Case Report

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Empowering Care: A Clinical Case Report of Severe Intellectual Disability Disorder in a Teenage Boy

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ABSTRACT

The child, K.N., was a 15-year-old boy who was brought to the Psychiatry ward of Mayo Hospital, Lahore, by his mother. He was referred to the clinical psychologist with complaints regarding behavior, aggression, speech problems, personal care, hygiene, and seizures. He also lacked behind other children of his age regarding intellectual performance. The psychologist used Clinical Interview with the mother, Behavioral Observation, Baseline, Portage guide to early education (PGEE), Raven's Colored Progressive Matrices (CPM), Child behavior checklist (CBCL), and Children's Adaptive Behavior Scale (CABS). The child was diagnosed with a severe Intellectual Disability. His therapeutic techniques include Structured individual sessions, Rapport Building, Psychoeducation, planned ignoring, Social Stories, Positive reinforcement, Prompting, Differential reinforcement of alternative behavior, functional communication training, Modeling, Shaping, Backward chaining, Therapy blueprint, and Compliance Training used to work on presenting complaints of the child. Post-assessment was done at the end of the therapy which revealed an overall 39% improvement in problematic complaints as reported by the mother.

Keywords: Intellectual Disability; Assessment; Diagnosis; Management

Abbreviations: IDD: Intellectual Disability Disorder; PGEE: Portage Guide to Early Education; CPM: Raven's Colored Progressive Matrices; CBCL: Child Behavior Checklist; CABS: Children's Adaptive Behavior Scale

Introduction

IDD represents a diverse group of neurodevelopmental disorders with the hallmark features of deficit in intellectual functioning and adaptive behavior [1]. A report indicated an 8.6 % prevalence of developmental disabilities in children with an age range of 3 to 17 years [2]. The exact cause of IDD is still unknown but there are several factors that contribute to etiology. These factors include, but are not limited to Genetic mutations, metabolic disorders, chromosomal anomalies, Prenatal exposure to nutritional deficiencies, infections, and toxins, and disruptions in early brain development [3]. People with IDD usually have 2 standard deviations below the average IQ of 70. It manifests across 4 levels of severity: mild, moderate, severe, and profound. These individuals face challenges in three domains including conceptual, social, and practical (Figure 1). The intensity of problems varies across different levels of severity [1]. IDD co-occurs with several other conditions such as sensory impairments, epilepsy, autism spectrum disorder, etc. To manage IDD, a multi-disciplinary approach has been utilized. The multifaceted nature of IDD demands a coordinated effort among educators, caregivers, therapists, and healthcare workers. Different educational programs were modified keeping the individual's abilities and special needs, different behavioral interventions, occupational therapy, speech therapy, and family counseling are pivotal components of the management strategy [4].

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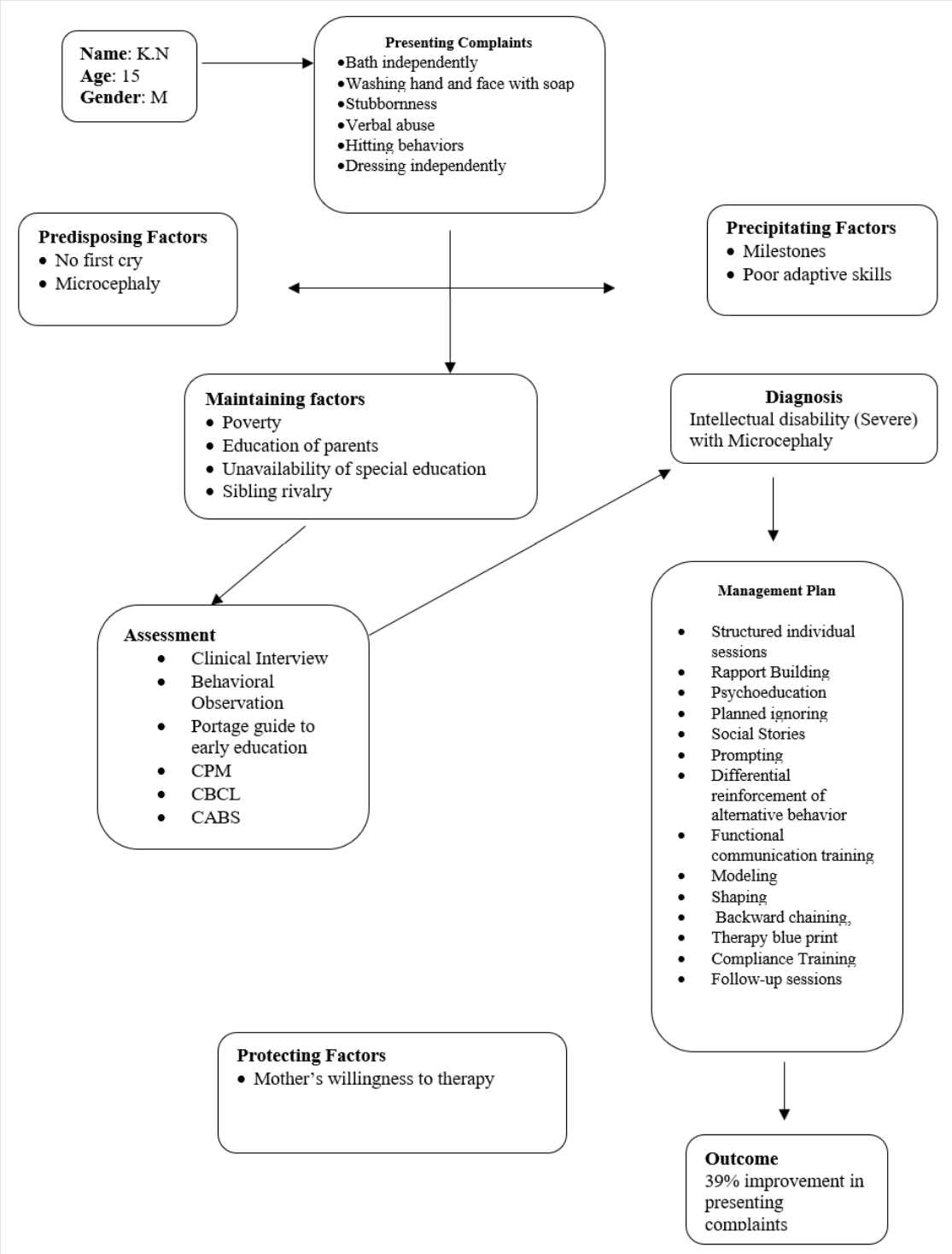

Figure 1: Summary of Case Formulation.

Case Report

(Table 1).

Table 1: Case Report.

Name	K.N.
Age	15 years
Gender	Male
No. of siblings	3rd
Birth order	2nd
Socioeconomic Status	Lower
Family System	extended
Informant	Mother

Reason for Referral

The child was brought to the Mayo Hospital by his mother with the presenting complaints regarding behavior problems, temper tantrums, non-compliance, hitting and verbally abusing others, and inability to take bath and hygiene care. He also lagged behind other children of his age regarding intellectual performance. He was referred to the clinical psychologist for the assessment of his problems (Table 2).

Table 2: Presenting Complaints.

	Complaints (Verbatim)	Duration
1	His hands and feet get curled as a result of fit. Stays in the same condition for 2-3 minutes with no consciousness, and after that he gets to sleep.	2 years
2	He is very arrogant and stubborn, and doesn't comply with anything	10 years
3	Now he started abusing (verbally)	1 year
4	After the birth of his younger sister, he used to hit her, he hit her even now.	12 years
5	He is unable to take a bath or even can't wash his hands and face	15 years

History of Presenting Problems

The history of presenting problems dates back to the child's birth. The mother didn't report the immediate cry at the time of his birth. Moreover, after a few weeks of his birth, he suffered from Pruritus. His developmental milestones were also delayed. He started holding his head around the age of 6 months. He started sitting independently at the age of 1 year. Moreover, he never crawled but with a lot of struggles he started standing with support around the age of 2.5 years and thus walked around the age of 3 to 3.5 years. His monosyllabic speech started at the age of 4.5 years. He started speaking sentences at the age of 7 years. He achieved the milestone of independent dressing at the age of 10 years. He never achieved the milestones of bathing without help. At the age of 9 years, he started going to the government special education school. At the age of 11 he refused to go to school by complaining that he couldn't wake up early in the morning for school and can't stay there for six hours. When he was 13 years old, he had his first epileptic fit. The duration of the fit was about 2-3 minutes. According to the mother, the child exhibits non-complaint, abusive and stubborn behavior at home with his parents and siblings. He was also engaged in hitting his younger sister. He demands a lot of attention and always wanted someone to play with him. His mother reported that he can't take bath independently and cannot wash his hands and face with soap. The mother was concerned about his dependency, behavioral issues, and fits.

Personal History

The child didn't cry after his birth. He was normal and healthy at the time of birth. But he caught a cold and after few weeks of his birth he got infection 'pruritus'. Thus, his health started declining and he started frothing. His mother breast fed him for two years but according to his mother he used to refuse feeding and it was so challenging to feed him. He showed temper tantrum and aggression toward family members. He often hit his younger sister very inhumanly. He verbally abuses other family members as well. On the other hand, his relationship with his peer was friendly. His mother further explained that the child had completed his course of immunization. The attainment of his developmental milestones was delayed as evident in Table 3. The child was diagnosed with epilepsy at the age of 12 years, his height was age appropriate, but his weight was very low. His hearing, eyesight, appetite, and sleep were normal. He had no bed wetting problem. According to the informant he can't take bath independently. His attention was good he responded well to the therapist. However, in the first few sessions he was little bit shy in front of therapist. His visual motor and fine-motor skills were intact. According to his mother, he was so energetic and had a lot of friends.

Table 3: Showing achieved age of milestones in contrast to normal age of achieving milestones.

Milestones	Age of Achievement	Normal age
Head Holding	6 months	3 months
Sitting	1 year	6-8 months
Crawling	Never achieved	8-10 months
Standing	2.5 years	9-11 months
Walking	Around 3 years	14-15 months
Speech Single word	4.5 years	9 months
Complete sentences	7 years	3 years
Bowel control	3 years	3 years
Dressing without Help	10 years	3-4 years
Taking bath without Help	Still not developed	4-5years

Family History

The child belonged to a family of lower socio-economic status. He lived in an extended family system. The child lived with his uncle's family, parents and two siblings. There are 10 people living in

the house. The authority figure of the child's family was his father. The general environment of the house was happy and the significant stressor to the family was this child.

Father: His father was a 49-year-old man working in a furniture shop. He was an introvert and did not talk too much. He usually remains silent and has no temperament issues. He cares about the child and shows affection, but he gets disappointed when the child exhibits non-compliance behavior.

Mother: The child's mother was a 38-year-old lady, educated up to 6th class and was a housewife. She was a friendly and cooperative person of normal temperament. According to her, among other children K.N. was his favorite and received most care and protection from her due to his illness. In total she had 3 three children.

Siblings: The child had 2 siblings, one elder brother and one younger sister. The elder brother Z.A. was 18-year-old who worked in a factory. M.M was his 12-year-old sister who was a 4th grade student. According to his mother the attitude of K.N. siblings toward him was loving but he doesn't love them back, verbally abuse them and hit them often.

General Home Environment

The client lived in an extended family system. The general home environment was normal.

Educational History

In 2014, at the age of 9 years his mother started sending him to a special education institute. At school he was a good student regarding academics and behavior. He used to stand 3rd in his class. But as he grew older, he refused to go to school he was bothered by the school timings. At the age of 11 years, his family stopped sending him to school due to increased stubbornness.

Preliminary Investigation

To get a clear picture of the child's behavioral problem and to make an effective management plan, a complete assessment was recommended. Psychological assessment of the child was done at the Informal and Formal levels.

Informal Assessment:

- Clinical Interview.
- Behavioral Observation.

Formal Assessment:

- PGEE
- CPM
- CBCL
- CABS

Clinical Interview

Clinical Interview is a general form of conversation between a clinician and a patient his caregiver aimed at determining diagnosis, history, causes of problems, and possible treatment options. A detailed clinical interview was conducted by the trainee clinical psychologist, during which he collected presenting complaints, detailed history of the child's problems, family background, and personal history from the child's mother. The onset of the problem, medical complications, and treatment was asked. Detailed family history was taken and the child's relationship with his parents and family members was assessed. Moreover, formal, and informal assessment was carried out in a well-ventilated and enlightened room.

Behavioral Observation

Behavioral Observation is the primary assessment approach for preverbal and nonverbal children. It focuses on vocalizations (e.g., crying, whining, or groaning), verbalizations (e.g., echolalia, pragmatics), facial expressions, guarding of body parts, temperament, activity, and general appearance [5]. The child apparently looked to be a young boy of 10 years. His height was appropriate according to his age whereas his weight appeared to be low as compared to his chronological age. Moreover, the size of his head was smaller than normal size. He was wearing a neat dress with properly cut nails and combed hair. His gait was normal and was walking without any support. He was a bit shy in the beginning, but rapport was easily built. In the very session, he shows no resistance when the therapist tried to engage him in activity of coloring. His speech was not clear and his eye contact was not properly maintained, especially when talking to the therapist. His time and place orientation were appropriate as he reported that it was morning, and he was in the hospital. Moreover, he had an insight into his problem as his mother reported that he said he want to ride a bike and that's why he wants to get cure of his illnesses. In later sessions his shy behavior turned in to friendly behavior. He laughed and engaged himself in discussion with therapist. He started maintaining appropriate eye contact with the therapist. Moreover, it was noticed that he started showing non-compliant and disrespectful behavior toward his mother such as he said his mother to let's go home in a very disrespectful way.

The Baseline for Problematic Behaviors

The baseline is the condition or phase in which no treatment is implemented. The baseline is usually taken to be the initial measurement but in ongoing treatments fresh baseline scores can be obtained to measure subsequent change [6]. Baselines were given to investigate the frequency, duration, and intensity of the child's problematic behaviors.

Qualitative Analysis: The table 4 depicts the triggering factors, average duration, and frequency of the child's problematic behaviors as per the baseline filled by the child's mother during the initial

weeks. The average intensity of the independent bath-taking problem was 10 because he can't wet his body while taking a bath or applying soap to it. Likewise, the intensity of his hand and face washing problematic behavior was 9. Moreover, the average frequency of the child's stubbornness was 9 which indicated that he was frequently engaged in this behavior. The triggers identified for his stubbornness were identified as when his demands were not fulfilled when he was asked to comply with instructions, and when forced to do something against his will. His hitting and verbal abuse had an intensity of 7 on a 10-point scale which indicates the severity of his problematic behaviors. The triggers for his hitting behavior were his sister talking to him, standing in front of him, playing in front of him, or touching his stuff. His verbal abuse had an intensity of 7 and its triggers were other family members doing anything against his will, demands not being fulfilled, brother sleeping in his bed. Also, the problem of dressing independently includes the factors of buttoning and unbuttoning the buttons and fastening or unfastening the zipper. That's why he was rated 4 in the domain. The intensity of the abovementioned problematic behavior was 77%.

Table 4: Showing the pre-assessment of the problematic areas in the first week.

Problematic area	Average duration	Average intensity (0-10)	Triggering factors
Bath independently	-	10	-
Washing hands and face with soap		9	-
Stubbornness	3 hours	9	Sister cooks food, Demands not fulfilled when asked to comply with instructions, when forced to do something
Verbal abuse	15 min	7	Demands not fulfilled, brother sleeping in his bed.
Hitting behaviors	10 min	7	Standing in front of him, not playing with him or touching his stuff
Dressing independently	-	4	-

Identification of Reinforcers: Potential reinforcers were identified through direct questioning, selecting from generalized reinforcers and observing the routine of the child. Potential reinforcers were first identified and tested to see if they accelerate target behavior.

Qualitative Analysis: (Table 5) Reinforcers were identified by asking the mother and through direct observation. It was observed that the child loved to play a board game name Ludo. Moreover, he also likes to play cricket and mobile games. Money was the biggest reinforcement for him. Moreover, in edibles, he loves to eat "sooper" biscuits. After identification, the therapist designed the management sessions accordingly. The therapist introduced and utilized reinforcers within tasks and delivers them on the completion of the task or on the correct execution of the desired behavior. At the end of the session, if the child had performed better throughout the session his mother buys him a small pack of the "sooper" biscuit.

Table 5: Table showing Different Types of Reinforcers for the child.

Types of Reinforcers	Identified Reinforcers
Social Reinforcers	Praise, acclaim, and attention
Tangible Reinforcers	Biscuits
Activity Reinforcers	Playing ludo (a board game), playing with a ball and mobile games

Portage Guide to Early Education (PGEE): The rationale of test administration of Portage Guide to Early Education (PGEE) was to assess the extent to which a child's verbal, motor, social, cognitive, and self-help skills are developed. PGEE of Urdu version (translated by the Ministry of Education and Social Welfare, Islamabad) was administered to the child in a well-ventilated, enlightened, and distraction-free room.

Table 6: Showing developmental age in months on PGEE.

Sr. no	Sub scales/ area of functioning	Current functioning age (CFA) in months	Discrepancy between CFA and Chronological age (CA) in months (CA-CFA)
1	Socialization	62	120
2	Self-help	56	126
3	Cognition	64	117
4	Motor skills	60	122
5	Language	72	110

Qualitative Analysis: (Table 6) From the above-mentioned quantitative analysis, it can be concluded that the child was lacking skills in most areas. His self-help area was least developed, socialization and cognitive skills are better than self-help but far behind according to his chronological age. His language was better than any other area. In the language domain, his developmental age was 6 years. No significant delays have been noticed as the client passed all the items of the respective domain. In the cognitive area, his developmental age was 5 years and 3 months. His first failed item was item # 66 (of age 2-3) indicates "copy and draw the exact faces" and passed item # 73 "Names position of objects first, second and third". The child was unable to do complex mental tasks like counting up to 100. Moreover, in the socialization domain, the developmental age of the client was 5 years and 1 month. He failed first item # 47 (of age 2-3) indicates "play dressing up in adult clothes" and passed item # 73 (of age 5-6) "chooses own friends". Likewise, in the motor area, the child's developmental age

was 5 years and hence was lacking behind his chronological age. He failed first item# 75 (of age 3-4) indicates "snips with scissors" and passed the last item # 108 "uses pencil sharpener".

His deficits in the motor domain indicate that he could perform simple motor movements but was still unable to perform complex motor tasks like using scissors, cutting, and drawing. His developmental age in self-help was equivalent to a child of 4 years and 6 months. This area was the least developed and needs a lot of improvement. His first failure on item # 17 (of age range 1-2) indicates "puts hand in the water and pats wet hand on face in imitation". This item failed as it was reported by the mother of the client that he was unable to imitate to wash hands and face. Similarly, the child passed the last item # 94 (of age 5-6) "serves guests and passes serving dishes." Severe deficits in the self-help domain were found as the child was unable to wash himself after using the toilet, and unable to change his own clothes and chores regarding self-care.

The Colored Progressive Matrices (CPM): The rationale to test the administration of CPM was to check the degree to which an individual can think clearly and nonverbal reasoning. It has three sets which were directly administered to the child. It took 15 minutes to complete the test.

Qualitative Analysis: (Table 7) K.N. scored 07 which lies below the 5th percentile. The IQ of the child was below 40 which indicates severe intellectual deficits. Moreover, due to the lower total score, it was not possible to measure the discrepancies. These are clear indications that the child was lacking in intellectual abilities than his age fellows.

Table 7: The following table gives general data about how the client compares to the group norms.

Sr. No.	Subscale	Raw Score	T-score	Percentile	Guideline
I	Somatic complaints	0	55	<69	Scores were in a normal range
II	Schizoid	4	69	97	Scores were in a normal range
III	Uncommunicative	6	61	85	Scores were in a normal range
IV	Immature	7	81	>98	Scores were in a clinical range
V	Obsessive-compulsive	3	60	85	Scores were in a normal range
VI	Hostile withdrawal	5	64	92	Scores were in a normal range
VII	Delinquent	3	61	84	Scores were in a normal range
VIII	Aggressive	26	77	>98	Scores were in a clinical range
IX	Hyperactive	9	69	97	Scores were in a normal range
Social competence Subscale					
I	Activities	3.2	11	>2	Scores were in a borderline range
II	Social participation	5.66	40	15	Scores were in a normal range
III	School performance	-	-	-	-
Internalizing and Externalizing problem					
I	Internalizing problem	14	61	-	Scores were in a normal range
II	Externalizing problem	34	71	-	Scores were in a clinical range
III	Total problem	48	132	-	

Child Behavior Checklist (CBCL): The child behavior checklist which was created by Thomas Achenbach and Craig Edelbrock was supposed to obtain information based on the direct observation of parents and teachers on children's social competencies and behavioral problems. The observation of the informants was treated and interpreted using the Likert scale so that problematic behaviors can be defined empirically.

Qualitative Analysis: (Table 8) Analysis of behavior problems shows that the child was behaviorally maladjusted since at least two of the scores fall outside the normal range. On the empirically based program scales, the parent's ratings emphasized that the child's externalizing scores were in the clinical range (above the T score of 70) for boys aged 12-16 years. His internalizing score was in the normal range. According to his mother's report, his scores on somatic complaints, schizoid, uncommunicative, obsessive-compulsive, hostile withdrawal, delinquent, and hyperactivity were in a normal range. His scores on the subscales of immaturity and aggression were in the clinical range above the T score of 70. The child was significantly exhibiting externalizing behavioral problems. Findings suggest that he may be experiencing immaturity and aggression and this raise concern regarding his functioning. Moreover, his score on the activity domain of social competence was below the baseline score. The school domain wasn't accessed as the child was not school-going.

Table 8: Quantitative Analysis.

Areas	Raw Scores	Age Equivalent
Language development	29	6
Independent functioning	21	11
Family role performance	19	16
Economic vocational activity	22	11
Socialization	18	16
Total	106	62

Child Adaptive Behavioral Scale (CABS): Child Adaptive Behavioral Scale was an assessment tool that was used within the functional age range of 6 to 11 years to assess a child's skills in five domains of functioning i.e., language development (LD), independent functioning (IF), family role performance (FRP), economic-vocational activity (EVA), socialization (S).

Qualitative analysis: (Table 9) The child had a chronological age of 15 years. His age equivalency at each area of CABS showed a marked discrepancy between her chronological age and present level of functioning. He had significant deficits in family role performance as he was unable to tell the story of something that happened in his family last week. The child had significant delays in socialization as he was unable to answer what to say if he bumped into someone unintentionally.

Table 9: Table showing criteria of DSM 5 of Intellectual Disability.

DSM 5 Criteria	Yes/ No
Deficits in intellectual functions such as academic performance	Yes
Deficits in adaptive function	Yes
Symptoms must be present in the developmental period	Yes

Diagnosis

319 (F72) intellectual Disability (Severe) with microcephaly.

Case Formulation

The child was a 15-year-old boy with complaints of seizures, non-compliance, stubbornness, hitting and verbally abusing others and personal hygiene. He also lacked behind other children of the same age regarding intellectual capabilities. His developmental milestones were also delayed. According to DSM-5, when the symptoms characteristic of intellectual disability cause impairment in social, occupational, or other important areas of functioning predominate the problem and these symptoms meet significant criteria of the neurodevelopment disorders, a diagnosis of severe intellectual disability was given [1]. In this case, K.N. had delayed the attainment of developmental milestones. His intellectual functioning was relatively less adequate as compared to other children of his age and his level was severe enough to warrant a diagnosis of intellectual disability. His speech sound also appears to be dysfunctional, but this cannot be exclusively diagnosed as having speech sound disorder [1]. Also, the child was suffering from a condition name microcephaly. This brain condition is highly comorbid with developmental delays in children [7]. Moreover, microcephaly is highly related to intellectual disability and epilepsy [8]. At the time of his birth, there was no immediate cry. It affects intellectual functioning and can lead to developmental problems [9].

Client's Prognosis

The prognosis of the child appeared to be bad due to the organicity of the illness. The delayed mental growth and microcephaly was an aspect that was not in the client's favor to make significant progress. There was no sign of substance abuse or psychosis.

Management Plan

The management plan of K.N. was devised depending on his unique and specific needs. The aims were to improve his pre-requisite skills and decrease his problematic behaviors. It also aimed to work on his developmental delays and make him on the way toward being self-sufficient. Moreover, the tasks or activities included in the session were of the child's interest and of highly preferred play material. It was devised mostly based on Behavior Therapy using Behavior Modification Techniques.

Short Term Goals:

- Structured individual sessions of face-to-face interaction in a distraction-free environment were organized twice weekly. Initial sessions focused on the development of pre-requisite skills that are considered the foundation of development and to reduce problematic and undesirable behaviors of the child. Later sessions focused on the generalization of early requisite skills and the acquisition and maintenance of other developmental skills.
- Rapport Building was done to build a trusting relationship between the child and the therapist to make the child easy, open, and compliant towards the therapy process.
- Psychoeducation with the child's parents was done to reduce their distress, and confusion, and to cultivate hope and realistic expectations in them. It also aimed to guide the parents about ways to effectively manage and take care of the child.
- Planned ignoring was used to reduce his crying spells and stubbornness.
- Social Stories were a description of social situations that involve social cues and appropriate responses will be used to teach the child situation-specific and appropriate social skills.
- Positive reinforcement in the form of a reward was when the child performed something good, achieved competence in

some tasks, and engaged in desirable behaviors.

- Prompting (physical prompts, verbal prompts, modeling prompts) were used to help him engage in correct forms of behavior.
- Differential reinforcement was used to improve the likelihood of the occurrence of desirable behaviors of the child and decrease the likelihood of the occurrence of undesirable behaviors of the client.
- Modeling of the task was first done by the therapist so that the child may imitate him and exhibit the desired behavior.
- Symbolic modeling using videos will be used to assist in learning social stories and to teach desirable behaviors to the child.
- Shaping will be used with the child to teach him the difficult developmental tasks regarding personal hygiene.
- Backward chaining was used to teach children complex tasks like bathing.
- Therapy blueprint was provided to the child's mother at the end of the therapy for conceptualizing and revising the skills learned in therapy.
- Compliance Training It was carried out to build compliance of children towards therapy.

Long Term Goals:

- Continuation of short-term goals will be done to enhance the improvement in the child.
- Follow-up sessions will be conducted to ensure and enhance the improvement and positive changes brought about by the therapist in the member.

Sessional Report and Discussion:

Session 1 to 3:

Goals:

- To build rapport and bond with the child.
- To obtain history to get in-depth information about the child.
- To clarify diagnosis by asking more relevant questions.

Techniques:

- Floor time technique.
- Rapport Building.
- Clinical interview.

Time:

- 3 sessions with 1 hour each session.

Procedure: Rapport was built with the child by asking him questions of his interest. More questions were asked about his routine and daily activities. Meanwhile, the information regarding his presenting problems and history was taken from his mother. More relevant questions were asked to reach a diagnosis.

Session 4 to 6:

Goals:

- Psychoeducation of family.
- Assessment through a formal method to ensure diagnosis.
- Behavioral techniques to decrease hitting behavior.

Techniques:

- Psychoeducation.
- Portage guide to early education.
- CPM
- CBCL
- CABS

Time:

- 3 sessions with 1 hour each session.

Procedure: The mother of the child was psycho-educated about the nature and needs of the child and his illness. The child was administered assessment tools to reach and confirm the diagnosis. Moreover, the table and chair were arranged in a separate room in a corner where there was the least distraction, and all distracting things were out of the sight of the child. The child was engaged in a coloring activity to engage him.

Session 7:

Goals:

- Eye Contact building.

Techniques:

- Eye contact maintenance.
- Modeling.
- Reinforcement.

Time:

- 1 hour.

Procedure: The child was taught eye contact through "Tunnel technique" in which a piece of paper was folded, and the therapist looked from one side of the tunnel while the client saw it from the other side. He enjoyed the activity and maintained eye contact for 3 seconds, he was instantly reinforced. The therapist held the favorite marble of the client close to her eyes, when the child tried to snatch it, she asked him to look at her eyes first. As he looks into the therapist's eye, K.N. was immediately given reinforcer. Reinforcement was given in the form of appraisal every time the child showed good performance.

Session 8 to 10:

Goals:

- To reduce stubbornness.
- Developing compliance.
- Eliminating negative behaviors.

Techniques:

- Building compliance.
- Planned Ignorance.
- Differential reinforcement of alternative behavior.
- Functional communication training.

Time:

- 3 sessions with 1 hour each session.

Procedure: Every time child showed unwanted and undesired behavior like stubbornness, he was ignored until he learned he will no further include in activities of his choice. No reinforcement was given when he did undesirable behavior and continuous reinforcement was given on desirable behaviors. For building compliance, the basic eight rules for compliance were employed. Moreover, he was taught how to communicate his problem to the mother before reacting.

Session 11 to 13:

Goals:

- Self-care training.
- Bath-taking training.

Techniques:

- Shaping.
- Backward Chaining.
- Differential reinforcement.
- Homework assignment.
- Prompt.

Time:

- 3 sessions with 1 hour each session.

Procedure: The child self-care training includes washing hands, buttoning and un-buttoning, and fastening and unfastening zippers. These skills were taught by using shaping and prompts. The therapist teaches them to take a bath using backward chaining, differential reinforcements, and prompts. Homework assignments were also given to the child. After the management of the client, 39% of improvement was reported by the informant.

Conflict of Interest

The authors declare no conflict of interest in relation to the publication of this clinical case report.

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