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Article:	**Navigating Tantrums: A Clinical Case Study of Autism Spectrum Disorder in a Teenager**
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ABSTRACT

The case study was about a 14-year-old teenager who was referred to a trainee clinical psychologist with complaints of difficulties in learning academic skills, intellectual functioning, temper tantrums, poor socialization, speech, and communication. Informal assessment consisted of clinical interviews with parents and teachers, behavior observation, identification of reinforcement survey, and portage guide to early education (Sturmey & Crisp, 1986)). The formal assessment was based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) in 2022 criteria, Childhood Autism Rating Scale (CARS) (Schopler et al., 1988) and the Slossan Intelligence Test (SIT) (Slosson, 1965). Scores on these tests were 34 indicating a moderate autistic category at level 3, and IQ 49, severe level, respectively. The client was diagnosed with autism spectrum disorder (F84.0) requiring substantial support, with intellectual and language impairment with co-morbidity of intellectual developmental disorder of moderate level (F71).A management plan was devised and implemented Individualized Intervention Plan incorporate behavior modification techniques such as reinforcement, prompting, imitation, symbolic modeling, shaping, chaining, fading, floor time (DIR), and pivotal response treatment (PRT) were used to overcome self-disruptive behaviors and encourage communications and social skills. The difference between pre- assessment and post-assessment clearly showed improvement in the client's selected tasks like eye contact, 40 % improved, and 80% decreased in temper tantrum after 16 sessions.

Keywords: Autism Spectrum Disorder, Teenager, Clinical Case Study

Introduction

Autism Spectrum Disorder (ASD) is a neurodevelopmental disease with deficits in social, communication, and linguistic skills, along with repetitive behaviors usually manifesting in the early years. The prevalence of ASD is approximately 1 in 160 young in South Asia (World Health Organization, WHO, 2020) and 1 in 54 in the Unites States (Centers for Disease Control and Prevention, 2014). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), in 2022 written criteria for autism spectrum disorder in difficulties in social interactions, cognitive decline, and disruptive repetitive behavior. There is a societal stigma surrounding ASD in Pakistan, where several parents avoid socializing their children due to the care they need. Several research indicated that individuals with ASD usually experience sensory overload and prefer rigid routines which trigger their temper tantrums (Maich & Belcher, 2012). Imran et al. (2011) described that adolescents are unable to express their needs, so they get easily frustrated and show anger outbursts. Furthermore, their symptoms range from mildly irritated to extreme meltdowns depending upon the severity of their symptoms. Moreover, emotional deregulation is critical during adolescence, which leads to behavioral issues including aggression, tantrums, and self-destructive behaviors. Understanding its origin can help to build a comprehensive therapeutic approach for emotional regulation, verbal and nonverbal communication challenges, and social interaction difficulties (Afzal et al., 2024). For professionals and carers, working on these factors can improve the ASD individual's overall well being. Co-morbidity with intellectual disability makes it more complicated to diagnose and manage, particularly in adolescents. DSM-5 TR indicated that around 75% of clients with ASD also exhibit intellectual disability. The bio-psychosocial model (Egen, 1977) suggests that ASD is influenced by both genetic and environmental factors.

This paper illustrated a 14-year-old Pakistani teenager diagnosed with ASD who exhibited recurrent tantrums, poor eye contact, and other developmental deficits in cognition, motor, social, language, and self-help skills. Understanding the triggering factors of tantrums and their underlying causes is crucial for developing effective therapeutic interventions that help to improve clients' socialization, verbal and nonverbal communication, speech, and emotional health. By exploring these factors, the study attempts to raise understanding and acceptance of ASD in Pakistani society and recognize the bio-psychosocial causes of ASD. It also helps to develop assessment and treatment plan options for individuals with ASD.

Initial behavioral observation:

The client was a 14-year-old boy of strong build with average height, wearing a school uniform, exhibiting tantrums, stubborn behavior and unclear speech. Mostly his mother was replying. His fine motor skills were better than his gross motor skills. He could not get downstairs with alternate feet. He could not squat and jump. His on-sit behavior was poor, and most of the time, he remained off-seat. He liked to talk about political parties, cricket, vegetable cutting, painting flags and sticker collecting and sharing things, etc. His ability to follow instructions, attention span, and concentration fluctuated during the assessment. The client’s hobbies were watching songs, videos and playing computer games. His disliked were playing outside because he felt tired most of the time due to walking on toes. He had a swayback due to faulty sitting posture. Mostly, he sat quietly aside on a bench, moving his legs, keenly observing his surroundings, he spoke a few times (jargon words) and laughed himself, and only engaged in two-way communication when someone else initiated it.On the playground, he was not playing with a ball alongside other children. He was showing a bossy attitude towards younger children and hitting and pushing them.He was showing some repetitive behaviors and shouting, clapping, and spinning himself.He also showed unusual vocalizations such as grunting, throaty noises, and hardly understandable words. When the bell was ringing after

recess, he ran by toes to his class and then removed his shoes and seat on the mat to take some rest due to his fatigue.

History of Present Illness:

The client visited the present special education institution along with his parents with complaints of difficulties in learning academic skills, low intellectual functioning, temper tantrums, poor eye contact, stubborn behavior, and poor socialization, sensitive to noises, poor speech and communication. The client was referred to a trainee clinical psychologist for assessment and management of his problems.

At the age of 5 years, when a client's admission was rejected from two schools due to his learning problems, then his parents realized that he was a special child. Mother reported that he started showing some specific behaviors like spinning, walking on toes, using jargon language, and poor socialization after age 4. Initially, his feet remained slightly outward while walking, but later he started walking on toes at age 5. He was also not able to do tasks assigned by his mother with attention and show tantrums when someone forced him to do some tasks that needed concentration. His mother stated that he had been attached to a teddy bear for a long time in the past. According to his mother, it took too long to convince him to throw the teddy away. After that his fixation had been established with flags. He painted flags and kept them under his pillow so that nobody took them away. She also reported that sometimes he lined up nips of pencils. He always complains of tiredness because of his foot muscle contractions due to constant toe walking. Then suggested his parents fix a 3 inches high sole in his shoes to support his heel and stabling his walk. Now, the client was walking better after using that sole. The surgeon has recommended surgery for the permanent treatment of his walking problem by releasing contractions of his foot muscles, but it had risk of some complications in the operation, so parents were reluctant to take any a risk of surgery. They thought that the client's walking might got worse if surgery became unsuccessful.

Personal History:

The client was born through caesarean (c-section). He had a prenatal and neonatal history of complications. His mother reported that she was suffering from epileptic seizures, and she has fainted for 5 minutes during the 7th month of her pregnancy. During this fit, she vomited, and her urine also passed. The client also got pneumonia when he was 2 months old, then he was hospitalized for 5 days due to his serious condition.

The clients's developmental milestones were delayed. Details are given below with a comparison with normal milestones presented by CDC (2018).

Table 1 *Showing details of client's developmental milestones (Centers for Disease Control and Prevention, 2018)*

Developmental Milestones	Child age to achieved	Normal age range of
Head/neck holding	5m	3m
Social smile	9w	6-8w
Sitting	10m	6-8m
Crawling	14m	8-11m
Standing	4y	1 ½ y
Walking	17m	11-15m
Speech single word	5y	1 ½ y
Speech (Complete sentence)	10y	3 ½ y-4y
Bladder control	4y	2 ½ y-3y
Taking Bath	Still with help	4y
Dressing	Still with help	4 ½ y-5y

The mother reported that he started single -word speech at 5 years and spoke a complete sentence at almost 10 years old. The client did not have toilet training till 4 years, however, at the age of 6 years, he was partially toilet trained. Now, he was able to use the toilet, dressed up, and took a bath with a little help from his father and was not fully trained yet. No incident of bed wetting was reported. Spinning and rocking were reported. He also showed temper tantrums when things were not going as he wanted to be. He liked vegetable cutting and used to help with his mother in the kitchen. There was no previous history of psychiatric consultation.

Family History:

According to his mother, client parents were first cousins. Their marital relationship was normal. His father was 52 years old and graduated. Currently, he is working as a website designer. His general health was normal and his attitude towards client was loving and caring. He used to help him take baths but was unwilling to help him in his studies due to the client's stubborn behavior. He was also over-protective towards client. He always pampered him during misconduct and allowed him to do what he wanted.client's mother was 45 years old and graduated. She was a housewife. She was suffering from stomach ulcer and epilepsy. According to her, she never took any medicine for this and nor went to any doctor for a diagnosis. She also explained that she first experienced this problem when she was in class 8th. Last time, she experienced this seizure was about 5 months ago. She said that her paternal uncle, who was also her father-in-law, suffered with this problem. Her attitude towards client was loving and caring. She has a congenial relationship with the client more than any other family member at home. She usually helped client in his homework. She looked after her 3 other children too with client. She reported that if there is any conflict started between the client and his siblings, then she always took the client's side and explained to other children not to argue with him.

Child younger brother who was 11 years old and studying in class 3. He had good health. The client tried to play with his brother, but he did not involve him in play. They sometimes fought at home due to the TV remote control because they both wanted to watch their favorite channels. Parents always gave favor to the client over his brother so it was making a gap between both. They hardly play together. Client has one younger sister who was 10 years old and studying in class 3. She had good health. According to mother, the client tried to play with his younger sister, but she felt irritated. Client had one brother who is 6 years old and studying in nursery class. He had good health. The client was very caring towards his younger brother. His brother also liked him so much. Client has an authoritative attitude toward his siblings because his parents always tried to make him realize that he is older one. His siblings did not involve him in play. He mostly stayed at home and sat in front of the computer and played computer games but did not like to go out and play with other peers like most boys used to do at his age.

A Home Visit:

A trainee clinical psychologist visited client's home so that client could be assessed and observed in his home environment, also to find out his interactions with his family members and explore his needs for further improvement. Client warmly welcomed along with his mother. He was neatly dressed up. He tried to reply when something asked of him. He behaved well mannered. He was trying to participate in a mutual conversation. He made his own snack plate with a cup of tea. He went outside twice to take away cats who were making noise. At the end, some suggestions were given to client's parents regarding client's needs for further improvements e.g.; client's father should be engaged in client's study, playing educational games on the computer instead of wasting time on other computer games, giving time concepts by using a clock, giving math, science, and social study concepts, setting a proper time for study, be firmed about rules following, engaging him in cooking, baking and computer

designing, controlling behavioral issues, especially anger, shouting,abusing etc., focusing on two way talk through Q-method by asking ` why', when, where, who, what questions, and cross questioning.

Opinions of Experts Regarding Client's Condition

Class teacher

Good in math, Urdu, English and took an interest in drawing different pictures but mostly refused to work and show tantrums.

Sports Teacher

The client was assessed during the game period for his sporting skills. He was good at "Young Athletes Kit" but needed practice a lot for table tennis skill. He remained moody, authoritative, and aggressive during his game period. During play, he felt tired after a while.

Informal assessment

Clinical Interview

A clinical interview was conducted with the client's mother, class teacher, and sports teacher to be fully aware of the nature, severity, and aetiology of the client's problems.

Baseline Chart

The rating on the scale 1 to 10 was done by the trainee clinical psychologist and mother to assess the performance of clients on certain tasks during pre- and post-treatment. These results were presented in a graphical presentation of baseline charts to better understand the outcomes of the treatment.

Table 2 *Pre-rating of subjective complaints by teacher and mother*

Presenting complaints	Presenting complaints ratings
Difficulty controlling emotions	9
Difficulty controlling voice volume	9
Difficulty maintaining eye contact	8
Temper tantrums	9
Head banging	7

Note: 0 =No Problem; 5 = Average Problem; 10 = Severe Problem

Reinforcement Identification Survey

The reinforces were identified by mini- survey with the help of mother and teacher to presenting theclient with different things while achieving desired task. List is mentioned below.

Table 3 *Primary and secondary reinforces by teacher and mother*

Tangible Reinforcers	Edible Reinforcers	Social Reinforcers	Activities
stickers of flags, stars, smiling face	chips,	praise	table tennis,
calming bottle	candy	clapping	listen to the music,
bubbles	chocolates		play computer games
	biscuits		maze
	nimko		

Portage Guide for Early Education

Results:

Quantitative Analysis:

Chronological Age: 14years and 10 months

Table 4 *Portage guide of early education for client developmental age and age deficits (Sturmey & Crisp,1986)*

Areas	Calculated Developmental Age			Age Deficits
	Years	Months	Days	
Language	5	5	0	8 years and 6 months
Cognition	5	8	6	8 years and 3months
Socialization	5	8	2	8 years and 3 months
Self-help skills	5	9	0	8 years and 2 months
Motor skills	5	0	0	9 years and 11months

Qualitative analysis:

The performance of the client on the five areas of Portage Guide to Early Education (PGEE) showed that client was behind in all developmental areas as compared to other children of the same age. The client was 14 years old and his age deficits in socialization, language, cognition and self-help skills are more than 8 years and in motor skills age deficits were 9 years and 11 months, which showed the significant lack in client's functioning.

Formal Assessment:

Quantitative Analysis:

Table 5 *Childhood Autism Rating Scale (CARS) category and ratings, (Schopler et al.,1980).*

Sr. No	Category	Subject Scores
I	Relating to People	2
II	Imitation	2
III	Emotional Response	2
IV	Body Use	3
V	Object Use	2
VI	Adaptation to Change	2
VII	Visual Response	2
VIII	Listening Response	2
IX	Taste, Smell, and Touch	2
X	Response and Use Fear or Nervousness	2
XI	Verbal Communication	3
XII	Non-verbal Communication	2
XIII	Activity Level	3
XIV	Level and Consistency of Intellectual Response	2
XV	General Impressions	3
TOTAL SCORE	**Severity level 3: mildly moderate Autistic**	**34**

Qualitative Analysis:

The client lies in autism spectrum disorder mildly moderately level 3 category. His total score is 34, that is above the cut-off score of 30.

Slossan Intelligent Test (SIT)

Results:

Quantitative Analysis:

Date of Administration: 2-11-2008

Table 6 *Showing the score of Slossan Intelligence Test, (Slosson, (2019)*

Date of Birth	23-12-2003
Chronological Age in Years	14 years and 10 months

Chronological Age in Months	178 months
Mental Age in Years	7years
Mental Age in months	81 months
Ratio IQ	17881×100=45.5
Standard Errors of measurement	±4.3
Standard Errors of estimation (SEM)	45.5+ 4.3 =49.2
	45.5- 4.3 =41.2
IQ Range /IQ	**41.2-49.2/49.2**

Qualitative Analysis:

Client's SIT results depicted that client's ratio IQ is 49.2 and his IQ range is 41.2-49.2. According to this, he falls into the category of extremely low intellectual functioning. The chronological age of client was 14 years and 10 months, and his mental age was 7 years. There is a difference between his chronological age and mental age as his mental age lags his chronological age by about 7 years and 10 months.

Diagnosis:

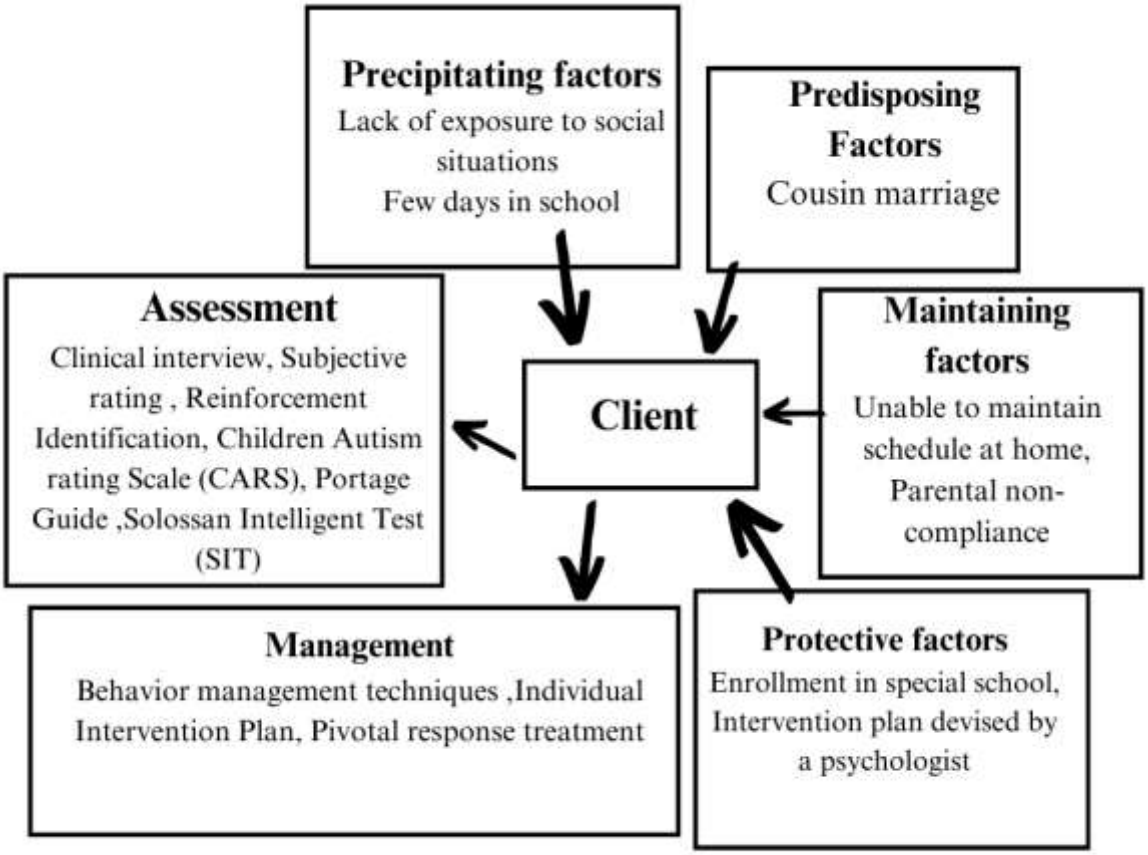
According to (DSM, 2013) autism spectrum disorder requires substantial support with Intellectual and language impairment (F84.0) and was co-morbid with Intellectual Developmental Disorder at a severe level (F72).

Case formulation:

Most of the symptoms of ASD is found in client like deficits in social-emotional reciprocity and deficits in verbal and non-verbal communicative behaviors use for social interaction, as he could not understand and engage in normal back and forth conversations with others. His severity of autism was at level 3. He also showed restricted and repetitive patterns of behavior. His mother reported that these symptoms appeared before age 3 but gradually became worse.

Most of the features were present in the client as he was not capable of making friendships like other children of his same age. He also had problems understanding and using verbal and nonverbal communication like he was unable to do back and forth conversation. Deficit in developing, maintaining and understanding relationships as he couldn't be able to understand social cues of facial expression and gestures and found it difficult to make friends on his own. He could not engage in playful activities with other peers and sit alone on a bench. In the playground he usually started spinning or running here and there instead of mutual play with other children. The client showed temper tantrums when any change happened in his routine. Mother reported that he started to pull his hair and beat himself while experiencing extreme anger. He was also sensitive to noise at a moderate level. Whenever he knew about the source of noise then he did not react towards noise. Client used to do spinning and tiptoe walking. He also used to self-talk (jargon words) which were not understandable. He has good creative abilities in painting which he showed in his art class. He always showed enthusiasm about his artwork by pre-planning his drawing theme. Clients also exhibited low intellectual abilities which was clearly reflected by the assessment of PGEE, SIT and DSM-5 criteria of autism spectrum disorder and intellectual disabilities. His cognitive level and language abilities scores were far behind his age group.

Figure 1 *An idiosyncratic case conceptualization by using the biopsychosocial model (Egen,1977).*



Management Plan:

Short term Goals:

- Rapport was established to maintain a supportive relationship for assessment and management.
- Psycho-education was given to the mother regarding a client's problems.
- Help client maintain eye contact to facilitate learning new skills.
- Floor time (DIR) was applied to expand client communication and social circle.
- Pivotal Response applied to encourage client to initiate conversation and making requests.
- Different behavior modification techniques such as prompting, reinforcement and modeling were used to help client learn new skills.
- Group activities were conducted to enhance client's socialization and communication.
- Client individualized intervention program ITP was formulated to attain new skills.

Long Term Goals:

- Continuation of short-term goals so that the client may carry out his learnt skills.
- IEP goals were carried out.

Summary of Therapeutic Intervention:

Psycho-education

The client's mother was psycho-educated regarding client's problem, aetiology, treatment and prognosis after assessment. The bibliography was handed over to mother to read in detail.

Family counseling

During the diagnosis parents reacted with grief and despair. Family counselling was provided to help in recognizing their client's strengths, and in dealing with their feelings of guilt and desire to overprotect. Behavioral management plans derived at school will need to be generalized to the home, so close links should be fostered between parents, teachers and speech therapists. Written instructions for taking the session daily at home were given. Furthermore, she was suggested to use physical exercises (punching bag or any sports activity) for the client so his energy could be utilized in a positive manner. Moreover, positive practice, differential reinforcement and physical restraint (when necessary) were suggested to control client's tantrums.

Individual Education Plan

The client's IEP was also devised based on the scoring of the Portage Guide to Early Education (PGEE). The aim of the therapist was to keep the IEP as realistic as possible.

Group Activities

Several group activities were conducted to facilitate clients. In art class, client socialized with other children, and all engaged in cooperative activity. They expressed their ideas and feelings through artwork. Client played mutually with other groups of children like musical chair to learn social skills and communication. Badminton was a great source for socialization and motor skills.

Behavior Modification

The goals of behavior modification procedures are to decrease the occurrence of undesirable behaviors head banging, making loud noises and temper tantrums.

Reciprocity

The reciprocity technique was used to establish rapport with the client. For this purpose, the trainee clinical psychologist watched videos on the computer with client and talk with him about his favorite topics like political parties' songs, and trip to Zoo during initial sessions, the trainee clinical psychologist gave stars, chips, candy and nimko to him. The rapport building process continued throughout the therapeutic sessions.

Task Analysis

All the selected tasks for treatment were broken down in the implest form to better understand for the client. Task mentioned below.

Discrete trial

As for clients, all tasks were divided into simple parts and practiced continuously.

Positive Reinforcement

The client was reinforced by reinforces like candy, chocolate, nimko and chips, praise (clapping, well done, star, stickers doing a favorite activity) and treats (candy, chips, and biscuits) used after completion of the task. The client mostly complained about headaches and tiredness when it's time to start doing his classwork so allow him to go to bed without doing his homework.

Premack Principle

Client was asked to finish work then you can play your favorite game.

Token Economy

Conditioned reinforcers like candy, chocolate, nimko and chips, were used as TOKENS. Client was presented with tokens while showing good behavior.

Symbolic Modeling

Modeling was used to teach the client about how to lace shoes, how to dribble a ball and how to communicate effectively. Moreover, video modeling was used to teach the client about harmful effects of anger by seeing the client cartoon videos in Urdu language about anger. Further, role play was conducted by trainee clinical psychologist to teach the client about how to behave appropriately when interacting with others in everyday routine.

Shaping

The psychologist reinforced the client for lifting right leg first then reinforced lifting left leg and step-down. This process continued until the client stepped downstairs independently with alternative feet.

Chaining

Chaining was used to teach client to dress up independently by taking a shirt from drawer and holding it and slipping arms in it and then buttoning up. Then comb hair independently. This continues until the learner can exhibit the whole chain of behaviors without any prompts (Miltenberger, 2012).

Extinction

Client's angry behavior was extinct by ignoring his behavior.

Aversive therapy

As client explained that due to his aggressive behavior no one will like him anymore.

Punishment

As for client, guided compliance time out, response cost, over correction, physical restraint, and positive practice were used timely.

Emotion regulation training

Client was taught how to replace angry mood with happy emotions by using different strategies e.g.; distraction, start doing his favorite activity like artwork, listening to music and talking to someone.

Social skills training

As client was trained to express his needs verbally in a low voice tone or politely.

Prompts

Visual prompts were given to client to boost his performance in cognitive (concept more and less, angry and happy difference) and self-help domains (laces shoes), gestural prompts and verbal prompts were given in all domains (motor, social, cognitive, self-help and language) to improve client's performance. Response prompt was used to teach the client how to laces shoes the client's hand can be held by the therapist at first when the task was initially introduced, next the therapist did the modeling for the client to imitate the laces shoes and then the client was only provided with verbal prompts. Similarly, while teaching to dribble the ball, firstly physical guidance was given then the therapist did the modeling for the client to imitate, then client was provided with gestural prompts and then only to the verbal prompts were provided until the client was able to do the task on his own. The extra stimulus prompting was used to mark number on the laces hole and the within stimulus prompting when asking point to the 'more' objects then picture with 'more object' was put a bit close to the client. Furthermore, some other types of prompts, positional, gestural, partial, full physical, hand over hand, verbal cues, and inadvertent prompts were used to teach client different tasks.

Fading

Physical prompts were reduced gradually through the use of fading technique in different tasks like word opposite, more and less concept and laces shoes.

Summary of sessions

In the first two sessions, an unstructured clinical interview was conducted with the mother of the client. Behavioral observation was done during session and at the time when the client was playing with other children in the ground in his break time. A reinforcement survey was also conducted in the second session with the client's mother. In the 3rd session, significant information regarding clients' problems was gathered from different experts with whom the client had daily interaction like class teacher, art teacher, sport teacher and speech therapist. Rapport was built through one-to-one interaction between the therapist and client in third session by talking with client around his favorite topics (political parties, favorite cartoons, songs and trip to Zoo.). Common interests and his daily routine were also explored by the

client. In the 4th,5th and 6th sessions, trainee clinical psychologist worked on further rapport building and assessment by administrating Portage Guide to Early Education (PGEE), Diagnostic Statistical Manual (DSM-5), Slosson Intelligence Test (SIT) on the client. In the coming sessions,after proper assessment, trainee clinical psychologist psycho-educated and socializing the client's mother regarding symptoms, causes, prognosis and treatment. The management plan was devised with the collaboration of the client's teacher and mother. To improve the eye contact of the client, the clinical psychologist used cards and toys with bright colors, fancy lights and music. Psychologists put them in front of her face and instructed the client to look at her face for 5 minutes, while psychologist told the story. The client also visited the sports room to play badminton, which trained to reduce the loud volume and support emotional regulation. The cards with different emotions were presented to the client to recognize and manage difficult feelings. Moreover, floor time activities were introduced to encourage social interaction and increase communication skills with others. The client enjoyed painting on different ports. Finally, he practiced to step-down stairs with alternating feet. Physical restrain, time out and reinforcement were used to control client's tantrum. Other sessions consisted of the Individual Education Plan. Selected tasks were pre-rated by trainee clinical psychologist and mother. At the termination of therapy, post assessment was done, and important suggestions were given to mother and teacher regarding his future Individual Educational Plan. Total 16 sessions brought significant improvement in client's symptoms.

Post Assessment

Table 7 *Pre and Post assessment by subjective Rating of IEP*

Areas	**Task**	**Previous Functioning Level %) by therapist**	**Previous Functioning Level (%) by parents**	**Present Functioning Level (%) by therapist**	**Present Functioning Level (%) by parents**
Socialization	to control his emotions	10%	10%	70%	70%
socialization	Maintaining eye contact	20%	30%	60%	70%
Motor	Dribble the ball	30%	30%	80%	90%
Cognition	to tell opposite of 10 words	10%	10%	90%	90%
Cognition	to tell the 3–5-part story	10%	10%	50%	50%
Cognition	Names positions, First, Second, Third, Fourth, fifth	10%	10%	90%	90%
Cognition	2 to 5 times tables	10%	10%	70%	60%

Cognition	to tell about concepts of more and less	20%	20%	70%	80%
Language	explain rules of musical chair game	10	10	50	60
Language	to control his voice volume 70 % time	10	10	70	70
Cognitive	One digit addition and subtraction	30	30	90	90
Self-help skill	Dress up clothes and comb hair by looking in mirror	30%	30%	50%	60%

Figure 2 *Graphical Representation of Pre and Post Assessment Ratings of IEP given by Trainee Clinical Psychologist:*

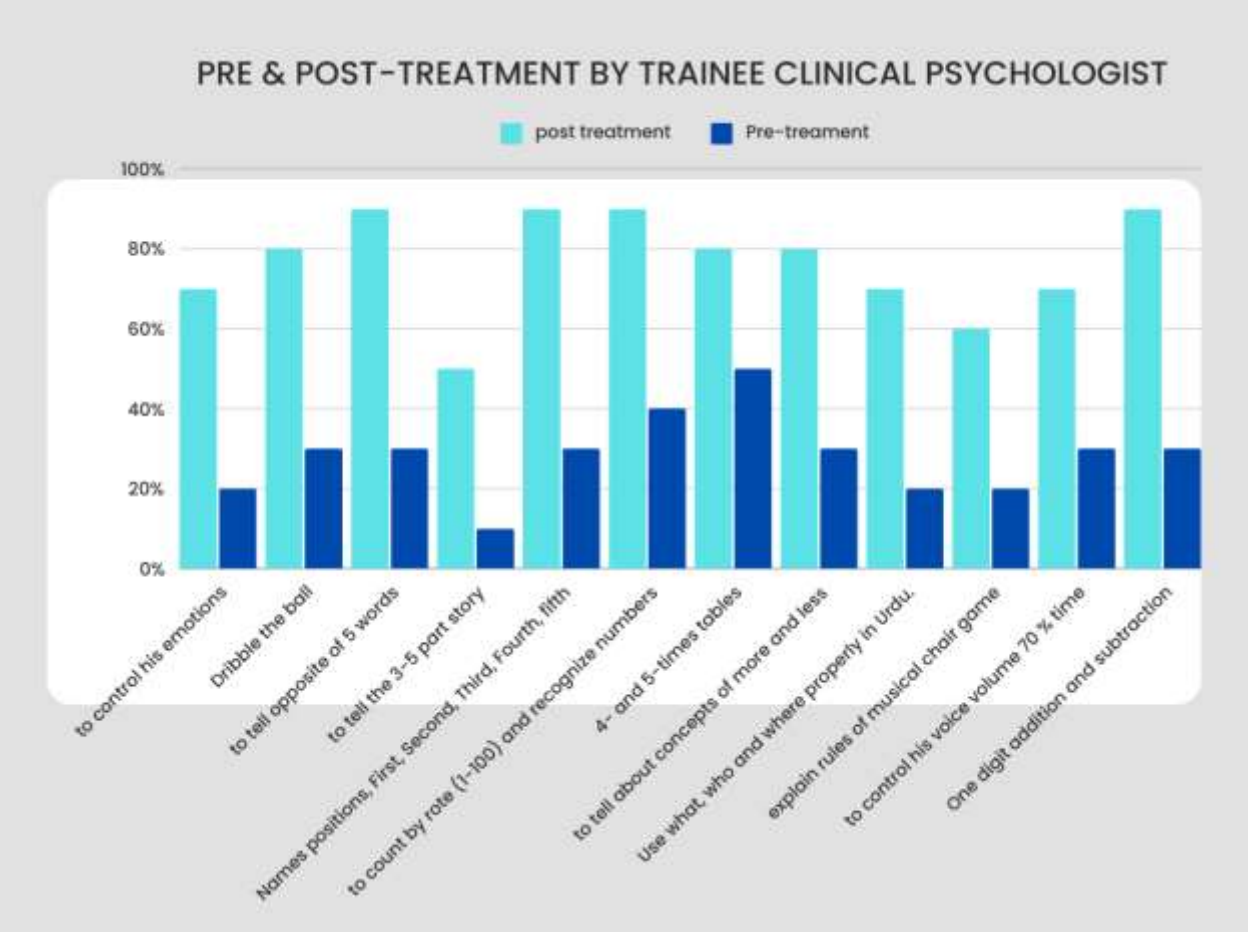
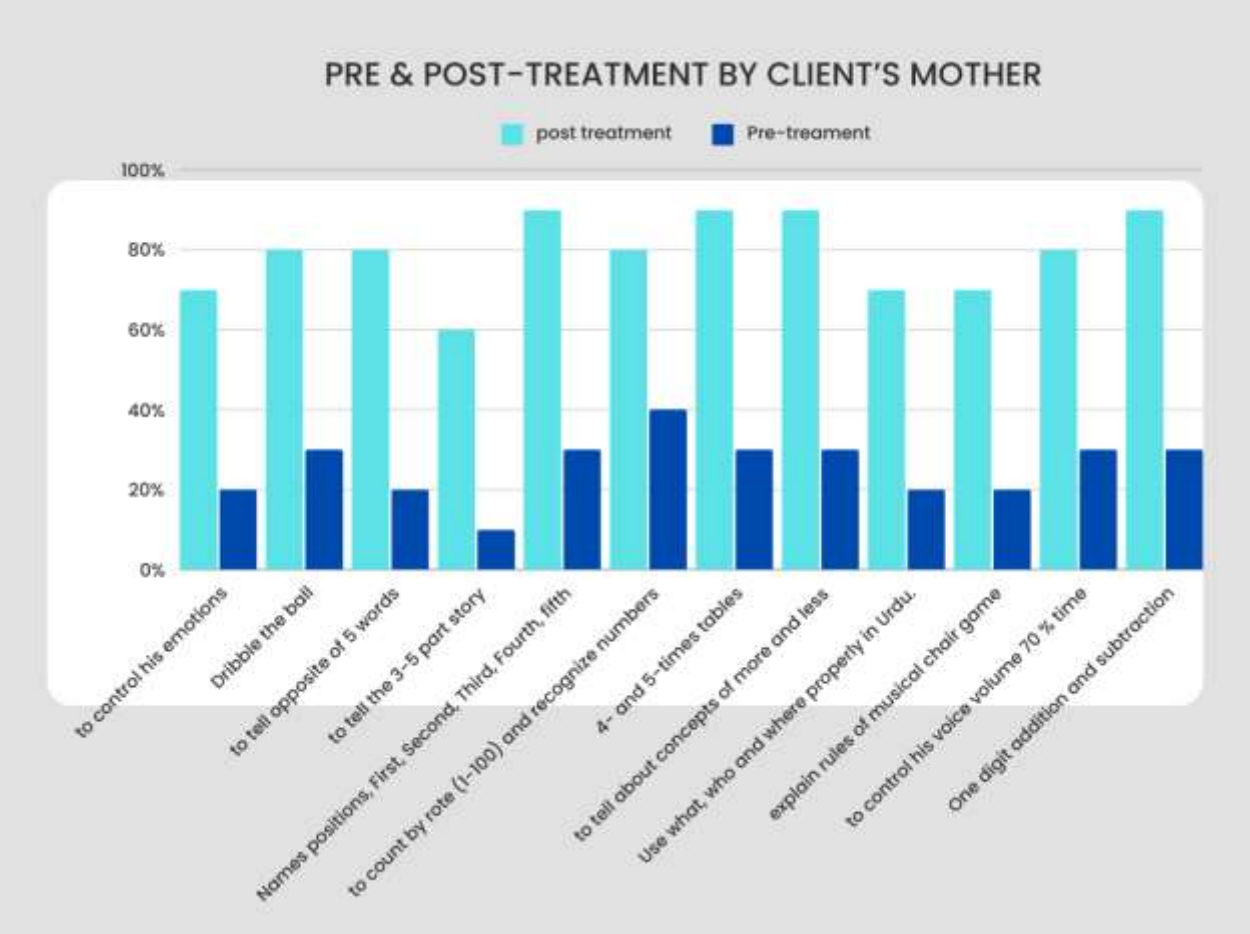


Figure 3
Graphical Representation of Pre and Post Assessment Ratings of IEP given by Client's mother.



Outcome

The client's overall improvement in selected tasks was noteworthy, especially in language and cognition.

Termination

At the termination of therapy, the client's follow up sessions were planned with school psychologist and therapy blue prints were given to his teacher and mother regarding his future educational plan.

Limitation

- Duration of therapy was very short.
- Mother herself had health issues and looked after her 3 other children.
- We could get better results if the father was involved in therapeutic process.

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