

Case Presentation of Gretel

Annalise Shaffer

School of Behavioral Sciences, Liberty University

Author Note

I have no known conflict of interest to disclose.

Correspondence concerning this article should be addressed to Annalise Shaffer,
Liberty University, 1971 University Blvd, Lynchburg, VA 24515. Email:
agiordano2@liberty.edu

Case Presentation of Gretel

Identifying Data

Date of initial assessment – 03/24/2024

Client's name: Gretel Gerstenhagen

Race: White

Age: 10

Ethnicity: Austrian

Gender: Female

Marital Status: Single (minor)

Sexual Orientation: N/A

Employment Status: Unemployed/student

Part I: Intake Information

Reason for Referral/Presenting Problem

Gretel was referred by her school counselor following multiple incidents where she stole another student's lunchbox and refused to give it back. When discussing this incident in the initial clinical interview, Gretel stated "It was for this kid's lunch, and it was ugly... and I just thought I would take it." Gretel has had to meet with both the assistant principal and principal at school due to her escalating behavior. It was expressed that there are heightened tensions in Gretel's home as well, as she refers to her stepmother as "the witch."

Confidentiality

Confidentiality was reviewed with the client in age-appropriate terms. Gretel was informed that information will not be shared or reported with others unless she discusses instances of someone hurting her, Gretel hurting or causing harm to someone else, or Gretel hurting herself. The client verbally stated she consented and understood these limitations of confidentiality. Gretel's father knew this counseling session was taking place, as a psychological evaluation had been part of the action plan discussed between her father, stepmother, and school counselor.

Source of Information

The source and manner in which data was obtained in preparation of this report is an initial 10-minute clinical interview with Gretel and information from the school counselor. Background information was provided with client. While only a semi-structured interview was used in this specific case, it would be useful to use an assessment tool as well. Appropriate assessments that could be utilized are the DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure for children ages 6–17 and the Level 2—Anger—Parent/Guardian assessment for children ages 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent) (American Psychiatric Association, 2022).

Part II: Assessment**Observational Data/Mental Status Exam**

A mental status exam was not conducted in the initial clinical interview. In real practice, one would be conducted. Gretel's orientation to person, place, time, and current situation would be assessed. Gretel was wearing a traditional Germanic child's outfit, which she got from a previous school play. Despite the uncommon clothing, she appeared to be well-groomed and put together. She made moderate eye contact. She had normal tone, volume, and rate.

Psychometric Assessment

No psychometric assessments were conducted with Gretel. In real practice, assessments such as the SNAP-IV Teacher and Parent Rating Scale or Disruptive Behavior Disorders Structured Parent Interview (DBDSPI) could be utilized to help enhance the validity of the diagnosis.

Biological Assessment

Gretel is a ten-year-old white female who was originally born in Austria. She is a fraternal twin. Details such as sexual orientation, marriage, and children were not covered in the initial interview given Gretel's age. If Gretel spoke about knowing or being curious about her sexual orientation, then this could be a conversation topic.

Sleep

The topic of sleep was not discussed in the initial interview. In real practice, asking Gretel and her father about the quality of sleep gotten, the typical amount/duration of sleep, and if there are any current or were any previously existing abnormalities in regard to Gretel's sleep schedule and/or health would be important.

Diet

While diet was not covered in the interview with Gretel, it is known that she has been diagnosed with juvenile diabetes. It is important to discuss if her diabetes affects her behaviors or functions some of her emotional responses. In real practice, questions could be brought up about Gretel's eating habits to ensure there is no disordered eating, as well as ensuring that she is taking care of both her mental and physical health.

Exercise

Exercise was not discussed in the initial interview. In practice, assessing this subject this could be done by asking Gretel if she takes part in any sports teams or recreational sports. It may also be of value to explore if she knows if exercise is a part of her treatment plan for her juvenile diabetes. If she is not exercising, it could be explored as to why.

Medication

No current or past medication was reported by Gretel. In practice, Gretel's father would be asked to recall and describe her medication history and use.

Medical History

Aside from the juvenile diabetes, there were no other medical diagnoses shared.

History of Developmental Milestones

Developmental milestones were not discussed with Gretel or her father directly. In practice, Gretel's father could be asked how he would describe Gretel's physical, cognitive, and emotional development thus far. Any concerns he has regarding Gretel's development and her future could be explored as well.

Psychological Assessment

Gretel was not asked directly if she has had any other mental health difficulties in the past. There were no reported prior hospitalizations.

Addiction Screening

Addiction was not brought up directly in the initial interview with Gretel. In real practice, Gretel could be asked if she knows of any substances that she knows only adults are supposed to have. This will help me understand if she knows what illicit substances are, given her young age. If she knows what these substances are, it could be explored if she has ever used them and would reassure her that she would not be in trouble no matter the answer.

Risk Assessment

Gretel has previously stated "maybe I'll just kill myself." This information was reported and explored in the initial interview. To assess potential risk of self-harm and/or suicide, it was asked if Gretel knew how she would carry out this statement. Gretel stated that she did not mean it seriously, and that she did not have any formulated plan to carry out the threat of suicide.

Family Psychiatric History

While not explicitly asked, there was no disclosure of family history in regard to psychiatric treatment reported by Gretel. In real practice, this would be a topic that needs to be discussed with Gretel's father to get a clear understanding of any behavioral health predispositions for Gretel.

Piaget's Theory of Cognitive Development

Gretel is in the Concrete Operational Stage, which is ages seven to eleven. Beyond Gretel's age, Gretel demonstrated some of the foundational skills for this stage of development. Gretel showcased the ability to problem solve in ways that are logical to her. In this stage, children can hypothesize and understand abstract ideas such as love and justice (Malik & Marwaha, 2023). Gretel has shown she has the cognitive ability to use both of these skills through plotting to purposefully make her stepmother upset and by eliciting an emotional reaction from people.

Social Assessment

Cultural Factors

It is important to note that Gretel and her family immigrated to the United States when she was seven years old. Gretel explicitly discusses how she misses her native home of Austria and wishes she could go back to live there. Gretel feels that her behavior is one of the only things she can control, which may make some of her behavior a negative reaction to her current circumstances. It was not disclosed if her Austrian culture plays a role in her life.

Family of Origin

Gretel's family system consists of her twin brother, Hansel, her biological father, and her stepmother. Gretel details that her and her brother are close and often "stick together". Gretel's family is fourth-generation military. Her father works as a carpenter. Gretel's biological mother

was sick throughout her pregnancy with Hansel and Gretel and remained sick for the first two years of the children's lives. The children were only allowed to visit their mother for short periods of time while she was bedridden. Their mother died right before the children turned three. After moving to the US, their father remarried to the children's current stepmother. The stepmother works in the home. Gretel has openly expressed her distain for her stepmother and calls her "the witch." Gretel wishes her stepmother was not in her life, and often acts out against the stepmother which causes high tensions in the family dynamic. The stepmother has been reported to neglect both Hansel and Gretel and put her own needs before the children. It is stated that she never wanted kids but fell in love with their father.

Current Living Arrangements

Gretel, Hansel, their father, and their stepmother all reside in one residence.

Academic History

Gretel's academic success was not discussed in the interview. In practice, this topic could be approached by asking Gretel what her favorite and least favorite subjects are, who her favorite teacher, and whether or not she enjoys school. It could also be asked if she does well in school in regard to grades, if she gets along with other students, and if she thinks her grades are important.

Occupational History

There is no occupational history to report given Gretel's age. She is a fourth-grade student.

Current Social Support

Gretel is not reported to have many friends. Due to her behavior, she is hard to get along with. She states that she and her brother are very close, and they do almost everything together. When they scheme, they are always carrying out their plan together. Gretel does not confide her feelings in father or stepmother and lacks a close bond with them.

Erikson's Psychosocial Stages

Gretel is age ten, which aligns with Erikson's industry versus inferiority (school age) stage of development. During this stage of development, children are learning to navigate their environment by utilizing the available tools to produce desirable outcomes (). In Gretel's case, she is using her behavior (the available tool she can control) to try and manipulate the circumstances of her life and get what she wants- which is ultimately to have her stepmother out of her life. In Gretel's case, her early childhood experiences have not appropriately prepared her for the expectations within the school setting.

Spiritual Assessment***Spiritual/Religious History***

The topics of spirituality and/or religion were not discussed with the client in the initial interview. There was no information provided on if Gretel and her family have ever attended church or if they believe God. This could be explored in practice by asking Gretel if her family attended church in the past. If so, then it could be asked if Gretel enjoyed going, what kind of church it was, what they did there, etc.

Present Spiritual/Religious Beliefs

As previously stated, this topic was not discussed with Gretel. After learning about if and when her family ever attended church, more personal questions to explore this subject in more detail could be utilized. These questions can include how she would describe church and religion, whether or not it is important to her, if she believes what is told to her in church, etc. It would be explored as to if believing in God or having faith is something that she thinks about.

Fowler's Stages of Faith Development

This information is not known directly. Based on her age alone, Gretel would be in Fowler's second stage of faith development, mythic-literal. In this stage, children are unbiased when it comes to religious matters, but they do believe in the principle of justice (de Andrade Alvarenga et al., 2024). Gretel has highlighted that she thinks her behavior is just through her reasoning and excuses. In Gretel's mind, her stepmother is a "witch" and is causing her behavior. It is unknown if Gretel views God with anthropomorphic image and how she would interpret religious metaphors. If it is learned that she views God as having human-like characteristics and interprets religious metaphors literally, she would further align with the mythic-literal stage of faith (de Andrade Alvarenga et al., 2024).

Integration Assessment

It was not assessed whether Gretel would like her spiritual beliefs to be incorporated into the counseling process. In real practice, this could be done by asking if Gretel would like to talk about church, God, or any related topics. Questions revolving around the topics of prayer and worship as a tool to aid in the counseling process could be used as well.

History of Presenting Problem

Before moving to the US and after the death of their mother, Gretel and her brother were under the care of an au pair hired by her father. Both experienced harsh punishment and a lack of a caregiver bond. Gretel also referenced this woman as the "evil witch." Because of this fostered negative relationship, the children learned how to manipulate the au pair at an early age. This time period was the onset for manipulative-type behavior. Due to the harsh manner in which the children were treated, the au pair was eventually fired. However, it was not prior to the children learning unhealthy behaviors and experiencing adverse childhood experiences. Forming meaningful relationships and healthy attachments is a known area of dysfunction.

After moving to the United States, her symptomology began to increase in severity and frequency. It is not known when the symptoms began exactly, but the remarriage of Gretel's father exacerbated Gretel's symptoms and behavior.

Barriers to Treatment/Success

Gretel's oppositional nature and behavior could be barriers to treatment. Gretel knowingly and purposefully does the opposite of what she is instructed to do. It will be important to build a rapport and find ways to have Gretel learn the significance of behavior change. Another barrier to the treatment process and success is the rising hostility and tension between her and her stepmother. They live together, and she seems to be the root of a lot of behavioral issues for Gretel. It will be difficult to have Gretel return to that environment and make progress without cooperation from her father and stepmother as well.

Part III: Diagnosis

F91.3 Oppositional defiant disorder, moderate (principal)

Z91.49 Personal history of psychological trauma

Z60.3 Acculturation difficulty

250.00 Type II juvenile diabetes

Diagnostic Rationale

Based on the current presenting symptomology, Gretel is severe experiencing oppositional defiant disorder (ODD). She meets all of the DSM-5-TR diagnostic criteria (American Psychiatric Association, 2022). Gretel meets more than the necessary four symptoms within Criterion A (American Psychiatric Association, 2022). Gretel was reported by her father and her teachers that she has a "short fuse" and often loses her temper (Criteria A.1). If given feedback from an adult about her behaviors, she becomes touchy in response to the attention

(Criteria A.2). Gretel has also been reported to become “loudly angry” (Criteria A.3). It was recounted that Gretel often argues with adults and authority figures (Criteria A.4). She has been reported to yell and mutter under her breath. In class, if given as instruction, Gretel will often refuse to comply with instructions (Criteria A.5). An example of this is deliberately being out of her seat in class during the instructed “quiet time.” Gretel also recounted that nothing is ever her fault, and it was shared that she often blames others for mistakes or bad behaviors (Criteria A.7). Gretel has shown spiteful and vindictive behavior when she stole a classmate’s lunch box and refused to give it back and when she stated, “maybe I’ll just kill myself... that’ll teach her [her stepmother]” (Criterion A.8). These behaviors overall occur on a relatively normative basis. Gretel’s disturbances are associated with the distress she feels over living with her stepmother, negatively affect her ability to make friends, and is impacting her overall performance at school (Criterion B). Gretel does not meet the criteria for any other DSM-5-TR disorder and there are no reports of substance use (Criterion C). She meets the moderate specifier for ODD because her symptoms are present in two or more settings. She is described to exhibit these behaviors at home and at school.

Gretel’s diabetes diagnosis is included and listed because it may have an impact not only on Gretel’s well-being, but also plays a role in her family system and overall functioning.

Gretel also qualifies for a number of Z codes, which are indicative of clinical attention. Z91.49 personal history of psychological trauma applies as Gretel has gone through the death and loss of her biological mother, her father has remarried, and her home is often a high-stress environment. Z60.3 acculturation difficulty also applies, as Gretel’s family relocated to the United States from their native land of Austria. In her interview, Gretel discusses how she wishes

she could move back to where she is originally from. She discusses how she does not like how her life has changes since her family's move to the US. Part IV– Case Conceptualization

Part IV: Case Conceptualization

Theoretical Orientation

The theoretical orientation of the counselor is cognitive behavioral therapy (CBT). The foundational belief of CBT is that one's thoughts and cognitions have an impact on emotions, which then drives or functions an individual's behaviors (Beck, 2020). Through the lens of CBT, all psychological dysfunctions have one factor in common- dysfunctional thinking (Beck, 2020). The three levels of cognition that are foundational to the mechanisms of CBT are core beliefs, dysfunctional assumptions, and negative automatic thoughts (Fenn & Byrne, 2013).

Narrative of the Case Conceptualization

When assessing Gretel's case through a cognitive-behavioral lens, the diagnoses of oppositional-defiant disorder (ODD) as well as the associated z-codes (American Psychiatric Association, 2022) are due to dysfunctional schemas (core beliefs) Gretel holds about herself and the world around her. Gretel mainly showcases one of the three negative core beliefs, which is "the world is unfair" (Fenn & Byrne, 2013). Gretel has openly acknowledged that she engages in problematic and troubling behaviors such as stealing items that belong to her classmates and refusing to give them back, running away from home, purposefully disobeying directions at school, quickly becoming angry, blaming others for her actions, and threatening to kill herself. Gretel is surrounded by circumstances that she cannot control, including the death of her mother, the selection of the au pair that was hired to look after her when she was a young child, moving to the United States, and her father's remarriage to her stepmother. Because Gretel believes that the world is unfair, which is a maladaptive cognition, her feelings towards her surroundings as

well as herself are inaccurate. This leads to dysfunctional assumptions (e.g., unless my stepmother goes away, I cannot be happy) and negative automatic thoughts (e.g., my life is terrible, she always gets me in trouble, I will never be happy). Because the consequences of her behavior do not result in her desired outcome (her stepmother leaving), not only are her negative automatic thoughts reinforced, but her maladaptive core beliefs are as well (Josefowitz & Myran, 2021).

Part VI: Treatment Plan

Problems
<ol style="list-style-type: none"> 1. Oppositional defiant disorder (ODD)- angry mood, argumentative behavior, defiant behavior, vindictiveness, places blame on others for misbehavior, annoys others on purpose 2. Other personal histories of psychological trauma—death and loss of biological mother, remarriage of father to current stepmother, relational tension with stepmother in household 3. Acculturation difficulty— family geographic relocation to the United States from Austria 4. Type II juvenile diabetes

Goals for Change
<ol style="list-style-type: none"> 1. Oppositional defiant disorder <ul style="list-style-type: none"> • Understand the relationship between errors in cognition, maladaptive core beliefs, and oppositional defiant disorder • Increase engagement in non-problematic behaviors and activities to reduce that result in the same function of behavior (attention, access to someone/something, escape from task, etc.) • Correct the maladaptive cognition “the world is unfair”, which will in turn correct dysfunctional assumptions and negative automatic thoughts 2. Other personal histories of psychological trauma <ul style="list-style-type: none"> • Understand the relationship between histories of trauma, thoughts, feelings, and behaviors • Increase realistic relational schemas within the family system to reduce conflict both in-home and in other settings • Gretel will explore her feelings surrounding specific areas of trauma in her life • Eliminate faulty core beliefs in regard to her feelings 3. Acculturation difficulty <ul style="list-style-type: none"> • Reframe beliefs about moving to US • Interrupt negative thought patterns and replace them with truthful, positive patterns of cognition, thus affecting mood and behaviors

4. Type II juvenile diabetes

- Learn to follow the instructions given to Gretel and the family as a whole by pediatrician without opposition

Objectives & Therapeutic Interventions

The client will engage in 12 weekly, individual and family sessions of CBT (Schwitzer and Rubin, 2015; Beck, 2020; Helander, 2021). Additional weeks of intervention will be added as needed if not meeting treatment objectives and goals.

Oppositional defiant disorder (ODD)

The client and her family will learn about oppositional defiant disorder and emotional regulation through an age-appropriate lens, as well as factors that impact its development and perpetuation.

- The counselor will provide psychoeducation about ODD, as well as CBTs conceptualization and treatment for ODD. It is important to note that the information that will be shared and taught will not be targeted at the client's individual life to avoid feelings of blame and shame.
- The counselor will provide psychoeducation about emotional regulation (what it is, why it's important, how it relates to ODD, etc.), as well as provide strategies (role playing, mindfulness) on how to build this skill.
- The counselor will implement elements from the Stop Now and Plan (SNAP) Program (Derella et al., 2019). This program includes both parent and child treatment groups.
- The counselor will implement anger-management techniques as a part of client education.

The client will learn to identify and challenge maladaptive core beliefs, dysfunctional assumptions, negative automatic thoughts, and the associated behaviors. The client will learn to replace these with effective alternatives (finding positive replacement behaviors that result in same wanted outcome).

- The counselor will help the client identify antecedents and consequences of oppositional behavior (ABC sequence). The counselor will help the client identify behaviors that can result in the same consequence.
- The counselor will apply Socratic questioning as a means of cognitive restructuring.
- The counselor will help identify examples of maladaptive thoughts/beliefs in the client's life. The counselor will help the client examine evidence that support or contradict these. (Farmer & Chapman, 2015).
- The counselor will positively challenge the client to substitute more reasonable beliefs in place of maladaptive automatic thoughts and core beliefs (Farmer & Chapman, 2015).

- The counselor will assign “homework” assignments, such as tallying disruptive/defiant behavior, for the client to increase positive interactions and behaviors in various settings (school, home).

The client will learn resiliency techniques to uphold treatment progress and knowledge gain.

- The counselor will implement the model to build resilience (search, construct, apply, practice).
- The counselor will help the client identify ways in which she can take control in her own life in an appropriate, meaningful, positive way.
- The counselor will help the client and her family identify social support resources within the community.

Other personal histories of psychological trauma

The client will work through her current feelings in regard to death/loss of biological mother, remarriage of father to current stepmother, and the relational tension with stepmother in household.

- The counselor will apply Socratic questioning as a means of cognitive restructuring.
- The counselor will implement elements of trauma-informed care to ensure the client feels comfortable discussing sensitive topics.
- The counselor will help the client learn a number of coping skills (deep breathing, mindfulness, acceptance, identifying and redirecting thoughts, etc.) to alleviate the effects of negative emotions, maladaptive core beliefs, dysfunctional assumptions, negative automatic thoughts, and combative behavior.

Due to its severity, the client, her father, and stepmother will learn to work together and form positive bonds with one another through family therapy.

- The counselor will hold sessions in which all parties are present in order to come up with collective, attainable goals using successive approximation.
- The counselor will help each family member recognize unhealthy cognitive patterns and make the necessary adjustments.
- The counselor will assign “homework” assignments for family members to increase positive interactions. Examples of this could be giving out a specific number of compliments/positive feedback to one another, trying to limit the number of hostile interactions, purposefully using manners, journaling, etc.

Acculturation difficulty

The client will learn to reframe her thoughts about her move to the US and find the positive aspects of the situation.

- The counselor will administer a culturally responsive assessment which considers both the client’s positive and negative aspects of immigrating to the US (Hays, 2019).

- The counselor will utilize goal setting and problem-solving activities to aid the client in reframing cognitive thoughts about her life/circumstances in the US.

Type II juvenile diabetes

The client will learn how physical health and behavioral health are related and connected.

- The counselor will help the client identify circumstances in which physical health impacts mental health.
- The counselor will work with the client and her family to reframe the importance of instructions/treatment recommendations given by pediatrician.

Outcome Measures of Change

Increased prosocial behavior, decreases in anger and irritability, decreases in vindictive/annoying and defiant behavior, increases in accepting responsibility, improved family relationships, decreased animosity between Gretel and stepmother.

- The client and her family both reported improved familial relationships and a decrease in household tension.
- The client reported being able to identify, challenge and replace negative core beliefs, maladaptive thoughts, and maladaptive cognitions.
- The number of tallies on the client's disruptive/defiant behavior chart decreased over time.
- The client reports an improvement in adapting to her life in the US and is able to identify positive things about her current life.
- The counselor observes an improvement in symptomology via symptoms reduction.
- The counselor observes an improvement in automatic thoughts, assumptions, and core beliefs.
- Post-measurements on the DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure for children ages 6–17 show improvement.
- Post measurement on the Level 2—Anger—Parent/Guardian assessment for children ages 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent) show improvement.

References

- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). <https://doi.org/10.1176/appi.books.9780890425787>
- Beck, J. S. (2020). *Cognitive behavior therapy: Basics and beyond*. United Kingdom: Guilford Publications.
- de Andrade Alvarenga, W., da Cruz, I. E. C., Leite, A. C. A. B., Machado, J. R., Dos Santos, L. B. P. A., de Lima, R. A. G., & Nascimento, L. C. (2024). "God gives me hope!": Hospitalized children's perception of the influence of religion in coping with chronic illness. *Journal of Pediatric Nursing*, 77, 13-20.
<https://doi.org/10.1016/j.pedn.2024.02.022>
- Derella, O. J., Johnston, O. G., Loeber, R., & Burke, J. D. (2019). CBT-enhanced emotion regulation as a mechanism of improvement for childhood irritability. *Journal of Clinical Child & Adolescent Psychology*, 48(sup1), S146-S154.
<https://doi.org/10.1080/15374416.2016.1270832>
- Farmer, R. F., & Chapman, A. L. (2015). *Behavioral interventions in cognitive behavior therapy: Practical guidance for putting theory into action, second edition*. American Psychological Association.
- Fenn, K., & Byrne, M. (2013). The key principles of cognitive behavioural therapy. *InnovAiT*, 6(9), 579-585. <https://doi.org/10.1177/1755738012471029>
- Gross, Y. (2020). Erikson's stages of psychosocial development. *The Wiley Encyclopedia of Personality and Individual Differences: Models and Theories*, 179-184.
<https://doi.org/10.1002/9781118970843.ch31>

- Hays, P. A. (2019). Introduction. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 3–24). American Psychological Association. <https://doi.org/10.1037/0000119-001>
- Helander, M. (2021). *Effects of child CBT and parent management training for children with disruptive behavioral disorders*. Karolinska Institutet.
- Josefowitz, N., Myran, D. (2021). *CBT made simple: A clinician's guide to practicing cognitive behavioral therapy*. United Kingdom: New Harbinger Publications.
- Malik, F. & Marwaha, R. (2023). *Cognitive development*. StatPearls Publishing.
<https://www.ncbi.nlm.nih.gov/books/NBK537095/>
- Schwitzer, A. M., & Rubin, L. C. (2015). *Diagnosis and treatment planning skills* (2nd ed.). SAGE Publications, Inc. (US). <https://bookshelf.vitalsource.com/books/9781483355153>