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Case Study

Behavioral Modification Training among children with Intellectual Disability: A Case Report

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ABSTRACT

Background: Intellectual disability (ID) is a neurodevelopmental disorder characterized by deficiency in intellectual, adaptive functioning and have onset during the developmental period. India has a prevalence of 10.5/1000 in ID. Children with ID engage in difficult behaviors such as temper tantrums, hyperactivity, rebellious, anti-social, fear, repetitive behavior, odd behavior, misbehavior with others and also self-injurious behavior (SIB), making parents very anxious about the modification of these problematic behavior in children with intellectual disabilities. **Aim**: The present study examined the effectiveness of behavioral modification training among children with intellectual disability. **Method**: A single case study method was adopted wherein after conducting the baseline assessments and clinical interview, the patient was diagnosed with Intellectual Disability as per ICD-10. The Behavioral Assessment Scale for Indian Children with Mental Retardation (BASIC-MR) was used to measure the behavioral issues of the patient. Thereafter, behavior modification training as a treatment modality was provided to the patient and subsequently, pre-post analysis was conducted to evaluate the effectiveness of the training. **Results**: The results indicated significant improvement in the behavioral issues as measured by BASIC-MR in the patient indicating the effectiveness of behavioral modification training in treating the problematic behaviors among patient with intellectual disability. **Conclusion**: Behavioral Modification Training was observed to be effective in the treatment of problematic behaviors among patient with Intellectual Disability.

Keywords: *Intellectual disability, adaptive functioning, behavioral modification, problematic behaviors, Therapeutic Intervention*

The term "mental retardation" has been replaced by "disorders of intellectual development" in the ICD-11 (WHO 2019) classification of diseases. Additionally, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA 2013) uses the phrase "intellectual disability." According to American Association on Intellectual and Developmental Disabilities (AAIDD), "*Intellectual disability is characterized by significant limitation both in intellectual functioning and in adaptive behavior as expressed in conceptual, social and practical adaptive skills which originates*

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before the age of 18 years". According to PWD Act 1995 (Equal opportunities, protection of right and full participation) "*Mental retardation means a condition of arrested or incomplete development of mind of a person which is specially characterized by sub normality of intelligence*."

Intellectual disability is characterised by deficits in intellectual and adaptive functioning, and its prevalence has been estimated to range between 1% and 3% of the population, with some regional variations (Patel, 2020). The age-appropriate behaviors required for children to live independently and carry out activity of daily living safely and appropriately are categorised as adaptive behavior. Adaptive behavior includes ADL such as grooming, dressing, safety, meal time activity, etc. (Raj, 2020). In intellectual disability there are deficits in adaptive behavior functioning as well as deficits in cognitive abilities such as reasoning, problem solving, planning, abstract thought, judgement, academic learning, and learning from experience, as determined by both clinical examination and a customised, standardised IQ test (DSM-5). A diagnosis of intellectual impairment (ID) refers to a diverse group of people with an intelligence quotient of less than 70, who make up about 3% of the population (Belanger, 2012). ID have different level according to their severity of the condition (table 1).

Classification of Intellectual Disability

Over the past few decades, various classification systems for children with intellectual disability (CWID) have been created. According to the AAIDD classifications of intellectual impairment, there are four levels of disability severity (mild, moderate, severe, and profound intellectual disability).

Table 1: Showing Severity Levels of Intellectual Disability

Severity category	**IQ Classification**
Mild	50-69
Moderate	36-49
Severe	20-35
Profound	below 20

Table 2: Classification of ID according to DSM-5 and ICD-11

Classification of ID	**DSM-5**	**ICD-11**
Mild Intellectual Disability	According to the Conceptual domain children with Mild ID face difficulties in academics area which include reading, writing and arithmetic concepts, they are support needed in one or more areas to meet age related expectation. According to social domains the person's social interactions are underdeveloped when compared to agemates who are typically developing. According to the practical domain, the person may do age-appropriate personal care. Individuals need more assistance	Mild disability of intellectual development is a condition that first appears during the developmental period and is characterised by significantly below average intellectual functioning and adaptive behavior that are about two to three standard deviations below the mean (roughly 0.1 to 2.3 percentile). Affected people frequently struggle with learning and understanding challenging linguistic ideas as well as academic skills.

Classification of ID	DSM-5	ICD-11
	than their peers do with complex daily tasks. During adulthood, support typically involve daily living activities like child care organizing, transportation money management, and nutritious food preparations, etc. Although judgement relates to well-being and organisation around recreational support, recreational skills resemble those of age-mates.	
Moderate Intellectual Disability	According to the conceptual domain every stage of growth the person's conceptual abilities is noticeably inferior than those of peers. Language and pre-academic skills for preschoolers develop gradually. and for school-age children, learning to read, write, do math, and comprehend time and money happens slowly. The individual exhibits substantial distinctions from peers in social and communicative conduct across developmental stages, depending on the social domain. Although spoken language is frequently the main method of social interaction, it is far less complicated than that of peers. According to the practical domain, the person can take care of their own personal needs as an adult, including eating, dressing, eliminating, and maintaining hygiene. However, it will take a long time and a lot of teaching for the person to become independent in these areas, and care may be required.	Moderate disorder of intellectual development is a condition that first appears during the developmental period and is characterised by significantly below-average intellectual functioning and adaptive behavior that are about three to four standard deviations below the mean (roughly 0.003 to 0.1 percentile).
Severe Intellectual Disability	The attainment of conceptual skills is constrained by the conceptual domain. The person generally has little knowledge of written languages or ideas related to quantity, time, money, and number of things. caregiver for lifelong problem-solving. According to the social domain, the vocabulary and grammar of the spoken language are relatively constrained. Speech can consist of a single word or a sentence and can be	According to appropriately normed, individually administered standardised tests or by comparable behavioral indicators when standardised testing is not available, a severe disorder of intellectual development is a condition that first appears during the developmental period and is characterised by significantly below average intellectual functioning and adaptive behavior that are approximately four

Classification of ID	DSM-5	ICD-11
	enhanced by assistive technology. Speech and communication are centred on the present moment within routine activities. Relationships with family and close friends can be enjoyable and beneficial. According to the practical domain, the individual needs assistance with all activities of daily living, such as eating, dressing, bathing, and urinating. The individual needs constant supervision. Long-term instruction and ongoing support are required for skill growth in all areas. Self-harming behaviors are among the maladaptive behaviors that a significant number of people exhibit.	or more standard deviations below the mean (less than about the 0.003rd percentile).
Profound Intellectual Disability	According to the conceptual domain, the physical world is typically involved in intellectual skills rather than symbolic operations. The person may use things in a goal-oriented way for work, play, and self-care. The person has a relatively limited grasp of symbolic communication through voice or gesture, according to the social domain. Simple gestures or instructions may be understood by children. The person loves interactions with familiar friends, family members, and caregivers and initiates and responds to social interactions using gestural and emotional cues. Although he or she may be able to participate in some of these activities, according to the practical domain, the individual is dependent on others for all facets of daily physical care, health, and safety. However, a person without a severe physical impairment may help with some daily work tasks at home, such as bringing dishes to the table. An important minority of people engage in maladaptive behavior.	A condition known as a profound disorder of intellectual development is one that began throughout the formative stage and is defined by intellectual functioning that is much below average and adaptive behavior that is around four of more standard deviations from the average (about below the 0.003rd percentile), based on individual, properly normed, standardised examinations that are given to each test taker, or by equivalent behavioral markers in the absence of standardised testing.

Manifestation of symptoms

- **Speech**

Children with intellectual disabilities (ID) often experience delays in language development and have challenges in speaking and expressing themselves. The severity of these difficulties typically corresponds to the level of intellectual impairment. In mild cases, children may develop language skills that are only slightly below those of their typically developing peers. However, children with severe or profound ID may have very limited verbal communication or may only speak a few words.

- **Perception**

Children with ID generally process and react to environmental stimuli more slowly. They may also struggle with distinguishing subtle differences in shape, size, and color, which can affect their ability to interpret and interact with their surroundings effectively.

- **Cognition**

Intellectual disabilities often impact cognitive abilities such as analysis, reasoning, comprehension, and calculation, as well as abstract thinking, to varying degrees. Children with mild ID can usually acquire basic reading and math skills equivalent to those of a typical 9 to 12-year-old (Daily et al., 2000). Those with severe or profound ID, however, may lack the ability to read, perform calculations, or understand verbal communication.

- **Concentration and Memory**

Children with ID typically have limited concentration spans and weaker memory, often finding it challenging to remember information accurately. While most struggle with recall, there are occasional exceptions, such as savants, who display exceptional memory skills. In general, however, memory is less reliable and frequently inaccurate.

- **Emotion**

Emotional responses in children with ID are often more naive or immature, though they may show improvement as they grow older. They often have limited self-control, and impulsive or aggressive behaviors are common. Some children may also display timid, withdrawn, or shy tendencies.

- **Movement and Behavior**

Children with ID may display coordination difficulties, appearing clumsy or overly active. In severe cases, they may exhibit repetitive or stereotyped behaviors, such as rocking, head-banging, teeth-grinding, shouting, or tearing clothing. Some may also show destructive, aggressive, or self-injurious behaviors, such as biting or slapping themselves, especially in moderate to severe cases.

Comorbidities

People who have mental delays are more likely to develop a psychiatric disorder. Today's statistics show that this population suffers from two to three times as many mood disorders, anxiety disorders, and behavioral issues as people without intellectual disabilities. (Katz, 2008) When social, family, and academic expectations are too great, this sensitivity occasionally results in a collection of psychotic symptoms that are secondary to the stress felt. Contrarily, there are additional conditions that co-occur but are unrelated to this risk factor. The most prevalent of these are epilepsy, attention deficit and hyperactivity disorder, schizophrenia, and infantile cerebral paralysis, Fragile X syndrome, down syndrome, Rett

syndrome are some examples of conditions associated with intellectual disabilities (Patel, 2020).

In all cases of intellectual disability (ID), the cornerstone of effective treatment is early detection and timely intervention. Since up to 40% of cases have no identifiable cause and many known causes lack a definitive cure, the primary aim of treatment is not to "cure" but to alleviate symptoms and reduce disability. This includes minimizing risks (such as ensuring safety at home or school), fostering life skills, enhancing quality of life, and providing support to families and caregivers. The specific goals and treatment strategies for each individual will largely depend on the underlying cause, severity of ID, and any coexisting conditions. One such strategy could be using behavior modification techniques which can play a vital role in alleviating symptoms and improving the individual's quality of life.

Behavioral Modification

Behavioral modification is a psychotherapy approach primarily used to stop or decrease problematic behavior in both children and adults (Hannah, 2022). Through positive or negative reinforcement, behavior modification based on the principles of operant conditioning replaces undesired behaviors with more desirable ones (Swapna, 2016). Children with ID frequently experience behavioral disorders, which can be problematic in day-to-day living and conceal or show a mental health condition due to problematic behavior they harm or inconvenience they cause others, or to the children himself (Raj, 2020). Everyone who works for people with intellectual disabilities has as their main goal teaching them how to overcome the barriers to adaptive behavior.

The comprehensive rehabilitation of children with intellectual disabilities places a high priority on the modification of behavioral issues. In terms of the presence of psychiatric symptoms, the studies showed that people with severe challenging behaviors scored significantly higher than people without problem behaviors (Kearney & Healy, 2011). They also revealed that people with severe problem behaviors scored significantly lower on social skills tests than people without. These findings imply that the occurrence of maladaptive behavior in people with ID may have an impact on social skill deficiencies and mental conditions. An individual's quality of life may be impacted by behavioral issues, which can be a barrier to successful learning and social interaction. A study conducted in India which exhibited that both the CBR and the clinical context were proven to be effective interventional sites for behavioral modification. Because different behaviors are linked to varying degrees of ID severity, it was discovered that the degree of improvement varied depending on the degree of ID (Lakhan, 2014). Another study conducted in India which showed that children with severe intellectual disability (ID) frequently reported issues with tantrums and self-harming behavior (SIB). Problem behaviors were documented in eight domains among those with moderate ID, with the exception of antisocial, conduct and fear. In comparison to children with mild IDs, this group reported a larger percentage of instances in five areas: violent and destructive conduct, misbehavior toward others, rebellious behavior, repetitive behavior, and unusual behavior (Ngashangva, 2015). According to teachers and parents' reports, the majority of studies on psychological and behavioral assessment of people with intellectual and developmental disabilities were based on behavioral observation. These types of assessments appear to have been beneficial for ID population, as suggested by Will and Wilson's (2014) longitudinal study on parent and teacher ratings of behavior problems in children with and without intellectual disabilities at three time points over the course of three years. Over the course of the three time points,

children with IDs received greater evaluations for behavior problems than the group of kids without IDs (NIDs).

Keeping in view the behavioral problems associated with ID, the present paper attempted to examine the effectiveness of behavioral modification training among children with intellectual disability with a detailed case report.

METHOD

Case Description

The patient Miss P, 10 years old, belonging to low SES, nuclear family, was diagnosed as a case of Moderate Intellectual Disability with an IQ of 49. She was brought by her parents with the chief complaints of: poor academic performance, speech difficulties, throwing & biting behavior, poor articulation and comprehension, poor fine motor skills, and poor daily living activities and altered biological state, with insidious onset, progressive course, with no family history of major psychiatric illness. Birth history indicated prenatal difficulties, birth cry absent, 9-month normal delivery at a hospital and delayed developmental milestones. Her motor development was within normal limits for the major milestones of sitting, standing, and walking, but her language development was delayed. She started walking at the age of 1 year and speaking one word at the age of 2 years. Patient had a limited vocabulary and used short, simple words and a range of terminology to connect with other people and explain fundamental needs. Keeping in view the above symptoms, the parents sent her to a special school for further management of her academic skills.

Family History: Patient is the youngest member of the family. Patient ranks second in terms of birth order. According to the Functional Assessment checklist for programming, the patient studies in the primary level at the special school. Her father has studied till 12th standard and currently works as a plumber, and her mother is educated till 8th standard and is a housewife.
No H/S/O any psychiatric comorbidities.

Measures

Behavioral Assessment Scales for Indian Children with Mental Retardation (BASIC-MR Part B)

The measure used was Behavioral Assessment Scales for Indian Children with Mental Retardation (BASIC-MR Part B) designed by Peshawaria and Venkatesan (1992) to assess the current level of problem behavior. The Part-B scale consisted of 75 items grouped under 10 domains including violent and destructive behavior, Temper tantrums, Misbehavior with others, Self-injurious behaviors (SIB), Repetitive behavior, Odd behavior, Hyperactivity, Rebellious behavior, Anti-social behavior, and Fear. Each item is graded on a scale of Never (N), Occasionally (N), and Frequently (F) for severity and frequency of problem behavior (F). The scale goes from 0 for "Never" to 1 for "Occasionally" and 2 for "Frequently." The test-retest reliability value was found 0.68. The construct validity was determined to be statistically significant (p=0.001).

Therapeutic Intervention

The therapeutic approach utilized for the patient was behavior modification training, a structured and evidence-based technique aimed at altering maladaptive behaviors and reinforcing positive actions. This method is grounded in principles of operant conditioning, where desirable behaviors are encouraged through positive reinforcement, while undesirable behaviors are discouraged through specific consequences or lack of reinforcement.

Pre-Intervention Phase

During the initial contact with general services at the special school, a detailed assessment was completed, including a special education assessment. Behavioral problems reported by parents were recorded in the case study and behavioral goals were chosen during parental consultations. The parents were given a quick overview of the intervention.

Patient was observed 4 hours (2 hours a day; 2days) to asses and confirm the display and frequency of the behavioral issues. A behavioral modification plan was prepared after conducting the BASIC-MR (PART-B), which provided the problem behaviors of the child.

Intervention Phase

The structure of the intervention was planned wherein three sessions per week were conducted with the patient. The duration of each session was 45 minutes to 1 hour.

Through BASIC-MR (PART-B) the following goals were set to be worked on with the patient:

1. Throwing objects at others
2. Biting behavior
3. Interrupting behavior when others are talking

During the therapy sessions, a variety of behavioral modification techniques were applied through the entire course of intervention. These techniques were selected on the basis of the patient specific behavioral problem, its function, the severity of the problem and the ability of parents to carry out and conform to the technique (table-3).

Table 3: Types of behavioral modification techniques used during the intervention

Behavioral Techniques	**Features**
Changing the antecedents	The therapist tried to prevent the behavior from change of such factors which cause the problematic problem (e.g. sudden change in routine).
Extinction/ Ignoring	The regulating function of behavior was removed on the occurrence of the behavior. This included actions like not looking at the child, not talking to the child.
Time out	It included removing the patient from the task or the reward from the child for a particular period of time following a problematic behavior.
Response cost	This technique involved decreasing problem behavior in patient is to take away the rewards that the patient has earned by performing specific good behaviors.
Restitution	This technique did not only decrease problem behavior in the patient but also taught appropriate ways of behaving. Patient was instructed to undo the exhibited behavior. For example, if an item was thrown by a patient, the patient was instructed to bring the item back and fix the damage or disturbance that occurred as a result of the undesired behavior.
Differential reward techniques	In order to reduce problem behavior, this technique required the therapist to reward appropriate or non-occurring behavior in a structured manner. 1. Differential reward of opposite behaviors: Using this technique, the therapist rewarded the patient for appropriate behavior that was completely opposite of the problematic behavior the therapist wanted to

	reduce. 2. Differential reward of other behavior: With this strategy, the patient was rewarded every predetermined time period during which the targeted issue behavior does not occur. 3. Differential reward of alternate behavior: This strategy was effective when the goal was to reduce the severity of a misbehavior rather than to entirely eliminate it. 4. Different reward of alternate behavior: The patient was required to exhibit additional good behaviors, which the therapist pointed out and rewarded right away. This method was combined with others to lessen problematic behavior.

The intervention was based on both individual as well as group sessions. Positive reinforcement was a crucial part of the procedure throughout, and it took the shape of vocal praise, handclapping, tapping on the back, and nonverbal cues like a grin to motivate the patient to keep going and foster a therapeutic bond.

During the **initial phase** of the intervention, the patient was asked to be seated on the chair comfortably. Art material and some toys were placed on the table. Patient showed violent and destructive behavior while throwing objects on the floor as well as on the therapist.
The behavioral modification technique of Restitution was used by the therapist and the patient was instructed to undo the exhibited behavior. The patient was instructed to bring the items back he threw and keep them on the table. The therapist provided physical prompts and verbal prompts to complete the given task. The technique of Restitution was used with the differential rewards techniques with the patient. After a few sessions, the patient started showing opposite behavior i.e., the undesired behavior was reduced, the patient did not throw the items but started taking care of the items which were not placed on the table properly. Patient was reinforced with the help of rewards likes “bangles”.

During the **middle phase**, the intervention plan shifted to conducting group sessions. The patient was observed in the classroom setting with 12 other children diagnosed with ID. The patient bit other classmates when they irritated her or when somebody refused to give or share their material (like pencil, colours, etc) with her. Subsequently, the time-out technique was used by removing the patient from the given task and asked to stand inside the classroom so that behavioral observation could be noted. However, the time-out technique was not always successful, therefore the technique of response cost was applied wherein the rewards were taken away “bangles” which was earned by the patient for performing specific desirable behavior. This technique helped in decreasing the problem behavior.

For interrupting behavior, the technique of extinction/ ignoring as well as conveying displeasure was applied. Whenever the patient tried to interrupt in between any conversation the therapist provided clear verbal commands expressing displeasure for occurrence of a specific problem behavior while saying “Miss P! I don’t like the way you disturb the class. You should sit at one place and finish the work”. A review of 5-10 minutes was also taken at each visit in which patient was asked to tell his experience and feelings about the previous session, also feedback from parents were taken. At the same time patient was also given feedback for her cooperation, sincerity, and giving some positive statements e.g. “You have

a lot of potential; I am very proud of you". These statements helped to motivate the patient to develop an insight about her potential, and also to regain the self-confidence.

Patient was under the observation & whenever she performed inappropriate behavior the therapist used the behavioral techniques mentioned in table 3.

The **termination phase** was planned once all the targeted behaviors subsided which was essential for creating closure and solidifying the progress achieved. The progress was reviewed with the patient to help her understand the initial goals of behavior modification, such as reducing biting & learning alternative responses to frustration. The specific behaviors were highlighted which the patient had improved such as using alternative ways to express herself or follow coping strategies. The patient's hard work and small wins were celebrated. Self-monitoring strategies were discussed with the parent as well as with the patient. The parents were trained to continue reinforcing these behaviors at home and a small set of coping cards were provided to remind the patient of alternative ways to respond to frustration and aggression to prevent any relapse of problematic behaviors. The termination plan ensured that the patient felt encouraged and supported & that parent/caregivers were equipped to continue reinforcing positive behaviors in their daily environment.

Post-Intervention Phase

After the complete behavioral modification sessions, the patient was again assessed on BASIC-MR (PART-B) to evaluate the any reduction in problematic behaviors.

RESULTS & DISCUSSION

Behavioral modification techniques outcome showed effective in the reduction in problematic behavior in the children with ID (table 4). The behavioral modification techniques appeared to be effective, particularly in reducing violent/destructive behavior, misbehavior with others, hyperactivity, and antisocial behaviors. Some behaviors (such as temper tantrums, odd behavior, and fear) had no change, likely because they were already at 0 or were resistant to change. Other behaviors, like repetitive behaviors, also did not change, suggesting these may be more challenging to address or require different strategies. After post intervention assessment educator asked the parents to continue the sessions for other behavior like repetitive behavior.

Table 4: Showing the scores of Pre-test & Post-test findings on BASIC-MR (PART-B)

Domain	**Pre-test**	**Post-test**
Violent and Destructive behavior	12	8
Temper Tantrums	0	0
Misbehaves with others	5	2
Self-injurious behavior	2	0
Repetitive behavior	2	2
Odd behavior	0	0
Hyperactivity	1	0
Rebellious behavior	0	0
Antisocial Behaviors	2	0
Fear	0	0
Total	**24**	**12**

Behavior modification training involved identifying the patient's target behaviors that need change, setting clear, measurable goals, and developing a plan that includes rewards and consequences tailored to the individual. The approach in this article also incorporated self-monitoring techniques, skill-building exercises, and regular assessments to track progress and make adjustments as needed. By focusing on shaping behaviors systematically, this modality not only enhances adaptive functioning but also fosters self-control, resilience, and overall improvement in quality of life of the patient.

Behavior modification is a highly effective technique for individuals with Intellectual Disability by using structured, positive reinforcement strategies to encourage desired behaviors and discourage unwanted ones. Given the cognitive limitations associated with moderate intellectual disability, behavior modification approaches can be tailored to the child's comprehension abilities. By using the structured, empathetic behavior modification techniques, mentioned in this article, the therapists and caregivers can promote functional, social, and academic skills that can improve the child's quality of life, independence, and overall adaptive behavior.

CONCLUSION

Children with an ID frequently experience behavioral issues, which frequently negatively impact both the child's functioning and that of the others (Swapna, 2016). Results of this study showed that children with ID exhibited effective in the reduction in problematic behavior with the help of behavioral modification training. The effectiveness of this programme was largely dependent on educator and parental participation. In both settings, we promoted parents to learn behavioral skills, alter their unfavourable attitudes towards their kids, and improve their adjusting and coping skills in addition to behavioral management. It has previously been suggested that parents should receive psychoeducation and be included in the administration of behavioral management (Lakhan, 2014). An evidence-based strategy that can be utilised to assist kids with intellectual disabilities in learning new abilities and behaviors is behavioral modification training. With this strategy, undesirable behaviors are first identified, and then more suitable behaviors are encouraged by using positive reinforcement. This was used generically to refer to interventions designed to help people with their problem conduct. Interventions based on the principles of applied behavioral analysis, such as non-contingent reinforcement, FCT, PBS, and parental interventions with a behavioral approach, were deemed eligible for inclusion in the review (Prior, et al., 2023).

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Conflict of Interest

The author(s) declared no conflict of interest.

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