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Research Paper

Psychosocial and Behavioral Intervention in A Case of Childhood Emotional Disorder: A Multimodal Approach

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ABSTRACT

This case study presents the clinical evaluation and therapeutic intervention of an 11 year old adopted female child who presented with speech difficulties, academic underachievement, stubbornness, and aggressive behavior. Developmental delays, early neurological history, and challenging familial dynamics were explored. Psychological assessments revealed borderline intellectual functioning; IQ-72, internalizing and externalizing behavioral issues, and significant emotional and functional difficulties. A biopsychosocial formulation was applied to conceptualize the case, and a multimodal intervention approach including parent training, behavioral therapy, and cognitive remediation was implemented. Notable behavioral improvements were observed post-intervention. This case underscores the importance of early assessment, family dynamics, and targeted interventions in managing complex emotional and behavioral concerns in children with borderline intellectual functioning.

Keywords: *Borderline Intelligence, Behavioral Problems, Child Psychotherapy, Behaviour Therapy*

Borderline intellectual functioning (BIF), typically defined by an intelligence quotient (IQ) in the range of 70–85, represents a population that often falls through the gaps in both clinical and educational support systems. These individuals do not meet the formal criteria for intellectual disability, yet they experience significant impairments in learning, emotional regulation, and adaptive functioning (Salvador-Carulla et al., 2013; Emerson & Hatton, 2007).

In the Indian context, this service gap is further compounded by structural limitations in policy. Under the Rights of Persons with Disabilities (RPWD) Act, 2016, individuals diagnosed with intellectual disability (IQ <70) are eligible for a range of government-supported services, including disability certification, financial allowances, inclusive education accommodations, early intervention programs, vocational rehabilitation, and legal protection under employment and education quotas (Government of India, 2016; Narayan, 2008). However, children with borderline intellectual functioning do not qualify for these services, leaving them without access to structured remedial support, school accommodations, or social security benefits despite their significant cognitive and adaptive

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challenges (Salvador-Carulla et al., 2013; Emerson & Hatton, 2007; Hassiotis et al., 2008). This exclusion results in an underserved population that may experience academic failure, social marginalization, and higher risk for emotional-behavioral disorders (Vissers et al., 2010; Maulik et al., 2011).

Environmental adversities including early institutionalization, adoption, exposure to family conflict, and inconsistent parenting further exacerbate these vulnerabilities. In such contexts, children with cognitive delays are less resilient to stress, exhibit poor problem-solving abilities, and struggle with emotional self-regulation (Dekker et al., 2002; Vissers et al., 2010). In particular, children with adoption histories, who are often deprived of stable early attachments, are more likely to show symptoms of attachment insecurity, externalizing behavior, and academic regression (Rutter et al., 2007).

This case study presents the complete psychological evaluation and structured behavioral intervention for 11 years old adopted female child with BIF, speech impairment, emotional difficulties, and familial conflict. The case is notable for its integration of a biopsychosocial conceptualization and application of behavioral and parent management strategies, aligned with current best practices for children presenting with comorbid emotional-behavioral challenges and cognitive limitations.

What distinguishes this report is its practical demonstration of how structured parent training, token economy systems, and psychoeducation can improve outcomes even in socioeconomically modest and psychosocially strained families. This case contributes to the growing call for individualized, family-inclusive interventions for children with BIF.

Patient Information

Demographics: An 11-year-old adopted female, residing in a nuclear middle-class household in Ahmedabad, India. She lives with both adoptive parents and is currently in the 6th grade in a Gujarati-medium school. The child is unaware of her adoption status.

Presenting Complaints

The patient was referred for psychological assessment and intervention at Hospital for Mental Health- Ahmedabad (HMH-A) with the following primary concerns: speech difficulty since early childhood, persistent academic underperformance, stubbornness and emotional dysregulation and social withdrawal.

Medical, Family, and Psychosocial History

The child has a medical history of two seizures between 9 to 12 months of age and delayed motor and language milestones. No prenatal/perinatal history is available. Her adoptive family has a history of intra-familial conflict. The father is short-tempered with prior verbal and physical abuse episodes toward the mother. Parenting was inconsistent, with different reinforcement patterns from each parent. The child experiences low peer acceptance and occasional teasing, affecting her confidence and social engagement.

Relevant Past Interventions

No prior formal psychological assessment and management is reported. The child had been placed in different schools and short-term tuition but showed limited academic progress. This was her first psychological evaluation and structured intervention.

Age	Significant Event
10 Months	Adopted from shelter
1 years	History of seizures (2 episodes)
2 years	Started walking (delayed milestone)
3 years	Speech initiated; stammering begins
4 years	Begins formal schooling; difficulty adjusting socially
6-9 years	Changes schools multiple times; bullied; academic struggles intensify
10 years	Displays irritability, aggression, stubbornness; withdrawn at school

Clinical Assessments

Multiple standardized tools were selected to provide a holistic understanding of her condition, triangulating self-reports, caregiver observations, projective assessments, and formal intelligence testing.

1. Binet Kamat Test of Intelligence (BKT): The BKT was administered to assess the intellectual functioning of the child. The child obtained a mental age of 7 years and 4 months, with a prorated IQ of 72, which falls within the borderline range of intellectual functioning.
2. Malin's Intelligence Scale for Indian Children (MISIC): Used to corroborate the BKT findings, the MISIC yielded a total raw score of 108, translating to an IQ of approximately 73, which is consistent with the BKT outcome. Both tools together confirmed that the child operates in the borderline intellectual functioning range.
3. Child Behavior Checklist (CBCL) Parent Report: These scores indicate that the child shows both internalizing symptoms (e.g., sadness, withdrawal) and externalizing behaviors (e.g., anger, defiance), requiring integrated intervention strategies.
4. House-Tree-Person (HTP) Test: The HTP test was administered to explore the child's inner world, personality structure, and unresolved emotional conflicts. Interpretation: The child demonstrates unresolved aggression, withdrawal, and guardedness. The mildly elevated Preoccupation with Sexual Content score may reflect normative pubertal curiosity, with no clinical signs of abuse.
5. Bender Gestalt Test–2 (BGT-2): Administered to evaluate visual-motor integration and neurological functioning. The score falls within the very low or mildly delayed range, indicating notable deficits in the child's visual perception, motor control, and hand-eye coordination. She may struggle with tasks involving fine motor skills, such as handwriting, drawing, and organizing space on a page. Her ability to retain and reproduce information in the correct spatial arrangement is compromised, which could affect not only academic learning (e.g., reading, copying from the board) but also following multi-step visual instructions.

Diagnostic Challenges

Several challenges were present in the diagnostic process: Lack of developmental history, due to adoption at 9 months, prenatal, perinatal, and early developmental data were unavailable. Speech difficulties: The child's stammering occasionally interfered with verbal responses, requiring patience and repetition during assessment.

Provisional Diagnosis

Childhood Emotional Disorder, unspecified Findings Supporting the Diagnosis:

- Clinically significant emotional disturbances (CBCL, and HTP)

- Social withdrawal, irritability, aggression, and low frustration tolerance
- Insecure attachment patterns and contextual stressors (family discord, peer bullying)

Prognosis

While the child demonstrated multiple functional impairments at baseline, the prognosis was considered guarded but optimistic due to: Supportive mother figure, no current neurological or physical impairment and positive response to structured, individualized behavioral and emotional intervention.

Therapeutic Intervention

The child presented with a complex interplay of behavioral, emotional, and cognitive difficulties, underpinned by borderline intellectual functioning and challenging family dynamics. Given this, a multi-pronged intervention grounded in behavioral theory, attachment theory, and parental systems training was chosen. The aim was not only to reduce maladaptive behaviors but also to strengthen parent child dynamics, emotional regulation, and functional independence.

The therapeutic plan was guided by Engel's Biopsychosocial Model, which framed the child's development in terms of interacting biological (borderline IQ, speech issues, seizure history), psychological (low self-worth, irritability, emotional dysregulation), and social (parental conflict, peer exclusion) influences.

1. Psychoeducation for Parents

Psychoeducation was prioritized in the early stages to ensure parental understanding of the diagnosis, the role of reinforcement patterns, and the impact of inconsistent parenting. Sessions included explanation of borderline intellectual functioning and its behavioral manifestations, emphasis on neurodevelopmental vulnerability due to early life adversity, raising awareness of negative discipline practices (e.g., shouting, physical punishment) and their long-term consequences.

2. Behavior Therapy

A token economy system was implemented as the primary behavior modification strategy, grounded in Skinner's principles of operant conditioning. The method is well-documented for its effectiveness in increasing desired behaviors in children with developmental and behavioral disorders (Kazdin, 2005).In children with cognitive limitations, tangible reinforcers such as tokens have been shown to be more effective than abstract rewards due to concrete processing styles (Matson & Boisjoli, 2009).

A Token Economy System was introduced as a structured reinforcement strategy:

- Desired behaviors (e.g., completing homework, following instructions, managing anger) earned the child tokens.
- Tokens could be exchanged for tangible or activity-based rewards (e.g., watching a favorite video, stickers, playtime).
- Noncompliance or tantrums led to token withdrawal.

This system capitalized on the child's strong responsiveness to immediate feedback and helped shape behavioral consistency through positive reinforcement and contingency

management. To track behavior systematically, an Activity Schedule was maintained, and parents were trained to provide consistent, non-punitive feedback.

3. Parent Management Training (PMT):

Given the child's home environment involving inconsistent and sometimes harsh parenting, Parent Management Training was essential. PMT is an evidence-based treatment for externalizing behaviors in children, with strong efficacy in modifying parental responses and improving family dynamics (Eyberg et al., 2008; Kaminski et al., 2008).

This component focused on enhancing the parenting skill and improving communication:

- Active Listening Skills: Training parents to validate the child's emotional experiences before directing or correcting behavior.
- Emotion Regulation: Parents were taught to help the child identify, label, and manage her emotions.
- Time-Out Strategy: Introduced as a calm, non-punitive way to manage escalation.
- Differential Reinforcement: Parents were encouraged to reward even small instances of compliance and ignore minor, attention-seeking misbehavior.

4. Cognitive and Emotional Skills Training for the Child:

Children with borderline IQ often display difficulties with emotional labeling, problem-solving, and impulse control. Studies show that building emotional vocabulary and self-monitoring skills reduces the intensity and frequency of emotional outbursts (Denham et al., 2012). Given the child's delayed academic skills and emotional vulnerability, the following individualized support was provided:

- Remedial Training: Focused on basic reading, writing, and mathematical skills using visual aids and repetition, tailored to her learning speed
- Emotional Regulation Techniques: Storytelling, drawing, and role-play were used to externalize and understand feelings
- Social Skills Training: Exercises were introduced to teach turn taking, understanding body language, and assertively responding to teasing.

5. Safety Education (Good Touch/Bad Touch):

Research underscores the importance of body autonomy education in children with developmental vulnerabilities, who are at increased risk of victimization (Kenny et al., 2008).

- The difference between "safe" and "unsafe" touch.
- How to seek help if she feels uncomfortable.
- Assertiveness in personal boundary setting.

The sessions used story-based and visual tools to explain concepts of appropriate and inappropriate touch, personal boundaries, and help-seeking behaviors. This intervention fosters protective behavior and reduces risk in vulnerable children who may lack social judgment or assertiveness.

Total Duration: The therapeutic intervention was delivered over 14 sessions spanning a period of four months. Sessions were conducted on a weekly basis, each lasting around 60 minutes.

Follow-up and Outcomes

The therapeutic intervention was evaluated through both clinician observation during sessions and parental reports from home settings. The dual-assessment approach allowed for a comprehensive understanding of behavioral change, emotional regulation, and generalization of therapeutic gains beyond the clinical environment.

The child's mother, as the primary caregiver and informant, was actively involved throughout the intervention and provided weekly reports on behavioral patterns, emotional responses, and task compliance at home. She maintained behavior logs that were documented.

Target Behavior	Improvement Noted
Following instructions	60% improvement
Reducing TV viewing duration	70% improvement
Anger and temper tantrums	90% improvement
Frequent crying	90% improvement
Homework completion	70% improvement

These improvements reflect reduced defiance, enhanced emotional regulation, and increased task compliance, which the parents attributed to both the token economy system and improved communication strategies learned during parent training sessions.

Clinician-Assessed Outcomes

- Increased verbal responsiveness and willingness to express emotions in sessions
- Greater frustration tolerance during structured tasks
- Improved ability to follow multi-step instructions.
- Better understanding of cause-effect relationships in behavior (e.g., understanding that token loss follows non-compliance)
- Gradual increase in self-confidence and task initiation

While residual difficulties in writing speed, peer interaction, and social assertiveness remained, the child showed steady progress in emotional regulation and structured behavior within the therapy setting.

DISCUSSION

This case underscores the complex interplay of cognitive limitations, emotional dysregulation, and family dynamics in a child with borderline intellectual functioning (IQ 72–73). Children in this cognitive range often fall below the threshold for intellectual disability yet experience significant functional impairments in academic, emotional, and social domains (Salvador-Carulla et al., 2013; Emerson & Hatton, 2007). Research consistently shows that children with borderline IQ are more likely to develop psychiatric disorders, particularly in the presence of psychosocial stressors (Vissers et al., 2010; Dekker et al., 2002).

The co-occurrence of internalizing (e.g., withdrawal, sadness) and externalizing symptoms (e.g., defiance, aggression) in this case is consistent with findings from longitudinal studies showing that BIF is a risk factor for both emotional and behavioral dysregulation in childhood and adolescence (Hassiotis et al., 2008; Maulik et al., 2011). Moreover, the

discrepancy observed between the child's self-report and the caregiver's report on emotional symptoms aligns with the literature on informant discrepancies, which often reflect lack of parental attunement to internal states (De Los Reyes & Kazdin, 2005).

The intervention model centered on behavior therapy, psychoeducation, and parent management training was selected based on its evidence base and adaptability for low cognitive profiles. The token economy system, rooted in operant conditioning, has demonstrated efficacy in increasing task compliance and reducing disruptive behaviors in children with intellectual and developmental disabilities (Kazdin, 2005; Matson & Boisjoli, 2009). Similarly, parent training programs have shown strong empirical support for improving parenting consistency, reducing coercive cycles, and enhancing child behavioral outcomes (Kaminski et al., 2008; Scott et al., 2010).

The inclusion of emotional regulation training and safety education further aligned with recommendations for integrated, multi-domain interventions in children with developmental and psychosocial vulnerabilities (Gottman et al., 1996; Kenny et al., 2008). The positive therapeutic outcomes, as evidenced by both clinician observations and parental reports, suggest that early, structured, and family-centered interventions can bring meaningful change even in cases marked by cognitive limitations and environmental stress.

While residual difficulties in writing speed, peer interaction, and social assertiveness remained, these areas present clear targets for future intervention. To address writing delays, occupational therapy focused on fine motor coordination and structured remedial education using multisensory methods can be beneficial (Feder & Majnemer, 2007; Swanson & Hoskyn, 2001). The use of assistive tools such as pencil grips or keyboard-based tasks may also reduce the physical strain of handwriting (Smith et al., 2014). Social skills deficits can be addressed through evidence-based Social Skills Training (SST), which incorporates role-plays, cooperative activities, and guided peer interactions to promote prosocial behaviors (Gresham et al., 2006). Structured group therapy and peer-mediated interventions can further support social learning in naturalistic settings (Odom et al., 1999).

Strengths:

- Comprehensive, multi-method assessment approach, integrating standardized cognitive, behavioral, emotional, projective, and neuropsychological tools to develop a well-rounded clinical profile.
- The intervention was tailored to the child's cognitive and socio-emotional needs, utilizing a multimodal therapeutic model that combined behavior therapy, parent training, psychoeducation, and emotional regulation strategies.
- The involvement of caregivers in both assessment and intervention phases enhanced treatment consistency and facilitated generalization of therapeutic gains to the home environment.
- The study documents both clinician observed and parent reported outcomes, providing robust evidence of change across settings.
- The case highlights a neglected population of children with BIF who often remain underserved due to policy gaps, thus contributing valuable insight to the clinical literature and public health discourse.

Limitations

- As a single-subject design, its findings are not generalizable to broader populations without further replication.
- The absence of standardized post-intervention testing limits the ability to quantify cognitive or emotional improvement beyond behavioral observations and parent reports.

Main Takeaway:

This case demonstrates that borderline intellectual functioning, when combined with speech deficits, inconsistent parenting, and emotional distress, can severely impact a child's academic and social trajectory. However, with targeted behavioral intervention, parental training, and consistent psychoeducation, significant improvements in emotional regulation, behavior, and parent-child interaction are achievable, even in resource-limited or challenging environments.

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Conflict of Interest

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