Hansel and Gretel's Gretel

Introducing the Character

Gretel is the young protagonist in the Brothers Grimm fairy tale *Hansel and Gretel*, which first appeared in print centuries ago and has since been depicted in a variety of media, including: short films, television cartoons, and an 1893 opera of the same name by 19th-century playwright Engelbert Humperdinck. *Hansel and Gretel* is a beloved fairy tale about a woodcutter's children who suffer the loss of their mother and who must then endure an evil stepmother (despite the common occurrence of blended families in contemporary life, stepparents often are stereotyped as "evil" in traditional fairy tales). As often happens in such old-school fairy tales, the woodcutter, about whom we know little other than that he is a hard worker, falls prey to his new wife's desires to be rid of Hansel and Gretel. She convinces him to cast them into the woods where they find a magical gingerbread house inhabited by a witch. Although the witch welcomes the children, they soon discover that she plans to eat them. Upon discovering her nefarious plan, Hansel pushes the witch into the oven. Thinking that the witch is dead, the children remain in the cottage and eat candy and sweets for days before finding their way home thanks to a marked path that they had cleverly left behind. The father, who was heartbroken over the loss of his children, eagerly welcomes them back and rids the family, once and for all, of his evil-doing wife. *Hansel and Gretel* is a timeless tale about parental loss, betrayal, and the resourcefulness and resiliency of children. Using *Hansel and Gretel* as our starting point, the following basic case summary and diagnostic impressions explore a clinically significant pattern of hostile and defiant behaviors we believe a similar 10-year-old girl named Gretel might be experiencing.

Basic Case Summary

Identifying Information. Gretel Gerstenhagen is a 10-year-old Austrian girl who is a fourth-grade student at the Gingerbread Learning Academy. Currently she lives at home with her fraternal twin, Hansel, her father, and her

stepmother, who only recently became a member of the family. In appearance, Gretel can be characterized as "a rosy-cheeked, blue-eyed girl with curly blond hair." She was dressed in a traditional Germanic child's outfit, left over from a school play in which she starred, which she reported wearing "because it annoys my stepmother." She lives in a socioeconomically lower middle-class neighborhood, her father is a skilled carpenter, and her stepmother works in the home.

Presenting Concern. Gretel was sent to the school counselor's office for an initial meeting by the assistant principal because she has several times stolen another student's lunchbox "as a joke" and refused her teacher's request to return the hidden lunchbox at lunchtime. Gretel had been sent to the principal's office on several occasions for similar behavior, which seemed to have escalated soon after her father remarried to a woman the child referred to as a "witch." Gretel also has been diagnosed with juvenile diabetes.

Background, Family Information, and Relevant History. Gretel and her fraternal twin Hansel were born in Vienna, Austria, to a fourth-generation military family headed by a father who worked as a skilled carpenter and traveled frequently, following house-building demand across the region, and a mother who was bedridden throughout her pregnancy and sick for the first 2 years of the children's lives. Reports indicate that Gretel and her brother were only allowed to visit their mother at her bedside for short periods. A day before their third birthday, their mother died, and soon after the father brought an au pair into the house. Apparently, unbeknownst to the father, the au pair was bringing men into the family home when the father was away. Gretel and her brother learned early how to manipulate this woman, whom they referred to as the "evil witch" and who reciprocated in kind with harsh punishment and withdrawal of privileges. Gretel recalled how the au pair used to bake gingerbread houses and eat them herself while the children watched and begged. One day during a rare outing to the park, one of the neighbors noticed the harsh manner in which the au pair treated the children and reported directly to their father, who immediately fired her.

Following this experience, he decided to spend more time with the children in order to make up for his many absences. By that time, the children were 7 years of age, and he decided that it would be beneficial to move to the United States where he took a job with a contractor firm. Although Gretel was upset at leaving the

familiarity of Austria and the friends that she had made, she soon found a safe and secure haven at the Gingerbread Learning Academy, where she and Hansel were enrolled in the third grade. Soon after the relocation, Hansel and Gretel's father married for a second time to a woman who had never wanted children but who fell in love with their father.

Several months after marrying, Gretel and Hansel's father returned to his busy work life, leaving the children primarily in the care of their new stepmother, who like the au pair they had in Austria, put her needs before those of the children. She would spend long hours on the phone talking to friends, neglecting the children, leaving them to fend for themselves, do their own homework, and even make their own food. Gretel became very adept at sneaking candy from the cupboards as well as stealing it from the small grocery at the corner of their street. Gretel also developed what teachers and her father described as a "short fuse," becoming touchy in response to even very minor adult feedback about her behavior, loudly angry at perceived insults, and argumentative at home, in class, and in the Gingerbread Afterschool Program. When household chores such as cleaning the playroom were left undone, she wrongly blamed her brother; at school, she blamed classmates for incidents on the playground. Increasingly, she yelled at her stepmother at home, muttered under her breath at her classroom teacher, and made a clear point of being out of her seat during classroom quiet time. Characteristically, after a particularly unpleasant evening with the stepmother, Gretel and Hansel ran away from home, living in a small park by the home, and subsisting only on the candy and cookies that they had pirated away before their departure, which Gretel said she did "to show that witch!" It was at that point that Gretel and Hansel's father were summoned to the school and told that unless he took immediate action to control his daughter (and son), they would be removed from the school and possibly even the home. Upon hearing this and realizing that their plan had failed, Gretel told her teacher "maybe I'll just kill myself . . . that'll teach her."

Goals for Counseling and Course of Therapy to Date. Several days after the meeting with the children, Mr. Gerstenhagen and his wife visited with the school counselor and the district school psychologist in order to develop a plan of action. It was decided that Gretel and Hansel would undergo psychological evaluations and

review by a planning team, after which a decision would be made determining whether individual or family counseling or both would be implemented.

Diagnostic Impressions

313.81 (F91.3) Oppositional Defiant Disorder; 250.00 Type II Juvenile Diabetes.

Other factors: V15.49 (Z91.49) Other Personal History of Psychological Trauma—Death of mother, remarriage of father, relational tension with stepmother; V62.4 (Z60.3) Acculturation Difficulty—Geographic relocation to United States.

Discussion of Diagnostic Impressions

Gretel was mandated to visit the school counselor's office after repeatedly hiding another student's lunchbox as a deliberately annoying joke and refusing her teacher's demands to return the lunchbox. Likewise, she has engaged in purposefully annoying behavior at home (such as dressing in odd costumes). Her parents and teachers report that she has a "short-fused" temper, is often argumentative, easily feels resentment, and at times seems spiteful. She also blames other children (e.g., her brother) or adults (e.g., her stepmother) for her own misbehavior.

Gretel's acting out behaviors are symptomatic of the disorders in the Disruptive, Impulse-Control, and Conduct Disorders chapter of the *DSM-5*. This group of disorders includes: Oppositional Defiant Disorder, Intermittent Explosive Disorder, Conduct Disorder, Antisocial Personality Disorder, Pyromania, and Kleptomania. The common feature of this grouping is an individual's difficulty in controlling their emotions and behaviors in a socially acceptable manner.

Using *Hansel and Gretel* as our starting point in this case example, we presented a 10-year-old girl named Gretel who was experiencing a clinically significant pattern of hostile and defiant behaviors beyond what is normally expected among her age and cultural peer group. Her behaviors have been persistent for many months, and they have become sufficiently problematic to impair Gretel's family relationships at home, her

relationships with teachers and peers at school, and her ability to perform and succeed in the classroom. Gretel's behaviors suggest a diagnosis of Oppositional Defiant Disorder, the key feature of which is a pattern of "angry/irritable mood, argumentative/defiant behavior, or vindictiveness" lasting for at least 6 months, typically in a child under 18 years old.

One differential diagnosis might be Conduct Disorder, Childhood-Onset Type. This is another diagnosis found among the group of Disruptive, Impulse-Control, and Conduct Disorder chapter in the *DSM-5*. This diagnosis is ruled out, however, since Gretel's behaviors, although negative and defiant, do not feature the aggressiveness to people and animals, destructiveness, deceitfulness, and serious rule violations characteristic of a Conduct Disorder. Another consideration is to assign no primary mental health diagnosis because oppositional behavior is typical of certain developmental stages such as early childhood and adolescence. In turn, the Oppositional Defiant Disorder diagnosis is appropriate only if "the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture" (APA, 2013, p. 462). Gretel's behaviors meet this standard.

To round out the diagnosis, Gretel's diabetes is listed because its presence may have impacted significantly upon the family system. Further, her family and social stressors are emphasized in the "Other factors" section. The information presented is consistent with the diagnosis portrayed by Gretel in this scenario.

Case Conceptualization

When Gretel came into the Gingerbread Learning Academy's school counseling office, her counselor first conducted an intake meeting in order to collect as much information as he could about the symptoms and situations leading to Gretel's referral. Included in the intake materials were a developmental history, client report, counselor observations, child-oriented clinical interview, play observation, parent report inventories, and information shared by Gretel's school principal and teachers (Knell, 1993, 1994). Based on the intake, Gretel's counselor developed diagnostic impressions, describing her presenting concerns by Oppositional Defiant Disorder. A case conceptualization next was developed. Whereas the purpose of diagnostic impressions is to *describe* the client's concerns, the goal of case conceptualization is to better *understand* and clinically *explain*

the person's experiences (Neukrug & Schwitzer, 2006). It helps the counselor understand the etiology leading to Gretel's Oppositional Defiant behaviors and the factors maintaining these concerns. In turn, case conceptualization sets the stage for treatment planning. Treatment planning then provides a road map that plots out how the counselor and client expect to move from presenting concerns to positive outcomes (Seligman, 1993, p. 157)—helping Gretel manage her oppositional behaviors and defiant thoughts and attitudes and improving her interpersonal interactions.

When forming a case conceptualization, the clinician applies a purist counseling theory, an integration of two or more theories, an eclectic mix of theories, or a solution-focused combination of techniques to his or her understanding of the client. In this case, Gretel's counselor based his conceptualization on psychotherapeutic integration of two theories (Corey, 2009). Psychotherapists very commonly integrate more than one theoretical approach in order to form a conceptualization and treatment plan that will be as efficient and effective as possible for meeting the client's needs (Dattilo & Norcross, 2006; Norcross & Beutler, 2008). In other words, counselors using the psychotherapeutic integration method attempt to flexibly tailor their clinical efforts to "the unique needs and contexts of the individual client" (Norcross & Beutler, 2008, p. 485). Like other counselors using integration, Gretel's school counselor chose this method because he had not found one individual theory that was comprehensive enough, by itself, to address all of the "complexities," "range of client types," and "specific problems" seen among his everyday student caseload (Corey, 2009, p. 450).

Specifically, Gretel's counselor selected an integration of (a) Child-Centered Play Therapy and (b) Cognitive Behavioral Play Therapy. He selected this approach based on Gretel's presentation of problematic behaviors and his knowledge of current outcome research and recommended practice literature with clients experiencing these types of concerns (Kazdin & Weisz, 2003; Lawrence, Condon, Jacobi, & Nicholson, 2006; Mowder, Rubinson, & Yasik, 2009). According to the research, Cognitive Behavioral Play Therapy is one treatment approach indicated when assisting clients who might benefit from a combination of cognitive and behavior change, whereas an integrated approach emphasizing Child-Centered Play Therapy is indicated when the counselor expects to facilitate the child's own problem-solving capacity (Knell, 1993, 1994; Landreth,

1991). The Gingerbread Child Guidance Clinic counselor is comfortable theoretically integrating these approaches.

The counselor used the Inverted Pyramid Method of case conceptualization because this method is especially designed to help clinicians more easily form their conceptual pictures of their clients' needs (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997). The method has four steps: Problem Identification, Thematic Groupings, Theoretical Inferences, and Narrowed Inferences. The counselor's clinical thinking can be seen in the figure that follows.

Gretel's Inverted Pyramid Case Conceptualization Summary: Psychotherapeutic Integration of Child-Centered Play Therapy and Cognitive Behavioral Play Therapy

1. IDENTIFY AND LIST CLIENT CONCERNS

Repeated hiding lunchbox as practical joke
Deliberately annoying classroom behavior
Deliberately annoying home behavior (costumes)
Blames other children for her misbehavior
"Short-fused" temper
Impaired classroom relationships
Argumentative
Impaired family relationships
Easy resentment
Spiteful, hostile
Mutters at teachers

Age 3 bedridden, absent mother
Death of mother at age 3
Age 3–7 punitive au pair
Au pair bringing men to house
Age 7 relocation to U.S.
Geographic and personal adjustment
Yells at stepmother
Stepmother emotionally neglectful
Stepmother neglectful of children's caretaking needs
Has recently run away
Absent father

2. ORGANIZE CONCERNS INTO LOGICAL THEMATIC GROUPINGS

1. History of absent, emotionally absent, neglectful, and/or punitive parents and adult caretakers since age 3
2. Current oppositional and defiant attitude and behaviors in school, home, and neighborhood

3. THEORETICAL INFERENCES: ATTACH THEMATIC GROUPINGS TO INFERRED AREAS OF DIFFICULTY
Psychotherapeutic Integration

Child-Centered Play Therapy
Gretel is engaging in hostile types of attitudes and behaviors in order to express negative, ambivalent, and anxious feelings she has toward parents, adults, and peer targets

Cognitive-Behavioral Play Therapy
Gretel has learned through her history of relationship experiences with parents, stepparents, and other adults that she is unsuccessful communicating her thoughts and feelings through realistic positive, responsible expressions and actions

4. NARROWED INFERENCES: SUICIDALITY AND DEEPER DIFFICULTIES
Psychotherapeutic Integration

Child-Centered Play Therapy
Gretel has failed to experience the types of attending, encouraging, unconditionally positive parental and adult relationships needed to promote her responsible self and management of self; instead she has experienced the types of non-attending, discouraging, conditional, negative parental and adult relationships that promote irresponsible, negative, un-self-managed expressions of self through hostile attitudes

Cognitive Behavioral Play
Gretel maintains the faulty belief that using hostile, negative behaviors is the only method she has for successfully expressing her attitudes, thoughts, and feelings, and behaviors

Step 1: Problem Identification. The first step is Problem Identification. Aspects of the presenting problem (thoughts, feelings, behaviors, physiological features), additional areas of concern besides the presenting concern, family and developmental history, in-session observations, clinical inquiries (medical problems, medications, past counseling, substance use, suicidality), and psychological assessments (problem checklists, personality inventories, mental status exam, specific clinical measures) all may contribute information at Step 1. The counselor "casts a wide net" in order to build Step 1 as exhaustively as possible (Neukrug & Schwitzer, 2006, p. 202). As can be seen in the figure, the counselor thoroughly noted not just all of Gretel's current oppositional and defiant behaviors occurring at school and at home, all of Gretel's aggressive and disrespectful behaviors occurring with peers in various school and neighborhood settings, and her running away and challenge of adults—but also, as much important information as he could find regarding Gretel's earlier developmental experiences, childhood life transitions, and parental and caretaker experiences. He attempted to go beyond just listing the main behaviors that precipitated the referral and to be as complete as he could.

Step 2: Thematic Groupings. The second step is Thematic Groupings. The clinician organizes all of the exhaustive client information found in Step 1 into just a few intuitive-logical clinical groups, categories, or themes, on the basis of sensible common denominators (Neukrug & Schwitzer, 2006). Four different ways of forming the Step 2 theme groups can be used: Descriptive-Diagnosis Approach, Clinical Targets Approach, Areas of Dysfunction Approach, and Intrapsychic Approach. As can be seen in the figure, Gretel's counselor selected the Areas of Dysfunction Approach. This approach sorts together all of the Step 1 information into "areas of dysfunction according to important life situations, life themes, or life roles and skills" (Neukrug & Schwitzer, 2006, p. 205).

The counselor formed two groupings. He grouped together all of Gretel's negative parental and family experiences (loss of mother, au pair difficulties, relocation, stepmother difficulties, absent father, etc.) into the theme "History of absent, emotionally absent, neglectful, and/or punitive parents and adult caretakers since pre-age 3." Likewise, he grouped together all of the remaining Step 1 items—Gretel's many past and current hostile

and problematic behaviors and attitudes—into the theme "Current oppositional and defiant attitudes and behaviors in school, home, and neighborhood."

So far, at Steps 1 and 2, the counselor has used his clinical assessment skills and his clinical judgment to begin critically describing Gretel's needs. Now, at Steps 3 and 4, he applies the theoretical approach he has selected. He begins making theoretical inferences to explain the factors leading to, and maintaining, Gretel's issues as they are seen in Steps 1 and 2.

Step 3: Theoretical Inferences. At Step 3, concepts from the counselor's theoretical integration of two approaches—Child-Centered Play Therapy and Cognitive Behavioral Play Therapy—are applied to the factors causing, and the mechanisms maintaining, Gretel's reasons for referral. The counselor tentatively matches the theme groups in Step 2 with this theoretical approach. In other words, the symptom constellations in Step 2, which were distilled from the symptoms in Step 1, now are combined using theory to show what are believed to be the underlying processes or psychological mechanisms of Gretel's current needs (Neukrug & Schwitzer, 2006; Schwitzer, 2006, 2007).

First, Child-Centered Play Therapy was applied primarily to Gretel's attitudes and use of behaviors for self-expression. According to the Child-Centered Play Therapy conceptual model, adult-child relationships characterized by warm, genuine, unconditional positive regard set the conditions for the child to develop his or her natural "innate human capacity" to "strive toward growth and maturity," become "constructively self-directing," and be able to responsibly and realistically express his or her thoughts, feelings, and attitudes (Landreth & Sweeney, 1997, p. 17). Without these relationship conditions, or with contradictory conditions, the child may not develop a positive striving, constructive self-direction, and responsible and realistic self-expression; instead, she may develop in problematic or frustrating directions (Landreth, 1991; Landreth & Sweeney, 1997). Correspondingly, as can be seen in the figure, Gretel's counselor made the theoretical inference that "Gretel is engaging in hostile types of attitudes and behaviors in order to express negative, ambivalent, and anxious feelings she has toward parents, adults, and peer targets."

Second, Cognitive Behavioral Play Therapy was applied primarily to Gretel's learned behaviors. According to the Cognitive Behavioral Play Therapy model, cognitive and behavioral learning principles apply to children so that the child's behaviors often may be understood as stemming from faulty learning or faulty beliefs; his or her thoughts, feelings, fantasies, and environment all may contribute to inaccurate learned behaviors and reactions (Knell, 1993, 1994). As also can be seen in the figure, when Gretel's counselor additionally applied these concepts, he developed a further Step 3 inference, as follows: Gretel has learned through her history of relationship experiences with parents, stepparent, and other adults that she is unsuccessful at communicating her thoughts and feelings through realistic positive, responsible expressions and actions.

Step 4: Narrowed Inferences. At Step 4, the clinician's selected theory continues to be used to address still-deeper issues when they exist (Schwitzer, 2006, 2007). At this step, "still-deeper, more encompassing, or more central, causal themes" are formed (Neukrug & Schwitzer, 2006, p. 207). Gretel's counselor continued to use psychotherapeutic integration of two approaches.

First, continuing to apply Child-Centered Play Therapy concepts at Step 4, the counselor presented a single, deepest theoretical inference that he believed to be most fundamental for Gretel from a child-centered perspective: Gretel has failed to experience the types of attending, encouraging, unconditionally positive parental and adult relationships needed to promote her responsible, positive, self-directed expression of self and management of self; instead, she has experienced the types of nonattending, discouraging, conditional, negative parental and adult relationships that promote irresponsible, negative, un-self-managed expressions of self through hostile attitudes and behaviors. Second, continuing to apply Cognitive Behavioral Play Therapy concepts, Gretel's counselor presented an additional, complementary deep theoretical inference, as follows: Gretel maintains the faulty belief that using hostile, negative behaviors is the only method she has for successfully expressing her attitudes, thoughts, and feelings. These two narrowed inferences, together, form the basis for understanding Gretel's current counseling situation as we have written her imagined clinical case illustration.

When all four steps are completed, the client information in Step 1 leads to logical-intuitive groupings on the basis of common denominators in Step 2, the groupings then are explained using theory at Step 3, and then, finally, at Step 4, further deeper explanations are made. From start to finish, the thoughts, feelings, behaviors, and physiological features in the topmost portions are connected on down the pyramid into deepest dynamics.

Treatment Planning

At this point, Gretel's clinician at the Gingerbread Child Guidance Clinic has collected all available information about the problems that have been of concern to her and the psychological team that performed her assessment. Based upon this information, the counselor developed a *DSM-5* diagnosis and then, using the "inverted pyramid" (Neukrug & Schwitzer, 2006; Schwitzer, 1996, 1997), formulated a working clinical *explanation* of Gretel's difficulties and their etiology that we called the *case conceptualization.* This, in turn, guides us to the next critical step in our clinical work, called the *treatment plan,* the primary purpose of which is to map out a logical and goal-oriented strategy for making positive changes in the client's life. In essence, the treatment plan is a road map *"*for reducing or eliminating disruptive symptoms that are impeding the client's ability to reach positive mental health outcomes" (Neukrug & Schwitzer, 2006, p. 225). As such, it is the cornerstone of our work with not only Gretel, but with all clients who present with disturbing and disruptive symptoms and/or personality patterns (Jongsma & Peterson, 2006; Jongsma, Peterson, & McInnis, 2003a, 2003b; Seligman, 1993, 1998, 2004).

A comprehensive treatment plan must integrate all of the information from the biopsychosocial interview, diagnosis, and case conceptualization into a coherent plan of action. This *plan* comprises four main components, which include (1) a behavioral definition of the problem(s), (2) the selection of achievable goals, (3) the determination of treatment modes, and (4) the documentation of how change will be measured. The *behavioral definition of the problem(s)* consolidates the results of the case conceptualization into a concise hierarchical list of problems and concerns that will be the focus of treatment. The *selection of achievable goals* refers to assessing and prioritizing the client's concerns into a *hierarchy of urgency* that also takes into account

the client's motivation for change, level of dysfunction, and real-world influences on his or her problems. The *determination of treatment modes* refers to selection of the specific interventions, which are matched to the uniqueness of the client and to his or her goals and clearly tied to a particular theoretical orientation (Neukrug & Schwitzer, 2006). Finally, the clinician must establish how change will be measured, based upon a number of factors, including client records and self-report of change, in-session observations by the clinician, clinician ratings, results of standardized evaluations such as the Conners 3 (Conners, 2008b) or a family functioning questionnaire, pre-post treatment comparisons, and reports by other treating professionals.

The four-step method discussed above can be seen in the text and is outlined below for the case of Gretel, followed by her specific treatment plan.

Step 1: Behavioral Definition of Problems. The first step in treatment planning is to carefully review the case conceptualization, paying particular attention to the results of Step 2 (Thematic Groupings), Step 3 (Theoretical Inferences), and Step 4 (Narrowed Inferences). The identified clinical themes reflect the core areas of concern and distress for the client, while the theoretical and narrowed inferences offer clinical speculation as to their origins. In the case of Gretel, there are two primary areas of concern. The first, "history of absent, emotionally absent, neglectful and/or punitive parents and adult caretakers since age 3," refers to the terminal illness and death of her mother when she was 3 years old, being raised by a punitive au pair between the ages of 3 and 7, the father's remarriage to an emotionally and behaviorally neglectful stepmother, and the subsequent absence of her father from the home for long periods. The second, "current oppositional and defiant attitudes and behaviors at school, home and neighborhood," refers to repeatedly hiding a lunchbox as a practical joke, deliberately annoying classroom and home behavior, blaming other children for her misbehavior, a short-fused temper, argumentativeness, resentfulness, spitefulness and hostility, yelling at her stepmother, muttering at her teachers, running away from home, and impaired classroom and family relationships. These symptoms are consistent with the diagnosis of Oppositional Defiant Disorder (APA, 2013; Matthys & Lochman, 2010; Parritz & Troy, 2011).

Step 2: Identify and Articulate Goals for Change. The second step is the selection of achievable goals, which is based upon a number of factors, including the most pressing or urgent behavioral, emotional, and interpersonal concerns and symptoms as identified by the client and clinician, the willingness and ability of the client to work on those particular goals, and the realistic (real-world) achievability of those goals (Neukrug & Schwitzer, 2006). At this stage of treatment planning, it is important to recognize that not all of the client's problems can be addressed at once, so we focus initially on those that cause the greatest distress and impairment. New goals can be created as old ones are achieved. In the case of Gretel, the goals are divided into two prominent areas. The first, "history of absent, emotionally absent, neglectful and/or punitive parents and adult caretakers since age 3," requires that we help Gretel to successfully grieve the loss of her mother, to begin reinvesting in relationships with others, and to resolve her feelings of sadness and anger that are associated with the loss. Successful achievement of this goal also requires that we help Gretel's father and stepmother understand and support Gretel through this grief process, while also strengthening their marital relationship and parent effectiveness. The second, "current oppositional and defiant attitudes and behaviors at school, home, and neighborhood," requires that we help Gretel to reduce the frequency and intensity of hostile and defiant behaviors toward adults, terminate her defiant and aggressive behavior and replace it with controlled, respectful, and obedient behavior, to resolve the conflict that underlies anger, hostility, and defiance, and to improve her relationship with peers, teachers, and parents. In order to achieve these goals, we must also help her parents and teachers to more effectively discipline her and to communicate with each other regarding her behavior at home and in school.

Step 3: Describe Therapeutic Interventions. This is perhaps the most critical step in the treatment planning process because the clinician must now integrate information from a number of sources, including the case conceptualization, the delineation of the client's problems and goals, and the treatment literature, paying particular attention to *empirically supported treatment* (EST) and *evidence-based practice* (EBP). In essence, the clinician must align his or her treatment approach with scientific evidence from the fields of counseling and psychotherapy. Wampold (2001) identifies two types of evidence-based counseling research: studies that

demonstrate “absolute efficacy,” that is, the fact that counseling and psychotherapy work, and those that demonstrate “relative efficacy,” that is, the fact that certain theoretical/technical approaches work best for certain clients with particular problems (Psychoanalysis, Gestalt Therapy, Cognitive Behavior Therapy, Brief Solution-Focused Therapy, Cognitive Therapy, Dialectical Behavior Therapy, Person-Centered Therapy, Expressive/Creative Therapies, Interpersonal Therapy, and Feminist Therapy); and when delivered through specific treatment modalities (individual, group, and family counseling).

In the case of Gretel, we have decided to use an Integrative Approach to counseling that combines Child-Centered Play Therapy (CCPT) and Cognitive Behavior Play Therapy, supplemented with Family Play Therapy. It is important to note that “specific interventions proposed for clinical disturbances . . . have included individual psychotherapy for the child and/or caregiver, parent training with emphasis on developmental expectations and sensitive responsiveness, family therapy or caregiver/child dyadic therapy” (Zeanah & Boris, 2005, p. 365). CCPT is a humanistic and nondirective approach to child counseling that derives from the work of Carl Rogers (Rogers, 1961, 1977) and Virginia Axline (1947). It is based upon the premise that children have an inherent capacity for self-understanding, self-expression, positive relationships, and mental health, which can be nurtured and facilitated under the therapeutic conditions of attuned empathy, congruence, and unconditional positive regard. In the nonjudgmental and nonhurried playspace that provides the child access to toys, materials, and activities for the full expression of thoughts, feelings, and behaviors, he or she can work through conflicts, gain self-acceptance, and develop effective coping skills for living in the world (Landreth, 2002; Moustakas, 1959; Nordling, Cochran, & Cochran, 2010). It has been effectively applied to a wide range of child behavior and emotional problems, including the symptoms of Oppositional Defiant Disorder (Baggerly, Ray, & Bratton, 2010; VanFleet, Sywulak, Caporaso, Sniscak, & Guerney, 2010). Specific techniques that will be drawn from this approach will include using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting with Gretel as she engages with the different materials and activities in the playroom (arts and crafts, puppets, dollhouse, drawing, storytelling, role-playing). With regard to Gretel’s Conduct Disorder symptoms, techniques drawn from this approach will include using unconditional positive regard,

acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom as she engages with different materials and activities (arts and crafts, puppets, dollhouse, drawing, storytelling, role-playing).

Cognitive Behavior Play Therapy was originally devised as a means of applying the empirically proven methods of cognitive and behavior therapy to working with children, particularly in the playroom (Knell, 1993, 1994). This approach relies on a variety of cognitive techniques (reframing, challenging irrational thoughts, and cognitive restructuring) and behavioral techniques (reinforcement for and shaping of adaptive behavior, extinction of maladaptive behaviors, systematic desensitization, exposure with response prevention). However, the cognitive behavioral play therapist may also use artistic and expressive playroom materials, such as board games, puppets, dolls, drawing, storytelling, and the sandtray to achieve these ends. An example would be engaging a child through the use of puppets in a conversation about angry feelings and defiant behavior for the purpose of refuting irrational thoughts and/or shaping positive behavior. This technique has been effectively applied to a variety of childhood emotional and behavioral problems, including symptoms of Oppositional Defiant Disorder (Drewes, 2009). Specific techniques drawn from this approach will include using puppets and role-play to address Gretel's oppositional defiant behavior, shaping prosocial behavior through sandtray miniature play, and creating cartoon-strip stories around the themes of opposition and positive engagement.

Family Play Therapy is a means of engaging and problem-solving with the entire family using the methods and materials of play therapy. Reliant upon play and playful interaction, it provides a comfortable medium for children and adults, engages family members in a common pleasurable task, allows for a deeper level of communication, facilitates a broad scope of diagnostic information, and encourages family relatedness (Lowenstein, 2008, 2010). Although the empirical evidence base for Family Play Therapy is evolving, techniques drawn from this modality have been effectively applied with children and families struggling with a wide range of problems, including bereavement communication difficulties and behavioral problems (Ariel, 2005; Gil, 1984; Schaefer & Carey, 1994). With regard to the case of Gretel, the therapist will use the family play genogram, family puppet play, family drawing, family house-building, and family sculpting.

Additionally, both parents and teachers will be given psychoeducation in child bereavement and Oppositional Defiant Disorder, the means with which to communicate with each other about Gretel's behavior, and Parent Effectiveness Training [PET] (Gordon, 2000).

Step 4: Provide Outcome Measures of Change. This last step in treatment planning requires that we specify how change will be measured and indicate the extent to which progress has been made toward realizing these goals (Neukrug & Schwitzer, 2006). The counselor has considerable flexibility in this phase and may choose from a number of objective domains (psychological tests and measures of self-esteem, depression, psychosis, interpersonal relationship, anxiety, etc.), quasi-objective measures (pre-post clinician, client, and psychiatric ratings), and subjective ratings (client self-report, clinician's in-session observations). In Gretel's case, we have implemented a number of these. Specifically, we used: pre-post changes in behavior (including conduct problems and impulse control) as measured by the parent and teacher version of the Conners 3 (Conners, 2008b): client self-report of friendly and prosocial relationships with peers at school: teacher- and parent-reported improvement in behavioral compliance; teacher- and parent-reported improvements in control of impulses, behaviors, and emotions; , and teacher and parent report of improved daily communication between school and home.

The completed treatment plan is now developed through which the counselor, Gretel, and her parents (and teachers) will begin their shared work of building an effective behavioral management system at home and at school, enhancing communication channels between parents and teachers, modifying and then reducing the impact of her Oppositional Defiant Disorder, and helping Gretel effectively grieve her losses. Gretel's treatment plan is as follows and is summarized in the table that follows.

TREATMENT PLAN

Client: Gretel

Service Provider: Gingerbread Child Guidance Clinic

BEHAVIORAL DEFINITION OF PROBLEMS:

1. History of absent, emotionally absent, neglectful, and/or punitive

parents and adult caretakers since age 3—Terminal illness and death of mother at 3 years of age, raised by a punitive au pair between the ages of 3 and 7, father's remarriage to an emotionally and behaviorally neglectful stepmother, subsequent absence of father from the home for long periods

2. Current oppositional and defiant attitudes and behaviors at school, home, and neighborhood—Repeatedly hiding lunchbox as practical joke, deliberately annoying classroom and home behavior, blaming other children for own misbehavior, a short-fused temper, argumentativeness, resentfulness, spitefulness and hostility, yelling at stepmother, muttering at teachers, running away from home, and impaired classroom and family relationships

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GOALS FOR CHANGE:

1. History of absent, emotionally absent, neglectful, and/or punitive parents and adult caretakers since age 3

Goals for Gretel

- Successfully grieve the loss of mother
- Begin reinvesting in relationships with others
- Resolve her feelings of sadness and anger that are associated with the loss

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Related Goals for Parents

- Understand and support Gretel through grief process
- Strengthening the marital relationship
- Current oppositional and defiant attitudes and behaviors at school, home, and neighborhood

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Goals for Gretel

- Reduce the frequency and intensity of hostile and defiant behaviors toward adults and peers
- Terminate defiant and aggressive behavior and replace with controlled, respectful, and obedient behavior
- Resolve the conflict that underlies anger, hostility, and defiance

- Improve relationship with peers, teachers, and parents

Goals for Parents and Teachers

- Guide parents and teachers to more effective discipline practices
- Communicate with each other regarding behavior at home and in school

THERAPEUTIC INTERVENTIONS:

A moderate-term course (4–6 months) of Integrated Counseling including Child-Centered, Cognitive Behavior, and Family Play Therapy, supplemented with Parent Effectiveness Training

1. History of absent, emotionally absent, neglectful, and/or punitive parents and adult caretakers since age 3

Techniques for Gretel

- Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom as client engages with different materials and activities (arts and crafts, puppets, dollhouse, drawing, storytelling, role-playing)

Techniques for Adults and Gretel

- Family play genogram
- Family puppet play
- Family drawing
- Family house-building
- Family sculpting
- Current oppositional and defiant attitudes and behaviors at school, home, and neighborhood

Techniques for Gretel

- Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom as client engages with different materials and activities (arts and crafts, puppets, dollhouse, drawing, storytelling, role-playing)
- Using puppets and role-play to address oppositional defiant behavior

- Shaping prosocial behavior through sandtray miniature play
- Creating cartoon-strip stories around the themes of opposition and positive engagement

Techniques for Adults

- Psychoeducation in oppositional defiant behavior
- Parent effectiveness training
- Psychoeducation in child bereavement
- Daily communication report between home and school

OUTCOME MEASURES OF CHANGE:

Reduced oppositional defiant behavior, increased behavioral and emotional compliance as well as prosocial behavior, and effective grieving as measured by:

- Pre-post changes in behavior (including conduct problems and impulse control) as measured by on parent and teacher version of the Conners 3
- Clinician and client self-report of friendly and prosocial relationships with peers at school
- Clinician observation of effective grieving through play
- Teacher- and parent-reported improvement in compliance; and increased control of impulses, behaviors, and emotions
- Parent and teacher report of improved daily communication between home and school
- Parent report of improved communication and relationship (including father's presence in home)

Gretel's Treatment Plan Summary: Psychotherapeutic Integration of Child-Centered Play Therapy and Cognitive Behavioral Play Therapy

Goals for Change	*Therapeutic Interventions*	*Outcome Measures of Change*

History of absent, emotionally absent, neglectful, and/or punitive parents and adult caretakers since age 3 *Goals for Gretel* Successfully grieve the loss of mother Begin reinvesting in relationships with others Resolve her feelings of sadness and anger that are associated with the loss *Related Goals for Parents* Understand and support Gretel through grief process Strengthening the marital relationship **Current oppositional and defiant attitudes and behaviors at school, home, and neighborhood** *Goals for Gretel* Reduce the frequency and intensity of hostile and defiant behaviors toward adults and peers Terminate defiant and aggressive behavior and replace with controlled, respectful, and obedient behavior Resolve the conflict that underlies anger, hostility, and defiance Improve relationship with peers, teachers, and parents *Goals for Parents and Teacher* Guide parents and teachers to more effective discipline practices Communicate with each other regarding behavior at home	**History of absent, emotionally absent, neglectful, and/or punitive parents and adult caretakers since age 3** *Techniques for Gretel* Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom as client engages with different materials and activities (arts and crafts, puppets, dollhouse, drawing, storytelling, role-playing) *Techniques for Adults and Gretel* Family play genogram Family puppet play Family drawing Family house-building Family sculpting **Current oppositional and defiant attitudes and behaviors at school, home, and neighborhood** *Techniques for Gretel* Using unconditional positive regard, acceptance, attuned empathy, focused tracking, and selective limit-setting in the therapeutic playroom as client engages with different materials and activities (arts and crafts, puppets, dollhouse, drawing, storytelling, role-playing) Using puppets and role-play to address oppositional defiant behavior Shaping prosocial behavior through sandtray miniature play Creating cartoon-strip stories around the themes of opposition and positive engagement *Techniques for Adults* Psychoeducation in oppositional defiant behavior Parent effectiveness training Psychoeducation in child bereavement Daily communication report between home	**Reduced oppositional defiant behavior, increased behavioral and emotional compliance as well as prosocial behavior, and effective grieving as measured by:** Pre-post changes in behavior, including conduct problems and impulse control, as measured by parent and teacher version of the Conners 3 Clinician and client self-report of friendly and prosocial relationships with peers at school Clinician observation of effective grieving through play Teacher- and parent-reported improvement in compliance; and increased control of impulses, behaviors, and emotions Teacher and parent report of improved daily communication between school and home. Parent report of improved communication and relationship (including father presence in home)

and in school	and school	

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