences we draw from these perceptions. They can be true or false. Negative inferences are irrational beliefs that occur in a person’s stream of consciousness which are easily tested against empirical reality. Many of them are associated with disturbed emotions (Beck, 2005; Diguiseppe et al., 2014). For example: *the teacher does not like me*. These inferences may be true or false and are empirically verifiable.

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The focus of REBT is on the second level cognitions, that is the evaluation of the possible truth of the inferences. If the inference is evaluated as awful (awfulizing), cannot be tolerated (frustration intolerance), or mean the person is worthless (global evaluation), and if the inference is evaluated as true, then emotional disturbance is the result (Diguiseppe et al., 2014). For example: '*It is awful if the teacher does not like me; I cannot stand it if the teacher does not like me; the teacher is a bad person if she does not like me.'*

The evaluative beliefs come from the third level of cognition: demand schemas. Demands are like a schema in that people construct the world as they want it to be, rather than how it is. Ellis identified three different kinds of these demands or musts: I must; you must; or the world must (Diguiseppe et al., 2014). For example: *the teacher must like me*.

It is the discrimination between inferential cognitions and evaluative cognitions that helps set REBT apart from other cognitive therapies. The REBT therapist acknowledges the importance of inferential beliefs (first level) and tries to modify distorted cognitions, but it is the evaluative beliefs (second level) that are the focus along with the imperative, demand, or schema from which they come (third level). These cognitive layers are the key to understanding pathological disturbance within the REBT framework (Diguiseppe et al., 2014).

2.7.1.3.3. Four categories of irrational beliefs

In summary, the four categories of irrational beliefs are:

- Global evaluation of self or others in that a person (self or other) can be rated to be worthless or worth less than others.
- Awfulizing: the exaggeration of the outcome of an event so that the resulting consequence becomes dreadful.
- Frustration intolerance which stems from demands for ease and comfort and an intolerance of discomfort; and

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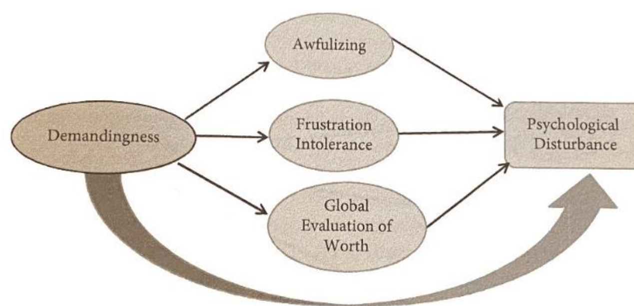
- Demandingness, the unrealistic expectation of how events or individuals should or ought to be in accordance with the individual's desires. Ellis claims that demandingness is the core irrational belief (Diguiseppe et al., 2014).

The assessment in REBT involves the ongoing gathering of several incidences of these activation events and associated thoughts and feelings. After many activating events and associated inferences are gathered and developed, common themes are identified, and the irrational beliefs challenged (Diguiseppe et al., 2014).

Figure 2

Ellis' Model Showing Demandingness as a Core Belief



Diguiseppe et al. (2014, p. 37)

2.7.1.3.4. The theory in action

While REBT has distinctive features, theoretical positions and clinical strategies, Ellis claims that there are multiple mechanisms of psychopathology that require different strategies for effective therapy to take place. Ellis used cognitive (disputing beliefs), behavioural (directly changing behaviour or contingencies), imaginative (visualization), and emotive (assist the client to access emotion) techniques. Some of the techniques that he used were not incorporated in the theory, although Diguiseppe et al. (2014) do not elucidate to which techniques they refer. Some recognised REBT techniques for identifying irrational beliefs (evaluative beliefs) are given below.

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The activating events are identified The activating events associated with the disturbed emotions are identified collaboratively between client and therapist. The model is elucidated to the client along with the belief that events do not cause emotional disturbance but rather such disturbance arises from the way in which we think about the events. Psychoeducational methods are used to attain this end (Diguiseppe et al., 2014).

The following strategies are examples of how clients can be helped to identify irrational beliefs associated with the triggering events.

Client awareness through induction Clients are facilitated in reporting inferences (the first level of cognitions) and challenging their accuracy. The thoughts associated with the disturbed emotions and trigger events are identified through Socratic questioning. In the repetition of this process, clients learn to associate these inferences with their problems and disturbed emotions; and eventually core patterns of beliefs emerge. Seeing these patterns allow the client to become aware of the evaluative beliefs (second and third level of cognitions). This strategy relies on self-discovery. The client comes to their own awareness of their evaluative beliefs (Diguiseppe et al., 2014).

For example:

Client (C): I think that things are unfair. I bring many examples of when I get into trouble and become angry. It is always when I think they are being unfair.

Therapist (T): Yes, it does seem that you do experience getting into trouble as unfair, even if that may not be accurate sometimes.

C: I think it is important to me that things always be fair for me and if I think it is not, then I get really angry.

Inductive Interpretation This is the same technique as described under induction above, but it is more directive. The therapist is the one to find the pattern of evaluative beliefs

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under the examples of the inferences provided by the client. Although the therapist provides an educated guess, it is preferable for the client to find the underlying patterns of beliefs through the therapist's use of Socratic questioning, as through induction above. The therapist suggests the underlying beliefs as hypotheses for the client to consider (Diguiseppe et al., 2014). For example:

C: This week I got into trouble and the teacher shouted at me. She was being unfair, as the other children were doing the same thing as me. So, I thought I would make that point so that it can be fair, and then she shouted even more.

T: Every time you get into a lot of trouble it seems that you have thoughts about the situation being unfair. It is so important for it to be fair that you must state your point to try and make it fair. At whatever cost, you want it to be fair. Do you think this makes sense?

Inference chaining The therapist poses the following two questions which lead the client through a process of identifying the irrational belief. What if that were true? What would that mean? The chain is followed until the underlying IB is identified using the client's own experiences (Diguiseppe et al., 2014).

C: The teachers do not like me.

T: Well, we have no real evidence for that, but if that were true, what would that mean?

C: It means that they will always pick on me.

T: And if they always pick on you, what does that mean?

C: It means it is unfair.

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Client awareness using conjunctive phrasing Client awareness of irrational beliefs is facilitated by using conjunctive phrasing. The therapist facilitates the client's identification of the inference and accompanying evaluative belief by encouraging them to continue speaking, using questions such as, "…and then…and what would that mean? and therefore…which means…?" This works well with intelligent clients but not with the more concrete, literal thinkers (Diguiseppe et al., 2014).

C: I know the teachers do not like me.

T: And then?

C: It will always be me that is in trouble.

T: And that would mean?

C: That is unfair.

The sentence completion chain The therapist places the inference in a sentence. "The worst thing about…." The therapist continues to question until the evaluative, irrational belief is made conscious. This technique keeps all the advantages of inference chaining strategies, but the added structure makes it successful with a larger number of clients (Diguiseppe et al., 2014). For example:

C: The teachers do not like me.

T: And the worst thing about the teachers not liking you is…

C: That would be unfair.

Deductive hypothesis driven assessment If the above self-discovery methods do not work, then more directive techniques can be offered. Hypotheses can be offered to the client based on the therapist's clinical experience. They are proffered as suggestions for the client's consideration (Diguiseppe et al., 2014). For example:

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T: So, if the teachers do not like you, then you will be the one in trouble all the time?

C: Yes, it will always be me, and the other children will get away with it

Asking for the must According to the REBT theory, the inferences and interpretations and emotional disturbance are derived ultimately from an imperative/demand. So, the therapist asks the client what it is that they demand, of the world, themselves, or of others (Diguiseppe et al., 2014). For example:

T: What are you demanding that makes you so angry?

C: Life must be fair.

Choice based assessment of IBs The therapist assesses the client's preference about A and obtains their agreement about the accuracy of the assessment. The therapist states that the client could hold one of two beliefs and asks permission to present these. One will be rigid and dogmatic (a demand) and the other will be a nondogmatic preference. The client is asked to identify which one will account for the dysfunctional emotion at C (that is the emotional consequences referred to in the ABC model discussed above) (Diguiseppe et al., 2014). This brings about clarity and awareness of the IB. For example:

T: Life must be fair for me all the time.

T: I would prefer life to be fair all the time, but life is fair for no one all of the time.

Behavioural and emotional consequences at C have multiple determinants. It is helpful to identify which C the client wishes to deal with first. The IBs related to this C can be identified and the core IB determined by using the above techniques and others. The IB most strongly connected to the dysfunctional C, the most frequent IB, or the IB most

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endorsed can assist in identifying the core IB. When the relevant IB has been targeted, pervasive change can occur (Diguiseppe et al., 2014).

In REBT clients are taught on an individual level to use these processes and techniques to discover the relationship between their thoughts, emotions, and behaviours; and to identify and challenge their IBs (Walen et al., 1992).

Although Ellis emphasised specific kinds of cognitions in emotional disturbance, he did recognise that some pathways to emotion are cognitive, and some are non-cognitive. The two recognised pathways for emotional disturbance in this regard are as follows: one is lower and quicker, results from conditioning, and accounts for 10% of emotional disturbance; while the other results from cognitions are slower, based in the cortex, and accounts for 90% of emotional disturbance (Diguiseppe et al., 2014). Disturbance from classical conditioning is not accompanied by thoughts. At some point the therapist must accept this and establish alternative beliefs that counteract the disturbed emotions (Diguiseppe et al., 2014).

2.7.1.3.5. Cognitive change strategies in REBT.

After the IBs are identified, they are challenged using the techniques below, including:

Disputation. Disputation is aimed at challenging the client's core schemas/evaluative beliefs as opposed to inferences. Inferences can be challenged, but if disputation is aimed only at inferences (the first level of cognitions) it will serve to provide reassurance only. Challenging the core cognitive schemas, however, provides change. There are various methods and styles of disputation available to therapists (Diguiseppe et al., 2014).

Methods of disputation Four of the methods of disputation available to clinicians are:

- Pragmatic/functional questioning such as: Where is this belief getting me? Is it helping me or making the situation worse?
- Empirical or reality testing questions such as: Where is the evidence to support this belief? Is it really that awful? Can I really not stand it? Am I a totally bad person?

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- Logical disputation questions such as: Is it a logical belief? Does this logically follow from my preferences? The client's beliefs are checked for logical consistency. The clarity of the use of language is of importance in this disputation.
- Metaphorical disputation: uses humour or stories in disputation to challenge irrational beliefs.

There is little research on the differential effectiveness of these various disputes, but practitioners trained at the Ellis Institute believe that the pragmatic/functional is the most effective (Diguiseppe et al., 2014).

Styles of cognitive disputation The therapist can use the various styles that follow within the different types of disputation:

- Didactic style: mini lectures, analogies and parables can all be used to make a point. These are best used when new ideas are presented. The therapist can ask the client to paraphrase what they, the therapist, have said, to ensure their understanding.
- Socratic questions can be posed by the therapist to help guide the client through self-discovery.
- A humorous style is encouraged by the REBT approach. Humour is used to make a point.
- Metaphorical style: using one concept to understand another; and
- Vicarious modelling is used by pointing out that others have similar activating events yet are not disturbed emotionally as they have different beliefs (Diguiseppe et al., 2014).

Creating Alternative Beliefs The irrational beliefs are weakened via the above disputations. A new evaluative belief (EB) is constructed that is rational and flexible. For the

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new EB to be established, the IB must first be identified. The client needs to acknowledge the connection between the IB and the dysfunctional emotion. Good disputation needs to have weakened the IB. A full understanding of what is irrational about the IB needs to be explored and realised so that the EB can counter it effectively. In other words, the core evaluative belief needs to be uncovered through repetition of the inferences. The client can then generate a useful EB if they understand the core of the IBs.

Self-discovery can be utilised to attain alternative rational beliefs. Socratic questioning can be used to ask the client if they have any alternative beliefs that they feel can change the dysfunctional emotion. If this does not work, the therapist can be more directive and offer alternative beliefs (Diguiseppe et al., 2014). After the new rational EB is generated, it needs to be rehearsed. Saying the EB repeatedly, recording it, and practicing it when the activating event occurs all helps to establish the EB. The therapist must emphasise the need to rehearse the EB to the client.

Creating alternative rational beliefs requires the following issues to be addressed:

- Demands: 'musts', 'oughts' and 'shoulds' are changed to preferences. 'It would be nice to perform well, but I don't have to in order to be worthwhile', etc.
- Anti-awfulizing: 'It may be unfortunate/disappointing, but it's not awful.'
- High frustration tolerance: 'I don't like it, but I can stand it.'
- Self-acceptance, acceptance of others, life-acceptance: 'I accept that human beings, both myself and others, are fallible.'

Concluding the session At the conclusion of the session, the therapist checks to see if there was anything that bothered the client and conversely what the client found helpful. As the cognitive model of change requires practice for enduring change to happen, homework assignments are negotiated to this end and the completion of homework contributes to a successful outcome. Consistency is important, and the homework assignment must follow the

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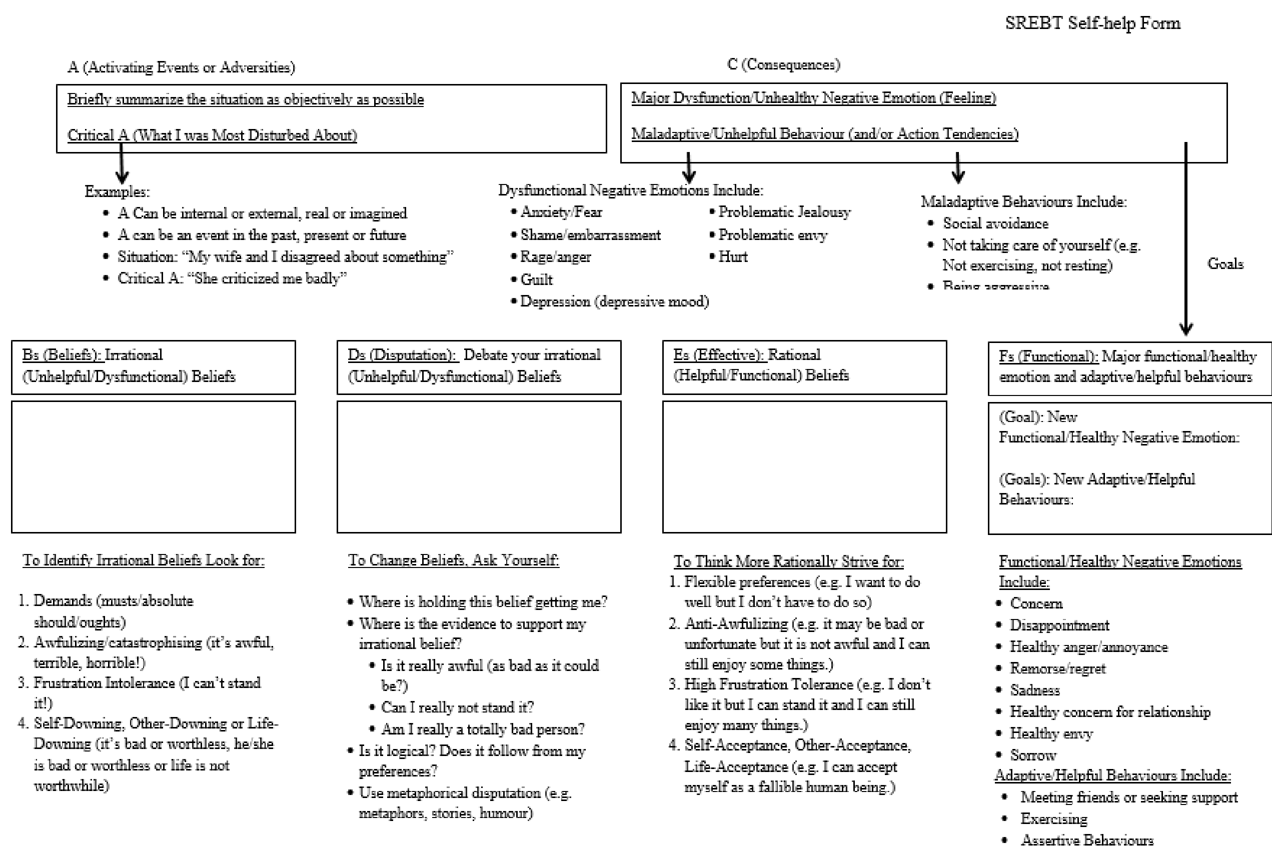
content of the session. It must have specificity and be explained in detail. Barriers to the completion of the homework assignment are identified. The REBT model can be practised in homework, identifying the activating events and associated feelings and thoughts. Disputation can be practised, and behavioural exercises can be implemented where the new evaluative belief can be practised. Homework is checked the following week (Diguiseppe et al., 2014).

Figure 3

REBT Model Representing Evaluative Beliefs and Disputations



SREBT Self-help Form

A (Activating Events or Adversities)

Briefly summarize the situation as objectively as possible

Critical A (What I was Most Disturbed About)

Examples:
- A Can be internal or external, real or imagined
- A can be an event in the past, present or future
- Situation: "My wife and I disagreed about something"
- Critical A: "She criticized me badly"

C (Consequences)

Major Dysfunction/Unhealthy Negative Emotion (Feeling)

Maladaptive/Unhelpful Behaviour (and/or Action Tendencies)

Dysfunctional Negative Emotions Include:
- Anxiety/Fear
- Shame/embarrassment
- Rage/anger
- Guilt
- Depression (depressive mood)
- Problematic Jealousy
- Problematic envy
- Hurt

Maladaptive Behaviours Include:
- Social avoidance
- Not taking care of yourself (e.g. Not exercising, not resting)

Goals

Bs (Beliefs): Irrational (Unhelpful/Dysfunctional) Beliefs

Ds (Disputation): Debate your irrational (Unhelpful/Dysfunctional) Beliefs

Es (Effective): Rational (Helpful/Functional) Beliefs

Fs (Functional): Major functional/healthy emotion and adaptive/helpful behaviours

(Goal): New Functional/Healthy Negative Emotion:

(Goals): New Adaptive/Helpful Behaviours:

To Identify Irrational Beliefs Look for:
1. Demands (musts/absolute should/oughts)
2. Awfulizing/catastrophising (it's awful, terrible, horrible!)
3. Frustration Intolerance (I can't stand it!)
4. Self-Downing, Other-Downing or Life-Downing (it's bad or worthless, he/she is bad or worthless or life is not worthwhile)

To Change Beliefs, Ask Yourself:
- Where is holding this belief getting me?
- Where is the evidence to support my irrational belief?
  - Is it really awful (as bad as it could be?)
  - Can I really not stand it?
  - Am I really a totally bad person?
- Is it logical? Does it follow from my preferences?
- Use metaphorical disputation (e.g. metaphors, stories, humour)

To Think More Rationally Strive for:
1. Flexible preferences (e.g. I want to do well but I don't have to do so)
2. Anti-Awfulizing (e.g. it may be bad or unfortunate but it is not awful and I can still enjoy some things.)
3. High Frustration Tolerance (e.g. I don't like it but I can stand it and I can still enjoy many things.)
4. Self-Acceptance, Other-Acceptance, Life-Acceptance (e.g. I can accept myself as a fallible human being.)

Functional/Healthy Negative Emotions Include:
- Concern
- Disappointment
- Healthy anger/annoyance
- Remorse/regret
- Sadness
- Healthy concern for relationship
- Healthy envy
- Sorrow

Adaptive/Helpful Behaviours Include:
- Meeting friends or seeking support
- Exercising
- Assertive Behaviours

Diguiseppe et al., (2014, appendix 5)

2.7.1.3.6. Application of REBT techniques across different levels of a system

In this study, the REBT techniques were applied to the following levels across the school system: the child; the parent of the child; and the teacher of the child. Contingency management was taught to the parent and the teacher and then applied.

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Application to the different levels of the school system As stated above the child is seen as embedded within multiple systems. Using this model as an integrative framework, REBT interventions were applied across these different levels of the child's school system (Henggeler, et al., 1996; Scott, 2008; Swenson et al., 2005).

Children Albert Ellis' theory about children's emotional and mental well-being follows the same principles and assumptions that guide the understanding of adult well-being (Bernard, 2008). Ellis (1994) sees children as gullible, teachable, and impressionable, adopting norms and preferences within the familial and cultural context. According to REBT principles, when experiencing emotional distress, adults and children alike are using irrational thinking. Ellis claims that children have an innate tendency for thinking that is illogical, irrational, non-empirical, and unhelpful, and this tendency remains throughout life (Bernard, 2008). Many practitioners now include the restructuring of cognitions as a direct way of changing a child's behaviour as well as changing external factors such as contingency management (DiGuiseppe & Bernard, 2006).

Irrationality is moderated by the developmental phase of the child. REBT therapists consider the developmental stage of children when engaging in the therapeutic process (Barnard, 2008), because children need to be able to reflect on thoughts and need logical reasoning skills for therapy to be successful (DiGuiseppe & Bernard, 2006). According to Piaget (Inhelder et al., 1958), children start to develop rational and logical reasoning at around the age of six years. He refers to this as the concrete operational stage of development. These skills are further enhanced after the age of 12 when children develop the capacity for abstract reasoning. Piaget referred to this stage as the formal operational stage of development (DiGuiseppe & Bernard, 2006). The children participating in this study were 12 years and above, so they were all able to engage in necessary abstract thinking.

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Parents Working with children alone is less effective than working with parents as well, as it is the wider context in which the behaviour occurs and is maintained. If parents and other contextual elements, such as the school context, are included in the intervention, the outcome is often more successful (Bruce & Jongsma, 2011; Terjesen & Kurasaki, 2009). This again acknowledges the bi-directionality of influence between the child, family, and wider contexts as noted in the systems models reviewed above (Swenson et al., 2005). REBT is a useful therapeutic strategy to address emotional stress in both teachers and parents, by changing unhealthy or irrational beliefs to enhance their emotional functioning. This allows teachers and parents to make more effective decisions regarding behaviour management of their children/pupils (Terjesen & Kurasaki, 2009).

REBT can be used in various ways to bring about positive changes for both children and parents. Through rational emotive education, parents can be taught to help their children to identify irrational beliefs and to associate these with negative emotions, and to express these emotions in a more positive manner. Parents can identify their own irrational beliefs in relation to their children's behaviour and how these beliefs are related to their emotional response, as opposed to the child's behaviour (Terjesen & Kurasaki, 2009).

Contingency management Although Ellis (1994) emphasises the importance of cognitions on emotions, he also recognises the importance of getting people to behave differently. Parent management training (PMT), based on learning theory, is well researched and is one of the most promising interventions in treating behavioural problems in children, especially with conduct disorder and related conditions. PMT aims at altering the pattern of interaction between the parent and the child, by reinforcing and supporting a pro-social rather than coercive pattern of interaction within the family (Kazdin, 2000). This is achieved by: using positive attention for good behaviour and other contingencies (negative consequences) to manage inappropriate behaviour; clear guidelines for expectations for behaviour; and swift

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action, where contingencies take more or less immediate effect (Kazdin, 2000). It is based on the general view that the behavioural problems of a child are developed and maintained in the home (Kazdin, 2000).

Parents are also trained to identify, define, and observe the behavioural problems of their children in new ways (Kazdin, 2000). During therapy sessions, the therapist adopts a relatively directive stance. Parents are coached to recognise the influence of their behaviour in encouraging or discouraging certain behaviours (Bruce & Jongsma, 2011; Kazdin, 2000). The therapist teaches parents to use the specific procedures described above to alter their interaction with their children (Kazdin, 2000). Contingency management, when applied appropriately and consistently, lends structure to the relational interaction (Firestone & Witt, 1982). This is an integral part of this therapy and is akin to the goals of the family therapies discussed above yet attained and conceptualised differently. Clear expectations for the kinds of behaviours required are described to the child (Kazdin, 2000). Agreed upon contingencies between child and parent are established. As behavioural change established in one context does not necessarily generalise to other contexts, in this current study, school behaviours are included in the home-based contingency management programme. Rewards are attained for appropriate school behaviours and school complaints result in negative consequences.

PMT is often used in conjunction with cognitive behavioural therapies and other multi-disciplinary techniques (Firestone & Witt, 1982). REBT can be used to alter the perceptions of parents. Parents can be taught to see how their irrational beliefs affect their interaction with their children and in turn affect the children's behaviour as well as their own. The beliefs around implementing the parenting management skills are explored through REBT education. Homework assignments are used to guide the process of implementation (Bruce & Jongsma, 2011). Usually only one parent attends sessions due to time constraints.

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There are usually between six and 25 sessions depending on the severity of the problem (Patterson, 1982).

Success rates are related to parents attending sessions and follow up appointments (Firestone & Witt, 1982). Consistency and practice in the application of techniques are associated with successful therapy (Barkley, 2013). The age of the children also affects results: the younger pre-school children have the greatest response, but school children also show improvements, and improvement increases again in adolescence. Intelligence of both parents and children is correlated with higher improvement rates (Firestone &Witt, 1982).

Parents with higher levels of psychopathology (especially depression, alcohol/drug dependency, adult ADHD) do not seem to do well in parent training programs (Chronis-Tuscano, et al., 2011; Patterson & Chamberlain, 1994; Sonuga-Barke, et al., 2002). They may start out resistant to training and homework assignments and seem to remain so throughout treatment (Fernandez & Eyberg, 2009; Frankel & Simmons, 1992). If parents suffer from ADHD, they often drop out of therapy or are less compliant rendering the programme less effective (Barkley, 2006). Parents demonstrating greater negativity and helplessness, or poor anger control also typically do not respond well in such training programmes, or they are likely to drop out of treatment (Fernandez & Eyberg, 2009; Frankel & Simmons, 1992). Marital discord also lessens effectiveness (Forehand, 2005). Single mothers were associated with less effectiveness regarding treatment outcomes as well as individuals experiencing elevated stress (Webster-Stratton & Hammond, 1990).

Experienced therapists seem to fare better with parent training than inexperienced therapists (Frankel & Simmons, 1992). Therapists who teach and confront are more likely to encounter resistance than those who use a more supportive approach (Patterson & Forgatch, 1985). The resistance from parents is likely to be high initially, but in less serious cases, resistance often lessens towards the middle of treatment and is possibly eliminated by the end

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of treatment. Such improvement does not always occur with more serious cases, and the therapist is likely to become more confrontational, which can increase resistance (Patterson & Chamberlain, 1994). This demonstrates responsiveness (Kramer & Stiles, 2015), the bi-directional influence between client and therapist on the therapeutic process and outcome. The responses of the client and therapist are dependent on each other and the context for feedback (Kramer, & Stiles, 2015).

Generally, parent management treatment has been documented to reduce deviant behaviour and increase pro-social behaviour (Kazdin, 2000; Swenson et al., 2005). Randomised control studies have indicated the effectiveness of various parent-management training programmes (Webster-Stratton et al., 2001; Weisz et al., 2004). The approach has demonstrated short-term and long-term effects (Hood & Eyberg, 2003; Reid et al., 2003). Research shows that 60% to 75% of children improve significantly. Gains have been recorded to be maintained from a one to three-year period (Long, et al., 1994).

Teachers As with the parents, REBT can be used to help teachers identify and challenge their irrational beliefs, replace them with more rational beliefs, and better handle the difficulties associated with teaching. Providing teachers with the means to challenge unhealthy patterns of thought and teaching them appropriate coping strategies may perhaps reduce teacher burnout and help with the effective implementation of interventions for behavioural problems (Terjesen & Kurasaki, 2009). In this study REBT therapies and techniques were applied to the teachers of the children with disruptive, impulse control and conduct disorder.

As suggested by Marais and Meier (2010) and Zondi (1997), teachers may lack the knowledge of how to manage the student's behaviour effectively in the classroom. If taught effective behaviour management strategies, however, these teachers may be able to implement them and thereby reduce the incidents of disruptive behaviour in the classroom.

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According to Martens, et al. (1996), research has indicated that teachers who participate in such research claim that their professional skills have increased, but little research exists that explores the variables of this improvement (Martens et al., 1996). In this current study, the contingency management training (Kazdin, 2000), described above, was applied with teaches as well.

Some results suggest that REBT techniques applied by non-mental health professionals, such as teachers and parents, produce greater effects than when applied by health practitioners (Gonzalez, Nelson, et al., 2004), therefore training the teachers in its application is in line with these findings. It would utilise the teachers as a resource in the school context, as suggested by Timm (2007). This finding is possibly related to the fact that, if the techniques are applied by the teachers and/or parents, the context (which usually maintains the behavioural problem) is likely to change. The behavioural techniques are likely to be applied more consistently than if they are applied by a therapist alone, once a week. Behaviour change is then likely to occur and be sustained in these contexts, especially as behaviour has been noted as context specific.

Additionally, the way forward is for school psychologists to train other school personnel and parents in the knowledge of psychology (Sarason, 1974). This can take the form of information sharing, training, and active collaboration as equal partners in advocating change in children. Involving and equipping teachers and counsellors is one avenue whereby the skills of school psychologists can filter down to larger populations of children. Teachers have the most direct access to children and many opportunities during a normal school day to reinforce good self-management habits. School psychologists can actively enlist the support of classroom teachers to encourage children to use their new skills, and to reward effort and success, in order that gains made during treatment sessions can be sustained long term (Terjesen & Kurasaki, 2009).

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2.7.1.3.7. Research in REBT treatment of behaviour problems

Some of the meta-analyses carried out on the CBT approach include REBT studies. David, et al. (2018) focusing specifically on REBT research data, cite four meta-analyses that review REBT research (Engels, et al., 1993; Gonzalez et al., 2004; Lyons & Woods, 1991; Trip, et al., 2007). The studies by Gonzalez et al. (2004) and Trip et al. (2007) were carried out with children and adolescents. The other two older studies (Engels, et al., 1993; Lyons & Woods, 1991) focused on adults. All conclusions depicted the efficacy of REBT treatment across various problems. The weakness of these studies is that they include a small number of controlled studies, which limits the conclusions. They focus on outcome analyses alone, and therefore provide effectiveness data only. No specific information on mechanisms of change is evident. The disorders treated vary greatly within the studies. Accordingly, it is difficult to compare and generalise results (David et al., 2018).

According to the meta-analysis carried out by Gonzalez et al. (2004), all 19 studies included showed the application of REBT therapy to be effective for children and adolescents with a variety of problem behaviours. The overall mean was rated positive and significant. Weighted effects sizes were computed for five outcome categories, those being anxiety, disruptive behaviour, irrationality, self-concept, and grade point average. Among these issues, REBT had the largest positive effect on disruptive behaviours (Gonzalez et al., 2004). The following points are noted:

- REBT is an effective treatment for children and adolescents with and without identified (diagnosed) problems.
- REBT has the most success in specifically decreasing disruptive behaviours in children and adolescents than any other issue.
- Non-mental health professionals are more effective at delivering REBT than their mental health counterparts.

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- The longer the duration of the REBT therapy, the greater the positive affect it has on the child; and
- Children benefit from REBT more than adolescents (Gonzalez et al., 2004 p. 21).

The meta-analysis carried out by David et al. (2018) overall depicted the efficacy of REBT treatment across various problems, indicating that REBT is used effectively across psychotherapy, educational, and counselling sectors. REBT is deemed effective across different conditions, regardless of age, clinical status, or delivery format (David et al., 2018). The alleged mechanisms of change, a process comment, is established within the REBT theoretical framework: post intervention there was a change from irrational beliefs to rational beliefs, which was linked to change in dysfunctional beliefs and behaviour. Overall, the studies are reported to be heterogeneous in scope, outcomes, and quality of reporting. For future research, more rigorous studies are required for the various diagnostic categories. Psychometric instruments for the measurement of mechanisms of change in REBT therapeutic endeavours are required. As with CBT, the research in the South African context on REBT, is limited. One master's thesis was found in the literature search for this current study (Ratsela, 2013). The results revealed REBT to be successful in reducing depression levels in adults suffering from acne.

2.7.1.3.8. Issues of transference and countertransference in REBT

Transference is when the client reacts to the therapist as they do to significant others in their life. Working with transference in REBT is not seen as necessary for the progress of therapy, but useful. Likewise, if the therapist is not aware of their own IBs and associated dysfunctional emotions, countertransference can occur and affect the therapeutic process. The therapist should ask themselves the following questions: 'What do I feel when this client is coming?' 'What are the reasons for this reaction?' 'How do I feel in the session?' 'What are the client's interactional styles?' The client can also be responding to the therapist's own

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issues. There may be a higher chance of countertransference affecting REBT compared to other therapies as it is an active therapy on the part of the therapist (Diguiseppe et al., 2014).

2.7.1.3.9. The therapeutic relationship

A therapeutic interpersonal relationship can be defined as one which is experienced by clients to be caring, supportive and non-judgmental. The therapist exhibits warmth, friendliness, genuine interest, and empathy. It facilitates effective communication of feelings and experience on the part of the client. The development and maintenance of such a relationship requires reflection on the part of the therapist (Kornhaber et al., 2016). The specific definition and emphasis of the different elements of the therapeutic relationship and the form that it takes depends on the theoretical orientation of the therapist (Safran et al., 1990).

In their metanalysis Safran et al., (1990) consider the existence of two phases in the therapeutic alliance, thus conceptualising the relationship as a process. Although the reference is older it was used because of the process conceptualisation of the relationship. The initial phase of the alliance focuses on collaboration and confidence building; client and therapist agree upon their goals, and the client develops a certain degree of confidence in the framework of the therapy. Tryon et al., (2018) agree that the degree of agreement on the goals, methods, and overall approach to therapy between client and therapist contributes to the strength of the therapeutic alliance (Tryon et al., 2018). In this current study the REBT framework facilitated the development of the therapeutic alliances in this way because it focuses on establishing goals with the client and on a collaborative relationship between client and therapist. Although the goals of therapy should be those of the client, the therapist's therapeutic orientation affects the process and the clients' goals are collaboratively joined with the aims of the REBT approach that directs the client to become more rational in their thinking, thereby decreasing emotional disturbance and increasing problem solving ability (Knox & Cooper, 2018).

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In the second phase the therapist begins to challenge the client's dysfunctional thoughts, affects, and behaviour patterns. The client may evaluate the therapist's more active intervention as a reduction in support and empathy; this can weaken or rupture the alliance between them (Safran et al., 1990). However, the REBT framework, along with the transparency of the methods and collaborative application of disputes facilitates this part of the therapeutic process, helping to counter the therapist's active stance.

Personal characteristics of both client and therapist can also affect the therapeutic relationship (Turner, 2010). The client's motivation and ability to form relationship contributes to both quality of relationship and therapy outcome. Clients with increased symptomology may have a decreased ability to become engaged and work (Dixon, 2016). Responsiveness, which occurs when the psychotherapist recognizes, attends to the client, and empathically responds to the client's needs during a session (Kramer & Stiles, 2015) also contributes to the building of relationship (Bachelor et al., 2007). Any attempt to measure the complexities of the therapeutic alliance involves conceptual and methodological challenges, which could have hindered the development of research regarding this topic. Single-case research is one method used to investigate this theoretical construct, but there are methodological drawbacks with this approach too (Safran et al., 1990). In this current study the same methodological shortcomings were noted when studying the vast complexities of the therapeutic process in general as well as the therapeutic relationship; the clinical experience of the relationship on the part of the therapist is described as part of the case study assessment.

2.8. Conclusion

Various socio-ecological facets, such as family, school and community are interconnected, and dynamic. Conduct problems are maintained by problematic transactions between various combinations of these different levels of the child's system. The contributions of the various

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facets are discussed in this chapter. Treatment models are discussed in terms of how inclusive they are of these influential facets. The models were chosen as each one discssed focussed on different elements of the system. Research results on these treatments are also included. According to the above reviewed literature treatment should be more effective if it focuses on the problematic dynamics and interactions between these facets rather than the conduct problems in isolation (Burton & Leoschut, 2013; Khan, 2008; Swenson et al., 2005).

The theoretical approach to this study is discussed in this chapter. The MST framework (Swenson et al., 2005) is used to organise this divergent and bi-directional information to provide an integrative framework with which to conceptualise both information and intervention. The REBT approach (Diguiseppe et al., 2014) is discussed as is contingency management (Kazdin, 2000). The concept of responsiveness (Kramer & Stiles, 2015; Stiles et al., 1998) is also used in this study as a means of recognising bi-directionality in the micro-interpersonal interactions. Through this concept, the understanding of human interaction as a system is carried through to the micro-interactions which take place in therapy between client and therapist and across the members of the school system: the teacher; the parents; and the children. As the REBT framework is chosen for this study, the bi-directionality of the irrational beliefs across the members of the school system is explored and applied in the following chapters. This clinical and research approach is discussed further in the methodology chapter as are the clinical and research methodologies.

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Chapter 3: Methodology

The research methodology of a study refers to the scientific process underlying data collection, condensation, and interpretation. The clinical methodology refers to the paradigms and procedures that guide the clinical process (Edwards, 2007). Both the research and clinical methodologies guiding this study are described and discussed in this chapter. The clinical process was guided by the Multisystemic Therapy (MST) framework (Swenson et al., 2005) utilising Rational Emotive Behavioural Therapy (REBT) evidence-based techniques and concepts (Diguiseppe et al., 2014) which were discussed in the previous chapter. In this chapter the focus is on how these approaches were implemented in the clinical methodology of this study. The research process was guided by the pragmatic (Fishman, 2013), embedded (Yin, 1994) case study research methodology. This approach and the way in which it was applied are reviewed in this chapter.

The MST approach was used in therapy to organise the multiple contextual and individual factors that influenced the problem of disruptive, impulse control and conduct disorder (Swenson et al., 2005). In each case study the child displaying disruptive, impulse control and conduct disorder, as well as the mother and teacher, all engaged in the therapy process. As result, the child's context of family (mother) and school (teacher) were included. The MST framework helped to organise and lend structure to this divergent and interactional information gathered from the various therapy processes (Harpell & Andrews, 2006). These processes involved REBT, and contingency management (Kazdin, 2000) therapies applied to the identified levels of the child's system.

The pragmatic, embedded case study method reflects the theoretical systemic conceptualisation in a research method as it includes different levels of a system in its analysis. The pragmatic element focuses on the collection and analysis of data in the process of practice-based research; this is a tool for understanding the practical application of the

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therapy process (Fishman, 2013). The embedded case study is a conceptual grid that allows for the identification of key components of both the phenomenon and its contextual systems (Scholz, 2011). In this current study the embedded case study research acted as a heuristic model in the understanding and exploration of the phenomena of disruptive, impulse control and conduct disordered behaviours. These phenomena were difficult to separate from their context of parents and school (Anaf et al., 2007). So, the pragmatic case study method provided a way of analysing the practical process of therapy for the problem of disruptive, impulse control and conduct disordered behaviours and the embedded element allowed the conceptualisation of this therapy process applied to the different levels of a system. The case study (the child with disruptive, impulse control and conduct disorder) was embedded in the contexts of the family (represented by the mother of these children) and the school (represented by the teacher).

The concept of responsiveness (introduced in the previous chapter) acknowledged that human interaction is also a system and that the therapeutic process is no exception (Kramer & Stiles, 2015; Stiles et al., 1998). This therapeutic system comprising therapist, client, treatment, and context partly depend on each other (Stiles, 2009). Responsiveness acknowledges the interaction of the various components of therapy described as feedback loops through to micro interactions between therapist and client. In other words, it conceptualised the analysis of the systemic interactional component of disruptive, impulse control and conduct disorder down to micro level interactions between the therapist and the clients. In this current study it was also used to explore the interactions between the members of the embedded case study. The interaction of the beliefs of the child, mother and teachers were explored. Both client's and therapist's behaviours were affected by emerging context which included perceptions of each other's behaviours and characteristics (Kramer & Stiles, 2015; Stiles et al., 1998). These perceptions included the rational and irrational beliefs as

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conceptualised by the REBT therapeutic approach across the participants in each pragmatic, embedded case study.

3.1. Research Methodology

The research process, guided by the pragmatic, embedded case study research methodology and is described below.

3.1.1. The pragmatic case study

The focus of pragmatism is on acquiring knowledge of how to deal with a specific social problem within a specific context, at a certain time, as opposed to proving timeless laws and principles (McLeod, 2010). The goal is not primarily to prove a theory, it is to establish what works and what does not work in the therapeutic process. Case study methodology provides a vehicle to analyse the complexity of knowledge discovered in context (McLeod, 2010), and it is a tool for understanding the practical process of therapy in action. The process builds narrative knowledge, which is the story of the sequence of events of the therapeutic process in chronological order. It is a systematic process in that it presents a common structure to apply across different case studies (Fishman, 2013). The structure elucidated below, is based on the disciplined enquiry model (Peterson, 1991) that conceptualises the interrelationships and feedback loops between its different components. This structure mirrors best practice in therapy (Fishman, 2013). Organising the material in a coherent manner presents a challenge, however, as the model lends itself to gathering vast amounts of complex knowledge. Due to the need for coherence, the therapist/researcher adheres to a therapeutic/philosophical perspective which helps to provide a focus in data collection (McLeod, 2010). The case study method can be applied to different therapeutic perspectives if they are evidence based (McLeod, 2010).

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Bromley (1986) claims that the case study is the 'bedrock' of scientific discovery. Knowledge is built on observation of specifics and detail of the world's phenomena (Edwards, 2018). In this way theoretical constructs are built through analysis of individual cases (McLeod, 2010). This is referred to as case law and is equivalent to grounded theory (Edwards, 2018). It thus provides the framework and structure to explore contextual and process knowledge necessary to investigate the therapeutic process in a diverse, developing country such as South Africa. This method specifically enabled me, the therapist/researcher, to answer the research questions: Is this approach effective and what about it is effective, within the context of this study.

3.1.1.1. The embedded element of the case study

As mentioned in Chapter 1, embedded case studies refer to the study of more than one unit (or level of analysis) in one participant or case study (Yin, 1994). In this current study, the multiple units of analysis are represented by the child, parent (family), and teacher (school). The identification of these different levels of analysis or sub-units allows for a detailed inquiry across these levels. It is this embedded element of the case study that is influenced by Systems Theory (Anaf et al., 2007). As such, it fits with the MST (Swenson et al., 2005) framework used to integrate the clinical and research process of this current study by allowing the research design to mirror the clinical framework. This combination of case study and Systems Theory is not often seen in the literature (Anaf et al., 2007). The combination of these approaches enables the consideration of the influence of broader systems and external environments in the case study of a phenomenon, in this case; disruptive, impulse control and conduct disordered behaviours (Anaf et al., 2007; Scholz, 2011). Scholz (2011) claims that the multilevel analysis of an embedded case study is a conceptual grid that allows this. The embedded case study was thus suited to guide the research process of this problem with its multiple bi-directional influences and thus act as a heuristic model (Anaf et al., 2007). The

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individual case studies were explored, and then commonalities were explored across all four case studies in the final chapter (Anaf et al., 2007).

3.1.1.2. 'Mixed methods'

The pragmatic case study provides a means of integrating both quantitative and qualitative research methodology (Scholz & Tietje, 2002; Yin, 2003). This mixed method approach to research is influenced by the concept of pluralism advocated by the postmodern approach (Fishman, 2013). Therefore, case study design utilises the strengths of both positivist and interpretive approaches (Dattilio et al., 2010). This lends methodological rigour and thoroughness to the data gathering and analysis process.

The strength of the positivistic approach lies in: the properties of numerical data that brings stable meaning across time, the quality control achieved by psychometric procedures, the ability to reduce large quantities of data, the provision of a normative context for the comparison of many individuals, and the ability to create deductive laws that move from known general principles to specifics (Stiles et al., 2006). In case studies this positivistic approach is utilised via the use of psychometric tests, the statistical testing of the results and graphical representation thereof. In this current study specifically, the Conners Rating Scales (Conners, 2007), and irrational belief scales were utilised. The psychometric tests lend rigour to the analysis of change in the participants thoughts and behaviour. The results were graphically represented and subjected to statistical analysis.

The strength of the qualitative paradigm is that it sees the data as context dependent and thus addresses context and client experience (Creswell, 1998). It provides a means of gathering rich descriptions of contextual information (Fishman, 2013). Data in the form of recordings of and notes on therapy sessions (containing non-verbal and verbal behaviour), are gathered. Such data can be used to construct narrative accounts of therapeutic processes. A system of bottom-up inductive knowledge is applied. Such a system can provide a basis for

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formulating clinical guidelines for making decisions in the therapeutic process applied in practice (Creswell, 1998).

In practice clients differ across many demographic characteristics such as age, race, gender, socio-economic status, historical, and cultural background. Individual case studies allow for the exploration of these differences (Fishman, 2013). Furthermore, clients tend to present with different problems and multiple disorders and have complex and varied life circumstances. These differences affect the outcome of therapy in that they can influence the therapeutic relationship, the implementation of the therapeutic model used, treatment contracting, and compliance with treatment. Individual case studies are more suited to allow for the exploration of these differences (Fishman, 2013). The nature of qualitative data analysis can capture these characteristics and explore the effects on the therapeutic process.

According to Kazdin (2003), research is a human endeavour that is influenced also by the researchers' values, ideas, beliefs, and histories. Therapists likewise vary in terms of characteristics and background such as experience in working with certain therapeutic techniques and modalities. All the above variations (and the interactions between them), impact the therapeutic process and the therapeutic relationship (Edwards et al., 2004). These characteristics and influence thereof can be explored through the qualitative approach.

Following this, pragmatic case studies have the potential to bridge the divide between research and practitioners, and qualitative versus quantitative research debates as they use both quantitative (positivistic) and qualitative (interpretive) analytical methods. They can complement randomised control studies in that they can be used to analyse individual, significant cases such as one that failed to change compared to one that was successful (Fishman, 2013). The qualitative aspect of this design offers rich description. The data is directly observed in context and carefully documented. This lends itself to the description of the therapeutic process (Fishman, 2013; Peterson, 1991) and allows the researcher to examine

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the therapist's responses and the client's reactions as related to change in the therapeutic process. The quantitative data attained through measurement, using for example questionnaires, lends itself to statistical analysis. This data can then be used to quantify any change in target areas due to therapeutic intervention.

Practitioners rarely consult research to learn more about therapeutic processes, as they do not find research results useful for application to practice. Some researchers have responded to this criticism by seeking, in their research, to develop the kind of contextual knowledge that is needed to guide psychotherapy practice (Edwards et al., 2010). However, it is difficult to control research applications in applied settings when investigating treatment and interventions (Kazdin, 2003) to gain this type of useful, contextual knowledge. The pragmatic case study lends a systematic approach and structure to research in naturalistic settings. In this way, complex data is organised so as not to lose sight of the central premise (McLeod, 2010). The methodology and mixed method approach lend further rigour and thoroughness to the process. Although this doctoral study is heavier with qualitative data, the psychometric tests and analysis brings in a quantitative element and is thus described on this basis as mixed methods. The pragmatic, embedded case study method utilised in this study is therefore both rigorous and relevant to practitioners.

3.1.2. Pragmatic, embedded case studies and the Disciplined Inquiry model

The Disciplined Inquiry model of professional practice conceptualises therapy as a complex adaptive system comprising several interconnected parts that do not have a linear relationship, but rather reciprocal loops feeding back into each other (Peterson, 1991). Reports are written up in a linear fashion and it is difficult to capture the overlapping and dynamic, practical process that is represented by this written structure. This approach attempts to conceptualise the study of the non-linear, fluid process of therapy in practice. This process also takes place between two or more people that bring further dynamics and idiosyncrasies. These factors

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and the changing internal and external environments of both client and therapist influence the outcome of therapy. This is a complex interaction of nonlinear relationships between client, problem, and therapist which are reciprocal and causal, and influence therapy outcome (Goodheart, 2011).

Peterson's (1991) model of Disciplined Inquiry is the template upon which Fishman's (2013) systematically structured pragmatic case study reports are based (McLeod, 2010). The flow of knowledge begins from the goals and problems of the client. The therapist forms a case conceptualisation according to the therapeutic theoretical framework. From this, a treatment plan is devised, and the progress of the case is monitored. As therapy proceeds, conversations take place with the client. If the client's goals are not met, then a reformulation takes place. Responsiveness to these feedback loops is an integral part of Fishman's (2006; 2009; 2013) pragmatic case study structure (McLeod, 2010). The model recognises the fluid and interactional nature of the various components of the systematically structured pragmatic case study reports provided by Fishman (2013).

On a micro level the disciplined enquiry model allows for the exploration of the interactional aspects of the therapeutic process in the form of the feedback loops between client and therapist (Peterson, 1991). The client and therapist respond to each other, and their actions depend, in part, on the other's responses. This conceptualisation allows for the exploration of the way in which the therapist chooses various responses throughout the therapeutic process. Therapists need to be flexible, adapting their responses to the client to facilitate the therapeutic process (Edwards, 2009). This adaptation is akin to the concept of appropriate responsiveness (Stiles, 2009). In this way case studies present the lived experience of both client and therapist (Goodheart, 2011). The structure of the pragmatic case study report is described below.

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3.1.3. The structure of the pragmatic case study method report

Each of the case studies in the following chapters adheres to the structure implemented by the pragmatic case study design (Edwards, 2018). This design includes five steps:

- *Contracting:* This is a contract between therapist and clients around the nature and implementation of the intervention. Clients are more motivated to engage in the process if they understand the rationale. If the case studies are for research purposes, the participant needs this knowledge to give informed consent (McCleod, 2010). In this doctoral study contracting was established in the first two sessions before therapy commenced. Due to the embedded nature of the case study, the contract was formed with the mothers, teachers, and children. The contracting phase was not a discrete element of the process. Due to the feedback loops contracting was a process that was adjusted throughout the study. The therapist's understanding of the client's problems and the causes thereof (case formulation), as well as the planned intervention, is shared with the client/s. The client, as a consumer, has a right to know what the therapist is offering; the transparency promotes a shared understanding of the goals of therapy and how these will be achieved (Horvath et al., 2011). This process also promotes the therapeutic relationship (Horvath et al., 2011) as does the extent to which client and therapist agree on goals, and the extent to which they agree upon tasks of the therapy (Horvath, et al, 2011).
- *Assessment:* The therapist gathers information to gain knowledge around the case and to determine whether a particular psychological intervention is appropriate (Edwards, 2018). Along with conversations between client and therapist, this step usually includes self-report scales that can be used for both seeing whether the intervention is appropriate and monitoring change throughout the therapeutic

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process (McLeod, 2010; Young & Edwards, 2013). The self-report scales do not need to be standardised due to the idiographic emphasis of the pragmatic case study (Edwards, 2018). Forming an alliance between therapist and client is a crucial element in this step. The alliance includes the overall connection between client and therapist (Horvath, et al, 2011). An individual case conceptualisation and treatment plan is devised from the assessment data (Fishman, 2013).

- *The development of the case formulation:* This is a set of clinical hypotheses about the events or processes that led to the development of the difficulties and the maintenance thereof in the present (Edwards, 2018; McLeod, 2010). The information gathered during the assessment phase provides the basis for this case formulation (Edwards, 2018). Again, adjustments are made throughout the process as information is gathered and understanding developed.
- *The intervention plan:* The interventions that will address the clients' difficulties and bring about change are selected. The choice of these interventions is based on literature and on the case formulation (Edwards, 2018). This plan is implemented over the course of therapy (Fishman, 2013).
- *Implementation and evaluation of impact:* The plan is implemented, and therapeutic process undertaken. The process is tracked, and progress monitored (Edwards, 2018). The therapeutic process is different for every client due to responsivity (Edwards, 2010).How the client responds to the therapist influences the therapist's ensuing response, and it will be unique to each client/therapist pairing (Kramer & Styles, 2015).
- All of the above elements were included in the case study reports written up in chapters 4, 5, 6 and 7. They form the basis of these reports under the following sections: *assessment,* this includes the contracting section which mainly occurred in

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the first two sessions of therapy; *case formulation* which includes the treatment plan and the *treatment implementation* (Edwards, 2018). A section on *evaluation* is included which examines the various test results along with verbal reports from the mother and teacher.

There are feedback loops that transform this static written representation into an interconnected fluid process. The clinical process (implementation) is subjected consistently to therapy monitoring which generates feedback loops (Petersen, 1991). If therapy is not proceeding well, then changes in case formulation and treatment plan may be required. If it does go well, in that it meets the needs of the client, and therapist and the client agree that treatment is no longer necessary, then therapy may be terminated. A concluding evaluation is made which feeds back into either confirming via assimilation the original case conceptualisation or adjusting the original conceptualisation through accommodation (Fishman, 2013).

Best practice calls for a systematic narrative description of the therapeutic process, linking it to the theoretical themes and processes from the formulation and treatment plan. It involves systematic evaluation of qualitative information and the use of quantitative measures and outcomes (Fishman, 2013). This is facilitated by the structure described above.

In summary, the pragmatic case study is rigorous and systematic, related to a scientific research design by the utilised mixed method model. It is responsive to practitioner needs by directly linking research to actual clinical practice of therapy via the individual case. The qualitative data are descriptively rich, directly observed in context, and carefully documented. Quantitative data is rigorous and suited to statistical analysis. The data is interpreted within the context of a scholarly, theoretical, empirical, and peer-reviewed literature. The more case studies are collected, the more power there is to generalise information to contribute to theoretical and practical knowledge of therapy (Fishman, 2013).

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3.2. Clinical Methodology

The clinical methodology refers to the paradigms and procedures that guide the clinical process (Edwards, 2007). The case study research process described above mirrors the therapeutic process and best practice. In this current study, the pragmatic case study model described above was applied to the therapeutic process below to bring rigour and structure (Edwards, 2018). The objective in this current study was to use evidence-based therapies, to reduce disruptive, impulse control and conduct disordered behaviours in children in South African schools and examine the process and efficacy of the intervention.

The format of the description and analysis of the pragmatic case study is written up within in the disciplined inquiry model conceptualisation of therapy with a focus on the client's process and feedback loops within the therapy (Fishman, 2013). The case study reports found in the following chapters were written up according to three sections (Edwards, 2018): *assessment,* this included the *contracting* section which mainly occurred in the first two sessions of therapy; *case formulation* which includes the treatment plan and the *treatment implementation* (Edwards, 2018). A section on *evaluation* is included which examines the various test results along with verbal reports from the mother and teacher. The pragmatic case study method as applied to the therapy process in this doctoral study is described below.

3.2.1. Assessment phase

The therapist gathered information to gain knowledge around the case and to determine whether an MST (Swenson et al., 2005) approach utilising REBT (Diguiseppe et al., 2014) evidenced techniques and therapies were an appropriate intervention for these participants. Different sources of data were utilised (Edwards, 2018).

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3.2.1.1. Initial screening interview

The principal of the school was approached, and the study and its goals, as well as the definition of disruptive, impulse control and conduct disordered behaviour were explained to her. The principal then identified children regarded as demonstrating behaviour related to disruptive, impulse control and conduct disorder that was out of keeping for the school context. She then approached the parents and teachers of those children to gain permission for me, the therapist/researcher, to approach them to participate in the study. This process was facilitated in part by means of a letter (appendix A) written by me, the therapist/researcher, in which the study and its aims were briefly described. Initial interviews were then carried out with the teachers as they were the level of the system that first identified disruptive, impulse control and conduct disordered behaviour in the classroom. They were asked to confirm the principal's initial assessment of the identified children. Each parent was then called in for an initial interview and the study was explained to them, as was their role in it and what would be expected. Their opinion of the child's behaviour at home and in the classroom was attained. Sometimes the behaviour at home was identified as being different to that which was described in the classroom.

The target behaviours for each participant were established by the schoolteachers and parents and verified by the therapist. I, the therapist/researcher, then verified that the target behaviours fell within the category disruptive, impulse-control and conduct disordered behaviour as defined in Chapter 1. The first and or second interviews were utilised to assess whether the children fit the criteria for disruptive, impulse-control and conduct disordered behaviour as defined in this thesis and the context by including the teachers and parents likewise verified this fit in accordance with the context (APA, 2013).

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3.2.1.2. Contracting phase

This was included in the assessment phase in this report. In the initial two screening sessions the research goals, and what would be entailed in the therapy were explained. All the details described below, were written up in a consent form and given to each participant. I, the researcher/therapist worked through the consent form with each participant. The requirements of each participant were explained: the self-report forms that would have to be filled in, the regular therapy sessions to be attended, and the contingency management (Kazdin, 2000) process. Permission to record the sessions was also obtained.

The limits of confidentiality were explained. As the case studies supply rich detail there is a possibility that those from the participant's immediate context could identify them even though pseudonyms were used and identifying data was removed as far as possible (Edwards, 2018). The people who would have access to the data were identified, and the way results would be disseminated was explained. The benefits of taking part in the study were discussed. This process was repeated for each participant: the child, the teacher, and the parent.

The premises of the therapeutic approach and the techniques to be utilised were explained to the participants so that they understood the approach to be used.

Later in the process, the individual case conceptualisation was shared with each participant (child, teacher, and parent) so that they understood how the therapist saw all the elements of the problem fitting together according to the REBT framework. The therapist then explained what each participant would be required to do to bring about change through the disputation of irrational beliefs and the practice of alternative beliefs through homework assignments. The individual case conceptualization and how thoughts, behaviours and feelings impacted the occurrence of disruptive, impulse control and conduct disordered behaviour was shared only with individual clients and not across the system. In this way confidentiality was

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maintained. The only information that was shared across the different members of the case study was the child's behaviour. The role of contingency management (Kazdin, 2000) or lack thereof in the maintenance of disruptive, impulse control and conduct disordered behaviour was also elucidated to the parents and teachers. In this way the goals and therapeutic process were kept transparent and collaborative between each participant and the therapist.

3.2.1.3. Scales used

The following measurements were used as part of the assessment to gain information around the case. They were also used as part of the quantitative analysis that compares behaviour before and after the treatment phase to monitor any change.

3.2.1.3.1. Conners 3 behavioural rating scale

Mash and Barkley (1998) state that the advantages of using behavioural rating scales during assessment are that they are excellent measures of parental and teacher perceptions of the child. The four-point likert scales are designed for children six–18 years of age. It includes five empirically derived scales: *hyperactivity/impulsivity, executive functioning, learning problems, aggression*, and *peer relations* (Conner, 2007). The test was used in this current study as an indication of change, or lack thereof, in the perception of teacher and parent regarding the children's behaviour. They were also used as an initial baseline of behaviour. The Conners Teacher Rating Scale (Conners scale) (Conners, 2007) is widely used and recommended for assessing children with behavioural problems (Mashalaba, 2004). The standard norms are said to be robust and appropriate for use across different ethnic groups (Conner, 2007). However, they are not standardised for the local context of South Africa. No specific rating scales for ADHD and related disruptive behaviours have been standardised in South Africa, but the Conners Parent Rating Scale and Conners Teacher Rating Scale are often used (Flisher & Hawkridge, 2013). As a result, they were used in this context.

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The Conners Scale 3 (Conners, 2007) was filled in by both parents and teachers before and after therapy and this allowed for perceptual comparisons of behaviour across the different levels of the system. The short form was used, as it was user-friendly for the participants. As the children do not necessarily have to meet the DSM-5 (American Psychiatric Association, 2013) criteria for an official diagnosis, the short form was considered an adequate measurement instrument. Descriptions of the various categories are found in table 1 below.

Table 1

Descriptions of the Scales Categories for the Conners Teachers' and Parents' Forms

Scale	Common Characteristics of High Scorers
Inattention	May have poor concentration/attention or difficulty keeping his/her mind on work. May make careless mistakes. May be easily distracted. May give up easily or be easily bored. May avoid schoolwork.
Hyperactivity/Impulsivity	High activity levels may be restless and/or impulsive. May have difficulty being quiet. May interrupt others. May be easily excited.
Learning Problems/Executive Functioning (LE total)	Academic struggles. May have difficulty learning and/or remembering concepts. May need extra instructions. May have executive deficits.
Learning Problems (LE subscale)	Struggles with reading, spelling, and/or math. May have difficulty remembering concepts.
Executive functioning (LE subscale)	May have difficulty starting or finishing projects, may complete projects at the last minute. May have poor planning, prioritizing, or organizational skills.
Defiance/Aggression	May be argumentative; may defy requests from adults; may have poor control of anger or may lose temper; may be physically and/or verbally aggressive; may show violent or destructive tendencies; may bully others; may be manipulative or cruel. May have legal issues.
Peer Relations	May have difficulty with friendships, poor social skills, limited social skills. May appear to be unaccepted by group.

*Learning problems and executive functioning appear as one category in the teachers Conners scale.

Relevant statistical properties. The raw scores were changed into scaled scores as dictated by the scoring criteria of the test. The scaled scores were transformed to t-scores. The psychometric properties utilised in the statistical analysis were the Cronbach's alpha and

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standard deviations for the parents and teacher's short version of the test available in the Conners manual and found in appendix (Conners, 2007, pp. 237, 239, 263). The t-scores interpretations are listed below in table 2.

Table 2

Table Showing Conners Rating Scales Ranges and Their Interpretation

T-Score	Percentile	Guideline
70+	98+	very elevated score (many more concerns than are typically reported)
65-70	93-97	elevated score (more concerns than are typically reported)
60-64	84-92	high average Score (Slightly more concerns than are typically reported)
40-59	16-83	average score (Typical levels of concern)
<40	<16	low score (fewer concerns than are typically reported)

3.2.1.3.2. Irrational belief scales

The measures used for assessing irrational beliefs in parents, teachers, and children are based on Albert Ellis's model of rational-emotive therapy (Bernard & Cronan, 1999). The following self-reporting Likert scales were completed by teachers, parents, and children before and after therapy:

- Child and Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015)
- Revised Belief Scale for Parents (PIBS) (Joyce, 1995) and
- Teacher Irrational Belief Scale (TIBS) (Huk et al., 2019)

These scales are not standardised but as the pragmatic case study's emphasis is ideographic, this is acceptable (Edwards, 2018). These scales helped to identify the irrational beliefs across the different levels of the system. They were also used to assess any changes in irrational beliefs of the children, parents, and teachers before and after the therapy process.

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The Revised Belief Scale for Parents

The Revised Belief Scale for Parents (PIBS) (Joyce, 1995) was used in this study. This version consists of 24 items as opposed to the original version that consisted of 60 items (Berger, 1983). It is a three-point likert scale in which three factors were identified:

Demandingness, this category of irrational beliefs contains absolutist, rigid beliefs which include should, ought to, have to and must statements.

Low frustration tolerance (LFT), these beliefs assert that one cannot tolerate an event or situation.

Self-worth (SW): Global evaluation of human worth. In this belief category, individuals are valued according to their success and skills (Joyce, 1995).

Total: This represents the average of irrationality across the three scales.

The relevant psychometric properties of the test are the Coefficient Alpha (0.75) and the standard deviations found in Joyce (1995, p.799). The raw scores were adjusted to scaled scores. In this scale, the higher the score the more rational the thought. The questionnaire for the PIBS is found in appendix F.

The Teacher Irrational Belief Scale

The TIBS scale is a 22 item likert scale (Huk et al., 2019). There are four different subscales. Description of the sub-scales on the TIBS are as follows:

Self-Downing (SD): corresponds to self-oriented demandingness, namely *"I must do well, or I am a bad person."*

Low frustration tolerance (LFT): A high score on this subscale represents the belief that teaching should be easier than experienced and require less effort.

Attitudes towards the school organisation: Items on this subscale are related to teachers' needs to be involved in the running of the school, i.e., that they be involved in decision-making, that their problems be listened to, etc.

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Authoritarian attitudes towards pupils: A high score on this subscale implies intransigence towards the discipline problems of the pupils. Respondents believe that they cannot stand the children misbehaving and that in such cases, they should be severely punished (Popov et al., 2015).

The *total average score represents* the average of irrationality across the four sub scales.

The raw scores were changed into scaled scores as dictated by the scoring criteria of the test. The psychometric properties utilised in the statistical analysis, the Cronbach's alpha and the standard deviation were taken from Huk et al., (2019 p.799). In this scale the lower the score the more rational the beliefs. The questionnaires for the TIBS are located in appendix E.

The CASI irrational belief scale

The CASI (Kassay et al., 2015) is 36 items, five-point likert scale (Kassay et al.,2015)

A description of the children's irrational belief sub-scales are as follows:

Demand: demands for fairness and how the world 'should' or 'must' be

Low frustration tolerance (LFT): Intolerance of Frustrating rules or work

Other downing (ROW-O): others are bad people

Self-downing (ROW-S): 'I am not good enough'

Awfulizing: Evaluating a situation as the worst thing that could happen

Total: the average of the five scales

The raw scores were changed into scaled scores as dictated by the scoring criteria of the test (Kassay et al., 2015). The psychometric properties utilised in the statistical analysis the Cronbach's alpha and the standard deviation. These were supplied by St John's University, New York, and were derived from a South African population. In this scale the lower the score the more rational the beliefs. The questionnaires for thee CASI are found in appendix G.

The clinical interpretation of the standardised scores is represented in table 3 below.

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Table 3a

The Irrational Belief Scale Ranges and Interpretation of Scores

Clinical Interpretation of Scores Range	
4.0-5.0	High Level of Endorsement of Irrationality; Target for Clinical Intervention
3.0-3.9	Moderate Level of Irrationality; Consider as Secondary belief or situational
1.0-2.9	More Rational Philosophy Endorsed; Explore What Cognitions May Lead to Presenting Problem

The PIBS (Joyce, 1995) is a three-point likert scale.

In this scale the higher the score, the greater the rationality.

Table 3b

The PIBS Ranges and Interpretation of Scores

Clinical Interpretation of Scores Range	
1 - 1.67	High Level of Endorsement of Irrationality; Target for Clinical Intervention
1.67 - 2.34	Moderate Level of Irrationality; Consider as Secondary belief or situational
2.35 - 3	More Rational Philosophy Endorsed; Explore What Cognitions May Lead to Presenting Problem

Statistical test: As stated, all the responses across the different questionnaires were changed to standardised scores according to the dictates of each test. A reliable change (RCI) index (Jacobson & Traux, 1991) was used to establish whether any noted change in the standardised scores could be interpreted as significant or not. For a change to be regarded as greater than the measurement of error it must attain a 5% level of significance. The reliable change index (RCI) (Jacobson & Traux, 1991) must be greater than or equal to 1.96 to be in the 5% tail of error distribution and therefore not due to error of measurement.

The Conners Manual provides reliable change index scores for t-scores (Conners, 2007, pp. 262–263). These reliable change scores attain a 10% level of significance only and these were used to corroborate the reliable change index statistical procedure that was carried out on the Conners 3 (Conners, 2007) raw scores.

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Behavioural charts

Behavioural charts constructed by the therapist in collaboration with teachers and parents were used to measure baseline behaviours and the nature and frequency of the child's identified target behaviours (Mashalaba & Edwards, 2005). The target behaviours were identified by parents and teachers in the initial two interviews. The behaviour of the children was observed and measured for three weeks before the therapy was introduced. The parents and teachers indicated whether the behaviours were good, moderate or bad. The charts were administered by the parents and teachers initially to track the identified target behaviour and any changes that occurred throughout the therapy process. These charts were likewise used to administer the contingency management (Kazdin, 2000) of the children and in that way also formed part of the treatment phase in that they rewarded the child for good behaviour and discouraged bad behaviour either with lack of reward or punishment. The children were also involved in identifying the contingencies for the home context that they considered rewarding and appropriate. The charts were therefore constructed collaboratively by the child and parent with my, the therapist/researcher, assistance. This ensured that the contingencies used were effective for specific children and therefore more likely to be successful in bringing about change. The process of collaboration between parent and child helped to unite them in setting a common goal and enhanced the engagement and motivation of the child in the process of behaviour change. Consultation with the therapist/researcher helped to build an alliance necessary for the therapeutic relationship between therapist and child.

As the charts were erratically completed, they were not, in the end, used to measure change in behaviour but rather as part of the treatment process in that they encouraged contingency management (Kazdin, 2000) of behaviour.

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3.2.1.4. Cognitive testing

Psychometric testing was used to establish an indication of the child's cognitive strengths and weaknesses, possible learning problems, and general IQ score. REBT techniques utilise cognitive ability and memory, therefore cognitive ability could affect the success of the interventions (DiGuiseppe et al., 2014; Feindler & Ecton, 1988). These interventions are sometimes thought to require cognitive abilities in the average intellectual range (Feindler & Ecton, 1988). However, the child in the study carried out by Mashalaba and Edwards (2005) had below average cognitive ability, yet nevertheless responded to similar therapeutic techniques.

In this study, cognitive assessment was used to enhance the case conceptualisation of each child in terms of understanding their general cognitive profile and to add detailed information as to the interplay between cognitive ability and its possible effect on REBT (Diguiseppe et al., 2014) intervention. The Senior South African Individual Scale-Revised (SSAIS-R) (Van Eeden, 1991) was used to assess cognitive functioning of the child. The SSAIS-R (Van Eeden, 1991) is standardised on home language English and Afrikaans speakers only. So, it was statistically valid for only some of the children in this sample. However, all children were taught in English and used a mixture of vernacular and English at home. The test was used to get an indication of the participants' cognitive functioning only. It was not used for diagnostic purposes. It was however a useful indicator for co-morbid conditions such as attention deficit/hyperactivity disorder.

3.2.1.5. Background and life history

The assessment also included taking the clients' history such as gathering information around living situation, symptoms, and other problems. These details were attained in the initial two interviews with teachers, parents and children and details were added throughout the therapeutic process (Fishman, 2013). A detailed history of the children, their school

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behavioural problems and the family background was taken. As the teachers and parents also received the REBT (Diguiseppe et al., 2014) cognitive restructuring therapy their backgrounds were also taken and later related to the development of their irrational beliefs regarding teacher/parent roles and discipline of the children. Again, this information was gathered over the process of therapy at different times depending on the participant and developing alliance between client and therapist.

Background and history of the problem behaviour was also attained from the child. How they saw the problem, when it began and how they experienced their family and history was explored in the initial interviews and throughout the process.

3.2.1.6. Establishment of client-therapist relationship.

The alliance between client and therapist was established according to the REBT theoretical framework. The relationship in this approach is collaborative, so the process was made explicit, and the goals were agreed upon. The boundaries and expectations for therapy (such as the time limits and future homework assignments and client expectations) were likewise established (DiGuiseppe et al., 2014, Edwards, 2018). One of the main problems in establishing rapport in this current study was that none of the participants asked for therapy; they were identified and referred by the school because of their unacceptable behaviour. As is standard in REBT, rapport was established through doing therapy and through the collaborative and transparent approach to the process (DiGuiseppe et al., 2014). Relationship had to be established across each of the different levels of the system with children, parents, and teachers. The assurance of confidentiality in therapy seemed to assist in building the therapist/client relationship, in most cases.

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3.2.1.7. Summary

All the above assessments gave information around the target behaviours and relevant contributing contingencies for the individual participants. The irrational belief scales gave information about the irrational beliefs to be treated across the different levels of the system. All this information was used as a basis for case conceptualisation and developing the treatment plan. The irrational beliefs and target behaviours were used as examples to identify the triggers of thinking, feeling, and behavioural sequences to be identified and treated. The collaborative process gave the opportunity for alliance forming between the participants across different levels of the system and with the therapist. The information from the tests was also used to monitor the behaviours and beliefs across time.

3.2.2. The development of case formulation

The case formulation is a hypothesis of the aetiology and maintenance of the presenting problem. This formulation was based on the assessment data gathered in the first step of the process described above (Edwards, 2018).

I, the therapist/researcher, used my theoretical orientation in the conceptualisation. According to the REBT model, there are three main psychological aspects of human functioning, specifically thoughts, emotions, and behaviour. An REBT case conceptualization connects the participants' behaviour with their emotions and beliefs. It provides information of the aetiology of the participants' difficulties in that behavioural problems are seen to be connected to irrational thinking and accompanying feelings. Adherents to this model consider it to be both multimodal in conceptualisation and integrative. Change in one aspect will bring about a change in another, as all three are intertwined and interconnected. If a client thinks about a situation differently, they will likely feel differently and then behave differently. Changes in behaviour can likewise bring about difference in thinking and feeling. In the experience of an activating event (a), if there is irrational thought (b), there will follow a disturbed emotion (c). If the irrational belief is

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challenged and replaced with a rational belief (d), then a new emotional and behavioural consequence will occur (d) (DiGuiseppe et al., 2014). The REBT case conceptualisation identifies these connections and the irrational beliefs: the inferences which are the second level of cognitions, the evaluative/irrational beliefs, and the more central imperative demands that are likewise classified as irrational. The irrational beliefs can originate from the participants' background. Each conceptualisation is flexible and idiosyncratic to the individual client (DiGuiseppe et al., 2014). The case conceptualisation forms the basis for the treatment phase (Edwards, 2018).

In this doctoral study these formulations were carried out on an ongoing basis for each participant at the different levels of the system: the teachers, parents, and children. How the behaviour was sustained by the context was also examined within the REBT framework (DiGuiseppe et al., 2014). The ecological case study method allowed for the exploration of the responsiveness (Stiles, 2009) of irrational beliefs across the different levels of the system and how these interacted to maintain the disruptive, impulse control and conduct disordered behaviour.

The contingency management (Kazdin, 2000) of the target behaviour also addressed how the behaviour was maintained and then changed due to reinforcement schedules. The collaborative way in which the contingency management (Kazdin, 2000) was established, helped in structuring the interactions between parent and child in a positive manner. Treatment is integrative in that it draws from both cognitive and behavioural interventions. The MST (Swenson et al., 2005) heuristic framework is integrative and used to organise the application of these therapies to the different levels of the system.

3.2.3. Treatment intervention

The case conceptualisation led to a treatment formulation (Fishman, 2013; McLeod, 2010). The intervention plan was established during this phase according to the Multisystemis and

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REBT (Diguiseppe et al., 2014) framework. A full description of the techniques utilised were described in Chapter 2.

The treatment plan was formulated in line with the therapeutic models used (Fishman, 2013). As established, the MST approach (Swenson, et al., 2005) is the overall framework guiding this clinical process and provides an integrative framework for applying REBT. The REBT therapy and techniques were applied to the teachers and parents as well as to the children. This addressed the factors that help to maintain the problem behaviours across the system. The treatments included enabling the client to identify the triggers and irrational beliefs that led to emotional intensity and the behaviour that was linked to it. Awareness of these irrational beliefs led to disputation of them and the development of alternative beliefs that could be associated with adaptive emotions and behaviours (DiGuiseppe et al., 2014). Likewise, the MST (Swenson et al., 2005) approach guides contingency management (Kazdin, 2000) therapeutic approaches across different levels of the system to which the child displaying disruptive, impulse control and conduct disordered behaviour belongs.

Some of the techniques used were:

- Doing cognitive homework to identify irrational evaluative and absolutistic beliefs behind the problematic behaviours.
- The use of cognitive disputation to challenge the absolutist and irrational evaluative beliefs; logical disputation, empirical disputation; metaphorical disputation, and pragmatic disputation; and
- Rational alternatives were derived and established (DiGuiseppe et al., 2014).

The treatment used behavioural based interventions along with the cognitive disputation to change thinking, feeling and behaviour in the children (DiGuiseppe et al., 2014). The parents and teachers were given parent management skills (Kazdin, 2000). The skills helped the parents and teachers to alter the behaviour of children in the school and

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home contexts. Rules and expectations were established. Parents and teachers were taught, through psychoeducation, to use specific procedures to alter interactions with their children, promote pro-social behaviour and decrease deviant behaviour. In the home pro-social behaviour was reinforced while deviant behaviour was punished in an appropriate way (Kazdin, 2000). The rationale being that interactional patterns at home could help to maintain behavioural problems both at home and in the school context. As stated, the collaborative element in the process had the potential to enhance the alliance between child and parent; and in some instances, restructure the interactions within the relationship.

3.2.3.1. Responsiveness and feedback loops

The therapy was implemented and adjusted according to the responsiveness of the client (Fishman, 2013; Edwards, 2018). Therefore, the number of sessions for each participant varied. The techniques used for each participant likewise varied. All sessions were recorder with all participants. Notes were also taken during and after the sessions. Regular measurement and discussion of the target behaviours with parents, teachers, and the children themselves were all used to monitor the progress of the children. In response to these feedback loops, and if therapy was not progressing, then the treatment plan was altered. The therapy, and even target behaviours, were altered in response to the participants' responsiveness, report-back, and monitoring of target behaviour. Termination was planned if it was determined via the measurement of the target behaviour and child, teacher, and parent report that the symptomatic behaviour prompting the referral had been reduce and/or reached tolerable intensity (Edwards, 2018; Fishman, 2013).

3.2.3.2. Different types of sessions held across the school system

As the approach was embedded, the therapy sessions were held with the participants across the different levels of the school system to which the child belonged:

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- REBT (Diguiseppe et al., 2014) principles and techniques were applied to the children identified as exhibiting disruptive behaviours.
- REBT (Diguiseppe et al., 2014) therapeutic principles and techniques were applied to parents' and teachers' own irrational beliefs in relation to the child with disruptive behaviours.
- Parent management skills and contingency (Kazdin, 2000) management were taught to the parents of the children with disruptive behaviours.
- Teachers were taught contingency (Kazdin, 2000) management skills.
- Joint sessions were held between parent and child.

3.2.4. Evaluation of impact

The feedback from all the participants was used to monitor the progress of therapy, so the evaluation section interprets the therapy monitoring. The behavioural charts monitored behavioural change of the child, as did verbal feedback from both teachers and parents. School records of demerits were also used, when available. The psychometric tests further assisted in evaluating the degree of change across all clients/participants. The pre-and post-tests results were compared, and graphical representations were created. The reliable change index (Jacobson & Traux, 1991) was used to compare pre-and post- test results for significant change. At a period of approximately two months post-therapy a follow up phone call was made to the school to establish whether, or not, any changes were maintained.

A summary of the overall therapeutic and research process are depicted below in the form of a diagram (figure 4) adapded from (Fishman, 2013). The pragmatic case study framework is represented showing: client, **assessment/data gathering, case conseptualisation, treatment, treatment monitoring** and **evaluation.** In the written reports the evaluation section interprets the therapy monitoring. This represents how the therapeutic process was carried out and how the research reports are written up across the case study

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chapters. It shows the feedback loops occurring in the therapeutic process via bidirectional arrows. If **therapy monitoring** suggests success the therapy process is terminated, and the information is assimilated into **research/experience**. If the process is not successful the therapist and client return to **case conseptualisation** and the therapeutic process recommences. In this way the therapy process itself is seen as a dynamic system. The **therapeutic relationship** is depicted as a system with bidirectioanl arrows indicating responsiveness (Kramer & Stiles, 2015) between client and therapist. The embedded element of the case study, influenced by systems theory, is represented by the three levels of the system; **parent** (representing the family level of the system),**child**, and **teracher** (representing the school level of the system). The pragmatic case study design is repeated across the levels of the system. The bidirectional arrows represent the interactional nature of the different levels of the system.

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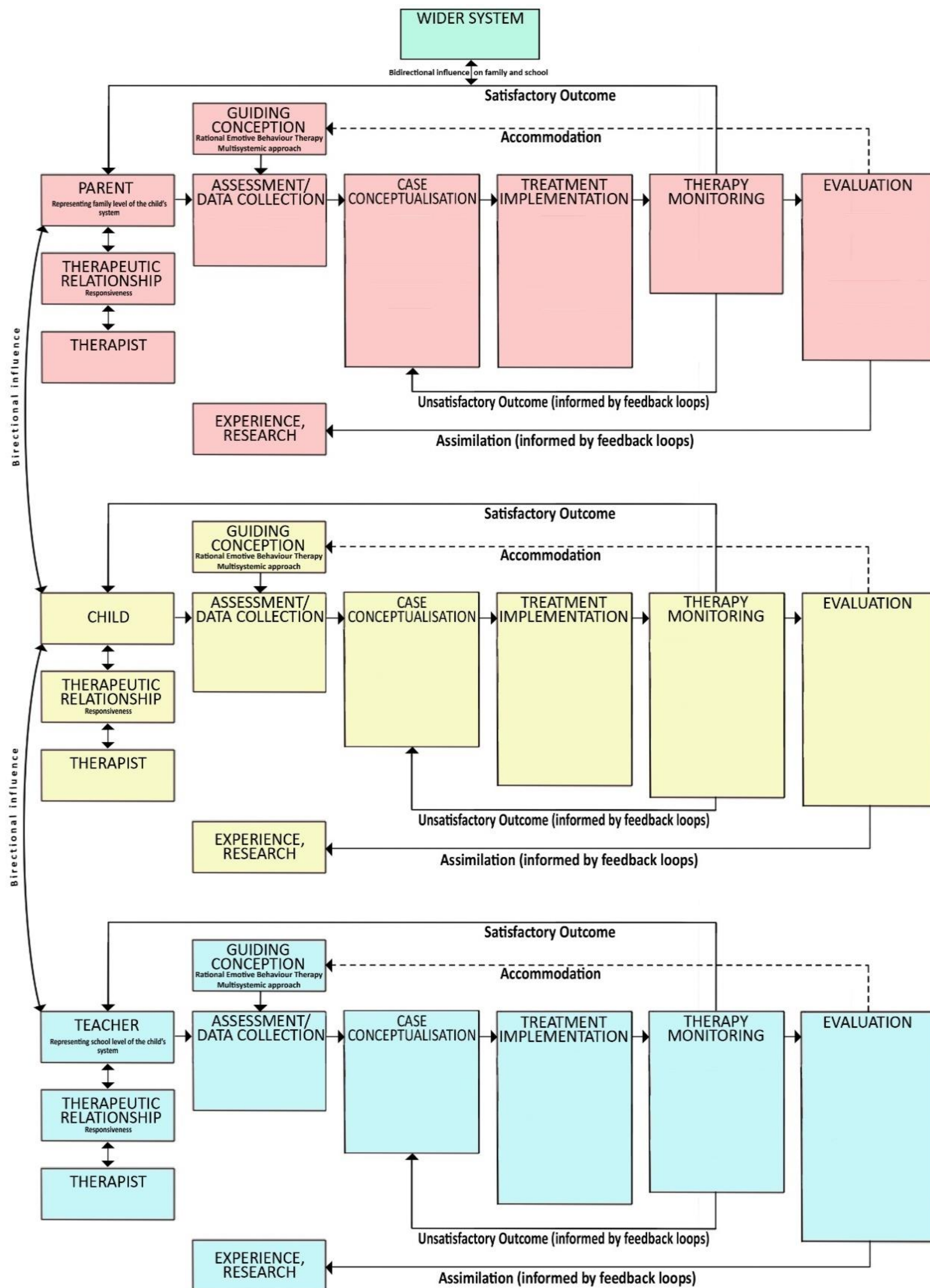
Figure 4

Model of the Therapeutic and Research Process and Framework



This image was produced by Timm in 2022 depicting a model of the embedded case study utilising Multisystemic and REBT therapeutic approaches. It was adapted form D. Fishman, 2013, *Pragmatic Case Studies in Psychotherapy*, *9*(4), p. 425.

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3.3. Sampling Technique

A purposive sampling technique was used, in that participants were chosen because they illustrated some feature or process that was of interest to the study (Harsh, 2011). As alluded to above, children were identified to participate in this study because they exhibited symptoms of disruptive, impulse-control, and conduct disorder behaviours in school and were then selected for the sample because they exhibited the behaviour of interest. The school principal identified potential children. The teachers and the children's parents were consulted to confirm the problem behaviours.

The participants, children, their teachers, and parents were taken initially from six schools, the sample used in this study came from three different private schools in the Gauteng area. The private schools were chosen as it was easier to gain access to working in them compared to government schools. Schools were approached and asked if they had children with disruptive, impulse control and conduct disordered behaviour. If they had such children in the school and agreed to be a site for the study, then the therapy process commenced. Of the cases written up in this study, two were primary schools and one was a high school.

3.3.1. Participants

Nineteen children were referred for the study. Of these, one child was not included due to already being in therapy. Another child was not included, as the parents were in an acrimonious divorce process. The mother agreed to the therapy but did not want the father to know about the process. Three children who were initially included, moved to different schools, and did not complete the therapy. Data from a further seven children was lost due to the theft of the device on which the data were stored. At the end of the process, seven case studies were carried out and the data retained. Of these seven children, all were male (American Psychiatric Association, 2013). Only one female was referred, and her data was

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lost due to theft. The four children written up in this current study all displayed disruptive, impulse control and conduct disorder behaviour according to the criteria as summarized in Chapter 1 of this study and were male. They ranged in age from 11-13 years of age so were capable of abstract thinking according to Piaget's theory (DiGuiseppe et al., 2014). Other than in gender, all children varied in demographics, three boys were black African in race, and one was white. The economic status varied, two children came for underprivilege backgrounds, one was from an affluent background, and one was from a lower middle-class background. Two children lived with both parents and two lived with their mothers only and had limited contact with the fathers. All four studies chosen revealed some common patterns across their data and were chosen for this reason (McLeod, 2010). Two case studies were considered particularly successful according to the REBT cognitive restructuring framework and were chosen for this reason. The other two were chosen as they came from an underprivileged background and lived in areas considered to be violent. These areas are underexposed to therapeutic intervention of any kind and the children were chosen for this reason. Of these two case studies, one mother (Neo's) dropped out, yet some success with behavioural change in the child was still attained which was why this case was included. Case studies were thus chosen as they showed common patterns or had an idiosyncratic detail that was of interest (McLeod, 2010). The diversity in the sample was deemed useful for case law as explained below under the section on case study rigour (Edwards et al., 2004).

3.3.2. Inclusion criteria

Although the children chosen for this study had to display symptoms of disruptive, impulse-control, and conduct disorder behaviours as described in Chapter 1 of this study, they did not necessarily have to meet the DSM-5 criteria for diagnosis. These criteria were used as a reference for the types of behaviours indicated, but they were considered by their teachers to exhibit inappropriate behaviour for the school context (APA, 2013; Gordon & Browne,

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2004). As such the context was considered in the diagnosis (APA, 2013). All case studies written up in this current study did meet the DSM-5 (APA, 2013) criteria.

Subsequently the participants were screened by me, the therapist/researcher. The participants would only be included if I, the therapist/researcher was satisfied that they met the criteria for disruptive, impulse control and conduct disordered behaviour according to the definition elucidated in Chapter 1 of this study. They had to be proficient in the English language as the therapy was conducted in English; therefore, only schools that taught in English were approached.

Private schools were approached to participate in the study, because permission to conduct the research was easy to attain. These schools were small private schools that did not only cater for children from affluent backgrounds. The infrastructure of the schools was considered, for the most part, to be functional, even though one school lacked resources. The schools were all within a maximum of 40 minutes travel time by car from the researcher's/therapist's home.

3.4. Ethical Issues

Ethical issues around case studies are more complicated than that of statistical, anonymous research, as the process is described in rich detail, and this reaches the public domain (McLeod, 2010). It is therefore important to consider issues around informed consent and confidentiality. Informed consent means knowing consent, in that the participant and their legal guardian are enabled to knowingly choose to participate in the study and the possible ramifications thereof (McLeod, 2010; Walters et al., 1997), and that they have the right to withdraw at any time (Kvale, 1996). This requires that a full explanation of the study must be given to the participant in a language that is understandable to them (Anastasi & Urbina, 1997). Informed consent in this study was attained from the specific schools involved, the

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parents of the children, teachers participating, and the children themselves gave accent in the initial interviews prior to the commencement of therapy.

Any limitation regarding confidentiality was discussed with the participants (Anastasi & Urbina, 1997). It was communicated with the client in the initial interview, that as the therapy was to be written up in the form of a case study, it would be possible that someone may identify them. However, to promote confidentiality pseudonyms were used for the participants (Edwards, 2018; Kvale, 1996; McLeod, 2010). Furthermore, details that could identify the client were changed if they were unimportant to the psychological aspects of the case. For example, broad, rather than specific details are given i.e., the descriptive word "township" is used as opposed to the specific name of the relevant town (Edwards, 2018; McLeod, 2010). Permission was also attained from all participants in the initial screening session to record the process.

If, after the therapeutic intervention was terminated, and further therapeutic intervention was deemed necessary, alternative applicable resources were made known to the participants. My practice was opened to the participants for follow up appointments regarding the issues that were addressed by the study. To date (2019) two participants have returned for a follow up session.

Benefits to the participants in this study were the therapeutic intervention and, for the children specifically, the scholastic assessments screened for learning problems, as these often accompany behaviour problems (Hester, 2002; McLeod, 2010). Information gleaned from the assessments was used as a basis for referral to appropriate intervention with respect to any learning problems.

3.5. Data Condensation

Data condensation refers to methods used to reduce large amounts of data to a manageable size (Miles et al., 2013).

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3.5.1. Sources of data collection

The sources used for data collection were described in detail in the assessment section of the case study report. They are listed here below:

- *Recordings* The data collection in this study included audio recordings of each session (Edwards, 2018; Mahrer, 1988). The instrument used, a voice recorder, allowed for better monitoring of the data than would have been without it. Transcripts were written from these audio recordings (Mahrer, 1988).
- *Notetaking* Notes were taken by the therapist during and after the sessions. Notes from supervision sessions were also utilised. These were used to write up the case studies and plan the sessions that followed.
- *Thought records* Thought records and behavioural experiments were carried out by the client during the session and for homework between sessions. These were used to plan the next session, and as a way of monitoring whether the client could both apply and generalise the disputation (cognitive restructuring) and other techniques when outside of the therapy sessions. They were therefore used in feedback loops to monitor progress (Petersen 1991).
- *Cognitive testing* Psychometric testing was used to establish an indication of the child’s cognitive strengths and weaknesses, possible learning problems in the children, and general IQ level.
- *Irrational belief scales* These scales were used before and after therapy. These were used as part of the quantitative analysis that compares irrational beliefs before and after the treatment phase to monitor any change.
- *Conners behavioural rating scales* (Conners, 2007) These were used as part of the quantitative analysis that compares behaviour before and after the treatment phase

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to monitor any change. As these were filled in by teachers and parents, they gave data from two levels of the system.

- *Behavioural charts* Behavioural charts to monitor behaviours were kept by the teachers and the parents (Kazdin, 2000). These charts identified the behaviours for each child. They were used to monitor behavioural change and thus acted as information for feedback loops as to the success of therapy. They were not used for quantitative data analysis as application in the field was inconsistent. They acted as an indicator to me, the therapist/researcher as to how the behaviour was changing or not.
- *Interviews and verbal reports.* Interviews and verbal reports were also obtained from teachers and parents regarding the behaviours of each child (Edwards, 2018). These conversations were also used to monitor behavioural change and thus acted as information for feedback loops as to the success of therapy (Petersen 1991).

Regarding the tests utilised, none of them were standardised for the South African context. This is acceptable in this study due to the idiosyncratic nature of case studies. The irrational belief scales used in this study are the only scales sourced that measured irrational beliefs within the REBT (Diguiseppe et al., 2014) framework. The CASI (Kassay et al., 2015) was initially developed 30 years ago. The items on the CASI (Kassay et al., 2015) were originally developed in Australia and in a subsequent publication and analysis in 1999 (Bernard & Cronan, 1999). Some South African normative data was attained from St. John's University New York. Subtle differences in language use were noted in the TIBS that influenced item functioning in this US sample (Huk et al., 2019). This could also apply to the South African context. The Conners Rating Scales (Conners, 2007) also has no normative information for the South African context. However, these scales are recognised behavioural scales in South Africa, and thus they are frequently used. There is no other measure for

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disruptive behaviours or irrational beliefs that were standardised for the South African context.

3.5.2. Quantitative data

The quantitative analysis comprised the scoring of the self-report forms which included the irrational belief scales (Huk et al., 2019; Joyce, 1995; Kassay et al., 2015), the Conners Rating Scales (Conners, 2007). Quantitative analysis was applied to the following:

- The behaviour before and after therapy. This was achieved using Conners Rating Scales (Conners, 2007) (within case).
- Irrational beliefs before and after therapy with the children. This was achieved using the CASI (Kassay et al., 2015) (within case).
- Analysis of irrational beliefs before and after therapy with the teachers. This was achieved using the TIBS (within case).
- Analysis of irrational beliefs before and after therapy with the parents. This was achieved using the PIBS (Joyce, 1995) (within case).

These results are graphically represented in Chapters 4 - 7.

A reliable change index (Jacobson & Traux, 1991) was used to establish the significance of the change in scores.

3.5.3. Qualitative analysis

As stated, the case study research process described above mirrors the therapeutic process (Edwards, 2018). In the analysis, the data is summarised into an *assessment phase*; a *case formulation*; and *treatment implementation.* These are presented as a written report in the following chapters that comprise the case study series. Finally, a treatment *evaluation* phase is added. The case conceptualisation and treatment phases are more than data condensation, as they are also interpretive. Although interpretive, the different phases must be grounded in

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observations and information (Edwards, 2018). Direct quotes from the transcriptions and other data contribute to this grounding.

3.5.3.1. Assessment

A clinical theory is applied to the assessment data gathered. In this study the MST (Swenson et al., 2005) and REBT (Diguiseppe et al., 2014) clinical theories were applied to interpret the data. The themes were created by using the theories.

Level one of the data condensation thus comprised a thematic summary of the information attained in the assessment phase in the form of an assessment report (Edwards, 2018) that summarised the client's presenting concern (disruptive, impulse control and conduct disordered behaviour), history, and participants' background. The themes also included information relevant to the research questions such as information about contextual elements that may have affected assessment, or treatment (Padmanabhanunni, 2010).

3.5.3.2. Case formulation

The second level of the data reduction was case formulation, based on the information gleaned from the assessment. Hypotheses were derived as to how the different elements affect, maintain, and contribute to disruptive, impulse control and conduct disordered behaviour. This was an interpretive stage in which MST (Swenson et al., 2005) and REBT (DiGuiseppe et al., 2014) frameworks were applied to the data of the three people involved in the different levels of each embedded case study. In keeping with the REBT (DiGuiseppe et al., 2014) model, the connection between thoughts, emotions and behaviour were an important part of this conceptualisation. How these patterns of interconnected thoughts, behaviours, and emotions maintained the problem of disruptive, impulse control and conduct disorder was conceptualised for each individual in the embedded case study, as well as the interconnect responsiveness, (Kramer & Stiles, 2015) of these different patterns of thoughts,

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feelings, and behaviours across the different levels of the embedded case study. The contingencies around the child's behaviour, or lack thereof, were identified and related to the disruptive, impulse control and conduct disordered behaviour. Predisposing historical events in the life history and context were likewise linked to disruptive, impulse control and conduct disordered behaviour. Following this conceptualisation, hypotheses were derived as to how these different elements affected, maintained, and contribute to disruptive, impulse control and conduct disordered behaviour. A case formulation was thus conceptualised. The process of therapy revealed the accuracy of these hypotheses and the process allowed for the updating of these hypotheses within the case conceptualisation.

3.5.3.3. Treatment implementation

In the third step, a narrative of the treatment process was told. The therapy narrative is a chronological record of what occurred in the therapy sessions. This narrative was constructed from therapy and supervision notes, together with the recorded sessions, the latter being selectively transcribed. After initial transcribing, the data was read and re-read to gain familiarity (Rice & Ezzy, 1999). The elements were selected according to the research questions and therapeutic framework. The narrative account is therefore thematic according to the research questions and therapeutic framework (McLeod, 2010; Padmanabhanunni, 2010).

The case study draws on central themes that answer the research questions and aims. The questions were directed at what interventions were used, which ones were successful and which ones were less effective. This is again an interpretive step. Other themes brought up by reflection on the case were likewise included. The repetitive and contrasting patterns (themes) were identified. The themes, questions, and clinical approach became lenses through which I, the therapist/researcher, analysed the case to answer and reflect on the research questions.

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The relevance of the case study to the questions was made explicit. The data gathered through the case studies provides the evidence for the conclusions drawn (Edwards, 2018).

The process of writing up narratives was reflexive. It resulted in returning to rewrite the narrative after reflection or writing up other case studies. If an aspect in one case recurs in another, then the context in which it occurs is examined in both cases to make sure it is adequately represented. Contrasting and idiosyncratic themes were likewise noted. This process facilitated cross case comparison (Padmanabhanunni, 2010). Likewise, aspects in literature that occurred were also illuminated. Petersen's (1991) feedback loops, and the concept of responsiveness, were used as analytical concepts to evaluate the process of change in therapy and responsive interaction between therapist and client. Due to the MST (Swenson et al., 2005) lens, this concept was also used to look at the feedback loops between the irrational/rational beliefs of the members of the embedded case study/system to illuminate how these feedback loops held the problematic behaviour of disruptive, impulse control and conduct disorder in place or facilitated change due to change in the irrational beliefs as a result of intervention. Contingency management (Kazdin, 2000) was also explored for change in application and associated behavioural change.

3.5.3.4. Evaluation

An evaluation section was added which used the various tests described above, irrational beliefs and Conners Rating Scales (Conners, 2007) along with verbal feedback reports on behaviour from the teacher and the mother of each child, to evaluate the effectiveness of the therapeutic process in each case study.

3.5.4. Data interpretation

This section describes the case-by-case, and across case analysis of the case studies to answer the research questions.

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3.5.4.1. Phase one

This phase includes the case-by-case analysis of the case studies according to the research aims and questions. The case narrative was examined with such questions as the following in mind:

- Was the treatment model useful for this particular client?
- What aspects of the therapy did the client find most useful?
- Were there any aspects of the client or context that impacted on the implementation of the treatment model?

Once the themes have been identified in this process, the literature was searched for any information that illuminated the identified themes, client, and treatment process. In this way the best explanation for the outcomes and dynamics of the process and treatment outcomes was given. To ensure rigour of the interpretations, the lead research supervisor at the host university reviewed the interpretations of the narrative to see whether these were credible. The interpretations were written in the case-study format described above (Padmanabhanunni, 2010). Themes that were identified as idiosyncratic to individual case studies were noted to identify and report variability in treatment response. The case-study interpretations were given to the relevant participant to ensure that they agreed with the interpretations.

3.5.4.2. Phase two

In phase one idiosyncratic themes across cases were identified in the series of case-study chapters. The second phase comprised cross-case comparisons. In this process, common themes, were identified. Questions such as: what aspects in the background, context, or treatment outcome, etc., are common? What common elements influences the process and outcome of the treatment model? The literature was then explored to gather information on

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these identified themes to establish whether it supported or contradicted the findings, and the influence of the treatment outcome and process. This information served to further illuminate the case studies. The lead research supervisor at the host university ensured that the interpretations were relevant and reflexive of the case studies (Padmanabhanunni, 2010). Despite being represented as a linear process, qualitative analysis is reflexive and recursive (Fereday & Muir-Cochrane, 2006). The written versions of the case studies were revisited after the completion of subsequent case studies. The interaction of the themes across the different levels of the individual case studies were re-examined. In this way, the extent to which disruptive, impulse control and conduct disorder was held in place systemically was explored.

3.5.4.3. Rigour in case study research

Rigour in a case study refers to the process of ensuring the quality of the study (Padmanabhanunni, 2010). Rigour in the clinical methodology was attained by way of regular bi-monthly consultation with an expert in REBT (Diguiseppe et al., 2014) therapeutic approach to ensure adherence to the model (Fishman, 2013). Lincoln and Guba (1985) use the term trustworthiness to refer to rigour in research. Trustworthiness is about how well founded and significant the conclusions are. Trustworthiness consists of four elements: credibility, transferability, dependability, and confirmability (Edwards, 2018).

3.5.4.3.1. Credibility

Credibility involves the evaluation of whether the interpretation of data is a credible interpretation of the participant's original data (Guba & Lincoln, 1994). To address credibility, a rich and thick description of the case study, the client, the therapist, the therapeutic process, and the context is required so that the reader has enough detail to assess the interpretation. Each embedded case study and therapy process was described in depth.

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Further, in this study, the case formulations were shared with the clients to see if they resonated with my, the therapist/researcher's, interpretation. Within the REBT framework the therapeutic process is transparent and collaborative, so the case formulation is shared with the client (DiGuiseppe et al., 2014). The clients need to know that their case is fairly represented. This was achieved through a collaborative relationship in which understandings of the case were shared throughout the process (Edwards, 2018). This practice was followed with each client. Only the individual case studies were shared with each client. In this way, the client was able to agree with or refute the credibility of the interpretation of their own case study. These conceptualisations were written up along with the clients thought-challenging disputations and given to them at the end of the process.

The case studies were assessed by the lead research supervisor at the host university for credibility. In this way the narratives and interpretations are interrogated to review the arguments for credibility. The rich description and the interpretations were grounded with verbatim quotes from the transcripts to assist in this process (Padmanabhanunni, 2010).

A post-graduate researcher was enlisted to randomly check the recordings with the transcripts for accurate representation of the original data. If accuracy was compromised, it was assessed whether it effected the meaning of what was originally said in the session (Padmanabhanunni, 2010).

Qualitative research data collection requires the researcher to immerse themselves in the participants' world (Bitsch, 2005). Prolonged exposure to the clients' world through various sessions of therapy helped me, the therapist/researcher, to understand the clients' world and this facilitated credibility. The prolonged data gathering lasted from eight-14 months and necessitated this kind of immersion.

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3.5.4.3.2. Transferability

Transferability parallels the concept of generalisability in quantitative studies. It refers to the extent to which the results can be applied to a broad population from which that the sample was selected. This kind of generalisation is not possible in qualitative research (Guba & Lincoln, 1994). In case studies, transferability is created through qualitative research by providing rich description so that it can be decided whether the context is similar enough to another context for the findings to be transferred (Edwards, 2007). It is also attained via the carrying out of multiple case studies. The difference in the circumstances and contexts adds to the likelihood that the findings of one case are applicable to another. The theory of case law is constructed through this process of building up several case studies (Edwards et al., 2004). There are four embedded case studies in this study that facilitated the process of identifying idiosyncrasies and commonalities across cases. The case studies were described in rich detail for readers to be able to ascertain whether the cases shared similarities with which they might wish to make comparisons. The details of each case study were also interrogated against literature and theory to look for correspondence with previous findings (Edwards, 2018).

3.5.4.3.3. Dependability

Dependability in quantitative research refers to the extent to which the research results can be replicated. This kind of dependability is not possible in qualitative research. In case study research, dependability is achieved by allowing the reader to follow the interpretation of the data without experiencing unexplained leaps. The lead research supervisor's academic input contributed to this kind of dependability. Thick description allows enough detail for the reader to assess under what circumstances the case might be replicated (Williamson et al., 2003).

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3.5.4.3.4. Confirmability

Confirmability overlaps with the concept of dependability. It refers to the likelihood that other clinicians will be able to evaluate the cases and replicate the results when working with new cases (Padmanabhanunni, 2010). This again requires detailed description of the process and interpretations being clearly derived from the data (Tobin & Begley, 2004). Thick descriptions as well as direct quotations were used in this study to attain possible confirmability by future researchers.

3.6. Ethical Considerations Regarding the Dual Role of Researcher Versus Therapist

The dual role of researcher and therapist can be an ethical concern in research. The therapist could be biased and write the case study up in a way to prove their chosen theoretical orientation or lens by selecting or distorting certain aspects. This would be problematic regarding the trustworthiness of the research. These challenges were addressed in this study by using transferability, dependability, credibility, and confirmability to improve rigour in case studies and guard against therapist bias (Edwards, 2018). The structure and rigour in the case study method, Petersen's (1991) model of disciplined enquiry, and the systematic reporting of the case study and the concept of responsiveness (Stiles et al., 1998) all lent structure and rigour to the analysis of the process and interactional components of therapy in this current study.

However, on the other hand, there are significant contributions to science when therapists/researchers write up case studies. The dual role has advantages in that the therapist is deeply immersed in the case and this enhances understanding of the case. The therapist/researcher is in the unique position of being able to comment on the clinical process in a way that is meaningful in real-world settings of practice (Goodheart, 2005). Therapists/researchers are trained to observe the responses of clients/participants and their own responses with depth of understanding (Yanos & Ziedonis, 2006). Thus, the

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therapist/researcher is enabled to integrate procedural clinical knowledge into analysis and interpretation of data (McNair et al., 2008).

3.6.1. Reflexivity (the impact of the therapist)

Reflexivity is the process whereby the context of knowledge construction is focused on the effect of the researcher on knowledge production at every step of the research process. ‘A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions’ (Malterud, 2001, p. 483-484).

The therapist needs to be aware of their own needs and motives for ethical decision making to take place (McLeod, 2010). Below I, the researcher/therapist, focus on my own reflexivity in this study.

In this study the MST (Swenson et al., 2005) and REBT (Diguiseppe et al., 2014) therapeutic approaches were utilized along with contingency management techniques (Kazdin, 2000) to bring about change. I, the therapist/researcher am a registered counselling and research psychologist. I also trained at a master’s level at the University of Pretoria in the CBT and REBT approaches for approximately six years. I have had hours of supervised practice in the model used, and additional post registration qualifications in the REBT approach. The primary and secondary practicums were completed and attained through the Albert Ellis Institute. I thus felt competent to implement the REBT therapy in this study.

Regarding the topic of study, as a school child I did get into some trouble at school as I was outspoken and talkative with peers. However, I lacked the aggression or a DSM V diagnosis that was evident in these child participants. My behaviour was however in keeping with that of my classmates and would have been considered normal for my context. My experience of what was tolerated at my school was quite different to the current school

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contexts. The behaviour exhibited by the child participants in this current study would not have been tolerated.

My own reflexivity in this current study happened in the therapeutic process and supervision, the writing up of the case narrative, and during the interpretation. I believe that although the experience affected me, the therapist/researcher it did not directly influence the therapeutic process.

I, the therapist/researcher, did however experience a pressure to move the therapy process to 'best REBT practice.' I spent much time trying to instruct the children in the technically preferred REBT alternate beliefs, ones that were technically worded. My ownd irrational thoughts, demands for 'best practice' and for the participants to use 'techinically correct REBT alternative thoughts put pressure on me and possibly added to the length of the therapy process. At the end of the process, I realised that the disputations and alternate beliefs as worded by the participants themselves worked better. I also realised that I was a therapist like any other therapist in the context which was useful for research purposes as the results findings would be applicable to most therapists. This alternate framing reduces stress.

3.6.1.1. Teachers

During the prolonged therapy process the worlds of the teachers became understandable to me. Sometimes the therapy process with these children became frustrating. Change, for the most part was slow and erratic. The attitude and lack of motivation present in some of the children was likewise frustrating at times. I could understand the teachers' struggles on a day-to-day basis. My mind multiplied the number of children in front of me, imagining a classroom situation. As I emersed myself in the teachers' world, I could understand the stress and anxiety caused by these children regarding their behaviour and the lack of recourse to available effective disciplinary measures. I could identify with one teacher (Heidi in chapter 6) who recognised that these children came from a different era to the one I experienced

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growing up regarding the kind of behaviour that was tolerated. This was compounded by lack of support from some of the parents involved.

3.6.1.2. Parents

As a parent I could identify with the concern of the mothers but struggled to empathise when there was an apparent lack of it. After a session I sometimes drove home, counting my blessings with respect to my own two adult children as my mother's heart spoke. Sometimes, what was initially hypothesised as lack of concern turned into over-stressed, single parent mothers, using all their resources just to ensure that their family survives. A different world to the one I experience as a mother. Hypotheses changed as prolonged engagement facilitated the understanding of the worlds of these mothers.

3.6.1.3. Children

The participant towardswhom I felt an emotional reaction was a 14-year-old boy (Chapter 4). I was first aware of this reaction while discussing the child in supervision. We discussed the boy's situation, his absent father and demanding, seriously ill mother. On reflection I realised that aspects of this boy's background resonated with my own. Living with a mother who suffered a serious illness from the age of 9, and losing her in my mid-teens, was an experience that I shared with this boy. Similarly, the boy and I both had experiences of an uninvolved father. I could identify with this boy's situation of basically having to raise himself. The only support he had, seemed to be a mathematics teacher, and I wondered what the future would hold for him if his mother were to pass. I recognised my own 'soft spot' for this child and where it originated. The disconnect between my own situation and that of this boy was that I came from a middle-class background and grew up in relatively safe areas where aggression was not established as a norm. Opportunities were available to me. The

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township this boy lived in was impoverished and aggression levels were high. My mother, despite illness, was always present and supportive.

This child had a demand for the world to be fair. During the disputation process I began, what I realised would be the difficult task of finding where the world had been unfair in his favour, in order to help him change the demand for fairness to a preference. I looked at this boy from an underprivileged township area, in a school with few resources, a seriously ill mother, and absent father, and wondered where I would find such an example. This boy's situation impacted me. Life had not been fair. I tried to use the intelligence he was born with as an example of life being unfair in his favour. He was strong academically, but this did not seem to move him. Eventually, together we landed on the example of his friend getting into trouble for something that he, the client, had done. Apparently, this happened quite often, and this small favour brought a smile to his face and the acknowledgement that, in this way, life was unfair in his favour. The reality of this boy's situation impacted me again and I admired the resilience in him; despite his situation, he was taking full advantage of this therapeutic opportunity. For the most part it was difficult to identify with some of the world views of these children.

3.6.2. Conflict of interest

One problem that I found with working systemically, was conflict of interest. Friction did occur between teachers, children, and the parents. As I was seeing all three participants in the embedded case study, the boundaries around confidentiality had to be kept firm. On one occasion I was asked to present a report on a disciplinary hearing for a child. I had to explain that I could not present anything that could be seen to be harmful to the child, that any written report would need to be given with the child's permission, and that the content of the sessions could not be divulged. The school pressurised me to give feedback, even asking the mother to phone me for a report. The child was 13 years of age, so his assent had to be obtained. The

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issue was resolved after an initial discussion with the boy. After I spoke to him it was agreed that I would send a report to the mother giving information on the reason for the referral, length of time seen in therapy, and the therapeutic approach used. When issues arose between the parents and the teachers, or children and the teachers, it did present a conflict of interest for me. I had to remain as neutral as possible, reflecting the clients' (teachers', parents', children's) opinions and experiences and they would differ. The conflict of interest did affect the relationship with one of the teachers as she seemed to believe that I had claimed that she did not like the boy concerned. This occurred post-therapy, had we still been in therapy it would have affected the therapy process. This conflict of interest could be avoided by involving more than one therapist so that different therapists can work with different levels of the system.

3.7. Conclusion

In this chapter, both the research and clinical methodologies were described, motivated and integrated. How the approach fits with the aims of the study was elucidated. The ethical considerations, and how rigour was achieved in this study was discussed. In the following chapters, this methodology is applied to four, pragmatic, embedded case studies. These are written up according to the format described in this chapter.

Each of the four case studies includes: a summary of the *assessment* process, *case formulation*, *treatment implementation* and *evaluation*. Through these case study reports a narrative of the therapy process is told. In the *evaluation* section a summary of the responses to the self-report scales (if available), in the form of a graphical representation are given. These children included in the study, varied in their understanding and ability to independently apply the cognitive restructuring element of the therapy. Teacher and parent involvement, and consistency in contingency management (Kazdin, 2000), varied across cases. The case studies exhibited some common elements as well as idiosyncratic elements.

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Two participants aged 13/14, Neo and Moses, were from underprivileged township contexts, and they shared the same teacher. Jonathan was 11/12 years old, and from a lower middle-class background. His behaviour was not as extreme as the other three. Thabo, also aged 13/14, was from an affluent background. The processes with the boys, along with their parents and teachers, are presented in the ecological case studies written up in the following chapters. The following chapter describes the case study of Neo.

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Chapter 4: Pragmatic, Embedded Case Study of Neo

This is the embedded, pragmatic case study of Neo, a 13-year-old, grade seven boy living in a South African township. Levels of violence and violent crime amongst young people in South Africa are extraordinarily high and, there is evidence of lawlessness and moral decay in this township. There is a need to identify the social issues and rules governing this violence. In the analysis of accounts of violence attained from youths living in a Township in Cape Town, five apparent rules of violence emerged: using violence to defend dignity, the importance of social positions in using violence, violence as means of social sanction in the absence of institutional action, the rules of revenge and valuing the threat of violence over violence itself (Swartz & Scott, 2014). Violence in such high-risk communities is reported to look different to violence in other places. Where more risk factors are present, drug and firearm trafficking, gang proliferation, and higher rates of lethal and nonlethal violent crime are likely to be present. The context in which people grow up is likely to have long term effects on their behaviour and general well-being (Campie et al., 2017).

Neo lived in such a township and attended a school in a more affluent suburb. The school was attached to a church that belonged to a large, socially active, Christian denomination. The resources in the school were limited. It was run from a house. Nevertheless, it provided children like Neo with a decent education and smaller classes compared to some of the overcrowded government schools situated in Neo's township. It had qualified teachers, some computers, and a small yard for the children to play in, but resources were limited. Neo's case study was included in this study, as the therapy was regarded as successful to an extent in that his behaviour was reported to change, even though the system in which he was embedded did not change. The change in Neo, however, did not, as reported by his principal, maintain to the same level of improvement after the therapy ended and this was likely due to the lack of change in the system and some characteristics in Neo that are

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discussed in this chapter. Nevertheless, after consequences were applied, his behaviour did return to the improved level. The following case study report was written according to three sections (Edwards, 2018) described in the methodology (Chapter 3): *assessment,* this included the contracting section which mainly occurred in the first two sessions of therapy; *case formulation* which includes the *treatment plan* and the *treatment implementation* (Edwards, 2018). A section on *evaluation* is included which examines the various test results along with verbal reports from the mother and teacher. This section contributes to the understanding of change in Neo's oppositional defiant disordered behaviour.*Please note that in the case studies single quotation marks (' ') represents a paraphrased disputation or belief while double quotation marks (" ") indicates direct speech.

4.1. Assessment

Most of the information for this assessment was attained from the first two initial screening interviews with all three members of the embedded case study: Neo's teacher Mbali his mother Rumbi, and Neo himself. The irrational belief scales and behavioural scale obtained in the first two sessions were also used. As therapy progressed information was added.

4.1.1. A background and life history

Neo was in grade seven and lived with his seriously ill mother (Rumbi), his sister and her three young children. They lived in a poverty-stricken township that was known for its violence. This community context and narratives influenced Rumbi's beliefs (Ndinga-Kanga, 2015) around Neo: *"it scares me because he's a boy, and boys are different from girls… And where we stay… If you look at the neighbour's kids, they are not on track."*

Rumbi had two life-threatening illnesses (HIV and cancer). One of these illnesses (cancer) first appeared when Neo was nine years of age. He was aware of this illness, and he stated that from then on, he felt he had to *"play his cards right"* in order not to stress his

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mother, for fear of making her seriously ill again. At the commencement of his therapy, both illnesses were under control; but according to Rumbi sometime after the fourth and last session with her, medical tests revealed that one of the illnesses had progressed. This was given as the reason for her early withdrawal from therapy. Rumbi worked long hours and she was the only breadwinner in this family of six. She worked night shifts, slept during the day and left home around 17:00 to start work. She often worked weekends to supplement her income. Neo therefore did not have much contact with her. Neo got himself ready for school in the morning, his mother did not have time to supervise him or his homework in the afternoons and she was not there in the evenings to supervise his curfew time. She complained of fatigue related to both her ill health and work situation. In every session that Rumbi attended she mentioned this fatigue and her energy levels seemed low.

According to Rumbi, Neo's father had been uninvolved since his birth but had been asked to contribute financially to Neo's upbringing now and then. Neo and his mother both confirmed that Neo had little contact with his father. Being a single mother compounded the financial burden and the availability of support in raising Neo.

The relationship between Neo and his sister was strained. They experienced conflict despite a large age difference. He thought that she bossed him around, as she sent him on errands when he was about to do something he perceived as important. There seemed to be no other family relationship that provided Neo with any support. He had a maternal grandmother who passed away three to four years before the time of therapy. She had been a support to Neo, and although he did not live with her, he had often visited her. Neo had experienced many deaths in the family in his 14 years. Two uncles had also passed away; one committed suicide, and one died of natural causes, but neither of his uncles had a close relationship with him. As a result of Neo's context, there were no supportive adults, apart from a maths teacher who took a special interest in both Neo and his friend Moses.

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4.1.2. Presenting problem

The presenting behavioural problems in school included talking disruptively in class, denial of misbehaviour, and challenging the teacher when reprimanded. The teachers differentiated between disruptive talking and ordinary talking. Neo's talking was described as loud and incessant. He disturbed others and the teachers with this talking. His classmates found his comments very funny, even when, according to Neo, he was not trying to be amusing. He often denied his behaviour, even when he was caught in the act. This denial/challenge was the element in the behaviour that escalated the conflict between Neo and his teachers. They experienced this as challenging. He was also reported to have physically fought occasionally, but these behaviours were not reported to be as problematic as his disruption, denial of behaviour, and challenging of teachers in this denial.

Neo had attended this school since grade three. From Neo's perspective, his problems of getting into trouble had started in grade five. His teachers and mother claim that the behavioural problems had been severe for the entire duration of the previous year (grade six). On referral to me, he had been suspended for accessing pornography on the school computers, in the library, along with a group of other children.

Rumbi reported that she had problems at home with getting Neo to do chores and to respect his curfew by coming inside from playing in the streets respecting his curfew. He would stay out in the streets until after dark and she was concerned that he would follow in the footsteps of many of the youths in his neighbourhood that committed crimes and ran in gangs. She was, however, not often there to enforce any change in this behaviour. She also stated that he did not listen to instructions.

In therapy sessions Neo was generally polite and co-operative. However, he continued to deny problematic behaviour, even when it happened within sessions and was addressed during the session. On one occasion, for example, when I enquired as to why he was

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laughing, he promptly denied that he had been doing so. Thus, the denial about his behaviour described by the teachers was evident in the sessions. Some joint sessions were held with Neo and his friend Moses, who had also been referred to me for this study, and in these sessions his laughing initially increased. This was again accompanied with denial.

4.1.3. Diagnosis

Neo met the criteria for oppositional defiant disorder (ODD). He had four of the symptoms listed in the DSM5 (American Psychiatric Association, 2013), and their duration was more than six months.

- He often argued with authority figures, like teachers, about what he had done and would deny it even when caught in the act.
- He often actively defied or refused to comply with requests from authority figures or rules. When asked to stop talking or laughing he would just continue. Most of the time, he challenged punishment given to him.
- He often blamed others for his own mistakes or behaviour. He claimed that it was other children talking and not him, or that it was their reaction to his behaviour that caused the problem; and
- He was often angry and resentful about teachers and his mother having too high expectations of him.

The ODD behaviour was mild to moderate, as it was reported to occur in two settings: the school and home contexts. In the school context he met the full criteria of listed ODD behaviours in that he displayed four of the listed symptoms. In the home setting, his mother initially reported that he did not listen, do chores, or meet his curfew time; but after the initial two assessment sessions, she reported that this behaviour no longer occurred. From the outset

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his mother had reported milder behaviour compared to that described by the teachers. Neo presented with ODD without co-morbid learning problems.

4.1.3.1. Test administered and scales used

The following tests were used to assist in assessment and understanding of later change or lack thereof in thoughts and behaviour.

4.1.3.1.1. Conners Rating Scales

Neo's mother dropped out of therapy early so her Conners Rating Scale (Conners, 2007) results were not available. The Conners Rating Scale (Conners, 2007) scores from Neo's teacher are represented in Figure 8 (the interpretation for the Conners Rating Scales and scores are tabulated in tables 1 & 2).

Neos class teacher rated his behaviour as follows:

A very elevated score was received for *'impulsivity/hyperactivity'*, *aggression/defiance,'* and *'peer relations.'* From the descriptions of Neo's behaviour, difficulty keeping quiet, being argumentative regarding reprimands, and generally defying the requests of adults were the likely actions that elevated the scores. *'Inattention and learning problems',* both attained an average score, indicating typical levels of concern which would suggest that there was no evidence of ADHD. Neo had no academic difficulties in school. This confirms the diagnosis of ODD without co-morbid ADHD.

Neo was reported by both teachers and classmates to be popular and to have influence. Moses, who had some joint sessions with Neo, pointed out in one of these sessions that many children wanted to be like Neo as he had influence, and this was possibly why the teachers wanted him to behave. Neo acknowledged that this was true. His poor score for *'peer relations'* was thus likely due to inappropriate behaviour and interaction.

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4.1.3.1.2. SSAIS-R

The Senior South African Individual Scale-Revised (SSAIS-R) (Van Eeden, 1991). could not be used as a diagnostic tool in Neo's case as it was only standardised for Afrikaans and English (first language) speaking populations. The results obtained from the SSAIS-R, (Van Eeden, 1991) however, seemed to corroborate that there was no scholastic or learning problems present. Neo's *Verbal IQ score* fell within the above-average range, the *non-verbal IQ* scores fell within the average range and *full-scale IQ* fell within the above-average range. These results were attained even though the test was administered in English. Overall, Neo's academic ability was considered a strength by his teachers and his mother. Neo was taught in English, but spoke mostly Zulu, and only a little English at home. In therapy, he sometimes seemed to battle to find the words to express himself. His speech was sometimes indistinct. He mumbled and mostly gave short answers. The performance on the *'vocabulary sub-test'* was lower than the rest of the verbal sub-tests at a five percent significance level. In contrast to this, his performance on the *'similarities sub-test'* was adequate, indicating strong abstract verbal reasoning ability in English. I, the therapist/researcher thought that this would be a strength regarding the understanding of the REBT concepts and utilisation of the model outside of therapy sessions. Although Neo's English was not as strong as some of the other participants in this study, I thought he was proficient enough to be in therapy, benefit from the process, and understand the REBT concepts that would be explained in English.

On the Conners Rating Scale (Conners, 2007) for *'learning problems and executive functioning,'* and *'inattention',* Neo's class teacher gave him an average score, indicating typical levels of concern. These results are in keeping with no diagnosis regarding learning problems.

In summary, Neo met the criteria for ODD without co-morbid ADHD or any other learning problems. He was generally considered academically strong. Therapy being carried

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out in his home language could possibly have been more effective as suggested by the significantly lower performance on the English *vocabulary test* and his difficulty in expression during therapy.

4.1.4. Establishment of client-therapist relationship

The alliance between myself, the therapist/researcher, and the participants was established according to the REBT (Diguiseppe et al., 2014) theoretical framework. As far as possible, the goals were set collaboratively. Neo was engaged in changing his behaviour, as he was tired of getting into trouble, and did not want his misbehaviour to stress his mother. Neo was consistent in coming to therapy without any persuasion being necessary and he maintained this engagement throughout the process. During sessions he was quieter compared to other participants in this current study and often just agreed or disagreed. It seemed that Neo was not strong in communicating with adults.

Neo and his friend Moses, described in the following chapter, had some joint session together. During the second session Moses mentioned that he thought that his own ability to communicate with the teachers helped them to recognise his change in behaviour. According to Moses, *"I used to tell the teachers that I am trying to change my behaviour. I think the communication between me, and the teachers made them see I am really trying."* Considering this realisation, Moses suggested to Neo that he should attempt to have similarly open communication with teachers to try to change his reputation. Moses had a better relationship with his teachers compared to that of Neo. Moses was recognised for any effort that he made, whereas Neo was not.

Lack of communication could have been to Neo's detriment regarding forming connections and being able to effectively put forward his point of view. This could also have contributed to his lack of a more active role in disputations and the creation of functional/rational beliefs. Despite this, he did focus, and could repeat most of the

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disputations in sessions, which indicated engagement. When I, the therapist/researcher gave the option of ending therapy, as behaviour was reported to be good from the teachers, he chose to continue even though his friend Moses chose to terminate. Again, this showed engagement in the therapeutic process and a functional therapeutic relationship.

Relationships with Neo's mother and teacher were established in the same way structured by the REBT (Diguiseppe et al., 2014) collaborative, transparent framework, and responsiveness (Kramer & Stiles, 2015). However, Neo's mother did not form a therapeutic relationship. She withdrew after Neo misbehaved due to her pre-existing irrational beliefs. The teacher likewise did not engage due to pre-existing beliefs. These beliefs are explained below. I, the therapist/researcher, experienced the relationship with the teacher to be un-cooperative and the relationship with Neo's mother as obligatory as the school requested that her son take part in the process. As a result, people in Neo's system did not form effective therapeutic relationships and thus did not engage in the therapy process.

The assessment information was gathered from the initial two interview sessions. During this time contracting with the participants also took place. Information was gathered throughout the therapy narrative, and these details were then added. Contracting was likewise negotiated throughout the process. Based on this information, a case formulation was created using a multisystemic framework (Swenson et al., 2005) within which contingency management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014) therapies were applied to different levels of Neo's system.

4.2. A Multisystemic Case Formulation

The case formulation is a set of clinical hypotheses about the events or processes that led to the development of the disruptive, impulse control and conduct disordered behaviour, in this case, ODD, and the maintenance thereof in the present (Edwards, 2018; McLeod, 2010). REBT (Diguiseppe et al., 2014) and Multisystemic (Swenson et al., 2005) theories were

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utilised to structure this conceptualisation. All evaluative beliefs and inferences are taken from sessions and thought records created in sessions by client and therapist. The understanding of the contextual development and maintenance of ODD behaviour is facilitated by knowledge of the contribution of the context. The beliefs and case conceptualisations of Rumbi, Neo's mother, and his teacher were not in-depth, as I, the therapist/researcher, was unable to fully engage these levels of the system.

4.2.1. Neo's mother (Rumbi) and his home context

The following describes the case conceptualisation of Rumbi, Neo's mother who represents the home level of the system. Apart from the two initial assessment interviews, four sessions were held with Rumbi. Rumbi had been close to her mother who had helped her in raising Neo. There were no other adults to assist her in the raising of Neo apparat from her daughter, Neo's sister. Neo's father was rarely involved with him apart from some sporadic financial support. According to the Revised Belief Scale for Parents (PIBS) (Joyce, 1995) represented in figure 6, all Rumbi's responses fell within the high level of irrationality. In sessions the cognitions that could have contributed to the presenting problems regarding ODD behaviour, were explored.

4.2.1.1. Demand schema

A demand schema that *'he must behave at all times'* was noted. Rumbi recognised this demand, in relaying the following belief: *"I'm expecting too much from him…I expect more goodness from him, that's why I withdraw when he does something wrong."* This inference came from the demand schema, *'he must behave at all times'* which was also linked to the inferences of catastrophic predictions, *'or he will go off track [run in gangs or become a criminal, like the other children in the neighbourhood].'*

Therapist: What does it tell you about Neo, if he's not good?

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Rumbi: It scares me, because he's a boy, and boys are different from girls… And where we stay… If you look at the neighbour's kids, they are not on track.

These beliefs and inferences were linked to emotions of anger and anxiety. Neo was then disciplined while the associated anger was intense, and not with effective, consistent contingencies.

The rigid demand for constantly good behaviour underlay Rumbi's high expectations of Neo. Any negative behaviour resulted in her ignoring any positive achievements and improvements. Rumbi was able to connect her thinking and behaviour regarding this demand. She acknowledged that she was *"sensitive",* got hurt, stressed or angry and thereafter behaviourally withdrew. Insight alone was not sufficient to change her behaviour. New thinking and behavioural patterns needed to be established.

The associated catastrophic predictive inference *'or he will go off track [run in gangs or become a criminal, like the other children in the neighbourhood]'* was associated with anxiety and implied awfulizing. These beliefs and inferences were triggered by her receiving complaints from Neo's school about his behaviour.

4.2.1.2. Dysfunctional inference

The following dysfunctional inference was likewise triggered by complaints about Neo's behaviour: *"he thinks little of himself or me, especially me, as he knows I am not a fit [well] person."* This expressed inference was linked to the emotion of hurt and anger. This hurt led to the withdrawal from Neo that followed the initial anger and accompanying inappropriate discipline. The implied demand was that *'Neo should always be considerate.'*

This demand schema is represented in table 4.

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Table 4

Tabulation of Rumbi's Irrational Evaluative Beliefs and Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Neo's mother learns that he gets into trouble at school.	Demand: *'He must always be well behaved.'* Expressed: "*I'm expecting too much from him…I expect more goodness from him…*"	Emotional consequence: Anger Behavioural consequence: Loses her temper and disciplines physically and out of control, (smashing cell phones and throwing things). She later withdraws.
Catastrophic inference *"It [Neo's behaviour] scares me because he's a boy and boys are different from girls… And where we stay… If you look at the neighbour's kids, they are not on track [in gangs and engage in criminal behaviour]."*	Awfulizing: *'It is the worst thing if he misbehaves'*	Emotional consequence Anxiety Behavioural consequence: Shouts at Neo, and disciplines in an uncontrolled manner.
Dysfunctional inference: *"He thinks little of himself or me, especially me, as he knows I am not a fit [well] person."*	Demand: '*He must be considerate at all times.'*	Emotional consequence: Anger Behavioural consequence: Withdrawal

4.2.1.3. Contingency management in the home context

There had always been a lack of effective contingencies around Neo's behaviour at home. This ineffective discipline (behaviour) was linked to Rumbi's evaluative beliefs above. Rumbi was weakened by her illnesses, which likewise made it difficult for her to engage in disciplining Neo. Her harsh work schedule made her an absent mother for a large percentage of the time. Rumbi was hardly ever home, and when she was, she was tired. Neo was left to his own devices most of the time but if there were complaints from school, he would be punished severely and in anger. Rumbi would later simply withdraw. He was expected to just display *"goodness"* without any disciplinary guidance or supervision. The absence of Neo's father added to the above inconsistency and fatigue in Rumbi. There was no supportive adult to assist in reigning in Neo and disciplining him when Rumbi was absent or fatigued. This all contributed to the ineffective discipline of Neo, as he felt bad about himself for that moment,

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but he did not maintain behavioural change as reasonable, consistent contingencies were not applied. Rumbi did not have the resources at the time to expend energy on changing the contingencies around Neo or attending therapy sessions.

4.2.2. Neo's teacher (Mbali) and the school context

The following describes the case conceptualisation of Mbali, Neo's teacher who represents the school level of the system. Initially I experienced this teacher as willing to co-operate with this current study, by engaging in monitoring Neo's and his friend Moses' behaviour and engaging in her own therapeutic process using a REBT (Diguiseppe et al., 2014) approach. As time progressed, I generally experienced this teacher as being uncooperative. She had to be convinced to monitor the behaviour with charts and it proved difficult to attain consistency in this task. I then resorted to weekly face to face feedback reports or WhatsApp messages, describing behaviour for the week, to monitor Neo's and Moses' progress, or lack thereof. When I explored the reasons for this reluctance, the teacher said she was concerned about the information becoming part of the children's permanent school record. She found monitoring time-consuming and believed that it did nothing to change the children's behaviour. The teacher relied on the latter reason primarily to justify her lack of cooperation in the process. She claimed that she wanted the children to change internally, and that monitoring behaviour only assisted her when she needed evidence for expulsion. Mbali spoke constantly, to the extent that it was difficult to interject into the conversation. As a result, she was a poor listener so it could be that she did not process the explanation of the study during the initial two interviews. Monitoring behaviour to evaluate behavioural change as well as contingency management (Kazdin, 2000) had been explained to her in these initial interviews.

Mbali, Neo's and Moses' class teacher, was known for being a good disciplinarian with no problems in her classroom. She was asked by the principal to participate in the study, as she had the most contact with both of the boys that I was working with. In the initial

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sessions her thoughts were seen to be rational around her work and disciplining children. Her disciplinary techniques included sending the children out of the class when they misbehaved. As the therapy narrative unfolded, it was apparent that she was not open to different kinds of discipline. She had the belief that there were no problems in her classroom and discipline in the classrooms of others was the responsibility of those teachers. Her thinking was rigid regarding these issues. Sending Neo out of the classroom did work sometimes, as Neo did not want to miss work. At other times, however, he found his friends outside who had also been sent out of the classroom and this cheered him up, undercutting the punishment.

As she did not engage in therapy for herself, only limited and general cognitions around discipline and difficulty in the discipline of children were established. She became irritated by the children who wasted their own potential, parent's money, and the educational opportunity that could be given to someone else. This is an inference and could be true; however, it is rigid thinking, as I experienced with this teacher, it is likely coming from irrational evaluative beliefs, and this conclusion was corroborated by the TIBS (Huk et al., 2019) found in figure 7.

The presence of irrational beliefs were corroborated by the category *attitudes towards the school organisation* on the TIBS (Huk et al., 2019). The items on this subscale are related to teachers' needs to be involved in the running of the school, i.e., that they be involved in decision-making, that their problems be listened to, etc. This teacher attained a high level of endorsement of irrationality, indicating rigidity of thought in this category. In interpersonal interactions, she came across as being domineering. Her lack of engagement in the process could have been due to the principal asking her to participate. In these circumstances she may have felt compelled to participate. During contacts with her, it increasingly came across that she believed she had everything under control in the classroom, so was not in need of any help. It later unfolded that the principal found this teacher difficult to work with. She initially

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chose another teacher to participate, but this teacher did not have daily contact with the boys I was working with, so this class teacher was then approached.

Another confirmation of irrational beliefs in this teacher was found in the score for *authoritarian attitudes towards pupils* category on the TIBS (Huk et al., 2019). A moderate level of irrationality, which was considered as a secondary belief, as opposed to the main irrational schema, was attained for this category. An elevated score on this subscale implies intransigence towards the discipline problems of the pupils. Respondents believe that they cannot stand the children misbehaving and that in such cases, they should be severely punished. The above inferences (*'students who wasted their own potential, parent's money, and the educational opportunity that could be given to someone else'*), could bring intolerance if held too rigidly. She was not a popular teacher with the boys that I worked with, but she did keep boundaries within the classroom. This level of irrationality would likely have led to some intolerance of the children that misbehaved.

This teacher was resistant to having individual sessions for herself. Initially she accepted using the sessions for her own well-being but could never find the time to see me for more than a few minutes. She later expressed that she did not need any input and believed that the focus should be on the child: *"Are you saying that the focus has shifted from the child to me?"*

The punishment of sending children out of the classroom seemed to be a way of keeping the classroom undisturbed as opposed to a way of remediating the behaviour. If the children did not come into the classroom or skipped class, they were ignored, or given a demerit. When I mentioned the lack of consequences for this behaviour, the teacher replied: *"Truly, I can't be expected to physically drag the child inside the class."* Trying to find alternative disciplinary approaches was a problem with this teacher. She would use techniques that were part of her current practices. This was likely due to her thinking that she

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did not need any help and she did not have any problems. She was not willing to alter her approach to attain remediation. She had found a way of making the classroom situation work for her and the children that wanted to learn. That was where her responsibilities, as she saw them, ended.

4.2.2.1. Contingency management in the school context

All the participant teachers were taught contingency management skills (Kazdin, 2000) within the first two initial sessions and throughout the the sessions part of the session was devoted to these concepts and skills. Identifying the target behaviour and immediate negative and positive reinforcement were amongst the skills taught (Kazdin, 2000). The discipline in this school system was inconsistent across teachers, and even across different occasions and situations with one teacher. Some behaviours (such as not coming to class were tolerated), while other behaviours were not. In some classes the children got away with more than they did in other classes. The usual demerit system was utilised. The children received detention after an initial reprimand and then three demerits. These demerits were given over a two-week period; so, if only two demerits were given in this cycle, the child was not detained. If detention was ultimately given, however, the children had forgotten why they had been given detention by the time it was implemented. Neo claimed that he did not know which teacher gave him demerits and that the different misdemeanour codes used approximated the behaviour that was targeted; the actual behaviours did not quite fit the codes. This approach did not follow research findings that suggest clear definitions of expected behaviours and immediate consequences (Kazdin, 2000). Accordingly, the school's contingency management was not effective, as many incidents would occur before punishment was given, and these demerits were also not applied consistently. Furthermore, according to Neo's class teacher, the children could work the system as they could work out where they were in the process to

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avoid punishment: *"Anybody that's that smart, can work the system. He's* [Moses] *working the system* (Mbali)*."*

The class teacher did seem to recognise these inherent problems, but was unwilling to change anything, as it did not affect her or her classroom directly. She was not willing to cooperate with other teachers to find a wider solution for the school disciplinary problems. She thought it unfair if she had to give up her time for others who could not discipline their classrooms. This made her effective in her own classroom in keeping an atmosphere where those who wanted to learn could learn, but she saw this as the maximum extent of her responsibility. This system was not effective for Neo's or Moses' behaviour generally, as they spent a lot of time being sent out of the classroom, so it failed to remediate their behavioural problems. In fact, Moses sometimes elected to stay out of the classroom himself.

4.2.3. Neo's case conceptualisation

According to the Child and Adolescent Irrational Belief Scale (CASI) (Kassay et al., 2015) all Neo's scores for the *low frustration intolerance* (*LFT*), *other and self-evaluation (ROW-O; ROW-S);* awfulizing and the average irrational belief score fell within the *'more rational philosophy endorsed category'*, meaning that few irrational beliefs were indicated. In sessions irrational beliefs were noted in self and other evaluative beliefs as well as awfulizing that contributed to Neo's ODD behaviour. Demandingness fell within the *'high level of endorsement for irrationality'* and this was noted in sessions (figure 5). The following section describes the case conceptualisation of how Neo's ODD behavioural problems were held in place according to the REBT (Diguiseppe et al., 2014) conceptual framework regarding his own irrational thinking.

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4.2.3.1. Demand schemas

The demand schema,*' Life must be fair, and if it's not fair, I will make it fair'* underlay most of Neo's ODD behaviour. Neo wanted to see and make the world as he preferred it: fair (DiGuiseppe et al., 2014). This demand and associated inferences and other evaluative beliefs, discussed below, were triggered when Neo was reprimanded for ODD behaviour. The problem behaviour was mostly in Neo's maladaptive reaction to being reprimanded for disruptive and oppositional behaviour. The action of challenging the reprimands and not accepting his wrongdoing, were associated with inferences flowing from the demand schema:

- *If I get into trouble, it's because they pick on me, and that's unfair/wrong;*
- *They punish me because they don't like me and that's unfair;*
- *They blame me all the time when others are doing the same thing and that's unfair;*
- *It is my peers' reactions to my behaviour that are getting me into trouble, not my behaviour, and that's unfair; and*
- *I can make situations I find myself in fair by making my point.*

This thinking was associated with Neo's anger. Due to these inferences that emanated from the demand schema, '*life must be fair',* Neo would not accept punishments and he would fight back, becoming oppositional. In his words, he explained his reaction to getting into trouble. The following happened after Neo had just been reprimanded for talking:

Neo: They were making a noise, and I shouted and told them to stop talking… mam wants to speak, and the teacher shouted at me…I needed to make a point…

Therapist: And what did you need to make a point for?

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Neo: Because it's not fair when I talk and they complain, but when they talk, I must just keep quiet [Neo was trying to make the situation fair for himself].

Due to his demand *'for fairness'* and *'trying to make things fair,'* he did not accept the reprimand and tried to make his point. Self-defeating and irrational patterns of thinking were evident across his inferences as others were believed to be acting in an unfair manner towards him on a constant basis. This led to the anger and resistance.

A representation of Neo's demand schema is tabulated in table 5.

Table 5

Tabulation of Neo's Demands Regarding Unfairness

Activating event	Irrational Belief	Consequence
Situational Activating Event: Neo gets into trouble for ODD Behaviour. *'it's not fair.'* *Associated inferences* *'If I get into trouble, it's because they pick on me, and that's unfair/wrong.* *They punish me because they don't like me and that's unfair.* *They blame me all the time when others are doing the same thing and that's unfair.* *It is my peers' reactions to my behaviour that are getting me into trouble, not my behaviour, and that's unfair, and* *I can make situations I find myself in fair by making my point.'*	Demand; '*It must be fair.'* *'If it is not fair, I must make it fair.'*	Emotional consequence: Anger Behavioural consequence: denies his misbehaviour and challenges the reprimand.

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Demand schema: 'Others should not have too high expectations as it is unfair; People must recognise my changed behaviour'

The unrealistic expectations of others triggered the demand schema that *'others should not have such high expectations of him.'* This demotivated Neo, as did the lack of recognition (contingency management) of any change in his behaviour and his evaluation thereof. His associated inferences were that *'if people do not recognise his behavioural change, it means they think he has "gone back to square one* (Neo)" *and he will 'never meet up with their expectations.'* This led to sadness and giving up on improving behaviour.

The inferences cited above did seem to be true regarding Neo's mother. She expressed in the last therapy session that there had been no positive reports about Neo's behaviour, even though the class teacher had given some, and even noted this in his report. Rumbi then followed her pattern and withdrew from therapy. She claimed that the withdrawal was due to ill health, and indeed she had health problems, but her behaviour also followed her previous pattern and the negative-other rating that Neo had done nothing positive, was also evident. When Neo misbehaved, any previous improvement disappeared from her thinking, and she became angry, and then withdrew. A representation of Neo's demand schema is tabulated in table 6.

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Table 6

Tabulation of Neo's Demand Regarding Other's Expectations and Recognition

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Neo's Mother becomes very angry about Neo getting into trouble at school and withdraws from him. Inferences: '*The expectations are too high and too hard to reach'.* *"Let's say, that I'm behaving, she thinks mam, that I'm gonna stay like that forever mam. Then the one-time mam, let's say mam. I make a mistake mam; she will think that I've gone back to square one."*	Demand: *'Others should not have too high expectations as it is unfair.* *People must recognise my changed behaviour'.*	Emotional consequence: Anger Behavioural consequence: Neo becomes demotivated and gives up on trying to improve behaviour.

Demand schema: I must not be controlled

Due to lack of supervision at home, Neo was used to deciding for himself what he did and when he did it. When told what to do, reprimanded, or restricted, it sometimes triggered the inference: *'If others tell me what to do, it means they are trying to control me, and that is negative;'* which comes from the demand schema: '*I must not be controlled.'* He associated these beliefs with feelings of powerlessness.

Near the end of his sessions with me, Neo described this latter belief as a feeling: *"It feels like control."* He associated the feelings of anger and powerlessness when he believed he was being controlled. There were many things in Neo's life that he could not control, such as his mother's expectations of him, her reactions to him, her illness and his father's lack of involvement. His father was not mentioned much in therapy, apart from initial sessions and when he was mentioned, he seemed to be a person that Neo did not consider often. Neo thought that his absence did not affect him. The absence of Neo's father did affect his wider context in that his mother was a single mother struggling financially and struggling with

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raising her 14-year-old son by herself. A representation of Neo's demand schema is tabulated in table 7.

Table 7

Tabulation of Neo's Demand Regarding Control

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Being reprimanded. Behaviour being restricted or channelled. Inferences *'I am powerless.* *They are trying to control me (and this is negative as I should not be controlled).'* *"It feels like control."*	Demand: *'I must not be controlled.'*	Emotional consequences; Anger. Behavioural consequence: Refusal to accept reprimand or instruction.

4.2.3.2. Negative self-evaluation

Neo's negative self-evaluation that rated him in a negative light can be paraphrased as follows; *'if I don't meet their expectations, it means I am not good enough.'* It was triggered when he was shouted at by his mother or teachers.

Neo was discouraged by his mother's and teachers' perceived expectations of him: his mother demanded consistently good behaviour, and he thought that his teachers did the same. Neo in turn demanded; *'they should not have such high expectations of me as that is unfair.'* And *'Life should be fair.'* The resulting associated inferences demotivated him in maintaining any behavioural change:

- *'If I misbehave, everyone sees me as going back to square one';*
- *'They expect too much of me and that's unfair'; and*
- *'I cannot meet the expectations so why bother to try.'*

Using the technique of inference chaining, these inferences were found to flow from the demand schema that people must be fair towards him. This confirms the current REBT

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theory that states that all evaluative beliefs flow from demands (DiGuiseppe et al., 2014). This Negative self-rating was associated with sadness and giving up on trying to maintain good behaviour, as there was no point in trying.

Neo: "*Mam, I don't know mam, but mam, I think because many times I'll be seen as naughty, so sometimes if it's like that you give up because, ah mam, I'm always in trouble so you feel, what's the use, 'cause eventually you will be in trouble again.*"

These inferences are tabulated in table 8.

Table 8

Tabulation of Neo's Negative Self-Rating Regarding Not Being Good Enough

Activating Event	Irrational Belief	Consequence
Situational activating event: Neo's mother becomes very angry about him getting into trouble at school and withdraws from him. Inference: *"Let's say, that I'm behaving, she thinks mam, that I'm gonna stay like that forever mam, then the one-time mam, let's say mam, I make a mistake mam, she will think that I've gone back to square one"*	Negative self-rating: '*If I don't meet their expectations, it means I am not good enough.*' Expressed: Q: *"Do you then think that you are not good enough?"* A: "*Yes*"	Emotional consequence; Sadness Behavioural consequence: Neo gives up on trying to improve behaviour.
Inference: *Self-defeating inference: The expectations are too high and that is unfair.* *"I'm always in trouble, so you feel, what's the use, 'cause eventually you will be in trouble again."*	Demand: *They should not have too high expectations, as it is unfair (implied).* Expressed. *"It's unfair."*	Emotional consequence: Anger Behavioural consequence: Neo gives up on trying to improve his behaviour.

4.2.3.3. Awfulizing

Neo's evaluative belief which awfulizes the situation can be paraphrased as: '*it is the most awful thing to get into trouble, because it will have disastrous effect on my mother's health.*' This belief was likewise triggered by getting into trouble for ODD behaviour. This irrational

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belief and associated inferences likewise led him to challenge the teacher, thereby becoming oppositional.

The other inferences that Neo held, which were also related to his mother's illness, did not allow him to accept his wrongdoing. Neo could not afford to take responsibility for his own misbehaviours due to the catastrophic prediction of subsequent events that he envisaged would follow the admission of guilt: he believed the stress of it would cause his mum to become seriously ill again. When referring to the illness that occurred when Neo was nine years old, he stated *"but on that day, mam, I knew that I must play my cards nice."*

The following inferences were associated with this:

- *'If I get into trouble, it will affect my mum's health badly';* and
- *'If I deny what I did, then I may get away with it.'*

Not wanting to stress his mum out due to getting into trouble, is a rational belief, but when it was associated with the evaluative belief that awfulises the situation: '*it is the most awful thing to get into trouble, because it will have disastrous effect on my mother's health',* it leads to dysfunctional emotions and behaviour. In Neo, it led to anxiety and denial of any wrongdoing and the challenging of teachers in this regard. He would often cite that the main reason for his denials were that he *"cannot afford it"* [to get into trouble]. These irrational beliefs and their consequences are represented in table 9.

Table 9

Tabulation of Neo's Awfulizing Regarding Getting Into Trouble

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Neo gets into trouble for ODD Behaviour. Inferences: *'If I get into trouble, it will affect my mum's health badly'; and* *'If I deny what I did, then I may get away with it.'*	Awfulizing; *'it is the most awful thing to get into trouble because it will have disastrous effect on my mother's health.'*	Emotional consequence; anxiety Behavioural consequence: denies his misbehaviour and challenged the reprimand.

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Activating Event	Irrational Belief	Consequence
"I cannot afford it." [to get into trouble]		

4.2.4. Summary and treatment plan

The plan was based on the identification of the kinds of irrational beliefs stated above. In summary, Neo did not seem to recognise, or could not "*afford*" to recognise, the part his behaviour played in getting him into trouble. Recognition of his behaviour in the sequence of events needed to be addressed in therapy. Lack of recognition of his own wrongdoing was related to the above evaluative beliefs and associated self-defeating inferences:

- The demand schema 'Life must be fair and if it's not fair I will make it fair; I*f I get into trouble, it's because they pick on me, and that's unfair/wrong etc;*
- Awfulizing of *being in trouble due to the envisaged subsequent events that would follow the admission of guilt; he believed it would cause his mum to become seriously ill again. "I cannot afford it"*; and
- The demand schema '*I must not be controlled.'* If others tell me what to do, it means they are trying to control me, and that is negative. *"It feels like control."*

Neo's oppositional defiant behaviour was triggered mostly when he was reprimanded. The demand schema: '*it must be fair, or I must make it fair;*' awfulizing: *'it is the most awful thing to get into trouble because it will have disastrous effect on my mother's health,'* and the demand schema: *'I must not be controlled;'* needed to be addressed in therapy, along with the associated self-defeating inferences. These beliefs perpetuated disruptive, impulse control and conduct disordered behaviour and the behaviour of not accepting his wrongdoing and challenging the reprimand for wrongdoing. Negative self-evaluation: *'I am not good enough if I don't meet their expectations,'* also needed to be addressed. These evaluative beliefs and inferences were associated with the feelings of anger (demand for fairness and control),

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sadness (negative self-evaluation), and anxiety (awfulizing). These beliefs played out against a backdrop of the inconsistent and sometimes ineffective contingency management at the school, together with the home contingencies vacillating between harsh and non-existent. This did not encourage the development or maintenance of appropriate behaviour or the decrease in oppositional behaviour.

The contingency management was as it was because of Rumbi's and the teacher's evaluative beliefs. Rumbi: *"I'm expecting too much from him…I expect more goodness from him, that's why I withdraw when he does something wrong."* This belief came from the demand schema: *"he must behave at all times"* which was linked to, the catastrophic prediction: *"or he will go off track"* [run in gangs or become a criminal, like the other children in the neighbourhood]. The *"goodness"* was expected from Neo, yet no contingencies or supervision were applied to shape this *"goodness." "Goodness"* was just expected to be there. The teacher had a management plan for her classroom that worked generally with most of the children: behave or get out. Through this she kept control of her teaching context effectively. She preferred that Neo and other children like him would develop internal strategies to control their behaviour. The emphasis was on the general context in her individual classroom, as opposed to remediation of these children's disruptive behaviour or other teachers' disciplinary problems. Her classroom was under control for those who wanted to learn. In this way the different thoughts across the system of these three people: Neo, his teacher and his mother interacted and held his oppositional behaviour in place. The contingencies for his behaviour were not held in place due to the teacher's and the mother's beliefs. Neo's mother just expected "*goodness from him"* and Neo, in turn, realised that; *'I am not good enough if I don't meet their expectations,'* and that these expectations were too high and therefore, *"unfair."* According to the REBT (Diguiseppe et al., 2014) treatment plan these evaluative beliefs that Neo held needed to be challenged as they held his

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ODD behaviour in place and the evaluative beliefs held by the teacher and mother needed to be challenged as they affected their behaviours regarding the discipline of Neo. Neo also responded to the irrational beliefs around him.

4.2.5. Responsiveness across irrational beliefs

The interplay across the different beliefs was as follows: Neo's mother Rumbi was the only adult that was present in his life and as such she was really important to him. Rumbi's demand for perfect behaviour resulted in her believing that Neo reverted to square one whenever he misbehaved. Considering the issue, Neo remarked that, *"let's say, that I'm behaving, she thinks, mam, that I'm gonna stay like that forever mam, then the one-time mam, let's say mam, I make a mistake mam, she will think that I've gone back to square one."* Rumbi's irrational expectations made it difficult for Neo to admit to wrong and it discouraged him from maintaining changes in his behaviour because "*what's the use, 'cause eventually you will be in trouble again."* He responded to his mother's irrational beliefs in this way and this along with the fear of his mum becoming sick because of his behaviour ; *"but on that day [that he found out about his mother's illness], mam, I knew that I must play my cards nice."* He denied wrongdoing in the hopes that he would avoid getting into trouble and stress her. This reaction however, got him into further trouble. Even his fear of making his mother ill due to his misbehaviour mirrored her thinking. When discussing Neo's misbehaviour Rumbi linked it to lack of consideration as to how this was affecting her and her condition;.*".he knows I am not a well person."*

4.3. Treatment and Implementation

The intervention plan was based on the case formulation above (Edwards, 2018) and was then implemented during therapy (Fishman, 2013). It was conceptualised according to the REBT (Diguiseppe et al., 2014) framework. The irrational beliefs above would be disputed to bring

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about alternate beliefs using REBT (Diguiseppe et al., 2014) theory and techniques. The MST (Swenson et al., 2005) approach is the overall framework that guided this clinical process and provided an integrative framework for applying the therapeutic approaches across different levels of part of Neo's system. As such, an attempt was made to apply therapy to Neo, his mother, and his teacher.

The approach was embedded by holding therapy sessions with the participants across different levels of part of the school system to which Neo belonged: 19 sessions were held with Neo and four joint sessions with Neo and his friend Moses, utilising the REBT (Diguiseppe et al., 2014) therapeutic approach; with the teacher and Neo's mother utilising the REBT (Diguiseppe et al., 2014) therapeutic approach and contingency management (Kazdin, 2000) (although Neo's teacher did not fully engage, particularly with the REBT sessions). The mother withdrew early claiming ill health as the reason. The mother had four sessions. The part of Neo's system involved in this study (mother and teacher) did not fully engage.

4.3.1. Home context: treatment of Neo's mother (Rumbi).

This process consisted of teaching contingency-management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014) sessions. The parent management (Kazdin, 2000) element utilised pasychoeducatopnal techniques to impart knowledge of standard procedures such as praise and reward, limit setting and establishing behavioural expectations. Neo was included in the application of the contingency management programmes, as he helped to identify what rewards and punishments, he thought to be appropriate and effective (Kazdin, 2000). Using REBT (Diguiseppe et al., 2014) techniques the irrational beliefs were weakened, and functional/rational beliefs were created. As Rumbi terminated early, the disputations and therapy process were incomplete. The following information was gathered from thought

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records compiled in and outside of sessions and quotes were taken directly from sessions to illustrate the examples and process.

I, the therapist, spent some time explaining the nature of irrational beliefs with Neo's mother, Rumbi, and the connection of her thoughts to her feelings and behaviour regarding her reaction to Neo. Rumbi had insight and an attempt was made through disputation to develop alternative thinking.

The methods involved in REBT treatment of Neo's mother included:

- The connection between Rumbi's thinking, feeling and her behaviour was established with regards to Neo.
- Irrational beliefs were disputed in a systematic and logical way, for example, her language was changed from shoulds, oughts and musts to preferences.
- Contingency management was explained.

Rumbi had the following irrational beliefs and inferences in relation to Neo and his behaviour and discipline:

- demand for consistently perfect behaviour, *'he must behave at all times;'*
- Inferences containing catastrophic prediction, *'if he misbehaves it means he may end up like others in the neighbourhood, and turn to criminal behaviour;'* and
- dysfunctional inferences in which Neo was perceived as consistently misbehaving and as an inconsiderate child: *"He thinks little of himself or me, especially me."*

Accordingly, Rumbi noted Neo's negative behaviour but did not deal with it effectively.

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4.3.1.1. Disputation

Empirical and logical disputations were all used in sessions held with Rumbi to dispute the irrational thinking that led to her experiences in connection with Neo and the often-ineffective way of disciplining him.

4.3.1.1.1. Demands

Empirical disputation was mostly used in sessions held with Rumbi to dispute the irrational thinking that led to her ineffective discipline of Neo and her dysfunctional emotions associated with Neo's behaviour. For example, through Socratic questioning and reflection, Rumbi's irrational inferences regarding Neo's bad behaviour being a general condition was explored and evidence was gathered for his improvement regarding higher incidences of good behaviour. An empirical disputation was used for this, which culminated in the functional/rational statement: *'no one can be perfect all of the time.'* In this way a basis for challenging the demand for perfection (the demand for *"goodness"* and that *'he must behave at all times'*) was established by finding evidence for Neo's good traits which did not just disappear when he misbehaved. His bad and good behaviour existed side by side. The following excerpt is from an empirical dispute that answers the empirical question: what evidence do you have that Neo has good traits and behaviour that continue to exist regardless of his bad behaviour? A didactic style was used.

Therapist: He's got good, he's got bad…

Rumbi: Agrees…

Rumbi: When I see him, nobody doesn't know him, the kids they only love Neo. They know him, everyone knows him.

Therapist: Others love him.

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Rumbi: They all love him, he never fights, he sees other kids fighting, he will stop them.

Therapist: Ya, I've noticed that he tries to help out.

Rumbi: Ya, he was going through a phase last year, seriously, 'cause he's not that type of person anymore.

Therapist: He's not that person, but sometimes he can be that person, but it doesn't make the other side of him disappear.

Rumbi: Disappear, ya.

Catastrophic inferences were associated with this demand: *'It is the worst thing in the world if he gets into trouble'* (implied from catastrophic inferences). Rumbi believed that due to the area in which they lived Neo would join a gang and engage in criminal behaviour; *If you look at the neighbour's kids, they are not on track [in gangs and engage in criminal behaviour]."* These inferences were challenged by logical disputation.

Another inferred demand was that *'Neo should always be considerate.' "He thinks little of himself or me, especially me as he knows that I am not well."* This was challenged using an empirical dispute. Rumbi looked for evidence that Neo was a caring child despite his misbehaviour. At the end of the session, she was able to concede to a nondogmatic preference; *"He does care. He is just acting up for that moment."*

In the final session with Rumbi, a discussion was held around Neo being in trouble that week. His behaviour had regressed but not to the level at which it had been before therapy began. All of Neo's improvements disappeared from Rumbi's thinking and she claimed that there had been no positive reports. Evidence was pointed out, such as the comment on his latest school report, that he indeed had many positive acknowledgements for his behaviour, and that he had bad reports for the last two weeks only. Despite this evidence,

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Rumbi repeated the behavioural pattern and withdrew from the session. Neo had an accurate perception of how his mother would react if he made a mistake.

To make it easier for Rumbi to attend, therapy sessions were offered at her place of work, but she declined this offer saying that, due to her illness, she could no longer participate but that I could continue sessions with Neo. Rigorous disputation had not yet begun in earnest with Rumbi, and she withdrew before the therapy process was completed.

At the end of the final session, Rumbi made a request to work on improved communication with Neo. In response, a joint session between her and Neo was arranged for the following week. This session unfortunately never materialised. Had this session occurred, improved communication between the two could possibly have been initiated. This, along with working on Rumbi's tendency to negatively evaluate Neo every time he did something wrong, and her demand for perfection, could have effectively changed Neo's context. Rumbi's behaviour could have been replaced with effective contingencies, empowering her as a parent, and supplying Neo with the necessary structure with clear guidelines. Neo's behavioural change would have been more likely to be sustained, as it would have been supported by the context. Examples of empirical and logical disputations used in the four sessions held with Rumbi are found in table 10. This table also includes Rumbi's empirical disputations tabulated against her irrational beliefs.

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Table 10

Rumbi's Disputations Are Tabulated Against Her Irrational Beliefs

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Neo's mother learns that he gets into trouble at school.	Demand: *'He must always be well behaved'* Expressed: *"I'm expecting too much from him…I expect more goodness from him."* [than he can deliver].	Emotional consequence: Anger Behavioural consequence: Loses her temper and disciplines physically and out of control, (smashing cell phones and throwing things). Later withdraws.	Empirical disputation; to lessen the dogmatic demand for perfection. Q: What tells you that Neo has good and bad behaviour that exists side-by-side. A: Therapist: *"He's got good, he's got bad…" "Others love him… he means well… if he sees other kids fighting, he will stop them."*	Rational Belief: Nondogmatic preference. *'No one can be perfect [display goodness] all the time. I cannot expect it.'* *'It [bad behaviour] doesn't make the other side of him disappear."*
Situational Activating Event: Neo's mother learns that he gets into trouble at school. Inference: *'If he is not consistently well-behaved it means he will become a criminal.' "It [Neo's behaviour] scares me because he's a boy, and boys are different from girls… And where we stay… If you look at the neighbour's kids, they are not on track[in gangs and engage in criminal behaviour]."*	Awfulizing: *'It is the worst thing in the world if he gets into trouble.'* (Implied from catastrophic inferences.)	Emotional consequence: Anxiety Behavioural consequence: Shouts at Neo and disciplines in an uncontrolled manner.	Logical dispute: to de-catastrophise the inference that all the children in the area are criminals and the prediction that Neo will be too if he misbehaves. Q: Do all the boys in the neighbourhood belong to gangs and engage in criminal behaviour? A: *"Some are fine. They listen to me, and they respect me."* *'Just because he is naughty, it does not necessarily follow that he will become a criminal.'*	Rational belief: non-catastrophic alternatives. *'Not all of the children in the neighborhood engage in criminal behaviour'.* Logical alternative statement *'Just because he is naughty, it does not necessarily follow that he will become a criminal.'*

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Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Neo's mother hears that Neo got into trouble at school. Inference: *"He thinks little of himself or me, especially me as he knows that I am not well."*	Demand: *'He should always be considerate.'*	Emotional consequence: Hurt Behavioural consequence: Withdraws from Neo.	Empirical disputation: to challenge the demand for constant consideration and establish that sometimes Neo is caring, despite his misbehavior. Q: *"What tells you that Neo is sometimes a considerate and caring child?"* A: *"He wants to know what I think ... No, he does care, I know that one I know. ...you can see when he's called into order, he regrets the acting up then he feels ashamed you know."*	Functional belief: Nondogmatic preference to challenge the inference. *"He does care. He is just acting up for that moment."*

4.3.1.2. Contingency management

During the contingency management sessions, psychoeducation was used to teach Rumbi the principles of identifying the target behaviour clearly and defining it for Neo, finding effective rewards for the absence of these behaviours and the punishments for behaviours that needed something more than just the absence of reward as a deterrent. The emphasis was on positive reward for good behaviour. These contingencies were hypothesised as specifically effective for Neo. Pocket money was utilised as a reward, and not being allowed out with friends, was used as a punishment for challenging adults or being disrespectful. Rewards were to be given for the target behaviours of coming inside at his assigned curfew time, completing his chores, and listening to instructions without challenging. The school behaviours were included in the home chart. If no complaints were received from the school, he was to be given a monetary reward and punishment was given if he had challenged adults or had been disrespectful.

In the first session that occurred after the introductory sessions the focus was on establishing a consistent and effective contingency management (Kazdin, 2000) for Neo. At least part of each session was spent emphasising the importance of contingency management

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(Kazdin, 2000), yet Rumbi did not engage. I suggested that Neo record his own behaviour on the chart that we made, as I realised that Rumbi would not have time or energy to record the behaviour. The behaviour occurred mostly when she was not there. Unfortunately, this did not happen in practice. Rumbi did say in the final session that she had taken Neo out and was spending more time with him. This could have been used as a reward for his changed behaviour, but she did not return to explore this further.

4.3.1.3. Responsiveness

Responsiveness (Kramer & Stiles, 2015) to Rumbi occurred when I arranged a joint session to meet her request to open communication between her and Neo, in trying to find an alternative venue to make it easier for her to attend sessions, and in attempting to get Neo to fill in his own behavioural chart. I offered to meet Rumbi at her place of work for further sessions. Rumbi had too many financial and health stresses to engage in the process. The disputes were not completed due to the prematurely terminated process.

4.3.2. School context: treatment of Neo's teacher (Mbali)

As with Neo's mother, this process was supposed to involve sessions of contingency-management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014). The teacher, Mbali, gave report-backs on Neo's behaviour but did not engage in REBT for her own rigid thinking around the discipline of the disruptive behaviour of Neo. She did alter contingencies around Neo if they were already part of her behavioural repertoire. During the feedback sessions she became more consistent around application of these contingencies and conceded to reward Neo with prefect duties for good behaviour, as she had done previously with his friend Moses who features in the following chapter. This reward included such things as monitoring the class when the teacher left the room and other responsibilities. Neo had wanted to be a prefect

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but had not been awarded the role due to his disruptive and oppositional behaviour. Sending him out of the classroom was already in place as a punishment.

The teacher initially claimed that she got attached to the children and took it personally when they did not fulfil their potential. When this happened, she thought that they were wasting their parent's money, their potential and her time and taking the opportunity to learn away from someone else. This could be true, but if there is any rigidity of thought due to irrational thinking, this could lead to anger when dealing with these children. According to the TIBS (Huk et al., 2019). *Attitudes towards the school organisation* score fell in the high level of endorsement of irrationality category, the *authoritarian attitudes towards pupils* attained a score in the moderate level of irrationality category, so both these scores indicated irrationality which supported that there was rigidity of thought. Initially this teacher claimed that she would think that she could have done more to help these children and that this thought stressed her. On exploration of this through Socratic questioning, she later claimed that she knew that her hands were tied and that she recognised that it was beyond her control. It was evident that she could rationalise when it came to discipline of the children and achievement of control within the classroom even though she would not be able to explain the process in terms of the REBT (Diguiseppe et al., 2014) model. She claimed that she had no stress or feelings around her work. As she did not consent to the REBT (Diguiseppe et al., 2014) sessions apart from an initial introductory session to explain the model, the irrational beliefs indicated by the teacher and evident in the TIBS (Huk et al., 2019) were not addressed therapeutically. Despite the initial sessions, she had no understanding of the model, other than that I was working with the way in which the children thought about situations. This teacher believed she was good at her job and was not open to change.

I failed to engage any of Neo's system. This was one of the reasons that this case study was included, as Neo did respond to therapy, even though his system did not fully

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engage. According to the MST framework this intervention would be less effective, especially as Neo was a teenager and therefore intrinsically linked to his context (Swenson et al., 2005).

4.3.2.1. Contingency management in the school context

Despite not fully engaging, Neo's class teacher did apply contingency management (Kazdin, 2000). It was however her already applied interventions as opposed to picking up any new methods form those described to her in the process (Kazdin, 2000). By the end of the process she was more consistent in her application and her focus on positive reinforcement for good behaviour increased. He was sent out of class on a more or less consistent basis. Although Neo sometimes found friends outside, this did work as an effective punishment for him, as he did not want to miss schoolwork. What did change through discussion was that prefect duties were used by his teacher as positive reinforcement, and this was not present before even though they had been introduced for Neo's friend Moses. They were, however, less effective with Neo. As stated, it seems generally that the contingencies were more systematically and robustly applied due to the weekly conversations that I had with the teacher.

This teacher worked in a way that accommodated for the average child. She created an atmosphere in which learning could take place; but as for the remediation of behavioural problems the phrase *"I can't be expected to…"* describes how this teacher saw the situation of disruptive children. There are many children in the classrooms and the behavioural problems are widespread. She was the educator, and her primary role should not be that of remediating disruptive, impulse control and conduct disordered behaviour. This teacher did have a lot of work to do and her own family responsibilities, so it was difficult to engage someone in this position in a multisystemic approach (Swenson et al., 2005). Her pre-existing thinking around the situation, that she did not regard the behavioural problems as her primary responsibility was the main reason for the lack of engagement in the process. Due to this she

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was not motivated to engage as she believed that she had dealt with the situation well according to her own needs and perceptions.

4.3.3. Treatment of Neo

Connections between thinking, behaviour and feeling were explained to Neo according to the REBT (Diguiseppe et al., 2014) theory and concepts. His irrational beliefs, stated above, were challenged through the REBT (Diguiseppe et al., 2014) therapeutic disputations initially to weaken them, and subsequently find functional/rational beliefs that would influence his behaviour. Initially, and throughout the process, psychoeducation was used to explain and introduce the approach and concepts.

The methods involved in the REBT (Diguiseppe et al., 2014) treatment of Neo included:

Most of the techniques described in the literature review (DiGuiseppe et al., 2014) were utilised. General therapeutic techniques such as Socratic questioning and reflection were used to explore Neo's world. This helped to establish relationship by creating an understanding of and communication of this understanding regarding Neo's beliefs and how they maintained his ODD behaviour. Psychoeducation was used to initially explain the REBT (Diguiseppe et al., 2014) model, the connections between thinking, feeling, behaviour, and other concepts. Both client awareness through induction and inductive interpretation (Diguiseppe et al., 2014) were used in Neo's process. The latter, more directive approach of the therapist having to find the irrational belief patterns under the examples of the inferences provided by the client, was often used in Neo's case. Through these techniques and disputations, the irrational beliefs were weakened before functional/rational beliefs could be established.

I, the therapist/researcher, always presented these discovered patterns as hypotheses. Homework assignments were used to solidify concepts, disputations and alternate ways of

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thinking and check the understanding and application of the techniques. Other perspective taking was used to help Neo to see that his thoughts about what people were thinking and doing were not always accurate. Others were thinking about things differently to the way he did. These sessions were used as evidence that his inferences about certain situations being unfair were not always true. Neo was asked repeatedly to explain the discussions back to me, or I would ask him how he understood a disputation I, the therapist/researcher presented. He was also often asked to explain the REBT (Diguiseppe et al., 2014) model back to me to make sure that he understood what had been discussed:

Therapist: So how do we help you? And how do we help you to stay out of trouble? …

Neo: To change my behaviour. [Neo identifies his behaviour which was often his focus]

Therapist: And how do we do that?

Neo: Accepting when I've done something wrong. [we spent time in this session on denial of bad behaviour and what effect this had on others]

Therapist: And when you haven't done something wrong…

Neo: Trying to stop me from getting angry. [Neo identified his feelings]

Therapist: What are we looking at that you haven't said yet?

Neo: What the other person feels? [he had absorbed other perspective taking focused on in this session]

Therapist: Yes, what the other person feels and what else?…what were we looking at with you? [I tried to get him to identify his thoughts]

Neo: I go into denial. [He explained his behaviour]

Therapist: …What part have you left out?

Neo: What did you think?

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Therapist: Ya, ...The way you think, how is it going to affect you?

Neo: My actions, what I'm going to do and feel.

Therapist: …what is the thinking pattern...that is attached to your behaviour?

Neo: The behaviour is not fair." [It was often difficult to guide Neo to any evaluative belief, such as 'it must be fair']

4.3.3.1. Disputations

The two main disputations used were:

- The pragmatic/functional which used questions such as: 'Where is this belief getting me? Is it helping me or making the situation worse?'; and
- The empirical or reality testing which used questions such as: 'Where is the evidence to support this belief? Is it really going to be that awful? What tells me that I am not good enough?'
- The functional disputes seemed to be the most effective with Neo. This is in keeping with the experience of practitioners at the Ellis Institute (Diguiseppe et al., 2014). This was the disputation that Neo used outside of the sessions in the classroom. *'Life is unfair, how does it help me to demand that it is?'* He often focussed this dispute on concrete behavioural elements: *'How will this behaviour help me to stay out of trouble? What can I do differently to stay out of trouble?'*

When asked what had helped him most at the end of the process, he stated that it was the disputations that challenged the inferences and demand for fairness.

Here follows an example of an excerpt from a functional dispute along with an example of responsiveness (Kramer & Stiles, 2015). The dispute was changed to a functional one, as Neo was not completely convinced of a different dispute:

Therapist: …you are brighter [more intelligent] than a lot of other people…

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What do you think about that?… Sometimes life is unfair to our disadvantage and sometimes it's unfair to our advantage… And sometimes, sometimes it helps us to deal with unfairness when we can see that there are other things are unfair in our favour… It's kind of like an acceptance of the unfairness.

Neo: Maybe.

When I thought he may not be convinced of the current argument (as he replied "maybe"), I tried a different disputation. I moved to a functional dispute. This is an example of responsiveness and a functional dispute:

Therapist: … Does it help to get angry when things are unfair? [from a functional dispute]

Neo: No, it makes it worse [this way of thinking seems to make sense to Neo].

Homework assignments based on the sessions were also part of treatment and were used either for identifying thoughts, feelings, and behaviour related to a certain trigger or practicing a disputation. Homework assignments were used to solidify what had happened in the session and to check understanding.

4.3.3.1.1. Demands

If the demand for fairness could be weakened and the thinking become less rigid (changed to a preference) it was hypothesised, in accordance with REBT theory (Diguiseppe et al., 2014), that Neo would no longer need to insist on challenging the teacher's reprimands to make life fair. The following were taken from homework assignments and sessions, and these were used by Neo to accept the situation in the classroom that was sometimes unfair. They were collaboratively created by Neo and me, the therapist/researcher:

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The functional dispute worked best with Neo to weaken this demand:

'How will it help me to demand that life is fair? I'm just going to frustrate myself by demanding that I must make it fair.'

"I won't be able to drop it [the classroom situation where he is reprimanded] *and move on* (Neo)*"* [stop challenging the teacher and move on with his day].

The functional/rational beliefs that Neo used outside of therapy were not always what would be the technically preferred REBT (Diguiseppe et al., 2014) conceptualisation. The question *'how does it help me to demand fairness?'* is used in functional disputation. When this question was asked, Neo would list the way in which the demand would be unhelpful: *"I won't be able to drop it [and accept the reprimand]."* The more concrete thinking seemed to make more sense to Neo. Due to this, inferences were often disputed, and rational inferences were used as alternate beliefs. Evaluative beliefs were challenged less often, and this was mostly initiated by me, the therapist/researcher. It still falls under the functional disputation but is not as adept as using the functional/rational disputation for the demand for fairness which could have been generalised across different contexts. Disputing inferences were effective for a specific context.

After the irrational beliefs were weakened through disputation, the following alternate, functional/rational beliefs (listed below) were found for the demand for fairness.

'Life is not fair. Life is not fair for anyone all of the time.' In Moses and Neo's words (taken from joint sessions), *"Not everything can go your way. Let me just accept it."* Using these, functional/rational beliefs, Neo's demand for fairness was weakened.

Another functional/rational belief used to help Neo accept unfairness was: *'Sometimes life is unfair in my favour as others get into trouble for what I have done.'*

After dropping this demand for constant fairness and subsequent exploration of the sequence of events that led him into trouble, he was able to recognise his part in the situation

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that he found himself in. The functional/rational inference "*if I am honest with myself, I can let it go* (Neo)" led to relief and the de-escalation of anger and less behavioural challenging:

Neo: Mam, I feel a bit of closure.

Therapist: So, you won't get so angry?...

Neo: Mam, I won't, if I'll be honest with myself…

Initially the elegant solution according to REBT (Diguiseppe et al., 2014) (to accept the above inferences as true) was used, and as such it was accepted that the teachers' reprimands were indeed unfair. This helped to establish a therapeutic alliance and helped Neo to deal with his demand for fairness.

Dropping the demand for fairness allowed Neo to relinquish trying to make it fair for himself as he perceived it. At the end of the therapeutic process, he was able to say*, "It will make it worse"* if I try and make it fair *"I can let it go"* and then the anger will decrease. Neo's disputations in this regard are represented in table 11.

Table 11

Neo's Disputations and Functional/Rational Beliefs Are Tabulated Against His Demand 'It's Not Fair'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: *Neo gets into trouble for ODD behaviour. "it's not fair."*	Demand; '*this is not fair. It must be fair. If it is not fair, I must make it fair.*'	Emotional consequence: Anger Behavioural consequence: Denies his misbehaviour and challenges the reprimand.	Functional disputation Q: Functional dispute: How does it help you to demand fairness? A: *"I won't be able to drop it [the classroom situation where he is reprimanded] and move on"* [stop challenging the teacher and move on with his day] if I demand fairness.	Rational beliefs: nondogmatic preference. *"It will make it worse" if I try and make it fair. "I can let it go"* (If I drop the demand and change it to a preference).

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I must deny behaviour as I must avoid getting into trouble. Neo denied his misbehaviour in order to get out of trouble, so that his mother would not find out and become seriously ill because of it.

An empirical disputation was used to challenge the inference that denying behaviour would avoid trouble: *'Evidence shows that I do get into trouble, even if I deny it. Denying misbehaviour only helps me to get out of trouble 5% of the time.'*

This functional rational belief was attained through challenging associated inferences using functional disputation. *'If I deny what I have done, it makes things worse for me. It helps me if I am honest with myself. I can "let it go."* Neo could let the perceived unfair situation go and admit his behaviour.

Awfulizing and associated inferences flowed from the demand I must avoid getting into trouble*:*

The inference, I will make my mother seriously ill if I get into trouble and implied awfulizing, was weakened by a logical dispute. After therapy Neo believed that, although he may upset his mother if he gets into trouble, this was not the reason that she became seriously ill.

An excerpt from the logical dispute follows:

Therapist: When you were nine Neo, were you as much in trouble as you are now?

Neo: No mam, I didn't get in trouble back then.

Therapist: You hardly got in trouble back then?

Neo: Mam, just today I was talkative, tomorrow I was quiet…

Therapist: Ya, so you were not in trouble then, but your mom got sick.

Neo: Yes mam.

Therapist: So, how could that have been your fault Neo?

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	[How does it logically follow that your behaviour caused her illness if you were not in trouble then, but she became ill]
Neo:	Mam, it's not that it was my fault mam, it's just that I didn't want to…
Therapist:	Put any more strain on [her]?
Neo:	Yes mam.
Therapist:	So that's …a big responsibility.
Neo:	Yes mam.
Therapist:	…you can't make someone else sick.
Neo:	Upset.
Therapist:	[they can get] upset yes, she's going to be maybe upset but being upset doesn't make you sick [HIV positive and cancer].
Neo:	Mam, I know."

Here it was necessary to challenge the irrational inferences that Neo held.

Neo's disputations in this regard are tabulate at table 12.

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Table 12

Neo's Logical Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'I Must Deny Misbehaviour/ I Must Not Get Into Trouble' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Neo gets into trouble for ODD behaviour. Inference: *If I get into trouble it will make my mother ill. 'I cannot afford it"* [to get into trouble].	Demand: '*I must deny misbehaviour/ I must not get into trouble.'* Awfulizing: *'it is the most awful thing to get into trouble, because it will have disastrous effect on my mother's health.'*	Emotional consequence: Anxiety Behavioural consequence: Neo denies his misbehaviour and challenges the reprimand.	Logical Dispute: Q: If my mother became ill when I was well-behaved, how does it logically follow that my behaviour caused her illnesses? A: 'Neo changes "ill" to the word "upset."'	Rational Belief: *'Getting into trouble is not the worst thing in the world as it does not cause these awful illnesses.' 'She may be "upset" by my behaviour, but it will not cause illness.'*

Demands: Others should not have such high expectations of me. They must recognise my change. His associated inferences were that *'if people do not recognise his behavioural change, it means they think he has "gone back to square one* (Neo)" *and he will 'never meet up with their expectations.'* This led to sadness and giving up on improving behaviour.

An empirical disputation was used to challenge the inferences that Neo could not meet teachers' expectations. The evidence of this was attained by comparing the changing of the attitudes of the teachers towards the two boys, Neo and Moses, during the therapeutic process. The joint sessions with both Neo and Moses in attendance provided concrete evidence and examples of this. This presented evidence that Neo could reach expectations some of the time and that his behaviour was viewed as: *"not that bad"* (Neo), by his school system. When his behaviour changed the teacher's changed towards him. Out of 12 teachers, Neo thought that about five recognised his change in behaviour. At parents evening, which happened once a term, Neo was now recognised as behaving well. An excerpt from this disputation follows:

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Therapist: What about this one [example] that we spoke about? [as evidence that he can meet expectations]

Neo: Parents meeting?

Therapist: Ya, isn't that your general report?

Neo: Mam, parents meeting only happen once a term.

Therapist: They happen once a term; and all these incidents happen throughout the term; but at the end of the term, if they tell you that you've been okay, what does that tell you about how they generally feel about you?

Neo: Mam, that I'm not that bad.

According to Neo the functional/rational belief that *"I have tried, and I have improved"* helped him to counter these demands and inferences. The inferences cited above did seem to be true regarding his mother. The elegant solution (accepting that this indeed was true) was used, and no matter whether others recognised this or not, Neo could acknowledge his own behaviour had changed. Neo believed that the teachers were unfair towards him and that this may not change. Accordingly, the acknowledgment of this fact, and finding a way of thinking that could still allow functional emotion and lend motivation to maintain change, was explored. The functional/rational belief that would be effective according to Neo was: *"I have tried, and I have improved."*

Neo's disputations in this regard are tabulated at table 13.

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Table 13

Neo's Empirical Disputation and Functional/Rational Beliefs Are Tabulated Against His Irrational Beliefs Relating to 'People Must Not Have Such High Expectations of Me' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Neo's Mother becomes very angry about Neo getting into trouble at school and withdraws from him. Inferences: *'The expectations are too high and too hard to reach'. "Let's say, that I'm behaving, she thinks mam, that I'm gonna stay like that forever mam. Then the one-time mam, let's say mam. I make a mistake mam; she will think that I've gone back to square one."*	Demand: *'Others should not have too high expectations as it is unfair.* *They must recognise my changed behaviour'.*	Emotional consequence: Anger Behavioural consequence: Neo becomes demotivated and gives up on trying to improve behaviour.	Empirical Disputation: to prove that sometimes he does meet teachers' expectations and things are improving. Q: What evidence do you have that you do meet expectations some of the time? A: *"...parents meeting...comment on report...prefect duty rewards...developing self-control." 'Sometimes I meet expectations as: 'When I behave the teachers' behaviour towards me changes. Changing my behaviour changes their reaction.'*	Functional belief: *'This was the most helpful belief according to Neo; even if they do have too high expectations, I know that, "I have tried, and I have improved."'*

'I must not be controlled' To weaken this dogmatic irrational belief, the inferences were challenged by identifying situations that Neo could control in his life, such as choosing his own friends, doing what he wanted to do when at home, etc. This was not highly effective. This is in keeping with the REBT theory that advocates those challenging evaluative beliefs as opposed to inferences is the more effective technique (Diguiseppe et al., 2014). There were many situations in Neo's life that he could not control. *'Not all control is bad control',* seemed to be more effective dispute and conversations that considered the consequences of no control. The following were compiled by Neo and me, the therapist/researcher the therapist/researcher during these conversations:

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- *'If no one was controlled, then life would be difficult;'*
- *'If everyone behaved like me, it would be very hectic in class;'*
- *'Not all control is bad control;' and*

  The demand was challenged by introducing the following rational statement which encouraged Neo to, accept the situation as it was, drop the demand and turn it to a preference.

- *'It's not possible to have a life without control, so I cannot demand it...*

I, therapist/researcher, responsively changed to a different dispute when these did not seem to be as effective as I would have preferred. The following functional/rational belief was the most effective: *'there's control and power in self-control.'* This belief seemed to be the most effective, as lack of control was linked to the feeling of powerlessness. This functional/rational belief showed an alternate way of perceiving power: *'If I control myself, there will be less need for others to control me.'*

Here is an excerpt from the functional dispute:

Therapist: Because with that discussion [we had previously] of self-control, what happens then?

Neo: Mam, if I know that I can, like when I'm talking, and I know if I just stop myself, the teacher won't have to be shouting at me and tell me what to do.

Therapist: Ya, so when you've got self-control, others control you less

Neo: Yes…

Although this did not weaken the demand for control, it worked within it; it utilised a functional dispute to attain an alternative, adaptive way of perceiving control.

Neo's disputations in this regard are tabulated at table 14.

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Table 14

Neo's Functional Disputation and Functional/Rational Beliefs Are Tabulated Against His Demand 'I Must Not Be Controlled' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Being reprimanded. Behaviour restricted. Inference: *'I am powerless. They are trying to control me (and this is negative as I should not be controlled).' "It feels like control."*	Demand: '*I must not be controlled.'.*	Emotional consequence: Angry Behavioural consequence: Neo refuses to accept a reprimand.	Functional disputation: Q: Will self-control lessen control by others? A: '*If I control myself ,there will be less need for others to control me.' Neo: "Mam, if I know that I can, like when I'm talking, and I know if I just stop myself, the teacher won't have to be shouting at me and tell me what to do."*	Rational belief: '*There's control and power in self-control.'* Neo*: "...instead of them controlling me, I must have self-control." [Neo gave this as the most helpful rational thought].*

When asked what had helped him most at the end of the process, he stated that it was the disputations that challenged the inferences and demand for fairness. This is in keeping with the REBT model that places the demand schema as the underlying belief from which the evaluations and inferences originate and the challenging of the demand schema is the most effective (Diguiseppe et al., 2014).

4.3.3.1.2. Negative self-evaluation

The negative self-evaluation*: 'I must meet others' expectations, or it means I am not good enough'* was noted in Neo's sessions. This negative self-evaluation was related to demotivation, giving up and the emotion of sadness. It flowed from the demand*; 'I must meet other's expectations.'*

The functional/rational beliefs were used to challenge negative self-rating. Again, most effective functional/rational belief was, *"I have tried, and I have improved"* despite others' recognition of this or lack thereof. Therapist: *"It is you that needs to believe that you are*

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good enough" [despite not being perfect in everything]. Here the recognition of behavioural change and being good enough shifted to Neo himself. The functional question was asked *'How does it help you to behave in any case?'* in relation to concrete advantages for Neo to behave despite any recognition of this. His answer to this was: "*I will suffer" [if I do not behave].* Neo's disputations in this regard are tabulated at table 15.

Table 15

Neo's Empirical Disputation and Functional/Rational Beliefs Are Tabulated Against His 'Negative Self-Evaluation'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Neo's mother becomes very angry about Neo getting into trouble at school and withdraws from him. Inference: '*I cannot meet the expectations; they are too high, and that is unfair.*' *"I'm always in trouble; so, you feel, what's the use, 'cause eventually you will be in trouble again."*	Negative self-rating: *'If I do not meet expectations, it means I am not good enough.'* Expressed: Q: "*Do you then think that you are not good enough?"* A: *"Yes."*	Emotional consequence: Sadness Behavioural consequence: Neo gives up on trying to improve behaviour.	Empirical disputation: Q: When are you good enough? A: *"Sports, gaming, schoolwork."* Elegant solution: *'Even if it is true that no one recognises his change and he did not meet expectation Neo can recognise his own improvement and self-worth:* *"I have tried, and I have improved."* Functional dispute: *'How does it help you to behave despite others recognition?'* Q: How does it help you to behave in any case? A: "*I will suffer" [if I do not behave].*	Functional belief: This was the most helpful belief according to Neo. *"I have tried, and I have improved"*, [I am making progress despite their lack of recognition.] Therapist: *"It is you who needs to believe that you are good enough"* [despite not being perfect in everything]

4.3.3.1.3. Other perspective taking

This was used, after the demand for fairness was disputed, to help Neo accept that he was often misbehaving. I thought that this was one of the main achievements in the therapy. From

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Neo's eighth session onwards, he recognised what it was about his own behaviour that caused him to get into trouble. When considering why his peers got picked on less often than him, he stated:

Neo: I think because they don't do it [misbehave] often

Therapist: Okay

Neo: The teacher will think it's just one of those days [for his peers].

Therapist: So, it's maybe because you do it more often than others.

This technique was utilised to increase Neo's cognitive flexibility so that he could understand how others may experience his behaviour. This was utilised to help him challenge his negative other rating. At the end of this process Neo was more aware of the effect that his behaviour had on others and their possible evaluation of him. The following excerpt illustrates this awareness.

"Neo: 'Cause mam, they don't know why I am smiling, they don't know what I'm thinking about, so mam, they expect the worst…

Neo: Mam, it was because I have done it many times." [Neo always recognised the frequency with which his behaviour occurs]

He showed consistency in his new ability to recognise the problems regarding his own behaviour and how others could be seeing him throughout the process: "*Cause mam, they don't know why I am smiling, they don't know what I'm thinking about, so mam, they expect the worst…"(Neo)*

Neo was asked to focus on how his behaviour of denying what he had openly just done would come across to others. He recognised that others would assume that he thinks they are *"stupid"* or that he is *"lying,"* and they would get angry and feel disrespected:

Neo: *"Sometimes mam, I'd say when I deny mam, they usually know I'm lying…"*

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At the end of the process Neo replaced his demand for fairness with: *"I was being a problem."*

As therapy progressed, Neo's behaviour improved as he utilised the functional/rational beliefs above. The system around him, however, did not give him consistent contingencies of effective rewards. His mother's negative-other evaluation of him, acknowledged no change or anything positive when he misbehaved. Neo became discouraged.

4.3.3.1.4. Contingency management

As Neo's context was not engaged the context stayed mostly the same post-therapy. Neo's home context did not change as Rumbi, his mother, terminated therapy early. In the last session she stated that she had been taking him out more to spend time with him, but she seemed to be thinking of withdrawing this as Neo had misbehaved at school. Neo's teacher did become more aware of being consistent with contingency management and adding rewards. She applied the contingencies that she already used but more consistently. Neo now received rewards that had previously not been applied to him.

4.4. Evaluation of Impact

The plan was implemented, and therapeutic interventions were applied. The process was tracked, and progress monitored (Edwards, 2018). The evaluation and impact of the treatment was assessed using the self-report scales (irrational belief scales) and Conners Rating Scales (Conners, 2007) behavioural measurement scale administered before and after treatment. The irrational belief scales compared the teacher's, parent's, and child's irrational beliefs before and after treatment. The Conners Rating Scales (Conners, 2007) compared the child's behaviour before and after treatment. In this case, Rumbi withdrew from the therapy, so not much seemed to have changed in Neo's home context; and the only monitoring that occurred,

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was the mother's verbal feedback stating that after two sessions, Neo had improved at home. She did not complete the Conners Rating Scale (Conners, 2007) before or after therapy nor the PIBS (Joyce, 1995) post-therapy. The teacher, Mbali, was erratic in filling in behavioural charts for the week; so, after she was familiar with the target behaviours, I resorted to face-to-face sessions and WhatsApp messages to obtain reports on Neo's behaviour. These verbal reports were used to get an idea of changes in Neo's behaviour as perceived by the teacher. Precise measurement in this reagart that is required for rigorous research was not available due to lack of co-operation from the system.

4.4.1. Behavioural and self-report scales

The Child and Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015), Revised Belief Scale for Parents (PIBS) (Joyce, 1995) and Teacher Irrational Belief Scale (TIBS) (Huk et al., 2019). The scores for Neo's case are discussed below. The interpretation for these scores is set out in tables 3a and 3b. The Conners Behavioural Rating Scale (Conners, 2007) measured Neo's behaviour and the interpretation is set out in table 2.

4.4.1.1. Child and Adolescent Scale of Irrationality (CASI)

The following results appear in Figure 5 below.

Demand. Pre-therapy Neo's demandingness fell in the moderate level of irrationality, and was the highest score obtained on the CASI (Kassay et al., 2015). Much time was spent working on Neo's demand for fairness, as this was considered the underlying demand schema from which the other evaluative beliefs emanated. This score decreased substantially post-therapy from the moderate level of irrationality to the more-rational-philosophy-endorsed level. This result was congruent with Neo's reported opinion that it was the discussions around fairness that he found most helpful. The result was not significant according to the reliable change index (RCI) found in appendix J.

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Frustration intolerance (LFT). Neo's scores for *LFT* remained unchanged post-therapy and still fell into the more-rational-philosophy-endorsed level. This was corroborated in sessions, in that this evaluative belief did not seem to feature, suggesting that *low frustration tolerance (LFT)* was not a problem regarding Neo's ODD behaviour.

Other negative rating (ROW-O), although remaining in the more-rational-philosophy-endorsed level post-therapy, was seen to decrease after therapy but this decrease was not significant according to the RCI found in appendix J. Neo was upset by the perceived high expectations others had of him. He believed that no one recognised his behavioural changes. Evidence did exist to suggest that the inference that '*others' expectations were too high'* was indeed true, at least with regard to his mother. His friend, Moses also obtained more recognition from the teacher regarding behavioural change than did Neo, though the Conners scales (Conners, 2007) would suggest otherwise. According to this scale Neo's behaviour showed more improvement compared to that of Moses (figure 8 and figure 13). Neo's negative other rating was not directly addressed in therapy, although some related inferences were. This irrational belief became more prominent at the close of therapy at the end of his school year.

Negative self-evaluation (ROW-S) scores, both pre-and post-therapy, fell in the more rational level, but the post-therapy score decreased significantly according to the RCI found in appendix J. Some time was spent on the evaluative belief *'If I do not reach expectations, it means I am not good enough.'*

Awfulizing. Although both scores, pre- and post-therapy, were in the more-rational-philosophy-endorsed level, the *awfulizing* score increased non-significantly according to the RCI found in appendix J.

The total average scores fell in the more-rational-philosophy-endorsed level, both pre- and post-therapy, but decreased post-therapy non-significantly according to the RCI found in

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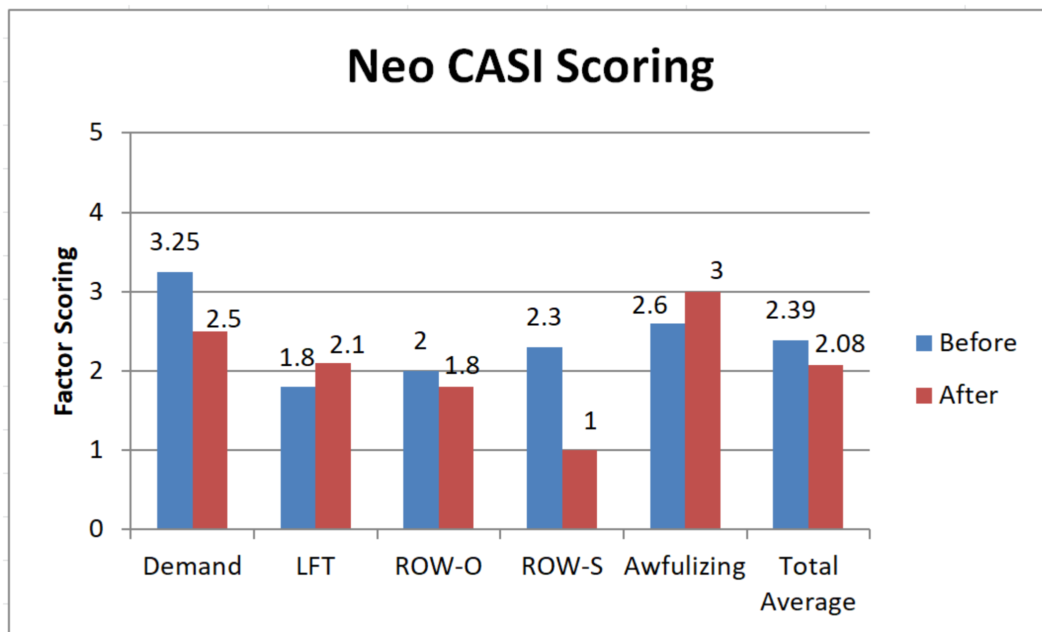
appendix J. Neo's CASI (Kassay et al., 2015) scores on each of the above, is set out in figure 5.

Figure 5

Bar Graph Showing Neo's CASI Scoring



4.4.1.2. Neo's mother's irrational belief scale

As Neo's mother dropped out of the study, only the questionnaire before therapy was available (the results of which appear at figure 1). The scores all fell within the high level of irrationality indicating the need for clinical intervention. In sessions Rumbi was invested in presenting a positive picture of her current situation with Neo. She did not want to speak of the problems that she had encountered with him the previous year. However, she would have needed to recognise her irrational thinking with regards to the behaviour in order to influence future behavioural change. She was an intelligent person with a responsible position in a hospital, so it is possible that she could have recognise irrational thinking and related behaviour if she had engaged in the therapy process. There was also evidence of her recognition of her own irrational thinking: *"I'm expecting too much from him…I expect more*

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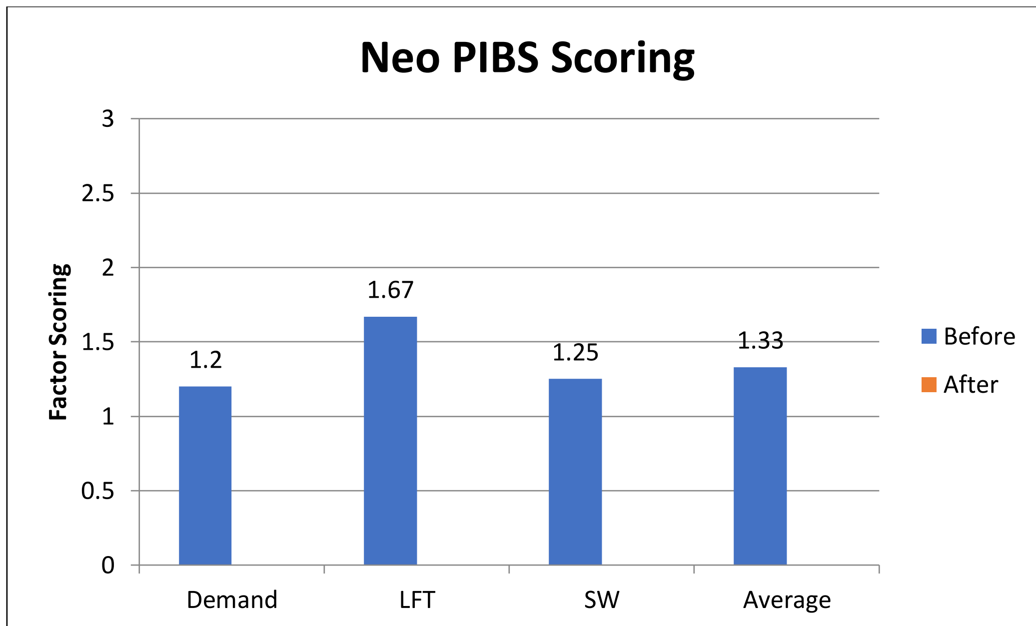
goodness from him, that's why I withdraw when he does something wrong." There is a possibility that the denial of anything being wrong observed in Neo's sessions and behaviour, could be mirrored here. This is the pattern that Rumbi modelled for him. Rumbi insisted that Neo's behaviour changed immediately and completely. This result found on the PIBS (Joyce, 1995) that reflected that Rumbi's thinking was mostly irrational was corroborated as sessions progressed. Demandingness and other irrational thoughts were evident. The results of the PIBS (Joyce, 1995) pre-therapy are found in figure 6 below.

Figure 6

Bar Graph Showing Neo's Mother's (Rumbi's) Scores



4.4.1.3. Neo's teacher's irrational belief scale

The teacher's *attitudes towards the school organisation* score significantly decrease according to the reliable change index (RCI), found in appendix I, from a high level of endorsement of irrationality pre-therapy, to a more-rational-philosophy-endorsed level post-therapy. The items on this subscale are related to teachers' needs to be involved in the

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running of the school, i.e., that they be considered in decision-making and that their problems be listened to, etc.

I, the therapist/researcher only pointed out to the teacher that demandingness was evident in her TIBS (Huk et al., 2019) responses, and that REBT (Diguiseppe et al., 2014) could be used to help decrease dysfunctional emotion that would be associated with these demands. The teacher replied that this was just how she thought it should be, not that she experienced these issues. If she did experience these issues, then the belief scores initially reported would give rise to intense feelings and the associated behaviour that would likely not be effective in addressing the problems.

For the category *authoritarian attitudes towards pupils,* the score fell into the moderate level of irrationality category, which decreased non-significantly according to the RCI found in appendix I, to a more-rational-philosophy-endorsed level post-therapy. A high score on this subscale implies intolerance towards the disciplinary problems of the pupils. Teachers believe that they cannot stand the pupils misbehaving, and that in such cases, they should be severely punished. The total category for irrationality decreased insignificantly according to the RCI, found in appendix I.

As this teacher was not engaged in the process for herself, I did not pursue REBT (Diguiseppe et al., 2014) therapy with her. I did realise that there were issues between some management members and this teacher which could have contributed to her resistance to engage fully in the therapy process. She also claimed that she did not want to fill in the charts as she did not want the information about the children to be placed on their records. Whatever the reason was for her lack of engagement, I think that the change in score occurred due to the awareness of how the questionnaire should be answered, as opposed to any change in thinking. These results are found in figure 7 below.

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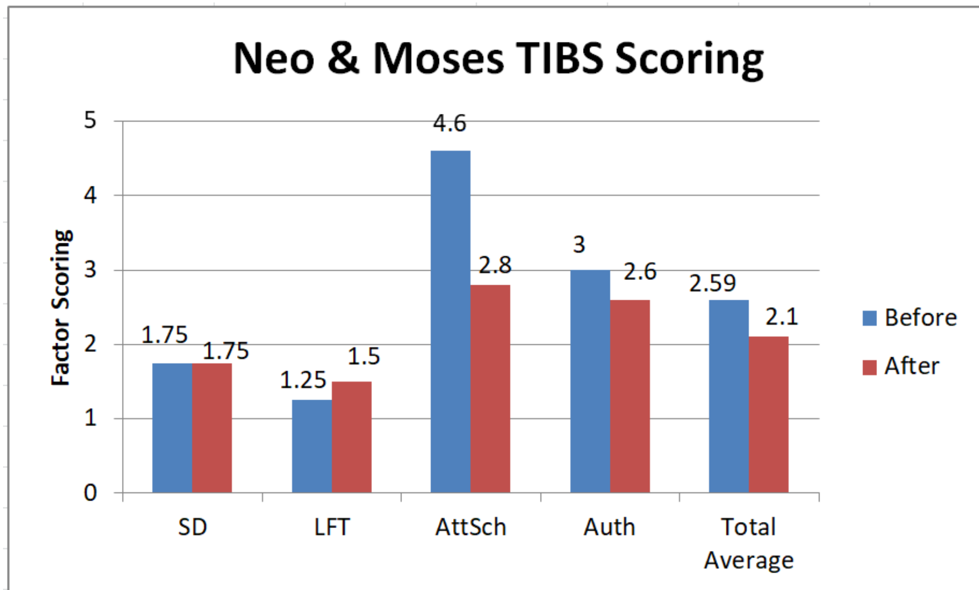
Figure 7

Bar Graph Showing the TIBS Scoring for Neo and Moses' Teacher (Mbali)



4.4.1.4. Conners Rating Scale as filled in by two of Neo's teachers

A very elevated score was allotted pre-therapy to Neo in the category *peer relations* and decreased significantly, according to the RCI found in appendix K, found in appendix K, to an average category post-therapy.

A very elevated score was allotted pre-therapy to Neo for the category *aggression/defiance.* Post-therapy, the score decreased significantly, according to the RCI, found in appendix K, to the elevated category.

A very elevated score *was* attained for the category *Hyperactivity/impulsivity* both pre-and post-therapy, but the score decreased non-significantly, according to the RCI, found in appendix K, post-therapy.

Learning problems and executive functioning attained scores in the average category both pre- and post-therapy with no significant change in the score according to the RCI, found in appendix K. The significance of the t-scores calculated using the reliable change index stipulated by the Conners manual (Conners, 2007) corroborated these results.

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Neo's before-and-after Conners (2007) rating scores from his class teacher are represented in figure 8.

Due to the difference in observations between the Conners Rating Scale (Conners, 2007) and the class teacher's verbal feedback, a second teacher was asked to rate him after therapy was completed. This teacher's allotted scores were much the same as Mbali's scores, although *defiance aggression* was slightly more elevated in the second teacher's assessment. The second teachers allotted Conners rating scores (Conners, 2007) are represented in figure 9.

Overall, although Neo's behaviour still caused concern although according to the Conners Rating Scale (Conners, 2007), it had significantly (RCI, found in appendix K) improved particularly in *peer relations* and *aggression/defiance.* Verbal reports from the class teacher gave a better report with regard to classroom behaviour and stated that he was *"...now like that of any other child."* Neo's behaviour could also be normalised as he had a difficult class to the extent that some teachers had refused to teach it.

Figure 8

Conners Rating Scale for Neo Pre- and Post-therapy (Class Teacher, Mbali)

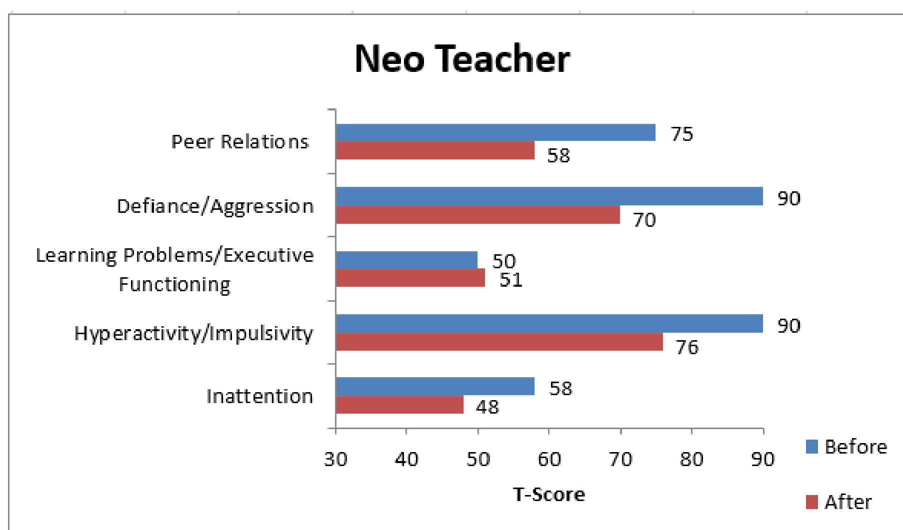

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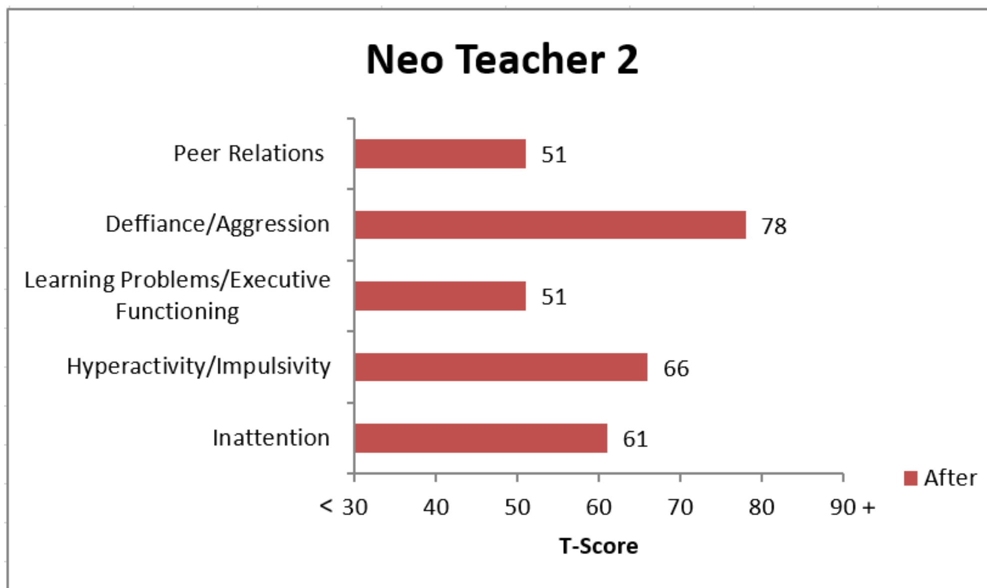
Figure 9

Conners Rating Scale for Neo Post-Therapy (Second Teacher)



4.5. Discussion

Overall, Neo's behaviour improved according to his teacher's weekly reports and her rating of his behaviour on the Conners Rating Scale (Conners, 2007) (figure 8). The weekly reports claimed, at the end of the process, that Neo was now like any other child in the class. The Conners Rating Scale (Conners, 2007), however, although showing a significant (RCI found in appendix K) improvement in the categories *aggression and defiance* and *hyperactivity//impulsivity*, these scores were still at a level that indicated more concerns than are typically reported. This discrepancy between verbal reports and allotted scores on the Conners Rating Scale (Conners, 2007) could be due to the comparison of Neo to his exceedingly difficult class, which was, according to his teacher, so difficult that some teachers had refused to teach it. His behaviour could have been average for that particular class. His behaviour had also significantly improved idiosyncratically, so this teacher may have been pleased with the improvement and viewed his behaviour now as acceptable, compared to what it was. It seemed from conversations with Neo however that his teachers'

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reactions to him were mostly unchanged. This could be Neo's own possibly inaccurate inferences about the situations, or it could be that the teachers' overall perceptions of the child, once he has earned a reputation, remain inflexible. The class teacher's verbal weekly reports did describe Neo more favourably though. Neo's friend Moses however did get more recognition for behavioural change than Neo did even though Neo's Conner's Rating Scale indicated greater change.

Mostly, the techniques of psychoeducation and inductive interpretation were used in Neo's therapy. He focussed very much on his own concrete behavioural changes 'How could I do this differently?' and less on changing his beliefs, although this quote itself indicates changed thinking regarding his behaviour. Irrational inferences were more often challenged than evaluative beliefs. I, the therapist/researcher, thought that the maintenance of his behavioural change would have been more reliant on contingency management if evaluative beliefs were not consciously included, emphasised, and disputed independently. I, the therapist/researcher experienced him as a more concrete thinker compared to the other three cases included in this current study. I also experienced his level of generalising as more limited. He would stay with the specifics of the situation, hence the frequency with which inferences were worked with as opposed to evaluative beliefs. I thought that these characteristics would limit Neo's capacity to use the treatment outside of the therapy situation.

The demand schema for fairness was one of the main irrational beliefs that was worked on during therapy. Neo's CASI (Kassay et al., 2015) (figure 5) showed a decrease in demand, but this decrease was insignificant according to the RCI (appendix, J). Negative self-rating showed a significant decrease according to the RCI (appendix, J). According to the CASI (Kassay et al., 2015), these evaluative beliefs indicated the largest change, both being within the more-rational-philosophy-endorsed level post-therapy. *LFT* remained in the more

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rational-philosophy-endorsed-level both pre- and post-therapy. Awfulizing increased from the more rational-philosophy-endorsed-level pre-therapy to a moderate level of irrationality post-therapy. This increase was slight and non-significant according to the RCI (appendix, J). The only significant change according to the RCI (appendix, J) was in Self Worth. Demandingness decreased just under significance level. As Neo did not develop an in-depth understanding of REBT (Diguiseppe et al., 2014), I, the therapist researcher, hypothesised that he would likely not use the REBT (Diguiseppe et al., 2014) model outside of sessions in a technically preferred way.

The inductive interpretation technique was utilised often, as well as psychoeducation; and this would probably have reduced the overall effectiveness of the approach outside of therapy, as both techniques provide guidance from the therapist, making the client less independent in the application of the model. This is a similar finding to that of Tshabalala and Visser (2011) when using a CBT approach while working with HIV positive women in an African context. It was noted that the cognitive techniques that were most effective were positive reframe and de-catastrophising. The more complex cognitive techniques, such as identifying underlying automatic thoughts and thus managing their own thoughts outside of the therapy situation, was not as successful. The therapist had to identify the thoughts for the clients in the therapy session (inductive interpretation). This finding was echoed in this case study. The disputations were mostly supplied by me, the therapist/researcher (inductive interpretation).

Socratic questioning was considered unsuccessful with most of the women in the study cited above (Tshabalala & Visser, 2011). In contrast, Socratic questioning was useful with Neo in disputation, weakening the irrational beliefs, and in the establishment of functional/rational thinking. It was suggested by Tshabalala and Visser (2011) that the techniques of trying to get the clients to identify their own thoughts and Socratic questioning

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could have been unsuccessful, as it was used too early in the therapy; or the women may not have the intellectual or self-reflective capacity to accomplish the identification of their own thoughts. They suggested that more time would be needed for clients to develop self-reflective skills. In this study, the process of therapy continued for seven months, so length of the therapy did not make a difference in Neo being able to identify his own thoughts independently. This could suggest that the extent to which REBT and other CBT techniques could be used is dependent on the cognitive ability or style and capacity to self-reflect. Some of the women (Tshabalala & Visser, 2011) were able to change negative thought patterns when the therapist highlighted these patterns, as did Neo; but the researchers doubted that the clients were equipped with the ability to manage their own negative thought patterns outside the therapy situation as do I, the therapist/researcher in the case of Neo.

In this current study, learning to understand the concepts of REBT (Diguiseppe et al., 2014) and the application thereof is a long, repetitive process in some cases where clients are not familiar with this kind of thinking. Although Edwards et al., (2012) conclude that CBT and REBT can be used as easily in the South African context as in the European and North American contexts where the approach originated, the level of application as to what works, and the degree of success may vary across these different contexts, age, and level of psychological sophistication of the client/or familiarity with the style of thinking that these approaches require.

The functional dispute seemed to be the most effective for Neo, but again, these disputations were often given to him (inductive interpretation). He did show an understanding of the specific examples we were working on when he was led through the process with Socratic questioning. He also demonstrated understanding of the REBT (Diguiseppe et al., 2014) model and the specifics of the disputation when he was led through the process. He

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used the functional questions and conclusions drawn from these disputes as functional/rational beliefs in the classroom situation and this independently.

It is however a high expectation for this adolescent boy working in his second language to be able to develop any further understanding of the concepts and model than he did. His understanding was adequate to attain behavioural change according to the teacher's reports and change in irrational evaluative beliefs according to the CASI (Kassay et al., 2015) results. The functional/rational belief that helped Neo, was that he knew that he had tried and changed no matter what others thought. He also believed that he would suffer if his behaviour did not change. These beliefs were Neo's own contribution. Own contributions were the ones most used in situations outside of therapy.

Neo's context remained mostly unchanged, and this could have increased the importance of changing his irrational beliefs to maintain his behavioural change. He would need a skill that would enable him to regulate his own behaviour. In summary the mother and teacher did not engage fully in the REBT (Diguiseppe et al., 2014) for their own irrational beliefs and therefore contingency management remained inconsistent at school, harsh or non-existent at home and generally ineffective across both contexts.

Neo's behaviour deteriorated after therapy as was hypothesised. At this point the school intervened with a contingency and said that they would deny him access to the end of year function if he continued to misbehave. His behaviour changed as it responded to this contingency instead of going into denial as he did previously. Post-therapy Neo was responsive to contingencies and reprimand. This contingency now reinforced his new alternate belief that he would suffer if he did not change his behaviour.

The following chapter looks at the case study of Moses. Moses supported Neo's inference that the teachers did not like him and behaved differently towards him compared to other children. Looking at the Conners Rating Scale (Conners, 2007) results, Neo was rated

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lower in *aggression and defiance* than Moses; and generally, his scores on the Conners Rating Scale (Conners, 2007) showed more significant change. However, Moses' behavioural changes were recognised with prefect duties before that of Neo's. The boys' inferences may have been true, Neo's improvements were not acknowledged to the same extent to that of Moses' improvements, either with prefect duties as rewards or in feedback sessions. This case study therefore supports the REBT practice of challenging the underlying demand schema; in this case, *"Life must be fair"* as being the most important technique (Diguiseppe et al., 2014). Neo had to deal with this situation when it was true, and life was indeed unfair.

The joint sessions, in this case held with Neo and his friend Moses, indicated that group work may be effective with these children. The child participants in this research project, had a common demand for fairness. If the situation was not fair, there was a need to make it fair. The irrational belief scales could be used to identify demandingness and other evaluative beliefs. The initial psychoeducation regarding teaching the model and some common irrational beliefs could be tackled in a group setting which would reduce the demand on the resources of the researcher/therapist. There is a possibility that the children could be used as a support for each other, and to generate ideas, as was noted with Neo and Moses.

This case highlighted that working with only one teacher is limiting, especially if that teacher is not co-operative. The contingencies need to be systematically applied to children across teachers in the school context and for this to be successful. Group sessions with teachers could be successful in ensuring that contingency management (Kazdin, 2000) around the child would be more systematically applied.

This case also suggests that the REBT (Diguiseppe et al., 2014) approach can initiate some change in behaviour even when the system does not change. However, concrete thinking and difficulty in generalising and understanding the model and application thereof can impede both maintenance and degree of change. The REBT (Diguiseppe et al., 2014)

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approach was useful for changing Neo's behaviour. If he could have applied the approach himself, and his context was engaged, I would hypothesise that Neo would have made greater and more sustained change.

This chapter described the case study of Neo's therapy process for oppositional defiant behaviour. The following chapter describes Moses' therapy process for Conduct Disorder.

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Chapter 5: Pragmatic, Embedded Case Study of Moses

This is the pragmatic, embedded case study of Moses, a 13-year-old boy who lived in a South African township. He turned 14 during therapy. He attended a school in a more affluent suburb, the same school as his friend Neo (Chapter 4). Like Neo he was in grade seven and in the same class. Both boys therefore shared the same teacher. As a result, some of the information in Moses' case study regarding the school and teacher overlapped with Neo's presented in the previous chapter. As Neo and Moses were friends and were aware of each other attending sessions, as were the families, permission was sought and granted to carry out some joint sessions with these boys. The school was attached to a church that belonged to a large, socially active, Christian denomination. The resources in the school were limited. It functioned from a house.

Nevertheless, it provided children like Moses with a decent education and smaller classes compared to some of the overcrowded schools in the township where he lived. It had qualified teachers, some computers, and a small yard for the children to play in, but resources were limited. Moses lived in a different township to Neo, but both areas were impoverished and violent. Moses had attended this school since grade naught. He has displayed behavioural problems since then. He reported that he struggled to make friends and only had a friend from grade three when Neo arrived at the school. Moses was included in this study as the school reported his behaviour to be aggressive towards other children and challenging towards teachers compared to others in his class. Moses' class was generally considered to be difficult to control behaviourally to the extent that some teachers had refused to teach it and Moses stood out even in this context as disruptive and aggressive. Moses' behaviour was considered to change for the better during therapy and the change in Moses was reported to be maintained after the therapy process ended, up to the follow-up enquiry two months after termination. The following case study report was written according to three sections

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(Edwards, 2018) described in the methodology (Chapter 3): *assessment,* this included the contracting section which mainly occurred in the first two sessions of therapy; *case formulation* which includes the treatment plan and the *treatment implementation* (Edwards, 2018). A section on *evaluation* is included which examines the various test results along with verbal reports from the mother and teacher. This section contributes to the understanding of change in Moses' conduct disordered behaviour. *Please note that in the case studies single quotation marks (' ') represents a paraphrased disputation or belief while double quotation marks (" ") indicated direct speech.

5.1. Assessment

Most of the information for this assessment was attained from the first two initial screening interviews with all three members of the embedded case study: Moses' teacher, his mother and Moses himself. The irrational belief scales and behavioural scale obtained in the first two sessions were also used. As therapy progressed information was added.

5.1.1. A background and life history

Moses lived with his mother (Thato), his baby half-sister and his mother's partner on weekends. Both Moses and his mother reported a good relationship between Moses' stepfather and Moses. Moses referred to him as 'dad' but did not speak about him in therapy unless he was asked. On weekdays Moses lived with his grandmother and his grandfather. His mother worked long hours, only returning from work around 7 pm or later and his grandmother was supposed to supervise Moses in the afternoons, but he was ineffectively discipline by her during the week. He would answer back, not do any of his chores and stay out past his curfew time instead of coming home to do his homework. Thato: "*My mom* [is mostly with Moses in the afternoons], *'cause I mean currently, ...it's too hectic, my timelines are just obscure, come home 7/8 in the evening, so by the time I arrive home my mother will*

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tell me he arrived at 7 o clock." Moses' mother lived just a few houses down from his grandmother. Moses did not like the arrangement of living with his grandmother as both he and his mother report that she shouted for no reason. The grandfather was an alcoholic and swore, shouted, and hit the grandmother when he was drunk. This seemed to occur mostly on Fridays when Moses was with his mother. If Moses saw his grandfather beginning to shout, he would go to his mother's house. The grandfather did not hit Moses, but he did swear at him when he was drunk.

Moses and his mother both reported that they have a close relationship. Moses said that his mother was the person that he spoke to about things that bothered him and that she cared about him. They spent time together talking and watching movies and television over the weekends. Although Moses' mother left much of his upbringing to his grandmother, whom she recognised as un-nurturing, inconsistent and unreasonable in discipline, she did take an interest in Moses. Most evenings during the week she went to her mother's house. She said her work commitments were problematic for her: *"An input of 90% and an output of 100% where do you find the work-life balance?"* (Thato).

Moses' biological father did not have much contact with Moses since he was about 18 months old. He requested contact with Moses when Moses was about 10 or 11 years of age but according to Thato, Moses wanted no further contact with him after an initial meeting. Thato was relieved about the decision Moses made as she thought that his father was unreliable regarding contact with him. In summary, Moses' family context is not optimal, yet his mother and grandmother did care about him. Moses' mother was the care-giver involved in the therapy as she had transport to get to my practice and she spoke English well. Initially I tried to involve his Grandmother but her English was very poor.

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5.1.2. Presenting problem

The presenting behavioural problems in school were talking disruptively in class, defying his teachers, and displaying physical and verbal aggression towards other children. Moses was also reported to have *"attitude"* (Mbali) when he would sulk, ignore instructions, or just walk away from authority figures while they were talking to him. Moses sometimes recognised his behaviour as a problem. To illustrate this, he described a time when he had punched a boy for using his deodorant without permission. The boy's mouth had bled, and he reported feeling *"bad about that."* He often had aggressive incidents like this while at school. Moses was often inappropriately aggressive during play but did show remorse after he hurt someone. He once, "*stabbed"* (Neo) Neo with a compass and, in a separate incident, bounced up and down on a 12-year-old girl's chest. Moses was in trouble almost every day, but he had not been suspended like his friend Neo. As stated, these problems were noted by teachers since grade naught when he started at the school.

His mother, Thato, also reported that at home she had difficulty getting Moses to do chores and to observe his curfew, the same as with his grandmother. Like Neo, Moses would stay out in the streets until after dark and Thato was concerned that he was not safe due to the violence in the area. In the home setting his mother initially reported that he would run away so as not to do chores. He generally did not follow his mother's or his grandmother's instructions.

In therapy sessions Moses was polite and co-operative. He tried hard in sessions to understand the concepts and work on his behavioural problems. There was only one short period when Moses depicted a negative attitude towards the process.

5.1.3. Diagnosis

Moses met the criteria for conduct disorder (CD). He displayed six of the symptoms listed in the DSM-5 and their duration was more than six months, as specified below:

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- Aggression to people and animals:
    - Bullies or threatens others. The other children were weary of Moses as he had a history of bullying.
    - Initiates physical fights. Moses' aggression was the main distinction as to why a diagnosis of CD fit better than did ODD. He often displayed physical aggression to other children.
    - Has been physically cruel to people. Moses could be cruel even in play. In one example he, *"stabbed"* his best friend Neo with a compass, in another he bounced up and down on a young girl's chest after tackling her to the ground.
- Serious violation of rules:
    - Stays out at night despite parents' prohibitions beginning at age 13. Although Moses did not stay out the entire night or for prolonged periods, he regularly ran away from home to avoid doing chores. He ignored his curfew and returned long after dark.
    - The disturbance in behaviour caused clinical disturbance in social, educational, or occupational contexts. Moses' behaviour affected him socially, he did not have many friends and struggled to make them and keep them. Neo, who also had behavioural problems (chapter 4) was his only friend. In the educational context Moses was always in trouble and sometimes he would sulk and just refuse to go into class which affected his educational progress.
- Deceitfulness or theft:
    - Often lies to obtain goods or services or to avoid obligations. In both the examples of cruelty listed above Moses claimed that he was playing and

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> did not realise that he was hurting the two children concerned. The girl however repeatedly asked him to stop, and she was crying. The incident with Neo occurred during a conflict situation. Whether he was playing or not is therefore questionable. He would lie and bend the truth to make himself appear in a better light. He would also appear at home with things that did not belong to him, and he would claim that others had lent him these things (American Psychiatric Association, 2013).

Moses did show remorse and guilt after the aggressive incidents with peers. He expressed this remorse in sessions and cried over the temporary loss of his friendship with Neo. He was able to see from the perspective of others. He cared about his school performance. He expressed deep emotion in sessions. Therefore, Moses did appear to have a conscience (American Psychiatric Association, 2013).

The CD behaviour was identified as mild to moderate as it was reported to occur in two settings, school, and home contexts. In the school context he met the full criteria of the diagnosis as he exhibited six listed CD behaviours (American Psychiatric Association, 2013).

5.1.3.1. Test administered and scale used

The following tests were used to assist in assessment and understanding of later change or lack thereof in thoughts and behaviour.

5.1.3.1.1. Conners Rating Scale

The teacher gave the following scores for Moses on the Conners Rating Scale(Conners, 2007) which are represented in figure 13. A very elevated score was given for *aggression/defiance*. An elevated score was given for *impulsivity/hyperactivity.* A high average score was given for *peer relations*. An average score was given for *Inattention* and *learning problems* and *executive functioning.*

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Moses' mother ,Thato, gave him the following scores which are represented in figure 15.

A very elevated score was given for *peer relations, aggression and defiance,* and *hyperactivity/impulsivity*. A high average score was given for *executive functioning* and *inattention.* An average score was given for *learning problems.*

Moses had no academic difficulties in school. This, along with the Conners (Conners, 2007) results confirms the diagnosis of CD without co-morbid ADHD or any other learning difficulties.

5.1.3.1.2. SSAIS-R

The SSAIS-R (Van Eeden, 1991) cannot be used as a diagnostic tool in Moses' case as it is only standardised for Afrikaans and English (first language) speaking populations, but the results obtained seem to corroborate the Conners' (Conners, 2007) finding that indicated no scholastic or learning problems. Moses' *verbal IQ score, non-verbal IQ* score and *full-scale IQ* all fell in the superior range. These results were attained even though the test was administered in English. Overall, Moses' academic ability was considered a strength by his teachers and his mother. It was a strength in therapy as he was able to grasp concepts quickly and he expressed himself well, whereas his friend Neo struggled. The performance on the *story memory sub-test* was lower than the rest of his performance on the verbal sub-tests at a one percent significance level, which can be an indication of possible auditory processing or attentional issues. Performance on the other sub-tests however did not corroborate auditory processing or attentional issues. His performance on the *similarities sub-test* was a stronger performance compared to the other verbal subtests at a one percent significance level, indicating strong abstract verbal reasoning ability in English. I, the therapist/researcher thought that this verbal abstract ability could be a strength with regards to the understanding

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of the REBT (Diguiseppe et al., 2014) concepts and utilisation of the model outside of therapy sessions.

In summary Moses met the criteria for CD without co-morbid ADHD or other learning problems. He was generally considered academically strong. Carrying out therapy in English did not seem to affect the process for Moses as his command of the language was considered sufficient.

5.1.4. Establishment of client-therapist relationship

The alliance between myself, the therapist/researcher, and the participants was established according to the REBT (Diguiseppe et al., 2014) theoretical framework. The goals were collaboratively set, as far as possible. Moses was engaged in changing his behaviour. He was close to his mother and did not want to anger her. He generally enjoyed being acknowledged and recognised for the right reasons, and his bad behaviour prevented this recognition. Motivation stemming from this contributed to his engagement in therapy. He completed his therapy homework most of the time but only after a reward system was introduced. He put effort into doing the homework which indicated this engagement in the therapy process. He asked for help regarding various problems he experienced, such as his friendship with Neo and asking his mum if he could live with her instead of his grandmother. He trusted me with confidential information and saw me as someone who he come to when something worried him. He disengaged for a short time and I, the therapist/researcher had to search for him on the playground as opposed to him just coming to sessions of his own accord. After this short period, he re-engaged. Moses communicated and expressed himself well and this made it easy to establish a rapport with him. His commitment is clear in his statement: "*I used to tell the teachers that I am trying to change my behaviour. I think the communication between me, and the teachers made them see I am really trying.*" Moses shared the same teacher as Neo, and she did not engage in the therapy process due to beliefs that she held prior to the

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commencement of therapy. The relationship was uncooperative in nature. Thato, Moses' mother, did engage in the therapy process. To develop the relationship I, the therapist/researcher was responsive to her needs regarding work commitments in the timing of the sessions that were held at 6.30 pm. or 7.00 pm. in the evenings. As she had transport and her township was fairly close to my practice, that location was convenient.

Based on the above assessment information a case formulation was created using a multisystemic (Swenson et al., 2005) framework within which, contingency management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014) therapies were applied to different levels of Moses' system.

5.2. A Multisystemic Case Formulation

The case formulation is a set of clinical hypotheses about the events or processes that led to the development of the disruptive, impulse control and conduct disordered behaviour, in this case CD, and the maintenance thereof in the present (Edwards, 2018; McLeod, 2010). All evaluative beliefs and inferences were taken from sessions and thought records created in sessions by client and therapist. The contextual development and maintenance of CD behaviour is facilitated by knowledge of the context.

5.2.1. Moses' mother (Thato) and his home context

Thato had come from the same abusive background that Moses experienced during the week. The mother/grandmother had shouted at Thato in the same way that she now shouted at Moses. The father/grandfather abused alcohol and his wife in front of Thato. According to the Revised Belief Scale for Parents (PIBS) (Joyce, 1995) all Thato's responses fell mostly within the high irrationality category apart from *demandingness* that fell into the mid-level irrational, (figure 11). In sessions the cognitions that contributed to the presenting problems regarding CD behaviour, were explored. Thato did mention, when filling in the Child and

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Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015), that the wording on the questionnaire was extreme. Apart from the two initial sessions, 10 sessions were held with Thato plus one joint session between her and Moses. Although she attended the most sessions in this current study, apart from Jonathan's mother (chap 6), the sessions were held sporadically. The irrational beliefs discovered in sessions are described below.

5.2.1.1. Demand schemas

The demand schema in Thato's session was noted: *"He should know better."*

Thato expressed that *"He [Moses] should know better."* This demand schema was linked to the following automatic thoughts: *"Why doesn't he get this?";* and "*Why don't you [Moses] just do it?"*

This demand and associated inferences were triggered by complaints about Moses' behaviour from school and/or his misbehaviour at home. They were linked to the emotion of anger and to Thato shouting at Moses and or withdrawing from him. This demand and associated automatic thoughts are tabulated in table 16.

The demand schema: "I should not have to be spending energy"

Thato expressed; *"I should not have to be spending energy." [on Moses misbehavior] and "I should be left in peace."* These demands were likewise triggered by Moses' misbehaviour in school and home contexts and was associated with anger, shouting and/or withdrawal. These demands likely contributed to Moses living with his grandmother during the week. From these demands the frustration intolerance: "I can't handle this" [Moses' misbehavior] flowed. These demands are tabulated in table 16.

5.2.1.2. Frustration Intolerance

Thato expresses frustration intolerance in statements such as*; "I can't handle this." [I am too tired], "I just can't deal"* [with Moses' misbehaviour]. The associated inferences were

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expressed as follows: *"I am too tired to believe in him," "He is stubborn", "I'm too tired, I will handle it later."* Frustration intolerance and associated inferences also led to anger, despair, and withdrawal from Moses. Moses would receive no effective disciplinary consequences. This irrational evaluative belief and associated inferences are tabulated in table 16.

5.2.1.3. Negative self-rating

Negative self-rating: *"I am a bad parent,"* was noted in sessions and the associated inference *"I am not following through [on discipline]."* This led to Thato feeling guilty and she would withdraw from Moses. This irrational evaluative belief and associated inferences are tabulated in table 16.

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Table 16

Tabulation of Thato's Irrational Evaluative Beliefs and Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Moses does something wrong. For example: Moses throws a tantrum when his phone is taken as punishment. Moses does not do his chores. The school complains about Moses' behavior. inferences *'He does not listen.* *He is disobedient.'* Thato: *"Why doesn't he get this?"* Thato: *"Why don't you just do it?"*	Demand: *'He should know better.'* *"I should not have to be spending energy."* [on Moses misbehavior] *"I should be left in peace."*	Emotional consequence: Anger Behavioural consequence: Thato loses her temper and shouts. Later she withdraws from Moses, goes silent and stays in her bedroom.
Inference. Thato: *"I am too tired to believe in him."* *"He is stubborn."* *"I'm too tired, I will handle it later."*	Frustration intolerance: Thato: *"I can't handle this."* *"I just can't deal."*	Emotional consequence: Anger and despair. Thato loses her temper and shouts. Later she withdraws from Moses, goes silent and stays in her bedroom.
Inference: Thato: *"I am not following through."*	Negative self-rating: *"I am a bad parent."*	Emotional consequence: Guilt Behavioural consequence: Thato is demotivated and withdraws from Moses.

5.2.1.4. Contingency management and responsiveness in Moses

Moses' mother did attempt to apply contingencies. She would often take his phone away if he refused to obey his curfew or do his chores, however, these were inconsistently applied. Moses would sometimes throw a tantrum when the negative contingencies were applied. Thato would then disengage from the situation without following through on discipline, she reported that she did not have the energy. This was linked to the frustration intolerance stated above: "*I can't handle this." "I'm too tired*" (Thato). In other situations, Thato would often become very angry, scream and shout and then withdraw from Moses by becoming silent and retreating to her bedroom. This ineffective discipline (of behaviour) was linked to Thato's demands *"He should know better"* and "*I should not have to be spending energy."* [on Moses' misbehavior]. Moses was meant to know how to behave without any discipline.

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Thato had a very demanding work schedule. She would sometimes cancel sessions due to her work commitments. These work commitments made her absent for a large part of the day and she was often fatigued. This fatigue added to her desire to disengage from disciplining. When Thato came home, Moses was sometimes already asleep. As a result of these late working hours Moses only lived with her during weekends and stayed with his maternal grandmother during the week. His baby half-sister occasionally stayed with Thato but mostly lived with her great grandmother in a different township, also due to the demands of Thato's work.

Moses' grandmother used to shout to try to discipline him. Both Moses and Thato claimed that the grandmother shouted continuously, even if it was not warranted. She had disciplined Thato as a child in the same way. Moses would then run away from the house and stay out late. According to Thato and Moses' description of situations, the grandmother was verbally abusive. The grandmother's disciplinary behaviour was completely ineffective, and his mothers' discipline was intermittently effective. An attempt was made to involve Moses' grandmother in therapy, but she could not speak English and due to her age and situation she lacked the resources for optimal change. In response to the shouting Moses would run away and he would therefore escape any meaningful, effective consequences, as after the shouting nothing further occurred. Moses' mother admitted: *"I am not following through."*

5.2.2. Moses' teacher (Mbali) and the school context

Initially I experienced this teacher as willing to co-operate with the study by engaging in monitoring Moses' and Neo's behaviour and engaging in her own therapeutic process using an REBT (Diguiseppe et al., 2014) approach. As time progressed, I generally experienced this teacher as uncooperative. She had to be convinced to monitor the behaviour with charts and this proved difficult to attain consistently. I then resorted to weekly face to face feedback reports or WhatsApp messages, describing behaviour for the week, to monitor Moses' and

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Neo's progress or lack thereof. When I explored the reasons for this reluctance the teacher said she was concerned about the information becoming part of the children's permanent record. Monitoring was also very time-consuming. The main reason according to this teacher was that monitoring behaviour did nothing to change the children's behaviour. She claimed that she wanted the children to change internally, and that monitoring behaviour only assisted her when she needed evidence for expulsion. This teacher spoke constantly, to the extent that it was difficult for me as the therapist to interject into the conversation. She was a poor listener so it could be that she did not process the explanation of the study and her expected role during the initial two interviews. Monitoring behaviour to evaluate behavioural change as well as contingency management (Kazdin, 2000) had been explained to her through psychoeducation in these initial interviews and throughout the sessions. Techniques such as identifying target behaviour and positive and immediate contingencies such as negative reinforcement were taught through psychoeducation.

This teacher, Moses', and Neo's class teacher was known for being a good disciplinarian with no problems in her classroom. She was asked to participate in the study by the principal as she had the most contact with both boys. As stated, in the initial two interviews she came across as willing. Her disciplinary techniques included sending the children out of the class when they misbehaved. Her thoughts were seen to be rational around her work and disciplining children during initial sessions. As the therapy narrative unfolded it was apparent that she was not open to different kinds of discipline. She believed that there were no problems in her classroom and that discipline in others' classrooms was the other teachers' responsibility. Her thinking was rigid regarding these issues. Sending Moses out of the classroom as disciplinary action was not that effective since he was intelligent and was able to do well irrespective of being in or out of the classroom. Sometimes he would decide of his own accord to stay outside of the classroom if he was upset or angry.

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As she did not engage in therapy to change her own behaviour. She shared only limited and general cognitions around discipline and difficulty in the disciplining of children. She became irritated by these students who wasted their own potential, parent's money, and the educational opportunity that could be given to someone else. This is an inference and could be true, however I regarded it as rigid thinking, which is likely coming from irrational evaluative beliefs. This was corroborated by the *attitudes towards the school organisation* category of the Teacher Irrational Belief Scale (TIBS) (Huk et al., 2019) represented in figure 12. *T*he items on this subscale are related to teachers' needs to be involved in the running of the school, i.e., that they be involved in decision-making, that their problems be listened to, etc. This teacher attained a high level of endorsement of irrationality, indicating rigidity of thought in this category. In interpersonal interactions she came across as domineering. Her lack of engagement in the therapy process could have been due to the principal asking her to participate, she may have felt forced to participate even if she did not want to. In feedback sessions with her it came across that she believed that she had everything under control in the classroom and did not need any help. This was how she was generally perceived by her wok context, as a good disciplinarian. It later unfolded that the principal found this teacher difficult to work with. She initially chose another teacher to participate in the therapy, but this teacher did not have daily contact with the boys I was working with. This class teacher was therefore approached.

Another confirmation of irrational beliefs in this teacher was found in the *authoritarian attitudes towards pupils* category on the TIBS (Huk et al., 2019). A moderate level of irrationality on this subscale implies intransigence towards the discipline problems of the pupils. Respondents believe that they cannot stand the children misbehaving and that in such cases they should be severely punished. A moderate level of irrationality, which was considered as a secondary belief, as opposed to the main irrational schema, was attained for

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this category. The above beliefs, *'students who wasted their own potential, parent's money, and the educational opportunity that could be given to someone else,'* if held too rigidly could bring intolerance. She was not a popular teacher with the boys that I worked with; she did keep boundaries within the classroom. She used the contingent 'behave or get out.' This level of irrationality would likely have led to some intolerance of the children that misbehaved.

This teacher was resistant to having individual sessions for herself. Initially she accepted using the sessions for her own well-being but could never find the time to see me for more than a few minutes. She later expressed that she did not need any input and believed that the focus should be on the child. "*Are you saying that the focus has shifted from the child to me?"*

The punishment of sending children out of the classroom seemed to be a way of keeping the classroom undisturbed as opposed to a way of remediating the behaviour. If the children did not come into the classroom or skipped class, they were ignored or given a demerit. When I mentioned the lack of consequences for this behaviour the teacher replied "*Truly, I can't be expected to physically drag the child inside the class."* In this case she was referring to Moses when he remained outside of the classroom. Trying to find alternative ways of changing children's behaviour was a problem with this teacher. She would use techniques that were part of her current practices. This was likely due to her thinking that she did not need any help and she did not have any problems. She was not willing to alter her approach to attain remediation. She had found a way of making the classroom situation work for her and the children that wanted to learn. That was where her responsibilities, as she saw them, ended.

5.2.2.1. Contingency management in the school

The discipline in the school system was inconsistent across teachers and even across different occasions and situations with one teacher. Some behaviours were tolerated (not coming to

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class) but other behaviours not. In some classes the children got away with more than they did in other classes. The usual demerit system was utilised. Neo, Moses' friend, claimed that he did not know which teacher gave him the demerit and for what behaviour. Different misdemeanour codes used approximated the behaviour that was targeted; Neo thought that the actual behaviours did not quite fit the codes. This approach did not follow research findings that suggest clear definitions of expected behaviours (Kazdin, 2000).

After three demerits the children received a detention. These demerits were given over a two-week period so if only two demerits were given in this cycle, the child was not detained. The process also commenced with a reprimand. By the time detention was implemented the children had forgotten what it was for. Even according to Moses' class teacher, the children could *'work the system'* as they could anticipate where they were in the two-week cycle: *"anybody that's that smart can work the system, he's working the system"* (Mbali). In this instance she was referring to Moses. This approach again did not follow research findings that suggest immediate consequences for behaviours (Kazdin, 2000). As a result, the contingency management was not effective as many incidents would occur before punishment was given and these demerits were also not consistently applied. The class teacher did seem to recognise these problems but was unwilling to change anything as it did not affect her in her classroom. She was not willing to cooperate with other teachers to find a wider solution for the school disciplinary problems. She thought it unfair if she had to give up her time for others who could not discipline their classrooms. This made her effective in her own classroom in keeping an atmosphere where those who wanted to, could learn, but she was not a team player. This system was not effective for Moses' or Neo's behaviour generally as they spent a lot of time being sent out of the classroom, so it failed to remediate their behavioural problems.

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5.2.3. Moses' case conceptualisation

The following section describes the case conceptualisation of how Moses' CD behavioural problems were held in please according to the REBT (Diguiseppe et al., 2014) conceptual framework regarding his own irrational thinking. According to the CASI (Kassay et al., 2015), demand, negative other rating and *awfulizing* fell in the moderate level of irrationality. Negative self-rating and the average of responses fell within the more rational philosophy endorsed category, meaning that few irrational beliefs were indicated (figure 1). Demandingness, negative other rating, *and* low frustration tolerance (LFT) were noted in sessions with Moses. The following irrational beliefs and associated inferences were identified in Moses case. These were associated with dysfunctional emotion and conduct disordered behaviour.

5.2.3.1. Demand schema

Moses' demand schema could be paraphrased as follows; *'Life must be fair and if it's not fair I will make it fair.'* Like Neo, this demand underlay most of Moses' CD behaviour. Moses also wanted to see the world, and make the world as he preferred it, fair (Diguiseppe et al., 2014). This demand and associated inferences and other evaluative beliefs, discussed below, were triggered when Moses was reprimanded for CD behaviour. Moses would challenge the reprimands and/or sulk or ignore the teacher. He would defy the teachers becoming oppositional, even shouting at them. The associated inferences flowing from the demand were:

- *'I often get into trouble and others do not and that is unfair'*
- *'Others do the same thing and get away with it and that is unfair'*
- *'They* [the teachers] *do not like me. It is not fair if I get into trouble just because they do not like me'*

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This demand schema was likewise activated when Moses was requested to do something that he did not like, especially if he was asked to do something repeatedly.

- *'I do not want to do this; it is unfair if I am told to do something that I do not want to do especially if I am asked over and over again'*
- Instructions to do things are: *"unfair because my uncle and grandpa hardly do a thing"* (Moses) and
- *"This [chore] is punishment"* (Moses)

This demand and associated inferences were linked with Moses' anger. Due to this demand schema and associated inferences Moses would refuse to take instruction. These self-defeating patterns of thinking were recognised across situations, others were seen as acting in an unfair manner towards him on a consistent basis. Tabulation of Moses implied demand '*it must be fair',* and associated inferences, taken from thought records created in sessions by Moses and therapist, are tabulated in table 17.

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Table 17

Tabulation of Moses' Irrational Evaluative Beliefs and Inferences Regarding His Demand 'It Must Be Fair'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Moses gets into trouble for CD behaviour. Inferences: *'I often get into trouble and others do not and that is unfair. Others do the same thing and get away with it and that is unfair. They [the teachers] do not like me. It is not fair if I get into trouble just because they do not like me.'*	Demand: *'It must be fair.' If it is not fair, I must make it fair'.* Expressed: *"It's not fair."*	Emotional consequence: Anger Behavioural consequence: Challenges the reprimand.
Situational Activating Event Inferences: *'I do not want to do this; it is unfair if I am told to do something that I do not want to do, especially if I am asked over and over again.'* It is *"unfair because my uncle and grandpa hardly do a thing. This [chores/requests] is punishment."*		Emotional consequence: Anger Behavioural consequence: Ignores and sulks. Runs away and refuses to do the chores or whatever was requested.

Demand schema: I must not be seen as weak

The following paraphrased demand schema *'I must not be seen as weak,'* was associated with the inferences: *'If I don't retaliate, they will see me as weak; If they see me as weak; they will take advantage; I will be powerless.'* They were triggered by Moses being teased or provoked by his peers. This demand and associated inferences led to Moses feeling vulnerable and angry. He would retaliate with aggression toward the perpetrators which was expressed verbally, physically, or both. An example of finding the relevant irrational beliefs and inferences follows:

Therapist: Which thought made you most angry?...

Moses: He keeps doing it

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Therapist: So, was it… I'm powerless to stop him?

Moses: … I couldn't stop him because I thought if I try stopping him and he was older than me mam he had more power than me

Therapist: So, were you thinking then I'm powerless to stop him? …he's not listening to me, there's nothing I can do that makes him listen?

Moses: That's what it was, there was nothing I can do to make him listen

Therapist: And the other people if you didn't fight would think what?

Moses: That I'm weak mam, that I'm scared of them

Therapist: And if they think that, what's going to happen to you?

Moses: Mam I'm gonna want to hit him

Therapist: Ok so you're going to want to hit him because then, what you're going to think when you hit?

Moses: Mam power over him.

The above demand and associated inferences are tabulated in table 18.

Table 18

Tabulation of Moses' Irrational Evaluative Beliefs and Inferences Regarding His Demand 'I Must Not Be Seen as Weak'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Moses is teased or provoked by other children. Inferences: *'If I don't retaliate, they will see me as weak. If they see me as weak, they will take advantage. I will be powerless.'*	Demand; *'I must not be seen as weak.'*	Emotional consequences; vulnerability and anger. Behavioural consequence; Responds aggressively to those provoking him.

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5.2.3.2. Frustration intolerance

Moses' frustration intolerance can be paraphrased as follows; *'I cannot meet their [his families] expectations; it is too hard as they are too high.'* He was discouraged by his families' perceived expectations of him that he thought were too high: *'I cannot meet their expectations; it is too hard as they are too high.'* The resulting associated inferences: *"They get disappointed easily* [if I do not do well]"; *"I am the different one* [in the family] *I am the top achiev*er; were related to sadness and anger. The inference: *"I am the different one [in the family] I am the top achiever"* implied the demand; *'I must do well, or I will not meet expectations and they will be disappointed.'* Behaviourally, he would then give up on schoolwork and going to class. When Moses did not return for his curfew, his grandmother told him that he would fail his exams. Moses believed that he would fail as his marks had come down compared to previous exams. It fed into Moses' demand to meet family expectations that he perceived were too high. However, his grandmother was trying to discipline him. Tabulation of Moses' frustration intolerance paraphrased as *'It is too hard for me to be the top achiever that everyone expects'*, is tabulated in table 19.

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Table 19

Tabulation of Moses' Irrational Evaluative Beliefs and Inferences Regarding Frustration Intolerance

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Moses' family have high expectations of him. Moses did not receive a scholarship that he was hoping for. His grandmother tells him that he will fail exams in an attempt to discipline him. Inferences: *'The expectations are too high and too hard to reach'.* *Moses: "They get disappointed easily [if I do not meet expectations]."* Moses: *"I am the different one* [in the family] *I am the top achiever."*	Frustration intolerance: *'I cannot meet expectations; it is too hard as they are too high.'* *'It is too hard for me to constantly be the top achiever that everyone expects.'*	Emotional consequence: Anger, sadness Behavioural consequence: When Moses thinks he will not do well (meet expectations), he withdraws and sulks. He stays out of class. Moses is demotivated.

5.2.4. Summary and treatment plan

The plan was based on the identification of the kinds of irrational beliefs stated above. In summary, Moses' conduct disorder was triggered mostly when he was reprimanded, given instructions to do something that he did not want to do, or when he was teased/provoked by others. The demand schema: *it must be fair, or I must make it fair*; frustration intolerance: *I cannot meet their expectations; it is too hard as they are too high*; and the demand; *'I must not be seen as weak',* all needed to be addressed in therapy along with the associated self-defeating inferences. These irrational beliefs were associated with the conduct disordered behaviour and the dysfunctional feelings of anger (demand for fairness and to be seen as powerful/not weak), sadness and anger (demand to meet expectations)**.** These irrational beliefs and associated dysfunctional emotions and behaviours played out against a backdrop of the inconsistent and sometimes ineffective contingency management of the school together with the home contingencies that vacillated between harsh and non-existent. This did not

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encourage the development or maintenance of appropriate behaviour or decrease in conduct disordered behaviour.

The contingency management was related to Thato's and the teacher's evaluative beliefs. Thato's demandingness: "*He should know better", "I should not have to be spending energy"* [on Moses' misbehaviour] and *"I should be left in peace";* frustration intolerance: *"I can't handle this."; "I just can't deal"* and negative self-rating: *"I am a bad parent"* influenced her behaviour when disciplining Moses. Moses was expected to know how to behave and apply this knowledge without any appropriate and consistent guidance from his context. The teacher had a management plan for her classroom that worked generally with most of the children: behave or get out. Through this she kept control of her teaching context effectively. She preferred that Moses and other children like him, develop internal strategies to control their behaviour. The emphasis was on the general context in her individual classroom as opposed to remediation of individual disruptive children or other teachers' disciplinary problems. Her classroom was under control for those who wanted to learn. According to the REBT (Diguiseppe et al., 2014) treatment plan the evaluative beliefs that Moses held needed to be challenged as they held his CD behaviour in place and the evaluative beliefs held by the teacher and mother needed to be challenged as they affected the behaviours regarding the discipline of Moses. Moses also responded to the irrational beliefs around him.

5.2.5. Responsiveness across irrational beliefs

Moses family had high expectations of him moving out of the current station in life that the family held. Moses' granny's attempt at disciplining Moses when he came home late *"my granny said I would fail"* (Moses) served only to provide evidence for Moses' evaluative beliefs about this situation and it demotivated him. As a result, he disengaged at school to the extent that he stopped attending classes for a time. He would feel sad and angry as it activated his own evaluative belief, frustration intolerance, and associated inferences: *"They get*

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disappointed easily [if I do not do well]; "I am the different one [in the family], I am the top achiever." He believed that these expectations were too high so he might as well give up. This evaluative belief and associated inferences were active during the time that Moses' behaviour deteriorated again at school, and he also started to disengage from the therapy process at the same time. He had at this time been applying for scholarships, none of which were successful. Although Moses did not acknowledge this as a trigger for frustration intolerance: *'It is too hard for me to be the top achiever that everyone expects.'* I, the therapist/researcher hypothesised that this did act as a contributing situational trigger.

Thato's irrational beliefs, although not directly responsive with Moses' irrational beliefs, did affect his CD behaviour in that they were associated with the inconsistent discipline of Moses and withdrawal being used as an ineffective disciplinary technique. Moses was able to do what he wanted without consequence, and he would mirror Thato's withdrawal with his own sulking behaviour.

5.3. Treatment Implementation

A treatment plan was based on the case formulation described above (Edwards, 2018). This plan was then implemented during therapy (Fishman, 2013). It was conceptualised according to the REBT (Diguiseppe et al., 2014) framework. The irrational beliefs above would be disputed to bring about alternate beliefs using REBT (Diguiseppe et al., 2014) theory and techniques. The MST (Swenson et al., 2005) approach is the overall framework that guided this clinical process and provided an integrative framework for applying the therapeutic approaches across different levels of part of Moses' system. As such, an attempt was made to apply therapy was applied to Moses, his mother, and his teacher.

The approach was embedded by holding therapy sessions with the participants across different levels of part of the school system to which Moses belonged: 16 sessions were held with Moses and four joint sessions were held with Moses and his friend Neo utilising the

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REBT (Diguiseppe et al., 2014) therapeutic approach; sessions were held with Moses' mother utilising the REBT (Diguiseppe et al., 2014) therapeutic approach and contingency management (Kazdin, 2000). Moses' teacher did not fully engage, particularly with the REBT (Diguiseppe et al., 2014) sessions. Moses' mother had 10 sessions plus two joint sessions with Moses.

5.3.1. Home context: Treatment of Moses' mother (Thato)

This process consisted of contingency-management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014) sessions. The irrational beliefs were weakened, and more functional/rational beliefs were created using REBT (Diguiseppe et al., 2014) techniques. Contingency management was discussed in most of the sessions. The parent management element included the standard procedures such as praise and reward, contingency management, limit setting and establishing behavioural expectations (Kazdin, 2000). Moses was included in the application of the contingency management programmes, as he helped to identify what rewards and punishments, he thought to be appropriate and effective (Kazdin, 2000). The following information was gathered from thought records compiled in and outside of sessions and quotes were taken directly from sessions to illustrate the examples and process.

I, the therapist, spent some time explaining the nature of irrational beliefs with Moses's mother, Thato, and the connection of her thoughts to her feelings and behaviour regarding her reaction to Moses. How she came to hold such thinking patterns were explored along with the link between her thinking, connected behaviour and Moses' behaviour. Through this insight and following disputation alternative thinking was developed.

The techniques involved in REBT (Diguiseppe et al., 2014) treatment of Moses' mother included:

1. The connection between Thato's thinking, feeling and her behaviour was established and was linked to Moses' problematic behaviour.

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2. An exploration of where the irrational beliefs may have come from in her childhood history was facilitated.
3. Irrational beliefs were disputed in a systematic and logical way, for example, her language was changed from shoulds, oughts and musts to preferences.
4. Identification of absolutistic beliefs behind the problematic behaviours were enhanced by the completion of thought records in homework assignments.
5. Contingency management (Kazdin, 2000) was explained.

Thato had the following irrational beliefs and inferences in relation to Moses and his behaviour and discipline: Demands: *He should understand how to behave: "He should know better"; "I should not have to be spending energy." [on Moses misbehaviour] "I should be left in peace."*

5.3.1.1. Disputation

Empirical functional disputations were used to challenge the irrational demands associated with Moses' misbehaviour that led to Thato's ineffective discipline of him and associated dysfunctional emotions.

5.3.1.1.1. Demands

An empirical dispute was used to challenge the demand that Moses should know how to behave. In this way the appropriateness of Thato's demands and inferences with reference to Moses' age and developmental stage were challenged: *"I cannot expect good behaviour to come naturally to a 13-year-old";* and *"Teenagers push boundaries, they all do it."* Through both Socratic questioning and using a didactic style, evidence was gathered. The empirical disputation culminated in the functional/rational belief: *'It would be nice if it came naturally to him, but it does not.'* Through discussion Thato realised that her dogmatic demand for

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Moses to be as she was as a child could not always be expected. *"Parenting is a variable… it is not a constant."* Thato [Tabulated in table 20].

The functional disputation was attained through using inductive interpretation where I, the therapist/researcher introduced the following using a didactic style:

Question: How do you help yourself to lessen your anger so you can discipline effectively?

Answer: Drop the [above] demands in exchange for a preference. [otherwise] I will just lose my temper [Tabulated in table 20].

After listening and commenting on both disputations Thato expressed a nondogmatic preference to challenge her demand: *"I can help myself by telling myself, parenting is a variable,… it is not a constant."* [I cannot expect him to comply to my demand that he will just know how to behave as I did. He is not the same child as I was].

Therapist: *"It would be nice* [preferable] *if he was one of these compliant children* [as you were], *but he isn't."*

[Tabulated in table 20].

Table 20

Thato's Functional Empirical Disputations and Functional/Rational Beliefs Are Tabulated Against Her Demand

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Moses does something wrong. For example: Moses throws a tantrum when his phone is taken as punishment. Moses does not do	Demand: *'He should understand how to behave.'* Expressed: *"He should know better."*	Emotional consequence: Anger Behavioural consequence: Thato loses her temper and shouts. Later she withdraws from Moses, goes	Functional disputation: Q: How do you help yourself to lessen your anger so you can discipline effectively? A: *'Drop the demand to a preference* [Otherwise] *I will just lose my temper.'* Empirical disputation: Q: What evidence do you	Rational Belief; less dogmatic preference: *'It would be nice if it came naturally to him, but it does not. I cannot expect good behaviour to come*

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Activating Event	**Irrational Belief**	**Consequence**	**Dispute**	**Functional/ Rational Belief**
his chores. Complaints are received from school about Moses' behaviour. <u>inferences</u> *'He does not listen He does what he wants.'* Thato: *"Why doesn't he get this?"* Thato: *"Why don't you just do it?"*	<u>Demand:</u> <u>Expressed:</u> Thato: *"I should not have to be spending energy."* [on Moses' misbehavior]. *"I should be left in peace."*	silent and stays in her bedroom.	have that you can expect Moses to just know how to behave? A: *'He is a 13-year-old boy and they often do not listen.' 'Teenagers push boundaries, they all do it.'* <u>Functional disputation.</u> Q: How will it help me to insist on not having to expend energy on Moses' discipline? A: *'It will just lead me to lose my temper and withdrawal from him.'* Thato: *"I need to sort his behaviour out for his own good."*	*naturally to a 13-year-old.'* Thato: *"Parenting is a variable,… it is not a constant." [as I demand it to be]*

5.3.1.1.2. Frustration intolerance:

Frustration intolerance was noted in Thato's statements; *"I can't handle this"; "I just can't deal."* Using inductive interpretation, I, the therapist/researcher introduced the following:

Therapist: Can I really not stand it?

Thato: I can do it [discipline Moses] it is just hard when I am tired.

Thato: [and on another occasion]… No, it's really not that awful.

Thato was encouraged through discussion not to avoid disciplining Moses with the following rational inferences**.**

Pain now will bring gain later.

If I implement it [discipline] now, it will likely be easier than if I leave it until later [he is older].

It will become easier with consistency [of discipline].

It takes less energy if I have a system [of discipline] in place.

I cannot afford to let him get away with this.

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Thato: *"I need to sort his behaviour out for his own good."*

These statements hypothesised that eventually less energy would be spent on disciplining.

The alternative frustration tolerant beliefs attained at the culmination of the disputations were: '*It is unpleasant, but I can handle it.'*

'It is difficult, but it is not impossible.'

Thato realised that if these rational frustration tolerant beliefs were used, she would lessen anger to the functional negative emotion of frustration and not have to continue expending ineffective energy with useless shouting. Not avoiding disciplining Moses could be helpful in reducing energy spent, whereas avoiding it could use more energy in the long run. [Tabulated in table 21].

Table 21

Thato's Empirical Disputations and Functional/Rational Beliefs Are Tabulated Against Her Frustration Intolerance

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Moses does something wrong. For example: Moses throws a tantrum when his phone is taken as punishment. Moses does not do his chores. Complaints are received from school about Moses' behaviour. Inferences: Thato: *"I am too tired to believe in him. He is stubborn."* *"I'm too tired, I will handle it later."*	Frustration intolerance: I cannot handle this because I am too tired. Expressed: Thato: *"I can't handle this."* Thato: *"I just can't deal."*	Emotional consequence: Anger Behavioural consequence: Thato loses her temper and later withdraws from Moses, goes silent and stays in her bedroom.	Rational inferences: Q: Can I really not stand it? A: '*I can do it* [discipline Moses] *it's just hard when I'm tired'.* Inferences to show that engaging in discipline could reduce energy spent. *'Pain now will bring gain later.* *If I implement it* [discipline] *now, I will likely be easier than if I leave it until later'* [he is older]. *It will become easier with consistency'* [of discipline]. *I cannot afford to let him get away with this.* *It takes less energy if I have*	Rational belief; Frustration tolerance statements *'It is unpleasant, but I can handle it.* *It is difficult but it is not impossible'.* Thato: *"No, it's really not that awful."*

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Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
			a system [of discipline] *in place.'* Thato: *"I need to sort his behaviour out for his own good."*	

5.3.1.1.3. Negative self-rating

Negative self-evaluation was noted in Thato's statement: *"I am a bad parent."* The inference associated with negative self-rating was I am a bad parent because *"I am not following through."* An empirical dispute was used to challenge the dogmatic negative self-rating using Socratic questioning:

Q: Where is the evidence that I am sometimes a good parent?

A: *I spend time with him on weekends.*

We have a good relationship and talk together.

I am the closest person to him.

This disputation culminated in the following rational self-acceptance beliefs:

Am I a tired parent or a bad parent?

Now that I know what to do, I am disciplining differently.

[Tabulated in table 22].

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Table 22

Thato's Empirical Disputations and Functional/Rational Beliefs Are Tabulated Against Her Negative Self-Rating

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Moses does something wrong. For example: Moses throws a tantrum when his phone is taken as punishment. Moses does not do his chores. Complaints are received from school about Moses' behaviour. Inference: *Thato; "I am not following through."*	Negative self-rating: Expressed: *Thato; "I am a bad parent."*	Emotional consequence: Guilt Behavioural consequence: Thato is demotivated and withdraws from Moses.	Empirical dispute: to change negative self-rating. Q: Where is the evidence that I am sometimes a good parent? A: *'I spend time with him on weekends. We have a good relationship and talk together. I am the closest person to him.'*	Rational belief: Self-acceptance statements. *'Am I a tired parent or a bad parent?'* *'Now I know what to do I am disciplining differently.'*

5.3.1.2. Contingency management in the home context

In the first therapy session that occurred post the initial introductory sessions the focus was on establishing a consistent and effective contingency management (Kazdin, 2000) plan for Moses. At least part of each subsequent session was spent emphasising the importance of contingency management (Kazdin, 2000) to Thato. Psychoeducation was used to teach her the principles of identifying the target behaviours clearly and defining them for Moses. Finding effective positive rewards for the absence of these behaviours, and the punishments for behaviours that needed something more than just the absence of reward as a deterrent, formed part of this process. The emphasis was on positive reward for good behaviour. These contingencies were hypothesised as specifically effective for Moses (Kazdin, 2000). Pocket money was utilised as a reward and the removal of his phone was used as a punishment for challenging adults or being disrespectful. Rewards were given for the target behaviours of

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coming inside at his assigned curfew time, completing his chores and listening to instructions without challenging. The school behaviours were included in the home chart. If no complaints were received from the school, he was to be given a monetary reward and punishment was given if he had challenged adults or had been disrespectful.

As Thato struggled to manage the chart due to her late homecoming Moses began to fill in his own chart with subsequent discussions with his mother as to his accuracy in doing this. I, the therapist/researcher, suggested also that the behaviour at the grandmother's house be included in the chart, as this was when most of the behavioural problems, such as not adhering to curfew, occurred. In practice, only weekend behaviour was monitored. The behaviour that Thato was trying to address occurred mostly when she was not there. This problem highlighted the need for adequate supervision for children. As a result of her absence, Moses was disciplined in a haphazard and inconsistent way even post-therapy. Most of the time he got away with things at home when Thato was not there. Thato did attempt to implement the charts when Moses filled them in. Moses also reminded her to do so as he wanted the rewards. She did maintain some form of discipline post-therapy, but it became less systematic, and specific than it was during the therapy, *.". it's still applied [the discipline], not on paper [as it was during therapy] but it is still applied…so I gave him a timeline to say I will fix it [his phone] by end of September but if by then his behaviour is not sorted out, he must just forget the phone."* According to Kazdin (2000), the lack of specificity regarding target behaviours and the lack of consistent rewards on a regular basis would make this discipline far less effective. Moses behaviour at school improved more than the behaviour at home. When Thato queried the reason for this, lack of contingencies in the home context compared to that of the school contest was given as a possible contributing factor (Kazdin, 2000). Thato did however report some improvement in behaviour, and she showed an increased awareness of the importance of the application of contingencies. "*The only thing*

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*that we're having issues with is the curfew, otherwise he's ok…" (*Thato) - curfew problems happened when Thato was not there.

5.3.1.3. Responsiveness

Responsiveness (Kramer & Stiles, 2015) to Thato occurred when I, the therapist/researcher, arranged sessions at my practice which was close to the township where she lived. I also held session 6.30 pm. -7.30 pm. to accommodate her work commitments. Moses was asked to fill in his own chart which he was willing to do. This was in response to the absence of Thato during the week due to her working schedule.

5.3.2. The school context: Treatment of Moses' teacher (Mbali)

Moses and Neo (in the previous case study) shared the same teacher. As stated in the previous case study this process with Moses' teacher, Mbali, was supposed to involve sessions of contingency-management and REBT (Diguiseppe et al., 2014). The teacher gave report backs on Moses' behaviour but did not engage in REBT (Diguiseppe et al., 2014) for her own rigid thinking around the discipline of the disruptive behaviour of Moses. As was the case with Neo she did alter contingencies around Moses if they were already part of her behavioural repertoire. During the time of the feedback sessions, she became more consistent around application of these contingencies and conceded to reward Moses with prefect duties for good behaviour. This worked particularly well with Moses as he was responsive with regards to others' acknowledgement of him. This reward included such things as monitoring the class when the teacher left the room and other responsibilities. Moses had wanted to be a prefect but had not been awarded the role due to his conduct disordered behaviour. Moses' improved behaviour was recognised with prefect duties before Neo's was. Sending him out of the classroom was already in place as a punishment before the time of therapy.

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The teacher initially claimed that she got attached to the children and took it personally when they did not fulfil their potential. When this happened, she thought that they were wasting their parent's money, their potential and her time and taking the opportunity to learn away from someone else. This could be true but if there is any rigidity of thought due to irrational thinking this could lead to anger when dealing with these children. According to the TIBS (Huk et al., 2019). the teacher scored as follows: *attitudes towards the school organisation,* her score fell in the high level of endorsement of irrationality category. On the *authoritarian attitudes towards pupils* she attained a score in the moderate level of irrationality category. Both these scores indicate irrationality which indicates rigidity of thought. Initially this teacher claimed that she would think that she could have done more to help these children and that this stressed her. On exploration of this through Socratic questioning she later claimed that she knew that her hands were tied and that she recognised that it was beyond her control. It was evident that she could rationalise when it came to discipline of the children and achievement of control within the classroom even though she would not be able to explain the process in terms of the REBT (Diguiseppe et al., 2014) model. She claimed that she has no stress or feelings around her work. As she did not consent to the REBT (Diguiseppe et al., 2014) sessions apart from an initial session to explain the model, the irrational beliefs indicated by the teacher and evident in the TIBS (Huk et al., 2019) were not addressed therapeutically. Despite the initial session she has no understanding of the model other than I was working with the children and how they thought about situations. This teacher believed she was good at her job and was not open to change.

This teacher worked in a way that accommodated the average child. She created an atmosphere in which learning could take place but as for the remediation of behavioural problems the phrase " *I can't be expected to…"* describes how this teacher saw the situation of disruptive children. In this instance she was specifically referring to Moses. There were

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many children in the classrooms and the behavioural problems were widespread. She was the educator, and her primary role should not be that of remediating disruptive, impulse control and conduct disordered behaviour. This teacher did have a lot of work to do and her own family responsibilities, so it was difficult to engage someone in this position in a multisystemic (Swenson et al., 2005) approach. She did not regard the behavioural problems as her primary responsibility. This pre-therapy thinking was the main reason that this teacher did not engage in therapy and had little motivation to change anything in this regard.

5.3.2.1. Contingency management in the school context

Despite not fully engaging, Moses' class teacher did apply contingency management when it was in line with the methods she already applied. Moses was sent out of class on a more or less consistent basis and rewarded with prefect duties. As stated, it seems generally that the contingencies were more systematically and robustly applied due to the weekly conversations that I had with this teacher.

I failed to engage fully the home and school system around Moses. Moses' home system was more involved than that of Neo's, yet the consistency was a problem. According to the MST framework this intervention would be less effective especially as Moses was a teenager and therefore intrinsically linked to his context (Swenson et al., 2005).

5.3.3. Treatment of Moses

Connections between thinking, behaviour and feeling were explained to Moses according to the REBT (Diguiseppe et al., 2014) theory and concepts. Initially, and throughout the process, psychoeducation was used to explain and introduce the approach and concepts. His irrational beliefs, stated above, were challenged through the REBT (Diguiseppe et al., 2014) therapeutic disputations initially to weaken them, and subsequently find functional/rational beliefs that would influence his behaviour. For example, his demands could be changed to preferences

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which could reduce anger to frustration. This was done through a process of disputation, where the pros and cons of beliefs were examined as well as the accuracy of these beliefs. Through the REBT (Diguiseppe et al., 2014) therapeutic framework the irrational beliefs were weakened and subsequently functional/rational beliefs that would contribute to changing his emotions and his behaviour were established.

5.3.3.1. Disputations

The two main disputations used were:

- The pragmatic/functional which used questions such as, where is this belief getting me? Is it helping me or making the situation worse?
- The empirical or reality testing which used questions such as: Where is the evidence to support this belief? Is it really going to be that awful? What tells me that I am not good enough?
- The functional dispute seemed to be the most effective with Moses. This is in keeping with the experience of practitioners at the Ellis Institute (Diguiseppe et al., 2014). This was the disputation that Moses used outside of the sessions in the classroom. Life is unfair, how does it help me to demand that it is fair? Moses was able to identify evaluative beliefs.

When asked what had helped him most at the end of the process, he stated that it was the disputations that challenged the inferences and demand for fairness. The demand for fairness was challenged first. This is in keeping with the REBT model that places the demand schema as the underlying belief from which the evaluations and inferences flow and the challenging of the demand schema is the most effective (Diguiseppe et al., 2014). Techniques used in Moses' therapy. Most of the techniques described in the literature review (Diguiseppe et al., 2014) were utilised. General therapeutic techniques such as Socratic

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questioning and reflection were used to explore Moses' world. This helped to establish relationship by creating an understanding of and communication of this understanding regarding his beliefs and how they maintained his CD behaviour. Psychoeducation was used to initially explain the REBT (Diguiseppe et al., 2014) model, the connections between thinking, feeling and behaviour and other concepts. Other perspective taking was used to help Moses to see that his thoughts about what people were thinking and doing were not always accurate. Others were thinking about things differently to the way he did. Client awareness through induction and inductive interpretation (Diguiseppe et al., 2014) were used in Moses' process. Moses was able to understand the concepts and disputations of the REBT (Diguiseppe et al., 2014) model. He was asked repeatedly to explain the discussions back to me or I would ask him how he understood the disputations. He was also often asked to explain the REBT (Diguiseppe et al., 2014) model back to me to make sure that he understood what had been discussed. For example:

Therapist: Can you explain it to me just so that I know if you've got it or not?

Moses: Mam how you thinking affects the way you feel and how you feel affects the way you behave.

Homework assignments based on the sessions were also part of treatment and were used either for identifying thoughts, feelings and behaviour related to a certain trigger or practicing a disputation. Homework assignments were used to solidify what had happened in the session and check understanding.

An example of psychoeducation was used to build Moses' awareness around non-verbal behaviour. Later, in the therapy process Moses did not often verbally challenge the teachers, but he would frown and walk away. Initially he did not understand the effect that this had on others. The teachers complained about his attitude and this non-verbal behaviour was what they saw as reflecting his attitude.

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Therapist: Now remember there was verbal behaviour and there was other behaviour that they (teachers) sometimes picked up from you.

Moses: Physical mam.

Moses now shows awareness of the kinds of behaviours that get him into trouble.

Therapist: Yes, what we would call non-verbal. What you are doing with your body. If you sulk, they will pick that up. If you ignore them, they're going to pick that up.

Through these techniques, awareness was created in Moses and through disputations, the irrational beliefs were weakened before functional/rational beliefs could be established. Moses showed a greater level of understanding compared to that of Neo described in the previous chapter.

5.3.3.1.1. Demands

After the irrational beliefs were weakened through disputation alternate, functional/rational beliefs (listed below) were found. The following beliefs and inferences and disputations were taken from homework assignments and taped sessions. They were collaboratively created by Moses and me, the therapist/researcher.

Demand: 'Life must be fair'

If Moses' *demand for fairness* could be weakened and the thinking become less rigid (changed to a preference) it was hypothesised in accordance with REBT theory (Diguiseppe et al., 2014) that Moses would no longer need to insist on challenging the teacher's reprimands, sulk or ignore them in order to make life fair.

A functional/rational belief used to help Moses to accept unfairness was: *"Sometimes life is unfair in my favour as others get into trouble for what I have done. I was born with more intelligence than most of the other children in my class. Others may think that is*

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unfair." Unlike Neo, having high academic ability was important to Moses and it was important to his family: *"I am the different one, I am the top achiever." "I am the first in my family to do this* [achieve academically]*."* So, his intelligence was something that he could identify as being unfair in his favour. However, the demand for fairness included a demand for it to be fair for others as well, so this weakened the effectiveness of this dispute, in response to this the functional dispute was used as an alternative.

The following functional dispute led to nondogmatic beliefs that were used by both Moses and Neo. The following example is taken from an excerpt from a joint session with Neo and Moses. The boys had both completed an example for challenging the demand *'it must be fair'* for homework and I led them through the example with Socratic questioning.

Therapist: … when you think something is unfair what happens to your anger?

Neo: It goes up.

Therapist: It goes up…the thinking here is that it's unfair, and sometimes it is, so sometimes we have to have what's called life acceptance…sometimes people in authority are gonna be unfair to you, like I said last time. Your action here would be what?

Moses: Retaliating.

Here Moses demonstrates his understanding of the ABC model when he is led through the process via Socratic questions.

Therapist: Ya, you'd retaliate, good….So, if something is unfair, how can you think differently so that your action changes and your feelings change?

Moses: Mam I think mam you should just take it as an adult giving me rule mam.

Therapist: Ok this is an adult giving me rule and that's very good cause then you've just described what's happened and you haven't interpreted

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[given an evaluative belief] what's happened and that is one way of doing it. …Maybe they are not trying to be unfair to you but sometimes people are going to be unfair and when they are unfair how can we think about that? … [I used the elegant solution].

Therapist: [If something is unfair]… the way that you act is either gonna be helpful or unhelpful to you in that situation, you can either help yourself around the unfair situation,..or you can make it worse.

Moses: Yes mam.

Therapist: ...Is challenging [the teachers behaviourally] gonna help you guys? Or make it worse? In your experience.

Moses: Mam it will help me mam [not to challenge] because the teacher will see we are not reacting the same way as before so…

Therapist: Ya because if you accept the consequence then they won't escalate the consequence...[gives examples]. So, what you're doing here is when you're saying life is unfair and we then say well it must be fair I'm going to make it fair, not so? …How would you try to make it fair before?

Moses: Shouting back at the teacher mam.

Therapist: Ya, so that you're hoping that's gonna change it [the situation]and make it fair…it's not gonna make it fair so that's unhelpful. So, to tell yourself it must be fair, and it has to be fair is just gonna do what…?

Moses: Make the anger go up.

Therapist: Make the anger go up. So now what we're gonna do is try and change that thinking around because all you guys have control over is your own thinking and your own feelings and your own reaction to it …you

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can make it [demand for fairness] matter less in your thinking. So …does it help you to think that sometimes life is unfair in your favour?

Life being unfair in my favour was not as useful. So, I responsively changed the disputation to one that worked better for Moses.

Moses: It doesn't make any difference mam even if it's unfair in my favour.

Therapist: Because you really want it to be fair…

Moses: Yes mam.

Therapist: …What about turning that to…a preference because that's how life is? You would prefer it to be fair so you can't demand that it's gonna be fair all the time, 'cause if we say that it must be fair, we're just gonna frustrate ourselves. So, if we change that to *'life is unfair'* to "*I would prefer it to be fair, but I can't demand it to be different, because no matter what I do here it's going to be unfair sometimes*." Is that helpful?

Moses: Yes mam.

Therapist: ...you've got to practice these 'side thoughts' (Moses called his alternate functional thinking "side thoughts"), you have to practice them, so that you get a new kind of thinking, because it's almost like a knee jerk reaction, this thinking; 'it must be fair and I'm gonna make it fair if it isn't fair.' It's kind of like that knee jerk

Neo: It happens quickly.

Alternative**,** functional/rational beliefs to challenge this demand were as follows: '*Life is not fair. Life is not fair for anyone all of the time.'* In Moses and Neo's words, *"Not everything can go your way. Let me just accept it."* Using these, functional/rational beliefs Moses' demand for fairness was weakened.

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Life must be fair, if it is not, I must make it fair This demand schema, life must be fair and if it is not, I must make it fair, in Moses' words; *"How can I change this to my advantage,"* led to Moses challenging the teachers and to persist in this challenge. One of Moses' homework assignments indicated this schema *'How can I make it fair for both sides in a good way.'* Even though Socratic questioning was used in the previous session and Moses answered as though he understood, through the homework it could be noted that he could not apply the rational beliefs outside of sessions, on his own. He was still trying to make things fair. A lot of repetition was required for the rational beliefs to become established and for the concepts to be used outside of therapy.

The demand for making things fair was challenged by again asking the boys to change the demand to a preference. '*Moses and Neo were not going to make things fair so how was it going to help them to try to make it fair by challenging the teacher?'* Both agree this would make it worse so *'how will this help me?'* was a useful question. This was the functional dispute used to help them not to escalate the situation when they were in trouble. I emphasised that they would need to practise this way of thinking. When Moses used this functional dispute and accompanying rational thoughts anger reduced to the functional negative emotion, irritation (Diguiseppe et al., 2014).

Therapist: Remember we said you demand it must be fair.

Moses: And I will make it fair.

Therapist: I'll make it fair, very good, if it isn't fair, and that was doing what to your feelings?

Moses: Made me angry mam

Therapist: Made you very angry, ya.

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Moses: Here I was just irritated. [referring to his homework where he had used the rational nondogmatic preference 'Not everything can go your way. Let me just accept it.'

Here Moses demonstrates his ability to identify functional negative emotions (Diguiseppe et al., 2014).

Therapist: Here you were just irritated, and you were irritated because you changed your thinking. [functional dispute is tabulated in table 23]

The most helpful disputations and the most helpful alternative beliefs were identified and ABCDE connections were reinforced.

Inferences

The inferences: *'I get into trouble because the teachers do not like me'; 'It is not fair if I get into trouble just because they [the teachers] do not like me,'* flowed from the demand schema that the teachers must be fair. This inference was disputed in the joint sessions held with Neo and Moses as both boys held the same demand for fairness and inference that they got into trouble because they were not liked. I held sessions with both Moses and Neo together so that they could both hear the logical dispute that the teachers' perceptions were changing about them, and it would therefore logically follow that it must be something that they were doing that influenced the teachers' opinions of them as opposed to just reputation based on their previous behaviour and dislike. If getting into trouble was based on a perception around their reputation or constant dislike, then opinion would likely not change. One week the teachers reported good behaviour and the next week bad. I asked them to help each other to identify the behaviour that was getting them into trouble. I thought that it may be easier for them to identify each other's behaviours rather than their own.

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Therapist: Now that your behaviours changed, has the teachers' attitude towards you changed?

Moses: A lot.

Therapist: So, was it that [does it logically follow that] they didn't like you or was it something you guys were also doing?

Moses: It was because of our behaviour.

At the culmination of therapy Moses was able to acknowledge the effect of his own behaviour on others.

Both Moses and Neo became cognitively more flexible and could understand how others may experience his behaviour and how it influenced them.

As with Neo, initially the elegant solution according to REBT (Diguiseppe et al., 2014) (to accept the situation as true) was used and as such it was accepted that the teachers' reprimands were indeed unfair. This helped to establish a therapeutic alliance and helped Moses to deal with his demand for fairness. [Tabulated in table 23]

Table 23

Moses' Functional Disputations and Functional/Rational Beliefs Are Tabulated Against His Demand 'It Must Be Fair'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/Rational Belief
Situational Activating Event: Moses gets into trouble for CD behaviour. Inferences: *'I often get into trouble and others do not Others do the same thing and get away with it.*	Demand: *'this is not fair. It must be fair. If it is not fair, I must make it fair. It must be fair as I understand fairness.'* Expressed: *"it's not fair"*	Emotional consequence: Anger Behavioural consequence: Moses challenges the reprimand, answers back or sulks.	Functional dispute: to change the demand for fairness to a preference. Q: Therapist: How does it help you to demand fairness? A: *'Life just cannot always be fair. I am just going to frustrate myself by demanding it.' Life is not fair. It is not fair for anyone all the time.'*	Rational beliefs: Nondogmatic preferences. *'Life just can't always be fair. I'm just going to frustrate myself by demanding it.'* Unfairness is part of life. *Moses: "Not everything can go your way. Let me just accept it."*

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Activating Event	Irrational Belief	Consequence	Dispute	Functional/Rational Belief
They [the teachers] don't like me. *It is not fair if I get into trouble just because they do not like me.'*			Empirical disputation: The question to challenge the inferences. Q: What tells you that getting into trouble may have nothing to do with whether they like you or not? A:"*Sometimes I act out of hand"*… [and I deserved to get into trouble]. Logical disputation: *'Changing my behaviour changes their reaction. It follows then that my behaviour affects their reaction to me.'*	*'Sometimes it is unfair in my favour as others get into trouble for what I have done.* *Others are not as clever as me.* *My behaviour influences their behaviour.* *My behaviour changes their reaction. So, what I do influences their behaviour which has nothing to do with being liked or not.'* *Moses: "It was because of our behaviour"* [that we got into trouble].

Other inferences associated with the demand schema for fairness were triggered when Moses was requested to do something that he did not want to do. They were associated with anger, and he would run away if he was at home or ignore the request both at school and at home. *'I do not want to do this; it is unfair if I am told to do something that I do not want to do especially if I am asked over and over again.'* Moses: *"It is unfair because my uncle and grandpa hardly do a thing";* and "*This* [chore] *is punishment."*

Challenging motivational statements were sought to counter the inferences that requests were unfair and a punishment. Other rational explanations that Moses created in a homework assignment were: [chores are not a punishment] they: *"are preparing me for my future responsibilities."* Moses: "*We all have to do things we do not want to do."*
[Taken from thought records created by Moses and therapist during sessions represented in table 24].

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Table 24

Moses' Functional Disputation and Functional/Rational Beliefs Are Tabulated Against Inferences Associated With His Demand 'This Must Be Fair'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Requested to do something that he does not want to do. Inferences. *'I do not want to do this; it is unfair if I am told to do something that I do not want to do especially if I am asked over and over again.'* Moses: It is *"unfair because my uncle and grandpa hardly do a thing."* Moses: *"This* [chores] *is punishment."*	Demand; *'This is not fair. It must be fair. If it is not fair, I must make it fair. It must be fair as I understand fairness.'* Expressed: *"it's not fair."*	Emotional consequence; Anger Behavioural consequence: Ignores and sulks. Runs away and refuses to do the chores or whatever was requested.	Motivational statements challenging the inference. Moses:..."*its just a normal thing that all children my age should be doing in order to be taught responsibility." "I'm also helping my granny because she has a lot on her shoulders because she mostly does everything."*	Rational belief: to challenge the inference [chores are not a punishment they] Moses: *"are preparing me for my future responsibilities. We all have to do things we don't want to do."*

Demand: ' I must not be seen as weak'

The following inferences: *'If I don't retaliate, they will see me as weak'* and *'If they see me as weak, they will take advantage'* and *'I will be powerless'* could be expressed as the implied demand; *'I must not be seen as weak or powerless.'* These beliefs were triggered by children teasing him: *"I couldn't stop him because I thought if I try stopping him and he was older than me mam he had more power than me"; "there was nothing I can do to make him listen* (Moses).*"* These evaluations related to feeling angry and vulnerable and the use of physical aggression towards other children. Questions such as, 'how will it help me to fight aggressively?' were asked. Through this questioning the inferences and the implied demand from which they flowed was weakened and alternative rational thinking was attained as given below. The other dispute that Moses responded to, changed his perception of power. Self-

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control was presented as a way of attaining a different kind of power, a functional power. The following alternative rational thoughts were established.

- If I am aggressive, I will be punished even if they started the fight.
- They [other children] will see that they are not disturbing me if I do not respond.
- If I have self-control, they cannot manipulate me.
- In Self-control lies strength/power.

The most effective alternative thought was: *"there is power in self-control."* In later sessions Moses said: "*Others now also see that when they can't control themselves, they get into trouble*." Here I, the therapist/researcher worked within the demand not to be perceived as or feel powerless.

[Tabulated in table 25].

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Table 25

Moses' Functional Disputation and Functional/Rational Beliefs Are Tabulated Against Inferences Associated With His Demand 'I Must Not Be Seen as Weak'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Moses is teased or provoked by other children. Inferences: *'If I don't retaliate, they will see me as weak. If they see me as weak, they will take advantage I will be powerless.'*	Demand: 'I must not be seen as weak because if I am seen as weak, they will take advantage of me.' Expressed: Moses: … *"I couldn't stop him because I thought if I try stopping him and he was older than me mam he had more power than me."* Moses:.. *"there was nothing I can do to make him listen."*	Emotional consequence: vulnerable and angry. Behavioural consequence: Moses retaliates with aggression when he is teased or provoked.	Functional Dispute: Q: How will it help me to fight aggressively to gain power? A: *'If I am aggressive, I will get punished even if they [other children] started the fight. They will see they are not disturbing me if I do not respond.'* Q: How will it help me to demand I must not be seen as weak? A: *"If I have self-control, they cannot manipulate me. In Self-control lies strength"*.	Rational Belief: Bringing acceptance of a different kind of power. *'There is power in self-control'*. Moses: "*Others now also see that when they can't control themselves, they get into trouble*."

Demand: 'I must not disappoint. I must meet expectations'

Moses believed that his family's expectations of him were too high. As his family were underprivileged, Moses reported: *"I am the different one [in the family] I am the top achiever."* They had high expectations of Moses to do well and move above the current economic situation and when he did not do well: *"They* [my family] *get disappointed easily* (Moses)." Implied demand *'I must meet expectations,'* and associated inferences were challenged using an empirical dispute. Through this dispute, evidence was gathered to challenge the inference that the expectations were too high to meet, sometimes he did meet them regarding his academic ability. His mother's expectations were also not consistently too high: *"My mum understands that I can't be the top all of the time* (Moses)." Both Moses' mother and his teacher thought that he had been extremely disappointed and demotivated because of unsuccessful scholarship applications for high school. It was at this time that

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Moses withdrew from school, did not attend classes, and disengaged from therapy. In sessions Moses did not acknowledge his disappointment around this situation. Despite this, the subject was discussed as was the possibility of future success. Through this disputation rational alternatives were crated for the beliefs and inferences Moses expressed.

For example, I used an empirical disputation to find evidence that Moses did meet his families' expectations some of the time. The question was asked: What evidence do you have that you do meet expectations some of the time? Sometimes Moses' academic performance was good, and he met expectations in this way. At the end of the therapy process Moses could think rationally around his families' expectations: *"It's just because I am the first in my family to do this." [That is why they have high expectations].*

To challenge the demand, Moses recognised that his mother's expectations were reasonable: *"My mum understands that I can't be the top all of the time."* Moses [tabulated in table 26]. He recognised that he could not reach expectations to be on top all of the time.

The rational beliefs constructed were:

- Sometimes I do meet expectations.
- There will be future opportunity for success
- To challenge the demand *'I must meet expectations'* the less dogmatic belief was used: *"I can't be the top all of the time."*

[Tabulated in table 26].

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Table 26

Moses' Functional Disputation and Functional/Rational Beliefs Are Tabulated Against Inferences Associated With Frustration Intolerance

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Moses' family expressing high expectations of him. Moses did not receive a scholarship that he was hoping for. His grandmother tells him that he will fail exams. Inferences: *"I am the different one [in the family] I am the top achiever.* *I the first to do this"* [Achieve academically].	Demand: *'I must not disappoint. So, I must meet expectations.'* (implied). Expressed: *"They get disappointed easily"* [if I do not do well].	Emotional consequence: Anger, sadness Behavioural consequence: When Moses predicts that he will not do well (meet expectations), he withdraws and sulks. He stays out of class.	Empirical disputation To challenge the inferences. Q: What evidence do you have that you do meet expectations some of the time?' A: *'Some academic marks were good'.* *"My mum understands that I can't be the top all of the time."* *'There will be other chances for scholarships later in Moses academic career.'*	Functional belief: less dogmatic belief to challenge the demand. '*Even if they do have too high expectations,* Moses: *"I can't be the top all of the time."*

5.4. Evaluation of Impact

The plan was implemented, and therapeutic evaluations were applied. The process was tracked, and progress monitored (Edwards, 2018) so the evaluation section incorporates and interprets the therapy monitoring. The evaluation and impact of the treatment was assessed using the self-report scales (irrational belief scales and Conners Rating Scales (Conners, 2007) administered before and after treatment. The irrational belief scales compared the teacher's, parent's and children's irrational beliefs before and after treatment. The Conners Rating Scales (Conners, 2007) compared the children's behaviour before and after treatment. Behavioural charts and reports given by Moses' class teacher throughout treatment monitored behavioural changes on a weekly basis. Thato did track Moses' behaviour at home, but this was intermittent, and she found it difficult to do when he was with his grandmother. She did apply some contingency management (Kazdin, 2000). Moses' teacher, Mbali, was erratic in

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filling in behavioural charts for the week, so after she was familiar with the target behaviours, I resorted to face-to-face sessions and WhatsApp messages to attain reports on Moses' behaviour. The behavioural charts and reports given by Moses' class teacher throughout treatment monitored behavioural changes on a weekly basis as did reports backs given by Thato, Moses' mother. The report backs were more an indication to me, the therapist/researcher, as to how any behavioural change was perceived by the mother and the teacher as opposed to precise measurement necessary for rigorous research purposes.

5.4.1. Behavioural and self-report scales

The Child and Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015), Revised Belief Scale for Parents (PIBS) (Joyce, 1995) and TIBS (Huk et al., 2019) scores for Moses' case are discussed below. The interpretation for the irrational belief scales are set out table 3a and 3b. The Conners Behavioural Rating Scale (Conners, 2007) measured Moses behaviour and the interpretation is set out in table 2.

5.4.1.1. Child and Adolescent Scale of Irrationality (CASI)

Demand: Moses' demandingness fell in the moderate level of irrationality pre-therapy. Time was spent working on Moses' demand for fairness both for himself and for others as this was considered the underlying demand schema for his evaluative beliefs. The score decreased, but not significantly according to the reliable change index (RCI, found in appendix J). Moses was able to dispute this demand and his report that the discussions around fairness were the most useful to him. Before and after therapy scores remained in the moderate level of irrationality.

Frustration intolerance (LFT) Moses' scores were in the rational philosophy pre-and post-therapy. The score increased but this change was non-significant according to the RCI found in appendix J. *LFT* was worked on during the therapy process and Moses was able to

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use rational alternatives in sessions and in homework exercises despite the slight increase in the score.

Other negative rating (ROW-O) score fell in the moderate level of irrationality pre-therapy. The score decreased post-therapy, but this decrease was insignificant according to the RCI, found in appendix J. Moses originally perceived others, teachers, and peers, in a negative light. After therapy Moses was able to accept that sometimes his behaviour caused him to get into trouble, it was not necessarily that the teachers were unfair or did not like him. This score indicated the largest change amongst Moses score, just under the significance level. Moses claimed that he was able to communicate with the teachers which allowed them to recognise his efforts to change his behaviour.

Negative self-rating (ROW-S) This score decreased non-significantly post-therapy even though both before and after scores fell in the more rational philosophy endorsed level according to the RCI index found in appendix J. It is possible that the rational belief :*"I can't be the top all of the time*," flowed from negative self-rating and therefore improved self-rating.

Awfulizing The *awfulizing* score fell in the moderate level of irrationality pre-and post- therapy. This score remained unchanged, but this irrational belief was not manifest in therapy and therefore not addressed.

The *total average* scores fell in the more-rational-philosophy-endorsed level, both pre- and post-therapy, but decreased non-significantly according to the RCI found in appendix J. The results for each category thus varied, although for the most part they decreased post-therapy or remained the same.

Moses did develop a good understanding of and subsequent use of the REBT (Diguiseppe et al., 2014) model. His awareness and understanding of the model were facilitated using amongst other techniques, induction, inference chaining techniques as well

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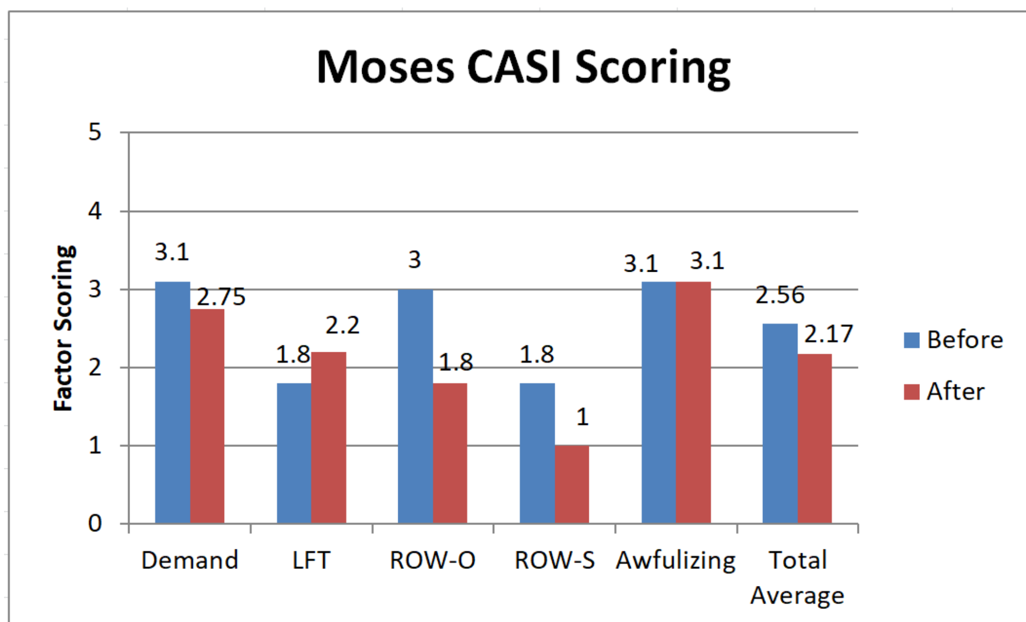
as Socratic questioning and psychoeducation. He was active in therapy and able to effectively use the approach outside of therapy as indicated by his homework. The teachers acknowledged his behavioural change and rewarded him with prefect duties that he really appreciated. The decrease in some scores on the CASI (Kassay et al., 2015) reflects this shift. Moses' CASI (Kassay et al., 2015) scoring on each of the above is set out in figure 10.

Figure 10

Bar Graph Showing Moses' CASI Scoring



5.4.1.2. Moses' mother's irrational belief scale

Moses's mother's results on the PIBS (Joyce, 1995) were as follows: *low frustration tolerance (LFT)*; *self-worth (SW)* and the average score all fell within the high level of irrationality category. All these scores reduced significantly, according to the RCI, found in appendix H, to a moderate level of irrationality. The demand scale fell within the moderate level of irrationality and remained so post therapy. The score reduced insignificantly post therapy according to the RCI, found in appendix H. During therapy LFT was identified. This thinking made Thato withdraw from disciplining Moses and likely contributed to Moses

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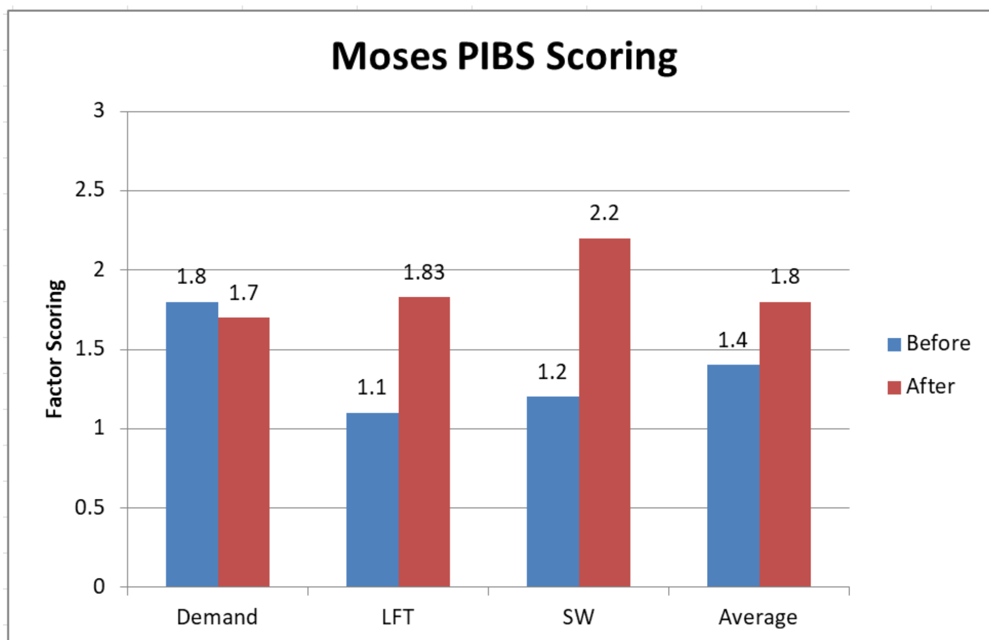
living a few houses down with his grandmother during the week. Demandingness with regards to Moses knowing how to behave himself well was also noted. Despite Thato was engaged in the therapy process and the scores recorded on the PIBS (Joyce, 1995) did reduce significantly across the three scores that showed the highest level of irrationality. Thato's PIBS (Joyce, 1995) scoring on each of the above is set out in figure 11.

Figure 11

Bar Graph showing Moses' Mother's (Thato's), PIBS Scoring



5.4.1.3. Moses' teacher's (Mbali's) irrational belief scale

These results can be found in figure 12 below.

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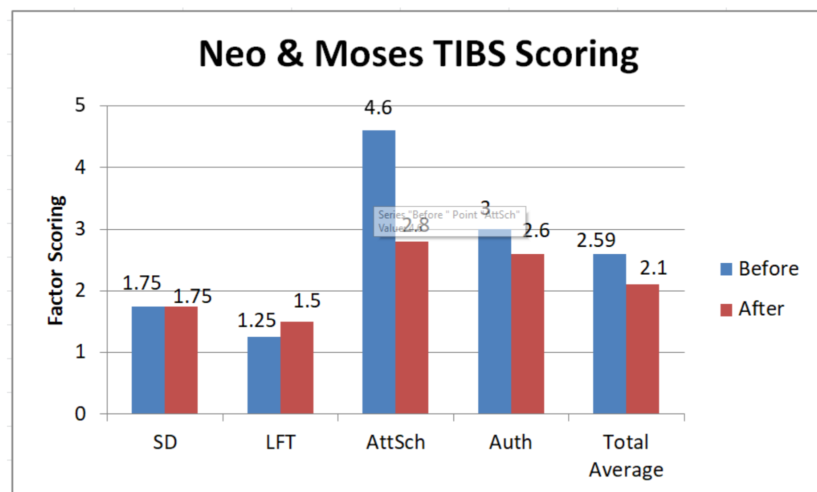
Figure 12

Bar Graph Showing the TIBS Scoring for Neo and Moses's Teacher, Mbali



The teacher's scores for *attitudes towards the school organisation* were seen to significantly decrease, according to the RCI, found in appendix I, found in appendix I, from a high-level-of-endorsement of irrationality; to a more-rational philosophy-endorsed-level. The items on this subscale are related to teachers' needs to be involved in the running of the school, i.e., that they be considered in decision-making and that their problems be listened to, etc.

I only pointed out to the teacher that demandingness was evident in these TIBS (Huk et al., 2019) responses and that REBT (Diguiseppe et al., 2014) could be used to help decrease dysfunctional emotion that would be associated with these demands. The teacher replied that this was just how she thought it should be, not that she experienced these issues. If she did experience these issues, then the belief scores initially reported would give rise to intense feelings and the associated behaviour would likely not be effective in addressing the problems.

For the category, *authoritarian attitudes towards pupils,* the score fell into the moderate level of irrationality category, which changed to a more-rational-philosophy-endorsed level post-therapy, but the decrease was non-significant according to the RCI, found

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in appendix I. A high score on this subscale implies intolerance towards the disciplinary problems of the pupils. Teachers believe that they cannot stand the pupils misbehaving, and that in such cases, they should be severely punished.

Mbali did not engage in REBT (Diguiseppe et al., 2014) therapy for her own irrational thoughts. I think that the change in score occurred due to the awareness of how the questionnaire should be answered, as opposed to any change in thinking. Mbali's scoring on each of the above is set out in figure 12 above.

Conners Rating Scale as filled in by two of Moses' Teachers

Mbali was very engaged in Moses' contingency management. She was quick to acknowledge any change in Moses' behaviour and to reward him with prefect duties. She was more responsive to Moses compared to Neo. This was perhaps due to Moses' ability to engage his teachers through communication

5.4.1.4. Conners Rating Scale as filled in by two of Moses' teachers.

Moses' scores as given by his teacher for *peer relations* decreased post-therapy from the category high average to average. The decrease was significant as calculated by the RCI, found in appendix K.

For *aggression and defiance,* he was allocated a very elevated score pre-therapy. Post-therapy this score, remained in the very elevated category, but decreased significantly according to the RCI, found in appendix K.

The *Hyperactivity/impulsivity* score was elevated pre-therapy and increased to a very elevated score post-therapy. This increase was non-significant according to the RC1 found in appendix K.

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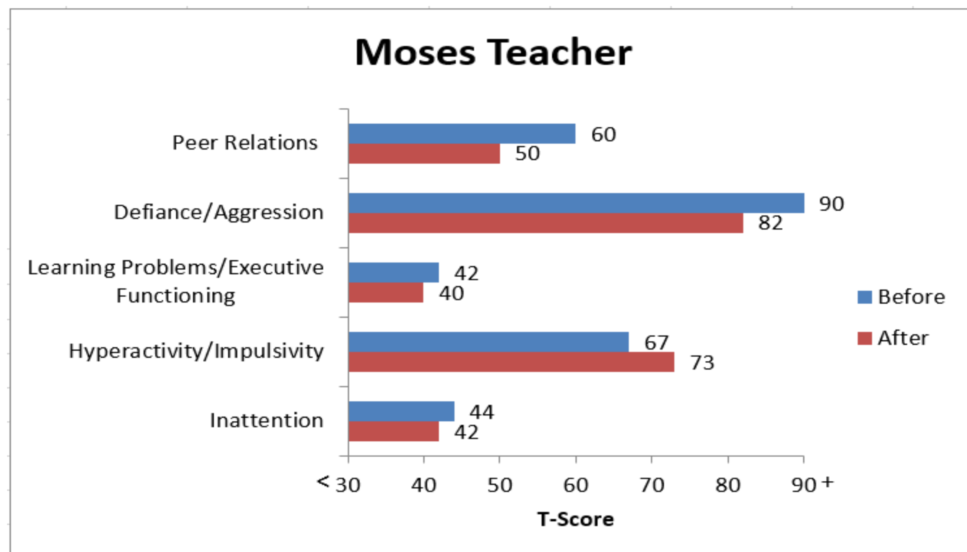
Both *executive functioning* and *inattention scores* remained in the average score pre- and post-therapy which continued to reflect no academic concerns or learning problems. The changes in the scores were non-significant according to the RC1, found in appendix K.

These scores are found in figure 13 below.

Figure 13

Bar Graph Showing the Conners Scoring for Moses' From His Class Teacher



The second teacher's responses reported post-therapy indicated average scores across the categories: *hyperactivity, attention, executive functioning,* and *peer relations.*

The only elevated score was given for *aggression and defiance.* This score was a very elevated score. This teacher noted that although Moses had improved, aggressive outbursts still occurred. These scores are found in figure 14.

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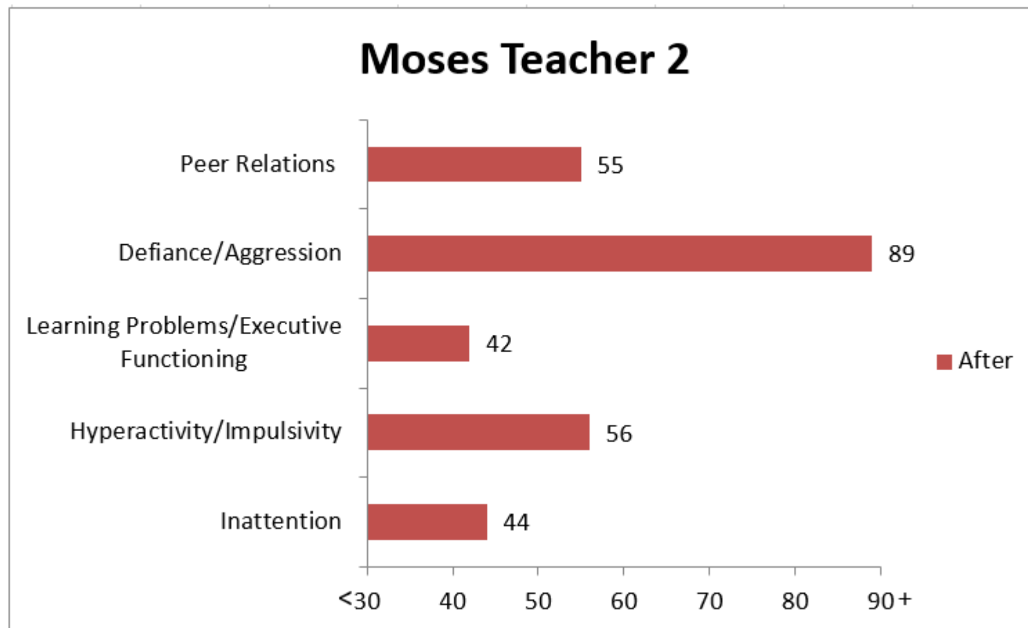
Figure 14

Bar Graph for the Conners Rating Scale for Moses, After Treatment Only, by a Second Teacher



Based on the comparative Conners Scales (Conners, 2007) of these two teachers it seems that Moses responded differently in different classes as indicated by the hyperactivity score which was lower for the second teacher. Differential behaviour across classes was corroborated by one of the feedback sessions with the class teacher. Overall, according to the scores allotted to Moses' by his teacher on the Conners scale (Conners, 2007) his behaviour was a concern even though it had improved. The improved scores on the Conners (2007) showed significant improvements on defiance and aggression and peer relations according to the reliable change index found in appendix K.

5.4.1.5. Conners Rating Scale as filled in by Moses' mother

The following scores are found in figure 15 below.

Thato's scores allotted for Moses on the Conners Rating Scale (Conners, 2007) showed a decrease post-therapy across all categories.

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Peer relations a very elevated score was given both pre-therapy and this score with no significant change according to the RCI, found in appendix K. Thato was concerned about the children Moses associated with in the neighbourhood and that he did not seem to be accepted at school.

For *aggression and defiance,* a very elevated score was attained pre-therapy and this score decreased significantly, according to the RCI, found in appendix K, to a high average score post-therapy.

The *Hyperactivity/impulsivity* score decreased significantly, according to the RCI, found in appendix K, from a very elevated score to average score post-therapy.

Both *executive functioning* and *inattention scores* attained a high average score pre-therapy which reduced to an average score post-therapy and the change was statistically insignificant for inattention but not for executive functioning according to the RCI, found in appendix K.

Learning problems remained in the average category both pre-and post-therapy and the change was non-significant according to the RCI, found in appendix K.

So, Thato's scores allotted to Moses on the Conners Rating Scale (Conners, 2007) confirmed her behavioural reports of Moses. The elevated scores decreased significantly. The reliable change index according to the Conners manual (Conners, 2007) corroborated most of these results apart from inattention that did not show significant decrease. The decrease did however put this score into the average category of concern.

Moses' before and after Conners rating scores (Conners, 2007) from his mother Thato are represented on figure 15.

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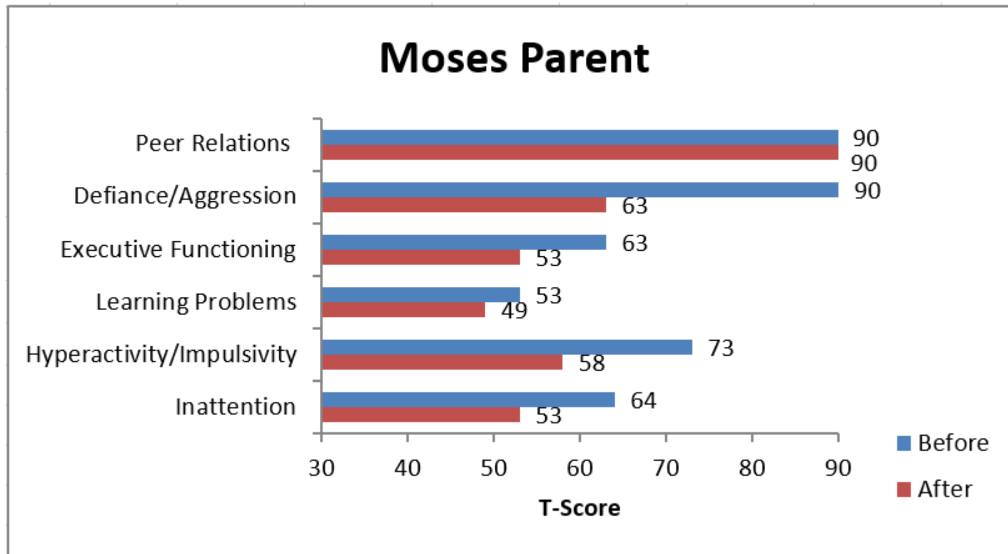
Figure 15

Bar Graph Showing the Conners Scoring for Moses' From His Parent (Thato)



5.5. Discussion

Overall, Moses' behaviour improved according to his teacher's and mother's weekly behavioural reports. The Conners Rating Scale (Conners, 2007) filled in by both teachers (figures 13 & 14) and parent (figure 15) likewise showed improvement. The teacher's Conners Rating Scale (Conners, 2007) showed improvement in the category *peer relations,* and the category *aggression and defiance* which were both seen to decrease significantly according to the RCI found in appendix K. As with Neo the weekly ratings gave a better impression of Moses behavioural change than did the Conners Rating Scale (Conners, 2007) as filled in by the teacher. The weekly reports claimed, at the end of the process, that Moses' behaviour had improved and was now satisfactory. The Conners Rating (Conners, 2007) despite showing a significant improvement, according to the RCI in appendix K, in *aggression and defiance,* the teachers' score still indicated a level with many more concerns than are typically reported. *Peer relations* improved significantly, according to the RCI in appendix K to that of an average score. It was noted that Neo's allotted scores on the Conners scale (Conners, 2007) showed more improvement than did Moses' allotted scores, however

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Moses was the first child to be acknowledged for the change in behaviour by his teacher and was the one that was seen to have maintained the behaviour post-therapy. According to the Conners scale (Conners, 2007) completed by Thato, his mother, Moses made improvement across all categories apart from *peer relations. Peer relations* remained a concern for Thato. The categories *defiance/aggression, hyperactivity, impulsivity, and inattention* all showed significant improvement according to the RCI found in appendix K. During the last session held with Thato verbal reports confirmed this: *"He's a bit calmer now, and that's what I have noticed about him, he's a lot calmer..."*

The home behavioural reports revealed that he had consistently improved and in the final session this was corroborated.

Thato:… *"it's not like a major change but I see that he tries. Like, I mean, compared to when we started off, before we started off, it was, sho, it was haywire…[now] When you ask him to wash the dishes, he does that"… The only thing that we're having issues with is the curfew, otherwise he's ok…"*

Therapist: Are you still finding him coming home with stuff that other people have 'given' him?

Thato: No that has stopped altogether… I've seen a vast improvement.

Thato seemed to maintain some of the contingency management practices post-therapy, but these were not as consistent and specific as prescribed by Kazdin (2000).

Thato: It still, it's still applied [contingencies], not on paper, but it is still applied…[Thato gives an example] so I gave him a timeline to say I will fix it [Moses' broken phone] by end of September, but if by then his behaviour is not sorted out, he must just forget the phone.

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Mostly the techniques of psychoeducation, induction, and inductive interpretation (Diguiseppe et al., 2014) were used in Moses' process. Moses was able to understand the concepts and disputations of the REBT (Diguiseppe et al., 2014) model. As a result, induction could be used as he did not always have to rely on me, the therapist/researcher for disputations. He was able to identify his irrational thoughts and find rational alternatives as evidenced in therapy sessions and homework assignments. He was also often asked to explain the REBT (Diguiseppe et al., 2014) model back to me, as well as the disputations, to make sure that he understood what had been discussed in sessions. He was intelligent and could think abstractly. Both irrational inferences and evaluative beliefs were challenged in therapy. As he understood the model and could apply it, I, the therapist/researcher, thought that the maintenance of Moses behavioural change would have been less reliant on contingency management.

The demand schema for fairness was one of the main irrational beliefs challenged during therapy. Moses reported that this was the most helpful of disputations. Despite this, the CASI (Kassay et al., 2015) (figure 10) results showed an insignificant decrease in Moses' score according to the RCI found in appendix J. However, *demandingness* post-therapy was now within the more rational philosophy endorsed. With regards to *Frustration intolerance (LFT*) Moses' increased non-significantly according to the RCI found in appendix J. *Other negative rating (ROW-O),* although initially in the rational philosophy endorsed level decreased non-significantly after therapy according to the RCI found in appendix J. Moses originally perceived others, teachers, and peers in a negative light. After therapy he was able to accept that sometimes his behaviour caused him to get into trouble, it was not necessarily true that the teachers were unfair or did not like him. Moses claimed that he was able to communicate with the teachers which allowed them to recognise his efforts to change his behaviour. The teachers acknowledged his changed behaviours, rewarding him with prefect

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duties that he really appreciated. The decrease in scores reflects this shift to more rational thinking. *Negative self-rating (ROW-S)* scores fell in, the more rational philosophy endorsed level both pre- and post- therapy and an insignificant decrease was noted post-therapy according to the RCI found in appendix J. It is possible that the rational belief *"I can't be the top all of the time"* also improved self-rating. The *awfulizing* score fell in the moderate level of irrationality. This score remained unchanged and was not manifest in therapy and therefore not addressed.

The functional dispute seemed to be the most effective for Moses and he was able to use this disputation and resulting rational beliefs independently. He used the functional questions and conclusions drawn from these disputes as functional/rational beliefs in the classroom situation.

Moses' context displayed some change in both the school and home environments. Thato did implement and maintain some form of contingency management (Kazdin, 2000). Thato also engaged in therapy around her own irrational thinking around Moses' discipline and behaviour. All scores according to the PIBS (Joyce, 1995) (figure 11) decreased and all of these changes were significant, according to the RCI found in appendix H, apart from *demandingness*. Thato's sessions were not attended consistently, and homework most assignments not completed. She did however attend 10 sessions and was motivated to change. Due to Thato's work situation, Moses remained with his maternal grandparents during the week where discipline was ineffective and verbally abuse was reported. Although the situation between Moses and his grandmother seemed to have improved according to Thato: "*Now he's not so bad as he was before, he can bear with her"* [gran]…, the situation was not optimal for Moses. If the situation had been such that Moses could have stayed with his mother on a permanent basis the improvements would likely have been better. This was suggested but did not happen. His class teacher did apply contingency management (Kazdin,

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2000) even though she did not fully engage in the process. The class teacher appeared to like Moses and was quick to reward improvement in him, so he gained acknowledgment from the school context.

Even though changes were noted in the TIBS (Huk et al., 2019) scores (figure 12) they were thought by me, the therapist/researcher, to be due to knowing how to fill the questionnaire in as opposed to any change in thought. The significant change was noted in *attitudes towards the school organisation* according to the RCI found in appendix I. This teacher did apply contingency management, even though she did not fully engage in the therapy process, and she believed that she needed no assistance. She did give Moses rewards for his good behaviour which was effective.

I contacted the school about two and a half months after therapy was terminated. The report was given by Moses' principal, and she claimed that Moses' good behaviour had been maintained. I would hypothesise that this was due to the acknowledgement that Moses attained from the school context in the form of prefect duties and his mother's acknowledgement of change. Moses could understand and use the concepts of REBT (Diguiseppe et al., 2014), and this would bring about the *"internal"* change that Moses' teacher was looking for, he would be less reliant on effective contingencies to manage his behaviour.

Moses' own opinion of his change when asked was expressed as follows:

Moses: "I'm changing mam and I see it in myself mam."

"...mam, they [the teachers] have been congratulating me on my behaviour..."

"...It makes me feel happy mam because I have improved from last year and it didn't maybe start last year mam,...it's a flaw of mine since a young age, I used to misbehave, but I think this programme has helped the teachers to see me in a different way mam."

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This chapter described the case study of Moses' therapy process for conduct disorder. The following chapter describes Jonathan's therapy process for oppositional defiant behaviour.

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Chapter 6: The Pragmatic, Embedded Case Study of Jonathan

This is the embedded, pragmatic case study of Jonathan, a 12-year-old boy in grade 6. He lived in a lower middle-class area. He attended a local, small private school in that area. It was better equipped than the school found in the previous two case studies, but still not well equipped. It was also run from a house as was the school in the previous two case studies. It appeared run down and, due to financial reasons, and was taken over by another school at the end of the year that the therapy took place. Some of the teachers were not fully qualified. Jonathan had attended this school for the past year. He had moved from a government school as he was unhappy there. He claimed that the teachers were too strict on all the children and that these teachers complained about his handwriting. In his current school he had some friends, but a lot of friction between him and his peers was evident. He was not a popular child. Jonathan's class teacher had her own interpretation of Jonathan's situation. In her thinking he wanted to be a leader, especially in group work, but his peers would not accept this. A peer was reported to have said: "*We don't always want to do what you say.*" The classes were small, there were only four boys in Jonathan's class, which accentuated his social problem as his choice of friends was limited and he frequently interacted with those with whom he clashed. It was difficult to find people of a like mind when he had such a restricted choice. He had more friends in his previous public school. Jonathan was included in the study as the metaphorical style (Diguiseppe et al., 2014) of working with him was different to that used in the other cases and it provided a good example of responsively (Kramer & Stiles, 2015) adapting the model to the client. The following case study report was written according to three sections described in the methodology (Chapter 3): *assessment,* this included the contracting section which mainly occurred in the first two sessions of therapy; *case formulation* which includes the treatment plan and the *treatment implementation* (Edwards, 2018). A section on *evaluation* is included which examines the various test results

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along with verbal reports from the mother and teacher. This section contributes to the understanding of change in Jonathan's oppositional defiant disordered behaviour. *Please note that in the case studies single quotation marks (' ') indicates a paraphrased disputation or belief while double quotation marks (" ") indicates direct speech.

6.1. Assessment

Most of the information for this assessment was attained from the first two initial screening interviews with all three members of the embedded case study: Jonathan's teacher, his mother, and Jonathan himself. The irrational belief scales and behavioural scale obtained in the first two sessions were also used. As therapy progressed information was added.

6.1.1. A background and life history

Jonathan lived with his parents and older sister. Both Jonathan and his mother, Mary, described the family as close within both the nuclear and extended contexts, although some competitiveness between Jonathan and his cousins was noted. His mother was also competitive regarding her children against their peers in general. She would often compare Jonathan with others in her therapy sessions. I, the therapist/researcher, experienced Jonathan's mother as very protective over her children. She defended them against any accusation made by peers and teachers alike. Jonathan's father was involved with both of his children. The teacher (Heidi) described Jonathan's mother as an involved parent and the family as *"a normal family."* The home life however was reported to be somewhat disorganised and lacking in consistency as Jonathan's mother had a busy schedule at work and was involved in community commitments in her spare time. She worked at the same school that both her children attended. She was as a receptionist and reportedly had many administrative duties. The class teacher claimed that Jonathan was like *"a mirror of his mother."* He would mimic his mother's ailments, particularly if his mother had a headache,

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Jonathan would complain of the same symptoms later in the day. Medication was frequently used for these ailments. According to Bernard (2004) and Ellis and Wilde (2002) children model on their parents' irrational beliefs as well. Jonathan's mother had training as a nurse but did not practice because of the effect that it had on her depression. Jonathan's class teacher had her own opinion of the family dynamics. She referred to Jonathan's sister as: *"…this perfect child"* and she believed that the parents could well be comparing the two children.

When Jonathan was a baby, his mother suffered from bouts of depression. She was hospitalised for a short period of time when he was three years of age when she was diagnosed with bipolar disorder. His mother reports that the first few years of Jonathan's life were *"a blur"* due to her experience of depression. The disorder was reported to be under control through medication. She believed that due to depression her bonding process with Jonathan was interrupted in his early years and that was part of the reason that she was reluctant to discipline him.

Mary: *"I think there's a lot of guilt in me, 'cause I had such bad post-natal depression after he was born... I don't remember much of the first year of his life I was so depressed, I felt I couldn't cope with both of the kids and I was gonna gas all three of us because there was nobody else who was going to look after my children and I think I was so worried about that, that I worked so hard, and I mean you would never say it if you look at us. You know there's none of these textbook indications that there's been post-natal depression, unless this is part of it, overcompensation, but I think that I feel guilty about that [depression]."*

Jonathan's previous school experience was reported to be highly stressful for him. One of the reasons that Jonathan left his previous school was due to his teachers criticising his handwriting and general neatness. He claimed to have experienced the discipline in this school as harsh and unfair with respect to himself and others. During this time Jonathan

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reported suicidal ideation and was placed on medication for anxiety and depression. He then moved to his current school. His reaction to this criticism contributed to Mary's reluctance to discipline him.

6.1.2. Presenting problem

In the school context Jonathan interrupted lessons by sharing what he referred to as his *"facts."* During these times Jonathan added to the lesson something that was usually a long detour from the topic at hand. When the teacher told him to stop as it was not relevant, and she needed to continue with the lesson, he would become angry and sulk. He also tended to correct the teacher and other children whenever he thought they had made a mistake. When the other children did not acknowledge him and his contributions, he would again become angry and sulk or get into verbal altercations. When teased by peers, Jonathan sometimes got into physical fights. He often did not complete work in class. Jonathan's teachers also complained about the neatness of his work, as did his previous school. When confronted with this Jonathan would again respond with anger and sulking. In the opinion of Jonathan's teacher all these behaviours were considered exaggerated when compared to the rest of the class. The teacher thought that Jonathan had been *"well brought up."* She described Jonathan as polite with good manners except for the interruptions in class and anger at being reprimanded for this: *"He's never the same, he's never consistent."*

The disruption in class presented a problem for both Jonathan and his classmates as it distracted from the work at hand. Untidy handwriting, carelessness, and not doing homework also detracted from Jonathan's academic performance. The long interruptions and correction of others also interfered with Jonathan on a social level as this alienated both his peers and some of his teachers, particularly his current class teacher. The school was concerned about Jonathan's lack of consideration of the consequences of his physical outbursts of aggression. He would take on children much older than himself if they teased him and in one instance a

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group of older children. In the school context these behaviours were considered to be developmentally inappropriate and exaggerated compared to that of his peers.

His mother had reported milder behaviour compared to that described by the teachers. The home context was also more accepting of his behaviour: Mary: *"My whole philosophy at home, is home is the place that we get to be disgusting. I might have said that to you before. You know we take out whatever we going through on the people we love the most because we know that they still going to love us."* In the home setting, his mother reported that he was angry and resentful; he would lose his temper with his sister. He did not listen to requests to get ready or do his homework which was experienced in the home context as more procrastination than active defiance.

6.1.3. Diagnosis

Jonathan met the criteria for oppositional defiant disorder (ODD). He had five of the symptoms listed in the DSM-5 and the duration of these was more than six months each.

- Angry/irritable mood: because of his hypersensitivity to criticism and teasing Jonathan was often angry and irritable.
- Often loses temper: Jonathan lost his temper regularly when he was teased by other children. He became angry when teachers criticised his work or made him redo it. At home he often lost his temper with his sister.
- Often touchy and easily annoyed: when his contributions to the classroom situation were not acknowledged Jonathan was easily annoyed.
- Often angry and resentful: both teacher and parent reported that Jonathan became resentful and angry when reprimanded and he would sulk.
- Often blames others for their own mistakes or behaviour: it was difficult for Jonathan to recognise that his own behaviour was a problem; he thought that the

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teachers were unreasonable and unfair when he was corrected or disciplined. He believed that others should always recognise his contributions and did not recognise that these were sometimes irrelevant for that time.

The ODD behaviour was mild to moderate as it was reported to occur in two settings: the school and home contexts. In the school context he met the full criteria of listed ODD behaviours in that he displayed five of the listed symptoms.

6.1.3.1. Test administered and scale used

The following tests were used to assist in assessment and understanding of later change or lack thereof in thoughts and behaviour.

6.1.3.1.1. Conners Rating Scale

The description of the Conners Rating Scale (Conners, 2007) is tabulated in table 1. The Conners rating scores (Conners, 2007) from his teacher are represented in Figure 18. Jonathan's scores on the Conners Rating Scale (Conners, 2007), as given by his teacher, were as follows: very elevated scores were given for, *'learning problems and executive functioning', 'hyperactivity/impulsivity'* and *'inattention.'* An elevated score was given for *'aggression/defiance.'* An average score for *'peer relations'* was given pre-therapy.

Jonathan's scores on the Conners Rating Scale (Conners, 2007) as given by his mother are represented in figure 17 and are as follows: an elevated score for *'peer relations'* and an average score for *'aggression/defiance'* was given pre-therapy. Compared to that of the teacher it seems that the mother was more concerned about peer relations and less concerned about the problem of aggression in Jonathan, and this, even though she wanted to address target behaviours such as anger, sulking and losing his temper with his sister. She also normalised *"disgusting"* behaviour in the home. For *'learning problems'* Jonathan's

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mother gave him an average score pre therapy. *Hyperactivity/impulsivity* was given a high average score. The category *'executive functioning'* was given a very elevated score.

All the following categories received a very elevated score from Jonathan's teacher: *learning problems and executive functioning ,hyperactivity/impulsivity,* and *inattention*. The following categories *executive functioning*, *hyperactivity/impulsivity* and *inattention* likewise attained a very elevated score from Jonathan's mother. This could indicate comorbid ADHD along with ODD.

6.1.3.1.2. SSAIS-R

Jonathan scored in the academically gifted category as measured by his performance on the SSAIS-R (Van Eeden, 1991). Both *verbal* and *full-scale IQ scores* were in the gifted category, yet there was a significant difference at a one percent level between the *verbal* and *non-verbal* category in favour of the *verbal IQ*. The *non-verbal IQ* score was in the superior category. Inter-test scatter was prominent. Within the verbal category the *vocabulary subtest* was above the rest of the verbal performance at a one percent significance level. The *comprehension subtest* was below the rest of the verbal performance at a five percent significance level. The *similarities* subtest was above the average verbal performance at a one percent significance level. These scores indicate strength in social reasoning and abstract verbal reasoning. The *number problems* subtest was below the average verbal performance at a one percent significance level. This could indicate auditory processing or attentional problems. The low performance on the memory for *digits* subtest at a one percent significance level confirmed this. Performance on the *story memory* subtest was above the average level of verbal performance at a five percent significance level. Possibly verbal memory was stronger when the material presented was meaningful. On the *nonverbal performance* the *missing parts subtest* was significantly lower than the rest of Jonathan's nonverbal performance at one percent significance level, indicating a possible weakness in attention to visual detail and/or

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possible long-term visual memory. This could indicate the underlying problem related to his very untidy handwriting, careless spelling errors, difficulty in copying down from the board and the omission of such things as full stops and commas. The visual problem had received no remediation or specific assessment. The *pattern completion subtest* was above the performance of the rest of his nonverbal performance at a five percent significance level indicating stronger visual abstract reasoning and analytical ability.

The general scatter in Jonathan's tests could also be due to attentional problems. This would confirm findings on the Conners Rating Scale (Conners, 2007) that indicated possible attentional problems. Jonathan did have a previous general assessment and it was conveyed to him and his family that his cognitive ability was in the gifted category. It was reported by his mother that the assessor claimed that his brain worked so fast that his hand could not keep up and that this was the reason for the untidy writing. Jonathan's strengths were in his visual analytical and abstract reasoning ability. Verbal abstract reasoning ability was also strong. I, the therapist/researcher, thought that the verbal strengths were advantageous for understanding and applying the REBT (Diguiseppe et al., 2014) concepts.

As stated in the literature review, Webb et al. (2005) claims that a major cause of behavioural problems in gifted children can be attributed to asynchronous development. This term refers to an uneven development across sensory, emotional, physical, and executive function skills. Some skills are superior while others lag. This interpretation could be applied to Jonathan's case study. He experienced a large degree of frustration relating to the visual and fine motor difficulties noted in both his performance on the SSAIS-R (Van Eeden, 1991) and his classroom work. As Jonathan was still in grade six the importance of neatness and handwriting was emphasised. These problems therefore prevented him from attaining his full potential with regards to marks in classwork and tests. Teachers found it difficult to recognise Jonathan's giftedness as he was unable to perform in a way that this could be acknowledged.

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When the teachers were informed that Jonathan attained a gifted performance on the SSAIS-R (Van Eeden, 1991) it was difficult for them to accept it.

As stated below one of Jonathan's main causes of dysfunctional emotion was his demand for acknowledgement of his ability. The problem area regarding Jonathan's handwriting, spacing, and spelling seemed to contribute to his behavioural problems as it detracted from his academic performance and the evaluative demand for recognition/acknowledgement of his ability. Despite assessments, no problem had reportedly been identified for remediation.

His mother (Mary) commented: *"I think he speeds up [so his writing becomes untidy] and I did also take him to an occupational therapist for a full thing, but within fine motor there's nothing… after he told me he wanted to hang himself, we took him. They suggested an occupational therapist just to see if there was a fine motor thing or if there was something we could do with exercise, what have you, and when she gave me the feedback, she said that there's absolutely no problem except that he's too big for his boots, he's too clever for his own good kind of thing. So, I don't know, and sometimes we do make him redo work."*

In summary Jonathan met the criteria for ODD with possible comorbid ADHD and other learning difficulties.

6.1.4. Establishment of client-therapist relationship

The alliance between myself, the therapist/researcher, and the participants was established according to the REBT (Diguiseppe et al., 2014) theoretical framework. As far as possible, the goals were collaboratively set. Jonathan was engaged in the therapy process as he wished to reduce his anxiety and work on the issues in the classroom that he perceived as unfair. His mother was positive regarding the process and Jonathan often mirrored his mother. Jonathan was easy to engage with. He expressed himself well and was aware of his own feelings. He joked in therapy, trusted me, the therapist/researcher, with personal information and shared

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things that interested him. Jonathan became bored and easily distracted so to help engage him, his interest of superheroes was incorporated into therapy. This communicated interest in his world and further engaged him in the process. The main goals of the therapy, to improve Jonathan's behaviour and identify and dispute the associated irrational beliefs, was sometimes set aside in favour of what Jonathan was concerned with at that moment. One time his grandfather was seriously ill in hospital so that became the main topic for two sessions. At another time study skills were addressed as he was concerned about exams. The relationships with Jonathan's teacher and mother were established in the same way as with Jonathan. Jonathan and his mother were familiar with the therapy process. This familiarity was helpful in establishing a relationship. Heidi's beliefs, pre therapy, about therapy and her capacity to change, also affected her process. These beliefs are explored further under the section on the school context in this chapter. With each client personal stories were explored and work stress, or other unrelated topics to the main goals of therapy, were discussed when the participants brought them up. Strong therapeutic relationships were established and every level of this system (as defined by the study) was engaged. According to the MST framework this intervention would be more effective as the system was engaged (Swenson et al., 2005).

The assessment information was gathered from the initial two interview sessions. Information was gathered throughout the therapy process, and these details were then added. Contracting was likewise negotiated throughout. Based on this information, a case formulation was created using a multisystemic (Swenson et al., 2005) framework within which contingency (Kazdin, 2000) management and REBT (Diguiseppe et al., 2014) therapies were applied to different levels of Jonathan's system.

6.2. A Multisystemic Case Formulation

The case formulation is a set of clinical hypotheses about the events or processes that led to the development of disruptive, impulse control and conduct disordered behaviours,

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specifically ODD with possible co-morbid attention deficit disorder (ADD) in Jonathan, as well as the maintenance thereof in the present (Edwards, 2018; McLeod, 2010). All evaluative beliefs and inferences are taken from sessions and thought records created in sessions by client and therapist. The contextual development and maintenance of ODD behaviour is facilitated by knowledge of the context.

6.2.1. Jonathan's mother (Mary) and his home context

I, the therapist/researcher, experienced Mary as the most engaged parent out of the four cases in this current study. Apart from the two initial assessment interviews, 26 sessions were conducted with Mary. This was the most sessions of any of the other mothers. However, the sessions were held at her place of work (the school), so this made them more accessible to her. According to the Revised Belief Scale for Parents (PIBS) (Joyce, 1995) (figure 17), *Demandingness, self-worth (S.W), low frustration tolerance (LFT)* and the ov*erall rationality* score fell within a high level of irrationality.

Mary grew up with harsh parents that she perceived as unsupportive. She experienced a traumatic childhood with little or no parental support in this regard. In adulthood she had experienced depression, and as stated, this was quite severe during Jonathan's early childhood where she was hospitalised for a short period of time and treated with medication from that time to date of the therapy. She experienced guilt due to the hospitalisation when Jonathan was a toddler. She also worked full time and she was very involved in community service and leadership roles outside of her working hours. Jonathan's mother's irrational beliefs are described below.

6.2.1.1. Demand schemas

The demand schemas: *'I must protect him from reprimand/perceived criticism and or conflict; he must not stand alone'; "He must know that I care",* were triggered when

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Jonathan did something wrong, or people criticised or reprimand him. The associated inference: *'If Jonathan is reprimanded it means they [teachers] are criticising him'* evaluated reprimands as criticism. Mary inferred that Jonathan would not be able to cope with the criticism and accompanying negative feelings. This inference was likely reinforced by Jonathan's history of a depressive episode, when at his previous school, he was criticised by teachers for his untidy handwriting and experienced other reported *"bullying"* incidents by teachers. This was associated with the demand *'he must not stand alone'* which was likewise activated whenever he was reprimanded or in any conflict situation; Mary: *"He must know that I care."* These demands seemed to have developed in Mary's childhood; Mary: *"Maybe also my mom and my relationship with my parents. I don't want my kids to have that feeling. I want them to know that I'm there, I'm involved, I'm interested and when I say, 'not now', I don't want him to think I'm not interested."* Mary did not want Jonathan to stand alone as she had done in her childhood, and this was reinforced by Jonathan's reaction to previous criticism as explained above. The associated inferences were: *'I know what it is like to stand alone and how he must feel; if he experiences negative emotions and situations and I do not support him [stand with him], it means I am like my parents.'* Consequently, Mary would protect Jonathan instead of focussing on his behaviour or what got him into trouble. If she did not protect him, she would feel guilty. These demands were also associated with anxiety and anger that was directed at the source of the reprimand/perceived criticism or conflict. The above demands and inferences are tabulated in table 27.

Demand: Mary thought that the negative feelings associated with criticism would overwhelm Jonathan and that: *"No one should feel like this,"* in the way she experienced it as a child and Jonathan had experienced in his previous school. This demand was closely related to the demands**:** '*I must protect him from reprimand/perceived criticism and or conflict; he must not stand alone',* as this is what Mary was protecting Jonathan from, being

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overwhelmed by negative feelings. She stated that this demand was generally triggered when anyone experienced a negative emotion, not just Jonathan. Mary: *"It's not just for him, I feel like I must take care of people because nobody should feel like that…"* Mary would say*: "I joke that it's [I have] a magic wand...I can fix things."* The above is tabulated in table 27.

Table 27

Tabulation of Mary's Demands 'I Must Protect [Jonathan]'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Jonathan does something wrong. People reprimand/criticise. Jonathan. inferences: *'If Jonathan is reprimanded it means they are criticising him.* *Jonathan will not handle criticism* *I know what it is like and to stand alone and how he must feel.* *If he experiences negative emotions and situations and I do not support him [stand with him], it means I am like my parents.'*	Demands: *'I must protect him from this criticism (implied).* *He must not stand alone in the face of criticism, especially if he feels bad.'* Mary:" *He must know that I care"*	Emotional consequence: Anxiety/Anger/upset Behavioural consequence: Mary does not focus on the criticism and tries to "fix" the situation for Jonathan by protecting him so that he is not alone while facing the negative situation.
Inferences: 'If Jonathan experiences reprimand or judgement, he will not be able to cope with it. He will feel very bad if he is criticized'.	Demands Mary *"No one should feel like this."* *'I must protect him from negative feelings associated with criticism.'* Mary: *"I joke that it's a magic wand...I can fix things."*	Emotional consequence: Anxiety/ upset Behavioural consequence: Focuses on defending Jonathan. Focuses on supporting him so that he does not experience negative feelings. Jonathan avoids consequences.

6.2.1.2. Negative self-evaluation

During sessions negative self-evaluation was noted; Mary: *"I am a bad parent."* This irrational evaluation was triggered when Mary shouted at Jonathan when Jonathan did something generally wrong, such as not doing his homework, losing his temper or when he got into trouble at school. Mary would think: *"it's a reflection of me and it's so bad."* Due to

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her experience of depression during Jonathan's babyhood Mary believed that she did not bond with him and that all his behavioural problems stemmed back to this.

Mary: *"Ya, and the relationship was so bad for that first year, I don't want anything to jeopardise it* [now], *even if I tell him 'you're being silly' or 'you're not telling the truth' or 'yes I knew that' instead of leaving him to explain things, how they work, or not how they work."*

The associated inferences were, Mary: *"Jonathan's problems are my fault."; 'Due to my depressive episode during his babyhood I did not bond with Jonathan and so all his behavioural problems stem back to this and I am therefore a bad parent'; 'Because Jonathan misbehaves and does not do his work, I am a bad parent'; If I do not know "where he's at" [understand him] all the time, this means I have not bonded with him and am a bad parent'; 'If Jonathan misbehaves it is a reflection on me and my parenting.'*

These irrational evaluative beliefs and inferences were linked to the emotion of guilt, which led to Mary constantly protecting Jonathan. She subsequently failed to discipline him effectively or consistently. As a result, Jonathan often escaped consequences for his bad behaviour. The above is tabulated in table 28.

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Table 28

Tabulation of Mary's Negative Self-Evaluation; 'I Am a Bad Parent'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Mary shouts at Jonathan Jonathan does something wrong. Inferences Mary: *"Jonathan's problems are my fault."* *'Due to my depressive episode during his babyhood, I did not bond with Jonathan and so all his behavioural problems stem back to this and I am therefore a bad parent.* *Because Jonathan misbehaves and does not do his work, I am a bad parent.* *If I do not know "where he's at" [understand him] all the time, this means I have not bonded with him and am a bad parent.'* *'If Jonathan misbehaves it is a reflection on me and my parenting.'* Mary: *"the relationship was so bad for that first year, I don't want anything to jeopardise it."*	Negative self-evaluation: Mary*: "I am a bad parent."*	Emotional consequence: Guilt Behavioural consequence: Tries to protect Jonathan from any negative consequences associated with getting into trouble. Jonathan gets away with misbehaviour.

6.2.1.3. Contingency management in the home context

The ineffective disciplining (Mary's behaviour) of Jonathan was linked to Mary's evaluative beliefs above. This ineffective discipline contributed to Jonathan's ODD behaviour. Mary would protect Jonathan from the consequences of most of his bad behaviour because of the above demands, she believed that most of his behavioural problems stemmed from her depression when he was a toddler, *"If Jonathan misbehaves it is a reflection on me and my parenting and it's very bad."* As a result, she protected her relationship with him above all else. Mary was also very busy, so the household was somewhat chaotic. Despite her engagement in the therapy process it was difficult for her to implement contingency management (Kazdin, 2000). A lot of follow up was required on my, the therapist's/researcher's, part in this regard for any contingencies to be implemented. The general atmosphere in the home was permissive due to Mary's perceptions: *"I mean I've got*

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good kids; we don't have issues at home. Somebody might get cross with the other one or we might have an argument or whatever, but then it's fine…." This dialogue contradicts her anger when Jonathan loses his temper with his sister. In the initial two interviews the target behaviours of procrastination with morning and evening routines and homework were identified as well as losing his temper with his sister and lying.

6.2.2. Jonathan's teacher (Heidi) and his school context

Heidi was in her seventies and was brought up in a strict but supportive home where children were expected to behave well. Her mother used to tell her that she attracted negative events in her life. She thought this statement accurately described her, and she adopted this irrational inference. She never had children of her own and had a very unhappy marriage that ended in divorce. She was ashamed of some of her ex-husband's behaviour as he had a criminal record. Some of the events in her marriage provided evidence that supported the irrational inference that she attracted negative events in her life. She never married again and at the time of this study, lived on her own. She also mentioned her mother's statement about attracting negative events when describing the children's behaviour in her classroom. She therefore took a lot of responsibility for things that went wrong in the classroom upon herself.

Heidi was engaged in the therapy process with both the contingency management (Kazdin, 2000) aspect and with her own personal REBT (Diguiseppe et al., 2014) sessions. This teacher's conservative background contributed to her expectations of Jonathan and the other children, and these expectations sensitised her to their bad behaviour. This context (Heidi's thinking and subsequent behavioural response) contributed to Jonathan being perceived as a difficult child as well as him meeting the criteria for ODD (APA, 2013). When talking about Jonathan's previous threatened suicide, Heidi asked herself the question: *"Am I too strict?" "Does he think I make him angry or anxious?"* This added to the insecurity around his discipline in this school context. Conversely, Heidi recognised that although Mary,

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Jonathan's mother, was involved with both of her children she believed that Jonathan escaped discipline. Heidi: *"I think he gets away with it."* Despite her own questioning of her discipline of Jonathan, Heidi did state her beliefs around his reported anxiety and threatened suicide: *"I think he plays it."* She also believed that there could be a comparison, on the part of his parents, between Jonathan and his sister who was a *"perfect child."*

As stated above, Heidi's beliefs pre-therapy impacted the therapy process and relationship. In sessions Heidi expressed that her beliefs and reactions were part of her personality, so initially to change her belief in her own lack of capacity for change, was difficult. Her thinking regarding her own inability to change did affect the nature of the interaction between client and therapist. She was always co-operative and listened but would remain fixed on the topic of Jonathan and the other children's behaviour as opposed to her own thinking. She would revert to this topic as soon as she could, even in the middle of creating a disputation. Creating the balance between responsiveness (Kramer & Stiles, 2015) and the therapeutic goals was tiring for me, the therapist/researcher, in these sessions. By the end of the process, her thinking around her own inability to change did shift.

The results on the TIBS (Huk et al., 2019) (figure 18) mostly mirrored those discovered in the therapy process described below. The *authoritarian attitudes towards pupils* fell in a high level of irrationality. This likely emanated from beliefs and demands that came from Heidi's own strict upbringing in a different era from that of the children she taught. Heidi's score for *attitudes towards the school organisation* fell in a moderate level of irrationality. The school was experiencing mismanagement and Heidi's personal discussions were often centred around frustration in this regard. The *self-downing* score initially fell in the moderate level of irrationality. Heidi's '*average score for irrationality'* also initially fell in the moderate level of irrationality range. *Negative self-evaluation* was noted in Heidi's sessions. The score for *low frustration tolerance (LFT)* fell within the more rational

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philosophy. *Frustration intolerance* was however noted in Heidi's sessions. The belief that Heidi could not stand Jonathan's interruptions was addressed in therapy. These scores are represented in figure 18. Heidi's demands, evaluative beliefs and inferences discovered in therapy and associated with her discipline of and response to Jonathan and his classroom behaviour are described below.

6.2.2.1. Demand schemas

The demands: *'People must think well of me all the time; I must do things perfectly all the time; I must not make mistakes,'* were noted in Heidi's therapy process in relation to her work as a teacher and life in general. These demands evaluated Heidi's experience. They were triggered by people 'criticising' Heidi or Heidi getting behind in her work, children misbehaving in her class and Jonathan challenging her, adding what he called *"facts"* to her lesson or correcting her. They led to anxiety and anger. They were associated with her shouting and being ineffective in disciplining the children. The above is tabulated in table 29. Heidi: *"Jonathan is forever interrupting me; he corrects me all the time. It's very disruptive… One day I smashed everything off his table."*

Some of the associated inferences that flowed from these demands were as follows: *'If children misbehave it means that I am not doing well; if Jonathan interrupts me, it means that he does not think well of me; if they [children and staff] criticise me, it means I am not doing well; if I do not get through to students, it means I am not doing my job properly*; *if they* [children and staff] *do not appreciate me, it means I am not doing my job well enough.* These inferences contributed to evaluating the triggers, of the children misbehaving or not listening, as Heidi not doing well. The above is tabulated in table 29.

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6.2.2.2. Frustration intolerance

Heidi's frustration intolerance flowed from the above demands. It was triggered by the same situations as the demands. Frustration intolerance evaluative beliefs were: '*I cannot stand doing things I am not good at; I cannot stand being criticised or thought badly of when I have not finished something or done it properly',* and they led to anger, anxiety, and the same ineffective discipline. Heidi reported frustration intolerance specifically regarding Jonathan's behaviour: "*I can't stand it when he interrupts."* Heidi evaluated Jonathan's interruptions as a criticism. The above is tabulated in table 29.

6.2.2.3. Negative self-evaluation

These evaluative beliefs flowed from the above demands: *if I do not do things well it means I am not good enough, I "feel like nothing."*

Heidi held the inference that she attracted negative events. This led to her taking responsibility for most of the negative events that happen in the classroom such as the children, including Jonathan, misbehaving. This coupled with demand for her own high performance (discussed under the above demands) led to hurt and anger. The negative self-evaluation was triggered when the children, including Jonathan, disrespected Heidi or misbehaved. The following inferences flowed from negative self-evaluation: *'This is my fault; if they criticise me, it means I'm not doing well; if I do not get through to students, it means I am not doing my job properly; I attract negative things; if they do not appreciate me, it means I am not doing my job well enough.'*

Heidi: *"Then I am nothing"* [negative self-evaluation].

This thinking was associated with shouting and ineffective discipline of Jonathan and the other children.

Heidi: *"… you know I put so much in my preparation, I put so much in my lessons and then a boy lies and sleeps on the table and he says, 'oh history is so boring,' then I think if*

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you know the trouble that I went to, to try make this lesson interesting for you, it makes you feel like nothing." [negative self-evaluation]. The above is tabulated in table 29.

Table 29

Tabulation of Heidi's Irrational Evaluative Beliefs and Associated Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: People criticising me or me getting behind in my work. Children misbehaving in my class Jonathan challenging me, correcting me, or adding his *"facts"* to the lesson. Inferences *'If they misbehave it means that I am not doing well.* *If Jonathan interrupts me, it means that he does not think well of me.* *If they [children and staff] criticise me, it means I am not doing well.* *If I do not get through to students, it means I am not doing my job properly.* *If they [children and staff] do not appreciate me, it means I am not doing my job well enough.'* Inferences: *'This is my fault.* *If they criticise me, it means I'm not doing well.* *If I do not get through to students, it means I am not doing my job properly.* *I attract negative things.'* *'If they do not appreciate me, it means I am not doing my job well enough.'* Heidi; *"then I am nothing"*	Demands: *'People must think well of me all the time.* *I must not be criticised.* *I must do well all the time.* *I must do things perfectly all the time.* *I must not make mistakes.'* Frustration intolerance *"I cannot stand doing things I am not good at"*; *'I cannot stand being criticised or thought badly of when I have not finished something or done it properly.'* Negative self-evaluation If I do not do things well it means I am not good enough, I *"feel like nothing."*	Emotional consequence: Anxiety/ anger Behavioural consequence: Shouts, and disciplines ineffectively.

6.2.2.4. Contingency management in the school context

The disciplinary punishment used in the school was applied through the usual demerit system which was characterised by delay in contingency application. Jonathan got demerits for work not done, but this rarely translated into detention. Heidi would usually use shouting to discipline Jonathan and his class. Her irrational, evaluative beliefs affected Heidi's discipline

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of Jonathan. Heidi also responded to Jonathan's previous incident of threatened suicide and wondered if he thought that she made him angry or anxious. This made her unsure in her discipline of him. Her negative self-evaluative beliefs that she was *"nothing"* if Jonathan did not enjoy her lessons, led to her losing her temper and not disciplining effectively. Jonathan believed that this was unfair and that she should acknowledge him and his contributions. He was supported in these situations by his mother who recognised his *"facts"* at home for fear of jeopardising her relationship with him. As a result, the contingencies around Jonathan's behaviour were not systematically applied in an effective manner and in Heidi's words *"he got away with it"* in both home and school contexts.

6.2.3. Jonathan's case conceptualisation

According to the Child and Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015) (figure 16) the scores for *demandingness* and *awfulizing* fell within the moderate level of irrationality; both were noted in sessions. The *frustration intolerance (LFT), other (ROW-O)* and *self-evaluation (ROW-S)* and the *average irrational belief* score all fell within the more rational philosophy endorsed category, meaning that few irrational beliefs were indicated. In sessions irrational beliefs were noted in self and other evaluative beliefs as well as frustration intolerance (figure 16). The following section describes the case conceptualisation of how Jonathan's ODD behavioural problems were held in please according to the REBT (Diguiseppe et al., 2014) conceptual framework.

6.2.3.1. Demand schemas

Jonathan's demand schema could be paraphrased as follows: '*Life must be fair. Life must be fair, if it is not, I must make it fair.'* Many of Jonathan's incidents at school were connected to this demand and the other evaluative beliefs and inferences associated with it. This demand schema was triggered when Jonathan did not do as well as he would have expected to or

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made mistakes in areas that he considered to be his strengths. This was intensified when his mistakes were pointed out through teasing by his peers or by his teachers, in a way that Jonathan evaluated as harsh. This demand led to anger and verbal and/or physical fighting with those who pointed out his mistakes. With peers he would react with verbal and/or physical aggression and with adults he would sulk. When he reacted with anger, his peers responded with further teasing in the classroom and Jonathan would often sulk.

The inferences associated with this demand were that *'if others do better than me it is because they have an unfair advantage over me'* and that is not fair. *'People tease me by pointing out my weaknesses or mistakes in a mean way,'* and that is not fair. As an example of this Jonathan gave an incident in rugby where a boy that was stronger and bigger than him sometimes did better at the sport. This was a sport that Jonathan believed he was good at. This triggered his demand schema for fairness and through this irrational belief the other boy's advantages were evaluated as unfair. A representation of Jonathan's demand schema for fairness and associated inferences are tabulated in table 30.

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Table 30

Tabulation of Jonathan's Demand 'It Must Be Fair'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Events seen as unfair in the sports field or other competitive situations. Especially if it was something, he was good at. His mistakes being pointed out by peers or teachers. Especially if he believed this to be mean or harsh. Inferences *'He can perform better than me due to advantages and that is not fair.'* *'People tease me by pointing out my weaknesses or mistakes in a mean way.'* *'Teachers are mean and harsh when they correct me.'*	Demand: *'Life must be fair. If it is not fair, I must make it fair.'*	Emotional consequence: Anger Behavioural consequence: Sulks and withdraws or fights with peers.

Demand: 'I must do well [be top] in everything that I see as my strengths,' and derivative evaluative beliefs are described here. Another demand related to these same competitive situations and mistakes being pointed out by peers or teachers was paraphrased as: *'I must do well [be top] in everything that I see as my strengths.'* This demand was related to anger and anxiety if it was not met. The derivative evaluative irrational belief was negative self-evaluation: '*If I do not well, it may mean that I am not good enough.'* These evaluative beliefs were associated with sadness. The following inferences were associated with both these demands and negative self-evaluation: *'I will lose my reputation if I do not do well; possibly I am not as good as I think I am.'* Overall, Jonathan believed that he must be on top [especially of things he was good at] [Tabulated in table 31]

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Table 31

Tabulation of Jonathan's Demand 'I Must Do Well [Be Top] in Everything That I See as My Strengths'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Events seen as unfair in the sports field or other competitive situations. Especially if it was something, he was good at. His mistakes being pointed out by peers or teachers,especially if he believed this to be mean or harsh. Inferences: *'I will lose my reputation if I do not do well.' Possibly I am not as good as I think I am.'*	Demand: *'I must do well [be top] in everything that I see as my strengths.'* . Negative self-evaluation *'If I do not well, it may mean that I am not good enough.'*	Emotional consequence: Anger/anxiety Behavioural consequence: Jonathan sulks and sometimes gets into verbal and/or physical altercations.

The demands: *'I must be listened to and acknowledged by others' and 'people must not underestimate me',* was associated with anger and hurt when it was not met, and Jonathan would sulk. If Jonathan was not acknowledged by teachers, ignored, or told to keep quiet in the classroom when he contributed to the lesson, the demand would be triggered. This demand was also triggered in class discussions when his peers did not acknowledge his input. With his peers he would get into physical or verbal fights.

The associated inferences flowed from negative self-evaluation paraphrased as follows; *'If they do not acknowledge me, it means that they underestimate me'*; and *'if others do not listen to or acknowledge me, it means that they think that my ideas are no good', 'if others think my ideas are no good there is a possibility that they are right about me,'* had the same triggers and emotional reaction as the demand. The inferences were likewise associated with hurt and sulking.

When he contributed his knowledge to the teacher's lesson his expectations were that she would be impressed by what he knew, as he experienced at home with regards to his mother. He thought she would recognise his knowledge and wondered why she did not acknowledge him or became irritated with him. In short, Jonathan demanded that others must

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acknowledge him, and his strengths and this demand led to anger and fighting or sulking when people did not. Due to the associated negative self-evaluation, Jonathan demanded: *"I must prove them wrong."* Jonathan's high ability was not recognised in the school context due to the staggered academic development and possible leaning problems noted in his assessment. It was difficult for teachers to accept his giftedness as his writing and special issues made it difficult for him to actualise this potential. This context could have encouraged the development of this demand to be recognised. These evaluative beliefs and their consequences are represented in table 32.

Table 32

Tabulation of Jonathan's Demand 'People Must Acknowledge Me'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: When people do not listen to Jonathan in class or group work. When people do not listen to him sharing his *"facts."* Inferences: *'If they do not acknowledge me, it means that they underestimate me'; 'If others do not listen to or acknowledge me, it means that they think that my ideas are no good', 'If others think my ideas are no good there is a possibility that they are right about me,'* [and I am no good].	Demand: '*People must acknowledge me.* *People must not underestimate me.'* Negative self-evaluation *'I am not as good as I think I am if people do not acknowledge/underestimate me.* *'If they do not recognise my ideas Then maybe they are not as good as I think they are.'* Demand *"I must prove them wrong."*	Emotional consequence: Anxiety/hurt Behavioural consequence: Jonathan sulks and withdraws with adults or gets into verbal or physical fights.

The demand: *'I must be acknowledged'* was closely linked to the demand, *'I must be liked by people',* and negative evaluation flowed from these demands if they were not met. As evident in the inferences above, Jonathan's self-worth was dependent on others: '*what makes me good enough is that somebody acknowledges that that was good enough.'* So, it was important to him that people liked him and acknowledged him. This demand and associated inferences were triggered by Jonathan's inference that people were being mean to him when he was not acknowledged. It led to anxiety, sadness, and sulking. He inferred that if people

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did not like him, awful things would happen such as teachers marking his work down. He believed that he would go crazy from loneliness if he was disliked as he would not have any friends in class. This demand and associated inferences are tabulated in table 33.

Table 33

Tabulation of Jonathan's Demand 'People Must Like Me'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: People being perceived as mean by Jonathan. Inferences: *'People are being mean to me. If my teachers do not like me, they will mark me down. If people do not like me, I will have no friends, start talking to myself and go crazy'.*	Demand: *'People must like me.'* Awfulizing *'It is awful if people do not like me as awful things will happen.'*	Emotional consequence: Anxiety/sadness Behavioural consequence: sulks

6.2.3.2. Frustration intolerance and awfulizing

Jonathan's frustration intolerance was triggered by his schoolwork and lessons: '*I cannot stand being bored.'* He also awfulized boredom: *'being bored is the worst thing in the world.'* These irrational beliefs were triggered specifically when Jonathan had to do things that he did not like or things that he was not good at. These thoughts led to frustration and procrastination. Jonathan did not finish school tasks, and this led to friction between him and Mary. This frustration intolerance tabulated in table 34.

Table 34

Tabulation of Jonathan's Frustration Intolerance

Activating Event	Irrational Belief	Consequence
Situational Activating Event: School work and lessons. Doing things that I do not want to do. Doing things that I am not good at.	Demand: 'I must not be bored.' low frustration tolerance 'I cannot stand doing this.' Awfulizing 'Being bored is the worst thing in the world.'	Emotional consequence: Anxiety Behavioural consequence: Procrastinates, rushes through it carelessly.

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6.2.4. Summary and treatment plan

The treatment plan was based on the identification of the kinds of irrational beliefs stated above. In summary, Mary's demands: *'I must protect him from criticism/reprimand and or conflict', 'he must not stand alone', "he must know that I care", "no one should feel like this",* were associated with protecting Jonathan from situations involving perceived criticism, reprimand, or conflict. Mary wanted to fix things for Jonathan so that he did not experience the negative emotions that she believed could overwhelm him. These beliefs were related to Mary's own anxiety and anger towards the perceived source of criticism. As Mary protected Jonathan, and stood by him, he would escape behavioural consequences. Mary's negative self-evaluation: *"I am a bad parent,"* was associated with feelings of guilt and again Jonathan's behaviour would be excused as Mary believed it was more her fault than it was Jonathan's, due to her depressive episode. As a result of this Jonathan was not consistently disciplined and Mary struggled to put any boundaries in for him: *"the relationship was so bad for that first year, I don't want anything to jeopardise it*" (Mary). Heidi noted these interactions between Mary and Jonathan as Mary worked at the school: *"He gets away with it"* and *"He plays it"* (Heidi).

Heidi's demand schemas paraphrased as: '*people must think well of me all the time', 'I must do well all the time', 'I must do things perfectly all the time', 'I must not make mistakes',* as well as her negative self-evaluation being *'If I do not do things well it means I am not good enough' and "I am nothing"* (Heidi), evaluated Jonathan's classroom behaviours as failure on Heidi's part. Heidi's frustration intolerance of not doing well: *'I cannot stand doing things I am not good at'* and *'I cannot stand being criticised or thought badly of,'* made Jonathan's behaviour unbearable at times. She became angry and hurt: *"Sometimes I go for him"* (Heidi).

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According to the REBT (Diguiseppe et al., 2014) treatment plan the evaluative beliefs that Jonathan held needed to be challenged as they held his ODD behaviour in place and the evaluative beliefs held by the teacher and mother needed to be challenged as they affected their disciplining of Jonathan. Jonathan also responded to the irrational beliefs and associated behaviours around him.

6.2.5. Responsiveness across irrational beliefs

As Mary did not want to jeopardize her relationship with Jonathan, she would allow him to explain things to her that she already knew and to carry on in explanation for as long as he wanted to: *"instead [I leave him] to explain things, how they work, or not how they work,"* (Mary). She would acknowledge how clever Jonathan was. This was the same behaviour noted in the classroom and Jonathan expected the same reaction from teachers and peers. Instead, his teacher could not stand the interruptions and they triggered her negative self-evaluation. This in turn triggered Jonathan's own negative self-evaluation as his demand to be acknowledged was not met: *"what makes me good enough* [is] *that somebody acknowledges that that was good enough"* (Jonathan) (inference that flowed from negative self-evaluation). The interaction of these irrational beliefs caused the friction in the classroom, the ineffective discipline and anger and hurt in both Jonathan and Heidi as each triggered the other's similar irrational beliefs.

6.3. Treatment Implementation

The intervention plan was based on the case formulation above (Edwards, 2018). This plan was then implemented during therapy (Fishman, 2013). It was conceptualised according to the REBT (Diguiseppe et al., 2014) framework. The irrational beliefs above would be disputed to bring about alternate beliefs using REBT (Diguiseppe et al., 2014) theory and techniques. The MST (Swenson et al., 2005) approach is the overall framework that guided

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this clinical process and provided an integrative framework for applying the therapeutic approaches across different levels of part of Jonathan's system as defined by this study. As such the therapy was applied to Jonathan, his mother, and his teacher. Jonathan participated in 24 sessions, his mother had 26 sessions and two joint sessions with Jonathan, and his teacher had nine sessions.

The approach was embedded by holding therapy sessions with the participants across different levels of the defined school system to which Jonathan belonged: sessions were held with Jonathan utilising the REBT (Diguiseppe et al., 2014) therapeutic approach and sessions were held with Jonathan's teacher and his mother utilising the REBT (Diguiseppe et al., 2014) therapeutic approach and contingency management (Kazdin, 2000). Jonathan's system fully engaged in this study and as a result, according to Systems TheorySystems Theory (Swenson et al., 2005), it was hypothesised that the intervention would be more successful than the case studies where the system was not involved.

6.3.1. Home context: Treatment of Jonathan's mother (Mary)

This process consisted of contingency-management and REBT (Diguiseppe et al., 2014) sessions. The parent management element included the standard procedures such as praise and reward, contingency management, limit setting and establishing behavioural expectations. Jonathan was included in the application of the contingency management programmes, as he helped to identify what rewards and punishments, he thought to be appropriate and effective (Kazdin, 2000). I, the therapist/researcher, spent some time explaining the nature of irrational beliefs with Jonathan's mother and the connection of her thoughts to her feelings and behaviour. The possible origin of her thinking patterns was explored along with the link between her thinking and her reaction to Jonathan's behaviour. Socratic questioning, reflection, induction, and inductive interpretation (Diguiseppe et al., 2014) were amongst the techniques used to bring about Mary's awareness of the model and

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application thereof to the situation. Through these insights and subsequent disputations of irrational beliefs, these beliefs were weakened, and alternative rational thinking patterns were developed.

The techniques involved in REBT (Diguiseppe et al., 2014) treatment of Jonathan's mother included:

1. The connection between Mary's thinking, feeling and her behaviour towards Jonathan in particular was established. The link between her thinking, feeling and behaviour was linked to Jonathan's problematic behaviour.
2. Psychoeducation was used to introduce the REBT (Diguiseppe et al., 2014) model and teach the underlying concepts. It was also utilised to teach the contingency management (Kazdin, 2000).
3. An understanding of where the irrational beliefs could have originated from in Mary's personal history was developed.
4. Disputation of irrational beliefs was carried out in a systematic and logical way, for example, changing her language from shoulds, oughts and musts to preferences.
5. Cognitive homework was used to identify irrational beliefs linked to the problematic behaviours and dysfunctional emotion, reinforce the models and disputations, and to check understanding of the concepts.

The irrational beliefs described below impacted Mary's discipline of Jonathan.

6.3.1.1. Disputations

Empirical, logical, and functional disputations were all used in sessions held with Mary to dispute the irrational thinking that led to her experiences in connection with Jonathan and the often-ineffective way of disciplining him.

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6.3.1.1.1. Demands

The demands: *'I must protect him from criticism/reprimand and or conflict; he must not stand alone'; "He must know that I care,"* were disputed as follows. Initially I worked within the demand schema and used the inelegant solution of challenging the associated inferences. As with the demands these inferences were triggered when Jonathan did something wrong and was *'criticised'* or reprimanded or he was in a conflict situation. The irrational inference that Jonathan could not deal with the criticism or reprimands was challenged through empirical disputation: what tells you that it is possible for Jonathan to handle criticism? Mary realised that Jonathan now had skills to deal with criticism. He was also on medication that would help him to cope. Mary recognised that he was stronger than he was at 10 years of age when he could not cope with criticism at his previous school. The inelegant solution (Diguiseppe et al., 2014) was also used to show Mary that sometimes Jonathan had misbehaved, and the reprimand was a just consequence of this, not a criticism of him. After therapy Mary could acknowledge that Jonathan was able to deal with criticism and that these reprimands from teachers were not necessarily a judgment of her or Jonathan (table 35). Mary was able to think about reprimand in a less dogmatic way. She was able to recognise that both her children were seen in a positive way most of the time. This laid the foundation for her to be able to dreop the demand 'he must not be criticised' as she could recognise that Jonathan could cope with it.

Mary: *"But you know, it's all* [thinking my children and me are being criticised/judged] *from me because when the teachers speak to me, they like 'your kid's got beautiful manners, they stand up every time I come in the room or whatever…even* [Jonathan's class teacher], *she looked at their reports and said these are beautiful reports, you've got lovely kids… It's me, in my heart being hard on myself and my mothering."* It was

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hypothesised that this changed evaluation would lay the foundation for the disputation of the demand: *'I must protect him from criticism/reprimand and or conflict.'*

Therapist: "*Notice I didn't say that you wouldn't be judged, I said if you are, it's not the end of the world…* [here I was challenging the irrational belief]. Mary reverted to inferences, but these were presented in a less dogmatic way. She no longer evaluated the situation of Jonathan getting into trouble as '*my child* [and therefore mothering] *is being criticised.'* She was able to recognise the power of her own beliefs and inferences in the evaluation of a situation.

Mary:	Ya, whereas now if he doesn't do something, he's got to take the consequences.
Therapist:	Ya, and I think now because you know he's going to be ok [not going to harm himself]
Mary:	Yes [he] just [wanted] to get out of the situation.
…	
Mary:	…but I think him being here with me especially coming from a situation where he did want to harm himself and when he did trash his room and he did put the hosepipe around his neck and pull and what have you, I think for me, me seeing that he can cope with things and him just being safe… and he's grown enough and learnt enough to know that he doesn't need to do that in order to express feelings, you know maturity wise, age wise, wisdom from you, you know.

The functional dispute was used to challenge the demand: *'I must protect him from criticism.'* The question was raised; how will it help Jonathan to be protected from criticism? In the disputation the following were raised. Sometimes Jonathan got into trouble because of what he had done not because teachers wanted to criticise him or make him feel bad. Mary

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realised that if she always protected Jonathan from being criticised or being reprimanded, he would escape consequences: *"My son will then not face any consequences* (Mary)." Allowing Jonathan to face consequences was a form of support in that she was allowing him to face the criticism. Therefore, it could be concluded that allowing Jonathan to face criticism was both helpful and supportive.

The alternate nondogmatic preferences created were: '*He will be criticized; it is part of life. I cannot protect him from all criticism, and it is not helpful to do so'; "but you've* [Jonathan] *gotta learn it because it's gonna happen in life and I'm not always gonna be there as your buffer or to protect you…* (Mary)."

Understanding the links between the demand: *'He must not stand alone in the face of criticism'* and associated inferences to Mary's history were facilitated. Mary had a general need to support people when they faced anything negative. The origin of this set of beliefs was discussed with Mary: "*maybe also my mom and my relationship with my parents, I don't want my kids to have that feeling, I want them to know that I'm there, I'm involved, I'm interested and when I say 'not now', I don't want him to think I'm not interested."* As she felt unsupported in her past in relation to trauma, it had translated into the development of certain demands and thinking about situations. Evidence was presented that others did not experience the same lack of support that she did in the face of trauma, or the associated inferences that described this:

Therapist: The feeling of aloneness comes from my [Mary's] past… you're putting that on them… That is what I had [experienced] but this is not what they have…

Therapist: This one here [on the thought record] could help you to put the boundaries in [around supporting everyone, including Jonathan, through negative feeling], not everyone feels the same way as I do in

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the face of being criticised, etc. I remember you saying… that you thought they [people she had previously supported] didn't have support but actually, they did have support…they had more support than what you thought they had. Sometimes they have more support than I [Mary] think they have. `

Mary: [as an alternate belief] "It doesn't all fall down all on me." [not all her responsibility]

And specifically, in relation to Jonathan:

Therapist: Facing consequences does not mean that he [Jonathan] is alone; I put that one in [on the thought record] by myself but I think it probably would be helpful?

Mary: Definitely, definitely, it's by letting him face consequence that I'm actually supporting him because it's preparation for life.

Therapist: And you don't leave him on his own to do it…

Mary: No…

Therapist: He's always got an ear…but if the teacher does complain about his handwriting next year you can say to him 'well Jonathan, we do need to look at your handwriting'…you are supporting him but letting him face the consequence by re-writing it [the untidy piece of work]. So, you are not letting him stand alone. [Tabulated in table 35]

Mary realised that when Jonathan did stand alone to face criticism, he was not necessarily unsupported. Allowing him to face criticism by himself was preparation for how life was and not how she would prefer it to be. I would prefer that he does not stand alone but sometimes he must and face consequences.

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The functional, alternate belief, the nondogmatic preference to challenge the demand, '*he must not stand alone'* was constructed using Mary's own words: '*Standing alone and facing criticism is part of life'*, "*it's preparation for life* (Mary)." At the conclusion of sessions Mary was able to say in light of criticism: *"I think I've changed a lot since this. I've become a lot more tough* [regarding Jonathan's discipline] *through what we've worked through."* All of the above is summarised and tabulated in table 35.

Table 35

Mary's Empirical Disputations and Functional/Rational Beliefs Tabulated Against Her Demand 'I Must Protect [Jonathan]'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Jonathan does something wrong. People criticise Jonathan or reprimand him. inferences: *'If Jonathan is reprimanded it means they are criticising him. Jonathan will not handle criticism I know what it is like and to stand alone and how he must feel. If he experiences negative emotions and situations and I do not support him [stand with him], it means I am like my parents.'*	Demands: *'I must protect him from this criticism. He must not stand alone in the face of criticism especially if he feels bad.' " He must know that I care."*	Emotional consequence: Anxiety/Anger/upset Behavioural consequence: Mary does not focus on the criticism and tries to *"fix"* the situation for Jonathan by protecting him so that he is not alone while facing the negative situation.	Functional dispute: to challenge the demand: *"I must protect him"* from criticism and the accompanying negative feelings. Q: How will it help him to be protected from criticism? A: *'It will not help Jonathan to demand that I protect him from all criticism or being in trouble.' "My son will then not face any consequences* (Mary)." *'He will be criticised; it is part of life.'* Empirical dispute: to challenge the inference that *Jonathan cannot handle criticism and feeling bad about it.* Q: What tells you that it is possible for Jonathan to handle criticism? A: *'He's got skills and medication to help him cope with criticism.*	Nondogmatic preferences: to challenge the demands. *'He will be criticized: 'it is part of life. I cannot protect him from all criticism, and it is not helpful to do so.' 'Standing alone and facing criticism is part of life.'* Functional belief: Nondogmatic preference to challenge the demand. *'I would prefer that he does not stand alone but sometimes he has to face consequences.' To stand alone: "it's preparation for life*." *'It is disappointing if he gets into*

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
			He is stronger that he was at 10 years of age and could not cope with criticism.' Q: What tells you that you do support Jonathan? A: '*Just because Jonathan faces consequences does not mean he stands alone.'*	*trouble, but sometimes, he gets into trouble and needs consequences.'*

Mary's demand: "*No one should feel like this,"* was challenged using the functional dispute. Mary would joke with people who were going through a difficult time that: *"I joke that it's* [I have] *a magic wand...I can fix things."*

The question was asked of Mary: how does it help me or Jonathan to demand that he never experiences negative emotions related to criticism? We all must experience negative emotions and situations. It is preferable if we do not, but it is part of life. To demand it is not so, will just upset me further. I cannot fix it all for Jonathan. If I let him handle this [negative feelings], I am giving him the skills to cope with adversity.

The elegant solution to dispute the demand was attained in the rational nondogmatic alterative belief: *'we all must experience negative emotions, its preferable that we do not but it is part of life and to demand that it is not so will just upset me....'* Therapist: *"You are not responsible for making the whole world feel better."*

This was the demand schema that was still evident in Mary's irrational thinking even at the termination of therapy, but it had shifted. In Mary's words: *"That is where I go to now* (no one should feel badly), *this is where I was going to* (demand not to be criticised)*…and even there* (no one should feel badly), *I mean, I can tell you that what we've done so far, I can tell you this is not really automatic* (thinking) *any more…which is great."*

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Mary did not automatically revert to her demands anymore. Jonathan created a superhero to help his mother when she wanted to fix things for people. He not only used the metaphorical style of working for his own irrational beliefs. He could also apply it to help his mother.

Mary: So the Chillaxinator is…

Therapist: Your superpowers?

Mary: When I see problems in front of me, because my whole life is made up of fixing problems ok, if I can't do anything about the problem, if I can't move the problem my power of water is that water can go around the problem and if it is something that I can do something about I've got to use my fire power and just burn it up and do it.

Mary would also procrastinate as Jonathan did.

Mary: …Chillaxinator can use the fire and just burn it up and do it…but I like the water because he said mom if you can't do something about it just let the river go around it, you know. So cute, 12-years-old.

Therapist: But did you have to fix it at the end if the waters gone round?

Mary: It's about not taking responsibility for things that aren't my responsibility which is very difficult.

Therapist: …I just wondered what that one was, because I was gonna say sometimes you actually can't fix it…

Mary: Mmm, 'cause there's things that I can't fix and things that are actually not my responsibility, like put it where it's supposed to be, don't hang on to it and let it block you, put it where it's supposed to be, so in other words the person who is supposed to be responsible, you know what I mean? Push back!

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Therapist: And that's actually the same for Jonathan as well because…some of the stuff is his responsibility. So…yes, you've got to help him obviously, you're his mother and yes he's only a 12-year-old little boy but you know it's also [that] then you would want to fix or you would want to protect…

Mary: We have to teach them to survive in the world and that's our job

Therapist: Because…it's a tough world…

Mary: It's just trying to get that balance…

Therapist: And then your waterpower can go around it and then you can say Jonathan this is your responsibility I'm letting the water go around it

Mary: Yes, because he came up with it for me.

The above disputation is tabulated in table 36.

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Table 36

Mary's Empirical Disputations and Functional/Rational Beliefs Tabulated Against Her Demand to Protect Others From Criticism

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Jonathan does something wrong. People criticise or reprimand me or my son. Inferences: *'Jonathan will feel very bad if he is criticized. Jonathan will not handle the feeling bad about criticism.'*	Demands Mary: *"No one should feel like this." 'I must protect him from negative feelings associated with criticism.'* Mary: *"I joke that it's [I have] a magic wand...I can fix things."*	Emotional consequence: Anxiety/ upset Behavioural consequence: Focuses on defending Jonathan. Focuses on supporting him so that he does not experience negative feelings. Jonathan avoids consequences.	Functional dispute: to dispute the demand Q: How does it help me or Jonathan to demand that he never experiences negative emotions related to criticism. A: *'We all must experience negative emotions and situations. It is preferable if we do not, but it is part of life. To demand it is not so will just upset me further. I cannot fix it all for him. If I let him handle this, I am giving him the skills to cope with adversity.'*	Rational belief: Nondogmatic alternatives. *'We all must experience negative emotions and situations. It is part of life. To demand it is not so will just upset me further.'* Therapist: *"You are not responsible for making the whole world feel better."* Mary: *"It doesn't all fall down all on me"*

Mary's demand: 'I must be liked' was challenged using an empirical dispute with the question: What evidence do I have that I need people to like me?

Therapist: People are being ugly to you [referring to a situation she was facing at school] and you are surviving it, so… you do not need people to like you.

Mary: I don't need it, but it still bugs me, it still bugs me, it's a lot to process, when I get that feeling [upset] but it's life and we are not all going to like each other.

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Therapist: It is a preference [now], you then dropped the demand …I prefer that they [people] did, obviously it's nice if they do, but if they don't it's not the worst thing in the world…

The alternate nondogmatic belief was taken directly from Mary's own words: *"it still bugs me,…but its life and we are not all going to like each other."* Mary was able to drop he demand to a nondogmatic preference.

The catastrophic prediction was challenged: If they do not approve of me the relationship will be *"obliterated* (Mary)" and that is awful. This catastrophic prediction implied awfulizing. The following paraphrased answers, constructed by me, the therapist/researcher and Mary, were used to challenge this irrational inference logically: *'If people disapprove of something I am doing, it does not follow that the relationship will end. If it does, then that relationship was not worth having in the first place.'*

Therapist: If they judge me what is the worst thing that can happen?

Mary: Absolutely nothing

Therapist: How would you have thought about it before?

Mary: The relationship or possible relationship will be obliterated and if that's going to be the case, the relationship would not have been worth it anyway. You know you've got to look at the value of it and see…is it worth getting all upset about…or…so what?

The alternate de-catastrophising belief used was: *'It is not the worst thing in the world to be judged or disliked. It is unpleasant to process but I have evidence that I will survive it.'*

Mary: We've come a far way hey, we've come very far.

The above disputations are tabulated in table 37.

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Table 37

Mary's Empirical Disputations and Functional/Rational Beliefs Tabulated Against Her Demand 'I Must Be Liked'

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Jonathan does something wrong. People criticise or reprimand me or my son. Inferences: *'I will be judged by people if Jonathan misbehaves as he is in the same school where I work.'* *'If they reprimand Jonathan the school staff will blame me or talk behind my back especially because I work here.'* *'If they don't approve the relationship will be "obliterated" so it is awful.'*	Demands Everyone must like me. Awfulizing To not be liked, judged by people, is awful.	Emotional consequence: Anxiety/ upset. Behavioural consequence: Avoids conflict if possible. Ruminates over conflict.	Empirical dispute: to dispute the demand people must like me. Q: What evidence do I have that I need people to like me? A: Therapist: *"People are being ugly to you [referring to a situation she was facing at school] and you are surviving it, so… you do not need people to like you."* Logical dispute to de-catastrophise the inference: *'If they don't approve the relationship will be "obliterated" so it is awful.'* *'If people disapprove of something, I'm doing it doesn't follow that the relationship will end If it does, then that relationship was not worth having in the first place.'*	Rational belief: Nondogmatic alternatives. To drop the demand to a preference. Mary: *"I don't need it [people to like me], but it still bugs me,… but its life and we are not all going to like each other."* De-catastrophising alternate belief. *'It is not the worst thing in the world to be judged or disliked.'*

6.3.1.1.2. Negative self-evaluation

Empirical disputation was used to challenge the negative self-evaluation; *"I am a bad parent (Mary)"* and associated inferences. Evidence was gathered in sessions between me, the therapist/researcher, and Mary to foster self-acceptance and less rigid thinking. Questions such as: *'What are the things that tell you that you are sometimes a good parent?'* were asked. The following were discovered in the answer. Mary was concerned that she had not bonded with Jonathan when he was a small child, yet she knew that she had a bond with him now; "*I'm his go to person* (Mary)" indicated to her that she was doing something right when

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parenting him. She also saw her parenting as negative due to seeing it through depressive lenses at that time: *"You see yourself as bad at everything* (Mary)." She saw herself as a bad parent as she was interpreting her role through the irrational beliefs that were associated with depression at that time and these thoughts were not true. Jonathan was now aware that he was a loved child. She was doing her best as a mother and her best was good enough. Mary was also very involved as a parent in both of her children's lives. Most children misbehaved and Mary realised that she would not even know about the negative incidents if she did not work at Jonathan's school. All of these were used as evidence to dispute the evaluative belief that Mary was a bad parent [tabulated in table 38].

An excerpt from such a dispute:

Therapist: …how do you know he knows you're interested? …And how would you know that the bond is strong between you and him?

Mary: Well already I engage, and I say to him 'well why do you think that?'…

Therapist: Take time to reason.

Mary: Take time to reason, ya, then sometimes, if it is all wrong, let's look it up together or whatever. This is like the facts or whatever. And then also, like there was a terrible thunder storm a few years ago, lightning storm, ah not lightning, hail, my car was written off it was that bad and they were at home with my maid and the lights went out as well, and he was petrified and he said to me: 'mommy I want to go see V… that Psychologist Em saw with her anxiety because I was really scared whenever I see a cloud in the sky, and I said ok and then I made an appointment so that he'd know that if there was a small thing he tells me I take him seriously, so that when there's a big thing I will take him

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seriously as well. So, and we didn't make a big deal out of it and after seeing V…, after seeing V… twice he said, 'oh I don't need to go back it's fine.' But for me the biggest thing about that was that he saw I took him seriously.

Therapist: He saw that, and what shows that your relationship is close?

Mary: That he'll tell me that. That he will tell me how he's feeling, what he's thinking and even when he has one of his outbursts or whatever he waits until him and I are alone, and he tells me about it…

Therapist: That's a good alternative thought I think, my child feels safe with me?

Mary: Yes, he does…

Mary: He'll tell me about the outbursts. He doesn't often have outburst and he doesn't direct them; they're normally not directed at anybody except himself, the outbursts, ya. It was funny the other day [Mary gives a personal example of personal information Jonathan shared]…This happens at certain times, and I'm worried about this, and I'm really scared when that happens…

Therapist: Reassure, so he feels safe with you.

Mary: I definitely think so.

Logical disputation was also used to challenge the negative self-evaluation and associated inferences. The question was asked: How does it logically follow that because Jonathan gets into trouble, I am therefore a bad parent? To answer this, Mary recognised that children misbehave. This served to normalise some of Jonathan's behaviour. When Jonathan misbehaved it did not mean that this was related to Mary's belief that she did not bond with him when she was depressed. Mary also believed that because she did not always understand Jonathan; I don't always know where *"he's at* (Mary)", it therefore followed that she was a

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bad parent and did not have a strong bond with him. It was argued that this did not mean that she did not have a bond with him as she could not expect herself to know where he was *"at"* all of the time [tabulated in table]. The alternate beliefs that were created during and after the disputations were: *'No one can be a perfect parent all the time. I cannot expect it. Sometimes I am too tired or busy to check homework. I am stressed and overcommitted parent but not a bad parent. My parental best is good enough.'*

In the final session when Mary was answering the PIBS (Joyce, 1995), in response to the question about her self-worth being related to her parenting, she answered that although it still was related, this had shifted; *"I feel like it [parenting] is related to my self-worth...But I think if you compare it [to when therapy started], a lot of the guilt is gone, like I said, you know what, they're kids, they're gonna do things, whereas when we started [therapy] I was like it's a reflection of me and it's so bad* (Mary)." Although self-evaluation was still evident, she seemed not to take full responsibility for Jonathan's behaviour, and she no longer held the belief that Jonathan's behaviour reflected her worth as a parent.

The above disputation and discussions are tabulated in table 38, and they are taken from thought records created in sessions by Mary and me, therapist/researcher.

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Table 38

Mary's Empirical and Logical Disputations and Functional/Rational Beliefs Tabulated Against Her Negative Self-Evaluation

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Mary shouts at Jonathan. Jonathan does something wrong. Inferences Mary: *"Jonathan's problems are my fault."* *'Due to my depression episode during his babyhood, I did not bond with Jonathan and so all his behavioural problems stem back to this, and I am a bad parent.* *Because Jonathan misbehaves and does not do his work, I am a bad parent.* *If I don't know "where he's at" [understand him] all the time, this means I have not bonded with him and am a bad parent'.* Mary: *"the relationship was so bad for that first year, I don't want anything to jeopardise it"*	Negative self-evaluation: Mary: *"I am a bad parent."*	Emotional consequence: Guilt Behavioural consequence: Tries to protect Jonathan from any negative consequences or situation including those associated with getting into trouble. Jonathan gets away with misbehaviour.	Empirical disputation to encourage self-acceptance: Q: What tells you that you are sometimes a good parent? A: *I have a bond with him today. "I'm his go to person* (Mary)*."* *'I love my child and he knows this. I do my best as a mum. My best is good enough. I know I am an involved parent. Most children misbehave. I would not even know about a lot of the incidents if I did not work at his school.'* Logical disputation: Q: How does it logically follow that because Jonathan gets into trouble, I am therefore a bad parent? A: '*All children get into trouble. It does not mean that this is related to me not caring or not bonding with him.'* *'I cannot be expected to know where "he's at'* (Mary)*[understand him] all the time. If I do not this does not mean that I have not bonded with him, do not care and am a bad parent.'* *To challenge the inference; "Jonathan's problems are my fault."* *'I saw my parenting as negative due to depressive lenses.'* Mary: *"You see yourself as bad at everything."*	Rational Belief: self-acceptance belief. *'No one can be a perfect parent all the time. I cannot expect it.'* *'Sometimes I am too tired or busy to check homework.'* *'I am stressed and overcommitted but not a bad parent.'* *'My best is good enough.'*

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6.3.1.2. Contingency management in the home context

During the contingency management (Kazdin, 2000) sessions, psychoeducation was used to teach Mary the principles of identifying the target behaviour clearly. She was also taught to define the behaviour for Jonathan and find effective rewards for the absence of these behaviours and the punishments for behaviours that needed something more than just the absence of reward as a deterrent. The emphasis was on positive reward for good behaviour. These contingencies were hypothesised as specifically effective for Jonathan. His chart was based on a token economy (Kazdin, 2000) where dots on his chart represented a certain value. Rewards were given for the target behaviours of getting ready for school, doing homework, listening first time, studying, and having no anger outbursts either at home or school. Tangible rewards were used for Jonathan such as a wimpy milkshake or a KFC dessert or working towards a book he wanted. The school behaviours were included in the home chart. Punishments, given for anger outbursts at home or school, were given in the form of taking his phone away or not being allowed to play on electronics.

In the first session that occurred after the introductory sessions the focus was on establishing a consistent and effective contingency management (Kazdin, 2000) for Jonathan. At least part of each session was spent emphasising the importance of contingency management (Kazdin, 2000) and altering the contingencies if necessary. The contingencies chosen for him were however variable due to the token economy. Jonathan had almost constant supervision at home from his mother, so this was helpful for the appliance of contingency management (Kazdin, 2000). Despite this, it was still difficult to attain a systematic application of contingency management. Their household was a generally chaotic one. As a result, Jonathan was asked to administer his own chart under the supervision of his mother. What follows is an explanation of how the chart was administered to suit this household:

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Jonathan: I, what we did was…I actually have Prestik in my room and my desk is by a wall, so like my boredom attack plan is on the wall and some of the thinking when I was like down, and when my uncle said that to me, and stuff like that, I've got that up there. [Jonathan placed some of the examples that he did in therapy on his wall]

Therapist: … I'm just summarising them [different examples from therapy] here so that you can add these to your wall as well.

Jonathan: I call it the wall of remembrance, we actually have a wall at our church called the wall of remembrance it's for people that have died, but mine is for a completely different reason for remembering.

Therapist: Ya, for remembering your thought records and, so is it helping to have them up there in front of you Jonathan?

Jonathan: Yes.

Therapist: 'Cause it reminds you all of the time [this was helping Jonathan to practice the disputations and alternate beliefs].

Jonathan: And it reminds me I must do my chart every afternoon when I do my homework and then so far, I've got four crosses, I'm doing ticks and crosses and so far, I've got four crosses and it's because of, it's because of what happened. [Jonathan explains that the crosses were for not getting ready in time but that this is now improving].

Therapist: Ok, so your routine is improving with this. Fights with your sister is that in there or is that not such a big thing anymore?

Jonathan goes on to explain what behaviours were included and how it was improving according to the chart.

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6.3.1.3. Responsiveness

Responsiveness (Kramer & Stiles, 2015) to Mary occurred when I, the therapist/researcher, arranged sessions that were at a convenient time for her and Jonathan during their school and workday. One session was held at their home for their convenience. Mary often wanted to talk about her work situation, which was stressful for her, but this had little to do with her interaction with Jonathan. Although this was not the focus of therapy, I allowed her to discuss these issues which built a rapport between us and trust. The REBT (Diguiseppe et al., 2014) model was used responsively in Mary's case, for example, even though elegant solutions were sought by challenging evaluative beliefs, inferences were also challenged. I started with whichever process I believed would work well with Mary. Initially, when working with the demand: *"he must know that I care",* I worked within the demand schema and used the inelegant solution of challenging the associated inferences first. In doing this, Mary could perceive that sometimes Jonathan was not being criticised by teachers. I believed that this helped to decrease any resistance when challenging the demand. Jonathan was involved in maintaining his chart with Mary's supervision.

6.3.2. School context: Treatment of Jonathan's teacher (Heidi)

Sessions using REBT (Diguiseppe et al., 2014) and contingentcy management were carried out with Heidi. The contingency management included training included education in techniques such as praise and reward, limit setting and establishing behavioural expectations (Kazdin, 2000). Using REBT (Diguiseppe et al., 2014) techniques the I, the therapist/researcher spent some time explaining the nature of irrational beliefs to Jonathan's teacher, Heidi, and the connection of her thoughts to her feelings and behaviour. How she came to hold her irrational beliefs was explored along with the link between her thinking and feeling in the classroom and subsequently her reaction to Jonathan's behaviour which in turn activated these irrational beliefs and inferences. Through this insight and subsequent

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disputation, the irrational beliefs were weakened, and alternative rational beliefs were developed. Heidi's irrational beliefs were as follows:

- Demand schemas: '*People must think well of me all the time; I must not be criticised; I must not make mistakes.*'
- Negative self-evaluation: '*If I do not do things well it means I am not good enough, I am nothing.*'
- Frustration Intolerance: '*I cannot stand doing things I am not good at; I cannot stand being criticised or thought badly of when I have not finished something or done it properly.*'

6.3.2.1. Techniques used in Heidi's therapy

Most of the techniques described in the literature review (Diguiseppe et al., 2014) were utilised. General therapeutic techniques such as Socratic questioning and reflection were used to explore Heidi's world. This helped to establish relationship by creating an understanding of and communication of this understanding regarding Heidi's beliefs and how they contributed to the sometimes-ineffective discipline of Jonathan and her reaction to his ODD behaviour. Psychoeducation was used to initially explain the REBT (Diguiseppe et al., 2014) model, the connections between thinking, feeling and behaviour and other concepts. Client awareness was facilitated through induction and inductive interpretation (Diguiseppe et al., 2014) in Heidi's process. She had the capacity to understand the REBT (Diguiseppe et al., 2014) theory and presented her own disputations. As with Jonathan's mother, this process involved sessions of contingency-management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014). Heidi gave report backs on Jonathan's behaviour.

The methods involved in REBT (Diguiseppe et al., 2014) treatment of Heidi included:

1. Identifying irrational beliefs and the associated feelings and behaviour as well as what triggered them.

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2. Disputing irrational beliefs in a systematic and logical way such as changing her language from shoulds, oughts and musts to preferences.
3. Facilitation of the understanding of where the irrational beliefs may have come from in her personal history.
4. Cognitive homework was used to check the understanding of the model such as identifying absolutistic beliefs behind her emotions and ineffective discipline in the classroom.
5. Psychoeducation was used to help Heidi with contingency management (Kazdin, 2000) of Jonathan and in the understanding of the REBT (Diguiseppe et al., 2014) model and concepts.

6.3.2.2. Disputation

All the disputes, functional, empirical, and logical disputations were used in sessions held with Heidi to dispute the irrational thinking that led to her experiences in connection with Jonathan and the often-ineffective way of disciplining him. Through these techniques and disputations, the irrational beliefs were weakened before functional/rational beliefs could be established. This is illustrated below.

6.3.2.2.1. Demands

Heidi's demands: '*People must think well of me all the time, I must not be criticised, I must do things perfectly all the time,'* and '*I must not make mistakes,'* were evident in therapy. The inferences associated with these demands evaluated any misbehaviour in the classroom as Heidi not doing her job properly. Evidence was gathered to challenge the inferences that Heidi was not doing well if the children did not co-operate in some way. The following emerged from the discussion. She did have feedback from her boss and colleagues to say that she was doing a good job. Heidi did concede that she made a difference in some of the

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children's lives. Heidi claimed that the following alternate thinking helped her to evaluate the above inferences differently: *'children come from different circumstances which affects how they behave in the classroom. This has nothing to do with my performance as a teacher.'* Heidi claimed that thinking about where the children came from regarding their personal backgrounds and that they came from a different era to her was most helpful to her in challenging the inference that any misbehaviour meant that she was not good at her job as a teacher. Although this disputation only challenged the inferences it lent evidence that she was not the only influence on the children's behaviour and that their behaviour could be unrelated to her performance.

A logical dispute was used to challenge the demands: '*People must think well of me all the time, I must not be criticised, I must do things perfectly all the time, I must not make mistakes.'* The question was asked: how does it follow that '*If people* [including Jonathan] *do not think well of me* (criticise me) *or if I do not do things perfectly* (make mistakes) *that I am doing a bad job?'* The following disputation was created by Heidi and me, the therapist/researcher. If they criticised Heidi, it did not follow that she must do better or that she was not doing well. Everyone is criticised at some point in time. The children criticise all staff members, not just Heidi. It did not necessarily follow that because the children challenged her or misbehaved or criticised, that she was not doing a good job. Children misbehave, it does not follow that she was doing her job badly. *"They* [different children] *don't see you as the same"* Heidi could see that some children did appreciate her. *"We are all targeted,"* Heidi recognised that criticism was not just levelled at her and that mistakes were part of being human.

The demands were challenged and thereby changed to preferences. It was put forward that it would be nicer if all the children appreciated the lessons, but they would not all appreciate them, some of the children appreciated the lessons. Alternate beliefs were created:

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'I would prefer that people think well of me and do not criticise me, but this is not possible all the time. I would prefer that I do well and not make mistakes, but I cannot expect this all the time. Everybody makes mistakes.'

A functional dispute was used to bring about acceptance of reality and nondogmatic preferences: *'It is impossible to have everyone approve of what I do or do consistently well and not make mistake, to demand this will not help me or change the situation, I cannot do well all the time; to demand this will just frustrate me*. The less dogmatic beliefs that helped Heidi were: *'criticism is part of life; to make mistakes is part of being human.'* Heidi's disputations in this regard are tabulate in table 39. The evaluative beliefs and inferences taken from thought records created in sessions by Heidi and therapist/researcher.

Table 39

Heidi's Logical Disputations and Resulting Functional/Rational Beliefs Tabulated Against Her Demands

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: People criticising me or my work. Children misbehaving in my class. Jonathan challenging me. Inferences *'If they misbehave it means that I am not doing well* *If Jonathan interrupts me, it means that he does not think well of me* *If they* [children and staff] *criticise me, it means I am not doing*	Demands: *'People must think well of me all the time* *I must do well all the time* *I must do things perfectly all the time.'* *'I must not make mistakes.'*	Emotional consequence: Anxiety/ anger Behavioural consequence: Shouts, and disciplines ineffectively.	Functional dispute Q; How does it help me to demand that I must do well all the time. A: '*To make mistakes is part of being human* *Everyone is criticised at some point in time. To demand that people/the children do not criticise me will not help me or change the situation.'* Logical dispute to challenge the inferences. Q: how does it follow that If people criticise me [including Jonathan] that I am doing a bad job? A: '*It would be nicer if all the children appreciate the lessons, but they will not all appreciate them. Children misbehave, it*	Alternative nondogmatic rational belief: *'It is impossible to have everyone approve of me and do consistently well. To demand this will not help me.* *I cannot do well all the time. To demand this will just frustrate me* *Criticism is part of life.*

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Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
well. *If I do not get through to students, it means I am not doing my job properly.* *If they* [children and staff] *do not appreciate me, it means I am not doing my job well enough.'*			*does not follow that I am doing my job badly.* *The children criticise all staff. If they criticise me, it does not follow that I must do better or that I am not doing well.'* Empirical dispute to challenge the inferences associated with the demand; '*People must think well of me all the time.'* Q: What is the evidence that If people criticise me [including Jonathan] I am doing a bad job? A: '*I have feedback from my boss and colleagues to say that I am doing a good job. Children come from different circumstances which affects how they behave.'*	*To make mistakes is part of being human.'*

6.3.2.2.2. Frustration intolerance

Heidi's frustration intolerance was derived from the above demands can be paraphrased as: *'I cannot stand being criticised or thought of badly and I cannot stand doing things I am not good at.'* This evaluative belief was triggered by the same situations that triggered the demand schemas and led to the same emotional and behavioural consequences. Frustration intolerance was challenged through empirical disputation: What evidence is there to say I cannot stand doing things that I am not good at? The anti-awfulizing preference was stated as: *'I would prefer not to do things that I am not good at, but I can stand it as it is not the worst thing in the world. Overall, I get good feedback about my performance as a teacher.'*

Disputes tabulated in table 40 were taken from thought records created in sessions by Heidi and therapist and described above.

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Table 40

Heidi's Logical Disputations and Resulting Functional/Rational Beliefs Tabulated Against Frustration Intolerance

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: People criticising me or my work. Children misbehaving in my class. Jonathan challenging me. Inferences *'If they misbehave it means that I am not doing well.* *If Jonathan interrupts me, it means that he does not think well of me.* *If they* [children and staff] *criticise me, it means I am not doing well.* *If I do not get through to students, it means I am not doing my job properly.* *If they* [children and staff*] do not appreciate me, it means I am not doing my job well enough.'*	Frustration intolerance: *' I cannot stand being criticised or thought of badly, I cannot stand doing things I am not good at.'*	Emotional consequence: Anger/hurt Behavioural consequence: Shouts, and disciplines ineffectively.	Empirical dispute to promote frustration tolerance. Q: What evidence is there to say I cannot stand doing things that I am not good at. A: *'I would prefer not to do things that I am not good at, but there is no evidence to say I cannot stand it. I can stand it as it is not the worst thing in the world.* *All staff are criticised at some point.* *I still get good feedback. Mistakes are part of life.'*	Alternative, frustration tolerance beliefs. *'I would prefer not to be criticized or to do things that I am not good at, but I can stand it as it is not the worst thing in the world.'*

6.3.2.2.3. Negative self-evaluation

Heidi's negative self-evaluation: *If I do not do things well it means I am not good enough; I "feel like nothing."* Negative self-evaluation flowed from the demands. In the face of criticism and not being thought well of Heidi believed she was *"nothing."* A logical dispute was used to challenge this irrational belief. The question was asked: how does it follow that because I do not do everything well all the time that I am nothing? The disputation was presented that criticism and mistakes are part of life. It does not follow that when this happens, I am *" nothing."*

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Negative self-evaluation was challenged by the self-acceptance alternate belief: '*It does not necessarily follow then that because the children challenge me or misbehave or criticise, that I am not doing a good job. We all make mistakes it does not mean that;' "I am nothing."* Through discussions Heidi was encouraged not to relate performance with self-worth. She was encouraged to recognise herself and her intrinsic worth.

Therapist: …"*if they don't appreciate me then I'm nothing, but you are something, you can appreciate you"…*

The above disputes are tabulated in table 41. These beliefs and disputers were taken from thought records created in sessions by Heidi and me, the therapist/researcher.

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Table 41

Heidi's Logical Disputations and Resulting Functional/Rational Beliefs Tabulated Against Her Negative Self-Evaluation

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: People criticising me or my work. Children misbehaving in my class. Jonathan challenging me. Inferences *'If they misbehave it means that I am not doing well. If Jonathan interrupts me, it means that he does not think well of me. If they [children and staff] criticise me, it means I am not doing well. If I do not get through to students, it means I am not doing my job properly. If they [children and staff] do not appreciate me, it means I am not doing my job well enough.'*	Negative self-evaluation *'If I am criticised or not thought well of it means I am not good enough, I' "feel like nothing."*	Emotional consequence: Anger/hurt Behavioural consequence: Shouts, and disciplines ineffectively.	Logical dispute to challenge negative self-evaluation: Q: How does it follow that because I am criticised, not thought well of I am nothing? A: *'Criticism and mistakes are part of life. It does not follow that; "I am nothing." 'I will never get through to all children, it is just impossible.'*	Rational belief: Self-acceptance statement. *'Criticism and mistakes are part of life. It does not follow that;' " I am nothing."*

Linking the triggered thinking pattern; *"I am nothing"* to its development in Heidi's past was also used as evidence that it was an irrational evaluation of the current situation.

Therapist: …if they start cheek, sleeping, disrespect, all of that, [Heidi thinks] 'I'm not doing well, I attract everything [negative], that was something that you said that your mom said.

Heidi: Oh yes, I'm very attractive.

Therapist: [through past experiences] …you…develop your own thinking patterns… I attract everything [negative] was one of your theories…

Therapist: …[the children] trigger you [the thinking pattern].

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Heidi: Oh, yes.

Therapist: … it's not your work habits or your work, it's not [your] work standard…, it's none of that Heidi…it's not all of the children [that act out] it's some of the kids [but] some of the kids are nice, some of the kids are respectful…If you can think of [your alternate belief], it's their context [Heidi's alternative way of thinking] it's got nothing to do with your performance?

Heidi: Now I understand that, you know, I've been really working at it since last year, that I've been speaking to you, I've been really working at it, it's just sometimes you feel so relaxed, so today's gonna be such a good day and then just one kid triggers it.

Heidi demonstrated acknowledgement and understanding of the theories, but she had difficulty applying it *"in that moment* (Heidi)." She was encouraged to practice the alternate thinking to develop new habits of thinking. Initially she believed that her personality was the reason that she thought negatively.

Heidi: my mom was right because I am like that, I've been like that for 74 years of my life that you know what if somebody says in the staff room, one of you, then I think it's me, … then it isn't me.

Therapist: because you think 'I attract things'…

Heidi: …I can try and believe that the children are not aiming at me…but you mustn't make it personal, I get that, and you can change that attitude, you can.

Therapist: It's just a thought pattern…, the thinking is something different to your personality and if you think if it's me…

Heidi: No, I can believe that I do get very negative at times.

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Therapist: Around yourself you know, …appreciate, you, for yourself [not] I'm the one there's something wrong with…

Therapist: …but you can change your thinking in terms of the…

Heidi: Negativity, ya.

Therapist: …you can train your brain, thinking in a different way…

Heidi needed to practice the alternate way of thinking to solidify what she could now cognitively grasp.

Heidi: I know all these things it's just hard in practice.

Therapist: It is hard in practice you've just got to practice it.

According to the TIBS (Huk et al., 2019) results there was not as much change in Heidi's thinking as I would have hoped. The practicing of the alternated beliefs is deemed necessary in REBT (Diguiseppe et al., 2014) and this needed to happen for significant and lasting change to occur in Heidi.

6.3.2.3. Contingency management in the school context

The demerit system was utilised in Jonathan's school. After a certain number of demerits, detention was given. An attempt was made to reward Jonathan for schoolwork finished quicky by giving him books to read or allowing him to bring them from home. I, the therapist/researcher hypothesised, that the books would be rewarding for Jonathan and therefore encourage him to finish his work. Reading books would also occupy Jonathan and possibly prevent him from being disruptive. However, the rewards were not systematically applied, and it was difficult for Jonathan to attain the target goal.

6.3.2.4. Responsiveness

As with all the clients/participants the sessions were held at a time that suited Heidi and at her place of work. Early in the morning was the time that suited Heidi the best. I, the

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therapist/researcher, would wait at the school after Heidi's session to see the other participants. This was done in accordance with the systemic approach (Swenson et al., 2005) that removes boundaries for the clients/participants so that they have access to the therapy. Heidi would often talk about the issues within the school and I, the therapist/researcher, followed her in this topic as this was of importance to her at that time. I, the therapist/researcher found it tiring to negotiate the goals of therapy which was to look at Heidi's irrational beliefs and how they affected her discipline of and reaction to Jonathan in the classroom along with her needs to discuss the school problems. I tried to keep to the goals while still allowing some digression.

6.3.3. Treatment of Jonathan

The REBT (Diguiseppe et al., 2014) model was explained initially using psychoeducational techniques. The relationship between emotions, thinking and behaviour was explained as well as the nature of irrational beliefs. Jonathan was encouraged to think about his own behaviours and how he could change it and have more control over his emotion, by changing his irrational beliefs. For example, his demands could be changed to preferences which could reduce anger to frustration. This was done through a process of debate, where the pros and cons of beliefs were examined as well as the accuracy of these beliefs. Jonathan's irrational beliefs were challenged through the REBT (Diguiseppe et al., 2014) therapeutic framework to initially weaken them and subsequently find functional/rational beliefs that would contribute to changing his emotions and his behaviour.

6.3.3.1. Disputations

The disputations used were:

- The pragmatic/functional which used questions such as, where is this belief getting me? Is it helping me or making the situation worse?

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- The empirical or reality testing which used questions such as: Where is the evidence to support this belief? Is it really going to be that awful?
- The logical dispute was likewise used in Jonathan's therapy. This dispute uses the question: How does it logically follow that because your classmates do not always recognise your ideas it means that your ideas are no good?

All the disputes seemed equally useful with Jonathan.

Most of the techniques described in the literature review (Diguiseppe et al., 2014) were utilised. General therapeutic techniques such as Socratic questioning and reflection were used to explore Jonathan's world. This helped to establish relationship by creating an understanding of and communication of this understanding regarding Jonathan's beliefs and how they maintained his ODD behaviour. Psychoeducation was used to initially explain the REBT (Diguiseppe et al., 2014) model, the triggers, and the connections between thinking, feeling and behaviour and other concepts. Client awareness through induction and inductive interpretation (Diguiseppe, et al., 2014) were used in Jonathan's process. He was able to understand the concepts and disputations of the REBT (Diguiseppe et al., 2014) model, so induction was often used. He was asked to explain the discussions back to me or I would ask him how he understood the disputations. He was also sometimes asked to explain the REBT (Diguiseppe et al., 2014) model back to me to make sure that he understood what had been discussed. Homework assignments based on the sessions were also part of treatment and were used either for identifying thoughts, feelings and behaviour related to a certain trigger or practicing a disputation. Homework assignments were used to solidify what had happened in the session and check understanding. In Jonathan's case, a metaphorical style, using superheroes, was used extensively to engage Jonathan and help him to conceptualise alternative rational beliefs. It was a method that worked well with him as it was a way of thinking that he found both interesting and familiar. Some of these superheroes pre-existed in

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media whilst others were invented by Jonathan. I, the therapist/researcher found images that represented these superheroes along with the concepts that they embodied. These were sometimes placed on Jonathan's *"wall of remembrance"* at home to help him to remember and solidify the concepts and alternate beliefs. On the termination of therapy, they were included in the booklet that was given to Jonathan along with his thought records. Other perspective taking was used to help Jonathan to see that his thoughts about what people were thinking and doing were not always true. Others were thinking about things differently to the way he did.

Jonathan was an abstract thinker, and he was able to understand the concept of the irrational beliefs and disputations. He was able to use the disputations and functional, rational beliefs outside of therapy. I, the therapist, hypothesised that this would allow Jonathan to generalise the concepts he used across different situations and maintain behavioural change.

The following disputations and alternative beliefs were collaboratively created by Jonathan and me, the researcher/therapist, and taken from therapy sessions and thought records completed in sessions and for homework. After Jonathan recognised the link between his own thinking, feelings and behaviour, the irrational beliefs were challenged by using the described REBT (Diguiseppe et al., 2014) therapeutic techniques and methods to initially weaken them and subsequently find functional/rational beliefs that would be associated with new behaviour. Jonathan had the capacity to present his own disputations. The following section contains summaries of the disputations of the irrational beliefs that were weakened and subsequently replaced by alternate, functional/rational beliefs.

6.3.3.1.1. Demand

The demand schema that: '*Life must be fair, if it is not, I must make it fair,'* was initially disputed before the associated inferences were challenged. In this way the elegant solution was used first. After this was accomplished the inferences as to the motives of others could

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be challenged. If the demand for fairness could be weakened and the thinking become less rigid (changed to a preference) it was hypothesised, in accordance with REBT theory (Diguiseppe et al., 2014), that Jonathan would no longer become extremely angry and fight or withdraw in the face of perceived criticism and teasing, or when he did not do well in activities that he believed to be his strengths. With the use of a functional disputation Jonathan's demand for fairness was weakened and unfairness became more tolerable. The question was asked: *'how does it help me to demand that life is fair?'*

Instead of the demand: *'Life must be fair,'* Jonathan was encouraged to rephrase this as a preference, *'I would like it if life were fair, but life is not always fair,'* and to add some other preferences such as, *'I would like it if life were fair, but I do not have to make it fair as this will cause conflict for me and just frustrate me.'* Through this process Jonathan realised that there was a difference between what he desired, and reality and that the universe would not feel obliged to supply him with what he desired (Digiuseppe et al., 2014). The demands he had would not help him to change this. At the completion of therapy whilst answering the questions on the irrational belief scale Jonathan was able to drop this demand: *"I want my teachers to act fairly but they don't need to*."

A rational reality acceptance statement was created. Jonathan was encouraged to consider that life was sometimes unfair in his favour. Jonathan created a character for himself that embodied where life was unfair in his favour. He called himself Testenator: *"I am Testenator",* which meant he was good at tests. He always did well in tests when spelling did not affect the marks. When his demand for fairness was activated, when he was disappointed with his sports performance, others were seen as having an unfair advantage in performance, or teased for making mistakes, he was to remember that life was sometimes unfair in his favour; he was "*Testanator.*"

Jonathan could find a lot of evidence for where life was unfair in his favour.

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Therapist: …that's what I was gonna say to you. I was gonna start building up the other side of it, which is when is life unfair in your favour?...

Jonathan: Like I get to use an erasable pen for work because it looks un-neat if I just scratch out the whole time.

Therapist: Ya, so I get to use, I can use (therapist starts writing the evidence on a thought record sheet)…

Jonathan: …and also when you [have] play[ed] cricket for longer and [for] some people it's only their second match…

Jonathan: When it's unfair, I remember sometimes things are unfair in my favour and I remember that was one of the things that [helped me]… I am Testenator.

Considering that life was sometimes unfair in his favour helped Jonathan to drop the demand for fairness to a preference [tabulated in table 42].

Jonathan's associated inferences such as: *'He can perform better than me due to advantages and that is not fair, people tease me by pointing out my weaknesses or mistakes in a mean way and that is not fair,'* evaluated certain situations as unfair. These were challenged through a series of questions: *'Why do you need life to be fair? What constitutes fairness? Is life sometimes unfair in your favour?'* Through open debate and discussion of these questions, Jonathan was able to view his irrational beliefs from different angles. He was able to see how his beliefs were related to his feelings and behaviour and how they impacted on his own well-being, and that his well-being was dependent on his ability to change his beliefs and associated feelings and behaviours. Post-therapy he was able to recognise that these situations were not necessarily unfair.

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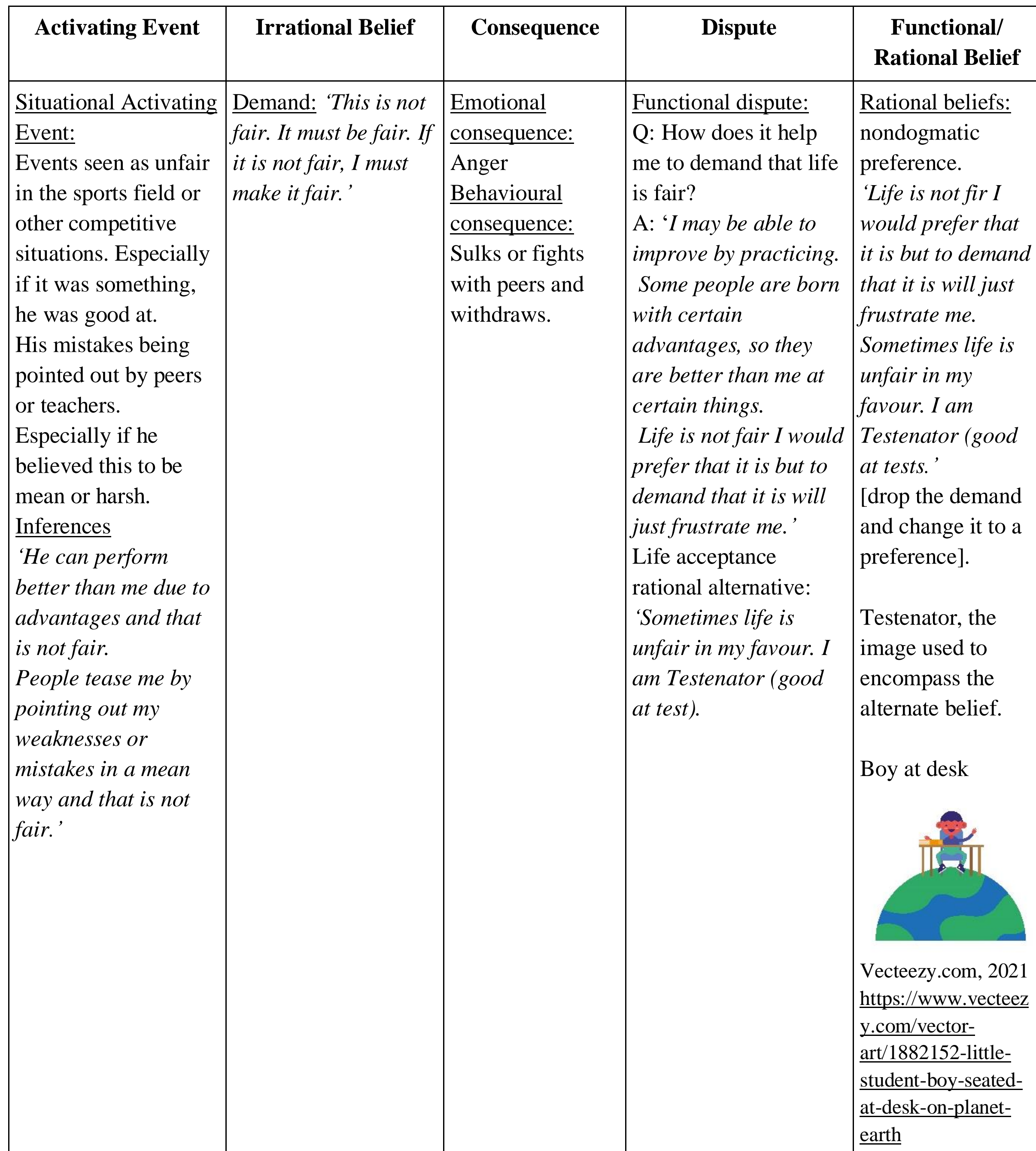
The above disputations and discussions are tabulated in table 42. The evaluative beliefs and inferences were taken from thought records created in sessions by Jonathan and therapist/researcher.

Table 42

Jonathan's Empirical and Functional Disputations and Functional/Rational Beliefs Tabulated Against His Irrational Demand That Life Must Be Fair



Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Events seen as unfair in the sports field or other competitive situations. Especially if it was something, he was good at. His mistakes being pointed out by peers or teachers. Especially if he believed this to be mean or harsh. Inferences *'He can perform better than me due to advantages and that is not fair.* *People tease me by pointing out my weaknesses or mistakes in a mean way and that is not fair.'*	Demand: *'This is not fair. It must be fair. If it is not fair, I must make it fair.'*	Emotional consequence: Anger Behavioural consequence: Sulks or fights with peers and withdraws.	Functional dispute: Q: How does it help me to demand that life is fair? A: *'I may be able to improve by practicing. Some people are born with certain advantages, so they are better than me at certain things. Life is not fair I would prefer that it is but to demand that it is will just frustrate me.'* Life acceptance rational alternative: *'Sometimes life is unfair in my favour. I am Testenator (good at test).*	Rational beliefs: nondogmatic preference. *'Life is not fir I would prefer that it is but to demand that it is will just frustrate me. Sometimes life is unfair in my favour. I am Testenator (good at tests.'* [drop the demand and change it to a preference]. Testenator, the image used to encompass the alternate belief. Boy at desk Vecteezy.com, 2021 https://www.vecteezy.com/vector-art/1882152-little-student-boy-seated-at-desk-on-planet-earth

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Demand: 'I must do well [be top] in everything that I see as my strengths,' and derivative evaluative beliefs were noted in therapy. An empirical disputation was used to challenge the demand again, a metaphorical style was used in disputation. Superman was used as a metaphor to show Jonathan that strengths and weaknesses exist side by side and that everyone has weaknesses. Even Superman has weakness, so we cannot expect to be on top all the time and not to make mistakes, even in our strengths. When Jonathan replied that Superman's weakness (kryptonite) eliminated his strengths for a while, I, the therapist/researcher responded with the concept that we were stronger than Superman as our strengths existed side by side with our weaknesses and did not eliminate them. Jonathan accepted this. Superman was the first superhero that I, the therapist/researcher used to help Jonathan conceptualise and remember disputations and alternate beliefs. From here Jonathan created his own metaphorical characters that embodied alternate functional beliefs. Jonathan was so engaged with this disputation that included Superman that he used it in an English speech that he had to give at school.

6.3.3.1.2. Negative self-evaluation

Negative self-evaluation flowed from the above demand: "*I must do well,'* otherwise *'I am not as good as I think I am.'* An empirical disputation was used to challenge this irrational belief. The following questions were asked: *'What evidence do I have that even if I do not do as well as I hoped to, I am still worthwhile?'* The argument was posited that we are all like Superman and have our strengths and weaknesses, good days and bad days, but unlike Superman our strengths do not disappear when our weaknesses appear, or we make mistakes. Unlike Superman our kryptonite does not destroy our strengths. We are stronger than Superman we keep our strengths alongside our weaknesses (kryptonite). *'My strengths do not disappear with my weaknesses.'*

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Therapist: Now if you don't do as well as them what is it saying to you there?

Jonathan: It used to say, 'oh, I'm not as good, I'm not as worthy as them', but now it's saying I just need a little bit more practice and I'll be as good as them, maybe even better.

Therapist: Ok, so that's an alternative way of thinking about it if you don't do as well as somebody. I'm not as experienced and I will improve.

Jonathan: Yes.

Therapist: If you learn better, if you practice better, all of those examples that we did, but now where I'm concerned is what happens if you don't improve?...

A dispute using a metaphorical style was used to find 'evidence' that we are good enough even when we are not doing as well as we want to.

Therapist: …what I'm trying to say is when there is a weakness, I don't want you… saying… I'm no good completely because the good parts of you disappear when you have a bad day or a bad subject, or on the soccer field, if you have a bad game or you make a mistake or something like that, then you think you're a bad player. Or if you're not as good as the next person at that, then I'm terrible, but I've got other aspects that are good enough and I am good enough.

Jonathan: I think that definitely will help me a lot.

Therapist: Can you think of any example there of a superhero that has strengths and weaknesses but he's still a superhero?

Jonathan: Definitely Batman 'cause they call him a superhero because, well he doesn't have superpowers but they call him a superhero because of what he does, he's one of the best superheroes because he does what

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everybody else does but without superpowers, and then like normally when he gets tied up then there's nothing like super strength or anything to get him out of it, then he always has something up his sleeve, literally, and then he just uses it right and unties himself and he gets out of the bad perspective, just by using his strength.

Therapist: What about if you're looking at Superman 'cause with kryptonite.

Jonathan: Well definitely Superman 'cause Superman is my favourite, ya and even when he has kryptonite, he always like crawls his way and he gets through it.

Therapist: But he's always going to be susceptible to kryptonite so you've got your own kryptonite, but it doesn't mean that all of your strengths then disappear even though that will always be there, that you have your own kryptonite, is that making sense?

Jonathan: Yes.

Therapist: 'Cause what we don't want you saying…I'm not good enough because there is still that element where you go try and prove that it [the weaskness] is not there…'I am going to beat you eventually at soccer' but you might not, he might always be better than you, there might always be somebody…it doesn't take your strengths away, so if Superman has a kryptonite weakness he can still fly and he's still good enough, ya, you wanted to add?

Jonathan: Like when he has a kryptonite weakness it normally takes away all of his powers but it's actually, I remember 'cause he's my favourite superhero, you always get through the tough times like even when he dies, he's not really dead…

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Therapist: …maybe I used a bad example with his kryptonite then. I didn't realise it took all of his powers away because with you, you're in reality, you're actually almost stronger than Superman because your kryptonite doesn't take away your other powers.

Jonathan: That's actually very cool I never thought of it that way actually.

Therapist: So that's the point I was trying to get across is that in reality people's weaknesses don't take away their strengths. I don't know how we would put that in a sentence for you …so that when you start feeling bad around something that you haven't done as well as you would want to and we can maybe say unlike Superman…

Jonathan: Unlike Superman I still have some strengths.

Therapist: Ya, unlike Superman my strengths don't disappear with my weaknesses…

The alternative nondogmatic belief that was established was: *'I cannot demand that I do well all of the time.'*

'Sometimes I do not do as well as I want to; everyone has weaknesses, or makes mistakes, even Superman.'

'We cannot expect to have perfect performance and never to have a bad run or make mistakes. It does not mean I am no good.'

The functional self-acceptance beliefs created were: *'Superman is still a superhero even with his weaknesses.'*

I am still good enough and have strengths despite varied performance, despite when *"even when he has kryptonite, he always like crawls his way and he gets through it."*

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At the end of the sessions Jonathan was able to change his demand to be top in everything that he felt he was good at to a nondogmatic preference; the statement on the irrational belief scale was posed: It's terrible when I'm not the winner.

Jonathan: *"Why? It doesn't matter if you are the winner or the loser, all that matters is you try your best."*

From Jonathan's answers it was clear that he understood how to recognise irrational beliefs and provide nondogmatic preferences. His intellect was strong so grasping the concepts came easier to him than it did to the other participants. However, being able to understand and apply the theory is different to using it in the moment. Therapist: *"Sometimes in the moment that might be different, but that's what you tell yourself."*

Sometimes discussions were held that did not use one of the main disputations: empirical, functional, or logical. They were general discussions, mostly using a metaphorical style, that changed irrational inferences and helped to support the change of evaluative beliefs.

The inference that Jonathan would lose his reputation when he did not do well was challenged through the following discussion. Jonathan's self-evaluation was placed solely on performance.

Therapist: …try and think of another way of thinking about that, would you really ruin your reputation? What makes up your reputation?

Jonathan: Getting good marks.

Therapist: Is that the only thing in your reputation?

Jonathan: Basically, and playing cricket.

Therapist: Ya.

Jonathan: I'm not the best but I'm not the worst playing cricket.

Therapist: What about how you are?

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Jonathan: I am?

Therapist: Like you're polite, you're helpful, is that also part of your reputation?

Jonathan: Not in this school or my last school no, but just good grades that's, ya, that's what they, that's what it seems like…

Therapist: It might seem like, but you know Jonathan, I've had a couple of people who have said "oh he's such a polite boy."

Jonathan: Who?

Therapist: A couple of your teachers.

Jonathan: Oh.

Therapist: They've noticed that about you.

Jonathan: Ok.

Therapist: More than one person has said you're a polite, oh he's such a polite kid, oh he's got such good manners, that kind of thing, so that's also part of your reputation. So, your reputation is wider than just grades. If you focus on just grades, then you've got one pillar you know what I mean?

Jonathan: Yes, and you can't have a building without more than one pillar.

Therapist: Ya, you need more than one pillar, so my reputation is wider than marks.

Jonathan: Yes, I never thought of it that way, thank you.

Therapist: Well there we'll put a little building here for you so that you know [what] you've got, your reputation is that you're a son, you're a friend, you know your reputation is much wider…so there you would need… more pillars than just one…reputation is about consistency…if you don't get good marks is it going to take your potential away?

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Jonathan: No.

Therapist: No, it won't.

Jonathan: I will still have potential to do good things.

The above disputations and discussions are tabulated in table 43. The evaluative beliefs and inferences were taken from thought records created in sessions by Jonathan and the therapist/researcher.

Table 43

Jonathan's Empirical Disputations and Functional/Rational Beliefs Are Tabulated Against His Demand 'I Must So Well' and Associated Negative Self-Evaluation

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Events seen as unfair in the sports field or other competitive situations. Especially if it was something, he was good at. His mistakes being pointed out by peers or teachers. Especially if he believed this to be mean or harsh. Inferences: *'I will lose my reputation if I do not do well. Possibly I am not as good as I think I am'.*	Demand: *'I must do well* [be top] *in everything that I see as my strengths. I must not make mistakes.'* Negative self-evaluation *'If I do not well, it may mean that I am not good enough.'*	Emotional consequence: Anger/anxiety Behavioural consequence: Jonathan sulks and sometimes gets into verbal and/or physical altercations. consequence: Anger/sadness. Behavioural consequence: Jonathan sulks.	Empirical disputation to challenge the demands. Q: What evidence do you have that you can do well all of the time at things you consider your strengths? A: '*We cannot expect to have perfect performance and never to have a bad run or make mistakes.'* Empirical disputation to challenge the negative self-evaluation. Q:What evidence do I have that even if I do not do as well as I hoped to, I am still worthwhile? *A: 'We are all like Superman and have our strengths and weaknesses, good days and bad days, but unlike Superman our strengths do not disappear when our weaknesses appear, or we make mistakes. Unlike Superman my kryptonite does not*	Functional belief: nondogmatic beliefs: *'I cannot demand that I do well all the time Sometimes I do not do as well as I want to. Everyone has weaknesses, or makes mistakes, even Superman.'* Functional, self-acceptance beliefs: *'Superman is still a superhero even with his weaknesses. I am still worthwhile and have strengths despite varied performance.'*

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Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
			destroy my strengths. We are stronger than Superman we keep our strengths alongside our weaknesses (kryptonite). My strengths do not disappear with my weaknesses.' An image of Superman and Kryponite was used metaphorically to illustrate the above dispute.	An image of Superman being weakened by Kryptonite was used metaphorically to illustrate the above dispute.

Demands: People must acknowledge me /listen to me; they must not underestimate me

A functional dispute was used to turn the demand to a preference. The question was asked: *'How does it help me to demand that people listen to me and acknowledge me?'* The ensuing discussion between Jonathan and me, therapist/researcher, can be paraphrased as follows: *'I would prefer people listen to me, but people generally are not great listeners, I would prefer people acknowledge me but to demand that they listen to me and acknowledge me will just frustrate me.'* Alternatively, *'I do not need others to acknowledge me. I can acknowledge myself.' I am "Silent Witness."* Jonathan used his own character, Silent Witness, to silently acknowledge himself when others did not. This character metaphorically embodied the alternate nondogmatic belief. *'I would prefer others to acknowledge me, but I do not need them to.'* Silent Witness was the character that could help Jonathan to recognise his own ideas as worthwhile.

Using the metaphorical character, Silent Witness, Jonathan could use the alternate belief: *"It is disappointing when people do not recognize me, but I can recognise myself. I am silent witness."*

A logical dispute was used to challenge implied negative self-evaluation and the associated inferences that flowed form the above demand. The question was asked of

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Jonathan: '*How does it follow that because they do not listen to me, my ideas are not good?'*

The discussion could be paraphrased as follows. There was evidence that the inference *'If they do not acknowledge me, it means that they underestimate me';* was not necessarily true as people are not great listeners, or the teacher could just be trying to keep him on the topic of the lesson. Jonathan's strengths were recognised in other ways, like his exam performance. Jonathan was recognised for doing well in tests and exams which was the strength that the character Testinator symbolised. The rational, nondogmatic belief created was facilitated by the superhero Jonathan created: *"I am silent witness"* a superhero that can witness his own worth, strengths and contribution. This was Jonathan's most effective alternate belief regarding the above demands and inferences.

An empirical disputation was used to gather evidence that self-worth lies beyond others' acknowledgment of your strengths. Subsequently a discussion encouraged self-worth as coming from self-acknowledgement which was embodied metaphorically in the character Silent Witness.

Therapist: …If somebody doesn't think I'm bright it doesn't mean that I'm not bright, that we've been through before. But there's also this [referring to a thought record]...if I don't perform well, I'm not good enough, and what makes you good enough, what are your other strengths?

Jonathan: When you, what makes me good enough that somebody acknowledges that that was good enough.

Therapist: …you'll need people to acknowledge you, to tell you that you're good enough before you feel good enough. … ok so here [referring to the thought record] we've got: "I'm not good enough if I don't do well", "I'm not good enough if people don't acknowledge that I am" or "if people don't see that I am good or see that I am doing well." How else

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can you see yourself as good enough? Other than around performance and other than depending on people to tell you, something that can come from inside of you.

Jonathan: Like sometimes like I think to myself that was really good? Jonathan, well done.

Therapist: Ya, so you can congratulate yourself, you can congratulate yourself on effort.

Jonathan: Ya, cause, we have a newspaper, it's called the challenge newspaper and like it's for, it's a Christian newspaper.

Therapist: Yes, I've seen it, ya?

Jonathan: And I gave it yesterday to a guy that was working next door to our house and two car guards, and I was like spreading, I was like yay, I'm spreading the Word of God that's an achievement for me, you don't have to preach to be able to spread it.

Therapist: I spread the Word of God and that's something that you're doing, what about something that's inside of you? Who thinks that you're good enough no matter what you do, no matter what you say…

Jonathan: I think my mom and my dad.

Therapist: Ya, so my family think I'm good enough, they might have an emphasis on doing well because they want you to do well but…that might not mean that they don't think you are good enough. So, my family think that I'm good enough, and what else is it other than performance that makes you acceptable? I mean if your mom loses her temper or if your mom is distracted by other things, do you still think she's good enough?

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Jonathan: Yes.

Therapist: Because she's a person so sometimes she'll go through a hard time or sometimes she'll just be stressed at work or, so she's good enough to you. And to God are you good enough to Him no matter what?

Jonathan: Yes, because like if I do my best, it's good enough.

Therapist: Ya.

Jonathan: But if I don't do my best? it's almost like I need to do my best.

Therapist: It would be nice if you did do your best but even if you don't do your best, are you still good enough as a person?

Jonathan: Yes.

Therapist: Because we don't always do our best all of the time Jonathan, so it's trying to think I'm good enough, I'm good enough whether Henry [his competition] recognises that I'm good or not, I'm good enough whether people recognise my 'facts' or not, I'm good enough whether [the class teacher] thinks I am or not, I'm good enough whether [another teacher] thinks I'm good enough or not…And you are good enough outside of performance and what you're doing and that you are intelligent and you have facts, we've gone through that before, you have, you're a kind hearted person, yes you lose your temper and you take all of those boys on at once if you needed to, but you are a kind hearted person.

Jonathan: Yes, my pastor also made like business cards, but it was fake business cards, but some of the stuff that was on there, I just felt like it was true 'cause he said he's a kind-hearted, loving boy, son of [mum] and [dad] and he's loving to his sister…

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Therapist: And sometimes you're loving and sometimes you're not when you and [sister] fight but generally you are, so generally I am a loving person.

Jonathan: Yes.

Therapist: And I think you see…it's like you have to be loving all of the time or you have to be, to be good enough, or you have to be doing your best all of the time to be good enough, you have to be good at a lot of things, all of the time, to be good enough but actually to your mom, to your dad, to your sister, to God, you are good enough, even [in] those times that you're not actually trying your best or even when you're in a bad mood…you think your mom is good enough whether she's in a bad mood or in a good mood, generally she's in an ok mood, or she might be very stressed around her job, so ok she's a stressed mom, but she's still a good enough mom, you know what I'm trying to say? So, it's that kind of thing, I am good enough just because…

Jonathan: Ya.

Therapist: Does, would that [help]? I'm good enough to the people that are important to me.

Jonathan: Yes, and that's important to me, I'm…

Therapist: …ok so I'm good enough to the people that are important to me, I'm good enough to God and what we really need is for you to believe that and say that I'm good enough for me.

Jonathan: I never really thought about it that way, so now that I am thinking about it that way, I think that will help.

Therapist: …I'm not good enough is at the bottom of this and that's why you're needing that acknowledgment and the acknowledgment to come from

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somebody else, when actually you know you're good enough for your family, you're good enough for God and you're good enough, well hopefully you're going to start seeing that you're good enough for you….

Jonathan: I think either way I am doing my best, I think.

Therapist: Yes, you are, you are doing your best for sure but even if sometimes you're not doing you best.

Jonathan: I'm still good enough.

Therapist: You're still good enough.

Jonathan: To my mom and my dad and my sister and my God.

Therapist: And can you also add you?

Jonathan: Yes.

Jonathan's disputations in this regard are tabulate at Table 44. The evaluative beliefs and inferences were taken from thought records created in sessions by Jonathan and therapist/researcher.

Table 44

Jonathan's Functional, Logical, and Empirical Disputes and Functional/Rational Beliefs Tabulated Against His Demand 'People Must Acknowledge Me and Negative Evaluation

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: When people do not listen to Jonathan in class or group work. When they do not listen to him sharing his *"facts."* Inferences:	Demand: *'People must listen to me and acknowledge me. People must not underestimate me.'* Negative self-evaluation *'I am not as good as I think I am if*	Emotional consequence: Anxiety/hurt Behavioural consequence: Jonathan sulks and withdraws or gets into a fight.	Functional dispute to turn the demand to a preference. Q: 'How does it help me to demand that people listen to me and acknowledge me?' A: '*I would prefer people listen to me and acknowledge me. To demand they listen to me and acknowledge me will just frustrate me.*'	Rational nondogmatic belief: *'I would prefer people listen to me acknowledge me but to demand they do will just frustrate me.'*

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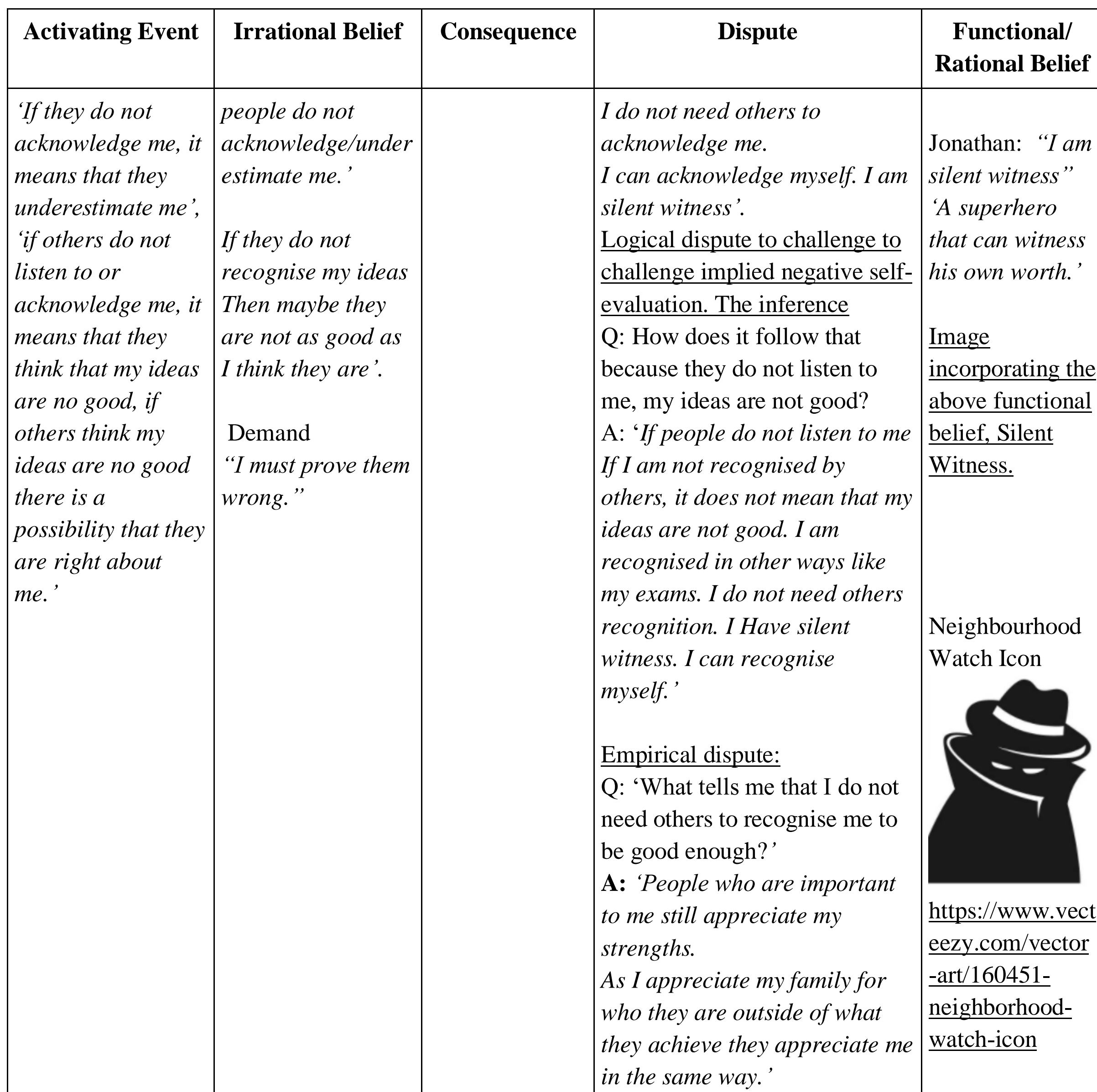

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
'If they do not acknowledge me, it means that they underestimate me', 'if others do not listen to or acknowledge me, it means that they think that my ideas are no good, if others think my ideas are no good there is a possibility that they are right about me.'	*people do not acknowledge/under estimate me.'* *If they do not recognise my ideas Then maybe they are not as good as I think they are'.* Demand *"I must prove them wrong."*		*I do not need others to acknowledge me.* *I can acknowledge myself. I am silent witness'.* Logical dispute to challenge to challenge implied negative self-evaluation. The inference Q: How does it follow that because they do not listen to me, my ideas are not good? A: '*If people do not listen to me If I am not recognised by others, it does not mean that my ideas are not good. I am recognised in other ways like my exams. I do not need others recognition. I Have silent witness. I can recognise myself.'* Empirical dispute: Q: 'What tells me that I do not need others to recognise me to be good enough?' **A:** *'People who are important to me still appreciate my strengths.* *As I appreciate my family for who they are outside of what they achieve they appreciate me in the same way.'*	Jonathan: *"I am silent witness" 'A superhero that can witness his own worth.'* Image incorporating the above functional belief, Silent Witness. Neighbourhood Watch Icon https://www.vecteezy.com/vector-art/160451-neighborhood-watch-icon

Demand: People must like me

A functional dispute was used to challenge Jonathan's demand that everyone must like him. This discussion between Jonathan and me, the therapist/researcher, can be paraphrased as follows: *'It is not possible to be liked by everybody. Everyone is disliked by somebody. It will not help me to demand to be like by all as there is no evidence to suggest that I can expect this.'* The alternate nondogmatic beliefs established were: *'I would prefer that everyone liked me, but this is just not possible.'*

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Jonathan also demonstrated several catastrophic inferences associated with the demand that people must like him. They were challenged using an empirical dispute.

He evaluated the loneliness that he would experience due to being disliked as so intense that he could go crazy, and this was disputed. The question was asked: *What is the evidence that I will go crazy if they do not like me? I have other friends, I have family, I have family at school. At the end of the dispute Jonathan declared: "I'm over thinking things…"* The following is an example of an empirical disputation to challenge the inferences of catastrophic prediction that Jonathan would go mad if he had no friends in class:

Therapist: …If you don't have a friend in class, what is the biggest downfall of that?

Jonathan: I think I'll go crazy and start talking to myself, things like that.

Therapist: …Why would you, what do you think would make you go crazy if there was no friend there in class?...

Jonathan: The loneliness.

Therapist: Ok, so it's lonely, you might be making the loneliness…bigger than what it should be because if we look at this (therapist draws a line on which to plot the likelihood of Jonathan going crazy) [we have] problems on a scale here. Lonely is how bad on the scale if you're looking at it and this was a hundred and [that] naught, that would be lonely at? (Jonathan points) 75. If you were to think but I've got other friends at break time which you do have hey? (he agrees). You do have friends, you said you have some older kids that you spoke to, and I think there was a couple of girls as well? If you think 'I've got other friends where would that take it to?' (Jonathan points) A 60. If you think you've got family at home that always love you?

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Jonathan: And at school 'cause my sister's here and my mom's here.

Therapist: And I've got family at school, and I've got family at home, (Jonathan points) 50. So, the likelihood of you, of that [loneliness] (therapist uses the diagram on the page) really affecting you to the extent that you would go crazy would be where? …I mean 'cause you're thinking that I'm gonna go crazy and that's 75% likely.

Jonathan: I'm over thinking things…

Therapist: So, there's not a very big chance of you going crazy…. That would be catastrophising (awfulizing) which means you're going to the worst possible case that could come from that…

Jonathan held the following catastrophic inferences regarding his teachers not liking him: '*teachers will mark your work down'* if they do not like you. The question was asked: *What evidence do you have that teacher's will mark your work down if they do not like you?* The discussion that followed is summarised as follows: No evidence could be found in Jonathan's experience that either he or his peers were marked down due to a teacher disliking them. Jonathan's homework assignment in this regard was reviewed in the following discussion:

Therapist: This says [thought record] she's going to, she will give me worse marks. Have you ever experienced that?

Jonathan: Mm-mm [disagrees]

Therapist: …are you going to the worst case there?

Jonathan: I don't think so, 'cause with some of the teachers it seems like they would do that.

Therapist: Ok, but it seems, that would be an assumption?

Jonathan: Mm [agrees]

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Therapist:	You've never really experienced it? or have you seen it happening to someone else?
Jonathan:	Mm [he explains how his aunt failed a driving test because the person taking her did not like her. He claims that his mother disagreed with this.]
Therapist:	Have you experienced it as well?
Jonathan:	No.
Therapist:	…did you experience that with your friends?
Jonathan:	No, my aunt [Jonathan tells the detailed story of his aunt]… my mom said they can't do that to you, that's illegal…
Therapist:	So, is that the only one that you've actually heard of?
Jonathan:	Yes.

The empirical dispute between me, the therapist/researcher and Jonathan is tabulated in table 45.

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Table 45

Jonathan's Empirical and Functional Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'People Must Like [Him]' and Associated Awfulizing

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: People perceived as being mean to Jonathan. Inferences: *'People are being mean to me.'* *'If my teachers do not like me, they will mark me down. If people do not like me, I will have no friends, start talking to myself and go crazy.'*	Demand: *'People must like me.'* Awfulizing *'It is awful if people do not like me as awful things will happen.'*	Emotional consequence: Anxiety/sadness Behavioural consequence: sulks	Anti-awfulizing Functional dispute *'It is not possible to be liked by everybody. It will not help me to demand this as there is no evidence to suggest that I can expect everyone to like me.'* Empirical dispute: Q: What is the evidence that people will mark me down if they do not like me. A: *'Jonathan's school experience provided no examples of this happening.'* Empirical dispute: Q: What is the evidence that I will go crazy if they do not like me? A: *'I have other friends I have family I have family at school.' Jonathan: "I'm over thinking things…"*	Nondogmatic alternative: *'It would be nice if everybody liked me, but it is not possible to be liked by everybody. I cannot expect this.'*

6.3.3.1.3. Frustration intolerance

An empirical dispute was used to challenge Jonathan's frustration intolerance regarding boredom: *'I cannot stand being bored.'* The question was asked: '*What evidence do I have that I cannot stand being bored?'*

Jonathan became bored and demonstrated frustration intolerance when he was not good at something or disliked doing it. The following paraphrases the discussion: *'When I am not good at doing something, it is frustrating, but I can stand it as I think that my weaknesses do not define who I am.'* The alternate, functional/rational nondogmatic preferences that were established after the demand was weakened were as follows: *'We are all bored at times. I can*

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stand this; I just do not like it. The task and boredom will not last forever and will soon be over.'

An excerpt from a disputation around frustration intolerance is given below:

Therapist: What I want you to do, when you procrastinate just check out what you're feeling and what you're thinking, just those 2. If mom tells you to do something and you really don't want to do it…

Jonathan: I think that it's probably gonna be SO boring… and also, do I have to do it? I'm feeling lazy.

Therapist: This is going to be boring. Ok so what, 'cause that is what we call low frustration tolerance, what you're telling yourself I can't stand being bored, when in actual fact it's [just] it's unpleasant.

Jonathan: But you can [stand it].

Therapist: But you can stand it…and what about it will be over quickly?

Jonathan: That's what sort of helps me most of the time.

Therapist: So, try out these two thoughts [I can stand it and it will be over quickly] and see if that helps you with the procrastination.

On the completion of therapy Jonathan could recognise frustration intolerance and could come up with the frustration tolerance alternate belief. In answering a question on the irrational belief scale, he stated: *"What its saying is that I can't stand it, but I can stand it."*

6.3.3.1.4. Awfulizing

Jonathan thought, *'being bored is the worst thing in the world.'* The alternate belief: *'It is not the worst thing in the world to be bored and to dislike some of the things we have to do,'* was discussed in therapy.

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Refer to the table 46 for the above beliefs and discussions, the evaluative beliefs and inferences were taken from thought records created in sessions by Jonathan and therapist/researcher.

Table 46

Jonathan's Empirical and Functional Disputations and Functional/Rational Beliefs Tabulated Against His Frustration Intolerance and Awfulizing of Boredom

Situation	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Doing things that I do not want to do. Doing things that I am not good at.	Demand: *'I must not be bored.'* low frustration tolerance *'I cannot stand doing this.'* Awfulizing *'Being bored is the worst thing in the world.'*	Emotional consequence: Anxiety Behavioural consequence: Procrastinates, rushes through it carelessly.	Empirical: Q:'What evidence do I have that I cannot stand being bored.' *A: 'I can stand this; I just do not like it.* *When I am not good at doing something, it is frustrating, but I can stand it as I think that my weaknesses do not define who I am.'* Anti-awfulizing: *'It is not the worst thing in the world to be bored and to dislike some of the things we have to do. This will not last forever, it will be over soon.'*	Rational Belief: nondogmatic preference *'We are all bored at times. I can stand it; I just do not like it. It will be over soon.'*

6.3.3.2. Other perspective taking

Other perspective taking was utilised to increase Jonathan's cognitive flexibility so that he could understand how others may experience his behaviour. This was utilised to help him challenge the inferences that were triggered by people not listening to him. He believed that when people did not listen to him it meant that they did not acknowledging him, did not recognise his ideas, were being mean to him and therefore unfair. The questions were asked of Jonathan to challenge these inferences:

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'Are they being mean or are they just not interested? Is the teacher being mean or is she frustrated with the interruption, or trying to keep you on track? What might she be feeling? Could she feel embarrassed? Could she be irritated by a child correcting her?'

Through these questions Jonathan was asked to focus on how his behaviour of providing *"facts"* or correcting teachers could come across to others.

An example of other perspective taking follows: Jonathan would get into trouble for doodling in class which he said he did because he was bored, and doodling, according to him, helped him to focus.

Therapist: …so if they don't understand why, you're doodling that would then get on their [teachers] nerves.

Jonathan: It's one of their triggers. [Jonathan shows understanding of the theory by using the correct terminology used in REBT and applying it to others]

Therapist: Exactly Jonathan, well done, it's one of theirs [triggers] so you're looking at what in your behaviour would trigger them.

6.3.3.3. Contingency management

In this case, the school contingency management did not alter significantly. The same demerit system was used and inconsistently administered. However, Heidi's attitude towards Jonathan's interruptions of her class changed. In the home context however, discipline administered by Mary became much more consistent and stricter compared to the pre-therapy lenient approach.

6.4. Evaluation of Impact

The plan was implemented, and therapeutic evaluations were applied. The process was tracked, and progress monitored (Edwards, 2018) so the evaluation section incorporates and

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interprets the therapy monitoring. The evaluation and impact of the treatment was assessed using the following scales, irrational belief scales comparing the teacher's, parent's, and child's irrational beliefs before and after treatment and Conners Rating Scales (Conners, 2007), comparing the child's behaviour before and after treatment. Behavioural charts and reports given by Jonathan's class teacher, Heidi, throughout treatment, monitored behavioural changes on a weekly basis and as the sessions progressed verbal reports were given. Jonathan's mother, Mary, and Jonathan co-operated in monitoring his behaviour with charts. Jonathan filled in his own charts under the supervision of his mother and his mother administered the contingencies. This was not carried out consistently enough for meaningful statistical evaluation. However, this family applied contingency management (Kazdin, 2000) most effectively out of all the case studies. The communication between school and home regarding Jonathan's ODD behaviour was not optimal even though Mary worked at the school. The fact that Mary worked at the school could even have made communication less effective. The teachers could have been reluctant to offend a fellow staff member.

6.4.1. Behavioural and self-report scales

The Child and Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015), Revised Belief Scale for Parents (PIBS) (Joyce, 1995) and The Teacher Irrational Belief Scale (TIBS) (Huk et al., 2019) scores for Thabo's case are discussed below. The irrational belief scale score interpretations are set out in table 3. Descriptions of the scales are found in Chapter 3. The Conners Behavioural Rating Scale (Conners, 2007) measured Jonathan's behaviour and the interpretation is set out in table 2.

6.4.1.1. Child and Adolescent Scale of Irrationality (CASI)

The following results appear in figure 16 below.

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Demand. Pre-therapy Jonathan's *demandingness* fell in the moderate level of irrationality and was the highest score obtained on the CASI (Kassay et al., 2015). Time was spent working on Jonathan's demand for fairness, his demand to do well at things he was good at, and the demand to be acknowledged for this by others. Although this score stayed in the moderate level of irrationality it decreased significantly according to the reliable change index (RCI, found in appendix, J).

Frustration intolerance (LFT). Jonathan's scores remained in the more-rational-philosophy-endorsed level both pre- and post-therapy although the score decreased it did not do so significantly according to the RCI found in appendix J. Although these scores were in the more-rational-philosophy endorsed level, *frustration intolerance* for boredom was noted and addressed during the therapy process.

Other negative rating (ROW-O) This score remained in the more-rational-philosophy-endorsed level both pre-and post-therapy and decreased below significance level, according to the RCI found in appendix J, post-therapy.

Self-rating (ROW-S) This score remained in the more-rational-philosophy-endorsed level both pre-and post-therapy. There was a non-significant decrease post-therapy according to the RCI found in appendix J.

Awfulizing Although the scores remained in the moderate level of irrationality the score decreased significantly according to the RCI found in appendix J.

The *total average* irrational beliefs score fell in the moderate level category of irrationality pre-therapy and decreased significantly, according to the RCI dound in appendix J, to the more-rational-philosophy-endorsed level post-therapy. Overall, Jonathan's scores decreased. Jonathan's CASI (Kassay et al., 2015) scoring on each of the above is set out in figure 16.

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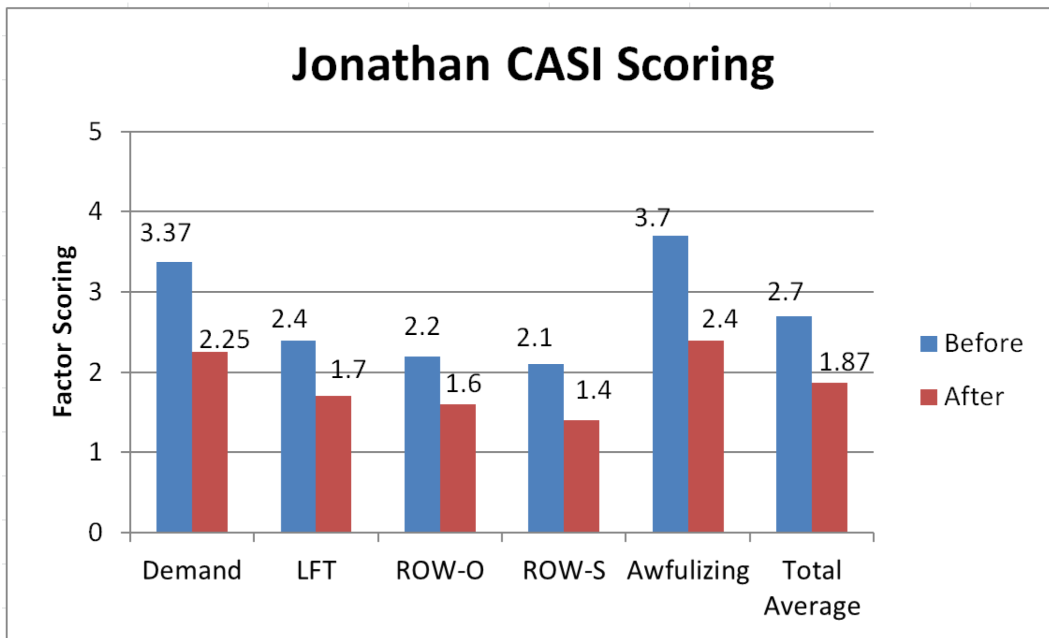
Figure 16

Bar Graph Showing Jonathan's CASI Scoring



6.4.1.2. Jonathan's mother's (Mary's) irrational belief scale

Jonathan's mother engaged fully in the therapeutic process for her own irrational beliefs around parenting Jonathan and the contingency management (Kazdin, 2000) of his behaviour. The results of the PIBS (Joyce, 1995) are represented in figure 17. In this test the higher scores represent higher rationality. All Mary's scores fell in the high level of endorsement of irrationality category both pre- and post-therapy apart from *self-worth* that fell in the moderate level of irrationality pre-therapy. The score for *demandingness* remained unchanged post therapy. The *low frustration tolerance (LFT)* score decreased insignificantly post-therapy according to the RCI found in appendix H.

The score for *self-worth* reduced significantly post-therapy, according to the RCI found in appendix H, and was the largest change noted on the scale. The negative self-evaluation: *"I am a bad parent"* was addressed in the therapy process.

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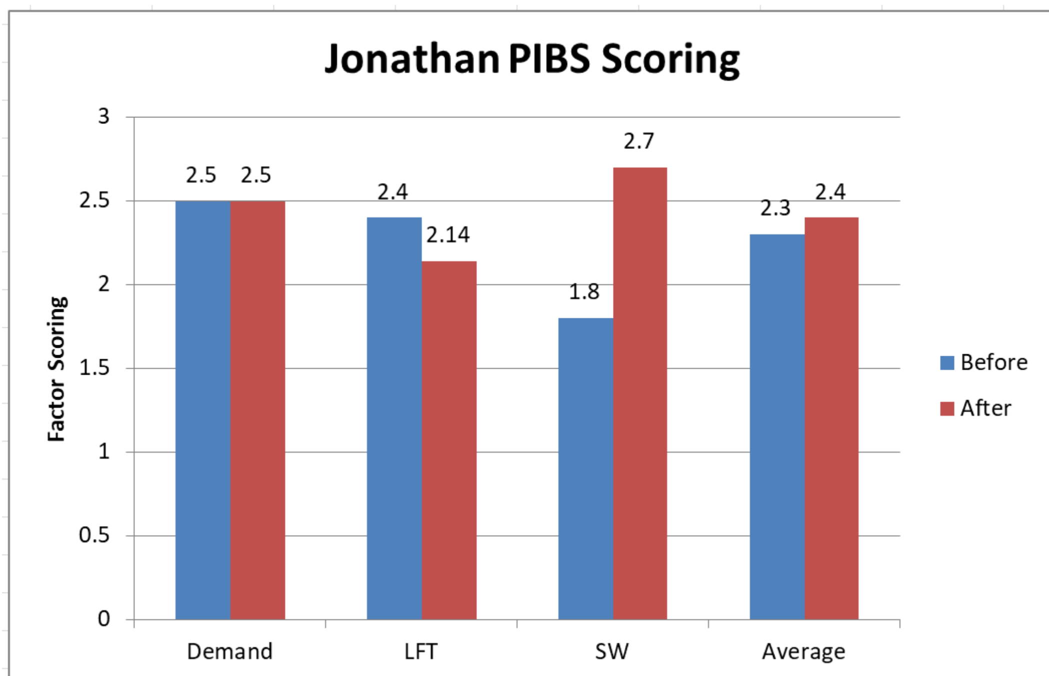
Overall, the *average score* for irrational beliefs increased non significantly according to the RCI found in appendix H.

Figure 17

Bar Graph Showing Jonathan's Mother's (Mary's) PIBS Scoring



6.4.1.3. Jonathan's teacher's (Heidi's) irrational belief scale

The following results appear in figure 18 below.

The *authoritarian attitudes towards pupils* decreased insignificantly according to the RC1, found in appendix I, from a high level of endorsement of irrationality to a moderate level of irrationality. Heidi reported that when the children misbehaved, she would think about the backgrounds of the children that were different to that of her own and sometimes harsh. This helped Heidi to change her demand for good behaviour to a preference. Although this was not worded in terms of the REBT elegant solution (Diguiseppe et al., 2014), it was Heidi's own cognitive restructuring of her associated inferences and because it came from Heidi herself it seemed to be effective.

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Heidi's score for *attitudes towards the school organisation* fell in the moderate level of irrationality pre-therapy and increased significantly to a high level of endorsement- of-irrationality, post-therapy. This change was significant according to the RCI, found in appendix I, in the wrong direction.

These evaluative beliefs were possibly triggered by the high conflict in the school context, as teachers were not receiving renumeration. The school was taken over by another school at the close of therapy and this teacher moved to a different school. The items on this subscale are related to teachers' needs to be involved in the running of the school, i.e., that they be considered in decision-making and that their problems be listened to, and in this extreme situation they were not.

Heidi's self-downing (SD) score pre-therapy fell in the moderate level of irrationality range and increased significantly to the high level of endorsement of irrationality post-therapy according to the RCI found in appendix I. Heidi reported that although she understood the disputations "in that moment" it was difficult for her to believe them. From this self-downing score and the attitudes towards the school organisation score above, it would seem that although she understood the therapy concepts, she had not yet embraced the alternative way of thinking. The tension in the school context did not allow for much affirmation of teacher achievements, so this could be the reason for this significant increase in negative self-evaluation, which in this context would have been triggered.

The score for *low frustration tolerance (LFT)* fell within the more-rational-philosophy endorsed-level both pre- and post-therapy and although it remained in the same category it deceased, but this was non-significant according to the RCI found in appendix I. The belief that Heidi could not stand Jonathan's interruptions was addressed in therapy.

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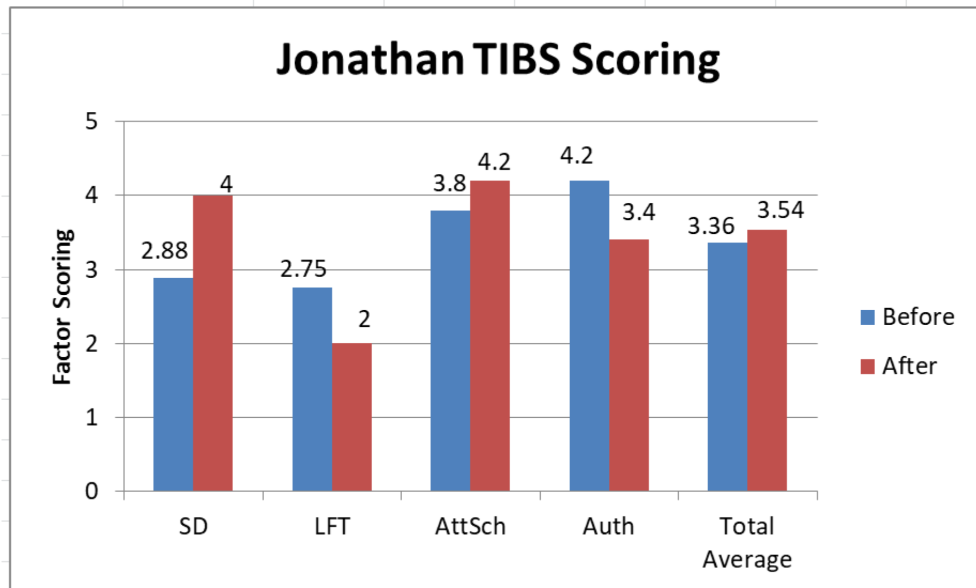
Heidi's *average score for irrationality* remained in the moderate level of irrationality range both pre-and post-therapy and showed a non-significant increase according to the RC1 found in appendix I. These scores are represented in figure 18.

Figure 18

Bar Graph Showing the TIBS Scoring for Jonathan's Teacher (Heidi)



6.4.1.4. Conners Rating Scale results Jonathan's teacher

The following results appear in figure 19 below.

Learning problems and executive functioning received a very elevated score, pre-therapy; post-therapy this score decreased significantly, according to the RCI found in appendix K, to average.

Hyperactivity/impulsivity received an elevated score, pre-therapy; post-therapy this score also decreased significantly, according to the RCI found in appendix K, to a high average score.

The score for *inattention* received a very elevated score both pre- and post-therapy. The decrease in this score post-therapy was insignificant according to the RCI found in

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appendix K. This issue was not remediated by therapy and could be an indication of possible co-morbid inattention such as ADD or ADHD occurring along with ODD.

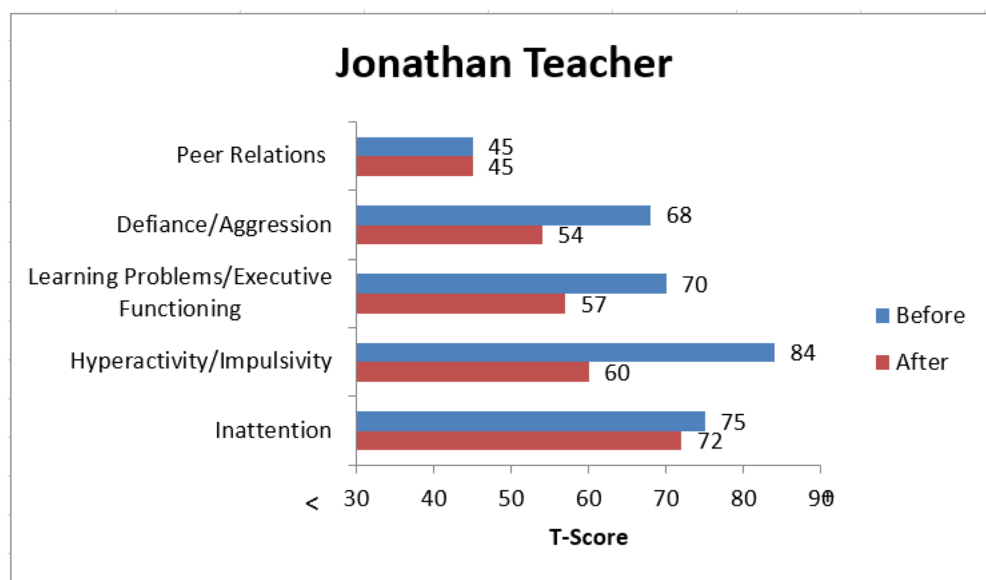
Aggression/defiance received an elevated score pre-therapy. Post-therapy the score decreased significantly, according to the RCI, found in appendix K, to average.

Jonathan's score on the Conners Rating Scale (Conners, 2007) as allotted by his teacher was average for *peer relations* both pre-and post-therapy, and it decreased non-significantly post-therapy according to the RCI found in appendix K. Most scores decreased significantly apart from *inattention.*

The Conners rating scores (Conners, 2007) from Heidi, Jonathan's teacher is represented in Figure 19.

Figure 19

Bar Graph Showing the Scores for the Conners Rating Scale for Jonathan by His Teacher (Heidi)



6.4.1.5. Conners Rating Scale as filled in by Jonathan's mother

The following results appear in figure 20 below.

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The category *executive functioning* attained a very elevated score, pre-therapy. Post-therapy the score reduced non-significantly to an elevated score according the the RCI found in appendix K. Therapy did not remediate this issue which could again indicate co-morbid inattention such as ADD or ADHD along with ODD.

The *Inattention* category attained an elevated score pre-therapy, this was reduced non-significantly, according to the RCI, found in appendix K, to an average score post-therapy. This was therefore seen to remediate after therapy to an average level of concern. Jonathan was following more instructions at home post-therapy.

Jonathan's scores on the Conners Rating Scale (Conners, 2007) as allotted by his mother for *peer relations* indicated an elevated score pre-therapy. This category was of more concern to his mother than it was to his teacher and decreased non-significantly, according to the RCI found in appendix K, post-therapy to an average score.

The score for *Hyperactivity/impulsivity* attained a high average score pre-therapy and increased non-significantly, according to the RCI, found in appendix K, by seven points to an elevated score post-therapy.

An average score was given for the category *aggression/defiance* both pre-and post-therapy level. However, the score decreased significantly post therapy according to the RCI found in appendix K. The problem of aggression was seen to be less sever in the home context than it was in the school context as reflected in this score.

For *learning problems* Jonathan's mother gave him an average score both pre-and post-therapy. Post-therapy the score deceased insignificantly according to the RCI found in appendix K.

Conners rating scores (Conners, 2007) allotted by Jonathan's mother are represented in Figure 20.

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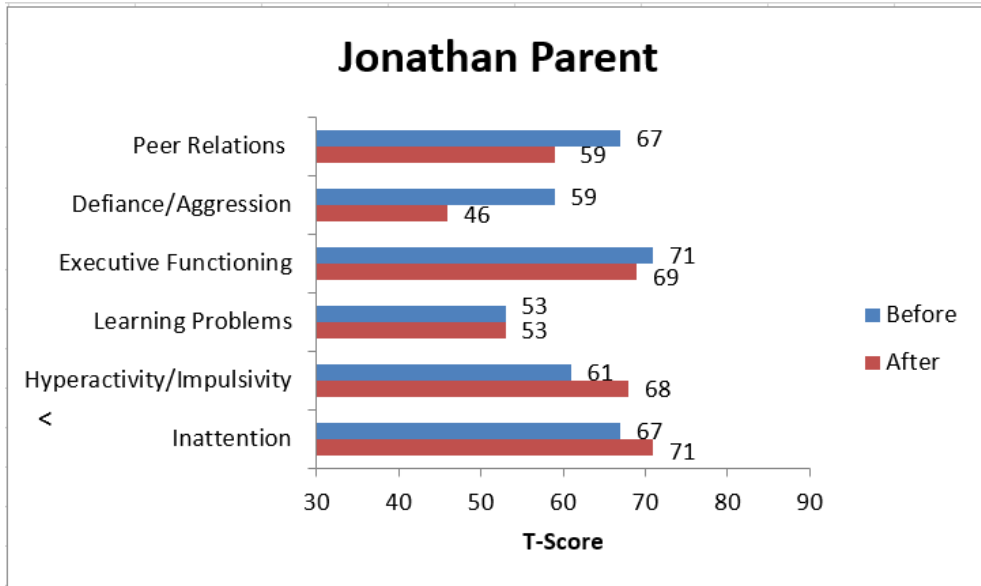
Figure 20

Bar Graph Showing the Scores for the Conners Rating Scale for Jonathan by His Mother (Mary)



6.5. Discussion

Overall, Jonathan's behaviour improved according to his teacher's scores allotted to him on the Conners Rating Scale found in figure 19 (Conners, 2007). Only *inattention* still caused concern, it remained a very elevated score, both pre-and post-therapy. Verbal reports from the teacher regarding Jonathan's classroom behaviour was that he was now "*…like the other children."* Jonathan's mother's allotted scores on the Conners Rating Scale (Conners, 2007) found in figure 20 showed change in *aggression* and *inattention*. *Inattention* decreased but not significantly according to the RCI found in appendix K. According to his mother's allotted scores *executive functioning/learning problems* and *hyperactivity* remained issues of concern post-therapy and the score increased significantly according to the RCI found in appendix K. It could be that these behaviours did improve to acceptable levels when discipline was administered as it was in the school. Jonathan's behaviour was more tolerated at home than it was in the school context. As the scores that remained elevated were

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inattention (teacher), *hyperactivity/impulsivity* and *executive functioning/learning problems* (mother) this could indicate ADD/ADHD or other learning problems were co-morbid. The school context had different problems to the home context. Some of the *executive functioning* or *peer relations* problems for instance may not have resulted in overt behavioural problems in the classroom but they would have remained a concern for Mary. Although Jonathan's mother had reported fewer problems pre-therapy and less change post-therapy, she reported change in his behaviour to the extent that she considered consulting with his psychiatrist to see if she could take him off his mediation; "*I am going to take him back to Dr…for a check-up…because I don't want to leave him on medication if he doesn't have to be, especially since he's done so well with this* [REBT therapy]." There are no exact cause effect relationships to be identified between the therapy process and behavioural change, yet overall REBT therapy (Diguiseppe et al., 2014) was successful when applied to Jonathan and his context, and Jonathan could understand the concepts and apply them. REBT conceptual framework recognises that multiple factors such as genetics and environmental influences affect the etiological antecedents to irrational thinking (Diguiseppe et al., 2014). These too will influence therapeutic outcome.

The inductive and deductive interpretation techniques were utilised often as well as psychoeducation and Jonathan was able to create his own disputes and challenges. Socratic questioning worked well with him. His intelligence enhanced the therapy process as he could identify irrational beliefs himself and develop his own disputes and applied these to novel situations. All his CASI (Kassay et al., 2015) (figure 16) scores reduced and three categories significant so according to the RCI found in appendix J. The only score that remained the same, in the more rational philosophy endorced category, was *negative other rating*. His *demandingness* reduced significantly according to the RCI found in appendix J.

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In Jonathan's case the most effective element in his process was the utilisation of the metaphorical style. This was idiosyncratic to his case. He was able to engage with the therapy concepts and process through this style and used his own imagination to create characters that metaphorically symbolised the disputes and alternative beliefs. Jonathan also presented with the mildest symptoms amongst the four case studies as reported and as measured by the Conners Rating Scales (Conners, 2007) (figures 18 & 19) and verbal reports by his teacher and mother.

Jonathan's context changed during the therapy process. His mother did report change in her own thinking and subsequent discipline of Jonathan. When the case conceptualisation and thought records were shared with Mary at the completion of her therapy, she no longer held some of the beliefs that she held pre-therapy. All the scores on the PIBS (Joyce, 1995) (figure 17) reduced post-therapy the and Self Worth decreased signinicantly accorfing to the RCI found in appendix H. The only score that remained the same was *demandingness*. She identified with the case study as written above and stated: *"I really do remember it, I remember it very much* [the thoughts as written in the case study]." "*I think I've changed a lot since this, I've become a lot more tough* [with Jonathan] *through what we've worked through. We've come a far way; we've come very far."* Jonathan's school situation had improved for him compared to his previous school: *"He's grown up a lot, he's learnt a lot from you, he's had a different environment for two years, a lot has changed in his life…*" (Mary).

In the concluding sessions Mary presented alternate inferences:

Mary: I'm becoming more secure, yes, I am becoming more secure in that [i.e. that she did not affect Jonathan as badly as she originally thought], like I say in the last few months when he's doing something silly or when he's telling a lie, when he's trying to procrastinate or you know, I

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am becoming better at saying 'no, go do what you've gotta do' instead of saying 'ok yes, ok' tell me more', I'm like, now is not the time, I do wanna hear, I am interested, but you've got things to do, so go and do it.

Therapist: So, go and do it and then I'll listen…

Mary: Ya, and in the beginning I felt terrible when I did this because there were some days when he really irritates me. It's just life, there's people these days that irritate each other, I realise that, but I feel so guilty with him when he irritates me.

Therapist: Ya, because you're thinking; 'I've harmed him…'

Mary: Ya, and the relationship was so bad for that first year, I don't want anything to jeopardise it, even if I tell him you're being silly or you're not telling the truth or yes, I knew that instead of leaving him to explain things how they work, or not how they work. [For example:] 'Did you know in 2005 there was a man who robbed a place and there was a lion at the zoo and the man went into the lion thing and the lion ate him' and I said yes, I did know it. He said, 'how did you know?' I said, 'it was all over the news and I remember.' Now previously I would've just let him explain the whole thing to me and say, 'wow you're so clever how did you know that?' So that kind of thing. [Mary's response to Jonathan was now different].

As stated her *self-worth* score on the PIBS (Joyce, 1995) showed a significant decrease in irrationality which seems to support the above statement.

Although Heidi's change, as measured by the TIBS (figure 18), was erratic, the category that presented with the most significant positive change to rational thought was,

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according to the RCI found in appaendix I, the *authoritarian attitudes towards pupils* category, Heidi reported that when the children misbehaved, she would think about the backgrounds of the children that were different to that of her own and sometimes harsh. This helped Heidi to change her demand for good behaviour to a preference. This would have been the category that was mostly related to her reaction to Jonathan's behaviour in the classroom.

Mary was more consistent in applying contingency management (Kazdin, 2000) to Jonathan post-therapy. The school's contingency management remained mostly the same pre- to post-therapy.

This chapter described the case study of Jonathan's therapy process for oppositional defiant behaviour. The following chapter describes Thabo's therapy process for oppositional defiant behaviour.

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Chapter 7: Pragmatic, embedded case study of Thabo

This is the embedded, pragmatic case study of Thabo, a 13-year-old boy in grade eight referred for disruptive classroom behaviour. He lived in a middle-class area and his parents were wealthy in that they had many assets, staff such as a driver and both of them were in high paying positions for South Africa. Thabo attended a local private school close to his home. This school was growing in numbers and therefore new classrooms were being built. The buildings were well kept, and sports fields were present. It was the most well-equipped school in this study. All the teachers were adequately trained. Thabo had attended the school for the past two years. The school had recently started a high school and Thabo was in the senior grade even though he was only in grade eight. He had a group of friends and, although he got into many fights with his peers, he was reported to be popular. Thabo was included in the study as he understood the concepts of the REBT (Diguiseppe et al., 2014) model. He could identify his evaluative beliefs and used the REBT concepts (Diguiseppe et al., 2014) outside of therapy. He was not a disadvantaged child, so he differed from the rest of the case studies. His parents originally had come from a poverty background but had moved upward economically. South African youth born after the fall of Apartheid make up almost 40 percent of the population and are often referred to as "born frees" (Mpongo,2016). Thabo was part of this generation, as were the other children in this study, yet Thabo's parents brought this concept into their understanding of him. His mother explained his behaviours as due to him being a *"free child."* The following case study report was written according to three sections (Edwards, 2018) described in the methodology (Chapter 3): *assessment,* this included the contracting section which mainly occurred in the first two sessions of therapy; *case formulation* which includes the treatment plan and the *treatment implementation* (Edwards, 2018). A section on *evaluation* is included which examines the various test results along with verbal reports from the mother and teacher. This section contributes to the

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understanding of change in Thabo's oppositional defiant disordered behaviour. *Please note that in the case studies single quotation marks (' ') represents a paraphrased disputation or belief while double quotation marks (" ") indicated direct speech.

7.1. Assessment

Most of the information for this assessment was attained from the first two initial screening interviews with all three members of the embedded case study, Thabo's teacher, his mother, and Thabo himself. The irrational belief scales and behavioural scale obtained in the first two sessions were also used. As therapy progressed information was added.

7.1.1. A background and life history

Thabo was an only child of older parents (compared to the other children/youths in this study); his mother was already in her fifties. As the only child he was spoilt and attained much of what he wanted. Even Thabo himself sometimes recognised this. His parents grew up in the Apartheid era where they were disadvantaged, but they improved their socio-economic situation. They taught Thabo to stand up for his rights and allowed him a voice. Thabo's mother recognised the need for him to alter his attitude when relating to other adults, but they had brought him up to have his own opinions. She realised that some of Thabo's reactions and opinionated challenges could get him into trouble and that is why she had given permission for him to participate in the study. Thabo's grandmother on his mother's side also battled with his attitude, but his mother claimed to understand this generation and that Thabo was a *"free child."* The family was reported to be close, by both Thabo and his mother. Friction did occur between Thabo and his mother but not between him and his father as reported by Thabo. The friction occurred when Thabo's mother wanted him to do something that he did not want to do. She also stood up to him when she disagreed with his opinions and attitudes. In Thabo's perception his father was more tolerant of him. The father was not

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involved in any of the sessions even though he was invited. He was likewise not involved in Thabo's contingency management (Kazdin, 2000). Both Thabo's parents often travelled for work, but his mother travelled more than his father did. This often left Thabo to his own devices.

According to Thabo if he wanted something, he usually went to his father who allowed him to do the things that he wanted to do. His mother confirmed that Thabo's father would usually buy him what he wanted. According to Thabo, sometimes Thabo's dad allowed him to do things that his mother told him not to do, without telling her. This would have made any contingency management of Thabo ineffective. According to Thabo his parents both supported most of his misbehaviour at school. He gave the example of a child that owed him money and his parents, in this instance, reportedly supported him in attaching this child's belongings in lieu thereof. The value of the items attached was going to increase in value until the debt was paid.

Thabo's mother describes a different picture:

Patience: *His dad does not talk too much, he sets rules, principles, he's very structured, rigid, and so on. I'm flexible in a way. I might say not now, but later on I might reconsider and say actually I will allow you now… But his dad is not like that, if it's a no it's a no, end of story.*

Therapist:…*He might push you because sometimes he can change you.*

Patience agreed that she was not consistent in applying rules as she could be persuaded.

7.1.2. Presenting problem

In the school context the main complaint around Thabo was that he constantly challenged teachers at every turn. Thabo was perceived as a bully. He was involved in fighting in which both verbal and physical aggression were used. He insisted on having his own way in every

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situation, causing frequent friction between him and his teachers and him and his school mates. These behaviours were considered by his school context to be developmentally inappropriate compared to that of his peers. Thabo was considered academically strong by both his mother and teachers, and his teachers reported that his behaviours did not affect his schoolwork. According to Thabo he always performed well without having to put in a huge amount of effort. In the home context Thabo's mother initially reported that he did not listen to her instructions and would want to do things in his own time and have things go his own way. From the outset his mother had reported much milder misbehaviour compared to that described by the teachers. Although he did not listen to her instructions, his behaviour was not considered to be a serious problem. The behaviour within the school context was reported by his teachers to be severe for that setting.

7.1.3. Diagnosis

Thabo met the criteria for oppositional defiant disorder (ODD). He had five of the symptoms listed in the DSM-5 (American Psychiatric Association, 2013) and their duration was in excess of six months:

- He often argued with authority figures, teachers, and peers whenever something did not go the way he wanted it to go.
- He often actively defied or refused to comply with requests from authority. He would challenge the punishment as not being appropriate.
- He often blamed others for his own mistakes or behaviour. He could only see the situation from his perspective and that the fault lay with someone else.
- He was often angry and resentful about teachers and peers if the situation did not have the outcome that he wanted.
- He often lost his temper when things did not go his way.

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The ODD behaviour was mild as it was reported to occur mostly at school. In the school context he met the full criteria listed ODD behaviours in that he displayed five of the listed symptoms. The home context reported much milder behaviour.

7.1.3.1. Test administered and scale used

The following tests were used to assist in the assessment of thoughts and behaviour as well as the understanding of later change or lack thereof.

7.1.3.1.1. Conners Rating Scale

The Conners rating scores (Conners, 2007) given by Thabo's teacher are represented in figure 20 below. The interpretation for the Conners Rating Scale (Conners, 2007) and scores are tabulated in table 2.

Very elevated scores were given for *impulsivity/hyperactivity* and *aggression/defiance.* An average score was given for *peer relations', Learning problems and executive functioning* and *inattention* which suggested that there was no evidence of ADD/ADHD or other co-morbid learning problems.

On the Conners Rating Scale (Conners, 2007), Thabo's mother, Patience, gave him the following scores which are represented in figure 22: an elevated score for *impulsivity/hyperactivity,* and a high average score was given for *aggression/defiance.* He was given an average score for *peer relations, learning problems and executive functioning,* which would again suggest that there was no evidence of ADHD. However, *inattention,* although this was likely due to Thabo's refusal to listen to and follow through on instructions, was a very elevated score.

Thabo's mother's Conners Rating Scale (Conners, 2007) indicated that his behaviour was less severe compared to that of his teacher's Conners Rating Scale (Conners, 2007).

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7.1.3.1.2. SSAIS-R

The SSAIS-R (Van Eeden, 1991) could be used as a diagnostic tool in Thabo's case as it is standardised for Afrikaans and English (first language) children. Thabo's family spoke both English and Zulu although Thabo mostly used English. Thabo scored in the average category on the *full-scale IQ* as measured by performance on the SSAIS-R (Van Eeden, 1991). He attained an above average score on the *verbal IQ* and an average score on the *non-verbal IQ scale*. The difference between the verbal and non-verbal was significant at a one percent level in favour of the verbal IQ showing a marked strength on the verbal tasks compared with the non-verbal. The *comprehension sub-test* was significantly higher than the rest of his performance at a one percent level on both the verbal and full-scale IQ performance, showing a significant strength in knowledge of conventionally accepted standards for behaviour, social adaptation, and social judgement. Performance on the *story memory sub-test* was significantly higher at a five percent level, indicating a strength in auditory memory when material is presented in a meaningful auditory form. Performance on the *number problems* sub-test was significantly higher, at a five percent level, than the rest of his performance. This indicates a possible significant strength in auditory processing, short term auditory memory, and auditory working memory as compared with his performance on both the *verbal* and *full-scale measures.* Despite inter-test scatters his academic performance was high. At the end of 2017 Thabo came first in his grade. His school had no selection criteria, so the competition was not strict, and at this level of education it was possible that the strong verbal skills and auditory memory assisted him in memorising facts, which was sufficient for doing well at a grade eight level. His verbal strengths could have proved helpful for the understanding of REBT (Diguiseppe et al., 2014) concepts.

In summary, Thabo met the criteria for ODD without co-morbid ADD/ADHD. Despite inter-test scatter on the SSAIS-R (Van Eeden, 1991) he was generally considered

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academically strong. The SSAIS-R (Van Eeden, 1991) indicated strong auditory memory and working auditory memory. The very elevated score for *inattention* given by his mother only, was therefore likely due to defiance as opposed to co-morbid ADD/ADHD. Thabo's command of English was strong, and he presented as fully bilingual. The therapy could be carried out in English.

7.1.4. Establishment of client-therapist relationship

The alliance between myself, the therapist/researcher, and the participants was established according to the REBT (Diguiseppe et al., 2014) theoretical framework. As far as possible, the goals were set collaboratively. Thabo was engaged in changing his behaviour, he requested anger management and was committed to self-development. The quality of the relationship was different to that of the other children in this study. It did not feel as though there was a deep connection. In one of Thabo's disciplinary hearings, he used the session as 'proof' of his argument that one of the teachers did not like him. He claimed that I, the therapist/researcher, had given him this information. When I returned for a follow up appointment about a month later, after weekly sessions had ended, he was not engaged, and I had to go and find him for the session. During sessions he was active and engaged in rigorous dispute. It was difficult to challenge some of his thinking due to the rigid nature of it and his need to win an argument. Thabo did claim that he found the sessions useful and that he had changed his thinking. I, the therapist/researcher, did think that if the sessions had not been useful, he would not pretend that they were, he would likely have left therapy. He was engaged due to the usefulness of the sessions. As soon as they lost their usefulness it was easy for Thabo to disengage. Thabo's mother and teacher were engaged using the same process. Common goals were established, and a collaborative process ensued. The teacher, Rajesh, was very engaged and used the sessions well for his personal growth and crises. He engaged around the current crisis of his divorce. The relationship was built initially on

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working around this personal problem. I the therapist/researcher responded to him bringing this into the sessions. It did demand more resources on my, therapist/researcher's part, as the focus of the research was on the irrational beliefs surrounding the discipline of Thabo. However, there were commonalities in thinking patterns across contexts. Thabo's mother had a functional relationship. She was interested in her son's development. Time commitment prevented her from engaging more in the process.

The assessment information was gathered from the initial two screening interview sessions. Information was gathered throughout the therapy narrative, and these details were then added. Based on this information, a case formulation was created using a multisystemic framework (Swenson et al., 2005) within which contingency management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014) therapies were applied to different levels of Thabo's system.

7.2. A Multisystemic Case Formulation

The case formulation is a set of clinical hypotheses about the events or processes that led to the development of disruptive, impulse control and conduct disordered behaviours, specifically ODD in Thabo, and the maintenance thereof in the present (Edwards, 2018; McLeod, 2010)**.** All evaluative beliefs and inferences were taken from sessions and thought records created in sessions by client and therapist. The contextual development and maintenance of ODD behaviour is facilitated by knowledge of the context.

7.2.1. Thabo's mother (Patience) and his home context

Thabo's mother did not attend many sessions. Apart from the two initial screening interviews, four sessions were held with Patience and one joint session with Thabo and Patience. She was extremely busy at work. Patience's main concern was that she did not spend enough time with him: *"The time that I spend with him. I missed some of his milestones."* I, the therapist/researcher, did experience Patience as engaged in the sessions

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and with her son. She was an older mother in her fifties and had lived through Apartheid and subsequent liberation. According to the Revised Belief Scale for Parents (PIBS) (Joyce, 1995), the *demand* sub-scale and total irrational belief sub-scales fell into the high irrationality level. *Self-worth (SW)* and *low frustration tolerance (LFT)* fell into the moderate level of irrationality (figure 18). In sessions I, the therapist/researcher, explored what cognitions might have led to and maintained Thabo's presenting problem. Her own schooling was described as strict, as was her mother. Due to her background Patience thought that she was too strict, "*I am strict, but I am improving a bit.*" Her mother came from a village and did not want her children to behave as those in the townships who were perceived as disrespectful. It was considered that perhaps due to this background and associated perspective thereof, Patience had adopted a more discursive approach with Thabo.

At home Patience's discipline of Thabo seemed to vacillate between frustrated shouting or giving up on enforcing the boundaries she set for his behaviour. When the misbehaviour occurred outside of the home, in the school context, she would mostly support Thabo. Her two contradictory irrational beliefs, described below, were in opposition and were linked to her inconsistent reaction to Thabo's misbehaviour.

7.2.1.1. Demand schemas

Patience held the inference that Thabo got into trouble at school because he was a *"free child"* and could express his opinion. It implied the demand that: '*He must be free to express his opinions.*' It was linked to the associated inferences that *'boys will be boys.'* This demand and associated inferences likely came from living through the liberation struggle and the importance of being free to have opinions and be able to express them. These beliefs co-existed with the demand that: *"he must be a respectful child."* This emanated from her own strict upbringing where respect was emphasised. These evaluative beliefs that could be contradictory, existed side by side and led to vacillation in her discipline of Thabo and

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different reactions to his behaviour according to the context in which they occurred. This implied demand: '*He must be free to express his opinions,'* was triggered by Thabo getting into trouble at school. It led to indignation in Patience, and she became resolute in her defence of Thabo according to the severity of the consequences he received. She held the inferences that she *'knew how to work with and handle generation x and millennials. Others did not know how to work with them.'*

The alternate demand schema: *"He must be a respectful child,"* was triggered when Thabo did not follow instructions at home and sometimes when he was in trouble at school, but if the school situation became serious for Thabo, his mother would stand by him and the alternate demand: '*He must be free to express his opinions'* was triggered.

The related demand: *"He must realise that he is not the only person in the world,"* pertained to such instances where Thabo insisted on getting his own way such as being taken to gym whenever he wanted to go, despite Patience's availability. He would also only tidy his clothes from the lounge in his own time. This demand led to anger in Patience and was triggered by Thabo not listening to, or following, Patience's instructions, or not taking 'no' for an answer.

These demands and associated inferences are tabulated in table 47. The evaluative beliefs and inferences were taken from thought records created in sessions by Patience and the therapist/researcher.

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Table 47

Tabulation of Patience's Demands and Associated Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Thabo gets into trouble at school Inferences: *'This is how boys behave. This is how children of his era behave He is a free child, and this is why he expresses himself the way he does.'* Patience: "*he is a free child*" *"People do not know how to handle generation x."* Situational Activating Event: Thabo not listening to Patience's instructions. When Thabo challenged Patience's instruction and did things in his own time or not at all	Demands *'He must be free to express his opinions.'* Demands *"He must realise that he is not the only person in the world."* *"He must be a respectful child."*	Emotional consequence: Indignation Behavioural consequence: Becomes indignant with the schoolteachers' complaint and Thabo getting into trouble at school. Emotional consequence: Anger Behavioural consequence: Shouts at Thabo and her discipline of him is ineffective.

7.2.1.2. Contingency management in the home context

There had always been inconsistent discipline around Thabo's behaviour at home. This ineffective discipline (behaviour) was linked to Patience's irrational evaluative beliefs described above. The two evaluative beliefs and associated inferences led to different reactions. Thabo also reported inconsistencies between Thabo's mother and father. Thabo reported that sometimes his father would contradict his mother but not let her know about this. Thabo was usually supported when the school disciplined him. Thabo's mother was very busy with work and often travelled to different provinces due to work commitments. Thabo was often left to his own devices at home.

In the initial two screening interviews the target behaviours of not listening to instruction and refusing to take no for an answer were identified as problem behaviours that Thabo's mother struggled with in the home context. During the initial two sessions and during the rest of the sessions contingency management was taught (Kazdin, 2000),

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7.2.2. Thabo's teacher (Rajesh) and the school context

Rajesh, Thabo's class teacher, had daily contact with Thabo. He originated from a family background where his father was abusive. This seemed to be where he developed some of the irrational beliefs associated with his fear of confrontation (discussed below) that affected his discipling of Thabo and other children and also affected other situations in his personal life. He was currently in a divorce process. His relationship with his ex-wife had further lent evidence to some of his irrational beliefs regarding confrontation.

Rajesh describing a home situation: "*but also when the family came home, like it was a whole lot of anxiety going through me, through my head and stuff, and I didn't want to go into the lounge and deal with the situation, I procrastinated, it took me an hour to get into the lounge and I think because of that…"* [he avoided conflict].

Rajesh avoided confrontation in any relationship, particularly intimate relationships, for fear of losing them. This made him interpersonally unassertive. It made sense that his childhood background of abuse formed the bedrock for the development of Rajesh's irrational beliefs in this regard. Rajesh's current irrational beliefs were triggered across different contexts. Therapist: *"There's an anticipation that it [confrontation] will end badly."* Rajesh realised that his reluctance to confront was affecting his work. The walking away from conflict helped Rajesh to control irritation but this built up slowly until he exploded. Rajesh's irrational beliefs affected his discipline of Thabo, thereby contributing to the maintenance of ODD behaviour in the school context.

Rajesh's results on the TIBS

These results are found in figure 23 below. Rajesh scored a high level of endorsement of irrationality for the *authoritarian attitudes towards pupils* category on the *TIBS* (Huk et al., 2019). A moderate score on this subscale implies intransigence towards discipline problems of the pupils. Respondents believe that they cannot stand the children misbehaving and that in

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such cases, they should be severely punished. In the school context, Rajesh was a popular teacher, he believed that he could, *"get down to their[the children's] level."* In my, the therapist's/researcher's experience Rajesh was lenient in the discipline of the children and this likely came from the irrational beliefs and associated inferences that he must avoid confrontation. He perceived confrontation as awful as it could have disastrous consequences which countered Rajesh's other demands (rigid expectations) that children should be well behaved as indicated by the TIBS (Huk et al., 2019). These irrational beliefs are discussed below. Contrary demands sometimes exist side by side as experienced with Thabo's mother, Patience.

For the category *attitudes towards the school organisation* on the TIBS Rajesh scored a high level of irrationality. *T*he items on this subscale are related to teachers' needs to be involved in the running of the school, i.e., that they be involved in decision-making, that their problems be listened to, etc. Rajesh indicated a need to be consulted in things affecting his work, yet if this need was not met, his anxiety associated with confrontation could lead to just accepting what he was unhappy with. It was my, the therapist's/researcher's experience of him that the beliefs competed for dominance against each other. *'I must not confront in case it ends badly'* outweighed *'I must be consulted'* (as indicated on the TIBS). In short, the TIBS (Huk et al., 2019) mirrored the irrational beliefs determined in therapy sessions.

Self-doubt and *frustration tolerance* both obtained an average score indicating that a more rational philosophy was endorsed.

7.2.2.1. Demand schemas

Rajesh's demand that held the most influence in relation to the school context and discipline of Thabo was: *'I must not confront'; 'I must discipline carefully'* and the associated catastrophic inferences: '*If I confront it will end in disaster; discipline could lead to confrontation with the parents*; *I could be reported by parents; if I am reported by parents, I*

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could end up with a warning letter; I could lose my job,' Rajesh claimed that other teachers had lost their positions due to parental challenge of disciplinary action. These demands and these associated catastrophic inferences led to anxiety and a tolerance of difficult behaviour in the classroom. Rajesh was also unsure sometimes of what kind of discipline was allowed in the classroom which added to his holding back on it. This thinking again led to the tendency to be lenient in the classroom and to let certain behaviours go unchallenged. He could tolerate difficult behaviour rather than confront it.

Rajesh: You know, I don't wanna be there, I don't like confrontation… and it filters through to my work and stuff…

Therapist: …which would be demanding…the must, the should…. I must not confront, to have to confront…is one of the worst things in my life…you catastrophise confrontation.

Rajesh: With this one [a disciplinary incident], I didn't really know if I was dealing with the problem in the correct way, if I was saying the correct thing at the time, or how I dealt with the situation…before it [the discipline] would happen I would catastrophise [the outcome].

Therapist: I must discipline carefully because…it's gonna end badly…

The above irrational beliefs are represented in table 48. The evaluative beliefs and inferences were taken from thought records created in sessions by Rajesh and therapist/researcher.

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Table 48

Tabulation of Rajesh's Demand Not to Confront and Associated Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Children being disrespectful and me (Rajesh)considering confrontation. Catastrophic Inferences *'If I confront it will end in disaster; discipline could lead to confrontation with the parents*; *I could be reported by parents; if I am reported by parents, I could end up with a warning letter; I could lose my job.'*	Demands; *'I must not confront.'* *'I must be careful when I discipline.'*	Emotional consequence: Anxiety Behavioural consequence: Cautious in discipline. Lenient on the children.

7.2.2.2. Awfulizing

The demand and associated awfulizing paraphrased as: *'I must not be criticised or blamed'*, *'It is awful to be criticised or blamed'* was triggered by Rajesh's work situation. He was apprehensive about anything going wrong in his work situation. The associated inferences: *'I will be blamed for things going wrong at work, I will get into serious trouble, I could lose my job,'* evaluated things going wrong and criticism as catastrophic. His awfulizing: '*It is awful to be criticised or blamed (implied) as really bad consequences can occur,'* was a derivative of the above demands. These irrational beliefs would lead to anxiety and rumination where Rajesh would replay the irrational beliefs and inferences over and over in his mind when triggered by something going wrong or criticism in his work situation.

The above irrational beliefs are represented in table 49. The evaluative beliefs and inferences were taken from thought records created in sessions by Rajesh and therapist/researcher.

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Table 49

Tabulation of Rajesh's Irrational Beliefs

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Criticism or something going wrong at work. Inferences *'I will be blamed for things going wrong at work, I will get into serious trouble. I could lose my job.'*	Demand *'I must not be criticised or blamed.'* Awfulizing *'It is awful to be criticised or blamed as really bad consequences can occur.'*	Emotional consequence: Anxiety Behavioural consequence: Ruminates about the situation

7.2.2.3. Contingency management in the school context

The discipline in the school system, as with all the schools presented in this current study, were inconsistent across teachers, and even across different occasions and situations with one teacher. This school was the most organised, resourced, and consistent with discipline and in general. However, some teachers were more tolerant or had different disciplinary styles compared to that of others. The usual demerit system was utilised. A certain number of demerits were allocated and then detention was given. As with other school systems this approach did not follow research findings that suggest immediate consequences for misbehaviour (Kazdin, 2000). Accordingly, the school's contingency management was not effective, as many incidents would occur before punishment was given, and these demerits were also not applied consistently. Furthermore, Thabo would challenge these contingencies if they were not consistent, and he was able to negotiate them. In the one example he cited being given too many demerits for leaving books behind. The teacher gave him a demerit for each book that he left behind, and he negotiated it down to receiving a single demerit for all the books concerned. Rajesh, the class teacher, was conflict avoidant (as described above) and concerned about the consequences of him disciplining the children. He was also unsure

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as to what kind of discipline was permissible in the classroom without him experiencing the feared consequences. As a result, Thabo's school discipline was largely ineffectual.

According to REBT (Diguiseppe et al., 2014), changing the demand: *'I must not confront'* and other demands to preferences coupled with de-catastrophizing confrontation, and the inferred outcome of confrontation by challenging the associated inferences, would assist in reducing Rajesh's anxiety and allow reasonable confrontation and subsequent discipline of inappropriate classroom behaviour.

7.2.3. Thabo's case conceptualisation

The following section describes the case conceptualisation of how Thabo's ODD behavioural problems were held in place according to the REBT (Diguiseppe et al., 2014) conceptual framework.

7.2.3.1. Demand schemas

The demand schemas paraphrased as: *'It must be fair the way I see it'*, *'It must be fair the way I see it, or I will make it fair,'* were associated with Thabo's ODD behaviour. Thabo wanted to see and make the world as he preferred it, fair as he understood fair to be (Diguiseppe et al., 2014). This demand and the associated inferences: '*If I do not get my way it is not fair; the way they see it is not correct; the way I see it is correct,'* were triggered when something did not go Thabo's way or when what he wanted was challenged. The inferences describe the way in which Thabo perceived fairness. These irrational beliefs were associated with anger and Thabo would argue his point of view. He got into physical fights with peers and refused to give in to their point of view. He evaluated things that did not go his way as *unfair* and as such this demand was associated with the demands: "*They must not dominate me; they must not disturb my will,"* found, in table 50.

The following excerpt shows Thabo's inferences and perception of fairness.

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Thabo: If they don't wanna do the right thing [Thabo's trigger for anger and fighting]

Therapist: The right thing?

Thabo: Ja…

Therapist: And the right thing would [be] going with the way you see it.

Thabo: Ja, Ja...

Therapist: And then when it doesn't go the way you want it to go, and you see it as unfair.

Thabo: Unfair, Ja.

A representation of Thabo's demand schema is tabulated in table 50. The evaluative beliefs and inferences taken from thought records created in sessions by Thabo and therapist/researcher.

Table 50

Tabulation of Thabo's Demand 'It Must Be Fair' and Associated Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Something not going my way What I want is challenged Inferences *'If I do not get my way it is not fair, the way they see it is not correct; the way I see it is correct.*	Demands: *'It must be fair the way I see it.* *'It must be fair the way I see it, or I will make it fair.'*	Emotional consequence: Anger Behavioural consequence: Argues his point of view. Gets into physical fights with peers. Refuses to *'give in'*

As stated, another demand related to ODD behaviour was paraphrased as: '*They must not dominate me; they must not disturb my will.'* This demand was activated when Thabo was told what to do by authority (when it was something he did not want to do) or when anyone's will clashed with his. As stated, this demand was related to the demand *'it must be fair'* as Thabo evaluated things that did not go the way he wanted them to, as unfair. He would argue

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and resist any instruction that was contrary to what he wanted to do. He would fight for things to work out the way he wanted them to. The following inferences were associated with the above demands: "*If I do not get my way, they are dominating me. If it is against my will, they are forcing me to do it." "It's unnecessary for me to do what they want me to do."* These demands and associated inferences were related to anger.

These demands and associated inferences are tabulated in table 51. The evaluative beliefs and inferences taken from thought records created in sessions by Thabo and therapist/researcher.

Table 51

Tabulation of Thabo's Demand 'They Must Not Dominate Me' and Associated Inferences

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Being told what to do by authority Anyone's will clashing with mine (Thobo's).	Demands *'They must not dominate me. They must not disturb my will.'*	Emotional consequence: Anger Behavioural consequence: Argues, resists any instruction that is contrary to what he wants to do. Fights for things to work out the way he wants then to.

Thabo also demanded: '*I must be top in things that are important to me' (such as body building).* This demand led to oppositional defiance behaviour and anger when his goals regarding the demand were thwarted in any way. He would insist on being top, second or third would not be good enough. He would insist on his way regarding any steps he thought he needed to take to fulfil this demand: *"This WILL turn out the way I want it,"*(Thabo) was related to this demand. Thabo illustrated this demand with an example of his mother not meeting his demand to take him to the gym and wait for him for two hours while he finished his session. She took him, but only worked out for an hour herself, and then walked around the mall to wait for him, but this did not fully meet Thabo's demand. This incident resulted in

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an argument between the two with Thabo insisting on his way without compromise. These incidents triggered Patience's demand: "*He must realise that he is not the only person in the world",* yet she sometimes gave up and allowed him to have his way. In this incident she waited a while but did not wait for the full two hours while he finished his session. Thabo's demand to be *"on top"* (Thabo) was related to negative self-evaluation when it was not met. If I am not on top, then *"I am nothing."* (Thabo). These demands are tabulated in table 52. The evaluative beliefs and inferences taken from thought records created in sessions by Thabo and the therapist/researcher.

Table 52

Tabulation of Thabo's Demand 'I Must Be Top in Things That Are Important'

Activating Event	Irrational Belief	Consequence
Situational Activating Event: Competition in things that are important to me. Being thwarted in the pursuit of this goal to be 'on top.'	Demand; *'I must be top in things that are important to me such as body building'* *"This WILL turn out the way I want it,*"(Thabo). Negative self-evaluation *'If I am not the top, then "I am nothing."'*	Emotional consequence: Anger Behavioural consequence: Pushes to develop in the area of importance. Becomes oppositional if his goals are thwarted.

7.2.4. Summary and treatment plan

The plan was based on the identification of the irrational beliefs stated above. In summary, when Thabo misbehaved at home Patience's demand schema: "*he must be a respectful child,''* was triggered as well as, *"He must realise that he is not the only person in the world."* However, Patience and Thabo's father believed the Thabo should be and was *"a free child."* So, although Patience wanted Thabo to be *"a respectful child"* and realise that he was *"not the only person in the world,"* it appeared that for the most part *"he is a free child"* [must be a free child] and *"this is how his generation are"* were the inferences/demands that appeared dominant in the evaluation of most of Thabo's behaviour. Patience's contradictory

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demands were related to Thabo's inconsistent and ineffective discipling of him. Furthermore, Thabo's father did not always support his mother and would later contradict her discipline. This coupled with the circumstance that Thabo was the only child and son of this older couple meant that he mostly got what he wanted. Thabo was used to getting his way. The school discipline, as with all schools, utilised the demerit system. So, contingencies were intermittent and inconsistently applied across teachers. Additionally, Rajesh's irrational beliefs: "*I must not confront* (demand), *I must be careful when I discipline* (demand) and associated irrational beliefs and inferences, '*If I confront it will end in disaster; discipline could lead to confrontation with the parents*; *I could be reported by parents; if I am reported by parents, I could end up with a warning letter; I could lose my job,'* made him reluctant to discipline in the classroom. As a result, Thabo mostly escaped effective contingencies at school for ODD behaviour. These were the irrational beliefs across part of Thabo's system that helped to maintain his ODD behaviour. According to the REBT (Diguiseppe et al., 2014) treatment plan these evaluative beliefs that Thabo held needed to be challenged as they held his ODD behaviour in place, and the evaluative beliefs held by the teacher and mother needed to be challenged as they affected their behaviours regarding the discipline of Thabo. Thabo also responded to the irrational beliefs around him.

7.2.5. Responsiveness across irrational beliefs

Patience's belief that Thabo was, and must be*, "a free child"* encouraged Thabo's demands: *'They must not disturb my will', "This WILL turn out the way I want it," 'It must be fair the way I see it, or I will make it fair.'* These irrational beliefs were associated with Thabo's ODD behaviour, his insistence on things going his way. At school Rajesh's belief *'If I confront it will end in disaster',* likewise discouraged him from curbing Thabo's *"will"* in the school context. This is how some of the beliefs across the system interacted.

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7.3. Treatment Implementation

The treatment plan was based on the case formulation above (Edwards, 2018). This plan was then implemented during therapy (Fishman, 2013). It was conceptualised according to the REBT (Diguiseppe et al., 2014) framework. The irrational beliefs above would be disputed to bring about alternate beliefs using REBT (Diguiseppe et al., 2014) theory and techniques. The MST (Swenson et al., 2005) approach is the overall framework that guided this clinical process and provided an integrative framework for applying the therapeutic approaches across different levels of part of Thabo's system. As such, an attempt was made to apply the therapy to Thabo, his mother, and his teacher.

Different types of sessions held across the school system The approach was embedded by holding therapy sessions with the participants across different levels of part of the school system to which Thabo belonged: 32 sessions were held with Thabo utilising the REBT (Diguiseppe et al., 2014) therapeutic approach; 29 sessions were held with the teacher utilising the REBT (Diguiseppe et al., 2014) therapeutic approach, and contingency management. Thabo's mother engaged in four sessions and one joint one with Thabo, she was extremely busy and often away for work.

7.3.1. Home context: Treatment of Thabo's mother (Patience)

The sessions held with Patience consisted of REBT (Diguiseppe et al., 2014) techniches and contingemcy management. The contingency management element included the standard procedures such as praise and reward, contingency management, limit setting and establishing behavioural expectations. Thabo was included in the planning of the application of the contingency management programme, as he helped to identify what rewards and punishments, he thought to be appropriate and effective (Kazdin, 2000). Using REBT (Diguiseppe et al., 2014) techniques I, the therapist/researcher, spent some time explaining the nature of irrational beliefs with Thabo's mother, Patience, and the connection of her

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thoughts to her feelings and behaviour regarding her reaction to Thabo. How she came to hold such thinking patterns were explored along with the link between her thinking, connected behaviour and Thabo's behaviour. Through this insight and disputation of the irrational beliefs, alternative thinking was developed.

The methods involved in REBT (Diguiseppe et al., 2014) treatment of Thabo's mother included:

1. The connection between Patience's thinking, feeling and her behaviour was established with regards to Thabo. The link between her thinking, feeling and behaviour was linked to Thabo's problematic behaviour.
2. An understanding of where the irrational beliefs came from in her childhood history was facilitated.
3. Disputing irrational beliefs in a systematic and logical way.
4. Changing her language from shoulds, oughts and musts to preferences.
5. Doing cognitive homework to identify absolutistic beliefs behind the problematic behaviours.
6. Contingency management was (Kazdin, 2000) explained.

Patience was able to connect her thinking to behaviour and feelings. She understood the concepts explained. She did not complete any homework assignments. She perceived the need for change in Thabo's behaviour as his responsibility more than that of her own although, on the completion of therapy, she did mention that she had learnt a lot. She seemed to recognise the importance of her role in Thabo's life, as in this same final session, she was considering taking a less strenuous role at work in order to be more available to him. There was no evidence however, that she utilised the disputations or the alternative thinking outside of the sessions. Patience held two contradictory sets of demands; *'He must be a free child' and "He must be a respectful child," "He must realise that he is not the only person in the*

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world." These last two beliefs, although not in themselves irrational, if they are rigidly expressed in the form of demands, they become unhelpful.

7.3.1.1. Disputation

Functional disputations were used in sessions held with Patience to dispute the irrational thinking that led to her experiences in connection with Thabo and the often-ineffective way of disciplining him. Through these techniques and disputations, the irrational beliefs were weakened before functional/rational beliefs could be established. This is illustrated below.

7.3.1.1.1. Demands

The functional dispute was used to challenge this demand that could be paraphrased as**:** *'He must be a free child***.'** The question was asked as to how it helped to demand that Thabo be '*free'* to express himself in all situations. It was discussed in therapy that Thabo and Patience needed to both change this demand, as it just resulted in him getting into trouble.

Discussions around the associated inferences: '*He is a free child, and this is why he expresses himself the way he does'* were also held and alternate more rational inferences were created such as:*' If he does not express every opinion, the way he chooses, it does not mean that he is not free.'* On a cognitive level Patience realised that other people evaluated Thabo differently to what she did and that there was a difference between expressing his opinion and doing this in a challenging manner. This was evident in the contrary demand: *"He must be a respectful child,"* tabulated in table 53. She stated that this was the reason she had agreed to letting him take part in therapy. Although she recognised the link between her way of dealing with Thabo and his behaviour, this was either not fully recognised, or not acted upon. She wanted Thabo and me, the therapist/researcher, to work on his issues. '*He must be a free child'* seemed to be the dominant demand for Patience. The above demand schema is

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represented in table 53. The evaluative beliefs and inferences were taken from thought records created in sessions by Patience and me, the therapist/researcher.

Table 53

Patience's Functional Disputations and Functional/Rational Beliefs Tabulated Against Her Demand 'He Must Be a Free Child' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Thabo gets in trouble at school. Inferences: *'He is a free child, and this is why he expresses himself the way he does.'*	Demands *'He must be a free child. He must be free to express his opinions.'*	Emotional consequence: Anger Behavioural consequence: Becomes indignant with the schoolteachers complain and Thabo is in trouble at school.	Functional dispute: to dispute the demand. Q: How does it help him to demand that he is *'free'* A: *'He also needs to change his demands to see that he does not have to express opinion every time or get all things to go his way to be free. This behaviour gets him into trouble.'* Q: How does it logically follow that he has to express everything he wants to, the way he wants to, for him to be free? A: *'If he doesn't express every opinion, it doesn't mean that he is not free. There is a difference between challenging and expressing opinion.'*	Rational belief: nondogmatic alternatives to evaluate the demand differently. *'Being free does not mean that he is free to express whatever he wants to and thinks it is important.'*

The demands: *'He must realise that he is not the only person in the world, He must be respectful,'* existed side by side with the above demand, *'he must be a free child',* and often acted in a contradictory manner. A functional dispute was used to challenge the demands. The question was asked, '*how does it help me to demand that he be respectful and considerate of me? It would be better if he was respectful and considerate but if I demand this, I will become angry, and he will just shut down.'* In this way Patience was encouraged to drop the demand to a preference. Patience expressed that she used to become very angry with

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Thabo but then she realised that this did not help as he would just shut down, she no longer lost her temper. "*I don't show him that I'm angry, because you know sometimes kids enjoy that…because if I lose it…I'm not going to do any good…he's going to test you again.*"

In the theoretical linking of thoughts, behaviour, and emotion, along with the expressed fictional dispute I, the therapist/researcher, hypothesised that the understanding would assist Patience to maintain her change. The alternative belief was created: '*If I demand he is respectful and considerate it will just frustrate me. Let me drop the demand and see it as preferable.'* The evaluative beliefs and inferences taken from thought records created in sessions by Patience and therapist/researcher and tabulated in table 54.

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Table 54

Patience's Functional Disputations and Functional/Rational Beliefs Tabulated Against Her Demand 'He Must Be Respectful' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Thabo not listening to Patience's instructions. When Thabo challenged Patience's instruction and did it in his own time or not at all.	Demands *"He must realise that he is not the only person in the world." "He must be respectful."*	Emotional consequence: Anger Behavioural consequence: Shouts at Thabo and her discipline of him is ineffective.	Functional dispute: to dispute the demand Q: How does it help me to demand that he be respectful and considerate of me. A: '*To demand that he is thoughtful of others will just frustrate me. It would be better if he was but if I become frustrated and angry, he will just shut down. He is selfish sometimes. If I demand that he is not it will just frustrate me. Let me drop the demand and see it as preferable.'*	Rational belief: Nondogmatic alternatives. *'I would prefer for Thabo to act in a way that I find respectful, I accept that while he would still not act this way some of the time, that demanding that he should all or most of the time will not change his behaviour and will just frustrate me and impact on my reaction to him and my ability to problem solve.'*

7.3.1.2. Contingency management in the home context

In the first therapy session that occurred post the initial introductory sessions the focus was on establishing a consistent and effective contingency management (Kazdin, 2000) plan for Thabo. At least part of each subsequent session was spent emphasising the importance of contingency management to Patience. Psychoeducation was used to teach her the principles of identifying the target behaviours clearly and defining them for Thabo. Finding effective positive rewards for the absence of these behaviours, and the punishments for behaviours that needed something more than just the absence of reward as a deterrent, formed part of this process. The emphasis was on positive reward for good behaviour (Kazdin, 2000). The target

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behaviours were identified as: not listening first time, not answering back, not being passive aggressive, such as, taking a long time to do something or leaving dishes partly dirty, and not doing homework. Initially financial rewards were used as positive incentives for the absence of the target behaviours, but later this changed to time at the gym as this was important to Thabo, and therefore more effective. In any case Thabo got most of what he wanted materially, and Patience did not want to reward him financially for behaviour. Appropriate school behaviours were included in the home chart. If no complaints were received from the school, he was to be given a reward; and punishment, in the form of grounding, was given if he had challenged adults or had been disrespectful.

It was difficult to engage Patience in the consistent application of contingency management (Kazdin, 2000). She did not agree with rewarding Thabo for behaviour that should occur naturally.

"It's not always the money, it's about you [Thabo] doing what you supposed to do, you supposed to be doing this anyway, we are just helping you…It should be a lifestyle for you to be a better person" (Patience in a joint session between her and Thabo).

Due to this belief, and that the time Patience spent with Thabo was limited due to work commitments, I suggested that he record his own behaviour on the chart that we made. When I enquired how his chart was going at home Thabo replied that it was going well as he was getting his rewards. The idea of behavioural change attached to these rewards did not appear to be of any significance to him. This was likely what Patience had noted in the quote above. Patience did agree in one of her sessions that looking at the chart and discussing Thabo's goals was something that the two of them could do together. The checking of the chart was particularly important in Thabo's case to ensure that he met the requirements. The decision to give the reward, or not, always rested with the mother and whether she agreed that the behaviour indeed met the requirement for the reward to be given.

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"One maybe must make time because one has to observe…the two of us to review that [behaviour] on a Saturday…review that together… and maybe let him take ownership also in terms of say…here I also crossed the line, here I agree with you, or if he disagrees, we can discuss it…. Patience's collaborative style of parenting was evident in this statement.

Patience indicated, in the above quote, that she recognised the importance of her general input into her child's life. Some form of contingency management was implemented at the end of the process, but it was their own version of rewarding Thabo for reaching certain goals which included behavioural targets. Their approach was not structured as stipulated for the research purposes of this current study; however, it did seem to represent a significant change in Thabo's home context as the parents adapted what was required in this study to what fit with their ideas and life.

Patience, referring to talking with Thabo stated: *"The reward you will get, I don't only look at the paper [chart],…you can see I'm busy, I'm between my home and Cape Town,…I look at your overall behaviour and I will give you the reward also when I want to give you…Now he said to me his watch is broken. I said, you know if you behave well, I will buy you another one. Because you know, in the past, he will go to his dad and say, 'you know I need one, two, three', and then his dad, without thinking, he will buy. Then this time around because we talk about it, he said, 'no Thabo, apparently there is some issues with your behaviour, you didn't do one, two, three so, I cannot buy you now, maybe later, prove me wrong and I will buy you one."*

The above quote shows more awareness with both parents as to the importance of contingencies and that they were now communicating with each other around Thabo's discipline.

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7.3.1.3. Responsiveness

Responsiveness (Kramer & Stiles, 2015) to Patience occurred when I arranged times and places for the sessions that were suitable for her. A couple of sessions were held at her place of work as it was sometimes difficult for her to come to the school and in these instances the driver took Thabo to school. Thabo was given the task of monitoring his own behaviour due to Patience's frequent absence.

7.3.2. School context: Treatment of Thabo's teacher (Rajesh)

I, the therapist/researcher, spent some time explaining the nature of irrational beliefs to Thabo's teacher, Rajesh, and the connection of his thoughts to his feelings and behaviour. How he came to hold his irrational beliefs were explored along with the link between his thinking and feeling in the classroom and subsequently his reaction to Thabo's behaviour which in turn activated these irrational beliefs and inferences. Through this insight and subsequent disputation, the irrational beliefs were weakened, and alternative rational beliefs were developed. Contingency management was included training included and techniques such as praise and reward, limit setting and establishing behavioural expectations (Kazdin, 2000).

The methods involved in REBT (Diguiseppe et al., 2014) treatment of Rajesh included:

1. Identifying irrational beliefs and the associated feelings and behaviour as well as what triggered them.
2. Disputing irrational beliefs in a systematic and logical way such as changing his language from shoulds, oughts and musts to preferences. De-catastrophising was used extensively with Rajesh.

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3. Facilitation of the understanding of where the irrational beliefs may have come from in his personal history.
4. Cognitive homework was used to check the understanding of the model such as identifying absolutistic beliefs behind his emotions and ineffective discipline in the classroom.
5. Psychoeducation was used to help Rajesh with contingency management (Kazdin, 2000) of Thabo and in the understanding of the REBT (Diguiseppe et al., 2014) model and concepts.

Most of the techniques described in the literature review (Diguiseppe et al., 2014) were utilised in Rajesh's therapy process. General therapeutic techniques such as Socratic questioning and reflection were used to explore Rajesh's world. This helped to establish the therapeutic relationship by creating an understanding of and communication of this understanding regarding Rajesh's beliefs and how they contributed to the sometimes-ineffective discipline of Thabo and his reaction to Thabo's ODD behaviour. Psychoeducation was used to initially explain the REBT (Diguiseppe et al., 2014) model, the connections between thinking, feeling and behaviour and other concepts. Psychoeducation was used extensively. Client awareness through induction and inductive interpretation (Diguiseppe et al., 2014) were both used in Rajesh's process. He had the capacity to understand the REBT (Diguiseppe et al., 2014) theory and presented his own disputations. As with Thabo's mother, this process involved sessions of explaining contingency-management (Kazdin, 2000) and REBT (Diguiseppe et al., 2014). Rajesh gave verbal report backs on Thabo's behaviour. He was the most engaged teacher in the case studies represented in this study regarding using the process for his own needs.

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7.3.2.1. Disputations

Two disputations were used to challenge Rajesh's beliefs, the empirical and functional disputation.

7.3.2.1.1. Demands

The demand: *'I must not confront; therefore, I must be careful when I discipline',* was challenged using a functional dispute to bring about acceptance of reality and nondogmatic preferences. The question was asked: '*How does it help me to demand that I must not confront and therefore must be careful when I discipline?'* The following is a summary of the disputation that developed between Rajesh and me, the therapist/researcher: I would prefer not to have to confront with discipline in case it ends in friction but confrontation as a teacher and in any relationship is inevitable. Even if I can tolerate the behaviour, it may escalate and become unpleasant. If I do not confront, the children will act out in my class. The demand not to confront is not useful. The alternative belief was developed: *'Confrontation as a teacher and in any relationship is inevitable.'*

An empirical dispute was used to challenge the associated catastrophic inferences that awfulized the evaluation of confrontation. The question was asked: *'How likely is it that the worst-case scenario would ensue from confrontation?'* The discussion can be summarised as follows: evidence suggested that parents may confront but, in most cases, it did not end in warning letters or teachers losing their jobs. This had only happened in Rajesh's experience in a hearsay case. Rajesh accepted that if he did follow policy, such as using the newly applied break detention contingency, then he was unlikely to be called into question. The break detention was also effective. Discussions were held around Rajesh's tendency to go to worse case regarding consequences of standing up to someone. Looking at the evidence, the likelihood of the catastrophic predictions happening was not high.

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Rajesh was asked what evidence he had that the catastrophic inferences would happen:

Rajesh: Especially after an incident involving a ruler [Rajesh had broken a ruler when a child continually refused to listen].

Therapist: Yes, and you can see the ruler incident is actually evidence that it does not end in the way you will think it will end, the other one [incident] is when…

Rajesh: Oh, what happened there, so yes, we got stranded at one of the schools and then we had to wait for the transport to come.

Therapist: Yes, that's right.

Rajesh: And the guy cancelled on us.

Therapist: And they said you hadn't organised it [properly]…it's not pleasant when, I mean this isn't positive thinking, it's not pleasant when those things happen but they're not gonna end as badly as you think because you weren't called in by [the principal]…

Therapist: …My minds going to the worst-case scenario…so when your anxiety is up, [ask] what am I thinking? …and then when I catastrophise and my anxiety goes up, pull back and see the full picture because it's not likely to go where you think it's going,…

Rajesh: Now my mind [now] goes to for example, how do I actually deal with this situation if it already happened instead of catastrophising, that's what I try to think.

The associated evaluative belief and the belief underlying the catastrophic inferences, awfulizing, was subsequently challenged. *'Confrontation is not the end of the world and*

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conflict is not the worst thing in the world. Confrontation and conflict are inevitable, it's part of life. It does not mean that it will end in disaster.'

These demands and awfulizing were triggered in conflicted situations in personal relationships as well as in the classroom. The same irrational beliefs were therefore evident across contexts. In response to Rajesh's goals, the personal relationship context was included in therapy, although not focussed on in this study. In this context, he would again evaluate conflict in personal relationships as catastrophic in that he thought it would end the relationship and he would be alone. Through discussion and disputation, it was concluded that if a relationship ended over confrontation, then it was not a worthwhile relationship in any case. Empirically, it was unlikely that healthy relationships would end due to conflict. It made sense to Rajesh that these demands, and catastrophic evaluations, had likely been developed in childhood, with the experience of an abusive father, and later in his experience regarding his problematic marriage and subsequent divorce. It did not follow that confrontation and conflict were the worst things in the world, as relationships that end due to conflict over confrontation are usually toxic or not worthwhile. Rajesh acknowledged that confrontation was therefore not the end of the world, nor was being alone as evidence showed him that although his divorce was a difficult experience, he had survived it.

On the completion of sessions Rajesh reported:

I'm getting more comfortable with confrontation.

...like I would put myself in situations where I would have to speak to a person, but I would try to be amicable about the situation, and then I would ask the person how did I deal with the situation, if it's a friend, and was I too, was I too strong [in] conversation? you know, things like that.

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These demand schemas and associated evaluative beliefs and inferences are represented in table 55. The evaluative beliefs and inferences taken from thought records created in sessions by Rajesh and therapist/researcher.

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Table 55

Rajesh's Functional Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'I Must Not Confront' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Children being disrespectful, and Rajesh considering confrontation. Catastrophic Inferences *'If I confront it will end in disaster; discipline could lead to confrontation with the parents, I could be reported by parents. If I am reported by parents, I could end up with a warning letter, I could lose my job.'*	Demands; *'I must not confront I must be careful when I discipline.'*	Emotional consequence: Anxiety Behavioural consequence: Rajesh is cautious in discipline. Lenient on the children.	Functional dispute: to dispute the demand Q: How does it help me to demand not to confront when I discipline? A: *'I would prefer not to have to confront with discipline in case it ends in conflict, but confrontation as a teacher and in any relationship is inevitable. Even if I can tolerate the behaviour, it may escalate and become unpleasant. The children will act out in my class.'* Empirical dispute to de-catastrophise the **inferences.** Q: How likely is that worst case scenario? A: *'Parents may confront but, in most cases, it does not end in warning letters or losing jobs. If I follow policy such as using the new break detention approach to discipline, then I should not be called into question. The break detention is effective.'*	Rational belief: Nondogmatic alternatives. *'Confrontation as a teacher and in any relationship is inevitable.'* Anti-Awfulizing statement: *'Confrontation and conflict are not likely to end in disaster'.*

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Demands and associated awfulizing

The following demands could be paraphrased as follows: '*I must not be criticised or blamed'* and the associated evaluative belief*;* awfulizing: *'It is awful to be criticised or blamed as really bad consequences can occur.'* A functional dispute was used to challenge the demands. The question was asked: *'How does it help me to demand that I am not criticised or blamed?'* In the discussion Rajesh agreed that it was not possible to be perfect or to be able to please people all of the time. Sometimes he did not do well, and was blamed, made mistakes, or was criticised. To demand that he not be criticised, would just frustrate him, and not change anything. This helped him to drop the demand and accept criticism and blame as part of life.

The associated inferences: '*I will be blamed for things going wrong at work, I will get into serious trouble, I could lose my job,* implied awfulizing when criticized or blamed*; 'It is awful to be criticised or blamed as really bad consequences can occur.* An empirical dispute was used to challenge these catastrophic inferences. The question was asked: *What is the evidence that criticism will end in disaster? Or that I will be blamed when things go wrong?* An incident was cited where things had gone wrong over transport for the children that had not been properly organised, and although Rajesh had been involved, he was not blamed. Further evidence was gathered that showed that even though Rajesh had been challenged over his work performance after his divorce, he had since improved his performance, and received a gift related to this. He had survived the criticism, increased performance, and it did not end in disaster.

With the subsequent alternate beliefs Rajesh accepted nondogmatic alternatives. The nondogmatic alternate belief: *'criticism is inevitable, so it does not help to demand that it does not happen'* and the anti-awfulizing alternate belief: '*criticism is not awful, it is unlikely to end in disaster,'* was created. It was hypothesized that these alternate beliefs would generally reduce anxiety regarding possible criticism and blame and reduce rumination about things that went

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wrong. The evaluative beliefs and inferences tabulated in table 56 were taken from thought records created in sessions by Rajesh and me, the therapist/researcher.

Table 56

Rajesh's Functional Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'I Must Not Be Criticised' and Associated Awfulizing

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Criticism or something going wrong at work. Inferences *'I will be blamed for things going wrong at work. I will get into serious trouble. I could lose my job.'*	Demands *'I must not be criticised or blamed.'* Awfulizing *'It is awful to be criticised or blamed as really bad consequences can occur (as per inferences).'*	Emotional consequence: Anxiety Behavioural consequence: Ruminates about the situation.	Functional dispute: to dispute the demand. Q: How does it help me to demand that I am not criticised or blamed. A: *'I will not be perfect or able to please all the time. Sometimes I do not do well, am blamed, make mistakes or am criticised. To demand that I am not will just frustrate me.'* Empirical dispute: to challenge the catastrophic inferences: Q: What is the evidence that when criticised or when things going wrong, I will be blamed, and this will end in disaster? What evidence do I have that criticism is survivable? A: *'Everyone experiences criticism. Things go wrong. It not the end of the world. It does not often end in disaster. I have experienced this at work and survived. I also have evidence that I am not always blamed.'*	Rational belief: Nondogmatic alternatives. *'Criticism is inevitable, so it does not help to demand that it does not happen.'* Anti-Awfulizing *'Criticism is not awful it is unlikely to end in disaster.'*

7.3.2.2. Contingency management in the school context

During the process Rajesh became able to discipline more effectively. He reported that his previous anxiety in this regard had reduced. The school disciplinary system had been changed

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in consultation with me, the therapist/researcher, and break detention had been introduced as a more immediate and effective punishment. This complimented the usual demerit system. Rajesh utilised this system and found it effective with Thabo and other children.

7.3.2.3. Responsiveness

Rajesh was consulted on the school premises to facilitate attendance. Rajesh's personal concerns that had nothing to do with the research aims of this study, were addressed. Although the irrational beliefs were relevant across contexts the process was adapted in this way to accommodate Rajesh's goals and engage him in the process. As with all the clients' responsiveness (Kramer & Stiles, 2015) on a moment-to-moment process occurred when either evaluative beliefs or inferences were challenged depending on which worked best for Rajesh.

7.3.3. Treatment of Thabo

The REBT (Diguiseppe et al., 2014) model was explained initially using psychoeducational techniques. The relationship between emotions, thinking and behaviour was explained as well as the nature of irrational beliefs. Thabo was encouraged to think about his own behaviours and how he could change it and have more control over his emotion, by changing his irrational beliefs. For example, his demands could be changed to preferences which could reduce anger to frustration. This was done through a process of disputation, where the pros and cons of beliefs were examined as well as the accuracy of these beliefs. Thabo's irrational beliefs were challenged through the REBT (Diguiseppe et al., 2014) therapeutic framework to initially weaken them and subsequently find functional/rational beliefs that would contribute to changing his emotions and his behaviour. Thabo was able to grasp the concepts of the REBT (Diguiseppe et al., 2014) model and apply them easily on a theoretical level in his everyday life.

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The disputations used were:

- The pragmatic/functional which used questions such as: 'Where is this belief getting me? Is it helping me or making the situation worse?'; and
- The logical: How does it logically follow that I am dominated by following an instruction?
- The empirical or reality testing which used questions such as: 'Where is the evidence to support this belief? Is it really going to be that awful? What tells me that I am nothing if I am not the top in everything that I am good at?'

Techniques used in Thabo's therapy. Most of the techniques described in the literature review (Diguiseppe et al., 2014) were utilised. General therapeutic techniques such as Socratic questioning and reflection were used to explore Thabo's world. This helped to establish relationship by creating an understanding of and communication of this understanding regarding Thabo's beliefs and how they maintained his ODD behaviour. Psychoeducation was used to initially explain the REBT model, the triggers, and the connections between thinking, feeling and behaviour and other concepts. Client awareness through induction and inductive interpretation (Diguiseppe et al., 2014) were used in Thabo's process. He was able to understand the concepts and disputations of the REBT (Diguiseppe et al., 2014) model, so induction was often used. He was asked to explain the discussions back to me, or I would ask him how he understood the disputations. He was also sometimes asked to explain the REBT (Diguiseppe et al., 2014) model back to me to make sure that he understood what had been discussed. Homework assignments based on the sessions were also part of treatment and were used either for identifying thoughts, feelings and behaviour related to a certain trigger or practicing a disputation. Homework assignments were used to solidify what had happened in the session and check understanding. Other perspective taking was

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used to help Thabo to see that his thoughts about what people were thinking and doing were not always true. Others were thinking about things differently to the way he did.

Here follows an example of leading Thabo through Socratic questioning to assist in the identification of inferences/assumptions about whether something is fair or not and the underlying demand for fairness from which the inferences flow.

Therapist: That's the immediate trigger, when you see it as unfair.

Thabo: Mmm…

Therapist: Is that a core belief or is that something you assuming?

Thabo: It's an assumption.

Therapist: It's an assumption…

Therapist: What would the demand be in your core belief up here? [referring to the thought record]

Thabo: The demand would definitely be, it must be fair.

Therapist: Very good, this is excellent Thabo.

Thabo: Fair...[writing down as well]

Therapist: Must be fair.

Thabo: Should.

Therapist: Should be fair.

Thabo's above average verbal intelligence and abstract verbal reasoning ability could have contributed to this understanding and application. Thabo was taught to recognise his own feelings and the role that his own thinking had in both feelings and behaviour. Thabo's irrational beliefs, stated above, were disputed through the REBT (Diguiseppe et al., 2014) therapeutic framework initially to weaken them and subsequently to find functional/rational beliefs that would change his behaviour. Initially, and throughout the process, psychoeducation was used to explain and introduce the approach and new concepts.

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Thabo's beliefs were challenged through a series of questions. Is it possible to have your way all of the time? How will demanding that help you? Can life always be fair? How does it help you to demand the impossible? Do you think that just because it does not go your way it is unfair? What about when life is unfair in your favour? Through open debate and discussion of these questions, Thabo was able to view his irrational beliefs from different angles. He was able to see how his beliefs were related to his feelings and behaviour and how they impacted on his own well-being, and that his well-being was dependent on his ability to change his beliefs and related feelings and behaviours. The tables below give a summary of the most important irrational beliefs along with some disputation and subsequent alternative beliefs.

7.3.3.1. Disputations

The following disputations were used to challenge the evaluative beliefs described in the case conceptualisation.

7.3.3.1.1. Demands

The demands: *'It must be fair the way I see it'; "This WILL turn out the way I want it," " It must be fair the way I see it, or I will make it fair,"* emerged during the therapeutic process. To assist in dropping the demand to a preference the argument was presented that sometimes life was unfair in Thabo's favour. His family was wealthier than the majority of families in his school. He was more intelligent than some and he, by his own admission, did not have to put a lot of work into his studies. The latter argument worked best with Thabo, he conceded that he was indeed more intelligent than most of the children in his class and that he had no competition in school. That life was sometimes unfair in his favour was used to help him accept unfairness and assist in dropping the demand to a preference, *'I would prefer life to be*

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fair but it is not fair so it will just frustrate me to demand that it is.' If he did demand it, it would just cause a lot of conflict for him.

The demand: *"This WILL turn out the way I want it,"* was related to the demand for fairness. If things did not go the way that he wanted them, then he saw this as unfair. The functional dispute was often used with Thabo. Thabo was invested in things going the way he wanted them to go, so if he could see this demand as unhelpful for him then it would be a useful argument.

During discussions Thabo conceded that life could not always go his way, so it was not going to help him to demand that it did. Thabo was encouraged to drop the demand to a preference: '*It would be nice if everything went my way, but it will not always, so to demand that it does, will not help me.'* After experimenting with dropping his demand Thabo claimed that he felt relieved as he did not have to fight it out and this, he thought, was beneficial for him.

Thabo did use this dispute in a Machiavellian way initially stating that if he did someone a favour [drop his demand to get what he wanted], they would in turn do him a favour [let it go his way next time]. Thabo gave an example of how he let another child have the rugby jersey that he wanted:

Thabo: Well then, I do it [experiment in dropping his demand] like on a match, because I do play number nine…

Therapist: Mmm…

Thabo: So, and this guy wanted to play number nine and I don't know why because he was the defender.

Therapist: Ya.

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Thabo: So, I said, no it's fine, take the jersey…You know, so it's a simple situation where I wanted it, I did not want to not have it. But I said no, it's okay, take it.

Therapist: And how did that feel?

Thabo: It made me feel like a bit uhh…I don't know what I can say…I don't know what to say.

Therapist: Did…you feel good?

Thabo: Ya, quite a bit, quite a bit.

Therapist: What was good about it?

Thabo: The fact that I…could overcome my need to have everything, that felt pretty nice….

Therapist: Was he appreciative?

Thabo: Ya, he was, he was.

Therapist: You want someone's respect or appreciation?...

Thabo: Ya, that but also if you do something for someone in return, they gonna do the same thing… He might return the favour.

Thabo did however state that he felt relieved when he did *"not have to fight it out"* and he felt good about overcoming this need to have everything go his way. These demand schemas and associated evaluative beliefs and inferences are represented in table 57 below. They were created by Thabo and me, the therapist/researcher during sessions.

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Table 57

Thabo's Functional Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'Life Must Be Fair' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Something not going Thabo's way. What Thabo wants is challenged. *Inferences 'If I do not get my way, it is not fair. The way they see it is not correct. The way I see it is correct. This is not fair'*	*Demands: 'Life must be fair.' It must be fair the way I see it, or I will make it fair.'* *"This WILL turn out the way I want it."*	Emotional consequence: Anger Behavioural consequence: Argues his point of view. Gets into physical fights with peers. Refuses to 'give in.'	Functional dispute Q: How does it help me to demand that life is fair? A: *'Life just cannot always be fair. I am just going to frustrate myself by demanding that it is.' I am going to get into a lot of conflict demanding that things go my way all the time without compromise.* *If I drop the demand, I am relieved as I do not have to fight this out. If I compromise, I may get someone to return the favour."*	Nondogmatic alternative *'Life just cannot always be fair. I am just going to frustrate myself by demanding that it is.'* If I drop the demand, *"I am relieved as I do not have to fight this out."*

Demands: 'They must not dominate me; they must not disturb my will'

Related to the above demands Thabo believed that any instruction by authority or difference of opinion *'disturbed his will.'* Working within the demand a discussion around the benefits of complying and self-control ensued in the light of instructions or directions from teachers ensued: '*The less I challenge their [teachers] instructions, the less they will try to keep me in line. If I remain under the radar by following the instructions, they will stay off my back. The more I challenge instruction, the more I face a battle with them. There will be more control of the situation [less dominating] when I learn to negotiate and practice self-control in the face of instructions and difference of opinion.'*

"I will not let their action determine my reaction" was Thabo's own alternate thought. Although this did not challenge the demand, *'I must not be dominated,'* it was

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effective as it came from Thabo himself and gave him a different perspective of control, self-control. This seemed to work the best with Thabo outside of therapy.

The rational nondogmatic alternatives to challenge the demand and associated catastrophizing was created by Thabo: *"The world will not melt."* Alternatives for following an instruction that went against his will, were as follows: '*No one gets their will complied with all the time, so it will not help me to demand that I do.'*

Here is an excerpt from a functional dispute used to challenge the associated catastrophising triggered when Thabo's mother gave him an instruction that went against his will:

Thabo: The world is just melting, now the world is really melting.

Therapist: Ya, so you would catastrophize …[his mother telling him what to do].

Thabo: Ya…

Therapist: …where is holding this belief getting [you]?..

Thabo: I'm more irritated now and I'm unhappy and you know.

Therapist: Ya, so…

Thabo: It really does not get me pretty far.

Empirical dispute

Therapist: Where is the evidence to support it? Is it really that awful?...

Thabo: No, … It's not that bad.

Therapist: [The] rational belief which are looking for the…

Thabo: It's not that bad … I can stand it.

Therapist: So, if we looking at that disturbance here, what is disturbing you? Your feeling?

Thabo: My thinking

Therapist: …your thinking or … that your mother is asking you to do something?

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Thabo: My thinking.

A logical dispute was used to challenge the inferences associated with the demand. The question was asked: *'how does it logically follow that I am dominated by following an instruction?'* The following argument ensued: My feelings are not always the truth. To follow an instruction does not mean I am dominated. It is just an instruction. Thabo added that, *"the world will not melt,"* if he followed an instruction that would disturb his will for that moment. This was a favourite alternative belief that Thabo used despite the dispute used or the belief challenged.

The question was also asked: *How does not getting what I want, mean that others are dominating me? They are putting their own needs forward that are just as valid as mine? "The world will not melt"* if I give into someone's will. These demand schemas and associated evaluative beliefs and inferences are represented in table 58 below and created by Thabo and therapist/researcher during the therapy process.

Table 58

Rajesh's Functional Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'They Must Not Dominate Me' and Associated Inferences

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Being told what to do by Authority Anyone's will clashing with Thabo's.	Demands *'They must not dominate me. They must not disturb my will.'*	Emotional consequence: Anger Behavioural consequence: Argues, resists any instruction that is contrary to what he wants to do. Fights for things to work out the way he wants then too.	Functional dispute Q: How does it help me to demand that instructions and the preferences of others not disturb my will? A: '*It is impossible for my will not to be disturbed sometimes. No one gets what they want all the time. So, it will just frustrate me to insist that I do get my will.* *I will be more in control of the situation when I learn to negotiate and practice self-*	Rational belief: Nondogmatic alternatives. *'No one gets their will all the time, so it will not help me to demand that I do "The world will not melt" if I follow an instruction.* *'There is an advantage to self-control.'*

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Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
<u>Inferences</u> *'If I do not get my way, they are dominating me.* *If it is against my will, they are forcing me to do it'.* *"It's unnecessary for me to do what they want me to do."* .			*control in the face of instructions and difference.* *If I remain under the radar by following the instructions, they will stay off my back.'* *The more I challenge, the more I face a battle with them.'* <u>Logical dispute to challenge the inferences</u> Q: 'How does not getting what I want mean that others are dominating me?' A: *'They are putting their own needs forward that are just as valid as mine?'* <u>logical dispute:</u> to dispute the inference Q: 'How does it logically follow that I am dominated by following an instruction?' A: *'My feelings are not always truth. To follow an instruction does not mean I am dominated. It is just an instruction.' "The world will not melt"*	*"I will not let their action determine my reaction"*

Demands: '*I must be top in things that are important to me such as body building.'*

A functional dispute was used to challenge the demand: '*I must be top in things that are important to me, such as body building.'* The question was asked, '*how does it help me to demand that I am always top in the pursuits that are important to me?'* The disputation followed that it was not possible to be top all the time, to demand this would be self-defeating. An alternative, rational belief arose from this disputation in which the demand was dropped and turned into a preference: '*I would prefer to be on top all the time but that is not possible, so to demand it is self-defeating.'*

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Here follows an example of an excerpt from the dispute to turn the demand into a preference.

Therapist: … And what would the more rational thought be? …

Thabo: I must be on top, the more rational would be. I could have been, I am not top now but there is always next time…

Therapist: I must be on top, okay next time, next time comes and then it's going to be: I must be on top, so you see your thought process?...

Thabo: Ya, it's going to go back, mmm... [to the same pattern of demand]

Therapist: … think in a rational way so you can cross that one out and what would you change it to?

Thabo: Uh… Won't always be on top.

Therapist: I won't always be, I would prefer to be on top, but I won't always be on top.

Thabo: I would prefer it, but I won't always get it.

Thabo was encouraged to practice his disputations and alternate beliefs.

Therapist: …I can accept [in] life that I am not always going to be on top.

Thabo: Mmm…

Therapist: But that's difficult, you have to practice every time this situation comes up…, which is someone is going to beat you, or someone does beat you, or somebody does better than you.

Thabo: Ya.

Therapist: It's okay if you, you know try to do better than them or set your goal to be on top, that's fine.

Therapist: My goal is I want to be on top, my thinking pattern when it does not [happen]…I would prefer to be on top, but I don't always have to be…

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Thabo: Mmm…

Therapist: … you will not have that frustration.

Thabo: Mmm…

Therapist: And anger

Thabo: Ya… ya, no…. I understand.

7.3.3.1.2. Negative self-evaluation

Negative self-evaluation flowed from this demand: If I am not the top, then *"I am nothing"* was discovered in the therapy process. A functional dispute was used to challenge negative self-evaluation. The question was asked: '*How does it help me to achieve my goals if I think "I am nothing" due to irrational demands?'* The argument followed that this would only serve to demotivate him in achieving his goals.

Logical disputation was also used to challenge negative self-evaluation further. The question was asked: '*how does it logically follow that if I am not top, "I am nothing?'* No one is top all the time. There is always someone better, it does not follow that I am nothing.

An alternative, rational belief: A self-accepting statement was created: *'there will always be someone out there that can be stronger than me, it does not follow that I am worthless or" nothing."'* These demand schemas and associated evaluative beliefs and inferences are represented in table 59 below, created by Thabo and the therapist/researcher during sessions.

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Table 59

Thabo's Functional Disputations and Functional/Rational Beliefs Tabulated Against His Demand 'I Must Be on Top' and Associated Negative Evaluation

Activating Event	Irrational Belief	Consequence	Dispute	Functional/ Rational Belief
Situational Activating Event: Competition in things that are important to Thabo. Being thwarted in the pursuit of this goal.	Demands *'I must be top in things that are important to me such as body building.'* Negative self-evaluation 'If I am not the top, then *"I am nothing."*	Emotional consequence: Anger Behavioural consequence: Pushes to develop in the area of importance. Becomes oppositional if his goals are thwarted.	Functional dispute Q: How does it help me to demand that I am always top in the pursuits that are important to me? A: '*It is not possible to be top all the time. To demand this will be self-defeating. It will only serve to demotivate me.'* Logical dispute to challenge negative self-evaluation Q: How does it logically follow that if I am not top, I am nothing.? A: *'No one is top all the time. There is always someone better, it does not follow that I am nothing.'*	Rational belief: Nondogmatic alternatives. *'I would prefer to be on top all the time but that is not possible, so to demand it is self-defeating.'* Self-accepting statement *'There will always be someone out there that can be stronger than me, it does not follow that I am worthless/"nothing."*

7.3.3.2. Other perspective taking

The inference: *'If I do not get my way, it is not fair'* was challenged using other perspective taking which increased Thabo's cognitive flexibility so that he could understand how others may experience his behaviour. It was used so he could appreciate that others held different viewpoints to that of his own and that these were equally valid. Thabo often mistook things for being unfair with things not going his way. Discussions were held around this by presenting the situation from the perspective of those he conflicted with. Socratic questioning was used.

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Therapist: … how did somebody else watching…see [it]? … when we brought in… [Thabo's teacher Rajesh was brought into a session with Thabo to assist in providing information as to how others experienced Thabo's behaviour].

Thabo: Well, if we had to get someone else, I think someone else will definitely see like anger between both people.

Thabo was asked questions such as 'are they being unfair or are they also just trying to get what they want, which is equally valid?' He was able to change his thinking paraphrased as follows: *'Sometimes I confuse fairness with things going my way. Other people also have desires that may not align with mine. I'm going to get into a lot of conflict demanding that it goes my way all the time without compromise. I cannot get my way all the time. Not getting what I want does not mean that it is not fair. It is just what it is. It did not work out the way I wanted it this time, next time it might.'*

7.3.3.3. Contingency management

In this case, Patience only attended a few therapy sessions, there were only slight changes in Thabo's home context regarding contingency management. This change was implemented when Thabo took charge of the behaviour chart himself, but Thabo was focussed on his rewards and these rewards did not seem to be systematically applied. Patience did say that she was going to use evaluating Thabo's goals once a week as a means of connecting with him but there was no evidence that this idea came to fruition practically. At the end of the sessions Patience was happy with Thabo's behaviour and thought that his behaviour had improved. Even before therapy she was more tolerant of Thabo's behaviour than the teachers were. Both Thabo's parents did use some form of contingency management, he no longer got whatever he wanted at any time.

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The teacher gave verbal feedback on Thabo's behaviour most weeks. The HOD of Thabo's high school section was also head of discipline. Together she and I, the therapist/researcher, discussed possible changes to the disciplinary system and policies that were currently in place, as these were recognised as being ineffective. We discussed the importance of immediacy when using contingencies, positive reward for good behaviour, clarity of behavioural requirements and consistency in application. I, the therapist/researcher consulted the children that I was working with in Thabo's school for their input as to what they believed would be an effective disciplinary system. Thabo came up with the idea of break detention as an immediate effective punishment. He thought that outings at the end of the term for those that had no demerits, called bad seeds in this school, would be an effective reward. He even had ideas for how funds could be raised by the children for such outings. Only break detention, out of these ideas, was implemented and the HOD ran break detention alone in lieu of any other duties. The reward system was not implemented. Break detention was reported to be effective overall by the HOD and Rajesh. A few children did repeatedly appear in break detention. It also took a long time to introduce break detention as any alteration in the disciplinary process had to be written into policy and signed by parents.

7.4. Evaluation of Impact

The plan was implemented, and therapeutic evaluations were applied. The process was tracked, and progress monitored (Edwards, 2018), so the evaluation section incorporates and interprets the therapy monitoring. The evaluation and impact of the treatment was assessed using the self-report scales (irrational belief scales) and behavioural scales (Conners Rating Scales) all administered before and after treatment. The irrational belief scales compared the teacher's, parent's, and child's irrational beliefs before and after treatment. The Conners Rating Scales (Conners 2007) compared the child's behaviour before and after treatment. Behavioural charts and reports given by Thabo's class teacher throughout treatment

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monitored behavioural changes on a weekly basis. As the charts were inconsistently filled in, they were not used for statistical analysis, and they were augmented by verbal reports from the class teacher that gave an indication of Thabo's behaviour for the week.

7.4.1. Behavioural and self-report scales

The Child and Adolescent Scale of Irrationality (CASI) (Kassay et al., 2015), Revised Belief Scale for Parents (PIBS) (Joyce, 1995) and the Teacher Irrational Belief Scale (TIBS) (Huk et al., 2019) measured the irrational beliefs of Thabo, Patience and Rajesh pre-and post-therapy. The interpretation of these irrational belief scale is set out in tables 3a and 3b. The Conners Behavioural Rating Scale (Conners, 2007) measured Thabo's behaviour and the interpretation is set out in table 2.

7.4.1.1. Child and Adolescent Scale of Irrationality (CASI)

Thabo's scores both pre-and post-therapy are found in Figure 21 below.

Demand. Pre-therapy Thabo's *demandingness* fell in the high level of endorsement of irrationality. In Thabo's case this was the highest score attained on his CASI (Kassay et al., 2015). One of the focal points of therapy was Thabo's demand for fairness. According to REBT (Diguiseppe et al., 2014) demand schemas are the underlying schema from which the other evaluative beliefs are derived. This score decreased significantly, according to the reliable change index (RCI, found in appendix J), post-therapy to a moderate level of irrationality. Thabo's demand for fairness proved resistant but according to the CASI (Kassay et al., 2015) irrationality did reduce. On completion of therapy Thabo did report that he still struggled with this demand.

Awfulizing. This score fell in the high level of irrationality, and the score reduced significantly post-therapy according to the RCI found in appendix J. This change was evident

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in therapy sessions. Thabo created his own alternate anti-awfulizing statement: *"the world won't melt.*"

Frustration intolerance (LFT). Pre-therapy Thabo's scores for *LFT* fell in the moderate level of irrationality. The score reduced non-significantly, according to the RCI found in appendix J, post-therapy to the more-rational-philosophy-endorsed level. So even though the change in the score was not significant it was now fell in acceptable levels of rationality.

Other negative rating (ROW-O). Pre-therapy Thabo's score fell in the more rational level and remained in this category post-therapy; a non-significant decrease was allocated according to the RCI found in appendix J. Thabo did have high demands on others to be fair, which was evident in sessions, despite the scores falling into more rational level category.

Self-Downing (ROW-S). Scores both pre-and post-therapy fell in the more-rational level but there was an insignificant drop in the score post-therapy, according to the RCI found in appendix J. Thabo had mostly a positive perception of himself and his worth apart from when he was not first in the things that were important to him: *"then I am nothing* (Thabo)." The irrationality around this trigger was very evident and resistant in therapy sessions despite not reflecting on the CASI (Kassay et al., 2015). Thabo had a rational evaluation of self-worth outside of this trigger.

The *total average* irrational beliefs score fell in the moderate level category of irrationality pre-therapy and decreased significantly to the more-rational-philosophy-endorsed level post-therapy according to the RCI found in appendix J. His scores decreased overall. The higher irrational belief scores had the more significant reductions post-therapy.

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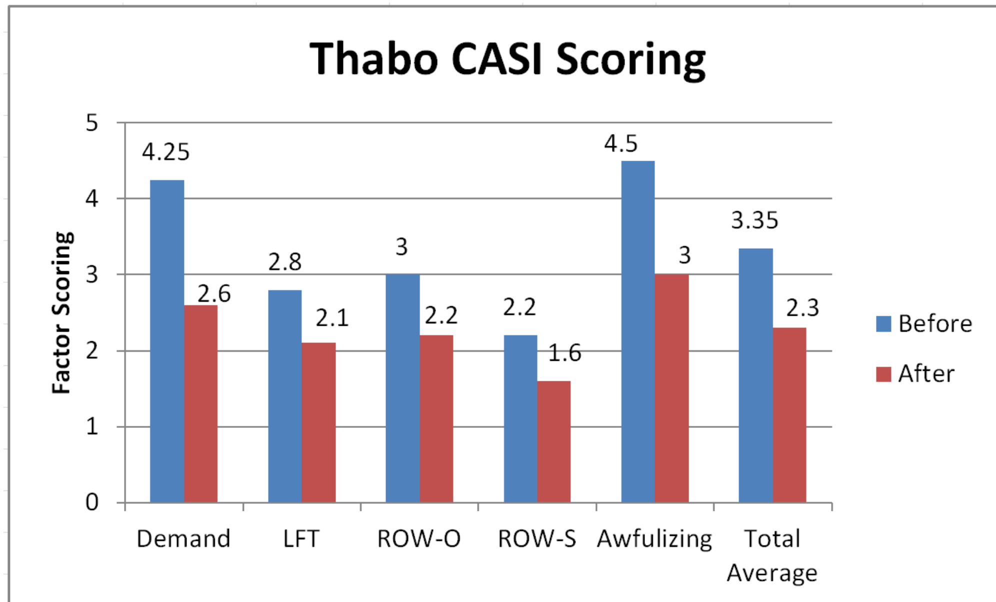
Figure 21

Bar Graph Showing Thabo's CASI Scoring



7.4.1.2. Thabo's mother's (Patience's) irrational belief scale

Patience's scores both pre-and post-therapy are represented in figure 22. Although Patience often sounded rational in her approach, her treatment of Thabo was lenient and often indulgent. His behaviour and dominant expression of ideas were evaluated as him being a *"free child."* All Patience's scores reduced post-therapy. The score for *demandingness*, and *awfulizing* reduced significantly according to the RCI found in appendix H. The *low frustration tolerance (LFT)* showed less irrationality and decreased non-significantly according to the RCI found in appendix H. The score for irrationality regarding self-worth decreased but not significantly according to the RCI found in appendix H. The average score for irrationality decreased significantly according to the RCI found in appendix H.

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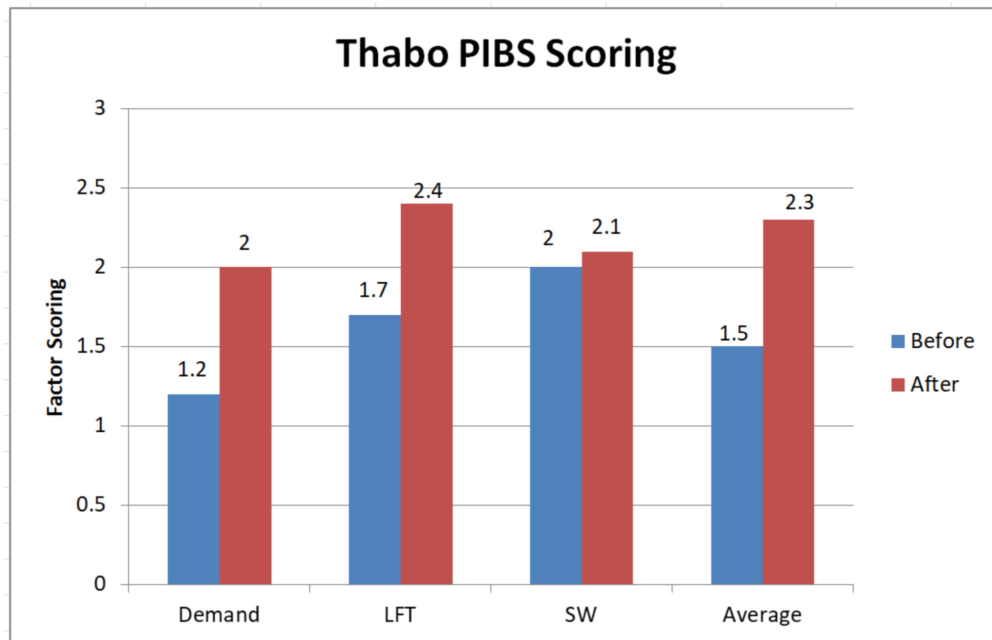
Figure 22

Bar Graph Showing Thabo's Mother's (Patience's) PIBS Scoring



7.4.1.3. Thabo's teacher's (Rajesh's) irrational belief scale

Rajesh's scores on the TIBS (Huk et al., 2019) (figure 23) revealed the following: *attitudes towards the school organisation* on the TIBS (Huk et al., 2019) fell in the high-level-of-endorsement-of-irrationality category; indicating rigidity of thought. This score was the highest score on the TIBS (Huk et al., 2019). The items on this subscale are related to the teachers' needs to be involved in the running of the school, i.e., that they be involved in decision-making; that their problems be listened to, etc. This would have likely clashed with Rajesh's demand to avoid conflict and the catastrophic predictions of the outcome thereof if the situation did not consider him or consult him regarding decisions that affected him. Rajesh would have been upset yet reluctant to confront the situation. This irrationality score decreased non-significantly, according to the RCI found in appendix I, to a moderate level of irrationality.

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The *authoritarian attitudes towards pupils* fell in the moderate-level-of-endorsement of irrationality. This score was the second highest score in the TIBS (Huk et al., 2019) for Rajesh. This irrationality score decreased non-significantly, according to the RCI found in appendix I, to a more-rational-philosophy-endorsed level post-therapy.

The *self-downing* score fell in the more-rational-philosophy-endorsed level both pre- and post-therapy and decreased in irrationality just under statistical significance according to the RCI found in appendix I.

The score for *low frustration tolerance (LFT)* fell within the more rational philosophy endorsed both pre-and post-therapy and deceased non significantly post-therapy according to the RCI found in appendix I.

Rajesh's *total average* score for irrationality fell in the moderate-level- of-irrationality and decreased non significantly post-therapy according to the RCI found in appendix I. The score was now however in the more rational level.

The irrational beliefs that affected his discipline of the children and his personal life addressed in therapy were not specifically the same focus as that of the irrational belief scale, nevertheless all the scores decreased in irrationality indicating a general decrease in irrationality and ability to utilise the concepts of the theory outside of therapy. Rajesh showed an overall non-significant decrease in scores across the TIBS (Huk et al., 2019).

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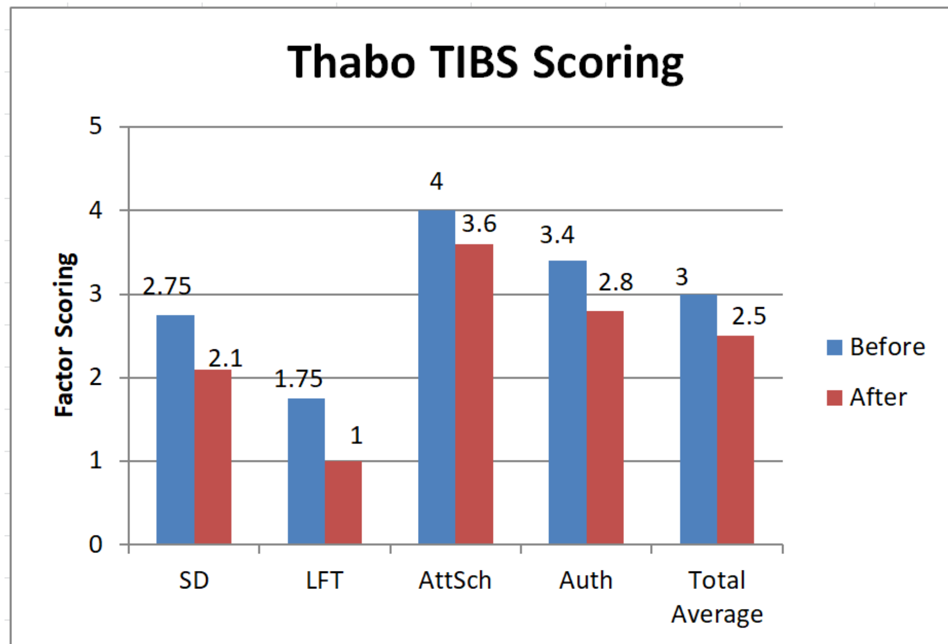
Figure 23

Bar Graph Showing Thabo's Teacher's (Rajesh's) TIBS Scoring



7.4.1.4. Conners Rating Scale as completed by Thabo's teacher

The following Conners Rating Scale scores (Conners, 2007) are represented in **figure 24** below.

Thabo's allocated scores on the Conners Rating Scale (Conners, 2007) for *peer relations* fell in the average category both pre-and post-therapy and decreased under the statistically significant level, post-therapy according to the RCI found in appendix K.

He obtained a very elevated score for *Aggression/defiance* both pre-and post-therapy. Nevertheless, the decrease in the score post therapy was significant according to the RCI found in appendix K. The score carried out on the Tscores and found in the manual eas not significant but the reliable change index caried out on the raw sore was. Thabo's behavior had improved yet it was still of concern and remained within the very elevated score with the same T-score.

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Hyperactivity/impulsivity decreased significantly, according to the RCI found in appendix K, post-therapy, from a very elevated score to an elevated score.

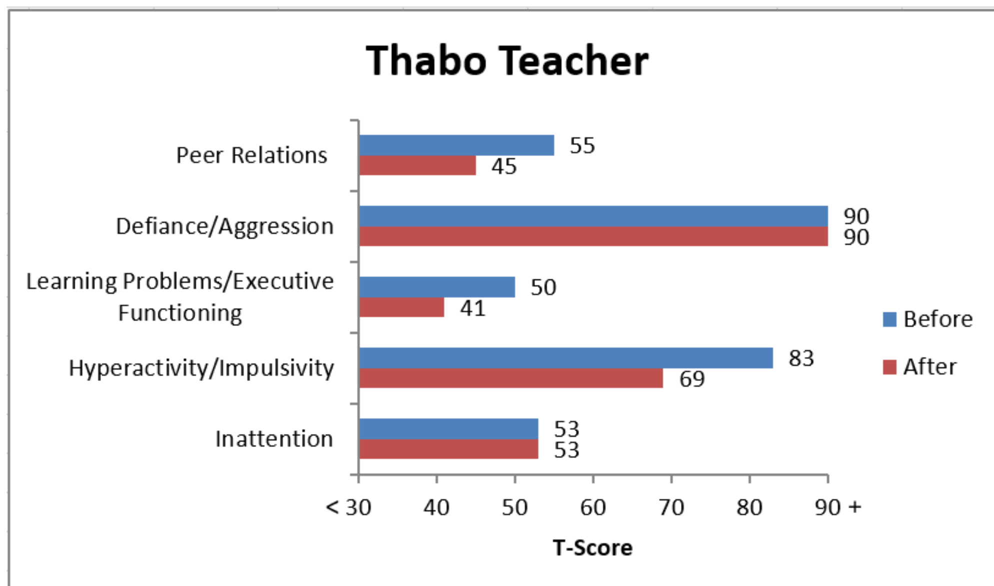
The scores for *Learning problems and executive functioning* were average both pre- and post-therapy and reduced non-significantly post-therapy according to the RCI found in appendix K.

The scores for *inattention* were average both pre-and post-therapy and remained the same post-therapy.

Overall, although Thabo's behaviour still caused concern, particularly related to the category *defiance aggression*, according to the teacher's rating, all categories had improved apart from *peer relations.* Verbal reports from the teacher with regard to Thabo's classroom behaviour was that he was no longer answering back or physically aggressive, but he still displayed a defiant attitude. The defiant attitude was likely responsible for this elevated score.

Figure 24

Bar Graph Showing Thabo's Conners Scores by His Teacher (Rajesh)



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7.4.1.5. Conners Rating Scale as completed by Thabo's mother

For *inattention* Thabo was allotted a very elevated score, reflecting many more concerns than are typically reported pre- therapy. Likely this was again due to Thabo's refusal to listen to and follow through on instructions as this was his mother's main concern. This score reduced significantly, according to the RCI found in appendix K, to an average score post-therapy. It substantiates Patience's report that she had noted an improvement in Thabo's behaviour and was content with his behaviour at home.

Patience allotted an elevated score pre-therapy for *impulsivity/hyperactivity.* Patience reflected more concerns than are typically reported for high activity levels which includes possible restlessness and/or impulsivity. This score reduced significantly, according to the RCI, found in appendix K, to an average score indicating typical levels of concern post-therapy

On the Conners Rating Scale (Conners, 2007), Thabo's mother, Patience, gave him an average score for *peer relations,* reflecting typical levels of concern regarding friendships, social skills, and acceptance by his peer group both pre-and post- therapy. However, this score increased, significantly, post-therapy according to the RCI found in appendix K. It was the only score that increased post-therapy in Patience's rating. The school believed that Thabo was an influential child regarding his peers. Contrary to this, Patience believed that others were a bad influence on Thabo, and this could account for the elevated score on this scale. Patience became more conscious of this perceived influence as time went on. Drugs had been brought onto the school property by Thabo's friends and Thabo's involvement in this incident was unclear. Initially, he was not involved in these incidents, a few months later, he was. The extent of his involvement was undetermined.

Patience gave Thabo a high average score for *aggression/defiance* indicating slightly more concerns than are typically reported, for being possibly argumentative; defying requests

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from adults; poor control of anger or loss of temper; possible physically and/or verbally aggressive behaviour; or bullying others. This was likely due to Thabo refusing to listen to his mother's instructions. This score reduced significantly, according to the RCI, found in appendix K, post-therapy but remained in the same descriptive category. *Aggression/defiance* attained the highest possible category in the teacher's Conners Rating Scale (Conners, 2007). This suggests that Thabo's behaviour was more tolerated at home than it was at school. His behaviour was different at home compared to that at school, and Thabo reported that his father and mother supported him when he got in trouble at school.

For *learning problems* Thabo was allotted average an average score both pre- and post- therapy there was no change post- therapy.

For *executive functioning* Thabo was allotted an average score, indicated typical levels of concern both pre- and post- therapy but reduced non-significantly post-therapy according to the RCI found in appendix K. Due to the last two scores and his academic performance no co-morbid learning problems were indicated.

These Conners rating scores are represented in **figure 25** below.

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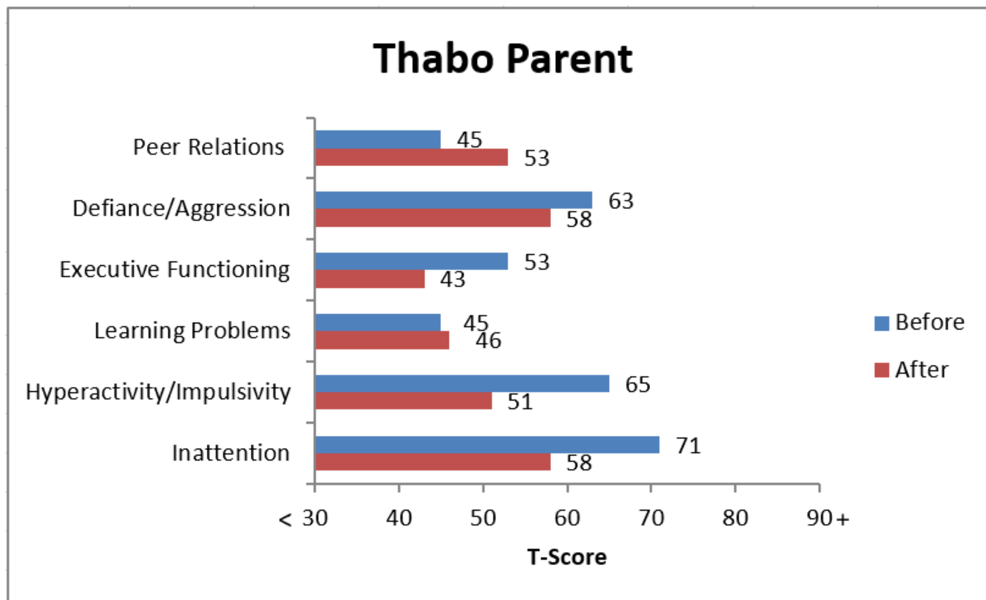
Figure 25

Bar Graph Showing Thabo's Conners Scores by His Mother (Patience)



7.5. Discussion

Overall, Thabo's behaviour improved according to his teacher's weekly reports and the Conners Rating Scale (Conners, 2007). The weekly reports gave a better impression of Thabo than the Conners Rating Scale (Conners, 2007). All allotted scores improved on the teacher's Conners Rating Scale (figure 24) apart from two, *learning problems* and *peer-relations*, which remained the same. One of the scales, hyperactivity/impulsivity decreased significantly according to the RCI found in appendix K, The verbal reports qualified this score, Rajesh expressed that Thabo no longer challenged the teachers as he did pre-therapy, nor did he get into physical fights, yet his attitude was still arrogant. This was confirmed by an outsider who was called to the school for a disciplinary hearing regarding Thabo. In a follow up, a month after termination of therapy, Thabo had been called in for a disciplinary hearing that included this outsider. Thabo had allegedly spearheaded a mass complaint about a teacher at the school that was not considered to be performing his duties properly. It was believed that Thabo incited the other children to complain and that he had behaved wrongfully in the way in

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which he dealt with this situation. Thabo was recused of other charges but the third-party expressed that he experienced Thabo as arrogant in attitude. The teacher the children complained about was later asked to leave the school. After the consequence of the hearing the principal reported Thabo became *"quiet"* again and they experienced no further issues. This indicated the importance of consequences for behaviour and Thabo being held accountable through contingency management. He was now more responsive to these consequences. The head of Thabo's section of the school, also the school disciplinary head, claimed that this incident was different to that of the others as it involved a legitimate problem. Contradictory opinions of Thabo existed in all contexts as to his changed behaviour. According to Thabo's teacher's reports, although there were still concerns, Thabo had improved. This was supported by his Head of department (HOD) at Thabo's school who was also head of discipline. The principal however believed that there had been no change.

The parent Conners Rating Scale (Conners, 2007) (figure 25) indicated improvement across all allotted scores post-therapy, apart from concerns over *peer relations.* Thabo's mother was concerned over the influence others had over Thabo, especially since the incident involving drugs. This seemed to be the source and trigger of Thabo's mother's concerns. All the other allotted scores post-therapy however indicated an average level of concern, including the three scores that were elevated pre-therapy, *defiance/aggression, hyperactivity and impulsivity*, and *inattention* and all decreased significantly according to the RCI found in appendix K. Inattention received the highest score pre-therapy. Thabo's mother reported that he did not listen to her instructions, but she claimed that this improved significantly post-therapy: *"I haven't signed a book for quite a while where he didn't do his homework. It's been long now."*

Patience summarised the improvement in Thabo's behaviour post-therapy from her perspective.

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Patience: *You know… I don't know what I've done with it [the behaviour chart]. I was living between here and Cape Town, I was flying to Cape Town almost every week, I don't know, I lost track, but generally he has improved…. I don't have to tell him when he come back from school that he must [load the dishwasher],… weekends he will vacuum the pool and refill the pool… I don't struggle with him anymore. And he doesn't really answer back…If he doesn't like what I'm saying he will look at me saying 'really mum' and I say 'Yes', and he will go away and do it. He's a completely different child now."* Generally, Thabo was following instructions without being instructed to do so. This could have come from the discussion around self-control in therapy. The more Thabo complied of his own accord, the less others would pressure him to do so.

"He still asks questions, but I think that now he has learnt that there is a way of talking to people."

Other discussions between Patience and myself, ensued around Thabo's attitude when he expressed himself and the difference between challenging and just expressing opinion.

Patience: *"His granny said, 'has he grown up or what?' because he is different."*

According to the CASI (Kassay et al., 2015) (figure 21) all Thabo's irrationality scores reduced. Three of the scales decresded signnificatly according to the RCI found in appendix K. Only one, awfulizing remained in the moderate level of irrationality. The CASI (Kassay et al., 2015) results confirmed a reduction in Thabo's irrational thinking in correspondence to the behavioural change indicated on the Conners Rating Scales (Conners, 2007) and verbal feedback given by his mother, Patience, and his teacher, Rajesh. These results on the CASI (Kassay et al., 2015) confirmed Thabo's ability to both understand and apply the REBT (Diguiseppe et al., 2014) theory.

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All the techniques discussed in Chapter 2 were used in therapy as were most of the disputations. The functional dispute was the most effective with Thabo in keeping with the experience of the authors Diguiseppe et al., (2014).

Thabo's school context engaged in therapy and subsequently changed. The head of discipline who was also Thabo's HOD implemented break detention so that punishment would be immediate. This was suggested by Thabo as something that would be effective. Thabo's class teacher was able to discipline Thabo more effectively as his irrational demands and associated awfulizing and catastrophic inferences associated with these demands were addressed in therapy. A reduction in irrationality was evident across all TIBS (Huk et al., 2019) (figure 23) scores even though these were non-significant according to the RCI found in appendix K. The discipline in the school context was therefore more effective.

Regarding Thabo's home context, his mother's the scores on the PIBS (Joyce, 1995) (figure 22) all indicated significant change according to the RCI found in appendix K. In the process she did acknowledge that her sometimes rigid demands for Thabo to be respectful and associated anger was not helpful. Her demand for him to be a free child and subsequent lenient evaluation of his behaviour was not shared by others. Some changes to contingency management in the home was made, although this was not consistent. She recognized the need to spend time engaging meaningfully with Thabo.

Apart from the changes in the context Thabo understood the REBT (Diguiseppe et al., 2014) model and how to apply it. He could utilise the concepts and disputations and generalise to situations outside of the therapy sessions. This would have increased effectiveness of the therapy and maintenance of change.

I contacted the school about two months after therapy was terminated. Thabo's behaviour was reported by the HOD to have improved. According to the class teacher, the HOD and the scales Thabo did exhibit change in both irrational beliefs and behaviour. The

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principal however did not believe that he had changed. Thabo's mother believed that there was a change and that this was positive and stable two months post-therapy. His grandmother also noted positive change.

This chapter described the therapy process for Thabo's oppositional defiant behaviour. The following chapter, the final chapter, looks at the findings of these case studies as a group and uses these findings and observations to answer the research questions and fulfil the research objectives of the study.

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Chapter 8: Conclusion: Evaluation and discussions of the process

This research project explored the implementation of a multisystemic (Swenson et al., 2005) approach utilising REBT (Diguiseppe et al., 2014) therapeutic techniques and processes that were applied to disruptive, impulse control and conduct disordered behaviours of children in a South African school context. The process and efficacy of this approach was considered. In this chapter the children's characteristics that influenced the process are discussed along with the influence of the school context (teachers), and the influence of the home context (mothers). The influence of the wider South African context on the problem of disruptive, impulse control and conduct disordered behaviours of South African school children was also considered. The therapeutic process along with the commonalities across the different cases are discussed thereby carrying out phase two of the analysis described in Chapter 3. The efficacy of the process and theory, applied in this context, are considered. Responsiveness (Kramer & Stiles, 2015) is reviewed between therapist and clients. Responsiveness in a different sense, regarding the interaction of the different irrational beliefs, within the case studies across teacher, parent and child are also explored. The influence of contingency management (Kazdin, 2000) on the child's behaviour is discussed. Recommendations for future therapy including reaching a wider number of prospective clients are considered as well as the strengths and weaknesses of the study. The research questions are considered regarding the process and results of this study.

8.1. Call for a Wide Approach

All recommendations in the literature, discussed in Chapter 2, point to a co-ordinated, wide approach to address disruptive, impulse control and conduct disordered behaviours (Burton 2013, Burton 2008; Ghazi et al., 2013; Leoschut, 2008; Pelser, 2008). The co-ordination of such an inclusive approach that incorporates community intervention seems to remain theoretical only. The practical implementation of such an intervention is not elucidated or

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operationalised in the literature reviewed in this study, it is only indicated. The current practical interventions in South Africa seem to comprise small interventions targeting elements of the addressed problem. This is possibly the reason why not much change is evident in problem behaviour indicators listed in the two cited Centre for Justice and Crime Prevention (CJCP) studies, carried out in South Africa, and conducted four years apart (Burton, 2008; Burton & Leoschut, 2013).

This doctoral study, although following the pattern of being a small intervention, focuses on the practical workings and process of the therapeutic intervention. The focus was on what such an intervention might look like and what would work. The intervention was also directed at more than one level of the child's system to illuminate the process of a wider approach, although resources to include the community at large in the intervention were not available. This current study had the following objectives to achieve the aim of designing, implementing, and exploring a multisystemic (Swenson et al., 2005) treatment intervention for addressing children's disruptive behaviours in South African schools.

- Design an intervention based on an integrative, multisystemic (Swenson et al., 2005) approach. Evidence-based rational emotive behaviour therapies (REBT) (Diguiseppe et al., 2014) and contingency management (Kazdin, 2000) are applied within this framework.
- Implement and document the application of this applied intervention to four case studies to document the process including such elements as:
  - Identify the therapeutic processes that are successful in the above therapeutic interventions.
  - Identify challenges and obstacles to effectiveness in the therapeutic intervention.

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  - Identify client-related aspects and contextual factors that influence the therapeutic process.
  - Note the difficulties experienced by the therapist/researcher and identify any therapist-related factors that could influence the therapeutic process.

- Add to the body of evidence-based case studies that will contribute to case-based research for the reference of other professionals working in this field in South Africa.
- Evaluate the success of the intervention through feedback from relevant people (teachers and parents) and through psychometric tests and the statistical evaluation thereof.

8.2. Description of the Different Levels of the Child's system

The following section describes the different levels of the system to which the child with disruptive, impulse control and conduct disordered behaviour belongs. The contributions of these levels, as noted in literature, are described with regards to the participants in this current study.

8.2.1. The characteristics of the wider South African context

All the children in this study were affected by the spiralling levels of violence in South Africa and the children were socialised through this violence (Pelser, 2008). In the case of both Moses and Neo, the townships in which they resided were particularly known for violence and poverty (Swartz & Scott, 2014). Poverty-stricken backgrounds such as these are also often associated with neglect or even mistreatment of children that can result in behaviour related to conduct disorder (APA, 2013). This was the case with both Moses and Neo. There were family expectations on both these boys to elevate themselves and their families out of this situation of poverty. The expectations however seemed too high to the boys and

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demotivated them. Jonathan and Thabo were likewise living in this violent context of the wider South African society. According to government statistics aggregate crime levels have generally increased. In 2017/18 compared to that of 2016/17 an increase in crime of 5% was noted. An aggregate increase was noted in household crime levels and individual crime levels across all provinces, Free State, KwaZulu-Natal, Northwest, Gauteng, and Mpumalanga (StatsSA, 2018).

Thabo and Jonathan, however, came from financially more secure backgrounds and less violent neighbourhoods compared to that of Neo and Moses. Jonathan and Thabo did not experience mistreatment in the home context as Neo and Moses did. The cases of Neo and Moses support the literature that claims poverty is a risk factor for disruptive, impulse control and conduct disordered behaviour, mistreatment at home, and lack of supervision (American Psychiatric Association, 2013). As measured by the Conners Rating Scales (Conners, 2007), Moses' and Neo's behavioural symptoms were worse than that of Jonathan and Thabo, only Moses' symptoms were severe enough to meet the criteria for conduct disorder (CD).

The organisation and implementation of a recommended wider intervention for disruptive, impulse control and conduct disordered behaviour would not be without challenge in the South African context. Eagle (2015) argued that in South Africa high levels of crime entailing interpersonal violence, reflects the ruptures in the social fabric, and likewise this interpersonal violence in turn contributes to social disorganization. There is a lack of social cohesion that threatens any project designed to address aspects of social relationships, such as done in this current study. The schools, affected by this context were not experienced by me, the therapist/researcher, as cohesive. It was difficult to facilitate cohesion amongst teachers. Communication between parents and teachers was likewise difficult to institute. There was not a general history or experience of working together as a team.

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8.2.2. Characteristics of the school context and teachers

The schools are affected by the wider community. The lack of unity in South Africa, spoken of by Eagle (2015), was apparent in the schools in this study regarding discipline and lack of an effective contingency management plan that led to ineffective management of misbehaviour. Only one school in this study was willing to implement a new disciplinary intervention. Thabo's school implemented a school-wide break detention which was an immediate, effective punishment for behaviour, and administered by the HOD in charge of discipline. The system of break detention was suggested by Thabo himself. This collaborative approach to contingency programmes is advocated in literature (Gergen, 2020; Rossouw, 2007). This intervention was reported to be effective by the teachers. The break detention was an immediate, effective punishment and the children could remember what it was that they were being punished for. The same intervention was suggested at Jonathan's school, but his teacher, Heidi, believed this would interfere with the teachers' break time. In Neo and Moses' school, Mbali, believed that such an intervention would be unfair if she had to contend with other teachers' disciplinary problems when she was in control of her own class. This reluctance to implement a unified disciplinary approach indicates a lack of unity both within and across schools in this context. The disunity experienced in and between the schools affected the implementation of the therapy as well as effective discipline in the schools. Each teacher was responsible for the discipline in their own class and reluctant to work as a team towards a unified disciplinary system.

All four of the case studies in this project were influenced by aggression in the school system. Burton (2008) reports high levels of aggression, bullying and other behavioural problems, yet despite these statistics, most children reported feeling safe at school. Relating this to the wider context of South African violence it suggests the normalisation of this violence in the schools and the wider community (Burton, 2008). Thabo, Neo and Moses

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were in classes that were considered by the teachers to be *"difficult"* classes with more behavioural problems than would be considered average for such a class. Mbali reported post-therapy, on more than one occasion, that these boys were now like *"any other child."* Despite Mbali's report, results on the Conners Rating Scale (Conners, 2007) indicated that the scores attained for *hyperactivity* and *aggression*, although reduced, were still elevated post-intervention. This could have been due to normalisation of disruptive behaviours in the respective difficult classes as opposed to Neo's and Moses' behaviour now being comparatively average compared to the general population. Jonathan's teacher also expressed that his behaviour was now like that of other children post-therapy. Jonathan's aggression score did however reduce to normal levels as indicated by the Conners Rating Scale (Conners, 2007).

Regarding classroom management, literature reviewed for this study indicates that there has been no alternative to corporal punishment in South African schools since its abolition (Marais & Meier, 2010) and that teachers require guidelines with regards to alternative available disciplinary procedures (Mestry & Khumalo, 2012; Thompson, 2002). In this study, Rajesh was unsure of what he could and could not do regarding discipline of the children in the classroom. For example, he was not allowed to send the children outside of the classroom as this would be denying them access to education, but he was always second guessing what it was that he was permitted to do. Heidi, like Rajesh, was unsure as to what procedures to use with Jonathan and she therefore second guessed herself as to whether she was being too harsh with Jonathan. In contrast to this, Mbali was the only teacher who disciplined with confidence and used the method of sending children outside of the classroom. Defined guidelines would assist these teachers in addressing misbehaviour consistently and confidently.

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Within the school system there is a clear bi-directional, interactional effect between the behaviour of children and teachers. Teacher behaviours such as classroom management and competence affect the behaviour of the children, and in turn the children's behaviour affects the teachers (Burton & Leoschut, 2013; Wolhuter & Steyn, 2003). Each teacher's personal background contributed to their irrational thinking that affected the way they disciplined the children. For example, Rajesh's father was abusive, and this led Rajesh to conflict avoidance generally and when disciplining the children.

8.2.2.1. Context of the teacher and their effect on research

As stated, there was no sense of a unified team in these schools. More unity around this specific study could possibly have been fostered by explaining the research at the outset of the process to a larger number of teachers. However, there would have been some teachers, like Mbali, who thought that any contribution that they had to make towards a disciplinary system across the school, such as break detention, was unfair if their class were under control or if the behavioural problems were not perceived as their responsibility.

8.2.2.2. The characteristics of the teachers' irrational beliefs as a context

The bi-directionality between children and teachers is influenced by the teachers' beliefs as well. The teachers' beliefs affected their reaction to the children's misbehaviour and, in turn, the children's response to their reactions. For example, Rajesh's **demand** *'I must avoid conflict,'* discouraged him from confronting the children when they misbehaved. Effective contingency management was therefore not applied. The contingency management as part of the teacher's reaction forms part of the context of the children's disruptive, impulse control and conduct disordered behaviour. The children, in response to lack of consistent contingency management, continued to misbehave.

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Both the context and nuances of the individuals' beliefs and how these interact in a dynamic and interdependent fashion impact change in the therapy process. The REBT (Diguiseppe et al., 2014) techniques and concepts were applied to this dynamic situation through the relationship between client and therapist.

8.2.3. Characteristics of the family context

The characteristics of the families represented in this current study confirmed findings in the literature review that parenting style and parents' modelling of irrational or rational beliefs plays a role in their children's behaviour (Bernard, 2004). According to social learning theory, the acquisition of any complex social behaviours such as the expression of aggression, are acquired through social learning (Khan, 2008). This was supported by Moses' and Neo's cases, where both witnessed violence in the home.

Through social interaction with parents, inconsistent disciplinary action and certain parenting styles, negative and positive reinforcement of anti-social behaviours occurs within the family contexts, and this then influences the expression of anti-social behaviour (Khan, 2008). This was noted across the four cases in this study as discipline was either inconsistent or absent. In the cases of Neo and Moses, discipline vacillated between being too harsh or non-existent. In Thabo's case the discipline was mostly permissive but at times it was harsh but ineffectual in that his mother just shouted. In Jonathan's case discipline was constantly permissive, and he escaped punishment; *"My whole philosophy at home is home is the place that we get to be disgusting* (Mary)." Inconsistency in discipline was the most common factor across all cases. In three cases there was poor supervision in the afternoons and evenings, none at all with Neo and Moses, and insufficient supervision with Thabo. Jonathan was the only child that received adequate supervision. He displayed the mildest symptoms of ODD in the current study. The styles of discipline were guided by the mothers' evaluative beliefs. The

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absence of any consistent and effective contingency management was noted across all cases and affected the discipline of the children and the expression of their behaviour.

Olweus (1995) identified four child-rearing factors that were likely to contribute to the development of aggressive reaction patterns in children: a predominantly indifferent attitude of the primary caregiver in the child's early years; lack of parental warmth and involvement; permissiveness for aggressive behaviour in the child, and inadequate limit setting; and use of power by the primary caregiver, such as physical discipline. The parenting styles experienced by Thabo and Jonathan were generally permissive and accepting towards their aggression. Moses and Neo experienced a neglectful parenting style and elements of verbal abuse and aggression were apparent in both contexts. Their poverty-stricken backgrounds were often associated with neglect, or even mistreatment, which can result in conduct disordered behaviour (American Psychiatric Association, 2013; Olweus,1995). The living environment contexts seemed to influence the thinking and disciplinary styles of the mothers. The evaluative beliefs of the two mothers from the townships led to vacillating discipline that was either too harsh or absent. Long working hours, related fatigue and absent fathers also contributed to the absence of discipline as there was either no adult present or a tired or sleeping adult. These factors impacted the prognosis of therapy as it affected contingency management and parental involvement. Neo's mother came to the school on her way back from night shift and she dropped out of the therapy after four sessions. Although this was due to her irrational thinking which led to withdrawal; *"I'm expecting too much from him…I expect more goodness from him, that's why I withdraw when he does something wrong",* the context and barriers to therapy could also have contributed to early termination. It was difficult for her to afford the taxi fare. I, the therapist/researcher, offered to pay the taxi fare to the sessions, but she refused this assistance even though she stated it as a problem. The parents were influenced by their context and the parents in turn influenced the context

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that their child experienced. In contrast Jonathan's family was characterised by close and supportive relationships. They lived in a more affluent area. His mother was the one that was most involved in her children's lives regarding available time spent with them and she was the most engaged in the therapy process. His symptoms were the mildest in this study and his mother attended the most therapy sessions.

Families of children with conduct problems are characterised generally as disorganised, and experienced high levels of conflict with officialdom such as the child's school institutions (Kazdin, 1996). Similarly, the DSM-5 (American Psychiatric Association, 2013) lists familial risk factors for disruptive, impulse-control, and conduct disorders to include amongst other things: criminality of parents, psychopathology such as substance abuse disorders, parental rejection, physical or sexual abuse, harsh punishment, and frequent changes in caregivers. All four families involved in this study were generally disorganised. All the families had friction with the school around the children's behaviour. Substance abuse was prevalent in Moses' household. Neo experienced rejection when he disappointed his mother. Jonathan's mother had a busy schedule at work and was involved in community commitments in her spare time. She suffered from bouts of post-natal depression when he was a baby and was hospitalised for a short period when he was three years of age, which caused for some absence from the family. She consequently felt guilty and was reluctant to discipline him. The household was emotionally close, yet somewhat chaotic in organisation.

The biological fathers of Neo and Moses were absent, meaning that Neo's and Moses' mothers had no one to help them financially or with the discipline and supervision of the boys. Conversely, the close bonds noted in Jonathan's family along with the involvement of his father, seemed to be a protective factor.

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8.2.3.1. Context of the parent as it affected the research

The most important element across all the participants was engagement in therapy. Engagement in therapy is multifaceted, it is affected by the beliefs and motivation of the client but also by the abovementioned practical, contextual elements. The practical, contextual elements can be addressed by the therapist; however, this can be demanding on the therapist's resources such as time and finances. Furthermore, REBT (Diguiseppe et al., 2014) and all CBT approaches, require active participation on the part of the client. So, although removing boundaries such as meeting at a workplace, as proposed by Multisystemic Therapy (Swenson et al., 2005), helps attendance, and gives an opportunity for the therapist to attempt to engage the client more actively, the downside is that it can contribute to passivity as the therapist takes responsibility for the therapy to be easily accessed. When active involvement is then required it is counter to the expectations originally set by removing barriers to therapy. Removing these barriers does however contribute to the attendance of sessions and even a few sessions seem to help raise awareness in parents of their own thinking around their child. Furthermore even a few sessions raised awareness around the contribution of contingency management to behavioural maintenance. This was noted in this study, even in the case of Neo and Thabo whose mothers only attended four sessions each. Insight however was not enough to change thinking and behaviour as indicted in Rumbi, Neo's mother. She had insight into her own thinking yet was not motivated to change it.

8.2.3.2. Characteristics of the parents' irrational beliefs as a context

According to Bernard (2004) and Ellis and Wilde (2002) children model on their parents' irrational beliefs. The parents' beliefs are described below, under the heading; 'The content of the irrational beliefs of the parents' (8.3.3.2.2.). The beliefs both guide the disciplinary reactions of the mothers toward the children as well as providing a model for the children's beliefs. As indicated in the section below, Responsiveness across the system of irrational

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beliefs (8.3.5), a relational influence of these beliefs (parent to child and vice versa) was noted, with the beliefs themselves forming a system.

8.2.4. Characteristics of the children

Children's and adolescents' beliefs, emotions and behaviours are influenced by their age and biological temperament (Terjesen, Kassay & Anderson, 2017). The boys in this current study ranged between the ages of 11 to 14 years at the start of the study and 12-15 years at the end of the study. Three of the boys were about to enter high school and Thabo was already in high school. Children entering high school are generally at the teenage stage of development, and are thus more likely to engage in grandstanding, to attract attention, in the classroom. Disruptive behaviour could be used as a form of grandstanding. There were more difficulties reported in the high school phase compared to the primary school section of these schools who had both high and primary sections. Any kind of psychological or biological deficiency may appear more exaggerated at this stage. The presence of such disorders as attention deficit disorder (ADD) and Attention deficit and hyperactivity disorder (ADHD) can lead to an elevation of associated disruptive behaviours (Ghazi et al., 2013). Jonathan's scores on the Conners Rating Scales (Conners, 2007) indicated possible ADD and he was officially diagnosed with ADD after this study. Jonathan was the youngest child in this study. He was 11 and 12 years of age when the therapy took place.

8.2.4.1. Neurological and biological factors

Based on Piaget's developmental theory, only when children are in the formal operational period, approximately 12 years and older, can they engage in hypothetical-deductive reasoning that is necessary for the disputation of irrational beliefs. (DiGuiseppe & Bernard, 2006) necessary for engaging in REBT (Diguiseppe et al., 2014). The boys in this study were all 11 years and above and capable of understanding the REBT (Diguiseppe et al.,

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2014) concepts and applications according to developmental stage. All had average to above average intelligence as measured by the SSAIS-R (Van Eeden, 1991) which also assisted in the understanding of the REBT (Diguiseppe et al., 2014) concepts. Some inter-test scatters were noted in performance on the SSAIS-R, (Van Eeden, 1991) but all children were considered academically capable in school. Jonathan had an IQ in the gifted range, however there were inter-test scatters typically found in children within this category. The cognitive discrepancies indicated by the scatter can be associated with behavioural problems (Webb et al., 2005). Neo and Thabo attained significant scores on the Conners Rating Scales (Conners, 2007) for *impulsivity* but not for *learning problems*. Thabo attained significantly high scores in both *impulsivity* and *hyperactivity*, but these scores decreased post-therapy as measured by the Conners Rating Scales (Conners, 2007) and were behavioural rather than neurological in nature.

In accordance with literature, stating that more boys than girls present with conduct disorders (American Psychiatric Association, 2013) all the children in this small sample were male. Gender was not specified when searching for participants for this study, yet only boys were referred. It seems that the way in which girls displayed problematic behaviour did not present as a much of a problem in the classroom as boys' behaviour. Girls tend to engage in more indirect and subtle bullying behaviour (Olweus, 1995; Olweus, 2003). Furthermore, impulse control, disruptive and conduct disorders are more prevalent in males than in females generally, although this proportion can vary across different age categories (American Psychiatric Association, 2013).

8.2.4.2. Personality

The personality features noted in children with disruptive, impulse-control, and conduct disorders are emotional negativity, poor self-control (including poor frustration tolerance), suspiciousness, temper-outbursts, toleration of punishment, and thrill-seeking and

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recklessness (American Psychiatric Association, 2013). According to Olweus (1995) bullying is linked to personality factors with respect to children of both genders: they have a need for control, power, and to dominate; they are impulsive; and they are described as having low levels of empathy (Harris & Petrie; 2003; Olweus, 1995). In this study Neo and Thabo's *impulsivity/hyperactivity* levels were elevated and their need for power and control was noted: Thabo *"I must be on top"; Neo "I must be in control."* Olweus (1995) claims that children who bully are low in anxiety and insecurity compared to their peers. This is in keeping with the biological finding of low cortisol levels noted above (American Psychiatric Association, 2013). In this study Jonathan had high anxiety levels but this was not noted in any of the other three boys. All the boys initially found it difficult to empathise with others as they could not see from someone else's perspective. The boys all had temper outbursts at the outset of therapy that were exaggerated in the teacher's opinions when compared to their peers.

The characteristics noted across the children, parents and teachers participating in this current study confirmed the findings in the literature review. What appears to be unique in the South African context affecting both participants and the research process, appears to be the high levels of crime and violence and ruptures in the social fabric (Eagle, 2015) that contribute to the prevalence of severe behavioural problems in the schools to the extent that they are described as being under siege (Jordaan, 2017).

8.3. An Integrated Report Summary: Commonalities across Assessment, Case Formulation and Intervention Plan

The commonalities and some idiosyncrasies in the therapeutic process across cases as well as their possible implications regarding disruptive, impulse control and conduct disordered behaviour are considered below. The following summary report was written according to the three sections described in the methodology; assessment**,** case formulation, and treatment as

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applied across all levels of the system, children, parents, and schools. This process corresponds to phase two of the analysis.

8.3.1. Assessment

Some of the information in the sections on characteristics overlapped with the assessment section on characteristics. In practice the assessment continued throughout the process.

8.3.1.1. A background and life history

Two of the cases, Moses, and Neo, came from homes of single mothers. The fathers had limited contact with the children. The dynamics between the biological mother and father were problematic as were the intergenerational relationships in both these cases. In Neo's case the dynamics between him and his older sister were problematic as well as between himself and his mother. There were problematic dynamics between Moses and his grandparents as well as between Moses and his mother. These two boys, Moses, and Neo, lived in local townships known for violence. Their families had limited means and the boys had little supervision in the afternoons and evenings. Moses was 'supervised' by his grandmother and Neo by his sister but neither of these custodians were effective or engaged and the boys ran in the streets until after their curfew. This context of lack of supervision and exposure to violence is relevant for many South African children in poor townships (Hall et al., 2012). These harsh circumstances diminish the parents' resources and their ability to be supportive and involved parents (Barbarin & Richter, 2013). More than 7 million children live in single-parent households in South Africa (Hall et al., 2012). Single parents cannot share their responsibilities which leaves them with less energy and increased economic hardship which elevates parental distress. It is more challenging for them to monitor, stimulate and care for their children (Barbarin & Richter, 2013).

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In the other two cases in this study the mothers also described themselves as 'busy' and only Jonathan was supervised adequately. Thabo, the only child from a very affluent area, was left to his own devices, as his mother was away a lot. The family dynamics were however functional in these two cases. Thabo's family was described as close, and the father was engaged with Thabo, although he often contradicted the mother's disciplinary decisions behind her back. The discipline was affected by this dynamic and was inconsistent and contradictory. Jonathan's mother had many commitments although he was not left unsupervised. This family came from a lower middle-class area. Jonathan was the child with the closest and most engaged family. His father was involved with Jonathan and his sister and the marriage between the parents was described as happy. Jonathan's symptoms were the mildest and these functional family relationships could have acted as protective, mitigating factors.

Considering this small sample of case studies, the problem of disruptive, impulse control and conduct disordered behaviour was across all socio-economic strata. The disciplinary styles of parents were either harsh and inconsistent or indulgent and inconsistent. Inconsistency in discipline was a commonality. Lack of supervision was a commonality across three of the cases. In this study the family dynamics were split equally between being described as positive or dysfunctional. The family dynamics, even when positive, affected the discipline. This was evident in Thabo's case where his father contradicted his mother's disciplinary actions. Most of the background features were consistent with literature and research on the topic as described in Chapter 2.

8.3.1.2. Presenting problem

The behavioural problems across the children were identified as mild to moderate as they occurred in two settings (American Psychiatric Association, 2013), school and home. Jonathan, Thabo, and Neo were diagnosed with oppositional defiant disorder while Moses

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was identified with conduct disorder because he violated the rights of others due to the level and frequency of aggression he displayed towards his peers. The results on the Conners Rating Scale (Conners, 2007) as given by the teachers confirmed these diagnoses of the children. Across all cases the home context did not report as severe behavioural problems as did the school contexts. The parents' Conners Rating Scale (Conners, 2007) of the children's behaviour indicated less severe symptoms. The rating scales thus supported the verbal reports given by teachers and parents throughout the sessions. This difference in severity of the behaviours and diagnosis thereof which varied across contexts (school and home) for each child supports the DSM-5 that states that the behaviour is context specific (American Psychiatric Association, 2013).

8.3.1.3. Conners Rating Scale

Across all the cases the *aggression/defiance* score was elevated on the teachers' and parents' Conners Rating Scale (Conners, 2007) before therapy although less elevated on the parent scale compared to that of the teachers. *Hyperactivity/impulsivity* mostly followed the same pattern except for Thabo where his mother gave him a higher score than the teacher. The *peer relations* score for both Moses and Jonathan were more elevated in the parents' scores than they were in that of the teachers' scores. Parents were also prone to evaluating their child's peers as influencing their behaviour negatively. The teachers and parents thus had different priorities. *Hyperactivity* and *aggression* were generally more of a problem in the classroom situation than in the home context. Even within the school context different teachers gave different verbal feedback/evaluations about the same child. Some believed that they could handle these children (Mbali) while others thought that they were uncontrollable (Rajesh).

Jonathan's case had the only scores that were elevated for *inattention, hyperactivity/impulsivity* and *executive functioning/learning problems* across both teacher and parent (except learning problems). This indicated the possibility of co-morbid ADD/ADHD

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or other learning problems. Post-therapy Jonathan was diagnosed with ADD by a psychiatrist. Thabo received an elevated score for *inattention* from his mother but other indicators for co-morbid learning problems were not significant. All four of these children, including Jonathan performed adequately or well academically. Learning problems were not found to be prevalent co-morbidities in disruptive, impulse control and conduct disordered behaviour displayed by the children in this study.

Even though the reliable change index RCI found in the Conners Rating Scales (Conners, 2007) Manual had a significance level of 10% they mostly corroborated the results established by the RCI using the raw scores and relevant psychometric properties.

8.3.1.4. Establishment of the therapeutic relationship across the cases

In this study relationships were established through the therapy techniques of Socratic questioning, reflection, summarising and validation. This facilitated the understanding of the clients' world and the communication thereof, which encouraged the forming of a therapeutic alliance and reduction in the possibility of interruption of the relationship caused by invalidation. These same therapeutic techniques were used across the children, parents, and teachers alike and they lent a structured framework to help with the forming of the relationship.

In their meta-analysis Safran et al. (1990) consider the existence of two phases in the therapeutic alliance, thus conceptualising the therapeutic relationship as a process. The initial phase of the alliance focuses on collaboration and confidence building, where client and therapist agree upon their goals, and the client develops a certain degree of confidence in the framework of the therapy. As stated by Safran et al., (1990), the therapeutic approach used, in this case the REBT (Diguiseppe et al., 2014) framework, facilitates the development of the therapeutic relationship by focusing the process on establishing goals with the client and developing a generally collaborative relationship between client and therapist. The REBT

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(Diguiseppe et al., 2014) approach, in this study, therefore facilitated the strengthening of the therapeutic alliances. This approach worked particularly well with the boys in this study as it was difficult to engage these adolescents, indeed all the clients in this study, as they were offered therapy as opposed to seeking it out. Collaborative goal setting was therefore essential for engagement. Regarding goal setting with the boys, Thabo wanted to deal with his anger, Moses and Neo wanted to stay out of trouble and Jonathan wanted to control his anxiety better. The parents' goals were generally to help their children. The teachers' goals were directed at personal issues in their lives. I, the researcher/therapist experienced the REBT (Diguiseppe et al., 2014) therapeutic framework as facilitative of the relationship due to its collaborative and transparent nature.

In the second phase of therapy the therapist begins to challenge the client's dysfunctional thoughts, affects and behaviour patterns with the goal of changing these (Safran et al., 1990). The client may evaluate the therapist's more active intervention as a reduction in support and empathy and this can weaken or rupture the alliance between them. In this study the collaborative and transparent nature of the REBT (Diguiseppe et al., 2014) therapeutic approach helped to avert this. The therapeutic partnership facilitated an active role on the part of the client in this phase. Alternative beliefs and disputations are collaboratively developed.

In more advanced phases of therapy, an interruption in the alliance may be triggered by several therapeutic scenarios, including when client's thoughts and emotions have been invalidated in some way. If the alliance is ruptured, it is necessary to repair the relationship if the therapy is to be successful. This conceptualisation implies that the alliance can be damaged at various times during therapy and for different reasons. The effect on therapy differs, depending on when the problem occurs. In the early phases, it may create problems in terms of the client's commitment to the process of therapy. In this case, the client may

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prematurely terminate (Safran et al., 1990). This was the case with Rumbi. The therapeutic relationship was not initially attained. Rumbi believed that Neo should just have *"goodness"* and she withdrew when this demand was not met. This was mirrored in therapy, and it interfered with the forming of a therapeutic alliance. At the first regression in Neo's behaviour Rumbi withdrew from the sessions.

During the different phases of therapy, an interruption in the alliance may be triggered by a few therapeutic scenarios, including when client's thoughts and emotions have been invalidated in some way. In situations such as this, the actual therapeutic alliance often reflects the client's unresolved conflicts (Safran et al., 1990) or as framed by the REBT (Diguiseppe et al., 2014) framework the irrational evaluative beliefs. At one point during the process, Moses stopped attending. He had also stopped attending classes at school. His grandmother had told him that he would fail the year as he was spending too much time in the streets. He had also at this time applied for scholarships which was unsuccessful. This triggered his demand to meet his family's expectations to be a top achiever which he believed was too high to reach. This unresolved irrational belief affected the therapeutic process. He re-engaged in therapy later after this conflict was addressed in a session.

According to Safran et al. (1990), many therapeutic relationships experience at least one or more ruptures in the alliance during the process. The therapist's focus is on the client's dysfunctional patterns and the client's involvement in addressing them rather than avoiding them. This can lead to a rupture in the alliance and overcoming this rupture can restore the involvement of the client and possible successful outcome of therapy (Safran et al., 1990). Rumbi avoided any challenges in her relationship with Neo, she repeated her unresolved thinking and behavioural patterns early in the therapy and again avoided problems relating to Neo. In this case the problem with the alliance was not successfully overcome and therapy was unsuccessful. In the case of Moses, the rupture happened later in the therapy process, and

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it was successfully addressed. In this process it seems that the later breach in alliance was easier to overcome as the therapeutic relationship was already previously established.

As explained below, disputing irrational beliefs and inferences were used responsively with the clients. Responsiveness (Bachelor et al., 2007) likewise built therapeutic relationship. For example, the sequence in which inferences versus evaluative beliefs were disputed depended on the individual client. A combination of REBT (Diguiseppe et al., 2014) techniques applied responsively developed relationship and the therapeutic engagement in a structured way. When the therapeutic techniques are used in a responsive way the client is likely to experience the process as acknowledging of their beliefs and feelings which is proved to enhance the therapeutic relationship (Safran et al., 1990).

The clients also brought individual characteristics to the therapeutic relationship (Lorenzo-Luaces, & DeRubeis, 2014). In this study Jonathan and Mary both formed strong therapeutic relationships. A year after termination Jonathan and Mary returned for a follow-up session. The year after that Mary again thanked me for the tools with which Jonathan had learnt to deal with life's difficult situations. At the outset of therapy Jonathan had the least severe symptoms and the family were supportive of each other and had close bonds. They had also experienced therapy previously. Thus, they could form relational bonds and were used to a therapeutic experience.

Thabo, Neo, and Moses each had an adequate therapeutic relationship and were engaged in the process. Neo was more difficult to connect to as he had poor communication skills (Miller & Rollnick, 2013). Moses noted in therapy that it was easier for him to relate to the teachers than it was for Neo. Neo displayed less of an understanding of the REBT (Diguiseppe et al., 2014) theoretical constructs, but nevertheless common goals were still attainable. Despite his struggle with communication skills, and struggle with connection to

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adults in general, he displayed some significant change. Neo's higher motivation (Miller & Rollnick, 2013) kept him responsive to therapy.

Heidi and Rajesh were the teachers that formed adequate relationships. All clients apart from Rumbi and Mbali trusted me with personal information and engaged around personal goals. The unresolved irrational evaluative beliefs held by each client likewise affected the therapeutic relationship. Rumbi dropped out of therapy after four sessions due to her busy life, illness, and particular demands regarding Neo. Mbali did not engage from the beginning. This was due to her own thinking that children's behavioural problems were not her responsibility. She believed she had things under control and that it was not her responsibility to manage behavioural problems. Monitoring behaviour just gave her more administrative work and she believed that this was unfair. The quality of the therapeutic relationship was affected by the evaluative beliefs and inferences that these clients presented at the onset of therapy.

8.3.2. Case conceptualisation with emphasis on the REBT theory

The commonalities and idiosyncrasies across the case conceptualisation of the four cases are explored below.

8.3.2.1. Children

The children received the most therapy sessions compared to the teachers and parents. Neo participated in 19 sessions, Moses in 14, Johnathan 24 and Thabo in 32. Some joint sessions were held with the mothers. Neo and his mother has no joint sessions. Thabo and his mother had two joint sessions as did Moses and his mother. Jonathan and his mother had four joint sessions. It was easier for the two of them as she woked at the school that Jonathan attended. Neo and Moses also had four joint sessions together with eachother. During the initial assessment and throughout therapy the following commonalities and idiosyncrasies in

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irrational beliefs across the children were noted. The results on the CASI (Kassay et al., 2015) and observations in therapy mostly correlated.

8.3.2.1.1. Child and Adolescent Scale of Irrationality (CASI)

Across all the cases responses on the CASI (Kassay et al., 2015) pre-therapy, the *demand* irrational belief sub-scale obtained the highest score, apart from Moses' case where it was more or less equivalent to the *awfulizing* scale. *Awfulizing* was the second highest category followed by *low frustration tolerance (LFT).* The *demand* scores and *awfulizing* scores fell mostly in the moderate level category of irrationality. In two of the cases (Thabo and Moses) the *'LFT'* scale obtained the moderate level category of irrationality. *Other negative rating (ROW-O)* and *negative self-rating (ROW-S)* scores fell in the more-rational-philosophy-endorsed level of irrational beliefs across all cases. Two cases, (Thabo and Jonathan) both obtained the moderate level category of irrationality for the *total average for irrational beliefs.*

As stated, *demand* was consistently high across all four cases, the other evaluative beliefs varied in intensity across the cases and flowed from the demands, which supports the REBT (Diguiseppe et al., 2014) theory stating that the demand schemas are the main irrational belief from which the other evaluative beliefs flow (Diguiseppe et al., 2014). The other evaluative beliefs often qualified the demands and were more idiosyncratic to the cases. There were therefore common patterns across the cases that have implications for treatment discussed in the section on treatment (8.6.3) below. These results supported the discovery of the content of the irrational beliefs in the therapeutic process described below.

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8.3.2.1.2. The content of the irrational beliefs of the children

These irrational beliefs described below were identified during the process of therapy. Both commonalities and idiosyncrasies were noted in this process. The commonalities are presented here.

Demands

Across each case a demand for fairness was noted in the children.

'Life must be fair and if it is not fair, I must make it fair.' This corroborated the CASI (Kassay et al., 2015) results where the *demandingness* category attained the highest score across the four cases. The inferences associated with the demands were idiosyncratic to each case. What each boy inferred was unfair varied idiosyncratically.

Thabo: *'If I do not get my way it is not fair.'*

Moses: *'I often get into trouble and others do not and that is unfair,' 'Others do the same thing and get away with it and that is unfair.'*

Jonathan: *'He can perform better than me due to advantages and that is not fair.'*

Neo: *'If I get into trouble, it's because they pick on me, and that's unfair/wrong.'*

'They punish me because they don't like me and that's unfair.'

I must make it fair

The boys would not drop the demand for fairness and insisted on making the situation fair. The following examples illustrate this.

Thabo: This WILL turn out the way I want it [fair].

Neo: They were making a noise, and I shouted and told them to stop talking… mam wants to speak, and the teacher shouted at me…I needed to make a point…

Therapist: And what did you need to make a point for?

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Neo: Because it's not fair when I talk and they complain, but when they talk, I must just keep quiet [Neo was trying to make the situation fair for himself].

These demands led to feelings of anger and the accompanying disruptive, impulse control and conduct disordered behaviours would be persistent.

I must be the best/on top

This demand was noted in both Jonathan and Thabo's cases.

Jonathan: *'I must do well [be top] in everything that I see as my strengths.'*

Thabo: *'I must be top in things that are important to me such as body building.'*

Thabo's demand to be *"on top"* was related to negative self-evaluation when it was not met, because then: *"I am nothing."*

The same pattern of evaluation was noted in Jonathan's case: *'If I am not top in the things that I am good at or if others do not acknowledge me…if I do not do well - it may mean that I am not good enough.'* In Jonathan's case he also inferred that it was unfair if he was not the top as it meant others had an unfair advantage over him.

This confirmed the REBT (Diguiseppe et al., 2014) theory that the other evaluative beliefs are derived from demands. This demand and associated negative self-evaluation made these boys insist on being top and resulted in anger and frustration as well as aggressive behaviour and sulking when it was not met. In accordance with the REBT theory the negative self-evaluation flowed from the demand (Diguiseppe et al., 2014).

The demand to be a top achiever was evident in Neo's and Moses' cases in the form of the demand to meet others' expectations of them.

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I must meet expectations

Neo and Moses both demonstrated this demand but believed that they could not meet the expectations of their families, and in Neo's case both his mother's and teachers' demands. These boys were both from poor townships and experienced the expectations placed on them, to better their situations, as being unrealistic. Both boys felt the demands that they held for themselves in this regard were also difficult to meet. This could be idiosyncratic to the South African context where expectations of children to make use of new post-Apartheid opportunities and lift the family out of poverty, is high.

Moses: '*I cannot meet their expectations; it is too hard as they are too high.'* The resulting associated inferences were, *"they* [my family] *get disappointed easily* [if I do not do well]*"*; *"I am the different one* [in the family] *I am the top achiever."* This implied the demand, *'I must do well, or I will not meet expectations and they will be disappointed.'* This demand and associated inferences were related to sadness and anger. These expectations and internalised expectations in the form of the demand discouraged Moses. When he did not get a scholarship to attend a different school, he regressed behaviourally and started to skip classes. He would stay outside in the playground and sulk.

This same pattern was noted in Neo's case although the focus was on both academic achievement and behaviour. His mother Rumbi recognised her demands of him, but recognition did not prevent her from reverting to her patterns of withdrawal from Neo when he did not meet the expectation. Rumbi: *"I'm expecting too much from him…I expect more goodness from him* [than is realistic]*."* Neo's response to not meeting the expectations was: *"Let's say, that I'm behaving, she* [his mother] *thinks, mam, that I'm gonna stay like that forever, mam. Then the one-time, mam, let's say, mam, I make a mistake, mam; she will think that I've gone back to square one."*

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These expectations discouraged both boys: Neo: *"I'm always in trouble, so you feel, what's the use, 'cause eventually you will be in trouble again."* Neo believed that he could not meet the demands for behavioural compliance at home or school.

I must not be controlled/dominated

Three of the boys, Neo, Moses and Thabo, expressed the demand not to be controlled or dominated by others:

Thabo: *'They must not dominate me; they must not "disturb my will."'*

Neo: 'I must not be controlled.' "It feels like control."

Moses: *'I must not be seen as weak.'* This demand was idiosyncratic in expressions across the three boys. These demands led to anger and aggression towards peers and oppositional behaviour towards teachers.

Demands were prevalent across the cases and therefore reflected the CASI (Kassay et al., 2015) results. The commonalities across the cases were the demand for fairness and the inability to drop this demand to a preference which was accentuated by the demand to make things fair (Neo, Jonathan, Moses, and Thabo). The demand to be *"the top"* in things that were important, or things that they were good, at was noted in two cases (Jonathan and Thabo). The demand to meet expectations was evident in the two cases (Neo and Moses) where the children came from disadvantaged township areas. There was pressure to fulfil the expectations on them to better their situation and lift the family out of poverty. These boys also shared the demand that they should not be seen as weak or dominated. This demand could likewise be influenced by the violent context in which they lived. If you were seen as weak, others could take advantage. Even the content of the demands was seen to have commonalities. The context influenced the development of these demands.

The idiosyncrasies in the cases occurred in the evaluative beliefs and the inferences that qualified the demands for fairness. For example, the negative self-rating, evident in

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Thabo and Jonathan's cases, flowed from the demand '*I must be on top.'* The things that the boys believed to be unfair varied as indicated by the associated inferences such as Jonathan who inferred that it was unfair if he was not top as it meant others had an unfair advantage over him.

Other common evaluative beliefs

These beliefs mostly flowed from the demands above or other demands.

Awfulizing

The evaluative belief that awfulizes the situation was noted across three of the cases, but it was again idiosyncratic in the form it took. It was idiosyncratically qualified by the inferences.

Neo: *'it is the most awful thing to get into trouble, because it will have disastrous effect on my mother's health',* was idiosyncratic to his case. This was related to anxiety and the inability to take responsibility and admit his wrongdoing.

For Jonathan: *'being bored is the worst thing in the world.'* This led to feelings of frustration, and he would try to alleviate the feeling of frustration by disrupting the lesson, sharing his opinions and facts.

Thabo awfulized not getting what he wanted: If I do not get what I want *"the world will melt."* This led to anger. This made him insist on getting things his way through aggression and refusing to co-operate with either peers or authority.

In the sessions with Moses awfulizing was not evident and therefore not focussed on. However, it was apparent as a moderate score on the CASI (Kassay et al., 2015). The feeling of anxiety was not acknowledged generally in Moses' sessions. It is possible that the acknowledgment of anxiety would have been experienced as vulnerability. It was also

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difficult for Thabo to admit vulnerability. This was noted in his difficulty to admit feeling less than others and to admit the feeling of anxiety.

8.3.2.2. Parents

During the initial assessment and throughout therapy the following commonalities and idiosyncrasies in irrational beliefs were noted across the mothers. The number of sessions held varied. Mary participated in 26 sessions and two joint sessions with Jonathan, Thato participated in 10 sessions and one joint session with Moses, and Patience participated in four sessions plus one joint session with Thabo. Patience was engaged in the sessions and did not drop out of the process, but she often travelled for work which made it difficult for her to attend therapy. Rumbi participated in four sessions and was the only parent that terminated therapy early.

8.3.2.2.1. Revised Belief Scale for Parents

Considering the results on the Revised Belief Scale for Parents (PIBS) (Joyce, 1995) the two participating parents that had the higher irrationality showed the most significant changes. All the mothers' scores on the PIBS (Joyce, 1995) mostly fell within the range of moderately irrational to a high level of irrationality. Mary showed the least irrationality in the PIBS (Joyce, 1995). Mary was also familiar with therapy and what the process could offer her, whereas the other families did not appear to be previously exposed to this resource. In all therapy cognitions were explored to see which were contributing to the problem of impulse control and conduct disordered behaviours in the boys. Within the therapy sessions patterns of irrational beliefs were identified across the mothers. These irrational beliefs affected the way the mothers evaluated the behaviour of their children and responded to it. The demands related to a split in the parenting behaviours between strict/harsh and withdrawal versus lenient.

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Removing the boundaries to therapy encouraged attendance and engagement in therapy. Mary attended the most sessions and these were held at her place of work. This was followed by Thato. In her case sessions were held at the therapist/researcher's practice which was close to her place of work and home. The sessions were held after hours so that Thato could attend. The two parents that engaged in only four sessions had difficulty attending due to being busy with work. Rumbi, who terminated early had no transport of her own and worked night shift. Even though Patience was only able to attend four sessions (after the two screening sessions), she did show significant change.

8.3.2.2.2. The content of the irrational beliefs of the parents

Demands

Demandingness was a commonality noted across the parents. For example, Thato demanded that Moses should naturally know how to behave himself well. Thato: *"He should know better", I should not have to be spending energy* [on Moses' misbehaviour]", *"I should be left in peace."*

Rumbi, Neo's mother, had similar demands of him. '*He must behave at all times*', *"I'm expecting too much from him…I expect more goodness from him, that's why I withdraw when he does something wrong."* Rumbi would repeatedly say that she was tired, and that Neo knew *"I am not a well person,"* inferring that she should not have to spend energy disciplining him.

In these two cases the demands were similar regarding the boys' inherently knowing how to behave and that energy should not be spent on discipline. Recognition regarding this belief was idiosyncratic, Rumbi being more self-aware than Thato. In these two cases awareness did not affect outcome as measured by the PIBS (Joyce, 1995) and as experienced in sessions. The emotional consequence of these demands for naturally occurring good behaviour was anger, which was felt by both mothers. The initial anger was intense, resulting

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in the boys been disciplined in this anger. Behavioural consequences were that the mothers shouted and later withdrew from the boys as a means of punishment. As such, no effective disciplinary methods were administered.

Both Thato and Rumbi lived in the townships. Although both were employed, they struggled financially as single parents. Thato, Moses' mother, was in a better financial position than was Rumbi. Both had been brought up with a strict background although Thato's parents were abusive and harsh rather than strict. Thato's mother disciplined her in a similar way to the way in which she disciplined Moses, except that Thato shouted less and used withdrawal more often, according to her own report.

This demand for good behaviour to occur naturally was also noted in Patience: *'He must be a respectful child.'* If he was not respectful it resulted in anger and shouting at Thabo. In one of their joint sessions Patience told Thabo that the contingency rewards were just to help him as this is the way he should behave without rewards. This was the most common demand across parents.

The two parents, from wealthier backgrounds (Patience and Mary), had different demands that resulted in more lenient behaviours with regards to disciplining the boys. Patience, although from an underprivileged background herself, was now wealthy. Coming from the Apartheid era herself, the demand was for Thabo to be a *'free child'*: '*He is a free child, and this is why he expresses himself the way he does.'* This contradicted her own strict upbringing that was echoed in her demand, *'he must be a respectful child.'* The two conflicting demands, seemingly one coming from Patience's traditional background and the other from her current context, resulted in vacillating discipline that for the most part left her inactive regarding disciplining Thabo. She would express anger but not follow through with any effective discipline. Her emotional response vacillated between anger at Thabo or anger

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at those that were in conflict with him. Conflicted situations would usually result in her defending Thabo as a *"free child."*

Mary's demands were for her protection of Jonathan and his feelings. *'I must protect him from criticism/reprimand and or conflict; he must not stand alone'; "He must know that I care"; "No one should feel like this."* Mary's unconditional protection of Jonathan led to anger at those who were in conflict with Jonathan, including teachers. Jonathan experienced support rather than discipline. These demands emerged from Mary's past experience of being unprotected by her own parents and left to stand alone in the face of adversity and Mary's guilt regarding not being available to him when he was younger.

In both these cases the demands led to permissive behaviour although idiosyncratically expressed.

Other evaluative beliefs

Negative self-rating: "I am a bad parent"

This was noted in both Thato and Mary's cases.

Thato: *"I am a bad parent"*; *"I am not following through."* The emotional consequence of this was guilt and behavioural withdrawal.

Similarly, Mary believed: *"I am a bad parent", "Jonathan's problems are my fault."* '*If I do not know "where he's at" [understand him] all the time, this means I have not bonded with him due to depression and am a bad parent.'*

Other idiosyncratic evaluative beliefs and inferences were noted as associated with the disruptive, impulse control and conduct disordered behaviour such as: *'he must behave, or it means he will run in gangs and become a criminal'* (Rumbi). These were specific to the cases and are explored in the individual case study chapters.

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8.3.2.3. Teachers

The teachers were the most difficult level of the system with which to engage. The number of sessions held with each one varied. Two of the teachers Heidi and Rajesh engaged in a therapy process whereas Mbali did not. Rajesh engaged in 29 sessions while Heidi engaged in nine sessions. In Mbali's case there were no actual therapy sessions. The contacts mostly took place over the social media platform, WhatsApp, and consisted of feedback around the boys' behaviour for the previous week. Rajesh engaged in the most sessions and showed the most consistent change in scores out of the teachers. There was an insignificant decrease across all scores.

The teachers' patterns of evaluative beliefs were more idiosyncratic in sessions than the other two levels of the system, the boys, and their parents. This could have been due to the way in which I, the therapist/researcher tried to engage the teachers. I noted that the teachers became more engaged if I used the issues outside of the school context that were of importance to them to teach them the REBT (Diguiseppe et al., 2014) principles and techniques. Later, the patterns of irrational beliefs noted were related to the research questions around disruptive, impulse control and conduct disordered behaviour. In short, I, the therapist/researcher, experienced the teachers in this context as the least engaged with the problem of disruptive, impulse control and conduct disordered behaviour of the children. They did not initially perceive it as part of their responsibility. During the therapy process Heidi and Rajesh noted that their irrational beliefs were affecting their work. The two elevated scores on the TIBS (Huk et al., 2019) that were common across the teachers were the categories: *attitudes towards the school organisation,* involving demands to be involved in decisions that affected them, and *authoritarian attitudes towards pupils* category, involving demands for the children to be well behaved.

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8.3.2.3.1. Common irrational beliefs of teachers

Demands were noted from the two teachers who engaged in the therapy process. In sessions with Rajesh the demand to avoid conflict and the catastrophic predictions of the outcome thereof was addressed. Rajesh could have been upset by a situation yet reluctant to confront it. He was tolerant of the children's behaviour and the behaviours of others in his life due to his demand to avoid conflict.

Heidi's demand was to do all things well. This was triggered by the school context as well and specifically Jonathan's behaviour. She demanded all work related to her teaching role was to be done well. The content of the demands was more idiosyncratic as compared to the other groups although they were triggered by the boys with disruptive, impulse control and conduct disordered behaviour.

Other evaluative beliefs and inferences

As with the other levels of the system these demands were qualified by other evaluative beliefs and inferences that flowed from the demands. Flowing from Rajesh's demand to avoid confrontation was the catastrophic predictions of the outcome thereof.

Flowing from Heidi's demand to do all things well was negative self-evaluation: '*If I do not do things well it means I am not good enough.'* For example, when Jonathan interrupted her lessons, negative self-evaluation was activated and Heidi *"*[felt] *like nothing."*

8.3.3. Responsiveness across the system of irrational beliefs

REBT (Diguiseppe et al., 2014) addresses interaction and relationship intra-psychically (within the psyche) to change family situations and interactions. Although this model is intra-psychic it can be applied systemically. In this study the concept of responsiveness (Kramer & Stiles, 2015) was used to look at the relationship across the irrational beliefs between the different participants of the ecological case study. Thus, it was applied inter-psychically

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(reciprocal influences between psyches) to address the bidirectional influences acknowledged by the MST (Swenson et al., 2005) approach. This was done as part of the case conceptualisation, thought records were not shared across the different participants and the information was not shared. Family therapy sessions could be used to share this across systems if participants were willing.

The irrational belief patterns held by the members of the embedded pragmatic case studies were triggered by each other and were connected to behaviour that systemically held disruptive, impulse control, and conduct disorder in place. The irrational beliefs of each client were triggered by and responsive to the other irrational beliefs within the system. For example, Mary's negative self-evaluation: *"I am a bad parent"* was associated with feelings of guilt and Jonathan's behaviour would be excused as she believed she was to blame. Because she believed that she had been a bad parent, she did not want to jeopardize her relationship with Jonathan. She would allow him to explain things to her and, in effect, reinforced the problem behaviour. Jonathan would repeat this behaviour in the classroom even if he interrupted Heidi, his teacher. He expected the same reaction from Heidi as he received from Mary. His experience with Mary encouraged Jonathan's demand, "*I must be acknowledged."* Heidi could not stand the interruptions as they triggered her negative self-rating and irrational belief: *"I am nothing."* This in turn triggered Jonathan's own negative self-rating as his demand to be acknowledged was not met. Heidi's and Jonathan's negative self-evaluation of the same situation interacted at that same moment. Regarding contingency management, Jonathan was protected from consequences by Mary's belief '*no one should have to feel like this (when criticised) and stand alone*.' As Jonathan's classroom interruptions triggered Heidi's negative self-rating, she disciplined in anger and as she acknowledged she would sometimes *"go for him."* This in turn would trigger Mary's demand to protect Jonathan and he experienced no effective discipline for his misbehaviour.

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Similar interactive patterns were found in the interaction of Neo, Rumbi and Mbali. When Neo misbehaved, his mother (Rumbi) perceived him as reverting to square one regarding his misbehaviour. Rumbi's demand schema: he *'must behave at all times',* and the catastrophic prediction in the inference that '*…otherwise he will "go off track"'* was triggered by any misbehaviour. Any positive behaviour or change for the better disappeared from her conscious thinking through this evaluation. This, in turn, discouraged Neo from maintaining and persevering in any changed behaviours. In turn, Neo remarked that, *"…I think because many times I'll be seen as naughty, so sometimes it's like that you give up because, ah mam, I'm always in trouble so you feel, what's the use, 'cause eventually you will be in trouble again."* Rumbi recognised this demand: *I expect too much goodness from him,"* but insight was not enough to change her thinking and behaviour. Neo's teacher (Mbali's) phrase *"I can't be expected to…"* describes how this teacher saw the situation of disruptive children. She did not regard the behavioural problems as her primary responsibility. She would rather provide an atmosphere of learning for those who wanted to. Both Neo's mother and teacher disengaged from him when he misbehaved. Again, no effective contingencies were in place to address disruptive, impulse control and conduct disordered behaviour.

Both Thato and Rumbi held the demands regarding Moses and Neo that: '*they must behave well and be on top academically.'* The boys believed that the expectations were too high for them to reach. This demotivated both boys. Moses would feel sad and angry as it triggered his own evaluative beliefs, the inferred demand to meet expectations, and inferred frustration intolerance, and associated inferences: *"They get disappointed easily [if I do not do well]; "I am the different one [in the family], I am the top achiever."* He evaluated these expectations as too high so therefore he felt he might as well give up. These evaluative beliefs and associated inferences were active during the time that Moses' behaviour

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deteriorated again at school, and he started disengaging from the therapy process. He had, at this time, been applying for scholarships, none of which were successful. Although Moses did not acknowledge this as a trigger for his thinking that: *'It is too hard for me to be the top achiever that everyone expects.'* I, the therapist/researcher hypothesised that this did act as a contributing situational trigger. These demands: '*they must behave well and be on top academically'* demotivated the children. These high expectations were associated with the demands for *"too much goodness* (Rumbi)" *and "He should just know* [how to behave] (Thato)*"*, and were linked to these parents not taking responsibility for consistent discipline and contingency management around the boys behaviour. The boys had little support in a harsh context.

Patience grew up in the Apartheid era. Her demand regarding Thabo was: *'He must be a free child.'* His misbehaviour was evaluated through this demand schema. This encouraged the development of Thabo's evaluation: *'everything must go the way I want it, and if it does not this is unfair.'* He was an only child of wealthy older parents and he got mostly what he wanted. Discipline at home was inconsistent and again his will was not challenged by the school context as Rajesh did not want to confront for fear of catastrophic consequences.

The irrational beliefs of the boys in this study can be seen to be growing out of the contexts that they experience and linked to the irrational beliefs of the people in their context, their mothers, and their teachers, as well as the behaviours of those in their context. The various cycles fit together forming a coherent case conceptualisation. As stated by Burton and Leoschut (2013) and Wolhuter and Steyn (2003) within the school system there is a clear bi-directional, interactional effect between the behaviour of children and teachers. This bi-directionality was noted in the irrational beliefs as well. These irrational thoughts drove the behaviour. The irrational beliefs play off against each other. This emphasises the importance of working systemically.

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Applying a systemic framework to the application of REBT (Diguiseppe et al., 2014) adds to the understanding of the case conceptualisation and how the disruptive, impulse control and conduct disordered behaviour is held in place. There is a complex interactional system of beliefs that are responsive to each other. However, this knowledge was not shared across the groups due to confidentiality. A way of sharing this information in family therapy sessions could be useful.

8.3.4. Treatment implementation

Most of the REBT techniques described in the literature review (Diguiseppe et al., 2014) were utilised in all case studies. General therapeutic techniques such as Socratic questioning, summarising, reflection, and validation were used to explore each client's world. This helped to establish the therapeutic relationship by creating an understanding of and communication of this understanding regarding their beliefs and how these beliefs maintained disruptive, impulse control, and conduct disordered behaviour of the children.

Psychoeducation was used to initially explain the REBT (Diguiseppe et al., 2014) model, the connections between thinking, feeling and behaviour and other concepts. Client awareness, understanding and rational thinking was developed through induction and inductive interpretation. Induction, where the clients came up with their own disputations and alternate beliefs, was most effective. The clients used these resultant disputations and alternate beliefs most frequently between therapy sessions. This held even when the beliefs or disputations were not couched in technically preferred REBT (Diguiseppe et al., 2014) language as in the case of Neo. All three disputes were used across all the case studies: the pragmatic/functional, the empirical or reality testing, and logical dispute (Diguiseppe et al., 2014). The functional dispute was the most useful with the boys. Both evaluative beliefs and dysfunctional inferences were disputed. The order in which they were disputed depended upon responsiveness to the client.

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In this study homework assignments were given after most sessions and their completion contributed to a more successful outcome, which confirms the stance taken by Diguiseppe et al., (2014). It was difficult to engage most parents in the REBT (Diguiseppe et al., 2014) homework assignments. This was mirrored by Rajesh, the teacher. He likewise applied the concepts taught and completed the most homework assignments. Mary was the mother who engaged in the most therapy sessions and completed the most homework assignments. Rajesh was the teacher that showed the highest reduction in irrational thoughts according to the TIBS (Huk et al., 2019). All the children completed homework assignments regularly and this was useful to assess their understanding of the REBT (Diguiseppe et al., 2014) techniques and application thereof. As the barriers to therapy were removed by the therapist/researcher the homework assignments helped the clients to take active responsibility for the therapy process.

Commonalities in treatment approach across the different groupings of children, teachers and parents will be discussed here. Idiosyncratic treatments used with clients were explored within each individual case study chapter.

8.3.4.1. Children

Although all the disputes were used with the boys, the pragmatic/functional was the most successful. The pragmatic/functional disputes which used questions such as: '*where is this belief getting me*?' or '*Is it helping me or making the situation worse*?' worked well. This confirmed the experience of REBT practitioners (Diguiseppe et al., 2014). Due to the developmental stage of the children, early adolescence, and their general tendency to struggle to see things from another's perspective, this pragmatic disputation worked well. The empirical dispute was used frequently and was likewise experienced as effective. The logical dispute, although less used, was still experienced as effective. Generally, I the therapist/researcher, experienced that with this group it worked well to challenge the

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evaluative belief first and then later the inferences. Once the boys could drop the demand for fairness and trying to make things fair it was easier to accept that their inferences might not be true, such as: '*if I am not recognised then it's unfair*' or '*if I do not get my way then it's unfair.*' Accepting that life was unfair helped them to feel understood.

All boys were asked repeatedly to explain the REBT (Diguiseppe et al., 2014) model back to me or how they understood the disputations this helped to consolidate the concepts.

Some common disputations were used across therapy with the boys as even some content of the demands was similar. Regarding the fairness dispute it was sometimes useful for the boys to consider how life could also be unfair in their favour. They were generally intelligent children and sometimes to see unfairness as an advantage evened out unfair situations. The most effective argument was to consider how it would help them to demand that life was fair when it was not always fair and impossible to make it so. With this disputation the boys could drop the demand and change it to a preference as the demand did not get them to their goal to make life fair, it just frustrated them and got them into trouble.

Self-control as a means of gaining control was used with all the boys who demanded to be in control and not to have their "*will disturbed*" (Thabo). This demand was noted in Neo, Moses, and Thabo. Seeing self-control as a form of control that allowed them to control themselves as opposed to someone else having to tell them what to do, was appealing to all the boys. Although this worked within the demand framework for control, it offered a different way of thinking about it that was more adaptive.

Homework assignments were also useful for checking the understanding of the model, its application and reinforcement for practice. It was initially difficult to ensure that homework was done. Sweets, crisps, and chocolates were used as rewards in my own contingency management programme to encourage the completion of homework. This was

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effective as there was only one occasion (with Moses) where homework was not done after this was implemented.

Alternative functional/rational beliefs

As with disputations the most effective alternate beliefs were the ones that the boys developed themselves, attained through induction (Diguiseppe et al., 2014). Even if the alternate beliefs were not technically superior in terms of what would be considered the best to challenge the evaluative beliefs from an REBT (Diguiseppe et al., 2014) perspective, they were the alternate beliefs that the boys used most outside of therapy.

Jonathan would remember himself as '*Silent Witness'*, when recognising his own strengths. He did not drop the demand to be acknowledged to a preference in the moment, but he was able to be satisfied with self-acknowledgement. I, the therapist/researcher, worked within the demand to change his way of thinking to something more useful and flexible.

Thabo's most frequently used alternate belief outside of therapy was, '*the world will not melt*', despite the kind of irrational beliefs being challenged. Even demands would be changed to, '*the world won't melt',* if the demands were not met, as opposed to changing the demand to a preference.

Neo would use, '*I have tried, and I have improved.'* As with Jonathan he used self-recognition to help himself when others did not recognise him. He did not use the technically preferred way of changing the demand to a preference; *'I would prefer that they recognised me, but they do not have to.'*

The REBT (Diguiseppe et al., 2014) sessions did improve behaviour of these boys and gave them skills to help them to create new ways of thinking. Sometimes the technically preferred language and concepts were not used. The extent to which REBT (Diguiseppe et al., 2014) skills were acquired varied but all the boys acquired some skills that could be used outside of the therapy sessions. The many individual sessions held were demanding on the

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resources of the therapist/researcher and did not reach a large enough number of children. I was one therapist/researcher working in a populated school context. Some group sessions could have alleviated this problem to some extent.

Joint sessions with Moses and Neo helped them to generate ideas together and they sometimes encouraged each other in the classroom to apply the techniques learnt. They also provided a mirror for each other as to how their behaviour appeared to others in a way that they could accept and understand. For example, Moses noticed that he was able to communicate with the teachers better than Neo was, which allowed the teachers to recognise his efforts to change his behaviour and they then rewarded him accordingly. Neo then tried to communicate with Mbali. Mbali mentioned this communication to me in a feedback session confirming Moses' assumption. This suggested that there is a possibility that group sessions could be useful in the treatment of children with disruptive, impulse control and conduct disordered behaviour.

The influence of the context on the outcomes and process of treatment

The influence of the context on the boys as well as their own evaluative beliefs were noted. The evaluative beliefs of those around the children reverted quickly in both the school context and home context (e.g., Rumbi, Neo's mother) whenever the children misbehaved after a few months of improved behaviour. The Conners Rating Scales (Conners, 2007) results, although generally indicating improved behaviour post-therapy, showed less improvement than the verbal reports that were given on a week-by-week basis. This could be due to the normative group that the children were compared to. Three of the children were reported to have difficult classmates. The teachers could have also been influenced by the significant change in the boys despite their behaviour still being challenging.

The constant nature of evaluative beliefs was noted in Neo's and Moses' cases. The same teacher completed both boys' Conners Rating Scales (Conners, 2007). Her ideas of the

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boys remained constant in her verbal feedback despite, in these specific cases, the reverse being evident on her Conners Rating Scale (Conners, 2007). Neo was always evaluated as more problematic than Moses in verbal reports, whereas on the Conners Rating Scale (Conners, 2007) his behavioural change was represented as larger than that of Moses. Although both boys had a significant change in *peer relations* scale, Neo's improvements on other scales were generally greater. Neo's mother indicated this same consistency/rigidity of beliefs. Every time Neo misbehaved, she thought that he had *"gone back to square one."* This same pattern was evident in therapy sessions when she withdrew. The filling in of daily behavioural charts over time could have acted as 'evidence' for change in behaviour but it proved difficult to get teachers and parents to follow through on this practical recording of behaviour

Neo was the only case where increases in irrationality were observed post-therapy. This was noted in both the *awfulizing* and *low frustration tolerance (LFT)* sub-scales of the CASI (Kassay et al., 2015). This seemed to happen in response to his context where Neo was not recognised for his behavioural improvements. The context is deemed particularly important in working with youth and behavioural problems in youth (Swenson et al., 2005). Neo did not fully understand and generalise the REBT (Diguiseppe et al., 2014) concepts to the same degree as the other three boys. It would have been more difficult for him to apply the concepts across different contexts and situations outside of therapy. It was hypothesised that Neo could have been more dependent on his context as he was less independent in the application of the REBT (Diguiseppe et al., 2014) concepts, but the context did not change or engage in this case-study. Despite these issues Neo's irrational thinking still decreased in *demandingness*, *negative self,* and *negative other rating.* The irrationality score for *negative self-rating* decreased on a significant level. There were accompanying changes in behaviour, particularly in the scales of *peer relations, aggression* and *impulsivity.* These scales all

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decreased significantly as depicted in the Conners Rating Scale (Conners, 2007) results as given by Neo's teacher.

Other perspective taking

Other perspective taking was utilised to increase the children's cognitive flexibility so that they could consider how others may experience their behaviour. Although this disputing did not follow the accepted three REBT (Diguiseppe et al., 2014) disputations, at the completion of this process, the boys' thinking became more flexible and they were able to hypothesise different perspectives to the original inferences, that the situation was unfair. An excerpt from Jonathan's case indicates this change in flexibility.

Jonathan: It's [Jonathan's doodling in class] one of their triggers." [Jonathan shows understanding of the theory by using the correct terminology for REBT, indicating that skills had been learnt]

Therapist: Exactly Jonathan, well done, it's one of theirs [triggers] so you're looking at what in your behaviour would trigger them.

Neo also displayed a similar flexibility in response to Socratic questioning.

Neo: 'Cause mam, they don't know why I am smiling, they don't know what I'm thinking about, so mam, they expect the worst…

The joint sessions between Moses and Neo were useful for helping both boys to see from the teacher's perspective and thereby challenge the inference that when things were not going the way they wanted them to go, they were unfair. They started to recognise that their behaviour affected the teacher's behaviour, and that the teacher therefore may not always be unfair. The boys were encouraged to help each other identify what it was that was getting them into trouble in the classroom. It was easier for them to hear a different perspective from

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each other than it was from a teacher. They provided each other with evidence that other perspectives were not always unfair.

Other perspective taking was used to challenge the inferences that the situation was unfair. In Jonathan's case this was utilised to help him challenge the inference that people did not listen to him which meant that they did not acknowledge him, did not recognise his ideas, were being mean to him and therefore unfair. The technique of Socratic questions was used:

'*Are your classmates being mean or are they just not interested? Is the teacher being mean or is she frustrated with the interruption, or trying to keep you on track? What might she be feeling? Could she feel embarrassed? Could she be irritated by a child correcting her?'*

Through these questions Jonathan was asked to focus on how his behaviour of providing "*facts"* or correcting teachers could come across to others. Socratic questioning was used across all four cases as a technique in other perspective taking.

An excerpt from Thabo's sessions:

Therapist: …how would somebody else watching this see it? … when we brought in [Rajesh]...

Thabo: Well, if we had to get someone else, I think someone else will definitely see like anger between both people [Thabo and the girl he was having a disagreement with].

Other perspective taking proved useful across all the boys in challenging inferences around what they believed to be unfair.

8.3.4.2. Parents

Stallard (2005) claims that not much is known about the best way to involve parents in the therapeutic process. The parents in this study were difficult to engage. The general

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impression from parents was that behavioural change was the child's and therapist's work and that the child should be reacting differently. Thato: "*He should know better"* and Patience: *"you should be doing this anyway* [without contingencies]*."* The best way to increase the probability of parents attending sessions was to remove barriers to therapy found in the context as advocated by Multisystemic Therapy (Swenson et al., 2005) such as meeting them for sessions at their place of work or at the school.

Alternate beliefs and disputations

As with all clients in this current study all three disputations were used with the mothers of the boys. The functional and empirical disputations were most useful. The most common irrational belief was the demand that the child should just know how to behave. This was evident across three cases (Patience, Rumbi and Thato). Generally, the mothers were encouraged to drop the demand to a preference and Socratic questioning was used as in Thato's case study:

Therapist: How do you help yourself to lessen your anger so you can discipline effectively?

Thato: Drop the demand to a preference [Otherwise] I will just lose my temper.

The empirical disputation was used to normalise the boys' need for guidance regarding their behaviour:

Therapist: What evidence do you have that you can expect Moses to just know how to behave?

Thato: He is a 13-year-old boy and they often do not listen. Teenagers push boundaries, they all do it.

The answer was gained using inductive interpretation.

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The functional disputation was likewise experienced as useful:

Therapist: How will it help me to insist on not having to expend energy on Moses' discipline?

Thato: It will just lead me to lose my temper and withdrawal from him.

The following alternative belief was not technically preferred according to REBT theory, yet it served to lessen anger and encouraged more effective discipline in Thato's case.

Thato: I need to sort his behaviour out for his own good.

Less dogmatic alternative statements were used to change the demand to a preference: '*I cannot expect good behaviour to come naturally to a 13-year-old*.'

The negative self-evaluation, *'I am a bad parent'* was identified in two cases (Mary and Thato). An empirical dispute was used to make the thinking around negative self-rating more flexible to include elements of good parenting as indicated in Mary's case: Socratic questioning was used to develop the disputation.

Therapist: Where is the evidence that I am sometimes a good parent?

Mary: I spend time with him on weekends; [later] We have a good relationship and talk together; [later] I am the closest person to him.

In disputation around Mary's demands '*I must protect him from this criticism*' and '*he must not stand alone in the face of criticism especially if he feels bad*', Mary started to realise the effect that her demand was having on Jonathan:

Therapist: '*How will it help him to be protected from criticism?*' (Functional dispute)

Mary: '*It will not help Jonathan to demand that I protect him from all criticism or being in trouble.*'

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Again, the alternate beliefs used were not always the technically preferred version as dictated by REBT (Diguiseppe et al., 2014) therapy, yet still effective.

Mary's alternate statement was: *"My son will then not face any consequences."*

Other evaluative beliefs were idiosyncratic to each case and are discussed in the case study chapters.

8.3.4.3. Teachers

The initial challenge with each client in this research project was to engage them in the process that was offered but not requested or sought after by them. The responsiveness (Kramer & Stiles, 2015) shown to the teachers was to apply the general concepts of REBT (Diguiseppe et al., 2014) to a personal challenge that they were invested in so that they could attain something of personal worth from the therapy process. This way of working emerged as I noticed that teachers started to talk about their personal issues during sessions intermingled with the discipline problems of the children. In response to this and to build a therapeutic relationship I, the therapist/researcher, thought that the REBT (Diguiseppe et al., 2014) principles could be applied to these examples and then generalised to the classroom situations. This engaged two out of three of these teachers in this study, even though they did not initially see themselves as part of the problem behaviour of the children. They were able, with varying degrees of success, to apply these REBT (Diguiseppe et al., 2014) concepts to the school, their working context, when the therapy process focussed on the research questions. The approach also gave depth to the process as it promoted an understanding of the development of the irrational beliefs in each teacher's life and it emphasised how these irrational beliefs acted as schemas that influence different areas of their lives such as personal and work areas. This was particularly successful with Rajesh.

On reflection, the commonality amongst the teachers was the initial lack of recognition that the behavioural problems of the children were related to the school's general

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ineffective discipline and that their own irrational thinking could contribute to the behaviours of identified children. The two teachers that were engaged in this way recognised that their thinking impacted their disciplinary process as the therapy evolved. They entered an in-depth therapeutic process, but the method used to engage them became demanding on my, the therapist's/researcher's resources due to the number of sessions. I constantly attempted to balance the focus of the research questions, while remaining responsive to the teachers and engaging them around something of importance to them. As with the other clients/participants the alternate thoughts and beliefs that the teachers created themselves, through inductive reasoning, was most effective.

For example, Heidi reported that when the children misbehaved, she would think about the backgrounds of the children that were different from her own and sometimes harsh. This helped Heidi to change her demand for good behaviour to a preference. Although this was not worded in terms of the REBT (Diguiseppe et al., 2014) elegant solution, it was Heidi's own cognitive restructuring of her inferences associated with the demand and because it came from Heidi herself, it worked.

Both Heidi and Rajesh had a demand to do well or not to be criticised but there were idiosyncrasies around this demand due to the irrational evaluative beliefs associated with this demand. Rajesh entertained catastrophic predictions around the outcome of criticising and confrontation: *'I must not be criticised or blamed'; 'It is awful to be criticised or blamed as really bad consequences can occur.'* For Heidi, the demand was qualified by negative self-rating, '*If I do not do things well it means I am not good enough'*, so when Jonathan interrupted her lessons, negative self-evaluation was activated and Heidi "[felt] *like nothing."*

All disputes were used in both cases to attain a different, less dogmatic rational belief. Heidi's demands were challenged using a functional dispute: '*it is impossible to have everyone approve of me and do consistently well. To demand this will not help me*.' Heidi

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attained her own alternative reasoning for misbehaviour, as the child's background, as opposed to her not being good enough.

Rajesh used an anti-awfulizing statement: '*Confrontation and conflict is not the worst thing in the world and would not likely end in me losing my position as a teacher.'* Rajesh's alternate beliefs were technically in line with REBT (Diguiseppe et al., 2014) theory.

Pre-therapy beliefs affected treatment, for example, Heidi's inference about therapy, that at 74 she could not change, made it difficult for her to embrace the process of change for herself. Mbali thought that discipline of very difficult children was not part of her responsibilities, and regarding extra effort she could not be "*expected to"* engage.

Both Heidi and Rajesh were unsure of their discipline in the classroom. The contingency management education provided confidence and skills as to how to implement classroom discipline.

8.3.4.4. Contingency management intervention

Children with disruptive, impulse control and conduct disorder are described as punishment resistant (American Psychiatric Association, 2013). As they do not respond as the normal population of children, the consistency in discipline is most important. Contingency management was addressed in both home and school contexts. The contingency management was taught using psychoeducation techniques and included training in techniques such as praise and reward, limit setting and establishing behavioural expectations (Kazdin, 2000). Using REBT (Diguiseppe et al., 2014) techniques the

8.3.4.4.1. Home level of the system

Contingency management in the home situation was altered responsively (Kramer & Stiles, 2015) to fit the very busy lifestyles of these parents. All four children were asked to fill in their own charts. The parents were then only required to supervise and approve this once a

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week when rewards were decided on. The rewards and punishments were specific to the individual child and so the contingencies were created responsively. Even though the children filled in their own charts, the contingencies were not consistently applied. If the child did generally well, they were rewarded and if they were obviously misbehaved, they were punished. Monitoring and rewarding behaviours according to Kazdin's (2000) specific recommendations were not applied. The records, in the form of charts, to assist in monitoring and consistency did not happen. Thato said post-therapy: *"It is still applied (contingency management)…so I gave him a timeline to say I will fix it by end of September but if by then his behaviour is not sorted out he must just forget the phone."*

Patience: [referring to talking with Thabo] *"The reward you will get, I don't only look at the paper [chart],.. you can see I'm busy, I'm between my home and Cape Town,.. I look at your overall behaviour and I will give you the reward also when I want to give you… Now he said to me his watch is broken, I said, you know if you behave well, I will buy you another one. Because you know in the past, he will go to his dad and say, you know I need one, two, three and then his dad, without thinking, he will buy. Then this time around because we talk about it, he said; no Thabo, apparently there is some issues with your behaviour, you didn't do one, two, three so, I cannot buy you now, maybe later, prove me wrong and I will buy you one."*

This was the general way in which the 'contingency management' was adapted to the home environment. The parents became more aware of contingencies, but they were not consistently and specifically applied. Psychoeducation around contingency management (Kazdin, 2000) however did serve to raise awareness of the importance of it and that acceptable behaviour does not just happen with children, especially in the case of children with behavioural problems. The results of behavioural change do not generalise across contexts (Firestone & Witt, 1982). Due to this, school behaviours were included in the chart

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to help to reinforce what the teachers were doing in the home environment as well. Due to little communication between teachers and parents this remained theoretical only.

8.3.4.4.2. School level of the system

The three schools involved in this study used the demerit system as a means of discipline. This is a contingency management system with delayed punishment as opposed to immediate consequences for misbehaviour as suggested by Kazdin (2000). The schools therefore do not have effective disciplinary systems in place according to suggestions laid down by Kazdin (2000) who claims that consistency and clarity of expectations are necessary to ensure efficacy. Accordingly, the school's contingency management was not effective as reported by Mbali, Rajesh and the HOD in Rajesh's school. The demerit system works in cycles. Every so often the slate is wiped clean so the children know that they can attain so many demerits within a certain time frame and then no more. They then behave until the relevant amount of time has elapsed. Children can manipulate this system:

Mbali: [Referring to Moses] *"Anybody that's that smart, can work the system. He's working the system."*

Even the children criticised this system. Thabo thought that the demerit approach was ineffective. Neo could not remember what behaviours were responsible for his punishment when he eventually received detention. He also believed that the behaviours and expectations were not well defined as there were several codes to classify behaviours but sometimes behaviours did not fit the codes. This is likewise in contrast to research stating that behaviours and expectations should be well defined if contingencies are to be effective (Kazdin, 2000).

The struggles with disciplinary systems in South African schools are noted in literature (Burton, 2008; Burton & Leoschut, 2013; Jordaan, 2017; Marais & Meier, 2010) and supported by findings in this study.

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The school policies support the disciplinary process and must be signed by the parents to show agreement at the beginning of the school year or when the child begins schooling at the institution. Any change in disciplinary procedures needs to be written into policy and agreed upon by parents, and any change is therefore a process. This made it difficult to try and implement change in behavioural management at the schools during this study.

During this study I tried to involve the children in brainstorming around more effective techniques. Thabo suggested break detention. This technique was added to his school's contingencies by the HOD at his school and it was expected to be effective, as it fit with Kazdin's (2000) findings regarding the efficacy of immediacy. After implementation of break detention, informal reports from the teachers claimed that it was an effective measure. However, the staff also need to be willing to implement this. The HOD of Thabo's school was willing to implement this change. In the other two schools the proposal did not gain support. Moses and Neo's teacher, Mbali, believed that it would not be fair towards her to be involved in disciplining children from other classes. In Heidi's school the teachers were likewise reluctant to give up their break time.

The importance of contingency management was noted on the six weeks follow up post-therapy in both Thabo's and Neo's cases. The principals of the schools believed that the boy's behaviour had deteriorated. In response to a specific incident each boy was given a consequence. Thabo was involved in leading the voicing of complaints about a teacher who was later fired, and Neo was believed to have reverted to disrespect again. Thabo was suspended and Neo was threatened with not being allowed to attend his grade seven year-end function. After these consequences were administered, both boys were reported to be well behaved again. On termination of therapy, it seemed that the boys were now more responsive to contingencies than they were pre-therapy.

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The REBT (Diguiseppe et al., 2014) approach was useful for changing the behaviour of the children represented in these four case studies to varying degrees of success. There was a general decrease in the behavioural scale and irrational belief scale scores, some of which were significant. It was hypothesised that if the children understood the concepts of REBT (Diguiseppe et al., 2014) and could have applied the approach themselves, it would ensure greater and more sustained change than if they could not. The cases of Neo and Thabo suggest that despite difference in the understanding of the REBT (Diguiseppe et al., 2014) approach and application thereof between these two boys, this element did not seem to reduce the importance of contingency management in either case. Thabo understood the REBT (Diguiseppe et al., 2014) concepts and application thereof and showed the greatest change in the CASI (Kassay et al., 2015) irrational belief scores, yet contingencies were still necessary. Neo showed the least understanding of the REBT (Diguiseppe et al., 2014) concepts, and the contingencies were similarly necessary. Neo's irrational belief scale, however, showed erratic change while Thabo's change consistent decrease in irrational thought. Significant behavioural changes in both boys were noted as measured by the CASI (Kassay et al., 2015).

8.3.4.5. Responsiveness

Responsiveness (Kramer & Stiles, 2015) was achieved through the systemic framework through which therapy is made accessible by removing boundaries (Swenson et al., 2005). Responsiveness forms part of the feedback loops emphasised by Peterson (1991) in case study research. Client and therapist respond to each other as the therapeutic process evolves. In this study the therapy was conducted at the school itself. This was to encourage attendance as the parents did not have to find transport for the children to and from therapy and there was no cost involved regarding this. Sessions occurred during times that the children were in unimportant classes that they could miss or during part of their break times. Sessions with the teachers were also held at the school to facilitate accessibility to sessions and they were

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carried out at times when the teachers were free. The parents were seen at the school when they dropped off or fetched the children. Sometimes they were seen at their place of work.

A central feature of the ethical practice of psychotherapy is the responsiveness of the therapist to the client. Responsiveness happens in moment-to-moment instances of micro-interactions during therapy (Stiles et al., 1998) referred to by McLeod (2010) as micro ethics where, for example, the therapist notes and responds to such things as a client's non-verbal expression. For example, a softer tone was used in the session with Rumbi when she became defensive over Neo's behavioural relapse.

The REBT (Diguiseppe et al., 2014) therapy framework was itself was used responsively. The order in which irrational beliefs and inferences versus evaluative beliefs were challenged, depended on how the client responded. The boys' demand for fairness was challenged first and later the inferences about what it was that was unfair. In Jonathan's case interest in superhero's emerged over time. This idiosyncratic interest was used to engage him in the therapy. The metaphorical style was used as a way of working with him and served as a vehicle to represent the REBT (Diguiseppe et al., 2014) concepts and make them accessible to him.

Heidi's and Rajesh's stressors were outside of the specific research aims. Focusing on these personal stressors established the therapeutic relationship and engaged them in applying the REBT (Diguiseppe et al., 2014) theory and techniques to aspects that they were invested in. The irrational beliefs appeared in patterns such as Heidi's negative self-rating, if she thought she was not doing well, and Rajesh's demand to avoid confrontation. These patterns were found across different contexts and could therefore be applied to the work situation as well.

Responsiveness (Kramer & Stiles, 2015) was also used with the parents by altering the contingency management programme. Here the boys were required to manage their own

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charts as the parents had limited time at home. The contingency management rewards and punishments were tailored to the children's personal preferences and dislikes.

Therapist responsiveness involved more than just adapting techniques to make them meaningful and acceptable to clients (Edwards, 2010). Meta-competencies (Roth & Pilling, 2008) are used in making strategic decisions in a coherent and responsive manner (Edwards, 2010).

Responsiveness (Kramer & Stiles, 2015) was used where each client established idiosyncratic goals that developed collaboratively. This helped to bring direction to the overall process. The REBT (Diguiseppe et al., 2014) theory and concepts provide a coherent framework that integrates the information given and directs the understanding of this information into a coherent whole. As the focus of REBT (Diguiseppe et al., 2014) is the identification of irrational beliefs the theory directed the process to the identification of these common patterns across contexts. So, the clients' goals and research goals could be unified through the identification of and challenging of these patterns, whilst addressing individual goals and needs.

8.3.5. Evaluation

The following changes were noted in the self-report and behavioural scales pre- and post-intervention. The scales were used to assess the participants across the different levels of the system. The reliable change index was used to asses the statistical significance of the results.

8.3.5.1. Children

Overall changes were found across the CASI (Kassay et al., 2015) and the Conners Rating Scales (Conners, 2007). The CASI (Kassay et al., 2015) scores showed a general trend in the reduction in irrationality. Likewise, the Conners Rating Scales (Conners, 2007) showed a decrease in behavioural problem indicators. Thabo made the largest overall changes on the

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CASI (Kassay et al., 2015), indicating the largest reduction in irrational thinking Jonathan was second. Although corresponding behavioural changes in his Conners Ratings Scales (Conners, 2007) were noted, they did not appear to be necessarily proportionally correlated. It is also possible that some boys such as Thabo had a good understanding of the theory and knew how to apply it, he could academically answer the questions on the CASI (Kassay et al., 2015) rationally, but without applying it adeptly in everyday situations to change behaviour. Nevertheless, behavioural problem indicators did show a declining trend on both his parent's and teacher's Conners Rating Scales (Conners, 2007) in Thabo's case.

Neo's perception that the teachers were harder on him than on others was supported by the results on the teacher's Conners Rating Scale (Conners, 2007). The same teacher filled in Moses' Conners Rating Scale (Conners, 2007). Neo showed generally greater change than did Moses on this scale; Neo receiving significantly decreased scores, according to the RCI found in appendix K, for *peer relations, hyperactivity/impulsitvity* and *defiance and aggression,* yet Moses' change in behaviour was recognised before that of Neo's and continued to be recognised throughout the process. Moses received no significant decreases in the Conners scores (Conners, 2007) although the score for *peer relations* was just under the significant level. The scores did reduce non-significantly according to the RCI found in appendix K. Neo's verbal reports, given by his teacher, were not as positive as that of Moses, yet he made these measured changes on the Conners Rating Scale (Conners, 2007) as filled in by this same teacher. Neo's mother dropped out of therapy when he first got into trouble at school during the therapy process. Neither Neo's mother nor his teacher recognised his behavioural changes, and this discouraged him from maintaining change. Neo's rise in the *low frustration tolerance (LFT)* score on the CASI (Kassay et al., 2015) could have been influenced and triggered by this context. This rise was not significant according to the RCI found in appendix J.

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Neo did not demonstrate the greatest insight into the REBT (Diguiseppe et al., 2014) theory as compared to that of the other cases. Despite this lesser understanding and application of theory, Neo exhibited the greatest number (3) of significant changes in behavioural problem indicators on the Conners Rating Scale (Conners, 2007) according to the RCI found in appendix K. Out of all the cases, Neo was the most motivated to change because he did not want to stress his mother because of her illnesses. I would hypothesise that motivation played a large part in Neo's change: *"but on that day, mam,*[the day his mother became ill] *I knew that I must play my cards nice."* Change is not only due to the understanding or application of theory; the idiosyncrasies of the child, such as motivation, also impacted change. However, Neo did have some insight into REBT (Diguiseppe et al., 2014) and used his own alternate ways of thinking even though it may not have been the technically preferred way of presenting it.

With regards to Moses, Jonathan and Thabo, the teachers' verbal reports gave a more positive description than did the teachers' Conners Rating Scale scores (Conners, 2007). Rajesh said that while Thabo still showed attitude, he no longer got into physical altercations or answered back. The *hyperactivity/impulsivity* score on the Conners Rating Scale (Conners, 2007), as filled in by Rajesh, reduced significantly according to the RCI found in appendix K but some levels remained a concern even though they reduced. Moses' teacher claimed that his *aggression* had improved to that of normal levels. On the Conners Scale (Conners, 2007), filled in by this same teacher, the *aggression* score decreased, but insignificantly according to the RCI found in appendix, it was still in the high average range. It could be that the teacher was happy with his improvement or that this was a normal level of aggression for this difficult class. Jonathan's teachers verbal reports and Conners Rating Scale (Conners, 2007) set of scores appeared congruent. In Moses and Thabo's cases the parents recognised more of a change than did the teachers.

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The general trend on the CASI (Kassay et al., 2015) and corresponding Conners Rating Scales (Conners, 2007) support that the REBT (Diguiseppe et al., 2014) therapeutic process, applied systemically, did assist in the increase of rational thought in the boys that brought about a corresponding decrease in problematic behavioural indicators as measured by the Conners Rating Scales (Conners, 2007) and verbal reports of those in the child's system (mother and teacher). The REBT (Diguiseppe et al., 2014) approach, systemically applied, was considered effective to varying degrees with these cases. There was a general trend of decrease in problematic behaviour and irrational thinking even if these results were not all significant. The greatest changes in irrational beliefs did not necessarily result in a proportional decrease in behavioural problems. There are many more factors such as motivation and contextual factors in the system that influence behavioural change in the child. The REBT theoretical constructs, although effective, are limited in the explanation of the complex interactions that comprise the therapeutic outcome and process. The inter-psychic application of the REBT (Diguiseppe et al., 2014) approach as demonstrated in the section tilted *Responsiveness (8.4.3.5)* adds to the understanding and case conceptualisation of the various factors that influence behavioural change. The problems of conduct disorder and oppositional defiant disorder are resistant yet responded to this treatment even when changes in the context did not occur. The larger changes in both thought and behaviour occurred mostly in initial higher scores. The parents generally recognised more change in the children than the teachers did.

8.3.5.2. Parents

According to the results on the PIBS (Joyce, 1995) this is the group that made the most significant changes in cognitions when they engaged in therapy. In sessions cognitions were sought that could be contributing to disruptive, impulse control and conduct disordered behaviour of children. Mary had the most sessions (28) including two joint sessions, and had

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attended therapy before, so she had previous knowledge of the benefits of it. She showed the least change in irrational beliefs but irrational thoughts regarding *self-worth* decreased significantly according to the RCI found in appendix H. She believed (pre-therapy) that Jonathan's behaviour was her fault because she had not bonded with him due to depression and was therefore a bad parent. Mary's scores showed less irrationality pre-therapy compared to the other mothers. Self-worth showed the highest level of irrationality pre-therapy. Thato showed a significant reduction in *frustration intolerance* around not being able to stand Moses' misbehaviour as well as a non significant reduction in the *demand* that he should know better without any intervention according to the RCI found in appendix H. All the other scores on the PIBS (Joyce, 1995) reduced significantly according to the RCI found in appendix H. Thato attended the second highest number of sessions (11) including one joint session. Patience only had four sessions but all scores on the PIBS (Joyce, 1995) reduced significantly according to RCI found in appendix H. Rumbi dropped out of therapy early and so had no post-therapy scores.

The PIBS (Joyce, 1995) results were supported by the sessions held with Mary, Thato, and Patience in that the beliefs apparent on the scale, were apparent in therapy. The reduction in these beliefs on the PIBS (Joyce, 1995) scores were likewise noted in sessions.

8.3.5.3. Teachers

The results found on the TIBS (Huk et al., 2019) showed the least change in irrational beliefs. Two of the teachers, Rajesh and Heidi, were engaged in the process. Rajesh showed a clear reduction in irrational thought although these were insignificant according to the RCI found in appendix H. Heidi and Mbali showed some reduction in irrationality and some increase, yet Mbali did not participate in a therapy process.

My clinical experience of Rajesh in the sessions was that he was engaged, and he reported that the sessions had personal significance for him. He was able to generalise the

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patterns of irrational beliefs, evident in his current personal crisis, to his work situation. As sessions progresses the patterns of Rajesh's irrational beliefs were identified, and he noted how they were affecting his work. Rajesh: *'I don't like confrontation…and it filters through to my work and stuff…'* Rajesh's scores decreased across all scales. *Self-downing* decreased just under significance level. Although the irrational beliefs as represented on the TIBS (Huk et al., 2019) were not always directly addressed in therapy, it is evident that in Rajesh's case he was able to generalise and apply the theory to other situations, so there was a general decrease in irrational thought. He engaged in 29 sessions.

Heidi's results on the TIBS (Huk et al., 2019) were varied post-therapy. She had nine therapy sessions. The *self-downing* scale increased significantly in irrational thought post-therapy according to the RCI found in appendix I. Irrationality detected in the *low frustration tolerance (LFT)* scale reduced non-significantly post-therapy. *Attitudes towards the school organisation* scale, that indicates wanting to be involved in decisions that affected her increased insignificantly in irrationality post-therapy. The *Authoritarian demands* scale for discipline decreased in irrationality insignificantly post-therapy. The RCI significance levels are found in appendix I.

Heidi reported that although she understood the disputations used in sessions, it was difficult for her to believe them *"in that moment."* From this it would seem, that although she understood the concepts, she had not yet embraced the alternative way of thinking especially regarding more core, rigid evaluative beliefs and demands such as *self-downing*. She also had the belief that at 74 years of age she could not change which made it difficult for her to embrace the process of change for herself.

Regarding *low frustration tolerance (LFT)* the belief that Heidi could not stand Jonathan's interruptions was addressed in therapy, so this changed score on the TIBS (Huk et al., 2019) mirrored the therapy process. The decrease in *authoritarian attitudes towards*

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pupils was mirrored in therapy in that Heidi changed her evaluation of the children's misbehaviour during the therapy process. She believed that the children's context was different to her own and sometimes harsh. This was now how she evaluated the misbehaviour as opposed to using *self-downing*. The *self-downing* score, however, showed an increase in irrationality. *Self-downing* was resistant to change, and the tension filled school context triggered the demand to be involved in decision making, *attitudes towards the school organisation,* regarding her work situation. The elevations in irrational thinking in these two scores seemed to be in response to increased contextual triggers with resistant irrational beliefs. It takes time to practice change in irrational beliefs before rational alternatives can be believed in that moment.

Mbali believed that the behavioural problems in the classroom were not her responsibility. She was there to teach those who were interested in learning and to provide a context where this was possible. The statistically significant decrease on the TIBS (Huk et al., 2019) ,according to the RCI found in appendix I,was in *attitudes toward the school organisation* scales, and *authoritarian attitude* also decreased but not significantly. *Demandingness* and *low frustration tolerance (LFT)* increased although not significantly according to the RCI found in appendix I. The average scale for irrational beliefs decreased but not significantly. Mbali was disengaged from the therapy; she believed that she *'could not be expected'* to change the behaviours of the child. I, the therapist/researcher, hypothesise that the change in score occurred due to awareness of how the questionnaire should be answered, as opposed to any change in thinking. The extreme scores were explained to Mbali when attempts were made to engage her in therapy. The 'sessions' held, however, consisted of feedback about the boys' behaviour. Mbali's case again indicates that knowledge of how to answer questions on the irrational belief scales can produce significant change in scores without the corresponding change in thought.

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In summary, the commonality across the teachers' TIBS (Huk et al., 2019) was elevated scores in *attitudes toward the school organisation* and the *authoritarian attitude* scales. The *attitudes toward the school organisation* scale could reflect the experienced disunity from the teachers towards the school as a wider system. The way in which I engaged the teachers was to use their personal problems to show them how to apply REBT (Diguiseppe et al., 2014) to irrational thinking. Some of the school organisational topics were not addressed in therapy. It could be that the teachers were not effective yet in applying the REBT (Diguiseppe et al., 2014) techniques outside of the therapy sessions or generalising the techniques to other situations. The teachers' progress in therapy depended on their motivation to be involved, and their pre-therapy irrational beliefs about change and responsibility also affected the therapy progress. Rajesh was both motivated and receptive to change and he showed the biggest change from irrational to rational thought. As with all clients inductive reasoning appeared to be the most effective technique in creating alternate beliefs.

8.3.5.4. Maintenance of change

I contacted the schools about two and a half months after therapy was terminated with respect to all the cases. Verbal reports were obtained from Moses and Neo's principal. Their teacher, Mbali, did not respond. Neo's behaviour deteriorated post completion of therapy. I would hypothesise that this was due to the discouraging context and that his context did not engage in the process of maintaining his good behaviour. Furthermore, Neo was not as efficient in using the REBT (Diguiseppe et al., 2014) model for himself as compared to the other boys. Neo would have been reliant on effective contingencies to manage his behaviour. The school threatened to not allow Neo to attend the end of year function; and after this, his behaviour again improved, and remained improved to the date of contact. Through therapy it seemed that Neo was now responding to contingencies. The REBT (Diguiseppe et al., 2014) approach was useful for changing Neo's behaviour. If he could have applied the approach himself, and

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if his context was engaged, I, the therapist/researcher, would hypothesise that Neo would have made greater and more sustained change. However, a similar pattern was noted in Thabo who could apply the model. The principal complained about his behavioural deterioration post-therapy; she cited a particular situation. Again, after the disciplinary hearing Thabo's behaviour had improved. These two cases indicate the importance of contingencies in the remediation and maintenance of appropriate behaviour, and both indicated that the boys responded to contingencies quicker than they did pre-therapy. In the case of Jonathan and Moses behaviour was reported to have both improved and maintained post-therapy.

Sometimes the teacher's opinions of the children were difficult to change, particularly if they had no REBT (Diguiseppe et al., 2014) therapy sessions for themselves, as seen in Mbali. This lack of recognition could demotivate the boys to maintain change, as was noted in Neo's response during therapy: *Neo; "I'm always in trouble, so you feel, what's the use, 'cause eventually you will be in trouble again."*

The parents acknowledged the change in the boys' behaviour more readily than the teachers did. The only parent that did not acknowledge change was Rumbi, Neo's mother. Her beliefs around Neo remained rigid. Mary, Patience and Thato all acknowledge change verbally and in the Conners Rating Scale scores (Conners, 2007). They were generally more invested in the children and their behavioural change than the teachers were. They retained an awareness of contingency management and applied it in a general unstructured way post-therapy.

The effectiveness of community-based interventions is reported to be less successful than control studies conducted outside of real-life situations (Scott, 2008). However, this REBT (Diguiseppe et al., 2014) approach was effective to varying degrees across all the

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children, two of the teachers and three of the parents, as indicated on the irrational belief scales, behavioural scales and as experienced in therapy.

8.4. Strengths and Weaknesses of the Study

The strengths and weaknesses and how they were addressed is described in the following section.

Practical emphasis

The strength of this study is the emphasis on the practical application and process of a systemically applied evidenced based treatment (REBT and contingency management), for disruptive, impulse control and conduct disordered behaviour in children living in South Africa. This makes the findings relevant for clinical application in naturally occurring settings (Edwards, 2018). Albert Ellis always maintained that there needs to be further investigation into the important contributions that REBT (Diguiseppe et al., 2014) can make with children (Bernard, 2008). This study investigated some of those possible contributions and what they could look like. Questions such as what worked in the therapeutic process, what was unhelpful, and other contributing factors were considered in the practical application of REBT (Diguiseppe et al., 2014) therapy and contingency management. The commonalities and idiosyncrasies across cases were discussed. All these discussions are relevant for clinical practice.

The study also addressed whether the implementation of the systemically applied evidence-based treatment (REBT), that works in other situations, works specifically to address disruptive, impulse control, and conduct disordered behavioural problems displayed by children in the South African school context with typically referred children. As the intervention is applied across different levels of part of the child's system the design is a strength when dealing with disruptive, impulse control and conduct disordered behaviours as

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the disorders are multifaceted and influenced by many contextual factors which requires such a wide approach (Burton, 2008; Burton & Leoschut, 2013; Swenson et al., 2005).

Credibility

Research requirements of rigour of credibility, reliability and confirmability are met as described in Chapter 3 of this study. The shortcomings in the credibility of results are that the analysis and interpretations were initially carried out by one person which was the therapist/researcher, and only later discussed with an REBT consultant. Even though some tapes were reviewed, most of the analysis was done by one person (Fereday & Muir-Cochrane, 2006). This was countered by sharing the interpretations with the clients to see if they agreed with them and grounding the case studies with direct quotes. The academic supervisor also later interrogated these interpretations through the supervisory process.

Lack of rigorous control

The strength of the study is also its weakness. It is difficult to attain experimental control in applied clinical contexts, although this fact of lack of control does mirror the therapeutic process in natural settings. The pragmatic case study design helps to attain some control with its structured guidelines (Fishman, 2013). The design is a strength in that it imposes rigour and structure to the natural process. Rigour was fostered by the bi-monthly consultation with an REBT therapist, and the psychometric tests used to measure change in behaviour and thinking.

Behavioural charts were introduced, but this was not completed consistently and accurately over time as the researcher/therapist intended, despite the revision to simplify them. The rigour required for any meaningful statistical analysis of these charts was not achieved. This also mirrors the real-life situation that practitioners face. Although the charts raised the parents' awareness of the usefulness of contingencies, these contingencies were

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applied in a general fashion during and post-therapy up to a period of two months. The same outcome was noted regarding the teachers. General feedback about behaviour was given verbally or via WhatsApp (texting app) because over time, the filling in of charts was just not attained. This weekly verbal/WhatsApp feedback acted as a general indicator for me, the therapist/researcher, as to how the children's behaviour had been for that week, but again, the information was not detailed and rigorous enough for meaningful statistical analysis. This happened despite adjusting the form of the chart and the way it was administered as a means of making it easier.

Clash of paradigms

Initially the much-discussed clash of paradigms in literature (Bryman, 2007) was noted in the process of the design of this study. The host university came from a quantitative orientation and as such quantity was important. Following this, the number of case studies carried out was more than was required. Bi-monthly verbal consultation with the REBT specialist added to rigour but supervision through verbal discussions is less rigorous than those involving recordings of the sessions. Although some recordings were reviewed, if there had been fewer case studies, more tapes could have been reviewed.

Demand on therapist's resources

Systemic interventions require multiple resources, time, and effort on the part of the therapist/researcher (Swenson et al., 2005). Due to this the case load of a systemic family therapist is approximately three to five cases per therapist at any one time, compared to four to six in the USA. The difference in number is due to the USA having longer working hours compared to that of Europe. The data gathering for systemic intervention is extensive. This produces a process that is demanding on the therapist's resources of time and finances within the South African context where support such as research grants is limited.

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Lack of co-ordination

The lack of co-ordination and unity in the SA context detailed in literature (Eagle, 2015) was evident in this study. Engaging all the participants/clients was demanding. The parents were generally difficult to engage as noted in literature (Stallard, 2005). The teachers were likewise difficult to engage as they did not regard this as part of their work. Engaging co-operation across the various system and across individuals within the levels of each system was difficult. Both parents and teachers initially understood the problem as residing wholly in the child; or from the teachers' perspective, residing in the child and parent; and from the parents' perspective, residing in the teacher and the child. Getting everyone to work together proved to be a challenge. As I, the therapist/researcher only worked closely with one teacher and a few gatekeepers, the general school system was not aware of the project, the approach, or its possible contribution.

Regarding the problem of disruptive, conduct disordered and impulse control behaviours, the problem is accepted as resistant to treatment (American Psychiatric Association, 2013). The children in this therapy process were not self-referred and therefore often difficult to engage in the process, to motivate to monitor behaviour and to do homework which is likewise demanding for the therapist.

Utilisation of the case study method requires both research and clinical expertise. If this is not available at the host university a level of co-ordination around the different inputs from consultants is required for the efficient and expedient completion of the case study process. More co-ordination across the expert consultants could have enhanced the expedient completion of this study.

Restricted awareness

Although the intervention was applied at different levels of the child's system, only one or two teachers from each school was involved. The intention was to incorporate a few

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participants for a pilot study, the emphasis being placed on process and what worked, or not, and influencing elements in this process. The school community as a whole was not involved. This worked well as a way for a single researcher/therapist to manage the large amounts of data gathered by reducing the number of people involved. However, this had a detrimental effect regarding awareness of the research at the sites where it took place. Due to lack of awareness, there were often interruptions during the sessions, as most staff did not understand the therapeutic process, or that I was a psychologist, or even what a psychologist does. I sometimes had to move to a different office in the middle of a session or I was offered a public place, such as the library, as an alternative. Possible ways of combatting this are described under '*A wider awareness'* (8.9.2.1) below.

8.5. REBT Theory and Approach Limitations

The REBT (Diguiseppe et al., 2014) theory did require a lot of repetition for the clients to understand and to use the techniques outside of the therapy. The concepts were not always easy for the clients to understand and utilise. Sometimes the preferred technical REBT theory and wording was not always used by the clients. As in the case of Thabo he used "*the world will not melt"* as an alternate belief for many of his evaluative beliefs, not just awfulizing.

Neo was the boy in this study who struggled to understand some of the REBT (Diguiseppe et al., 2014) concepts and techniques. He was not weak academically but more of a concrete thinker compared to the others. He also had the weakest command of English. In this small sample, the ability to use the theory was optimal in those with the strongest academic ability and abstract thinking ability. This suggested that application of this approach could be less effective in those with less academic ability and more concrete cognitive thinking. Conversely, understanding the theory did not always bring about expected corresponding behavioural change. For example, Rumbi had insight into her demands but no

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corresponding behavioural change. Neo made some significant behavioural changes without the corresponding change in irrational thinking.

It was sometimes difficult to describe everything that happened in therapy in REBT (Diguiseppe et al., 2014) language and concepts, as was noted by Diguiseppe et al. (2014). Challenging irrational beliefs did not always fit into the three disputations. For example, other perspective taking in the therapy was used as a successful technique for challenging. This technique encouraged more flexible thinking and challenged negative other rating but took the form of general discussion. Joint sessions between Neo and Moses were used to help the boys to see how their behaviour appeared to others. The sessions were used as evidence that others could have a different perspective of the boys' behaviour to that of their own.

There seemed to be a hierarchy of importance within the different categories of beliefs and demands not mentioned in theory. Sometimes one demand appeared dominant over others. Patience had two conflicting demands; '*he must be a respectful child'* and *'he must be a free child.' 'He must be a free child'* seemed to win over the other demand in situations that occurred around Thabo outside of the home. The combination of the different evaluative beliefs as well as the inferences would qualify the idiosyncratic form that these demands, and evaluative beliefs took. For example, the boys all had a demand for fairness, yet the inferences qualified what they believed to be unfair.

The simplistic nature of the theory however was why it was chosen as the approach of this study. I believed that it would be easier to educate the clients in this theory. Most participants did have the capacity to understand the theory.

As a pilot study this research provided useful information as to the process of this approach and what could be done to help alleviate some of the problems encountered as well as how to frame further research.

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8.6. The Scales as Applied to this Study

All of the scales used in the study were not standardised for a South African population. Due to the idiosyncratic nature of case studies standardised tests are not considered a prerequisite (Edwards, 2018). Standardised tests for South Africa however are needed generally, and if available, would have added to the rigour of the study. One of the mothers commented that the language contained in the PIBS (Joyce, 1995) questionnaire was extreme. Huk et al., (2019) noted that subtle language differences made a difference in item discrimination between Australian vs USA contexts. As well as variations in the English language, the diversity of language in the South African context would make the standardisation of tests a complicated process. Nevertheless, the scales used, as they were, were experienced as an effective clinical screen. Most of the irrational beliefs evident in the scales were confirmed in therapy.

There is a possibility that the scales may sometimes present low scores of irrationalities, as there is a difference when automatic thoughts happen on a preconscious level in the moment, compared to in the calm reading of these thoughts while answering a test. As Heidi noted, in the moment, she could not believe what she acknowledged in the therapy sessions. In the moment irrational thought would surface. The test may therefore also not reflect in the moment automatic thinking.

Although the Conners Rating Scale (Conners, 2007) is also not standardised in the South African context they are recognised behavioural scales and frequently used. Further research is required to enhance the psychometric properties of all the scales utilised in this study for the SA context. The CASI (Kassay et al., 2015) had South African norms available, and these were attained from St John's University, New York, and used in this study.

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8.7. Suggestions for Future Research and Intervention

The following section includes suggestions for future research and implementation of therapy based on the research experience of this current study and literature.

8.7.1. Wider intervention in society and policy

Swenson et al. (2005) concluded that the intervention programmes that work for disruptive, impulse control and conduct disordered behaviour are: family based; remove barriers to service access; use behavioural intervention strategies; include rigorous quality assurance policies; include well-supervised, well-structured, neighbourhood-based interventions and approaches and provide pro-social recreational activities for youth, such as the development of community centres with, for example, sporting activities, at times when supervision is low (Swenson et al., 2005, p.29). This would lend credence to the local researchers' (Brion-Meisels & Selman, 1996; Burton & Leoschut, 2013; Burton 2008; Pelser, 2008) suggestion that interventions should be integrated, involving different stake holders and the wider community context. This current study was typical of the small dissertation-based studies found in South Africa, but it did use a wider intervention that included the child's system. The effect of such individual interventions is limited in what they can achieve in scale; although they are useful for exploring the therapeutic process about which not much is known (Stallard, 2005) and what works or does not work in such a process that could then be more widely applied. Although there were no resources for an even wider intervention, the need for such, structured and funded by government policy, is however recognized.

The need for pro-social neighbourhood-based interventions that provide recreational activities for youth, such as community centres, at times when supervision is low (Swenson et al., 2005) are sorely needed for children such as Moses and Neo who are left to their own devices after school. Both boys ran in the streets after school. They did not do schoolwork and came home between 7pm and 9pm, after the curfew given to them by their mothers. In

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both cases the boy's mothers were not there to enforce the curfews, both were usually at work. Moses, before therapy, would come home with belongings that were not his and his mother would have no idea where he got them from. Although Moses claimed that they were borrowed, his mother and grandmother both suspected thefts. Recreational and community centres in their home areas would be invaluable to these boys and help to keep them off the streets and alleviate boredom. Neo's and Moses' townships were high in crime and violence (Swartz & Scott, 2014), the DSM-5 (APA, 2013) claims that such communities report an increased risk of disruptive, impulse-control, and conduct disorder (APA, 2013). The development of community centres would provide alternative pro-social activities during their unsupervised hours to help break the cycle of crime for youths (Swenson et al., 2005). Policy creation would be required to intervene at this community level (Ghazi et al., 2013; Khan, 2008; Pelser, 2008; Timm, 2007).

National policy across countries is reported in literature to influence the implementation and growth of MST therapeutic interventions (Schoenwald et al., 2008). The government needs to make the issue of violence and behavioural problems an issue of priority if schools are to be freed from the 'siege' (Lefusi) (Jordaan, 2017) they are currently under. A wider co-ordinated effort by educational authorities to use educational and counselling psychologists or registered counsellors by placing them in schools across the country as a resource to help address and remediate this urgent issue, would be more effective than the current use of independent psychologists in private practice. These professionals would then be part of the school system (Gottfredson et al., 2002) and gain the support of the system as well as financial recompense for their skills, efforts, and time. In this current study working as an individual outside of the school system, had little influence on the school system as an integrated whole.

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Students could be utilised for both research and practical counselling, and schools could be used as practical sites for gaining experience for students. Supervision could be given by resident psychologists or qualified registered counsellors if the state placed these professionals at these government sites (as mentioned above). Alternatively, supervision could be done offsite by the host universities. A systemic approach utilising REBT (Diguiseppe et al., 2014) therapies could be incorporated into the community B. Psych theoretical programmes and various psychology masters programmes. The greater part of the population affected by disruptive, impulse control and conduct disordered behaviour, according to the experience in this study, do not seem to voluntarily seek out therapy, but they make use of therapy if barriers are removed as they were in this study. Barriers would be removed, and remediation would be provided in the moment and in the context in which it occurred if psychologists and or student-psychologists were on site. Furthermore, if this resource were available, the children could be taught self-management behaviours in the school settings and thereby apply these skills immediately to the settings that trigger the difficult behaviour (Gottfredson et al., 2002).

A wider approach as described above would increase the number of children and families that could be reached for treatment. Continuity and follow up in the services rendered could be achieved in this way. To achieve this widespread and co-ordinated implementation suggested, policy involvement would be necessary (Ghazi et al., 2013; Khan, 2008; Pelser, 2008). Without policies and the wider community's involvement, interventions will remain brief, disconnected and dissertation based.

Despite this need for wider and coordinated interventions, research projects that focus on aspects of social relationships are under threat from the lack of social cohesion and social ruptures in the South African context (Eagle, 2015). This was noted in this dissertation-based intervention research. Division was noted across the different levels of the system and within

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the levels. Parents did not always co-operate with teachers. Teachers did not co-operate with each other and their wider school systems. Gergen (2020), an American author, confirms this by describing the school systems as exhibiting lack of trust between all levels: teachers and children, and teachers and administrators. Parents' ambitions for their children to achieve becomes alienating towards teachers who administer traditional methods of assessment; teachers in response become defensive. These relational rifts above were detrimental to the research process conducted in this study.

According to Gergen (2020) all aspects of school life such as after school activities, in the counsellor's office, break time, etc., constitutes the 'culture' of the school, which affects all aspects of relational school life, which affects the behaviour of the children towards each other (Gergen, 2020). The leadership of the school can set the tone for school relations in general. Gergen (2020) calls for a shift from authoritarian leadership to shared, distributed and invitational leadership. In this study the results on the TIBS (Huk et al., 2019), indicated a high demand in teachers, across all cases, for involvement in decision making. This would likewise support this idea for distributed and invitational leadership style. This could possibly draw teachers into a more supportive and involved school community. This style of leadership would include relational learning.

With regards to the children, peer-based programmes to address bullying is suggested for building solidarity (Gergen, 2020). Thabo's case study would lend support to this idea. When he was involved in the introduction of break detention as an effective contingency management, he was engaged and showed less resistance to consequences that included his own ideas. He was also aware of what would work with his classmates. The break detention was instituted and reported by the teachers to be successful. The rewards that he suggested, such as a school outing and fund-raising ideas for this, were, however, not supported. If they were, the intervention would have included more children.

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Lack of social cohesion does not only affect the interventions of disruptive, impulse control and conduct disordered behaviour of children, it also affects the development of these problems. The influence of factors impacting behavioural problems are emphasised if the society is in a state of flux (Wolhuter & Steyn, 2003). If the lack of wider social cohesion manifest in the above social issues and turmoil is not addressed, projects aimed at remediating behaviour problems are likely to have limited success, and the state of research in South Africa will remain limited to small, un-coordinated, university-based studies, likewise reflecting this lack of cohesion.

8.7.2. Suggestions for a wider approach at research level

This current intervention, although limited in scope, did implement, and explore a systemic approach. The resources available to me, the therapist/researcher, were limited in terms of what I could achieve at a dissertation level, and as an individual psychologist. A wider approach would not have been possible in the current study. The practical case load was equivalent to that of a full-time family therapist during the data gathering process (Swenson, et al. 2005). Resources in the South African context are limited, as no funding or sabbatical was available. However, future researchers, even at dissertation level, could consider the following to increase the width and impact of future research whilst remaining process focussed.

8.7.2.1. A wider awareness

Although the intervention was applied at different levels of the child's system, only one or two teachers from each school was involved. This affected the practical implementation of the study as described above under the section '*restricted awareness.*' The benefits of a wider awareness in the school could result in a wider intervention as well, such as the introduction of break detention in Thabo's school. This form of contingency management

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was introduced across the entire school. It was implemented by the HOD who was also head of discipline. She utilised my services as a consultant in this regard even though she was not directly involved in the study, she was aware of the research taking place. So, if more teachers were aware of this study, it could have widened its impact, as it did in the context of this one case. Confidentiality issues would have then been more complicated to manage, however, with a wider awareness, as the school would have been aware of who was attending therapy and what was involved. Attention to confidentiality would be necessary. A suitable, more private venue than the ones typically made available, for instance, would have helped with confidentiality.

A wider awareness could probably have been achieved with little extra time and effort on my, the researcher's/therapist's part. Initially, after attaining permission through the gatekeepers, it would be useful in future research, to introduce the study to the staff in general and not only to the one or two teachers that were chosen by the principal. Such an introduction can attain a wider awareness with a single one-hour session, that would involve as many staff members as possible. Although teachers are reluctant to give up personal time this likely could be achieved. It could also have made the process more voluntary as the teachers could have volunteered to participate as opposed to being approached by the principal, which in hindsight, could have made it difficult for them to refuse. Targeting just those responsible for discipline in their portfolios could also possibly have been more effective as they would then have regarded this as their responsibility.

8.7.2.2. Group sessions

Learning the principles of REBT (Diguiseppe et al., 2014) lends itself to group work. Group sessions to teach the general concepts could be used across the different clients, teachers, parents, and children. The number of sessions required would be reduced if general theoretical constructs could be taught in a group setting. A larger number of people, than in

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this current study, could be included with a group approach while at the same time reducing the demands on the therapist/researcher. A few individual sessions could be given to enhance confidentiality and to increase the responsiveness of the programme to idiosyncrasies in the individual clients' irrational beliefs. Contingency management principles for teachers and parents could likewise be relayed in groups. Individual sessions for the parents to find idiosyncratic rewards and punishments and to build personalised behaviour charts for specific children could be included. All groups would utilise a psychoeducational approach.

8.7.2.2.1. Children

In children's groups the CASI (Kassay et al., 2015) scales could be used to identify demandingness and other irrational beliefs. The common irrational beliefs could be discussed in a group setting. Even the content of common irrational beliefs such as demands shared some commonality. All the child participants in the sample used for this study, had a demand for fairness. If the situation was not fair, there was a need to make it fair. These content commonalities could also be addressed in a group setting.

The joint sessions in this study with Neo and his friend Moses indicated that group work may be effective with children diagnosed with disruptive, impulse control and conduct disordered behaviour. Children could be used as a support for each other, and to generate ideas such as alternate beliefs and disputations, as was noted with Neo and Moses. The joint sessions were also used to help them to see how their problematic behaviour appeared to others. It was easier for them to accept the alternate view from friends compared to adults. Again, some individual sessions could be held to identify idiosyncrasies and enhance confidentiality and responsiveness.

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8.7.2.2.2. Parents

Regarding parents, when using a group approach, confidentiality would be more difficult to negotiate. This would need to be addressed in the informed consent contract. The commonalities of parenting styles and effects thereof, could be addressed psycho-educationally and in groups. The common irrational beliefs such as a demand for good behaviour or negative self-rating, seen in the parents in this current study, could be identified using the PIBS (Joyce, 1995) and addressed in group sessions. The groups could be held at times that are responsive to the needs of the parents, such as on a Saturday. Working in groups could potentially reach a larger number of parents. The attrition of participants could be greater in group work compared to that of individual sessions due to less opportunity to form a therapeutic alliance. Group cohesion could make up for this as the therapeutic value of the groups were activated (Yalom, 1983). The parents' individual thought records would need to be discussed in individual sessions to enhance both confidentiality and responsiveness to idiosyncrasies. Individual sessions could be held to create contingency management that was responsive to each family unit.

As I complete this thesis in lockdown due to the global COVID-19 pandemic, my awareness of the possibility of online sessions could also be considered as a means of making the sessions more accessible to parents who travel or have long working hours and have access to internet. This would likewise reduce the demands on the therapist/researcher as they would not need to travel to the parent's place of work. Online group sessions could also be conducted.

8.7.2.2.3. Teachers

Introductory sessions around irrational beliefs and the general principals of REBT (Diguiseppe et al., 2014) could also be held in groups involving teachers as with the two other levels of the system described above. Commonalities in the teachers' irrational

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thoughts, such as *authoritarian attitude* towards the discipline of the children, was noted in the results on the TIBS (Huk et al., 2019). These commonalities could be identified on the TIBS (Huk et al., 2019) and addressed generally in group sessions. Group sessions could potentially focus on the research questions as personal problems would not be the focus in a group context. In this study it was difficult to remain responsive to the teachers' individual therapeutic needs and focus on the research questions. Their individual needs were used to engage them. Group sessions could facilitate a balance between the teachers' personal goals and the research questions. A few individual sessions could address idiosyncratic beliefs or any personal issue impacting on the teachers' work. The lack of unity and cohesion across the fabric of South African society (Eagle, 2015), mirrored in the school systems, would detract from implementing wider interventions as well as the reluctance on the part of the teachers to be involved in addressing the children's problematic behaviours. It should be possible however to have group sessions that at least involve those teachers whose portfolio involved responsibility for discipline in the schools.

As a pilot study, this study tried to engage one teacher around one specific child. However, including a wider intervention around general contingency management for the school could have been beneficial. The discipline at the schools was inconsistent and ineffective. In this study, the schools' discipline was based on the demerit system which does not provide an immediate contingency as suggested by Kazdin (2000). Brainstorming during large group sessions around what could work generally for a particular school system could be included. If suggested changes to the disciplinary approach were approved, they could be made part of the policy of the school system and therefore official and more consistently applied.

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8.7.2.2.4.   'Giving psychology away' as an intervention

The way forward for school psychologists to reach large numbers is to 'give psychology away' (Sarason, 1974) to school personnel and parents. This can take the form of information sharing, training, and active collaboration as equal partners in advocating change in children. Involving and equipping teachers and counsellors is one avenue whereby the skills of school psychologists can filter down to larger populations of children (Yeo & Cho, 2011). Teachers have the most direct access to children and many opportunities during a normal school day to reinforce good self-management habits. School psychologists can actively enlist the support of classroom teachers to encourage children to use their new skills acquired and to reward effort and success in order that gains made during treatment sessions can be sustained over time. This approach would also be cost effective (Yeo & Cho, 2011). Non-mental health professionals, such as teachers, have been reported in literature to be successful in the application of REBT (Gonzalez et al., 2004). This could be affective if teachers responsible for discipline and life orientation teachers (Timm, 2007) were targeted.

In an ideal world, approaches such as rational-emotive education (REE) would be routinely implemented in schools throughout the world in a systematic effort to enhance the emotional health of children. The major assumption of emotional education programs is that prevention is more effective than remediation, and that if we can teach children how to think rationally, they will approach both developmental and situational challenges in a healthier manner, which in turn will decrease the proliferation of self-defeating behaviours. To effectively implement REE, teachers and other school personnel must learn the theory and model it. Although REE lessons appear to be an effective way to help children and adolescents approach life more successfully, rational thinking principles need to be an inherent part of everyday experience. Adults are important role models, and although it is difficult to develop a rational stance toward life when surrounded by irrationality in the

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world, every effort to teach rational principles, directly or indirectly, will help facilitate healthy emotional development (Vernon & Bernard, 2019). This would need to be introduced at a policy level in schools and preferably at a national level.

8.7.3. The role of research in universities

If case-based research was implemented in professional training programmes at universities this could co-ordinate this much needed research. This could contribute to building case law (Edwards, 2018) which could be used to draw attention to both the need for, and what is an appropriate intervention for, disruptive, impulse control, conduct disorder behaviour (or any other diagnosis) in the South African context. Research of this nature could provide the practical application of much needed research into therapy (Edwards et al., 2010) which would not only provide a growing knowledge base for appropriate intervention for the developing South African context but would also be relevant to trainees in psychology due to its practical focus. As a past lecturer at a South African university, my experience was that each student carried out small, independent studies. These studies were disparate and un-co-ordinated as reflected in the literature review of this study. A co-ordinated effort in a university context could help to change research in the South African context from small dissertation-based research to a growing, more unified body of research that could impact policy. Unity and co-operation within the tertiary institution would be necessary for such a process to be successful. The general lack of unity mentioned by Eagle (2015) would negatively impact this process.

8.7.4. Application to the South African context

According to Edwards et al., (2012), CBT approaches can be used as easily in the South African context as it can in the European and North American contexts where the approach

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originated. The approaches are widely used in South African clinics and private practice to treat depression, anxiety, post-traumatic stress disorder, and disruptive behaviours.

Tshabalala and Visser (2011) utilised a CBT therapeutic approach with HIV-positive women. The most effective techniques used were positive reframe and de-catastrophising. The more complex cognitive techniques such as identifying underlying automatic thoughts and thus managing their own thoughts outside of the therapy situation was not as successful. The therapist had to identify the thoughts for the clients in the therapy session. The use of Socratic questioning did not assist in the development of self-reflection. Assertiveness training described by the authors as a behavioural technique was seen to be successful. So, in this SA context some techniques worked better than others.

Regarding the four cases in this current study, overall, the approach did contribute to improvement in both disruptive, impulse control and conduct disordered behaviour as well as irrational thought. Some clients understood the concepts and came up with their own disputations and alternate beliefs, some could not. If the client could apply the techniques for themselves such as Rajesh, Mary, and Jonathan the results were likely to be maintained.

Motivation also played a role in the success of treatment as it did in the case of Neo. His context demotivated him as his mother would not recognise the change in him when he made any mistake and behaved badly. The elements contributing to success of the therapy were idiosyncratic, related to individual characteristics and context as opposed to anything general regarding the South African context. No idiosyncratic responses were noted across race or economic status. This corroborates Edwards, et al., (2012), that REBT worked as well in the South African context.

The schools in this study were moderately well organised and equipped. Many schools in the South African context are not, they are underprivileged, lacking in resources and organisation. In a study in the USA (Gottfredson et al., 2002), CBT was applied to a

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difficult school context, such as some schools in South Africa, where expectations were low and school settings were disorganised with, for example, teachers arriving late for class. Despite these factors, CBT intervention produced changes in children displaying difficult behaviours (Gottfredson et al., 2002). This would indicate that despite the condition of schools in the context, the approach could still be effective.

8.8. Experience of the Therapist/Researcher

Therapeutically, conflict of interest was experienced on more than one occasion as I, the therapist/researcher was working across the different levels of the system in this study. Each sub-system had their own way of thinking about the situation and own set of motivations, and they talked about each other during their individual sessions. In Jonathan's case, Mary, his mother, supported him when he was in conflict in the school context. Heidi, his teacher, recognised Mary's support of Jonathan and her lack of support of Heidi's discipline of him. Mary and Heidi complained about each other in the individual sessions, and I felt the tension on myself, therapist/researcher, at that time.

Another situation arose in Thabo's case when he had conflict with the teacher. Both complained about each other in their individual sessions with me. Thabo then claimed I, the therapist/researcher had said that the teacher did not like him, which was not the case. This disrupted the relationship with this teacher, but she was not working with me directly in Thabo's case.

The schools' staff would expect support from me, the therapist/researcher in the form of reports regarding the children's behaviour for disciplinary hearings and found it hard to accept that ethically I could not contribute to a situation that could be detrimental to the boy I was working with. I experienced these conflicts of interest as stressful.

The bi-monthly consultation was limited with regards to covering all the sessions and the focus was therefore on the quality of the REBT (Diguiseppe et al., 2014) application.

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There is the need for the right supervisory support or consultation for case study research and work of this nature in the field. A structure of registered counsellors and psychologists along with psychology/registered counselling students could provide a team approach in the setting which would assist with conflict of interest and likewise provide support, in the form of a sounding board, for the therapists. Each member of the system could work with a different level of the system: parents, teachers, or children.

8.9. Conclusion

In this study the implementation of a multisystemic intervention (Swenson et al., 2005) using REBT (Diguiseppe et al., 2014) theories and techniques applied to four case studies were documented to analyse the process and contributing aspects and elements to the success, or not, of this process. The intervention was successful to varying degrees across clients of different demographics and socio-economic backgrounds. The REBT (Diguiseppe et al., 2014) techniques were used successfully to varying degrees with the boys, even when no significant change was noted in the context. The following questions were addressed in the study.

- Design an intervention based on an integrative, multisystemic (Swenson et al., 2005) approach within which evidence based rational emotive behaviour therapies (REBT) and contingency management are applied.

The systemic design that included the different levels of the system: home, family, and child, was described throughout this study, including how the REBT (Diguiseppe et al., 2014) approach and techniques were applied and worked within and across the levels of the system, as well as how it worked within individual clients. This was carried out in the individual case studies as well as in this final chapter. The bidirectional influence of the

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different levels of the system (child, parent teacher) was described and expounded on in the sections acknowledging the thoughts of the different participants forming a system.

- Was the treatment model useful for this particular client?

The REBT (Diguiseppe et al., 2014) model was found to be useful to varying degrees of success. Irrational belief scales and behavioural scales were used to assist in measuring the degree of success and the results were graphically represented. What worked best and how was noted. The mechanisms of how this theory was used was documented in the individual case study chapters. The idiosyncratic contributions that affected the application of the therapy positively was described within each case study chapter and the commonalities across the cases were noted in this final chapter. What techniques and disputations worked best for each client was likewise discussed and the commonalities were explored in this final chapter.

- Identify challenges and obstacles to effectiveness in the therapeutic intervention.

The general drawbacks of the application of this design were discussed in this final chapter. The idiosyncratic obstacles to the therapy process were discussed in the case study chapters and the commonalities across cases were explored in this final chapter. The REBT (Diguiseppe et al., 2014) techniques that were least useful were described in each case study chapter and the commonalities across cases were discussed here in this final chapter. The techniques that were less successful or difficult to use were noted.

- The difficulties experienced by me; the therapist/researcher were noted.

Overall, this study added to the body of evidence-based case studies that will contribute to case-based research for the reference of other professionals working with disruptive, impulse control and conduct disordered behaviour in South Africa using a multisystemic approach (Swenson et al., 2005) with REBT (Diguiseppe et al., 2014) therapies and techniques.

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In conclusion, a summary of the overall process and above findings are depicted below in the form of a diagram (figure 26) adapded from (Fishman, 2013). The pragmatic case study framework is represented showing: client, **assessment/data gathering, case conseptualisation, treatment, treatment monitoring** and **evaluation.** This represents how the therapeutic process was carried out and how the research reports are written up across the case study chapters. It shows the feedback loops occurring in the therapeutic process via bidirectional arrows. If **therapy monitoring** suggests success the therapy process is terminated, and the information is assimilated into **research/experience**. If the process is not successful the therapist and client return to **case conseptualisation** and the therapeutic process recommences. In this way the therapy process itself is seen as a dynamic system. The **therapeutic relationship** is depicted as a system with bidirectioanl arrows indicating responsiveness (Kramer & Stiles, 2015) between client and therapist. The embedded element of the case study, influenced by systems theory, is represented by the three levels of the system; **parent** (representing the family level of the system),**child**, and **teracher** (representing the school level of the system). The pragmatic case study design is repeated across the levels of the system. The bidirectional arrows represent the interactional nature of the different levels of the system. The various text boxes summarise the second phase of the analysis which looked the commonalities and some ideosyncracies across different levels of the identified system and therapy process.

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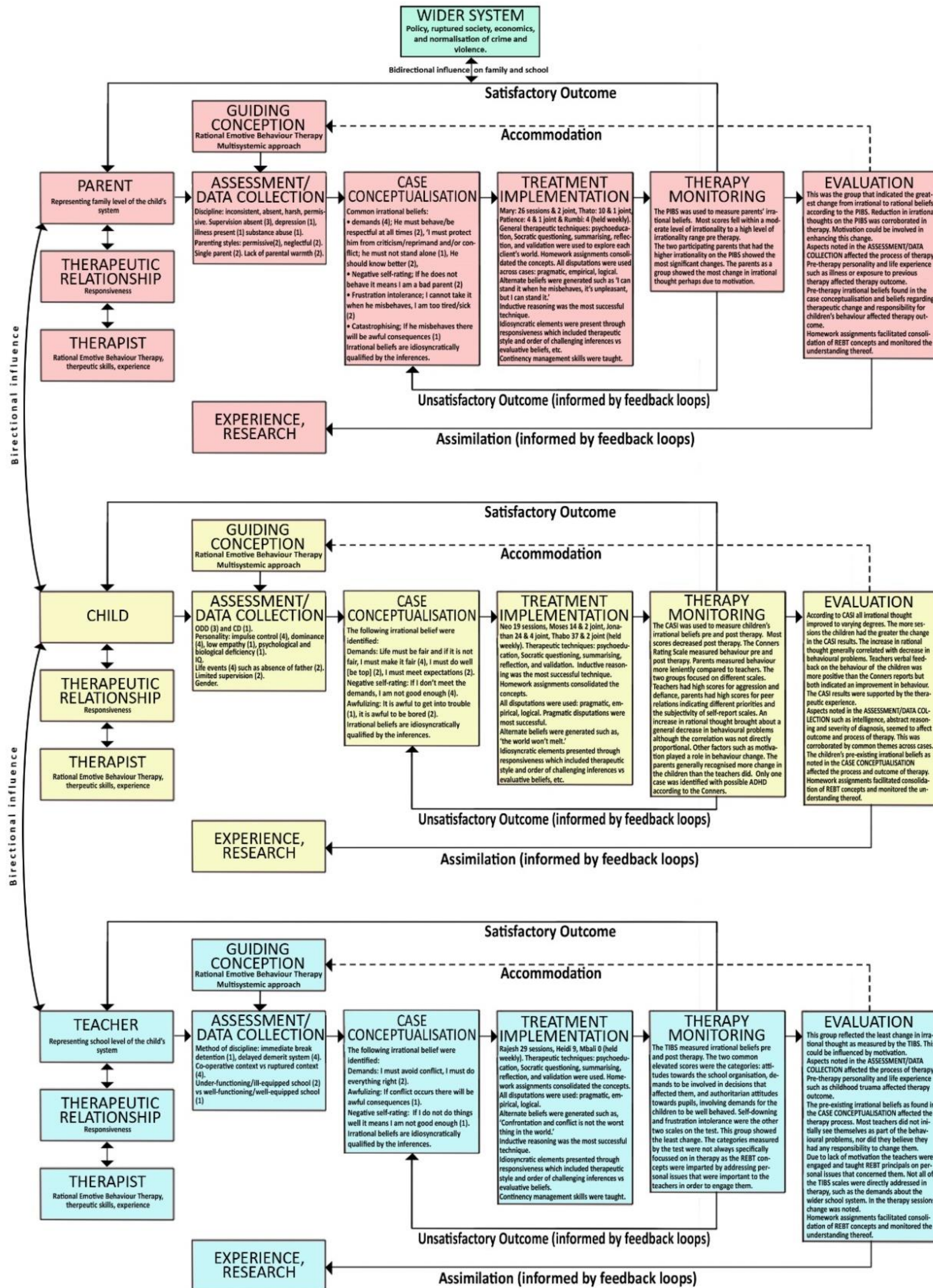
Figure 26

The Overall therapeutic and research process with content summary



This image was produced by Timm in 2022 depicting a model of the embedded case study utilizing Multisystemic and REBT therapeutic approaches and research findings summary. It was adapted form D. Fishman, 2013, *Pragmatic Case Studies in Psychotherapy*, *9*(4), p. 425.

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Appendix A: Parental Consent Form

Tel: (012) 420-2907

Cell:0827739088

Faculty of humanities

Department of psychology

Title of study: Disruptive behaviours in schools: A multisystemic intervention using rational emotive behaviour therapy.

Purpose of the study: This research will implement an intervention programme for behavioural problems, specifically disruptive behaviours, in schools. The intervention will use a therapeutic approach called rational emotive behaviour therapy (REBT). This approach emphasises the connections between behaviour and emotions and the way we think. It has gained some success in the treatment of disruptive behaviours. REBT therapeutic interventions will be applied to children identified as exhibiting disruptive behavioural problems. The teachers and parents/caregivers who have most contact with these children will also undergo REBT therapeutic interventions to help them in the way that they think about these behaviours so as to manage them more effectively. Parents and teachers will also be given training in the contingency (practical) management of disruptive behaviour. There are many incidents of disruptive behavioural problems in South African schools. This research wants to assess how helpful this approach (REBT) is.

Role of the participant: The children will be required to enter therapy for approximately three months. The parents and teachers will also

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have to commit to approximately six sessions of REBT and contingency management and parenting skills training. A parent/caregiver not involved in the therapy will be asked to measure the behaviours at intervals. Children, teachers and parents will also have to fill in self report questionnaires. The therapy sessions will also be tape recorded.

Information: The information gleaned from the above processes will be used as the basis for master's theses and a doctoral thesis in psychology. These theses will be disseminated in hardcopy and electronic formats and may be accessible on the university's website. Academic papers will also utilise the information. In the writing up of results the names of all participants will be kept confidential and any identifying information will be disguised. The efficacy of the therapy and its techniques will be made know to the schools involved in the form of a presentation. The focus will be on the efficacy of the therapeutic intervention and general trends and not the individual participants' process. An expert REBT specialist will used in the overall supervision of the intervention.

Benefits: The benefits for the children and the parents are as follows: The children involved will be given a full scholastic assessment free of charge to screen for any learning problems. The information obtained can then be used by educators to help the child with any difficulties. Parenting skills will be taught to parents to help with the management of disciplinary difficulties. The teachers will also be exposed to contingency management skills. The children and families and or teachers will be referred for further counselling if necessary. All therapeutic services offered will be

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given free of charge. All information will be treated confidentially and participation is on a completely voluntary basis.

Researcher: The privacy and confidentiality of participants will be respected at all times. The limits of confidentiality lie in the fact that the teachers, parents and children will all be part of the therapy. Participants will not however be given access to the content of each other's therapy sessions. Participation in this study is on a completely voluntary basis and the participants can withdraw from the study at any time. If they do withdraw all records will be destroyed. If any of the participants feel that they would like to discuss anything further they will be referred to a relevant professional. The researcher's cell phone number will be given to the participants so that they may contact her regarding the study for the duration of the research process. The data will be stored on the researcher's personal computer during the research process and a code will be used to protect the data from unauthorized access. Thereafter the information will be stored at the University of Pretoria for a period of 15 years, in accordance with the regulations of the University.

Consent Form

I, ……………………………………………………………………, parent/guardian

of……………………………….…………….hereby freely give permission for my

child/children to take part in this study. I also agree to participate in the study. I also give permission for other guardians/parents and teachers to be involved regarding their experience with my child.

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Parent/guardian's name:_______________________(Block letters please)

Parent/guardian's signature:_______________________

Date:___________________

I, ……………………………………………………………………, parent/guardian

of…………………………………….…………hereby freely give permission/do not give

permission for the researcher to use an audio/video tape recorder.
I give my permission for these results to be used for research purposes.

Parent/guardian's name:_______________________(Block letters please)

Parent/guardian's signature:_______________________

Date:___________________

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Appendix B: Assent Form for the Child Participant

Tel: (012) 420-2907

Cell:0827739088

Please indicate by means of Yes/No

Child Participant

The therapist has explained what the study is about and I understand what is required of me.

I am willing to participate in this study: ________________________

I am unwilling to participate in this study: ______________________

Participant:

Name in print: ____

Researcher:

The study will be explained verbally to the children in a language appropriate to their developmental stage. With the verbal conversation the therapist/researcher can assess whether or not the child has full understanding of the process.

Sign____

___ Date: ______________

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Appendix C: Letter To Parents

Tel: (012) 420-2907

Cell: 0827739088

Faculty of humanities

Department of psychology

Dear Parent/teacher

Re: Intervention for disruptive behavioural problems

I am a research psychologist and a counselling psychologist registered with the HPCSA in both categories. In response to the nationwide behavioural problems confronting our South African community I am conducting research in your primary school to help those confronted with this problem.

This research will implement an intervention programme for behavioural problems, specifically disruptive behaviours, in schools. The intervention will use a therapeutic approach called rational emotive behaviour therapy (REBT). This approach emphasises the connections between behaviour and the way we think. It has gained some success in the treatment of disruptive behaviours. REBT therapeutic interventions will be applied to children identified as exhibiting disruptive behaviour problems. The teachers and parents/caregivers who have most contact with these children will also undergo REBT therapeutic interventions to help them in the way that they see these behaviours so as to manage them more effectively. Parents and teachers will also be assisted in the practical management of disruptive behavioural problems.

The benefits for the children and the parents are as follows: The children involved will be given a full scholastic assessment free of charge to screen for any learning problems. The information obtained can then be used by educators to help the child with any

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difficulties. Parenting skills will be taught to parents to help with the management of disciplinary difficulties. The children and families and or teachers will be referred for further counselling if necessary. All therapeutic services to parent, teachers and child offered will be given free of charge. All information will be treated confidentially and participation is on a completely voluntary basis and the participants can withdraw at any time.

Yours sincerely

Vicky Timm

(Research psychologist and counselling psychologist)

Ps 0087203

Practice No. 0860000317039

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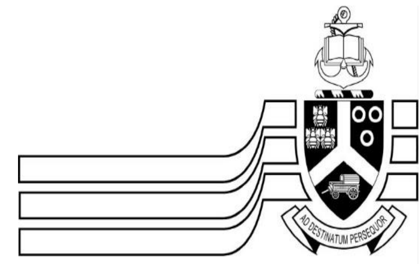
Appendix D: Teacher Consent Form



Tel: (012) 420-2907

Cell:0827739088

Faculty of humanities

Department of psychology

Title of study: Disruptive behaviours in schools: A multisystemic intervention using rational emotive behaviour therapy.

Purpose of the study: This research will implement an intervention programme for behavioural problems, specifically disruptive behaviours, in schools. The intervention will use a therapeutic approach called rational emotive behaviour therapy (REBT). This approach emphasises the connections between behaviour and emotions and the way we think. It has gained some success in the treatment of disruptive behaviours. REBT therapeutic interventions will be applied to children identified as exhibiting disruptive behavioural problems. The teachers and parents/caregivers who have most contact with these children will also undergo REBT therapeutic interventions to help them in the way that they think about these behaviours so as to manage them more effectively. Parents and teachers will also be given training in the contingency (practical) management of disruptive behaviour. There are many incidents of disruptive behavioural problems in South African schools. This research wants to assess how helpful this approach (REBT) is.

Role of the participant: The children will be required to enter therapy for approximately three months. The parents and teachers will also have to

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commit to approximately six sessions of REBT and contingency management and parenting skills training. A parent/caregiver not involved in the therapy will be asked to measure the behaviours at intervals. Children, teachers and parents will also have to fill in self report questionnaires. The therapy sessions will also be tape recorded.

Information: The information gleaned from the above processes will be used as the basis for master's theses and a doctoral thesis in psychology. These theses will be disseminated in hardcopy and electronic formats and may be accessible on the university's website. Academic papers will also utilise the information. In the writing up of results the names of all participants will be kept confidential and any identifying information will be disguised. The efficacy of the therapy and its techniques will be made know to the schools involved in the form of a presentation. The focus will be on the efficacy of the therapeutic intervention and general trends and not the individual participants' process. An expert REBT specialist will used in the overall supervision of the intervention.

Benefits: The benefits for the children and the parents are as follows: The children involved will be given a full scholastic assessment free of charge to screen for any learning problems. The information obtained can then be used by educators to help the child with any difficulties. Parenting skills will be taught to parents to help with the management of disciplinary difficulties. The teachers will also be exposed to contingency management skills. The children and families and or teachers will be referred for further counselling if necessary. All therapeutic services offered will be given free of charge. All information will be treated confidentially and participation is on a completely voluntary basis.

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Researcher: The privacy and confidentiality of participants will be respected at all times. The limits of confidentiality lie in the fact that the teachers, parents and children will all be part of the therapy. Participants will not however be given access to the content of each other's therapy sessions. Participation in this study is on a completely voluntary basis and the participants can withdraw from the study at any time. If they do withdraw all records will be destroyed. If any of the participants feel that they would like to discuss anything further they will be referred to a relevant professional. The researcher's cell phone number will be given to the participants so that they may contact her regarding the study for the duration of the research process. The data will be stored on the researcher's personal computer during the research process and a code will be used to protect the data from unauthorized access. Thereafter the information will be stored at the University of Pretoria for a period of 15 years, in accordance with the regulations of the University.

Consent Form

I, ………………………………………………………………………, teacher

of……………………………………….…………….hereby freely give permission for my to participate in the study.

teacher's name:_______________________(Block letters please)

teachers's signature:_______________________

Date:___________________

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I, ……………………………………………………………………, teacher

of……………………………..……………..hereby freely give permission/do not give

permission for the researcher to use an audio/video tape recorder.
I give/do not give my permission for these results to be used for research purposes.

teacher's name:_______________________(Block letters please)

teacher's signature:_______________________

Date:___________________

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Appendix E: Teacher Irrational Beliefs Scale

Teacher Irrational Beliefs Scale

Directions: Indicate the extent to which you agree or disagree with the following statements

Circle 1 for Strongly Disagree (SD)
Circle 2 for Disagree (D)
Circle 3 for Not Sure (NS)
Circle 4 for Agree (A)
Circle 5 for Strongly Agree (SA)

	SD	D	NS	A	SA
1. I think I'm really inadequate when I don't get approval or respect for what I want to do.	1	2	3	4	5
2. The prospect of teaching a class I don't have control over is more than I can take.	1	2	3	4	5
3. I think I'm a failure when I haven't "got through" to a student or class.	1	2	3	4	5
4. I really should be able to solve all my students' problems perfectly.	1	2	3	4	5
5. I should be able to succeed at all the important things I do at school.	1	2	3	4	5
6. To make mistakes or perform poorly as a teacher is for me one of the worst things in the world.	1	2	3	4	5
7. I feel totally hopeless when I don't get all my work done on time.	1	2	3	4	5
8. I can't stand being criticized or thought badly of when I haven't finished something or done it properly.	1	2	3	4	5
9. I find it too hard to balance my home and work demands.	1	2	3	4	5
10. I shouldn't have to work so hard.	1	2	3	4	5
11. Schools are really lousy places because they give teachers too much work and not enough time to do it.	1	2	3	4	5
12. It's really bad to have to put in so many hours both inside and outside the classroom.	1	2	3	4	5

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APPENDIX E (con't)

Circle 1 for Strongly Disagree (SD)
Circle 2 for Disagree (D)
Circle 3 for Not Sure (NS)
Circle 4 for Agree (A)
Circle 5 for Strongly Agree (SA)

	SD	D	NS	A	SA
13. One of the things I find totally bad is the lack of communication between teachers and central administration.	1	2	3	4	5
14. Teachers should be consulted about decisions.	1	2	3	4	5
15. Schools really should attend more to teachers' problems and it is totally unfair when they don't.	1	2	3	4	5
16. Without good teacher-administrator communication and support, schools are the very worst and terrible places to work.	1	2	3	4	5
17. I can't stand it when I am not consulted about a decision that affects my teaching.	1	2	3	4	5
18. As a teacher, I should have the power to be able to make my students do what I want.	1	2	3	4	5
19. Students should always be respectful, considerate and behave well.	1	2	3	4	5
20. Students who constantly misbehave are horrible and should be severely punished.	1	2	3	4	5
21. I can't stand it when students misbehave.	1	2	3	4	5
22. It's really awful to have to teach in a class where there are so many problems.	1	2	3	4	5

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Appendix F: Parent Irrational Beliefs Scale

(To be completed by parent)

Revised Belief Scale

People have different ideas. We are interested in hearing about your opinions and ideas regarding the following statements. Place an x through the number which best reflects your beliefs about each of the items.

1= Agree (A)

2= Uncertain (U)

3= Disagree (D)

	Statement	A	U	D
1.	My children obey my instructions.	1	2	3
2.	In a typical week I find myself having to put up with many awful situations with my family.	1	2	3
3.	Being inadequate as parent reduces my worth	1	2	3
4.	Situations are responsible for getting me upset.	1	2	3
5.	It's awful when my children don't behave as they should.	1	2	3
6.	As a parent I shouldn't have made certain obvious mistakes.	1	2	3
7.	There are "good children" and "bad children", as can be seen by watching what they do.	1	2	3
8.	There's really nothing about parenting I can't stand.	1	2	3

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9	Children should follow the rules of the household.	1	2	3
10	Even when I make many mistakes with my children, my self worth does not change.	1	2	3
11	I can't take it when I'm under stress with my children.	1	2	3
12	My children shouldn't do things I have asked them not to do.	1	2	3
13	It's important to teach children they can become "better people" by performing well and earning the approval of others.	1	2	3
14	I shouldn't make as many mistakes with my family as I do.	1	2	3
15	I can't deal with it when my children misbehave.	1	2	3
16	The situation in my home is often terrible.	1	2	3
17	When others don't act as they "should", anger is justified.	1	2	3
18	There is no reason I should be a better parent than I am.	1	2	3
19	It's terrible when my home situation is difficult and unpleasant.	1	2	3
20	I'd like to do a better job with my children, but there's no reason why I should.	1	2	3
21	Children who sin or harm others are not good as people.	1	2	3
22	I often can't stand it when my children aren't behaving well.	1	2	3
23	My children shouldn't act in undesirable ways.	1	2	3
24	My self-worth is unrelated to my ability as a parent.	1	2	3

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Appendix G: Child and Adolescent Scale of Irrationality (CASI)

When you are ready to begin, please reach each sentence below and pick your answer by *circling a number from "1" to "5."* The five possible answers for each sentence are:

1 = Strongly Disagree

2 = Disagree

3 = Not Sure

4 = Agree

5 = Strongly Agree

For example, if you were given the sentence "*I like to read comic books*," you would circle a "**1**" if you *Strongly Disagree*. If you were given the sentence, "*I like to keep my room neat and tidy*," you would circle a "**5**" if you *Strongly Agree*. Please be sure to answer all of the questions.

	Strongly Disagree				Strongly Agree
1.Parents who are too strict are total idiots.	1				5
2.I think others are better than me.	1				5
3.The worst thing is to have your friends mistreat you.	1				5
4.I must get good grades.	1				5
5.I think I'm pathetic when people don't like me.	1				5
6.It's too hard to deal with teachers who have favorites.	1				5
7.Parents have a responsibility to be nice to children.	1				5
8.When my friends don't ask me to do things with them I think I'm a loser.	1				5
9.Just because others may do better than me in some things, doesn't mean I'm a complete loser.	1				5

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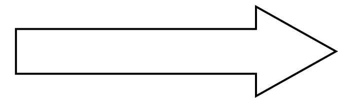
10. It's not so bad to have to follow rules all the time.	1				5
11. Other kids who aren't nice to me don't deserve for good things to happen to them.	1				5
12. When I don't succeed in school, I'm a complete failure.	1				5
13. I ABSOLUTELY need my friends to like me.	1				5
14. Teachers who treat students differently are not bad people.	1				5
15. If I make a mistake in front of others I think I'm a complete screw-up.	1				5

Questions *continued* on back

Please turn over



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	Strongly Disagree				S trongly Agree
16. People would like me better if I wasn't such a loser.	1				5
17. Too much homework is impossible to deal with.	1				5
18. It's terrible when I'm not the winner.	1				5
19. Homework should NEVER be boring.	1				5
20. I can't deal with having to follow rules at home.	1				5
21. I want my teachers to act fairly.	1				5
22. It's terrible when my parents get upset at me	1				5
23. I need to be able to do what I want when I want.	1				5
24. Things in my life would be easier if I wasn't such an idiot.	1				5
25. I think I'm totally stupid when I don't get good grades.	1				5
26. I can't stand having to follow rules in school.	1				5
27. Making mistakes are the worst things in the world.	1				5
28. A parent who acts badly toward his/her kids is a bad person.	1				5
29. When a teacher treats me unfairly, it's horrible.	1				5
30. Classmates who always behave and follow the rules are "suck-ups."	1				5
31. It's REALLY awful to have a lot of	1				5

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homework to do.					
32. I can't take my parents telling me what to do.	1				5
33. It's awful when someone stops me from doing what I want.	1				5
34. I have to do well in things that are important to me.	1				5
35. If my friends are mean to me, I can deal with it.	1				5
36. Other kids should ALWAYS be fair and friendly.	1				5

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Appendix H: Revised Belief Scale for Parents (PIBS) Reliable Change Index

Jonathan PIBS Scores		
	Before	After
Demand	25	25
LFT	17	15
SW	13	19
Overall	55	59

Thabo PIBS Scores		
	Before	After
Demand	12	20
LFT	12	17
SW	14	18
Overall	38	55

Moses PIBS Scores		
	Before	After
Demand	18	17
LFT	8	13
SW	9	15
Overall	35	45

Neo Pibs Scores		
	Before	After
Demand	1.2	
LFT	1.67	
SW	1.25	
Overall	1.33	

Jonathan PIBS - RCI						
	SD	**Cronbach Alpha**	**SE_m**	**SDIFF**	**RCI**	**Significant**
Demand	3.27	0.75	1.635	2.31224	0	No
LFT	2.68	0.75	1.34	1.89505	-1.0554	No
SW	2.75	0.75	1.375	1.94454	3.08556	Yes
Overall	5.77	0.75	2.885	4.08001	0.98039	No

Thabo PIBS Scores						
	SD	**Cronbach Alpha**	**SE_m**	**SDIFF**	**RCI**	**Significant**
Demand	3.27	0.75	1.635	2.31224	3.45985	Yes
LFT	2.68	0.75	1.34	1.89505	2.63846	Yes
SW	2.75	0.75	1.375	1.94454	2.05704	Yes
Overall	5.77	0.75	2.885	4.08001	4.16666	Yes

Moses PIBS Scores						
	SD	**Cronbach Alpha**	**SE_m**	**SDIFF**	**RCI**	**Significant**
Demand	3.27	0.75	1.635	2.31224	-0.4325	No
LFT	2.68	0.75	1.34	1.89505	2.63846	Yes
SW	2.75	0.75	1.375	1.94454	3.08556	Yes
Overall	5.77	0.75	2.885	4.08001	2.45098	Yes

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Appendix I: Teacher Irrational Belief Scale (TIBS) Reliable Change Index

Rajesh TIBS Scores	Before	After
SD	22	17
LFT	7	4
AttSch	20	18
Auth	17	14
Total Average	66	55

Gladys TIBS Scores	Before	After
SD	14	14
LFT	5	6
AttSch	23	14
Auth	15	13
Total Average	57	47

Heudu TIBS Scores	Before	After
SD	23	32
LFT	11	8
AttSch	19	21
Auth	21	17
Total Average	74	78

Rajesh TIBS Scores	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant
SD	5.04	0.79	2.30962	3.266293312	-1.530787202	No
LFT	3.65	0.78	1.712	2.421136097	-1.239087717	No
AttSch	3.16	0.79	1.44809	2.047914061	-0.976603481	No
Auth	3.92	0.75	1.96	2.771858582	-1.082306298	No
Total Average	11.26	0.86	4.21311	5.958231953	-1.846185259	No

Gladys TIBS Scores	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant
SD	5.04	0.79	2.30962	3.266293312	0	No
LFT	3.65	0.78	1.712	2.421136097	0.413029239	No
AttSch	3.16	0.79	1.44809	2.047914061	-4.394715663	Yes
Auth	3.92	0.75	1.96	2.771858582	-0.721537532	No
Total Average	11.26	0.86	4.21311	5.958231953	-1.678350235	No

Heudu TIBS Scores	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant	
SD	5.04	0.79	2.30962	3.266293312	2.755416964	Yes	Wrong direction
LFT	3.65	0.78	1.712	2.421136097	-1.239087717	No	
AttSch	3.16	0.79	1.44809	2.047914061	0.976603481	No	
Auth	3.92	0.75	1.96	2.771858582	-1.443075064	No	
Total Average	11.26	0.86	4.21311	5.958231953	0.671340094	No	

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Appendix J: Child and Adolescent Scale of Irrationality (CASI) Reliable Change Index

Jonathan Casi Scoring	Before	After
Demand	3.37	2.25
LFT	2.4	1.7
ROW-O	2.2	1.6
ROW-S	2.1	1.4
Awfulizing	3.7	2.4
Total Average	2.7	1.87

Thabo Casi Scoring	Before	After
Demand	4.25	2.6
LFT	2.8	2.1
ROW-O	3	2.2
ROW-S	2.2	1.6
Awfulizing	4.5	3
Total Average	3.35	2.3

Neo Casi Scoring	Before	After
Demand	3.25	2.5
LFT	1.8	2.1
ROW-O	2	1.8
ROW-S	2.3	1
Awfulizing	2.6	3
Total Average	2.39	2.08

Moses Casi Scoring	Before	After
Demand	3.1	2.75
LFT	1.8	2.2
ROW-O	3	1.8
ROW-S	1.8	1
Awfulizing	3.1	3.1
Total Average	2.56	2.17

Jonathan Casi - RCI	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant
Demand	0.45	0.29	0.37917674	0.536236888	-2.0886	Yes
LFT	0.65	0.61	0.40592487	0.574064456	-1.2194	No
ROW-O	0.63	0.42	0.47979371	0.678530766	-0.8843	No
ROW-S	0.72	0.73	0.37412297	0.529089784	-1.323	No
Awfulizing	0.64	0.58	0.4147674	0.586569689	-2.2163	Yes
Total Average	0.62	0.81	0.27025173	0.382193668	-2.1717	Yes

Thabo Casi Scores	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant
Demand	0.45	0.29	0.37917674	0.536236888	-3.077	Yes
LFT	0.65	0.61	0.40592487	0.574064456	-1.2194	No
ROW-O	0.63	0.42	0.47979371	0.678530766	-1.179	No
ROW-S	0.72	0.73	0.37412297	0.529089784	-1.134	No
Awfulizing	0.64	0.58	0.4147674	0.586569689	-2.5572	Yes
Total Average	0.62	0.81	0.27025173	0.382193668	-2.7473	Yes

Neo Casi Scores	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant
Demand	0.45	0.29	0.37917674	0.536236888	-1.3986	No
LFT	0.65	0.61	0.40592487	0.574064456	0.5226	No
ROW-O	0.63	0.42	0.47979371	0.678530766	-0.2948	No
ROW-S	0.72	0.73	0.37412297	0.529089784	-2.457	Yes
Awfulizing	0.64	0.58	0.4147674	0.586569689	0.6819	No
Total Average	0.62	0.81	0.27025173	0.382193668	-0.8111	No

Moses Casi Scores	SD	Cronbach Alpha	SE_m	SDIFF	RCI	Significant
Demand	0.45	0.29	0.37917674	0.536236888	-0.6527	No
LFT	0.65	0.61	0.40592487	0.574064456	0.6968	No
ROW-O	0.63	0.42	0.47979371	0.678530766	-1.7685	No
ROW-S	0.72	0.73	0.37412297	0.529089784	-1.512	No
Awfulizing	0.64	0.58	0.4147674	0.586569689	0	No
Total Average	0.62	0.81	0.27025173	0.382193668	-1.0204	No

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Appendix K: Conners Reliable Change Index

Moses Parent				
	Before (raw)	After (raw)	Before (T-score)	After (T-score)
Inattention	7	4	58	45
Hyperactivity/Impulsivity	8	4	73	58
Learning Problems	3	2	53	49
Executive Functioning	8	5	63	53
Defiance/Aggression	9	5	90	63
Peer Relations	7	6	90	90
Moses Teacher 1				
	Before (raw)	After (raw)	Before (T-score)	After (T-score)
Inattention	1	0	44	42
Hyperactivity/Impulsivity	7	9	67	73
Learning Problems/Executive Functioning	2	3	42	40
Defiance/Aggression	15	6	90	82
Peer Relations	3	1	60	50
Moses teacher 2				
	Before (raw)	After (raw)	Before (T-score)	After (T-score)
Inattention		44		44
Hyperactivity/Impulsivity		56		56
Learning Problems/Executive Functioning		42		42
Defiance/Aggression		89		89
Peer Relations		55		55

Neo Parent				
	Before	After	Before (T-score)	After (T-score)
Inattention				
Hyperactivity/Impulsivity				
Learning Problems				
Executive Functioning				
Defiance/Aggression				
Peer Relations				
Neo Teacher 1				
	Before	After	Before (T-score)	After (T-score)
Inattention	6	4	58	48
Hyperactivity/Impulsivity	16	10	90	76
Learning	3	5	50	51
Defiance/Aggression	15	3	90	70
Peer Relations	6	2	75	58
Neo Teacher 2				
	Before	After	Before (T-score)	After (T-score)
Inattention		61		61
Hyperactivity/Impulsivity		66		66
Learning		51		51
Defiance/Aggression		78		78
Peer Relations		51		51

Thabo Parent				
	Before	After	Before (T-score)	After (T-score)
Inattention	10	7	71	58
Hyperactivity/Impulsivity	6	1	65	51
Learning Problems	1	1	45	46
Executive Functioning	6	4	53	43
Defiance/Aggression	3	0	63	58
Peer Relations	0	1	45	53
Thabo Teacher				
	Before	After	Before (T-score)	After (T-score)
Inattention	5	4	53	53
Hyperactivity/Impulsivity	12	8	83	69
Learning	1	1	50	41
Defiance/Aggression	14	7	90	90
Peer Relations	0	0	55	45

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Jonathan Parent				
	Before	After	Before (T-score)	After (T-score)
Inattention	8	7	67	71
Hyperactivity/Impulsivity	5	7	61	68
Learning Problems	3	3	53	53
Executive Functioning	12	11	71	69
Defiance/Aggression	2	0	59	46
Peer Relations	3	2	67	59
Jonathan Teacher				
	Before	After	Before (T-score)	After (T-score)
Inattention	12	11	75	72
Hyperactivity/Impulsivity	14	6	84	60
Learning	13	7	70	57
Defiance/Aggression	3	1	68	54
Peer Relations	0	0	45	45

Jonathan Conners - Parent - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	2.9	0.93	0.76726788	1.085080642	-0.922	No	9.31	-4	No
Hyperactivity/Impulsivity	2.73	0.92	0.772160605	1.092	1.8315	No	8.06	-7	No
Learning Problems	2.66	0.85	1.03021357	1.456942003	0	No	9.31	0	No
Executive Functioning	3.59	0.88	1.24361248	1.758733635	-0.569	No	12.09	2	No
Defiance/Aggression	1.55	0.9	0.490153037	0.693181073	-2.885	Yes	6.58	13	Yes
Peer Relations	1.36	0.92	0.384666089	0.544	-1.838	No	4.03	8	Yes

Jonathan Conners - Teacher - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	3.36	0.94	0.823028554	1.163938143	-0.859	No	9.53	3	No
Hyperactivity/Impulsivity	3.37	0.93	0.891618192	1.260938539	-6.344	Yes	10.66	24	Yes
Learning Problems / Executive Fu	3.81	0.88	1.319822715	1.866511184	-3.215	Yes	10.14	13	Yes
Defiance/Aggression	1.34	0.91	0.402	0.568513852	-3.518	Yes	12.74	14	Yes
Peer Relations	2.18	0.94	0.533988764	0.755174152	0	No	11.4	0	No

Thabo Conners - Parent - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	2.77	0.93	0.732873113	1.036439096	-2.895	Yes	9.31	13	Yes
Hyperactivity/Impulsivity	2.62	0.92	0.741047907	1.048	-4.771	Yes	8.06	14	Yes
Learning Problems	2.69	0.85	1.04183252	1.47337368	0	No	9.31	-1	No
Executive Functioning	3.23	0.88	1.118904822	1.582370374	-1.264	No	12.09	10	No
Defiance/Aggression	1.64	0.9	0.518613536	0.733430297	-4.09	Yes	6.58	5	No
Peer Relations	1.27	0.92	0.359210245	0.508	1.9685	Yes	4.03	-8	Yes

Thabo Conners - Teacher - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	4.32	0.94	1.058179569	1.496491898	-0.668	No	9.53	0	No
Hyperactivity/Impulsivity	2.98	0.93	0.788433891	1.115013901	-3.587	Yes	10.66	14	Yes
Learning Problems / Executive Fu	3.91	0.88	1.354463732	1.915500979	0	No	10.14	9	No
Defiance/Aggression	1.55	0.91	0.465	0.657609307	-10.64	Yes	12.74	0	No
Peer Relations	1.95	0.94	0.4776505	0.675499815	0	No	11.4	10	No

Neo Conners - Teacher - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	4.32	0.94	1.058179569	1.496491898	-1.336	No	9.53	10	Yes
Hyperactivity/Impulsivity	2.98	0.93	0.788433891	1.115013901	-5.381	Yes	10.66	14	Yes
Learning Problems / Executive Fu	3.91	0.88	1.354463732	1.915500979	1.0441	No	10.14	-1	No
Defiance/Aggression	1.55	0.91	0.465	0.657609307	-18.25	Yes	12.74	20	Yes
Peer Relations	1.95	0.94	0.4776505	0.675499815	-5.922	Yes	11.4	17	Yes

Moses Conners - Parent - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	2.77	0.93	0.732873113	1.036439096	-2.895	Yes	9.31	13	Yes
Hyperactivity/Impulsivity	2.62	0.92	0.741047907	1.048	-3.817	Yes	8.06	15	Yes
Learning Problems	2.69	0.85	1.04183252	1.47337368	-0.679	No	9.31	4	No
Executive Functioning	3.23	0.88	1.118904822	1.582370374	-1.896	No	12.09	10	No
Defiance/Aggression	1.64	0.9	0.518613536	0.733430297	-5.454	Yes	6.58	27	Yes
Peer Relations	1.27	0.92	0.359210245	0.508	-1.969	Yes	4.03	0	No

Moses Conners - Teacher - RCI									
	SD	Cronbach A	SE_m	SDIFF	RCI	Significant	Conners T Score Sign Difference		Significance according to Conners T Score
Inattention	4.32	0.94	1.058179569	1.496491898	-0.668	No	9.53	2	No
Hyperactivity/Impulsivity	2.98	0.93	0.788433891	1.115013901	1.7937	No	10.66	-6	No
Learning Problems / Executive Fu	3.91	0.88	1.354463732	1.915500979	0.5221	No	10.14	2	No
Defiance/Aggression	1.55	0.91	0.465	0.657609307	-13.69	Yes	12.74	8	No
Peer Relations	1.95	0.94	0.4776505	0.675499815	-2.961	Yes	11.4	10	No

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