Imparting Self-Control Skills to Decrease Aggressive Behavior in a 12-Year-Old Boy: A Case Study

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Imparting Self-Control Skills to Decrease Aggressive Behavior in a 12-Year-Old Boy
A Case Study

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Abstract

• Summary: This paper presents the case of a 12-year-old boy with oppositional defiant disorder (ODD) who demonstrated no interest in participating in therapy. The aims of the paper were to present a multiple therapy design as an effective measurement for social workers to use in their regular intervention process; to learn about the relative effectiveness of three common methods for addressing ODD (behavior therapy being used in teacher supervision and parental counseling and cognitive therapy being used in the child’s individual therapy); and to present a self-control model for improving the child’s behavior.

• Findings: The case study pointed to the efficacy of the self-control model for helping the child change. Therapy facilitated a significant decrease in the child’s disruptive behavior as well as a significant increase in the child’s self-control and social interaction. Also, the case study presented the feasibility of the single case design as an effective way for social workers to assess and evaluate their intervention.

• Applications: The presented case study highlighted the ability of social workers:

1. to supervise parents and teachers as important change agents in the child’s environment;
2. to use the single case design in daily intervention; and
3. to utilize cognitive behavioral therapy as an effective method for change.

The efficacy of the intervention pinpointed the need to apply the proposed methods for other problems as well.

Keywords aggressive behavior emotion self-control thought
Introduction

Social work’s primary obligation consists of intervening for the welfare of weak and vulnerable populations. Thus, children encompass a major target of social work intervention, with a focus on abused and neglected children. Yet children who themselves mistreat other children do not receive the attention of mainstream social work interventions, despite the disruptive and harmful effects of these children’s behavior on their peer, school, and family environments, and despite these children’s high likelihood of future maladjustment in adulthood. These maltreating children do not easily collaborate with a therapeutic process unless mandated by a juvenile court or probation office. They seem to demonstrate no interest in therapy and appear very resistant to change. Among those who apply intervention, social workers comprise the only professionals who attempt to reach out and help such clients who lack motivation, even when the clients show no outward interest in being helped (Ronen, 1995).

This paper presents the case of a 12-year-old boy with oppositional defiant disorder who lacked motivation or interest in therapy. The aims of the paper were:

a. to present a multiple therapy design as an effective measurement for social workers to use in their regular intervention process;
b. to learn about the relative effectiveness of three common intervention methods that address oppositional defiant disorder; and
c. to present a self-control model for improving the child’s behavior.

Oppositional Defiant Disorder

Behavioral disturbances such as oppositional defiant disorder (ODD) constitute a major social problem and one of the most frequent reasons for children’s referrals (Kazdin, 1987, 1998). Behavioral disorders have a relatively poor long-term prognosis and are transmitted across generations (Kazdin, 1988, 1998). Estimates have indicated that children with behavioral disorders encompass from one-third to one-half of all child and adolescent clinic referrals (Herbert, 1987; Webster-Stratton, 1993).

The literature on behavioral disorders contains various definitions, a large range of therapeutic methods, and different means of assessment and evaluation (Achenbach, 1985, 1993; Kazdin et al., 1987). The various definitions mentioned in the attention-deficit and disruptive disorders section of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) include attention-deficit/hyperactivity disorder, conduct disorder, ODD, and disruptive behavior disorder.

The present study focuses on ODD (Scotti et al., 1998), which involves a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures. It includes at least four of the following criteria: loses
temper; often argues with adults; often actively defies or refuses to comply with adults’ requests or rules; often deliberately annoys people; often blames others for his or her mistakes or misbehavior; is often touchy or easily annoyed by others; is often angry and resentful; and/or is often spiteful or vindictive (American Psychiatric Association, 1994).

Kazdin (1998) stated that the main problem in ameliorating ODD lies in the lack of a standard, consistent explanation to link theory, assessment, diagnosis, therapy, and evaluation. Therefore, it is a complex task to determine systematic goals for intervention or effective data-based methods for changing this problem.

In a recent paper, Bandura et al. (2001) proposed a theoretical explanation for the development of aggressive behavior (a behavior that is considered to be the more serious type of ODD). They conceptualized behavior as the capacity to exercise some measure of control over one’s thought processes, motivation, affect, and actions, which all operate through mechanisms of personal agency. The most crucial of these mechanisms comprises the self-efficacy mechanism (Bandura, 1997). They suggested that aggressive behavior results from deficits in three main components: academic efficacy, social efficacy, and self-regulatory efficacy. These three interlinked components influence one another. All three relate to prosocial behavior as well as moral disengagement. Likewise, they all correspond with ruminative affectivity and therefore may result in transgressive behavior.

Kazdin (1998) mentioned three kinds of promising intervention programs for children who evidence behavioral disturbances: functional family therapy, parent and teacher counseling, and cognitive problem-solving models. These programs each offer some theoretical rationale to explicate how the dysfunction comes about and how intervention can redress the dysfunction. Basic research supports each program’s conceptualization, and outcome data for each have shown effective change.

The rationale for basing intervention on family therapy holds the family’s construction responsible for its problematic communication style, roles, and negotiations. Family therapy aims to change the members’ roles and teach them a better way to relate to each other (Forehand and McMahon, 1981; Herbert, 1987; Howard and Kendall, 1996; Kazdin, 1998; Patterson, 1982; Webster-Stratton, 1993).

The rationale for supervising teachers and parents relies on the tenet that behavioral disturbances produce positive outcomes for the child, such as a sense of being strong and capable of achieving one’s goals. Through supervision, parents and teachers learn to change these secondary outcomes and thereby to change the child’s behavior (Herbert, 1987; Hughes, 1988; Kazdin, 1998; Webster-Stratton, 1993).

Individual interventions in cases of ODD and conduct disorders are based on the range of cognitive deficits and distortions evidenced by these children (Bailey, 1998; Crick and Dodge, 1994; Hughes, 1988; Kendall, 1993; Kendall
and Braswell, 1985; Kendall and Chu, 2000). These children recall high rates of hostile cues in social situations, attend to few cues when interpreting the meaning of others’ behavior, and attribute the behavior of others to hostile intentions when in ambiguous situations. When they are in contact with other aggressive children, they tend to underestimate their own level of aggression.

Studies have pinpointed the efficacy of cognitive therapy in changing disruptive defiant behavior (Bailey, 1998; Durlak et al., 1991; Kazdin, 1994; Kendall and Chu, 2000; Ronen, 2003). The most popular cognitive techniques for reducing ODD and conduct disorders consist of cognitive problem skill training and the application of social skills training. Teaching a child to refrain from aggressive cognitions and to emphasize alternative social cognitions appears to decrease actual aggressive behavior successfully. Such programs incorporate constant reinforcements of prosocial behavior and discussions of antisocial behavior (Bailey, 1998), with training to improve social relationships via role play, observation, modeling, practicing techniques, and application of self-control skills.

In the present case study, we attempted to combine different effective intervention modes into one intervention that included teacher supervision, parent counseling and therapy, and individual cognitive therapy. To investigate the relative effectiveness of each of the components, we conducted this intervention using a single case design consisting of multiple therapies.

The Single Case Design

The unique feature of the single case design comprises its capacity to conduct experimental investigations with one single case, i.e. one client, while evaluating both the effect of intervention and the manner in which change occurs (Kazdin, 1982; Ronen, 2003). The efficacy of the single case design lies in its ability to infer about the intervention’s effects by utilizing the client as his or her own control (Kazdin, 1982, 1994; Ronen, 1993a, 1993b; Ronen and Rosenbaum, 2001). The employment of single case designs fixes attention on the process rather than the outcome of intervention, with a focus on how the client changes step by step through therapy (Ronen, 1993a, 1993b, 2003). This design allows therapists to determine what was really effective in the intervention, when, and how – thus making replication of the intervention process easier to accomplish. The single case design shows the effect of the intervention by comparing different conditions or therapeutic techniques with the same client, trying to pinpoint the changes that occurred (Kazdin, 1994).

This paper will present the use of a multiple therapy design, that is, three different methods that were introduced consecutively to learn which therapy was effective for which behavior. All three methods are available for social workers to apply and, together, provide an integrated intervention that can consistently help children change.
Assessment and Decision Making

**Intake session: the family** I conducted the intake session with David and his mother. David was 12 years old at the time of referral to my private clinic. David’s mother brought him to therapy because of his aggressive, undisciplined behavior. She was afraid that if he did not change, he would be moved to a special education school. David was constantly involved in physical fights with other children, and he teased, laughed at, and mistreated other children. He was disruptive at school, refused to comply with the teacher’s demands, did not complete his homework assignments, and spent many hours playing truant – wandering the school hallways, skipping school, or coming tardy to class. His mother said that he could sit still while playing the computer or watching television, but in school he would frequently get up, move around, and ‘drive the teacher crazy’. He was extremely rude toward adults. He used to be a fair enough student but lately had begun to receive lower grades, and his friends were no longer putting up with his aggravations. He was not invited to join friends’ activities, had no contact with peers, and dropped out of his afterschool football team and computer group, although he loved both.

David’s mother was a single parent. She delivered him when she was aged 17, while she attended a secretarial track at a vocational school, after having dropped out of regular high school. He never met his father. The mother claimed that David was the best thing that ever happened to her, and that becoming a mother saved her from turning to a life of prostitution. With his birth, for the first time, she felt a challenge to improve her life and to be good in order to be a good mother. She fought against the authorities who tried to take David away from her. With her social worker’s help, she was able to persuade her parents to let her stay at their home with David until she found work. She later found her current job as a secretary in a large company, but continued living with David at her parents’. She never married. She had many friends and a good relationship with her parents. She was a very organized, hardworking, and caring person, yet she spoiled David and found it difficult to set limits on his behavior. She felt that she had to compensate him for not having a father and a family, so she gave in to him and indulged him with anything he wanted. At home, he was constantly at odds with his mother, arguing to try to reverse her decisions and make her do what he wanted. She felt she no longer had the patience or energy to continue arguing with him. The mother said she was exhausted and felt helpless and hopeless.

**Assessing David** The assessment process entailed the first intake session (described above) with David and his mother, an individual session with David, and interviews and questionnaires with both the mother and the teacher.

**Interviewing mother, teacher, and David** Over the intake session, the mother reported on David’s disruptive behavior (as described above). In interviewing
the teacher, similar information was obtained: The teacher reported that, over the last month, she sent four letters of reprimand to the mother and called the mother twice to school, and David was suspended once for three days.

In the individual session with David, he tended to blame everyone else for his behavior, refusing to take responsibility for it. I observed that David was a very thin, tall boy, who looked enormously confident. Throughout the meeting, he appeared hyperactive, jumping from one chair to the other, shifting his gaze all over the room, trying to touch things around him, and asking questions that were not related to the discussion. Based on this observation, David seemed to be restless, showed difficulties focusing attention, and lacked motivation. For example, he stated that he did not need any help and he did not see any reason why he should change.

Assessment tools With reference to assessment tools, I considered both the characteristics of David’s age and developmental stage (adolescence) and the type of problems he presented (ODD). Adolescents with ODD usually view others as the main cause for their behavior and do not demonstrate an internal locus of control or responsibility. It is therefore important to focus on assessments from the environment. Both the mother and the teacher completed the Conners (1969) rating scale (comprising 12 items describing child behaviors such as impulsivity, hyperactivity, disobedience, and lack of control) and the inventory for child behavior problems for parents and teachers, which addresses the child’s ODD-related behavior with peers, siblings, and adults (Robinson et al., 1980).

Table 1 presents the various assessment tools. According to both the teacher and the mother, as reflected in the Conners (1969) rating scale and according to my own observation, David evidenced some attention difficulties, but these did not reach the level of attention-deficit/hyperactivity disorder. As for the inventory of child problem behaviors (Robinson et al., 1980), David received ratings higher than the norm (106 according to the mother and 112 according to the teacher), indicating a high level of behavioral problems. David clearly met the criteria for diagnosis of ODD according to the DSM-IV (American Psychiatric Association, 1994).

Making Decisions about Therapy
As seen in Table 2, the process of child intervention involved various phases of decision making (Ronen, 1993c, 2001, 2003).

The first phase concerned whether or not David needed therapy. I was able to reach conclusions concerning four sets of variables in order to make this decision:

1. According to clinical categories and environmental reports, David’s behavior clearly deviated from the norm and met the criteria for diagnosis of ODD (American Psychiatric Association, 1994; Scotti et al., 1998), thus
necessitating therapy. David’s behavior pattern was lifelong but had worsened over the last four months. It was unlikely to improve on its own, and this deterioration posed a risk to him academically as well as socially.

2. In terms of developmental variables, adolescents often exhibit disobedient behavior during their normal maturation processes, as attempts to establish a separate identity and forge an independent existence in the world (Ronen, 1997, 2003). However, David’s behavior was, by all accounts, much more extreme, deviating significantly from his age and sex group and from the norm in his surroundings.

3. In examining child and family variables, motivation appeared crucial. Children with disobedient behavior do not usually present personal motivation for change. Instead, parents and teachers are generally those who instigate a referral for therapy. Based on Kanfer and Schefft (1988), I believe that everyone has motivation. We need only to uncover what we are motivated toward. I thought I could increase David’s motivation for therapy by focusing on improving his peer relationships and by talking about ‘getting his mother off his back’.

4. Relating to therapy variables, ODD comprises a behavior that can be changed. Intervention must involve the environment in the change process, to supervise others in how to relate to David. Yet the necessary skills for controlling himself needed to be imparted to David.

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Ronen: Imparting Self-Control Skills

Table 1  **Assessment methods for disobedient and aggressive behaviors**

<table>
<thead>
<tr>
<th>Who should be assessed</th>
<th>Nature of the assessment</th>
<th>Assessment tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td>Structured questionnaires with known tools</td>
<td>Conners (1969) rating scale of hyperactive and impulsive behavior</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eyberg inventory of child behavior problems (Robinson et al., 1980)</td>
</tr>
<tr>
<td>School documentation</td>
<td>Documents in the child’s school file (e.g. letters of suspension, summons to the child’s family)</td>
<td></td>
</tr>
<tr>
<td><strong>Mother</strong></td>
<td>Reliable questionnaires</td>
<td>Conners (1969) scale</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eyberg inventory (Robinson et al., 1980)</td>
</tr>
<tr>
<td><strong>The child</strong></td>
<td>Self-reports</td>
<td>Self-control scale</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily records</td>
</tr>
</tbody>
</table>
The second phase of decision making concerns the need to classify David’s type of referral and goals for change (Ronen, 2001, 2003). Referrals may be classified into four main types of behavior that each correlate with an inherent goal for change: undercontrolled behavior that needs to be reduced (for example, aggressiveness, hyperactivity, impulsivity); overcontrolled behavior that needs to be increased (for example, depression, anxiety, loneliness); anxiety disorders that need to be removed; and developmental problems that need to be facilitated and improved (such as overdependence, lack of self-control, immature behaviors). David’s disobedient, defiant behavior could clearly be classified as the first of the four types of childhood behavior problems: an acting-out, undercontrolled behavior problem obviously needing reduction. I defined the major goal for David’s therapy as decreasing his negativism, defiance, and oppositional behavior. In addition, David also required therapeutic intervention related to the second type of goal for change – increasing a behavior – to help him improve his prosocial behavior.

The third phase of decision making, pinpointing the client at the focus of therapy, should consider the kind of behavioral disturbance and the child’s current developmental tasks. Disorders such as ODD respond well to training the environment in how to reinforce positive behavior and punish or avoid unwanted behavior. David’s problematic interactions at home and at school plainly suggested the urgency of supervision for his mother and teachers. At the age of 12, David’s major developmental task comprised the formulation of a healthy identity, suggesting that he must also participate in individual therapy. The risk was high that David, who already experienced continually hostile

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### Table 2  Decision making phases

<table>
<thead>
<tr>
<th>Phase</th>
<th>Aim of the phase</th>
<th>Variables to be considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Making a decision on the need for therapy</td>
<td>Clinical categories, Developmental variables, Child and family variables, Therapy variables</td>
</tr>
<tr>
<td>2</td>
<td>Classifying the referral and goals for change</td>
<td>Reducing undercontrolled behavior, Increasing overcontrolled behavior, Removing anxiety, Facilitating development</td>
</tr>
<tr>
<td>3</td>
<td>Making a decision on who should participate in therapy</td>
<td>Nature of the behavioral disturbance, Developmental tasks</td>
</tr>
<tr>
<td>4</td>
<td>Selecting the optimal therapy modes</td>
<td>Nature of the deficit, Developmental considerations, Nature of the client</td>
</tr>
</tbody>
</table>
emotions and held rigidly negative beliefs about the world and himself, might integrate these cognitions and affects into his developing identity, thereby reducing the likelihood that he could positively adjust to society in the future (Ronen, 2003). Thus, in combining the two aforementioned considerations, I determined to offer David individual therapy and to supervise his mother and his teacher.

The last phase of decision making selects the optimal intervention modes. Both his developmental stage and problem area highlighted the need to train David verbally in order to decrease his deviant behavior and improve his prosocial behavior. Also, David’s nature, as a bright adolescent with good verbal skills, enabled verbal therapy. The aim of therapy would therefore be to impart skills to the teacher that could cease his disobedient behavior; to train the mother in techniques that could reinforce desired behavior and decrease noncompliant behavior; and to teach David how to change his thoughts, emotions, and behaviors – mainly, how to acquire problem-solving skills that would alter his habitual responses. It seemed that a self-control model could be the intervention of choice for David. Research has pointed to the efficacy of self-control interventions for disruptive behavior disturbances.

Self-Control Intervention Model
Ronen and Rosenbaum (2001) developed the self-control intervention model (SCIM), which applies the self-control intervention developed by Ronen to address various childhood problems (Ronen, 1993a, 1993b, 1997, 2003). The model aims to equip children both with self-control skills and with self-help methods to facilitate their future independent functioning. Enhancing children’s self-help skills enables them to maintain the therapy’s successful outcomes by continuing to carry out self-therapy, by generalizing and transferring their basic learning, and by facilitating self-change.

The SCIM contains four modules (see Table 3):

1. Cognitive restructuring This module aims to teach the child that a behavior can be changed and that, as with many other kinds of behavior, this change depends on the child (Beck et al., 1979; Ellis, 1962). The therapist elicits cognitive restructuring by increasing children’s self-efficacy about their ability to achieve change (Bandura, 1997), as well as by utilizing redefinition, changing attributional styles, and reframing the child’s present functioning (Beck et al., 1979; Kanfer and Schefft, 1988; Meichenbaum, 1979). The techniques used include Socratic questions and paradoxical examples.

2. Problem analysis This module trains the child to observe the link between the brain, body, and final problematic behaviors. The therapist teaches the child to notice the links between thoughts, emotions, and behaviors and to learn the link between cause and effect (Beck et al., 1979; Ronen, 1997). The therapist uses rational analysis of these processes, employs written materials and anatomical
illustrations of the human body, and helps the child accept responsibility for behaviors by learning to change the brain’s commands. The child practices identifying automatic thoughts and using self-talk and self-recording to change unmediated thoughts into mediated ones.

3. **Attentional focus** This module aims to increase the child’s awareness of behavior and internal stimuli, raise sensitivity to the body, and particularly learn to identify internal cues related to the specific problem (Bandura, 1997; Mahoney, 1991, 1995). The therapist uses relaxation, concentration, and self-monitoring to promote achievement of these targets.

4. **Self-control practice** This module trains the child in self-control techniques such as self-talk, self-evaluation, self-monitoring, thinking aloud, and problem-solving skills (Barrios and Hartman, 1988; Brigham et al., 1985; Elias et al., 1986; Kendall and Braswell, 1985; Ronen, 1997). In the first stage of general skills training, the therapist assigns various kinds of practicing. Practice includes using self-instruction, both in the sessions and in homework assignments, to overcome disappointments. Through practice, the child learns that as confidence grows, the chances of success also increase (Bandura, 1997). The self-control techniques taught through this module for changing automatic behaviors to mediated ones include physical as well as emotional exercises such as resisting temptation, self-talk, self-reward, problem solving, and the use of imagery exercises (Meichenbaum, 1979; Ronen, 1997).

<table>
<thead>
<tr>
<th>Module</th>
<th>Aim</th>
<th>Techniques</th>
</tr>
</thead>
</table>
| 1      | Cognitive restructuring | 1. Redefinition  
2. Attribution  
3. Reframing |
| 2      | Problem analysis | Noting the links between:  
Thought-emotion-behavior  
Cause-effect |
| 3      | Attentional focus | Increasing awareness  
Increasing sensitivity  
Identifying internal cues |
| 4      | Self-control practice | Resisting temptation  
Self-talk  
Self-reward  
Using imagery |
Intervention

Teacher Supervision

As agreed with David and his mother, we started intervention only by instituting teacher supervision, in order to determine how effective this method would be within the multiple therapy design. I met with the teacher twice and began to converse with her twice a week by telephone. In those talks, I guided her in changing her punishment methods, which had been ineffective. For example, David was happy to miss class when the teacher sent him out or the principal suspended him, and he enjoyed the attention of his mother when she was summoned to school. We devised more effective punishments such as staying in class and missing recess if he had disturbed others. At the same time, we introduced reinforcements. He could choose a class to skip if he prepared his homework and behaved himself in all the other classes that day. As a reinforcement for trying not to get up and move around during class, he could go help the teacher in the computer center. I also instructed David’s teacher to begin sending his mother letters about his good behavior.

After the first two weeks, a slight change emerged in David’s behavior. Gradually, he decreased the number of classes that he skipped, and he reduced his disruptiveness. We continued with the teacher constantly giving him positive reinforcements. David became more involved in learning. After five weeks, the teacher reported that David was still not preparing homework assignments in full nor was he concentrating well during class assignments; however, he had stopped skipping classes or arriving late. The teacher felt that smiling to him, thanking him for not disturbing the class, and challenging him to be more involved (such as giving the class a lecture about basketball, something he loved and cared about) were all very helpful. She felt a change in David in that he was no longer rude to her or to the other teachers.

Counseling the Mother

David’s mother was very motivated to be helped. Six weeks after I started working with the teacher, it was evident that although an improvement had emerged in David’s school behavior, this improvement was insufficient. We then started counseling the mother as another step that might help David. I met the mother for four weekly sessions, in which we analyzed David’s behavior. We tried to learn the consequences of his various problematic behaviors and to assess, in behavioral terms, how David’s actions helped him receive what he wanted. Counseling focused mainly on helping the mother change the outcomes of David’s behavior by teaching him that disobeying his mother would result in losing things he wanted but that compliance with her wishes would achieve various reinforcements. I taught David’s mother how to avoid reinforcing unwanted behavior, how to limit his undesirable behavior, and how to reinforce positive behavior.
It was very difficult for her to refrain from giving David everything he wanted and from constantly lecturing him. It was also difficult for her to let him deal alone with the school and not to interfere. We practiced methods of avoiding giving David attention every time he was rude to her, of constantly reinforcing him for what he did well over the day, and of evaluating each day together with David. Over the first month, slight changes emerged in the atmosphere at home, in the mother’s feeling of budding control over the situation, and in both David’s and his mother’s ability to conduct conversations without arguing.

About 3 months later, as David started taking part in individual therapy, the change increased, and the mother felt more confident in changing her behavior with David.

**Individual Therapy with David**

Individual therapy with David started about three months after I first saw David and his mother (after six weeks of teacher supervision and four weeks of maternal counseling). While intervening with children and adolescents, an important part of therapy concerns establishing collaboration with the client. A prerequisite for collaborating with children and adolescents consists of the therapist’s ability to use simple language, even slang terms that are familiar to clients of that age, to help them feel that the therapist can understand them and talk with them at their level (Ronen, 1997). This is particularly important when using verbal therapy. Therefore, while herein describing conversations with David and the records I asked him to complete, I will employ such colloquial child-geared language. Therapy with David focused on verbal training in self-control following the SCIM model described above.

**Module 1: Cognitive restructuring and redefinition** David never took responsibility for his disruptive behavior, continually blaming everyone else. My first aim consisted of increasing his motivation for change and helping him understand that he could be responsible for what happened in his life.

David perceived himself as a strong child who was making all the decisions in his life and who could control the others around him. I redefined his behavior as that of someone very weak who was controlled by others. In the first few sessions, therapy focused on showing David that other children, as well as the teacher, were indeed controlling his behavior. They could make him feel angry or explode. Being strong means that he alone would decide when to explode rather than having them decide for him. David learned to observe his own and his classmates’ behavior over the week, to see which children were the ones whom most of the class followed, how they did it, who he saw as being strong, and how he would like to be strong. Inasmuch as David did not like my redefinition of him as a weak rather than strong young person, he worked hard to try and prove to me that I was wrong and that he was strong. In this process of trying to persuade me, he gradually started planning and deciding on his goals.
During those first three weeks, according to his own self-monitoring and observation, the frequency of his arguments with friends started decreasing, and he began improving his work habits during class (e.g. he put his books on the desk, read and wrote when he needed to, and completed assignments like other children).

His primary assignment in therapy comprised the usage of a continuum to constantly rate himself in comparison to his friends, relating to three questions: how strong they were, how much they controlled themselves, and to what extent they made decisions for themselves. About a month after we started therapy, David was able to accept my redefinition of his aggression as a behavior he himself was performing. I explained it as a way he thought would help him control others. I also emphasized that it was up to him to change it, if he thought change was important and was ready to invest the effort.

Module 2: Problem analysis

When David became more compliant and agreed to the idea that he could change his behavior if he wanted to, we started working on the second module: teaching David about the cause–effect link existing between his behavior and the way others responded to him. I instructed David to observe his teacher’s behavior, her response to other children, and other children’s behavior. He said that the teacher did not like him as much as she liked other children; she did not smile at him, and she kept blaming him for things he had not done. We started analyzing the way the teacher interpreted his behavior. He practiced various interpretations of events and learned to link the interpretation to emotion. We analyzed these processes, focusing on the role of expectations and learning about the way in which a behavior occurs. I started by presenting some exercises in the room. We conjectured about David’s ensuing feelings and behaviors, depending on the different thoughts he had about the reasons behind my action. As soon as David was able to identify the links between his own thoughts, emotions, and behaviors outside therapy, I asked him to begin maintaining a daily record of one event that occurred, noting his thoughts at the time, what kinds of emotions they aroused, and how he acted.

During those weeks, I asked David to practice eliciting alternative interpretations for others’ behaviors and to try to change his automatic, negative thoughts to positive, mediated ones. He tried to repeat the same exercise we did together in the session, but this time relating to his friends and thinking for himself about the various alternatives. For example, at first I asked David to interpret a gesture of mine. His first, automatic interpretation of my smile was: ‘Tammie is laughing at me’. Only when encouraged to practice positive thinking was David able to generate other explanations such as: ‘I think she is happy’ or ‘She is probably satisfied by what I said’. Next, as a homework assignment, he attempted at home to practice finding at least one positive explanation instead of his automatic negative thoughts about his mother’s or teacher’s behavior, every day. I next asked him to try applying this with friends as well. Finally, several weeks later, he was able to complete these tasks.
Module 3: Attentional focus

In this module, David learned to identify and discriminate his internal sensations and emotions, with an emphasis on focusing in on his feelings and predicting his own behavior. I asked him to try to monitor himself and listen for the very first internal cues that might tell him he was about to break down, shout, and explode. We practiced talking in front of a mirror to identify his facial expressions. We focused on his internal sensations to identify what he felt, how strong the feeling was, and what could help him change those emotions. We practiced relaxation exercises, deep breathing, self-talk, etc. for him to use to calm himself when he sensed these cues were transpiring.

David learned to rate his emotions on a scale of: very furious, a little furious, not furious at all, or calm. At this time, he also began writing a ‘sometimes’ self-help book: ‘Sometimes I feel . . . When I feel this way, I . . . When I feel this way, it is hard for me to . . . When I feel this way, the only thing that helps me is . . . , etc.’ In addition, I instructed David to find something every day that made him feel good. It could be music, a talk with a friend, reading a book, etc. He wrote down one thing he did for himself every day, and then he reported how much he had enjoyed it on a scale of one to ten.

Module 4: Self-control exercises

In this module, our main efforts focused on pinpointing methods that could help David overcome his urge impulsively to hit others, which had involved him in frequent physical fights with peers. We focused on techniques for controlling his behavior such as self-talk, imagination, reinforcement, and self-evaluation, and he began practicing these techniques. His instructions involved selecting one technique each day and then trying, first, to visualize himself practicing the technique and, second, to write down how realistic it seemed to him. Next, he had to attempt to apply the technique in real life.

Termination and Follow-up

Altogether, the process of intervention with David and his environment lasted six months: six weeks with the teacher, about four weeks with the mother, and then about four months with David alone. When therapy terminated (after six months), the teacher and mother each completed both the Conners (1969) and Eyberg (Robinson et al., 1980) scales again. A comparison between the teacher’s and mother’s pre-therapy and post-therapy scales revealed a remarkable decrease in ratings, to a normal score, thus providing an indication of the change in David. Likewise, a comparison between the baseline and the end of therapy intervals in terms of the school documentation (number of reprimanding letters, suspensions from school, and summons to the mother from school) demonstrated obvious, impressive change. Over the last six weeks of intervention, David’s mother received only letters telling her how much he had improved; he was not sent out of class or school; and his mother was not summoned. The school principal even called David once, telling him jokingly that she was bored because no one came to complain about him, and she was no
longer visiting her office. As we neared the end of therapy, the teacher reported that David had even started preparing larger parts of his homework assignments (although not all), and he was working better during class. David himself reported that he was ‘happy’, although he felt he had to say: ‘Well, they [his mother and teacher] have changed at least as much as I did . . .’.

At that time, because David had already shown six consecutive weeks of mainly positive behavior, illustrated clearly by a comparison of his initial and final self-recording scales, we decided to terminate therapy. At this termination interval, David also completed the self-control scale again. I invited him to three monthly follow-up sessions over the next three months to report on his behavior, talk about his successes, and try to pinpoint some areas of difficulty. It seemed that David possessed many social skills, and once his disruptive behavior ceased he was able to invest more efforts in making new friends. He even returned to the afterschool activities that he had dropped before.

Outcomes

An impressive decrease emerged in David’s disobedient behavior during the whole intervention, and through each of the separate phases. Looking at the first phase of intervention, the first six weeks of teacher supervision, a noteworthy change emerged in several aspects of David’s school behavior: truancy, tardiness, classroom demeanor, and compliance with tasks. These changes persevered during the next five months of mother supervision and individual therapy, as shown by comparing the teacher questionnaires at the baseline to those at termination. This improvement also lasted during the three months of follow-up. Thus, providing the teacher with behavioral methods and skills for positive reinforcement strategies, appropriate punishments, and ways to challenge David (Herbert, 1987; Kazdin, 1987; Kendall and Braswell, 1985) helped change those of David’s behaviors that were related to the teacher and to the way the class was conducted, even without David’s participation in individual therapy. However, the teacher’s changes could not impart to him the skills in which he was deficient, such as concentrating while studying, taking responsibility for homework assignments, or improving peer relationships by using personal skills.

Likewise, during the next four weeks directed at counseling the mother, I also mainly focused on the use of behavioral methods to help the mother reinforce positive behavior and avoid attention toward negative behavior. As in the first therapeutic phase, this part also effectively changed specific aspects of David’s behavior. He became more obedient to his mother and improved his communication style with her (Kazdin, 1987, 1998). However, the mother could not change David’s personal skill deficits such as his difficulty identifying what he felt, his poor self-control skills, and his negative automatic thoughts toward the world. The multiphase single case design highlights that these aspects necessitating direct intervention responded to therapy only when David participated in individual training through the self-control model that was directed...
specifically to provide him with those skills. His sensitivity to internal stimuli, ability to monitor and control himself, ability to change negative automatic thoughts to positive ones, and development of self-efficacy began to change only when David learned how to perform these skills and then practiced them.

Conclusions

The results of this study highlight several major conclusions. First, aggressive, disobedient behavior such as in ODD comprises a major problem that social workers face not only while working with abused children who are victims of aggression (and often become aggressive as an outcome) but also while working with the aggressors themselves. Learning to apply a structured, effective intervention for defiant, disobedient, and aggressive behavior can furnish an important skill for social work professionals. This can help both in decreasing the rate of aggression but also for developing preventive programs for children in schools, boarding schools, and other settings.

Second, the present intervention underscores the efficacy of cognitive behavioral methods for eliminating disobedient and disruptive behavior (Kazdin, 1998; Ronen, 1997, 2003). In Israel, where social workers most frequently employ dynamically oriented therapies, the effectiveness of the present single case intervention may challenge social workers to implement more structured cognitive-behaviorally oriented methods.

Third, most of the clients whom social workers meet in their daily practice suffer from multiple problems. In dealing with multi-problem families or difficult cases, social workers must execute careful decision making processes to determine what the client lacks and what the client needs, in order to make optimal decisions about therapeutic design (Ronen, 2001). The current application of three different interventions involving three different settings and modes of intervention (behavioral supervision with the teacher, parent counseling with the mother, and cognitive intervention with David) may facilitate an examination of each therapy’s relative contribution and may contribute to social workers’ understanding of how various methods and intervention settings can incur different changes. For example, teacher supervision elicited gains in David’s classroom behavior but not in his behavior with friends or at home.

Thus, the use of the single case design as a means to demonstrate the efficacy of intervention and how it influences the clients may play a very important role not only for researchers but particularly for social workers as an integral part of their daily implementation of interventions with various clients. As seen in this study, social workers are fully capable of conducting careful assessment and research methods such as the single case design, to learn what is effective for which client at what time. The single case design may indeed help social workers construct the process of intervention. Moreover, this intervention design may serve as a motivation-promoting tool for the client, helping
clients acknowledge their own ability to change by illustrating their areas of improvement following the application of each new intervention mode.

In their book concerning international perspectives on evidence-based practice in social work, Thyer and Kazi (2004) stated that resource cuts and the growth of the voluntary and private sectors alongside the public sectors emphasize the mounting need to evaluate social work practice. They proposed that the field of social work practice must provide evidence of its merit and worth. The single case design responds to these authors’ call by supplying a means for applying evidence-based intervention to clients.

In sum, the present study underscores the difficulties inherent in interventions targeting this problem area relating to aggressive, disruptive behaviors. This multiple therapy design attests to the insufficiency of focusing on only one aspect of the problem rather than on the whole spectrum of behaviors.

The wish to decrease disruptive behavior among children necessitates a combination of environmental changes as well as individual changes. Social workers comprise the professionals who possess all the skills and conditions needed to address this population optimally. Their familiarity with the community and the family enables them to conduct family counseling or family therapy to help the family deal with the child who exhibits problem behaviors. Their familiarity with both the child’s behavior and the environment facilitates better supervision of the school and the teacher. In light of the lack of motivation to participate in therapy on the part of children with acting-out behaviors, social workers who are versed in outreach methods can reach out to these children at home, in school, or in the environmental setting and try to help them individually. I believe that by combining all the needed settings – environmental and individual interventions – we can achieve the elusive but crucial goal of changing the disruptive behavior that has been steadily increasing in children and adolescents over the last decade.

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References
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