

Fight *with* **Autism**

*Love in Action,
Responsibility in Leadership.*

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BlueRoseONE^{.com}
S t o r i e s M a t t e r
New Delhi • London

BLUEROSE PUBLISHERS

India | U.K.

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ISBN: 978-93-7825-200-6

Cover design: Anuj

Typesetting: Tanya Raj Upadhyay

First Edition: April 2026

Preface

This is the first time I am putting my thoughts and actions into the form of pages in my first written book. Part 2 will be released after a year.

I had always had a desire to write so that the perception of living with our special child could be transformed.

I am excited that many of my known and unknown readers will join me in my journey and set an example to break the stereotypical boundaries of society. You are about to unlock a new thought as you turn the pages of this book.

All generations of individuals should read this book and bless the souls mentioned in the book.

I wish you all the very best as you start the journey.

(Note: Some names and locations have been changed or modified for confidential reasons.)

With Love

Dr (Hon.) Sukanta Nath Bhowmik

You are not different—you are unique.

The light within you will make you the best in the world.

You will conquer the world—All you need is belief and our unwavering
support by your side.

~Dr (Hon.) Sukanta Nath Bhowmik

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Chapter One

The Call that Changed Everything

It was just a fever. At least, that is what I believed. My younger son, Sreehaan, had a mild fever. Like any other child, he occasionally fell sick. There was nothing alarming about it. No warning signs. No dramatic symptoms. Just a normal childhood illness that parents handle every day. Nothing about that morning suggested that our lives were about to change.

My wife, Jaya, looked at him with concern and said gently, “We should take him to the doctor.”

I glanced at the clock. My office schedule was packed--meetings, project deadlines, staff responsibilities--everything demanded my attention that day. As a professional, I was used to managing pressure. As a father, I believed this was a routine situation.

“I have too much work today,” I told her. “Take Dr Divyanka with you.”

Dr Divyanka was my project manager--responsible, reliable, someone I trusted deeply. I felt reassured knowing she would accompany them.

They went to consult a homeopathic doctor.

I stayed back at work. To me, it was just another ordinary day.

But sometimes, life changes quietly--without warning, without preparation, without permission.

At 11:30 p.m., my phone rang. The late hour itself felt unusual. I picked up immediately. It was Dr Divyanka.

Her voice was serious--not her usual confident tone. Something was different.

“Sir... may I tell you something? Please don’t misunderstand. And for now, please don’t tell madam anything. She is a mother.”

My heart began to pound. “What happened?” I asked.

There was a brief silence—the kind of silence that carries weight.

“Sir... today when we visited the homeopathy doctor, the doctor mentioned that your son shows autistic symptoms.”

Autistic symptoms. Two words.

And in that instant, the world around me seemed to stop.

I had heard the term before—in news reports, in articles, in passing conversations. But it had always belonged to someone else’s story. Someone else’s child. Someone else’s life.

Now it was standing at my door.

After the call ended, I remained seated, motionless.

The room felt strangely quiet. Too quiet.



My thoughts began racing. What did it mean? Was it serious? Could it be wrong? Was this just a misunderstanding?

That night, fear took control.

I opened Google.

I searched YouTube.

I typed questions again and again:

What is autism?

Is autism dangerous?

Can autism be cured?

What is the future of a child with autism?

Each search led to more information. And each piece of information led to more fear.

Videos showed children struggling to communicate. Articles described developmental challenges. Research papers spoke about lifelong conditions. Stories from parents shared pain, confusion, and uncertainty.

Instead of clarity, I found anxiety.

Instead of comfort, I found overwhelming possibilities.

The more I searched, the more I felt lost.

I realized something important that night—the internet gives information, but not peace.

By morning, I had not slept.

The next day, I gathered the courage to speak to my wife.

I remember the moment clearly.

She was standing near the window, sunlight falling across her face. I hesitated. How do you tell a mother something that might shake her world?

“Jaya,” I said softly, “the doctor mentioned something yesterday.”

She looked at me.

I said that Sreehaan shows autistic symptoms.

The word hung in the air between us.

For a second, she did not react.

Then her expression changed.

It was as if the ground beneath her feet had disappeared.

“What?” she whispered.

I tried to explain calmly, repeating what little I knew. But she was no longer listening to explanations. She was listening to her heart—and her heart was breaking.

She cried. Not for a few minutes. Not for a single night.

She cried continuously for three days.

As a mother, her pain was deeper than words can describe. Mothers do not just love their children; they dream for them. They imagine futures. They create silent hopes.

And suddenly, all those hopes felt uncertain.

I watched her cry, and something inside me shattered too.

But I could not allow myself to collapse.

I held her gently and said, “Don’t worry. Please don’t take tension. You are a mother.”

But the truth was, I was also afraid.

Very afraid.

I was afraid of the unknown.

Afraid of society’s misunderstanding.

Afraid of labels.

Afraid of the future.

That fever was normal.

But that night was not.

That phone call did not just introduce a medical term into our lives. It introduced uncertainty. It introduced fear. It introduced a journey we had never prepared for.

I began thinking about Sreehaan, his smile, his small hands holding mine, the way he laughed freely. He looked like any other child. How could two words suddenly define his future?

Was autism a limitation?

Or was it simply a different way of experiencing the world?

At that time, I did not know.

All I knew was that I loved my son.

And love does not calculate statistics. Love does not read research papers. Love simply decides to protect.

In those early days, confusion surrounded us. Family members asked questions. Some offered advice. Some gave opinions without understanding. The word “autism” carried stigma, misunderstanding, and fear in our society.

But slowly, something began to change inside me.

The initial shock gave way to reflection.

The fear began to turn into determination.

If this was our reality, then we would face it--not with denial, not with shame, but with courage.

I realized that this was not a fight against my son.

It was a fight against ignorance.

A fight against fear.

A fight against social stigma. A fight for understanding. A fight for dignity.
A fight for his future.

That night, when the phone rang, I was just a father managing office responsibilities and routine life.

By the next morning, I was a father standing at the beginning of a new journey.

A journey filled with questions.

A journey filled with uncertainty.

But also a journey that would eventually give me purpose.

That phone call changed everything.

And this book begins there.

Chapter Two – The Waiting Room

After that night, I made a decision.

I could not sit back and drown in fear. Fear is heavy—it paralyzes thought, weakens courage, and quietly steals hope. But I knew one thing clearly: if something had to be done, I would do it properly. I would not leave my son's future to confusion or half-answers.

I decided to take Sreehaan to another state for consultation. I wanted the best medical advice available. I wanted clarity instead of assumptions. I wanted certainty instead of sleepless speculation. Most of all, I wanted hope—something solid to hold on to.

One evening, as I sat quietly reviewing medical notes, my elder son, Sreejith, came and stood beside me. He looked serious—more serious than a child his age should be.

“Baba,” he asked softly, “what happened to my brother?”

I paused.

How does a father explain something he himself is still trying to understand?

“It's called autism,” I replied gently.

He frowned. “What is that?”

I placed my hand on his shoulder.

“It's not a disease,” I said. “It's a disorder. It just means his brain works differently from ours.”

He thought for a moment. Then he asked the question every parent fears hearing:

“Will he be okay?”

Inside, my heart trembled. But on my face, I forced a calm smile.

“Yes, Baba,” I said. “He will be fine. That’s why we are going to Kolkata to see a doctor.”

A few days later, we boarded the train to Kolkata. The journey felt longer than usual. My wife sat quietly beside Sreehaan, watching him carefully. I watched both of them. My mind was racing, rehearsing questions I would ask the doctor, preparing myself for every possible answer.

The hospital in Kolkata was large, crowded, and overwhelming. Patients moved in all directions. The air smelled of antiseptic and anxiety. We completed registration, submitted documents, and waited for our turn. Doctors prescribed several tests—developmental assessments, behavioural evaluations, and neurological screenings. We did them all without hesitation.

Then came the hardest part—waiting.

We sat in the waiting room with reports in our hands. That room did something to me. It changed something inside me.

Around us were other parents.

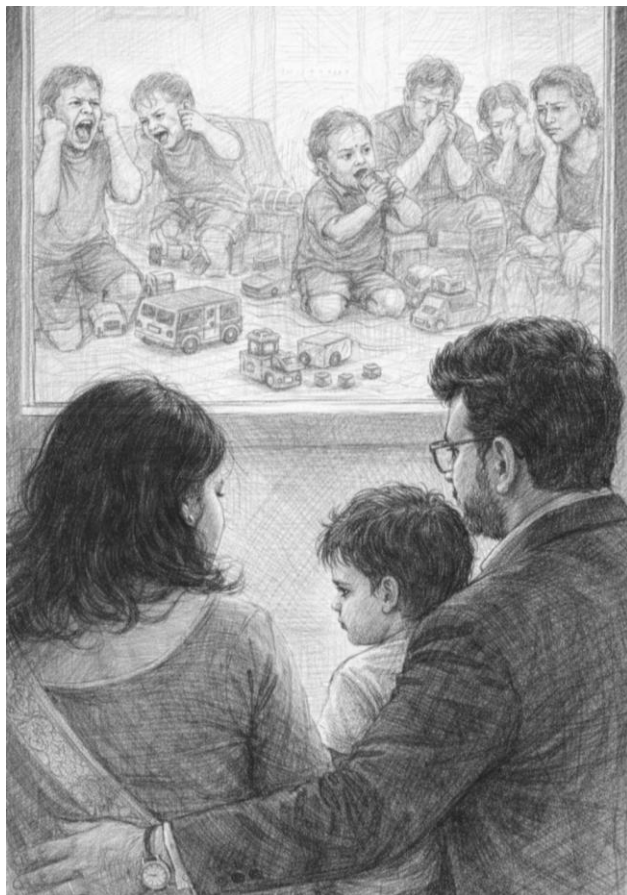
Some looked more anxious than we were. Some fathers stared blankly at the floor, as if searching for answers in the tiles. Some mothers wiped their tears silently, trying not to break in front of their children. There was exhaustion in their faces—not physical exhaustion alone, but emotional fatigue.

And the children...

Some were crying uncontrollably, their voices echoing across the corridor. Some were restless, running from one corner to another. Some were completely silent—sitting still, disconnected, their eyes wandering somewhere far beyond the room.

I watched them.

Each child’s face told a story.



Each cry carried confusion.

Each anxious mother carried fear.

Each father carried helplessness.

For a moment, a thought crossed my mind—my son's condition does not seem as severe as some of these children's.

Instead of relief, I felt guilt.

Why should I feel fortunate while another parent is drowning deeper? Why should my heart feel lighter when theirs is heavier?

The waiting room felt like a silent battlefield. No one spoke loudly, but everyone was fighting something inside.

I felt smaller there. Weaker. Alone.

Then our serial number was called.

We entered the doctor's chamber with nervous hands and hopeful eyes. I tried to remain composed, but the question was burning inside me.

"Will he be okay?" I asked.

The doctor looked at us calmly. She did not rush. She studied the reports carefully and then looked up.

"What do you do?" she asked.

The question surprised me.

"Ma'am," I replied, "I am a social worker and a businessman. My wife works in a government job."

She nodded thoughtfully.

Then she said something that slowly changed my thinking.

"Give your son time. Everything will improve. There is nothing severe. He needs attention, support, and structured guidance. Be patient."

Give him time.

The words sounded simple.

But in today's world, time is the most expensive thing.

We invest in money. We invest in status. We invest in growth. But do we truly invest time?

As we walked out of the chamber, my wife looked relieved. Sreehaan seemed happy, unaware of the weight we had been carrying. My elder son smiled, as if a burden had been lifted from his small shoulders.

But I was still quiet.

Because in my mind, the waiting room was still alive.

The cries.

The silence.

The helpless eyes of parents.

I realized something that day.

Autism was not only my family's struggle. It was a silent battle happening in thousands of homes--a battle fought behind closed doors, a battle misunderstood by society, a battle often judged, rarely supported.

On the way back to Tripura, as the train moved through the night, I stared out of the window. Darkness outside. Thoughts inside.

If I am a social worker...

If I call myself a responsible human being...

Then how can I think only about my own child?

Yes, my son was my world. But those children in the waiting room—they were someone else's world too.

I felt something shift inside me.

Fear was slowly transforming into responsibility.

Pain was slowly turning into purpose.

When we returned home, I met Dr Divyanka and shared everything—the consultation, the doctor's advice, the waiting room, the faces I could not forget.

"I want to do something," I told her firmly. "Not just for my son. For children with autism. And for their parents."

She looked at me carefully, as if measuring my seriousness.

"I know a doctor in Tripura," she said. "I can arrange a meeting."

That conversation was simple.

But it was not ordinary.

It was the beginning of something bigger than I had imagined.

Until that day, I saw autism as a problem that had entered my home. After that day, I saw it as a cause that had chosen me.

The fear that once broke me was now shaping me.

The uncertainty that once kept me awake at night was now giving me direction.

I understood that awareness was missing. Early intervention was missing. Emotional support for parents was missing. In many places, even acceptance was missing.

And I knew something had to change.

Not someday.

Not when someone else took responsibility.

But now.

That waiting room did not just show me suffering. It showed me the truth. It showed me reality without filters.

And it asked me a silent question:

What will you do about it?

By the time we reached home, my decision was clear.

My fight was no longer only for Sreehaan.

It was for every child who sat silently in that waiting room.

For every mother who cried quietly.

For every father who pretended to be strong.

That day, a father walked into a hospital seeking answers.

But he walked out with a mission.

And the journey had just begun.

Chapter Three – Alone in the Fight

Starting an autism centre was never just a professional decision for me. It was not a business plan drafted on paper or an entrepreneurial experiment. It was a promise—a deeply personal one. A promise I made to myself, and more importantly, to the children whose futures depended on someone choosing to stand beside them.

I began with hope in my heart and a clear vision in my mind.

I rented a building in the heart of the city. The rent was high—very high. Many advised against it. “Why take such a costly place?” they asked. “Start small. Move to the outskirts. Reduce expenses.”

But I chose that location deliberately.

I wanted accessibility. I wanted visibility. I wanted society to see that autism support belongs in the centre—not hidden in a corner as if it were something to be ashamed of. I wanted parents walking through the city to feel that their children deserved space in the mainstream, not isolation.

From day one, this was about dignity.

In the beginning, a doctor agreed to join me. His presence brought credibility. It felt like a partnership that would strengthen the foundation of the centre.

Before we formally began, he spoke clearly.

“You will have to give me a percentage of the profit.”

I did not hesitate. I agreed immediately.

Because my goal was never profit.

If sharing profit meant building something meaningful for autistic children—if it meant standing stronger beside struggling parents—I was ready. Money was not my motivation. The mission was.

But once we began, reality slowly unfolded in a different direction.

There was no financial investment from his side. No infrastructure contribution. No shared responsibility in setting up equipment or designing programs. The burden—administrative, financial, and emotional—quietly shifted onto my shoulders.

Still, I did not complain.

I believed in patience. I believed in the long-term vision. I told myself that partnerships take time to stabilize. I focused on the children. Their therapy sessions. Their small improvements. Their hesitant smiles.

And then one day, without warning, he came to me.

His tone was calm. Casual.

“From tomorrow, I will not come.”

That was all.

No discussion. No transition plan. No concern for the families who trusted us. No acknowledgment of the responsibility we had created together.



In that moment, I could have argued. I could have demanded an explanation. I could have expressed anger or disappointment.

Instead, I simply said, “Okay. Thank you.”

And just like that, I was alone.

Silence filled the space he left behind. But the rent did not disappear. The staff salaries did not pause. The electricity bills did not reduce out of sympathy.

Months passed—six, then seven.

Every month, the rent had to be paid. The official staff had to receive their salaries on time. Electricity bills, maintenance costs, therapy materials, and daily operational expenses—everything continued as if nothing had changed.

And I continued.

There were days when the numbers did not make sense. Days when I sat with accounts in front of me and wondered how long this could go on. Days when exhaustion felt heavier than hope.

But giving up never truly felt like an option.

At home, my wife watched me carry this weight. She saw the tension I tried to hide. She heard the late-night calculations. She understood the risk better than anyone.

One evening, she spoke gently.

“Leave all this. Stop. Why are you carrying this burden alone?”

Her words were not criticism. They were concern. She wanted stability. She wanted peace for our family. She wanted me to rest.

Even a respected senior, Dr Divyanka advised me practically.

“Convert it into a computer centre. It will be easier. More profitable. Less stress.”

For a brief moment, I imagined that path.

A computer training centre would bring predictable income. Lower emotional strain. Structured operations. Less uncertainty. Financial stability.

It was a logical suggestion.

But my heart refused.

I answered firmly, without hesitation:

“That is never possible.”

This was not just a rented building with therapy rooms. It was not a financial venture waiting to be redirected.

This was a fight.

A fight for autistic children who struggle to express themselves. A fight for parents who live between hope and fear. A fight against ignorance, stigma, and silence.

Walking away would mean betraying the promise I had made—not only to the children, but to myself.

I had seen mothers break down in my office because their child spoke a new word after months of silence. I had seen fathers sit quietly during therapy sessions, pretending to be strong while carrying invisible anxiety. I had seen children who were once withdrawn begin to make eye contact.

How could I abandon that?

So instead of shrinking my vision, I expanded it.

If support would not come to me, I would go out and search for it.

I began traveling beyond my state. I visited other centres. I observed different therapy models. I studied structured intervention programs. I explored better systems, better therapy frameworks, better operational designs.

I invested in knowledge.

Because if resources were limited, learning would be my strength.

I attended workshops. I spoke with professionals. I asked questions. I listened more than I spoke. I studied how multidisciplinary teams functioned in larger cities. I learned how structured assessment tools were implemented. I explored evidence-based therapy strategies.

Every journey costs money. Every trip added financial strain. But each one added clarity.

I was not building a small local centre anymore.

I was building a vision.

Slowly, my understanding deepened—not just of autism as a diagnosis, but of autism as a human experience. I realized that therapy was not only about improving communication or behaviour. It was about building confidence. It was about helping families breathe a little easier.

There were lonely days. Days when I questioned whether resilience alone was enough. Days when I felt misunderstood. Days when I wished someone would share the responsibility.

But in those quiet moments, I reminded myself of something important:

The strongest foundations are often built in the loneliest seasons.

When there is no applause, no financial cushion, no guaranteed outcome—what remains is conviction.

I chose conviction.

Every child who walked into the centre reminded me why I started. Every small milestone—a new word spoken, a reduced tantrum, improved eye contact, or better classroom participation—felt like evidence that the struggle was meaningful.

Parents began to trust us. Word slowly spread. Not because of marketing campaigns, but because of results.

Trust cannot be advertised. It must be earned.

I also learned a personal lesson during that period: leadership is not about comfort. It is about responsibility when things collapse.

Being alone forced me to grow faster. I had to make decisions independently. I had to solve problems creatively. I had to become stronger emotionally.

There were nights when sleep did not come easily. There were mornings when I questioned my own stamina. But every time I unlocked the centre's door and saw a child waiting with their parent, something inside me reset.

This was not a burden.

This was purpose.

Financial strain tests your patience. Professional betrayal tests your trust. Isolation tests your confidence.

But purpose tests your endurance.

And I chose endurance.

Looking back now, I realize that if that doctor had stayed, perhaps I would have depended too much on partnership. If the journey had been easy, perhaps the foundation would have been weak.

Instead, the struggle refined me.

It forced me to examine my motives. Was I here for recognition? For income? For validation?

No.

I was here because I believed that autistic children deserve structured support. They deserve trained professionals. They deserve systems that treat them with dignity. Their parents deserve guidance, transparency, and hope.

And hope is not built-in comfort.

It is built in commitment.

That phase of standing alone taught me that sometimes leadership requires silent resilience. Not dramatic speeches. Not public sympathy. Just daily consistency.

Paying the rent even when enrolment was low. Paying salaries even when income was delayed. Showing up even when discouraged.

That is how foundations are laid.

The centre survived those early months not because circumstances were favourable, but because the mission was stronger than fear.

And somewhere in that struggle, I stopped feeling alone.

Because when your work aligns with your conscience, loneliness transforms into strength.

This fight was never about me.

It was about every child who deserved a chance to grow.

And I knew, deep in my heart, that I would rather struggle for a meaningful cause than succeed in something that did not move my soul.

So, I stayed.

I worked.

I learned.

I endured.

And in that loneliest season, the real foundation of the centre was built—not with money or partnership, but with unwavering commitment.

Sometimes, being alone is not a sign of weakness.

Sometimes, it is the beginning of leadership.

Chapter Four – A Mission Greater Than Demands

When I stepped outside my state, I was not traveling for business expansion.

I was traveling for answers.

The journey was not about networking or recognition. It was about understanding something that had already begun to disturb me deeply—autism was not a small or isolated issue. It was growing. It was serious. And in our country, it remained dangerously misunderstood.

As I visited different states, I met professionals, observed therapy centres, studied intervention models, and listened to parents. I wanted clarity. I wanted to see where we truly stood.

What shocked me most was not the condition itself.

It was the lack of awareness.

In many places, autism was still confused with poor parenting. Some believed it was temporary. Others dismissed it as stubborn behaviour. Early diagnosis was rare. Structured intervention was inconsistent. Trained professionals were limited. And families were often left to struggle in silence.

The silence disturbed me more than anything else.

Behind every statistic, there was a child. Behind every diagnosis, there was a family trying to understand a future that suddenly felt uncertain.

The more I observed, the more I realized something important: if meaningful change was going to happen in my state, I could not build it on guesswork. I needed strong guidance. I needed experienced professionals who understood autism deeply.

During one of my visits, I met a professor whose insights impressed me. He listened carefully as I explained my vision for Tripura—the gaps, the needs, and the lack of structured support.

After a long discussion, he handed me two contact numbers.

“These are experienced therapists,” he said. “You can speak with them.”

Those numbers felt like possibility.

I returned to Tripura with renewed determination. I contacted both of them. One agreed to meet me.

When we sat down together, I explained everything—the centre, the children, the challenges, and the larger mission. I did not hide the struggles. I spoke honestly about the financial pressure and the long-term vision.

She listened carefully.

After a pause, she said, “Okay, I can work with you. But I have two demands.”

I nodded. “Tell me.”

“First, I must receive a fixed monthly salary.”

That was reasonable. Stability is important for professionals.

“Second,” she continued, “I want thirty-five percent of the profit.”

The words settled heavily in the room.

It was not a small percentage. And the centre was not generating large profits. In truth, there were barely any profits to discuss.

The demands were heavy.

But my dream was heavier.

I paused only briefly before responding, “I agree.”



Because my goal was not comfort.

My goal was to fight autism in my state.

If agreeing to those terms meant strengthening the centre's quality and building better systems for children, I was willing to take the risk. Once again, money was secondary. The mission was primary.

The work restarted with renewed energy.

With professional collaboration, therapy sessions became more structured. Assessments improved. Parents began noticing subtle changes in their children. There was movement—small, but meaningful.

Hope returned.

But within two months, reality began pressing harder.

Expenses increased steadily. Rent remained high. Staff salaries had to be paid on time. Therapy materials required upgrades. Administrative costs accumulated quietly but consistently.

When I reviewed the financial numbers at the end of the second month, I knew something was not sustainable.

The numbers did not match the income.

There is a moment in leadership when idealism meets arithmetic. That moment had arrived.

I could have delayed the conversation. I could have avoided it. But avoiding the truth does not protect a mission.

So, one day, I spoke honestly.

I said, “When we started, you had two demands. I agreed to both. But I will never be able to fulfil both of them long-term.”

There was no accusation in my voice. Only reality.

“My target is not profit,” I continued. “My target is to do something meaningful for these children.”

I explained the deeper concern that had been growing inside me.

“Society does not accept these children easily. In many cases, even parents struggle to accept the diagnosis. Some deny it. Some delay therapy. Some feel ashamed. I want to fight for them--not only in my state, but everywhere awareness is lacking.”

I paused, then spoke slowly.

“Autism is not a small issue. It is a massive challenge for our world. If we treat it like a business opportunity, we will lose the purpose.”

The room became quiet.

It was not a comfortable conversation. Financial expectations are real. Professionals deserve stability. But missions cannot survive under unsustainable pressure.

Then I said something that came directly from my heart:

“Please stand beside me. Not for demands, but for the mission.”

In that moment, everything felt uncertain. A partnership can shift when expectations change. I was prepared for negotiation, resistance, and even disagreement.

But what happened next surprised me.

Without hesitation, Dr Naisha said, “Yes.”

Just like that.

No bargaining. No argument. No defensive reaction. No ego.

It was a simple “yes,” but it carried weight.

That “yes” meant belief.

That “yes” meant alignment.

That “yes” meant the mission was larger than money.

In that moment, I understood something powerful:

When the mission is pure, the right people stay.

Not because it is easy.

Not because it is profitable.

But because it is meaningful.

That “yes” was more valuable than any legal contract, more powerful than any profit-sharing agreement. It created something stronger than a professional arrangement; it created shared purpose.

From that day onward, the centre no longer felt like a fragile structure held together by financial compromise.

It felt like a team.

A team that understood that this fight was not about revenue models. It was about changing mindsets.

It was about building acceptance.

It was about giving children opportunities that society had denied them for too long.

I began to see more clearly that autism work requires more than therapy techniques. It requires courage. Courage to educate families gently, to correct misconceptions respectfully, and to challenge stigma patiently.

Parents began opening up more during consultations. They shared fears they had hidden. They spoke about relatives who blamed them. They described schools that refused admission. They expressed guilt they carried unnecessarily.

And every time I heard those stories, my conviction strengthened.

This centre was not just a service provider.

It was becoming a place of reassurance.

The financial struggle did not disappear overnight. Sustainability remained a challenge. But when leadership and partnership align around purpose, obstacles feel different. They become problems to solve; not reasons to quit.

Dr Naisha's decision taught me another leadership lesson: people are not motivated only by money. They are motivated by meaning.

When professionals feel that their work creates real impact, their commitment deepens. When they see transformation in children—a new word spoken, improved social interaction, or better classroom participation—they begin to understand that their effort matters beyond income.

Gradually, the atmosphere within the centre shifted.

There was seriousness, yes, but also warmth. Structured programs, but also empathy. Professional discipline, but also human understanding.

And for the first time in a long while, I did not feel alone.

The loneliness that once defined my journey began to fade.

Not because the work became easier.

But because the burden was now shared by someone who believed in the same mission.

Looking back, I realize that Chapter Three tested my endurance. It asked whether I would continue when abandoned.

Chapter Four tested something different.

It asked whether I could transform demands into dedication.

The difference is subtle but powerful.

In the beginning, I was agreeing to conditions to survive.

Now, I was inviting people to join a vision.

And that shift changed everything.

Autism is not just a neurological condition. It is a societal mirror. It reflects how we treat those who are different. It exposes our patience, our empathy, and our willingness to adapt.

If we build systems only for convenience, many children will remain excluded.

But if we build systems with conviction, even limited resources can create change.

That day, when Dr Naisha said “yes,” it confirmed something I had begun to believe:

A mission greater than demands attracts commitment greater than contracts.

And from that point onward, the fight was no longer mine alone.

It was ours.

Chapter Five – The Day My Heart Changed

There are certain days in life that do not announce themselves.

They arrive quietly. No warning. No celebration. No dramatic beginning. And yet, when you look back years later, you realize that everything shifted on that day.

Not outside. Inside.

One such day came to me at my autism centre.

It was, in every visible way, an ordinary day. Therapy sessions were running as usual. Parents sat in the waiting area—scrolling through their phones or whispering anxious prayers under their breath. Therapists moved from one room to another with files in their hands. The air carried the familiar mix of structured routine and emotional uncertainty.

Nothing seemed unusual.

Until I noticed one child.

He was hyperactive—intensely so. Restless beyond comfort. His body moved constantly, almost violently, as if controlled by an invisible storm. He screamed loudly, his voice piercing through the calm rhythm of the centre. His cries echoed against the walls, sharp and repetitive.

Some people might describe it as “disturbing.”

Some might shrug and say, “It’s normal for hyper children.”

But that day, I did not hear noise.

I heard struggle.

Dr Naisha stood beside me and said calmly, “Children who are hyper behave like this. It is common.”

Her tone was steady. Professional. Experienced. She had seen many such moments. For her, it was clinical reality.

But I was not steady.

As I stood there watching him, I didn't see just hyperactivity. I didn't see a diagnosis written in a report.

I saw a child fighting a battle he did not understand.

His small hands were shaking. His breathing was uneven. His eyes darted from one corner to another, unable to focus. It was as if his body and mind were not in agreement.

There was something in his voice that went beyond sound. It carried confusion. It carried frustration. It carried helplessness.

And suddenly, something inside me felt heavy.

I asked myself quietly: What must it feel like to live inside a body that does not always obey you? What must it feel like to want to express something but not know how?

The therapists handled him with patience. They tried sensory techniques. They used structured calming strategies. They spoke softly. They tried to guide him back into balance.

But even as the session continued, I could not move from that spot.



I felt frozen.

Because I was not just watching a child.

I was watching a possible future.

That night, I could not sleep.

When I closed my eyes, I saw his face. His shaking hands. His restless eyes.
His cries.

For two days, I carried that image inside me.

And for two days, I cried.

Not because I did not understand autism.

But because I understood the future too well.

As a social worker, as someone who interacts with society daily, I know how cruel misunderstanding can be. I know how quickly people judge what they do not comprehend.

Questions filled my mind like an unstoppable storm.

What will happen to him when he grows older?

What will happen when he is no longer a small child whom people forgive easily?

If he struggles so much today, what will tomorrow look like?

Will society accept him?

Will schools show patience?

Will teachers try to understand instead of labelling him?

Will classmates be kind—or cruel?

Will workplaces ever open their doors to someone like him?

Or will he always be misunderstood?

These thoughts suffocated me.

Because autism is not only about therapy sessions. It is about life beyond the therapy room.

It is about playgrounds.

Classrooms.

Friendships.

Relationships.

Dignity.

Independence.

And I knew the world is not always gentle.

Then, a quieter thought entered my heart.

If my own son were like this... what would I do?

If Sreehaan screamed like that.

If Sreehaan struggled to control his body.

If Sreehaan faced judgment from society every day.

Would I give up?

Would I stop dreaming for him?

Would I quietly accept that his future must be smaller?

Never.

As a father, I know my answer.

I would search endlessly for solutions.

I would learn everything possible.

I would build opportunities where none existed.

I would stand like a wall between him and the world's cruelty.

I would fight—not in anger, but in determination.

And in that moment, something shifted inside me.

I realized these children are not just patients visiting my centre.

They are not statistics in a report.

They are not “cases” to be documented.

They are someone’s entire universe.

Someone’s dream.

Someone’s heartbeat.

Someone’s reason to wake up every morning.

They are just like my own child.

The difference is only in perspective.

That realization broke something in me.

And then it rebuilt something stronger.

Until that day, I was committed to helping children with autism. I believed in therapy. I believed in structured intervention. I believed in support systems.

But that day, my commitment became personal at a deeper level.

It was no longer professional.

It was emotional.

It was moral.

It was human.

Through tears and helplessness, a decision was born inside me.

I will not just observe.

I will act.

I will not just manage a centre.

I will build a movement.

I will not just provide therapy.

I will create awareness.

Because therapy alone is not enough if society remains ignorant.

A child can improve in a therapy room. But if the world outside refuses to understand him, improvement becomes fragile.

I began thinking about systemic change.

Parent education programs.

School awareness workshops.

Community outreach.

Early screening initiatives.

Training more therapists.

Creating employment pathways in the future.

I asked myself: Why should these children always adjust to society? Why can't society adjust to them?

Autism is not a tragedy.

Ignorance is.

Fear is.

Silence is.

That day, I realized my fight was not against autism.

Autism is a neurological condition—a different wiring of the brain.

The real battle is against misunderstanding.

Against stigma.

Against indifference.

Against the habit of labelling before learning.

And the more I reflected, the more I understood something profound.

These children do not need sympathy.

They need structure.

They need acceptance.

They need opportunities.

They need belief.

Belief from parents.

Belief from teachers.

Belief from society.

Belief from leaders.

Belief from people like me.

Because if I, who understand this field, remain silent... then who will speak?

If I, who see their daily struggles, remain passive... then who will act?

If I cannot fight for every child who walks through my centre's doors, then what kind of a father am I?

That question pierced my heart.

And it answered itself.

A father does not limit love to biology.

A father protects vulnerability wherever he sees it.

A father stands up when a child cannot.

That day, something changed permanently.

I stopped seeing "their children."

I started seeing "our children."

My heart expanded.

My responsibility increased.

My mission expanded.
I realized that real change does not begin with policies or funding.
It begins with empathy.
It begins with refusing to look away.
It begins with allowing yourself to feel uncomfortable.
That hyperactive child did not know what he taught me.
He did not know that his restless movements reshaped my thinking.
He did not know that his cries strengthened my resolve.
But he did.
He transformed me.
From that day forward, every therapy session felt different.
Every parent conversation felt deeper.
Every decision I made carried a stronger sense of purpose.
I was no longer building just a centre.
I was building a safe space.
A place where no child would be seen as “too much.”
A place where no parent would feel alone.
A place where difference would not mean deficiency.
That was the day my heart changed.
Not with applause.
Not with recognition.
But with tears.
And sometimes, tears are the purest form of transformation.
That day, I understood something simple yet powerful:

When you truly see a child—not as a problem to fix, but as a human to understand—your heart can never remain the same.

And that was the day this journey truly began.

Not as a service.

Not as a project.

But as a promise.

Chapter Six – From Awareness to Action

There came a point in my journey when I understood something with absolute clarity:

What I had done so far was not enough.

Yes, I had faced fear.

Yes, I had learned through experience.

Yes, I had started supporting children.

But intention alone is not transformation.

If I truly wanted to fight autism—not emotionally or symbolically, but effectively—I needed more knowledge. More structure. More preparation. Passion without expertise can inspire, but expertise combined with passion can change lives.

And so, I returned to being a student.

I enrolled in a professional course focused on child counselling and special child needs. I wanted to understand autism not only as a father and a social worker, but as a trained guide. I wanted scientific clarity—neurological understanding, behavioural frameworks, therapy models, and developmental psychology.

I wanted answers rooted in research, not assumptions.

The deeper I studied, the more I realized how complex—and yet how misunderstood—autism truly is.

Autism is not a disease to be cured.

It is a neuro-developmental condition—a different way the brain processes communication, behaviour, and sensory input. Every child on the spectrum is unique. No two children present the same way.

Some struggle with speech.

Some struggle with eye contact.

Some struggle with sensory overload.

Some struggle silently.

And most importantly, early intervention can change outcomes dramatically.

When I completed the course, I did not feel finished.

I felt responsible.

Because knowledge creates accountability.

Around that time, Dr Naisha stood firmly beside me. She did not just believe in therapy; she believed in purpose. Together, we realized that running sessions quietly inside a centre would never be enough.

Autism was not only a clinical issue.

It was a social issue.

And society was not ready.

So, we stepped outside the therapy room.

We began awareness campaigns across different areas:— schools, hospitals, offices, community halls, and public gatherings. We met teachers who had labelled children as “naughty” without understanding sensory overload. We met parents who believed speech delay was just “late talking.” We met families who were afraid of stigma more than diagnosis.

And what we discovered was alarming.

Many parents were not serious about autism.

Not because they did not love their children.

But because they did not understand.

There was confusion.

There was denial.

There was misinformation.

Some parents asked, “Will he become normal?”

Some whispered, “Is this because of something we did?”

Some said, “He will grow out of it.”

Some refused evaluation completely, fearing social judgment.

We began explaining patiently:

What autism really is.

What occupational therapy does.

Why speech therapy is important.

Why social communication difficulties happen.

How sensory integration affects behaviour.

Why early intervention is critical before the brain’s flexibility reduces with age.

Many had never heard these concepts before.

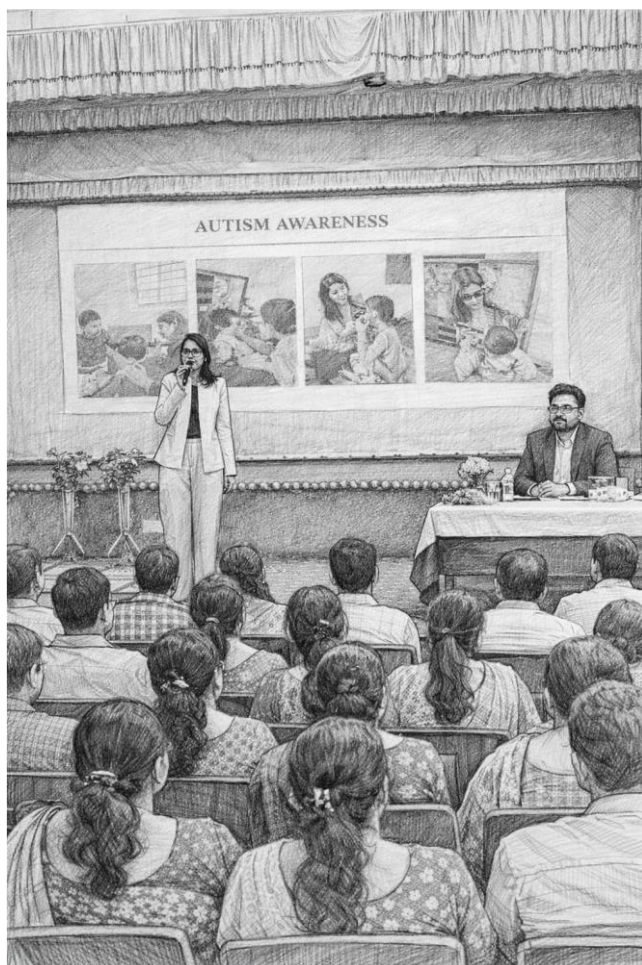
In schools, we explained how structured environments help. How visual schedules reduce anxiety. How positive reinforcement builds confidence.

How inclusive classrooms are not charity; they are progress.

We spoke to doctors about early screening referrals.

We spoke to administrators about policy-level sensitivity.

We spoke to anyone willing to listen.



And slowly, something began to shift.

We realized that fighting autism is not only about therapy sessions.

It is about education.

It is about awareness.

It is about dismantling stigma.

It is about changing mindsets.

Day and night, Dr Naisha and I worked together.

There were no fixed hours.

No comfort zones.

No weekends.

Only commitment.

Sometimes we travelled long distances to conduct small awareness sessions with just ten parents. Sometimes we spoke in larger gatherings. Sometimes we returned home exhausted—physically tired, but mentally awake.

Because change does not come from comfort.

It comes from consistency.

Gradually, something beautiful began to happen.

Parents began bringing their children.

At first, one.

Then two.

Then five.

Then ten.

Trust does not build in a day.

It builds through transparency.

We allowed parents to observe sessions. We explained therapy goals clearly. We documented progress. We involved families in home-based strategies. We did not promise miracles.

We promised effort.

And effort builds trust.

Conversations with parents became deeper.

They began opening their hearts.

They shared fears they had never spoken aloud.

They cried in front of us.

They asked difficult questions.

And instead of hiding from those questions, we faced them together.

In 2024, Dr Naisha independently started structured therapy sessions for one child—a carefully designed program with measurable goals, consistent intervention, and parent participation.

Then another child joined.

Then another.

Step by step, we refined systems.

We developed individualized therapy plans.

We incorporated occupational therapy frameworks for sensory regulation.

We emphasized speech therapy for expressive and receptive language development.

We focused on social skill-building.

We introduced structured play models.

We trained parents to continue exercises at home.

The more organized we became, the stronger the outcomes grew.

And today—on 26th January, 2026—something stands before us that once felt impossible.

We are working with more than 80 children.

Eighty families.

Eighty journeys.

Eighty unique neurological profiles.

But numbers alone do not define success.

Out of these children, fifteen have shown such remarkable improvement that they are now at home, studying, participating in school activities, and integrating into society with confidence.

Fifteen stories of hope.

Fifteen families who once feared the future—now smiling at it.

I remember one mother who once could not sleep because her son did not speak a single meaningful word at age four. Today, that child reads small sentences independently.

I remember a father who avoided social gatherings because relatives asked uncomfortable questions. Today, he proudly shares his child's progress.

This is not “recovery” in the traditional sense.

Autism does not disappear.

But potential unfolds.

Skills develop.

Confidence grows.

Function improves.

And that is transformation.

Every child who improves proves something powerful:

Autism is not the end.

It is not hopeless.

It is not a life sentence.

It is not a tragedy.

With early intervention, proper therapy, awareness, structured guidance, and strong family support, meaningful change is possible.

The brain has plasticity.

Behaviour can be shaped.

Communication can improve.

Independence can increase.

And dignity can be protected.

But delay is dangerous.

Denial is harmful.

Silence is costly.

One of the biggest enemies we fight is not autism.

It is late action.

Many parents come to us when their child is already seven or eight years old, after years of “wait and see.” Those years matter. Early childhood is when the brain is most adaptable. Early intervention is not a luxury; it is a necessity.

This realization strengthened our mission further.

We began pushing harder for early screening.

We began educating paediatricians to refer earlier.

We encouraged parents to seek evaluation at the first sign of persistent delay.

Because awareness must move faster than fear.

Looking back, I see how far we have come.

From one phone call that shattered my world.

To a structured centre serving more than eighty children.

From confusion.

To clarity.

From helplessness.

To action.

But this is only the beginning.

Because the need is greater than our current capacity.

There are still villages where parents do not know what autism means.

There are still schools that exclude instead of include.

There are still workplaces that lack sensitivity.

There are still families suffering silently.

And that is why our fight continues.

Our fight is not against the child.

It is against ignorance.

Against stigma.

Against delay.

Against societal judgment.

Against systems that are not inclusive.

We dream bigger now.

We dream of training more therapists.

We dream of expanding into rural areas.

We dream of creating structured vocational programs for adolescents on the spectrum.

We dream of influencing policy discussions.

We dream of building a model centre that can inspire other states.

Because a movement does not grow by accident.

It grows by vision.

And today, we are no longer just two people with concern in our hearts.

We are building a movement.

A movement of awareness.

A movement of structured intervention.

A movement of parental empowerment.

A movement of dignity.

I often reflect on something important:

When my journey began, I asked, “Why my child?”

Today, I ask, “Why not me?”

Why not me to create change?

Why not me to challenge stigma?

Why not me to build systems?

Pain, when redirected properly, becomes power.

Fear, when educated, becomes focus.

And responsibility, when embraced fully, becomes leadership.

This chapter is not about achievement.

It is about commitment.

Commitment to every child who walks into our centre.

Commitment to every parent who trusts us with their vulnerability.

Commitment to building a future where autism is understood, not feared.

And as we stand today, working with over eighty children, seeing fifteen shining examples of progress, we know one thing clearly:

Change is possible.

Not easy.

Not instant.

But possible.

And when possibility meets action,

Transformation begins.

This journey started with awareness.

But it will continue with action.

Because awareness opens eyes.

Action changes lives

Chapter Seven – Not Just a Director — A Father

Over time, something unexpected began to happen.

When we first started the centre, parents came with questions. They came with hesitation. They came with uncertainty. Their eyes searched for assurance. Their words were cautious. Their trust was fragile.

But slowly, something changed.

They no longer came only as clients.

They came as mothers and fathers carrying fear in their eyes—fear of the unknown, fear of judgment, and fear of the future. They did not just bring their children. They brought their vulnerability.

Many of them became emotional while speaking to me.

I have seen strong fathers break down in my office chair. I have seen mothers who had held themselves together for months finally release tears they had been hiding from everyone else.

They would say, “Sir, you are the only person who is not thinking only about our children’s present. You are thinking about their future—and our future too.”

At first, I would smile politely. I did not think I was doing anything extraordinary. I was simply doing what I believed was right.

But then, some of them would lower their voices and say something that would shake me deeply.

“Sir... we will not live forever. We may not stay long in this world. Please become a father to our children. Please take care of them when we are gone.”

Those words are heavier than they sound.

When a parent speaks like that, it is not a dramatic statement; it is a confession of fear. It is the fear that keeps them awake at night. The fear that after they are gone, their child may not find the same protection.

Whenever they said this, I could not respond immediately.

Because how do you promise something so sacred?

How do you tell a parent that their child will never be alone?

With a slight smile--and often a drop of tear in my eyes--I would say softly, "From the day these children entered this centre, they became my own."

And I meant it.

Not emotionally for a moment.

But permanently.

They are not just registered names in a file.

They are not case numbers.

They are not "spectrum severity levels."

They are my responsibility.

Responsibility is not a word I use lightly.

Because love is not only about kind words and motivational speeches.

Love is about protection.

And protection demands courage.

There is a difference between managing a centre and owning a moral duty.

Anyone can run a centre.

But not everyone can carry the weight of parental trust.

And one night, that trust was tested.

It was around 2:00 a.m.

I was lying in bed, but as often happens, sleep would not come easily. Running a centre like ours does not allow the mind to switch off completely. I have a habit of checking CCTV footage randomly—not because I doubt my team, but because I feel accountable.

Accountability does not mean suspicion.

It means responsibility.

That night, while scrolling through the footage on my mobile, I saw something that froze me.

During therapy hours earlier that day, one of our therapists had slapped a child on the cheek.

It happened quickly.

But not quickly enough to escape my eyes.

For a moment, I could not breathe.

My body felt cold.

Then anger rushed through me like a storm.

Not administrative anger.

Not professional anger.

Fatherly anger.

The child had been dysregulated. He was resisting an activity. He was overwhelmed. And instead of patience, someone chose frustration.

I replayed the footage.

Again.

And again.

As if my mind hoped I had misunderstood what I saw.

But I had not.

I immediately called Dr Naisha.

She picked up, startled by the late hour.

“Why was that child hit?” I asked, my voice shaking. “I am going to the therapist’s house right now. I will ask them, if that child were their own son, and another therapist slapped him, how would they react?”

My voice carried anger, but beneath it was pain.

Because the slap was not just physical.

It was a violation of trust.

Dr Naisha tried to calm me down. She understood my emotional state. She knew I was speaking not as a director, but as a father.

She said, “Please wait until morning. We will handle this properly. If you go now, things may escalate.”

She was right.

But logic does not calm a father easily.

That night, I did not sleep.

I kept thinking about that child.

Did he understand what happened?

Did he feel scared?

Did he think he had done something wrong?

Children on the spectrum often struggle to express their feelings verbally.

But they feel deeply. They remember emotionally.

And I asked myself a painful question:

If this had happened in my absence, and I never knew... would I have failed him?

Morning came slowly.

As soon as the office opened, I drafted an official termination email.

There is no excuse for violence.

Not in my centre.

Not in the name of therapy.

Not under stress.

Not under pressure.

Not under any circumstance.

Therapy is built on trust.

Trust is built on safety.

And safety is non-negotiable.

The therapist was asked to report to the centre immediately.

When they arrived, there were no raised voices. No public humiliation. But there was firmness.

I said clearly, "You will apologize to the child. And you will apologize to the child's mother in person."

Because accountability must be visible.

They apologized.

To the child.

To the mother.

And then they left.

That chapter ended.

But something else began.

The child continued attending therapy at our centre.

At first, I observed him closely.

Would he hesitate?

Would he withdraw?

Would he show fear?

But something remarkable happened.

He continued coming.

And one day, unexpectedly, he ran toward me and hugged me.

Children do not fake trust.

That hug was not rehearsed.

It was not symbolic.

It was instinctive.

Every time he wraps his small arms around me, I feel something powerful.

Trust.

Pure.

Unfiltered.

That hug is not just affection.



It is proof that we protected his dignity.
It is proof that he feels safe.
And in that moment, I understand something deeply.
Running an autism centre is not about management.
It is about moral responsibility.
Parents do not leave their children with us casually.
They leave them with hope.
They leave them with fear.
They leave them with prayer.
They leave them with expectation.
And if we fail them—even once—we fail humanity.
Some people measure success in numbers.
Eighty children.
Fifteen success stories.
Growing recognition.
But I measure success differently.
Success is when a child walks into the centre without fear.
Success is when a mother waits outside with calm instead of anxiety.
Success is when a father says, “I trust you.”
Success is when no child leaves our centre emotionally wounded.
I am not perfect.
I am not wealthy.
I am not politically powerful.
I do not have unlimited resources.

But I have one rule that will never change:
No child under my care will ever be harmed in the name of therapy.
Because therapy without compassion is cruelty disguised as discipline.
I have seen centres where compliance is forced.
Where children are restrained aggressively.
Where progress is measured only in silence and obedience.
But I do not want obedient children.
I want confident children.
I want regulated children.
I want expressive children.
I want children who feel respected.
Because autism is not misbehaviour.
It is a neurological difference.
And neurological difference requires understanding, not punishment.
After that incident, we strengthened our internal protocols.
Clear ethical guidelines.
Regular training on emotional regulation for therapists.
Monitoring systems.
Open communication with parents.
A zero-tolerance policy for physical aggression.
Not because one mistake defines us.
But because one mistake teaches us.
I also reflected on something personal.
Why did that incident shake me so deeply?

Because somewhere inside, I have already accepted these children as mine.

And when someone harms your child, your reaction is instinctive.

That is when I realized fully:

I am not just a director.

I am a father.

Fatherhood is not biology alone.

It is responsibility.

It is protection.

It is standing between vulnerability and harm.

Over the years, I have attended birthdays of children at the centre. I have watched them take their first independent steps in communication. I have celebrated small victories that others might overlook—a new word spoken, a tantrum managed, or a successful classroom transition.

Each milestone feels personal.

Because every step forward is proof that belief works.

Sometimes, late at night, I think about the parents who asked me to become a father to their children after they are gone.

That sentence still echoes in my mind.

It is not a legal promise.

It is a moral one.

And I carry it seriously.

We are now planning long-term structures—vocational programs, skill-based development modules, and community inclusion pathways—so that these children are not dependent forever.

Because true fatherhood prepares a child for independence.

Not dependence.

I know I cannot control the entire world.

I cannot guarantee that society will always be kind.

But inside these walls, I can guarantee one thing:

Safety.

Respect.

Dignity.

And sometimes, that is enough to change a life.

That night at 2:00 a.m., when I saw that slap, something inside me solidified.

Compassion is not optional.

Protection is not optional.

Ethics are not optional.

Because from the day they walk into this centre,

they are not just children with autism.

They are my children.

And a father does not look away.

Chapter Eight – Transparency Has a Cost

After that painful night—the night I saw a child slapped through a small glowing screen at 2:00 a.m.—something inside me became unshakably clear.

Trust is not automatic. Trust must be protected.

And protection requires systems, not just emotions.

Until that night, I believed our internal monitoring was enough. I believed that regular supervision, CCTV recording, and periodic review were sufficient safeguards. I believed that hiring trained professionals meant safety was guaranteed.

I was wrong.

Good intentions are not systems. Belief is not proof. And responsibility cannot depend on assumption.

The very next morning, after terminating the therapist who violated our ethical boundary, I made another decision—one that would reshape the culture of our centre permanently.

From that day onward, parents would be able to watch CCTV footage directly on a TV screen in the waiting room.

Live.

Unedited.

No secrecy.

No closed doors.

No hidden therapy sessions.

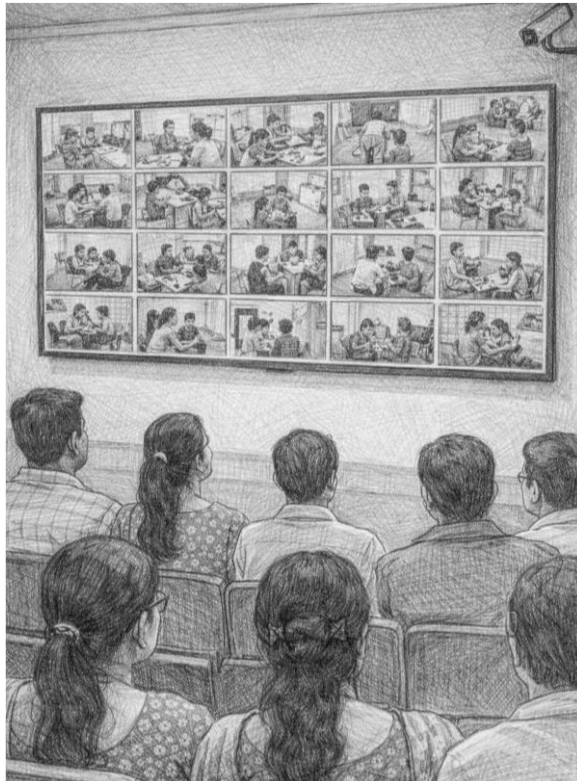
If we truly believed in our work, we should not fear transparency.

That very afternoon, I arranged for the installation of a dedicated CCTV monitor in the parents' waiting area. The wiring was adjusted. The screens were positioned carefully. The camera angles were reviewed to ensure both privacy and clarity—no compromise in dignity, but full visibility in conduct.

When the monitor turned on for the first time, something changed immediately.

The waiting room felt different.

Mothers who once sat anxiously began looking at the screen with relief. Fathers leaned forward in their chairs, observing carefully. Some parents smiled softly when they saw their children responding positively. Some wiped silent tears when they saw their child struggle—but this time, the tears were accompanied by understanding.



Because now they could see the effort.

They could see the patience.

They could see the process.

Trust should never be blind.

Trust should be visible.

Transparency is not a marketing strategy.

It is a moral declaration.

But leadership decisions are rarely welcomed by everyone.

A few days after the monitor was installed, some female staff members approached me.

Their tone was polite, but their discomfort was clear.

“Sir, this was not necessary,” one of them said.

I looked at them calmly.

“You are women,” I replied. “Many of you are mothers. Why would you say that? Shouldn’t you see these children as your own?”

There was silence.

Not angry silence.

Reflective silence.

Because the truth is simple:

If you treat every child like your own son or daughter, you will never fear observation.

If your hands are gentle, you do not fear cameras.

If your heart is clean, you do not fear visibility.

Transparency does not threaten integrity.

It protects it.

But not everyone sees transparency as protection.

Some see it as surveillance.

Some see it as mistrust.

Some see it as pressure.

A few days later, one of the staff members resigned.

The official reason mentioned “personal commitments.”

But the real reason was clear.

It was not workload.

It was not salary.

It was not distance from home.

It was fear.

Fear of being monitored.

Fear of accountability.

Fear of being observed every moment.

And I understood something important that day.

Not everyone is comfortable working in a culture of full transparency.

But culture is not built for comfort.

It is built for standards.

Being a therapist is not just a job.

It is not routine.

It is not mechanical.

You are not handling files.

You are handling futures.

You are not managing tasks.

You are shaping neurological pathways.

You are not supervising behaviour.

You are influencing dignity.

These children are vulnerable.

Some cannot express pain clearly.

Some cannot report mistreatment.

Some cannot explain what makes them uncomfortable.

That makes them doubly dependent on our integrity.

And that means our integrity must be stronger than our ego.

I do not want employees in this centre.

I want guardians.

A guardian does not complain about observation.

A guardian welcomes accountability.

A guardian understands that protection is not optional.

Yes, transparency has a cost.

Sometimes people leave.

Sometimes people criticize.

Sometimes people say, "Sir is too strict."

Sometimes they whisper, "There is too much monitoring."

But if maintaining high standards means losing staff, I am ready to accept that loss.

Because the safety and dignity of a child are more important than the comfort of an adult.

I often reflect on leadership.

Leadership is not popularity.

Leadership is not applause.

Leadership is not avoiding conflict.

Leadership is choosing what is right—even when it isolates you.

There were moments after that resignation when I questioned myself.

Was I too rigid?

Was I too demanding?

Would this discourage talented professionals from joining us?

But then I would remember the child's face on that CCTV screen.

And every doubt would disappear.

If I compromise once, I will compromise again.

If I bend standards once, I will bend them again.

And children will pay the price.

I refuse to build a centre that functions on convenience.

I want to build one that functions on conscience.

Over time, something interesting happened.

New staff who joined us knew from day one that this is a transparent centre.

This is a monitored environment.

This is a zero-violence policy institution.

And those who stayed adjusted.

Not because they were forced.

But because culture reshapes behaviour.

When therapists know parents can observe sessions, something shifts internally.

They become more mindful.

More patient.

More reflective.

Not out of fear, but out of awareness.

Accountability strengthens professionalism.

And professionalism strengthens outcomes.

Parents began expressing gratitude.

One mother told me, “Sir, now when I sit outside, I do not feel helpless. I feel involved.”

Another father said, “This is the first place where I feel nothing is hidden from us.”

That sentence meant more to me than any award.

Nothing is hidden from us.

Transparency did something deeper than just monitoring behaviour.

It built partnership.

Parents no longer felt like outsiders.

They became collaborators.

They understood therapy goals better.

They could replicate strategies at home more accurately.

They saw how therapists used visual cues.

They saw how structured play worked.

They saw how patience produced progress.

Education increased through observation.

And observation strengthened trust.

But transparency also exposed reality.

Sometimes parents saw their child struggling intensely.

Sometimes they realized progress was slower than they hoped.
And those moments required honest conversations.
Because transparency does not guarantee comfort.
It guarantees truth.
And truth builds long-term resilience.
I realized something profound during this phase:
When you choose integrity, you must accept isolation.
Leadership is lonely at times.
There were evenings when I sat alone in my office after everyone left.
The building was quiet.
The CCTV screens were dim.
The corridor was silent.
And I would ask myself: why does doing the right thing feel heavy?
Because the right thing often demands sacrifice.
Sacrifice of convenience.
Sacrifice of popularity.
Sacrifice of ease.
But integrity is not built on ease.
It is built on conviction.
At New Hope, one principle became crystal clear:
Every child deserves love.
Every child deserves protection.
Every parent deserves trust.
And those are not slogans on a wall.

They are operational rules.

Transparency is not only about cameras.

It is about communication.

It is about open progress reports.

It is about acknowledging mistakes quickly.

It is about inviting feedback.

It is about never hiding behind authority.

Over time, our centre developed a reputation.

Some called us strict.

Some called us disciplined.

Some called us uncompromising.

I accept all three.

Because compromise in ethics is not flexibility.

It is weakness.

There is another side to transparency that people rarely discuss.

It demands self-reflection.

When everything is visible, you cannot pretend.

You cannot hide behind titles.

You cannot say, "Trust me," without showing why.

Transparency forces leaders to live by the standards they preach.

I became more conscious of my own behaviour.

My tone.

My reactions.

My decisions.

Because when you demand accountability from others, you must model it yourself.

That is the hidden cost of transparency.

It exposes everyone.

Including the leader.

But exposure builds authenticity.

And authenticity builds legacy.

Sometimes I imagine a future when these children grow up.

When they are adults navigating the world.

What will they remember about this place?

Will they remember fear?

Or will they remember safety?

Will they remember control?

Or will they remember encouragement?

Will they remember punishment?

Or will they remember protection?

I want them to remember this:

There was a place where they were respected.

There was a place where no one raised a hand against them.

There was a place where their parents felt secure.

There was a place where transparency was not optional.

That place must exist.

And if I have to stand alone to maintain it—I will.

Because leadership is not about building comfort.

It is about building culture.
And culture defines destiny.
Transparency has a cost.
It costs convenience.
It costs complacency.
It costs fragile egos.
It sometimes costs staff.
But it protects children.
And that is a price I will always choose to pay.
At New Hope, we do not promise perfection.
We promise accountability.
We do not promise miracles.
We promise integrity.
We do not promise comfort.
We promise protection.
And that will never change.
Because from the moment a child walks into our centre,
they are not entering an institution.
They are entering a commitment.
And commitment must be visible.

Chapter Nine – The Hard Truth About Parents and Screens

As the years passed, I began noticing something deeply disturbing.

The number of children coming to our centre was increasing.

Autism diagnoses were increasing.

Speech delays were increasing.

Attention difficulties were increasing.

Social communication problems were increasing.

At first, I thought perhaps awareness was simply improving. Maybe more parents were recognizing early signs. Maybe screening was becoming better. That is partly true.

But there was something more.

Something uncomfortable.

Something modern.

Something glowing in almost every parent's hand.

And I began asking myself a difficult question:

Why?

Why are developmental concerns rising so rapidly?

Why are we seeing two-year-olds who do not respond to their names?

Why are three-year-olds unable to maintain eye contact?

Why are four-year-olds unable to sit for even a few minutes without agitation?

After speaking to hundreds of parents over the years, one pattern became impossible to ignore.

Mobile phones.

It almost always begins the same way.

When I gently ask, “Why are you giving the mobile to your child?” parents often reply without hesitation.

“Otherwise, they don’t eat.”

“They cry.”

“They disturb us.”

“It’s just for a few minutes.”

“It keeps them quiet.”

“It’s educational videos.”

“It’s harmless.



Then I ask another question.

“When you are holding your phone most of the time... when your spouse is holding their phone... what do you think your child will do? Children follow what they see. If you are on the screen, they will want the screen too. Isn’t that natural?”

At that moment, many parents look at each other.

And smile quietly.

Because they already know the answer.

Children are not taught to use screens.

They learn by imitation.

They observe silently.

They copy consistently.

If a child sees that the most powerful object in the house is a glowing rectangle that captures everyone's attention, that object becomes desirable.

It may begin with "just a few seconds."

It may feel harmless.

It may feel like a small convenience during feeding time.

But convenience, repeated daily, becomes habit.

And habit, repeated for months, becomes dependency.

Let me be clear.

I am not saying mobile phones alone cause autism. That would not be scientifically accurate. Autism is a neuro-developmental condition with complex biological and genetic components.

But uncontrolled, excessive screen exposure during early childhood can significantly worsen developmental delays and behavioural challenges.

Especially in the first five years of life.

Those early years are not ordinary years.

They are foundational years.

A child's brain develops more rapidly in the first five years than at any other time in life. Neural connections form based on experience. The brain wires itself through interaction.

And what does healthy brain development require?

Eye contact.

Human interaction.

Physical play.

Back-and-forth conversation.

Facial expressions.

Emotional bonding.

Responsive communication.

But what does a screen provide?

Fast-moving visuals.

Artificial sounds.

Instant stimulation.

No expectation of response.

No need for conversation.

No emotional reciprocity.

When a toddler spends hours watching videos, the brain becomes accustomed to high-speed stimulation. Real-life interaction, which is slower and more complex, begins to feel less interesting.

And then parents say, “He does not look at us when we call him.”

“He does not respond to his name.”

“He prefers to sit alone.”

“He becomes irritated when we remove the phone.”

These are not small issues.

These are life-shaping issues.

We are increasingly seeing children with:

ASD-like symptoms.

ADHD-like behaviour.

Social communication delays.

Speech delays.

Emotional regulation problems.

Some of these children may have underlying neuro-developmental conditions. Some may primarily be experiencing environmental overstimulation and screen dependency. In many cases, the lines blur.

But one fact remains clear:

Excessive early screen exposure does not help.

It reduces opportunities for language development.

It reduces interactive play.

It reduces imaginative thinking.

It reduces tolerance for boredom.

And boredom is important.

Boredom forces creativity.

Boredom encourages exploration.

Boredom builds attention span.

Today, many children cannot tolerate boredom for even two minutes. The moment silence appears, a device appears.

And that worries me.

Because real life does not operate like a video.

Real life requires patience.

Turn-taking.

Listening.

Waiting.

Negotiating.

Problem-solving.

None of these skills are built through passive screen consumption.

I remember one particular case.

A three-year-old boy came to us with a severe speech delay. He barely responded to his name. He avoided eye contact. He had frequent tantrums. The parents were terrified.

After a detailed assessment, we discovered he was spending nearly four to five hours daily watching videos—mostly during feeding time and when the parents were busy.

We did not begin with aggressive therapy.

We began with a lifestyle change.

Gradual screen reduction.

Structured interactive play.

Daily storytelling sessions.

Singing rhymes face-to-face.

Simple eye-contact games.

Within months, there was noticeable improvement.

Did the phone “cause” his delay?

Not necessarily.

But it definitely reinforced it.

And this pattern is repeating across families.

That is when I realized something important.

Parents are not careless.

They are overwhelmed.

Modern life is fast.

Both parents often work.

Nuclear families lack extended support.

Domestic pressure is real.

Screens become digital babysitters.

Convenient.

Available.

Silent.

But convenience can quietly become damage.

Instead of only criticizing parents, I decided to act.

Because blame does not build solutions.

Education does.

We started a Parents Volunteer Team.

Not just for therapy follow-up.

But for awareness transformation.

We selected parents who had already walked this journey—those who understood developmental challenges deeply. We trained them. We educated them about early brain development, screen impact, structured play techniques, and communication strategies.

Their responsibility is not only to support their own child.

It is to spread awareness in society.

They visit different areas.

They speak in small community meetings.

They share personal experiences.

They conduct awareness sessions in local groups.

Because sometimes, another parent's voice carries more power than a professional lecture.

We also encouraged parents to sit with therapists and learn practical strategies. Instead of waiting outside passively, they observe, ask questions, and practice techniques.

They go home and work with their children the way a therapist would—with structure, patience, and love.

Because therapy cannot be limited to one hour inside a centre.

Real change happens at home.

One hour of structured therapy cannot compete with six hours of unstructured screen exposure.

Parents are not the problem.

But parents must become part of the solution.

That requires uncomfortable honesty.

We must ask ourselves:

Are we present with our children?

Or are we physically present but mentally online?

Do we speak to them?

Or do we hand them a device to avoid conversation?

Do we tolerate their emotions?

Or do we silence them with cartoons?

These are hard questions.

But necessary ones.

I often tell parents:

Your child does not need a perfect home.

Your child needs a present parent.
Presence does not mean expensive toys.
It means sitting on the floor.
It means eye contact.
It means listening.
It means laughing together.
It means reading stories.
It means building blocks.
It means making mistakes together.
It means tolerating noise without escaping into a screen.
We must reduce screen dependency.
We must increase human connection.
We must reintroduce play.
We must reintroduce conversation at dinner tables.
We must reintroduce eye contact.
And most importantly, we must model behaviour.
If we expect children to reduce screen time, we must reduce ours.
Children follow what they see.
Not what they are told.
In our awareness sessions, I often ask parents to try something simple:
For one week, no phone during meals.
For one week, thirty minutes of dedicated play daily.
For one week, storytelling before sleep instead of video.
The results are powerful.

Children become calmer.

Communication increases.

Tantrums reduce.

Attention improves.

Not magically.

But gradually.

That is the power of human interaction.

The future of our children cannot be outsourced to a device.

Technology is not the enemy.

Irresponsible use is.

Screens can educate.

Screens can inform.

Screens can connect.

But they must not replace parenting.

They must not replace conversation.

They must not replace bonding.

If we want to fight autism and developmental challenges seriously, we must change lifestyle patterns.

We must act early.

We must monitor exposure.

We must create tech-free zones at home.

We must prioritize interaction over entertainment.

This is not an anti-technology message.

It is a pro-child message.

Because childhood is short.
Brain plasticity is time-sensitive.
Developmental windows close.
And once lost, they are difficult to reopen fully.
When I look at today's world, I see incredible technological advancement.
But I also see children who struggle to connect emotionally.
And that is concerning.
Because human connection is the foundation of mental health.
As leaders, as parents, as professionals, we must ask ourselves:
Are we raising connected children?
Or distracted ones?
Are we building attention?
Or reducing it?
Are we strengthening emotional regulation?
Or weakening tolerance?
These are not small social questions.
They shape the next generation.
And that is why this chapter exists.
Not to accuse.
Not to shame.
But to awaken.
Because sometimes the hardest truths are the most necessary ones.
Parents are not the enemy.
But parents must lead the change.

Because no therapy centre, no doctor, no policy can replace what happens at home.

And home must be filled with voices.

Not only notifications.

With laughter.

Not only videos.

With eye contact.

Not only screen light.

Because the future of our children depends not on how advanced our devices are—but on how present we are.

Chapter Ten – The Struggle Beyond Years

The struggle was never limited to one year. It was not even a battle of five or ten years. It was a struggle that followed me every single day, every single hour, every single second. It became a part of my breathing, a silent companion that walked beside me wherever I went.

In Tripura, the situation was harsh and painfully real. Qualified Occupational Therapists and Speech Therapists were almost impossible to find. Parents would travel hundreds of kilometres for a single consultation. Some would go to Kolkata; some would try Guwahati. Many simply gave up because they could not afford the journey. I saw the helplessness in their eyes. I saw mothers holding their children tightly, as if holding onto hope itself.

Giving up was never an option for me.

If resources did not exist in Tripura, then I had to go where they existed.

So, I began to travel.

I went to Kolkata first. I walked through university campuses and therapy institutes. I met professors and department heads. I explained to them about the children in Tripura—children who were intelligent, sensitive, full of potential, but deprived of structured therapy.

Then I travelled to Delhi. The scale of institutions there amazed me, but my purpose remained clear. I wasn't sightseeing. I wasn't networking for prestige. I was searching—searching for professionals who had both skill and heart.

Next came Mumbai. The city never sleeps, and neither did my determination. I visited colleges, therapy centres, and hospitals. I had long discussions with young therapists who were ambitious but hesitant about relocating to a small state in the Northeast.

Then I went to Guwahati, closer to home but still more resourceful than Tripura in terms of trained professionals.

Every city taught me something. Every journey costs time, money, and energy. But every journey also strengthened my mission.

After careful selection and multiple interviews, I convinced professionals from Kolkata, Mumbai, and Guwahati to come to Tripura. I offered them high salaries—not as an expense, but as an investment. An investment in our children's future.

Many people questioned me.

“Why spend so much?”

“Will it even work in Tripura?”

“Is there enough demand?”

But I was not calculating demand. I was calculating need.

Slowly, our centre began to grow. What started as a dream slowly became a structured institution. Therapy rooms were no longer empty. There were Occupational Therapists working with sensory integration. Speech Therapists conducting structured language sessions. Special educators designing individualized education plans.

Today, many professionals work at our Tripura centre. When I walk through the corridor and hear children attempting new words, responding to instructions, or maintaining eye contact, I know every kilometre I travelled was worth it.

Yet my mission never stopped at just building a team.

My mission was clear from the beginning:

Whatever needs to be done for special children, I am ready to do it.

I was ready to go anywhere in the world for them.

One day, during a parent interaction session, a father hesitantly raised his hand.

“Sir, we heard that in the USA, there is better treatment now—laser therapy.”

Many would have dismissed it as a rumour. Many would have said, “It’s too advanced,” or “It’s not practical here.” But I have learned something important in this journey—hope often begins with curiosity.

Instead of ignoring it, I started studying.

I researched Low-Level Laser Therapy (LLLT), also known as photobiomodulation. I studied where it was being used, how it functions at the cellular level, and what research existed regarding neurological improvements. I examined scientific papers, clinical case studies, and medical discussions. I did not want to introduce anything based on emotion or pressure. I wanted knowledge. Solid knowledge.

I wanted to understand:

Can this therapy improve communication?

Can it enhance neural activity?

What are the possible side effects?

Is it safe for children?

After months of careful research and discussions with experts, I came to a conclusion. While laser therapy was not a miracle cure, there was growing evidence that it could support neurological function in certain developmental conditions when used properly and ethically.

That was enough for me to consider the next step.

If this can help our children, we must bring it.

I spoke to Dr Naisha and said, “You need to take proper training.”

Without hesitation, she agreed. That moment meant a lot to me. When you have team members who share your mission, obstacles become smaller.

There was no time to delay.

An international team from the USA was scheduled to conduct advanced training in Ahmedabad. Around that time, my health was not good. I was physically weak. Doctors advised rest. But I had a target in my mind: improvement for our children.

So I went.

When I reached Ahmedabad, my health condition worsened. Eventually, I had to be admitted to a hospital. For two days, I stayed under medical supervision. Those hospital walls could have become an excuse. But they did not.

Every day, even from the hospital, I would step out for one or two hours to attend meetings and training discussions. Nurses questioned me. Friends advised me to rest. But inside me, there was only one thought: if I delay now, our children will have to wait longer.

And they had already waited enough.

After completing the necessary arrangements, documentation, and technical formalities, I brought the advanced laser treatment technology from the USA to our centre.

It was introduced in Northeast India for the first time.

That day was not a celebration of technology. It was a celebration of possibility.

Implementation was done carefully. We ensured safety protocols, proper training, ethical usage, and parental consent. We did not present it as a magical solution. We presented it as an additional supportive tool alongside occupational therapy, speech therapy, and behavioural interventions.

Over time, something beautiful began to unfold.

Some children showed better attention span.

Some showed improved response time.

Some began attempting words they had never tried before.

Some parents reported improved sleep patterns and calmer behaviour.

Not every child responded the same way. But many showed measurable improvement.

And then came the moments that truly matter.

A mother who once cried during every session now smiled when her child said “Ma” clearly.

A father who had stopped attending social gatherings proudly brought his son to a family function.

A child who avoided eye contact started looking directly at the therapist during sessions.

These are not small changes.

These are life-changing moments.

Today, when I stand and look back, I do not see the hospital bed in Ahmedabad. I do not see the long train journeys. I do not see the financial risks.

I see children improving.

I see confidence growing.

I see hope returning.

I see parents smiling again.

And that smile—that is the real success.

This journey was never about business.

If it were about business, I would have chosen a different field. A simpler field. A more profitable field.

This journey has always been about responsibility.

Responsibility toward children who cannot always express their needs.

Responsibility toward parents who trust us with their most precious gift.

Responsibility toward a state that deserves better healthcare and therapeutic support.

Sometimes people call me determined. Sometimes they call me stubborn. Maybe I am both.

Because when it comes to special children, compromise is not an option.

The struggle beyond years has shaped me. It has tested my patience, my health, my finances, and my emotional strength. But it has also given me something priceless—purpose.

When I see a child progressing, I do not feel pride. I feel gratitude. Gratitude that I was chosen to be part of their journey.

The fight is not over.

New challenges will come. New therapies will emerge. New research will question old methods. And we must continue to learn, adapt, and improve.

But one thing will never change.

I am still fighting.

Fighting for better resources in Tripura.

Fighting for awareness in society.

Fighting for inclusion in schools.

Fighting for dignity for every special child.

Because every child deserves opportunity.

Every child deserves therapy.

Every child deserves hope.

And as long as I breathe, I will stand beside them—not just as a professional, but as a guardian of their future.

The struggle beyond years continues.

But so does the promise.



Chapter Eleven – Understanding Autism: From Disorder to Diversity:

Autism Spectrum Disorder (ASD) is a neuro-developmental condition that influences how individuals perceive their environment, communicate, and engage socially. For decades, autism was viewed primarily through a medical lens that emphasized deficits. However, contemporary understanding increasingly recognizes autism as a variation in neurological functioning rather than a disease or abnormality. This shift reflects broader transformations in academic, medical, and social perspectives that prioritize inclusion, dignity, and diversity.

As global awareness expands, understanding autism has become essential for educators, healthcare professionals, policymakers, and communities committed to building supportive environments. This chapter explores the defining characteristics of autism, communication and social differences, sensory and behavioural patterns, strengths and challenges, diagnostic processes, support systems, and the critical role of inclusive societies.

The Spectrum Nature of Autism:

Autism is typically identified in early childhood, though recognition may occur later depending on access to evaluation and individual presentation. It is described as a “spectrum” because characteristics vary widely among individuals.

Some individuals require substantial daily support, while others live independently and succeed in academic or professional environments. Current research indicates that autism arises from complex interactions among genetic and environmental factors affecting brain development. Importantly, autism is not caused by parenting style, culture, or personal choice. Dispelling such misconceptions is vital to reducing stigma.

Communication Differences:

Communication differences are central to autism, though they present in diverse ways.

Some individuals use minimal spoken language and may rely on alternative communication systems such as visual supports or assistive technology. Others possess strong verbal skills but interpret language literally, finding figurative expressions, sarcasm, or implied meanings challenging. Eye contact, conversational timing, and interpretation of contextual cues may also differ.

These variations reflect neurological diversity rather than limitations in intelligence or emotional depth. Modern scholarship emphasizes evaluating communication broadly, recognizing multiple valid forms of expression instead of privileging conventional verbal norms.

Social Interaction and Emotional Expression:

Autistic individuals may approach relationships in distinctive ways. Some prefer structured or predictable interactions, while others may feel overwhelmed in socially complex environments requiring rapid interpretation of emotional signals.

Misreading tone, body language, or subtle facial expressions can create communication gaps. However, such differences do not imply a lack of empathy. Many autistic individuals experience profound emotional understanding but express it differently. Recognizing varied social styles is essential in schools, workplaces, and communities seeking authentic inclusion.

Behavioural Patterns and Focused Interests:

Repetitive behaviours, adherence to routines, and intense interests are frequently associated with autism. Actions such as rocking or repetitive hand movements may function as self-regulatory strategies that help manage sensory or emotional input.

Structured routines provide stability and predictability. Sudden changes may trigger distress due to increased uncertainty. Focused interests—

sometimes described as restricted interests—can involve remarkable depth of knowledge. When nurtured constructively, these interests often lead to specialization and professional excellence.

Rather than viewing these characteristics solely as limitations, it is important to understand their adaptive and empowering dimensions.

Sensory Processing Differences:

Many autistic individuals experience differences in sensory processing. Sensitivity to sound, light, texture, taste, or smell may be heightened or reduced.

A noisy classroom, bright lighting, or certain fabrics can become overwhelming. Conversely, reduced sensitivity may lead to seeking stronger sensory input. These variations influence daily participation and well-being.

Inclusive environments—such as sensory-friendly spaces, adjustable lighting, and flexible scheduling—greatly enhance accessibility and productivity.

Strengths and Abilities:

Historically, discussions of autism centred on challenges. Contemporary perspectives emphasize strengths as well.

Autistic individuals often demonstrate:

Exceptional attention to detail

Advanced pattern recognition

Strong memory retention

Analytical reasoning

Creative and innovative thinking

These abilities contribute meaningfully to fields such as technology, mathematics, engineering, research, and the arts. The concept of neurodiversity encourages recognition of cognitive variation as a societal asset rather than a deficit.

Balanced understanding promotes empowerment and positive identity development.

Diagnosis and Ethical Considerations:

Diagnosis involves a comprehensive evaluation conducted by trained professionals using developmental and behavioural criteria rather than laboratory tests. Early identification enables access to support services that improve long-term outcomes. However, diagnosis later in life can also provide clarity, validation, and access to accommodations.

Ethical practice emphasizes individualized support, respect for autonomy, and rejection of one-size-fits-all approaches.

Support Frameworks:

Support strategies aim to enhance independence and quality of life rather than alter fundamental neurological identity. These may include:

Speech and language therapy

Occupational therapy

Educational accommodations

Behavioural guidance

Psychological support for anxiety or stress

Effective intervention depends on collaboration among families, educators, and healthcare professionals. Modern approaches prioritize functional skills, comfort, and personal goals over rigid normalization.

The Importance of Social Inclusion:

Social inclusion significantly influences life outcomes for autistic individuals. Historically, stigma and misunderstanding led to marginalization in education and employment.

Inclusive education systems offer differentiated instruction and structured learning environments. Workplace adaptations—clear communication, predictable routines, sensory awareness—support professional success.

Public awareness initiatives play a critical role in dismantling stereotypes and promoting respectful engagement.

Identity and Lived Experience:

Autism represents one dimension of identity among many. Personal values, cultural background, interests, and experiences equally shape individual lives.

Daily experiences may involve navigating sensory and social challenges, yet they also reveal perseverance, dedication, and creativity. Interpersonal relationships flourish when mutual understanding replaces judgment.

Incorporating autistic voices into research, advocacy, and policy ensures that theoretical frameworks remain grounded in lived reality.

Autism Spectrum Disorder reflects a complex neurological variation influencing communication, interaction, behaviour, and sensory processing. Understanding autism requires moving beyond deficit-based interpretations toward recognition of diversity and capability.

Through balanced acknowledgment of strengths and challenges, comprehensive support systems, and inclusive societal structures, individuals on the spectrum can lead meaningful and fulfilling lives.

Ultimately, the study of autism affirms a fundamental truth: diversity in cognition and perception strengthens society, fosters innovation, and deepens collective empathy.

Chapter Twelve – Autism in Numbers: Global and Indian Perspectives

In recent decades, autism has gained increasing attention within medical, educational, and public policy discussions. Rising awareness and improved diagnostic capabilities have led to more systematic identification of Autism Spectrum Disorder (ASD) worldwide. Statistical analysis plays a crucial role in understanding the demographic distribution and socio-economic implications of autism across regions.

Reliable data enables researchers and policymakers to identify trends, allocate resources, and design evidence-based interventions that support autistic individuals and their families. This chapter examines global and Indian autism prevalence statistics, analyses factors influencing reported rates, and highlights the importance of data-driven policy development.

Global Prevalence and Statistical Trends:

Epidemiological research indicates that autism affects a significant proportion of the global population. Recent international estimates suggest that approximately 1 in 127 people worldwide were autistic in 2021. This figure represents a substantial increase compared to earlier decades, when limited awareness and underdiagnosis contributed to lower reported prevalence.

However, interpreting global statistics requires caution. Reported rates vary considerably across regions due to differences in:

Screening and diagnostic criteria

Healthcare accessibility

Cultural perceptions of developmental differences

Professional training and reporting systems

In low- and middle-income countries, incomplete surveillance systems may lead to underestimation. Therefore, variations in prevalence often reflect disparities in detection mechanisms rather than true biological differences.

Age-based analysis indicates that autistic characteristics are often observable in early childhood, though formal diagnosis may occur later depending on access to specialized services. Additionally, autism presents across a wide spectrum of abilities and support needs. Prevalence counts alone cannot capture differences in functional independence, quality of life, or support requirements.

Associated Conditions and Social Outcomes:

Statistical research also highlights the presence of co-occurring conditions among autistic individuals. These may include:

Anxiety disorders

Depression

Epilepsy

Attention-related conditions

Such associations influence healthcare planning and resource allocation. Beyond medical considerations, societal factors—such as stigma, inclusive education policies, and employment accessibility—significantly affect life outcomes.

Thus, statistical interpretation must integrate social context rather than relying solely on biological measures.

Causes and Risk Factors in Epidemiological Research:

Large-scale statistical investigations suggest that autism results from complex interactions between genetic and environmental influences. Research has identified associations with:

Advanced parental age

Premature birth

Low birth weight

Prenatal exposure to environmental pollutants

Importantly, these factors indicate statistical associations rather than direct causation. Epidemiological modelling must carefully control for confounding variables to avoid misleading conclusions.

Crucially, extensive scientific research has confirmed that vaccines do not cause autism, correcting earlier misinformation that negatively influenced public health perceptions. This demonstrates how rigorous statistical analysis and peer-reviewed research contribute to evidence-based communication.

Autism Statistics in the Indian Context:

Compared to Western nations, autism research in India has historically been limited. Nationwide surveillance data remain sparse; however, regional population-based studies provide insight.

One cross-sectional study of children aged 1–10 years across rural, urban, and tribal populations identified 43 cases among 28,070 children, resulting in a prevalence estimate of approximately 0.15%. This rate appears significantly lower than global averages.

However, several factors likely contribute to underestimation:

Limited screening infrastructure

Shortage of trained developmental specialists

Cultural stigma

Low public awareness

Variations in diagnostic tools

Regional variation was observed, with higher detection rates in rural populations compared to tribal communities. This suggests that socio-economic and demographic factors influence access to diagnosis and reporting.

India's linguistic and cultural diversity presents additional challenges. Screening instruments must be culturally adapted, and healthcare access

differs significantly between urban and rural areas. Small-scale studies often serve as proxies for national estimates, underscoring the need for large-scale surveillance initiatives.

Comparative Analysis: Global and Indian Data:

Comparing global and Indian prevalence estimates reveals notable differences. While worldwide figures indicate autism is relatively common, Indian studies often report lower rates.

This discrepancy likely reflects:

- Differences in diagnostic coverage

- Limited professional training

- Methodological inconsistencies

- Social stigma discouraging evaluation

From a statistical perspective, this comparison highlights a critical principle: numerical values cannot be interpreted without examining data collection methods. High-income countries typically implement systematic surveillance systems, whereas developing nations may rely on smaller research samples.

Therefore, cross-national comparisons must prioritize methodological equivalence rather than focusing solely on numerical disparities.

Policy Implications of Statistical Evidence:

Statistical research plays a vital role in shaping public policy. Reliable data informs decisions related to:

- Special education funding

- Healthcare infrastructure

- Early intervention programs

- Community awareness initiatives

Global prevalence data emphasize the need for inclusive education and workplace accommodations. Indian data, meanwhile, underscore the

importance of expanding screening services, improving professional training, and enhancing public awareness.

Statistical evidence thus functions as a bridge between research and policymaking, guiding interventions tailored to regional realities.

The Social Value of Data:

Beyond policy planning, statistics influence societal attitudes. Demonstrating that autism affects a significant proportion of the population challenges misconceptions that it is rare or abnormal.

Quantitative data:

Promotes awareness

Reduces stigma

Encourages early evaluation

Supports advocacy efforts

Accurate data collection and transparent reporting, therefore, carry ethical as well as scientific importance.

Statistical analysis of autism prevalence provides essential insight into the distribution, determinants, and societal impact of ASD. Globally, autism affects a substantial segment of the population, though prevalence estimates vary due to methodological and infrastructural differences.

In India, reported rates remain lower but likely reflect underdiagnosis and limited surveillance systems rather than true prevalence disparities. Comparative evaluation demonstrates that statistical figures must always be interpreted within cultural, economic, and methodological contexts.

Strengthening epidemiological research and expanding nationwide data systems are critical for advancing inclusive healthcare and education policies. As diagnostic awareness continues to improve worldwide, statistical research will remain central to understanding autism and supporting neuro-diverse communities effectively.

Chapter Thirteen – Understanding Speech Delay in Children

Before defining speech delay, it is important to differentiate between speech and language.

Speech refers to the physical production of sounds, including articulation, voice, and fluency.

Language refers to understanding (receptive language) and expressing (expressive language) thoughts and ideas through words, gestures, or symbols.

A child may have difficulty in speech production, language comprehension, or both. Proper evaluation helps determine the specific area of difficulty.

Speech delay occurs when a child does not achieve speech and language milestones within the expected age range. It may involve:

Limited vocabulary compared to peers

Difficulty forming words or sentences

Unclear pronunciation beyond the expected age

Inability to understand simple instructions

Limited use of gestures or pointing

Lack of meaningful communication

Speech delay is not a diagnosis in itself; rather, it is a symptom. It may be isolated, or it may indicate underlying developmental or medical conditions.

It is important to differentiate speech delay from:

Language disorder

Hearing impairment

Intellectual disability

Autism Spectrum Disorder

Global developmental delay

Accurate assessment by qualified professionals is necessary to identify the root cause.

Although individual variation exists, general developmental milestones provide guidance.

Birth to 6 Months

Coos and makes vowel-like sounds

Cries differently for different needs

Responds to loud sounds

Recognizes familiar voices

6 to 12 Months

Babbling begins (e.g., “ba-ba,” “da-da”)

Responds to own name

Understands simple words like “no”

Uses gestures such as waving or pointing

12 to 18 Months

Says 5–20 meaningful words

Points to desired objects

Understands simple commands

Imitates sounds and words

18 to 24 Months

Vocabulary expands rapidly (approximately 50 words or more)

Begins combining two words (e.g., “want water”)

Follows simple two-step directions

2 to 3 Years

Forms 2–3-word sentences

Speech is understood by familiar adults

Asks simple questions

Names common objects

3 to 4 Years

Uses longer sentences

Speech is mostly understandable

Engages in simple conversation

If a child consistently falls significantly behind these milestones, professional evaluation is recommended.

Speech delay may result from various factors. Identifying the cause is critical for effective intervention.

- **Hearing Impairment**

Hearing is fundamental to language learning. Even mild or fluctuating hearing loss due to frequent ear infections can interfere with speech development. A child who cannot hear clearly may struggle to imitate sounds accurately.

- **Autism Spectrum Disorder**

Children with autism may exhibit:

Limited eye contact

Reduced response to name

Minimal social interaction

Repetitive behaviours

Delayed or atypical speech patterns

Speech delay in autism is often accompanied by challenges in social communication.

- **Developmental Delays**

Global developmental delay affects multiple domains, including motor skills, cognition, and language. Speech delay may be one component of a broader developmental concern.

- **Neurological Conditions**

Conditions affecting the brain, such as cerebral palsy or genetic disorders, may impact speech and language development.

- **Oral-Motor Difficulties**

Weakness or coordination problems in the muscles used for speech can interfere with articulation.

- **Environmental Deprivation**

Children require rich language exposure. Limited verbal interaction, minimal storytelling, or excessive screen time can reduce opportunities for communication.

- **Bilingual Environments**

Exposure to more than one language does not cause speech delay. However, vocabulary may be distributed across languages. Professional assessment can clarify whether development is typical.

- **The Role of Brain Development**

The human brain undergoes rapid development during the first five years. Neural pathways related to language are strengthened through repeated interaction. Talking, reading, singing, and responsive communication stimulate brain growth.

Passive listening through television or mobile devices does not provide the same neurological benefit as interactive conversation. Language develops best in a responsive environment where adults engage with the child.

Brain plasticity decreases with age. Therefore, early stimulation and early intervention are more effective than delayed support.

Parental denial is common and understandable. Emotional attachment, fear, and social pressure influence perception.

Common reasons include:

Belief that “boys speak late”

Comparison with siblings who spoke late

Advice from relatives to “wait and watch”

Fear of labelling

Social stigma

Guilt or self-blame

However, waiting without evaluation may lead to missed opportunities for early support.

Seeking help does not mean accepting a negative label. It means prioritizing the child’s development.

Research consistently shows that early intervention leads to better outcomes. When therapy begins before the age of five:

Vocabulary grows more rapidly

Social communication improves

Behavioural challenges decrease

School readiness increases

Intervention may include:

Speech and language therapy

Occupational therapy

Behavioural therapy

Parent training programs

Special education support

Therapy is most effective when parents actively participate and continue strategies at home.

Parents should seek professional advice if a child:

Does not babble by 9 months

Does not respond to name by 12 months

Does not say single words by 16 months

Does not combine two words by 24 months

Loses previously acquired speech

Shows minimal eye contact

Does not point or use gestures

Regression—the loss of previously learned skills—is particularly concerning and requires urgent evaluation.

If left untreated, speech delay may affect:

Academic performance

Reading and writing skills

Social relationships

Self-esteem

Emotional regulation

Children who struggle to communicate may experience frustration, leading to behavioral difficulties.

Early intervention reduces the risk of long-term academic and social challenges.

Parents are the primary facilitators of language development. Daily interactions shape communication skills.

Effective strategies include:

Talking to the child during daily routines

Reading books regularly

Singing songs and rhymes

Encouraging storytelling

Limiting screen exposure

Giving the child time to respond

Avoiding excessive correction

Language grows through interaction, not pressure. Children need encouragement, patience, and consistent engagement.

Successful intervention requires teamwork. Paediatricians, speech-language pathologists, occupational therapists, teachers, and parents must work collaboratively.

Open communication ensures that strategies used in therapy are reinforced at home and school.

When adults work together, progress accelerates.

Speech delay is not merely a matter of “late talking;” it may be an early indicator of underlying developmental differences. Monitoring age-specific milestones, seeking timely evaluation, and initiating appropriate intervention are critical steps in supporting a child’s growth.

Ignoring early signs due to denial, stigma, or misinformation may delay essential support. The early years provide a window of opportunity that should not be missed.

Early recognition leads to early intervention.

Early intervention leads to better outcomes.

And better outcomes build brighter futures.

Chapter Fourteen – The Role of Occupational Therapy in Promoting Independence in Children

Every parent dreams of raising a confident, capable, and independent child. From the very moment a baby is born, parents imagine milestones—first words, first steps, school admission, academic success, extracurricular achievements, and social acceptance. Families often invest time, energy, and resources in ensuring that their child receives quality education, participates in music classes, engages in sports, and develops creative talents.

However, in the pursuit of academic excellence and talent development, one essential component of child growth is often overlooked: functional independence.

Independence is the ability to perform daily tasks without excessive reliance on others. It includes dressing, feeding, organizing belongings, managing personal hygiene, following routines, and regulating emotions. These skills form the foundation upon which academic achievement and social competence are built.

Occupational Therapy (OT) plays a critical role in fostering this independence. Rather than focusing solely on academic performance, occupational therapy addresses the fundamental life skills that allow children to function confidently in everyday environments.

True success does not begin in the classroom. It begins in the ability to manage daily life independently.

Occupational Therapy is a specialized, evidence-based healthcare profession that helps individuals develop, recover, or maintain meaningful daily living skills. The term “occupation” refers not to employment but to everyday activities that occupy a person’s time and give structure to life.

For children, occupations include:

Playing

Learning

Eating

Dressing

Writing

Participating in school

Interacting socially

Occupational therapists evaluate a child's strengths and challenges across multiple developmental domains and design individualized interventions to enhance independence and participation.

Key areas addressed in paediatric occupational therapy include:

Fine motor skills

Gross motor coordination

Sensory processing

Self-care abilities

Executive functioning

Emotional regulation

Social participation

The primary goal is functional independence—enabling children to engage successfully in daily activities appropriate for their age.

Independence is not simply about completing tasks; it contributes significantly to psychological and emotional development.

When children perform tasks independently, they develop:

Self-confidence

Autonomy

Decision-making ability

Problem-solving skills

Emotional resilience

Responsibility

A child who learns to button a shirt independently experiences mastery. A child who feeds themselves develops coordination and self-belief. These seemingly small achievements accumulate into a strong internal sense of competence.

Psychological theories of development emphasize autonomy as a central developmental need in early childhood. When children are given opportunities to try, fail, and try again within supportive environments, they build resilience.

Over-assistance, though often well-intentioned, may limit growth. Independence must be nurtured intentionally.

Modern parenting often emphasizes academic preparedness. Many families plan:

Early nursery school enrolment

Language classes

Music training

Sports coaching

Art and drawing lessons

While these activities enhance creativity and skill, they do not automatically ensure readiness for real-life functioning.

A child may demonstrate academic potential yet struggle with:

Holding a pencil properly

Sitting for structured tasks

Organizing school materials

Following classroom routines

Managing transitions

Functional skills form the foundation for academic success. Without them, children may experience frustration, behavioural difficulties, or reduced confidence.

Occupational therapy bridges the gap between aspiration and ability by strengthening the underlying skills required for daily functioning.

The core areas of Occupational Therapy Intervention are the self-care skills (activities of daily living)

Self-care includes dressing, feeding, toileting, grooming, and personal hygiene. These skills promote autonomy and dignity.

Occupational therapy helps children:

Learn dressing sequences

Develop coordination for buttoning and tying

Improve utensil use

Establish toileting routines

Practice grooming habits

Mastery of self-care skills builds independence and reduces dependence on caregivers.

Fine motor skills involve small muscle movements, particularly of the hands and fingers.

These skills are essential for:

- Writing
- Drawing
- Cutting
- Buttoning
- Manipulating small objects

Poor fine motor development may lead to difficulty with school tasks, reduced handwriting quality, and academic frustration.

Occupational therapy strengthens hand muscles, improves coordination, and develops appropriate pencil grip and writing mechanics.

Gross motor skills involve larger body movements such as balancing, jumping, climbing, and maintaining posture.

Proper postural stability supports:

- Sitting tolerance
- Attention
- Hand control during writing
- Physical endurance

Children with weak core stability may struggle to sit upright in classrooms, affecting focus and participation.

Occupational therapists incorporate movement-based activities to enhance strength, balance, and coordination.

Sensory Processing and Regulation refers to how the nervous system interprets and responds to sensory input such as touch, sound, movement, taste, and visual stimuli.

Some children may be:

Over-sensitive to noise or textures

Avoidant of certain clothing

Easily distracted by environmental stimuli

Constantly seeking movement

Under-responsive to sensory input

Sensory dysregulation can affect attention, behaviour, and emotional control.

Occupational therapy uses structured sensory strategies to help children regulate responses and function more comfortably in daily environments.

Attention and Executive Functioning include planning, organization, impulse control, and task completion.

Children with executive functioning challenges may:

Forget instructions

Struggle with transitions

Act impulsively

Avoid multi-step tasks

Occupational therapy strengthens these skills through structured activities that promote organization, sequencing, and sustained attention.

Social Participation requires emotional awareness, impulse control, and communication.

- Occupational therapy supports:

- ✓ Turn-taking
- ✓ Cooperative play
- ✓ Emotional recognition
- ✓ Conflict resolution
- ✓ Group participation
- ✓ Improved social skills enhance peer relationships and school adjustment.

The period from birth to six years is characterized by high brain plasticity. Neural pathways are flexible and responsive to intervention.

- Early occupational therapy can:

- ✓ Prevent secondary behavioural challenges
- ✓ Improve school readiness
- ✓ Enhance social integration
- ✓ Reduce long-term dependency

Children who may particularly benefit include those with:

- ✓ Developmental delays
- ✓ Autism Spectrum Disorder
- ✓ ADHD
- ✓ Learning disabilities
- ✓ Sensory processing difficulties
- ✓ Motor coordination disorders

Early intervention significantly improves functional outcomes and reduces the need for intensive support later in life. Occupational therapy is essential for children with identified developmental challenges. However, the principles of occupational development benefit all children.

Even typically developing children gain from structured opportunities to build independence, motor coordination, and self-regulation.

The objective is not labelling or medicalizing childhood. Rather, it is strengthening foundational life skills that support holistic development. Occupational therapy empowers children to reach their full potential. Modern parenting often involves high levels of supervision and assistance.

While safety is important, excessive intervention may limit independence.

When parents:

- ✓ Dress children who can dress themselves
- ✓ Feed children who are capable of self-feeding
- ✓ Complete tasks on behalf of the child

Guided independence, not overprotection, builds competence. Allowing children to struggle safely promotes resilience and problem-solving. Parents play a crucial role in reinforcing occupational skills outside therapy settings.

Practical strategies include:

- Establishing consistent daily routines
- Assigning age-appropriate chores
- Encouraging decision-making

- Allowing sufficient time for task completion
- Reducing unnecessary assistance
- Providing positive reinforcement

Independence develops gradually. Patience and encouragement are essential.

Children who develop independence early tend to:

- Exhibit stronger self-esteem
- Adapt effectively in school environments
- Manage stress more successfully
- Demonstrate leadership qualities
- Transition smoothly into adolescence

Functional independence contributes to academic achievement, social maturity, and emotional stability.

The effects extend beyond childhood into adulthood. Inclusive educational settings increasingly recognize the importance of supporting diverse learners.

Occupational therapists collaborate with:

- Teachers
- Parents
- Psychologists
- Speech therapists to design classroom strategies that promote accessibility and participation.

School-based occupational therapy supports children in adapting to structured environments and achieving educational goals.

Independence is not taught in a single session. It is cultivated over years of consistent support, practice, and encouragement.

Each small milestone—tying a shoelace, organizing a school bag, and completing homework independently—builds cumulative confidence.

Functional competence strengthens identity.

Children who believe “I can do it” approach life’s challenges with greater courage.

Every parent dreams of success for their child. Yet true success begins with independence.

While academic performance, extracurricular achievements, and talent development are valuable, they must be supported by strong functional foundations.

Occupational Therapy provides structured, evidence-based support that enables children to develop daily living skills, emotional regulation, motor coordination, and social competence.

When children learn to manage their own tasks, they do not merely complete activities—they build identity, dignity, and self-belief.

Independence today creates capability tomorrow.

Capability tomorrow creates confidence for life.

Chapter Fifteen – Photo-biomodulation and Autism: Exploring the Science of Light-Based Brain Stimulation

After multiple studies and research analysis over several months, my team and I understood the theory of laser light effectiveness in improving brain cells in the human body. Low-level laser (LLLA) biostimulation contributes to improving the symptoms and communication of children manifesting Autism Spectrum Disorder (ASD).

Disorders in language abilities and performance are one of the most common manifestations of ASD. Deficits in verbal communication and receptive language skills, which increase with more severe core manifestations, were frequently reported in children with ASD. Restricted interests and social isolation are among the parents' concerns that drive them to seek medical consultation. Many children with ASD fail to acquire expressive language. Even those who become able to utter sentences manifest syntactic and phonological disorders in addition to pragmatic deficits.

A well-known research study showed LLLA therapy as a safe and promising therapeutic procedure for improving the core manifestations and communication of the child.

The laser machines were imported from American autism therapeutic centres, and for the first time in the Northeast, New Hope introduced laser therapy.

A study was conducted by the National Library of Medicine on the evaluation of low level laser light therapy for autistic disorder. The purpose of this study was to determine whether the laser was effective in the treatment of irritability associated with autistic disorder in children and adolescents aged five (5) to seventeen (17) years.

Autism spectrum disorder (ASD) is a range of complex neurodevelopment disorders characterized by behavioural, developmental, cognitive, and psychological deficits that include social impairment, communication and language difficulties, hyperactivity, irritability, obsessive interests, and restricted and repetitive behaviours. Autistic disorder, sometimes called autism or classical ASD, is the most severe form of ASD. ASD occurs in all ethnic and socio-economic groups and affects every age group, with symptoms appearing before age 3. The Centres for Disease Control (CDC) estimates that 1 out of 88 children age 8 will have an ASD, with males four times more likely to have an ASD than females.

There is no cure for ASD and no single best treatment for all individuals with autistic disorder. The majority of diagnosed cases of autism are idiopathic with an enigmatic pathogenesis, and as a result, therapeutic approaches have focused on mitigating specific symptoms rather than treating disease etiology. The current standard treatment approach is a team approach to customize an individual, highly structured, specialized program or treatment plan, including medications, therapies, and behavioural interventions targeted toward improving the individual's specific symptoms.

The cause of ASD is not clearly understood, but it is believed that both genetics and environment likely play a role. Magnetic Resonance Imaging (MRI) studies have demonstrated increased brain volume and head circumference during early childhood development, suggesting that autistic brains experience a period of rapid overgrowth, which hampers further development during later developmental stages. Morphological aberrations have been observed in the hippocampus, anterior cingulate cortex, prefrontal cortex, amygdala, and cerebellum. Another consistent observation has been the reduction in cerebellar vermis volume, which helps to explain specific behavioural patterns in children.

Molecular analysis of post-mortem brain tissue has revealed reduced Purkinje cell numbers, which helps to explain aberrant locomotive activity and level pressure function. Another finding has been impaired neuronal

connectivity within the cerebellum, amygdala, anterior cingulate cortex, and dorsolateral prefrontal cortex. As a consequence, synapse structure and function have demonstrated impairment in post-mortem evaluations. Dendritic spines of glutamatergic neurons in autistic patients have shown morphological alterations and suppressed density, which, in turn, results in diminished synaptic transmissions. Nascent spines have been reported in frontal, temporal, and parietal cortices of autistic patients and have a negative correlation with cognitive abilities in autism. Other neurological aberrations include signalling through the metabotropic glutamate receptor (mGluR) and γ -aminobutyric acid (GABA) ergic system.

The elusive pathophysiology of autism provides a marked challenge for health care providers. One promising technology is low-level laser therapy (LLLT). LLLT uses photonic energy to modulate the behaviour and function of cells by stimulating molecular entities capable of absorbing discrete wavelengths. For instance, cytochrome c oxidase (CCO), a terminal enzyme of the respiratory chain, contains a tetrapyrrole prosthetic group that has been shown to absorb 635nm. Photon-induced activation of CCO increases cell bioenergetics, which, in turn, activates intra-cellular secondary signalling cascades that affect growth factor synthesis, cell proliferation, cytokine production, and expression of specific transcription factors. Studies have reported increased adenosine triphosphate (ATP) synthesis along with activation of the intracellular redox state following the production of reactive oxygen species (ROS). As an essential bio-catalyst, ATP lowers the activation energy required for pivotal biochemical reactions within cells. Concerning neurons, laser irradiation has been shown to promote the recovery of injured peripheral nerves and the spinal cord. Moreover, studies have revealed that excitable cells like neurons can be directly stimulated by light, enhancing the action potential of the cell, increasing the release of neurotransmitters such as glutamate and acetylcholine.

Clinical outcomes with LLLT trials include nerve regeneration, increased neurotransmitter release, growth factor synthesis, and neovascularization, to

name a few. It follows that positioning of the laser along impaired regions of an autistic brain could elicit a positive therapeutic outcome in a safe and non-invasive manner.

New Hope encompasses the natural variations in brain function and behaviour among individuals, including conditions such as ADHD, autism, dyslexia, dyspraxia, and Tourette Syndrome (TS). These children possess unique strengths, talents, and perspectives that can enrich our communities but may also face challenges in communication, social interactions, and sensory sensitivities.

Light therapy, also known as photo-biomodulation, is a cutting-edge approach that uses specific wavelengths of light to stimulate cellular processes in the brain. Unlike other therapies, light therapy is a non-invasive and drug-free approach.

The researchers investigated the potential of morning bright light therapy as a 3-week treatment for 29 adults with attention-deficit/hyperactivity disorder (ADHD) during the fall and winter months. The results showed a significant decrease in ADHD symptoms, improved mood symptoms, and a shift towards earlier sleeping and waking times. This shift was found to be the most important factor in predicting improvement in ADHD symptoms.

The research team of New Hope also found that brain light therapy reduced neuro inflammation, increased cerebral blood flow, reduced oxidative stress in children with ADHD, which consequently resulted in a greater ability to focus, organize, and manage the symptoms.

In a study investigating the effectiveness of low-level laser therapy on 21 children and adolescents on the autistic spectrum (aged 5-17 years), it was found that light therapy was effective in reducing irritability and other associated symptoms and behaviours.

The study evaluated the effects of low-level laser therapy (LLLT) on symptoms associated with ASD. A total of 30 children aged 5-15 years participated; 21 of these participants received the active treatment, consisting of 5-minute procedures administered to specific areas of the skull

over a 4-week period. All participants were evaluated using various behaviour scales at baseline, week 2, week 4, and week 8. The study found a statistically significant improvement in the irritability subscale score of the Aberrant Behaviour Checklist (ABC) in the test group compared to those children not exposed to LLLT. The results suggested a reduction in Autism Spectrum Disorder (ASD) severity and cognitive and behavioural rigidity, as well as an increase in sleep quality, improved attention, and a reduction in noncompliant behaviour. This also resulted in decreased parental stress.

At New Hope, the team is fully committed to supporting individuals with neurodivergent conditions and promoting inclusion. The professional therapists are dedicated to advancing research on neurological disorders, including neurodevelopment conditions, by pooling training and expertise towards this cause. By doing that, New Hope has gradually started to make a positive impact and improve the lives of countless neurodivergent individuals and their families.

Chapter Sixteen – The Responsibility of Schools in Identifying and Supporting Developmental Concerns

Schools occupy a central position in a child's developmental journey. Beyond delivering academic instruction, educational institutions serve as structured environments where children learn to communicate, socialize, regulate emotions, and adapt to routines. For many children, school represents the first formal social setting outside the home.

Within classrooms, playgrounds, and group activities, teachers observe children across multiple contexts: learning tasks, peer interactions, structured lessons, unstructured play, transitions, and emotional responses. Because educators spend several hours each day with students, they are uniquely positioned to notice patterns in behaviour, communication, attention, and learning.

Developmental differences such as speech delay, attention difficulties, behavioural regulation challenges, learning disabilities, or Autism Spectrum Disorder often become more visible in school environments. Tasks that require listening, following instructions, sitting for extended periods, sharing materials, and participating in group discussions may reveal concerns that were less noticeable at home.

However, in many instances, early signs of developmental concerns are not openly or effectively communicated to parents. Hesitation, uncertainty, or institutional pressures may delay meaningful discussions. When communication is postponed, early intervention is also delayed, potentially affecting long-term outcomes.

Schools are not merely centres of academic achievement. They are institutions entrusted with safeguarding children's holistic development. With that trust comes responsibility.

Children behave differently across environments. A child who appears relatively comfortable at home may struggle in structured group settings. Schools, therefore, provide valuable insight into developmental functioning.

Teachers may observe:

Limited verbal participation

Difficulty understanding classroom instructions

Reduced eye contact during interaction

Challenges with peer engagement

Frequent tantrums or emotional outbursts

Repetitive movements or restricted interests

Inability to remain seated for age-appropriate durations

Poor fine motor coordination affecting writing tasks

Avoidance of certain sensory experiences (noise, textures)

Such patterns may suggest developmental differences requiring further assessment.

It is important to emphasize that observing a concern does not equate to diagnosing a condition. Schools are not expected to function as medical authorities. However, they play a critical role in recognizing patterns and initiating supportive conversations.

Early identification is not labelling. It is preventive care.

Understanding developmental concerns in educational settings requires recognizing that they may present across multiple domains:

- Communication Challenges - Children may demonstrate:

- ✓ Limited vocabulary for age
- ✓ Difficulty forming sentences
- ✓ Reduced comprehension of instructions

- ✓ Minimal participation in classroom discussions

These signs may indicate speech delay, language disorder, or broader developmental differences.

- Behavioural Regulation Difficulties - Educators may notice:

- ✓ Frequent emotional outbursts
- ✓ Difficulty transitioning between activities
- ✓ Impulsive actions
- ✓ Inability to follow classroom rules

Such behaviours may be linked to executive functioning challenges or attention-related conditions.

- Social Interaction Difficulties - Children may struggle with:

- ✓ Making friends
- ✓ Sharing materials
- ✓ Understanding social cues
- ✓ Engaging in cooperative play

Social communication differences are often more visible in group environments.

- Learning and Cognitive Differences- Some students may:

- ✓ Struggle with letter recognition
- ✓ Demonstrate difficulty copying from the board
- ✓ Show inconsistent attention
- ✓ Avoid academic tasks

Learning differences can become apparent when academic demands increase.

Educational institutions are often the first structured systems to observe these patterns consistently. Despite recognizing concerns, some schools hesitate to initiate conversations with families. Several factors may contribute to this reluctance. In competitive educational markets, institutions may fear that suggesting evaluation or therapy could result in

withdrawal. Financial pressures may influence decision-making in private settings. Many teachers receive limited formal training in developmental psychology, neuro-developmental disorders, or early identification practices. Without adequate knowledge, educators may feel uncertain about raising concerns. Discussions about developmental differences can evoke strong emotions. Parents may experience denial, defensiveness, or distress. Schools may avoid conversations to prevent conflict.

Some institutions may worry that acknowledging developmental challenges could affect their reputation or perceived academic standards. In many communities, developmental differences are still associated with stigma. Schools may avoid discussions to protect families from perceived embarrassment.

While these concerns may be understandable from an institutional perspective, they do not justify silence. Delaying communication does not eliminate developmental challenges; it merely postpones intervention.

Educational institutions hold both moral and professional obligations to prioritize student welfare.

Ethical responsibilities include:

Acting in the best interest of the child

Providing honest and constructive feedback

Encouraging appropriate assessment when needed

Maintaining confidentiality

Promoting inclusive education

Schools are entrusted with children's growth. This trust requires transparency.

The core mission of education extends beyond examination scores and rankings. It includes nurturing intellectual, emotional, social, and physical development.

Prioritizing institutional image over child welfare undermines this mission.

The early years—particularly between ages two and six—represent a period of significant brain plasticity. Intervention during this window can dramatically improve outcomes.

When concerns are not communicated:

Early therapy is delayed

Learning gaps widen

Behavioural difficulties escalate

Social isolation increases

Emotional distress intensifies

Self-esteem declines

Parents lose valuable time for early intervention, which is often more effective and less intensive than later remediation.

Delayed identification may also place teachers in increasingly challenging classroom situations as academic demands grow.

Timely communication protects both the child and the learning environment.

Effective communication between schools and families requires sensitivity and professionalism.

Best practices include:

Scheduling private meetings

Presenting specific observations rather than assumptions

Using objective language

Avoiding diagnostic labelling

Encouraging professional evaluation

Offering support resources

For example, instead of stating, “Your child has a problem,” educators may say, “We have observed that your child finds it challenging to follow multi-step instructions. We recommend consulting a specialist to better understand how we can support their learning.”

Such framing reduces defensiveness and promotes collaboration.

Child development is a shared responsibility.

Collaboration may involve:

Regular developmental feedback sessions

Parent-teacher communication logs

Classroom accommodations

Referral networks for specialists

Individualized support plans

When schools and families work as partners rather than adversaries, children benefit.

Open dialogue fosters trust.

Inclusive education recognizes that children learn differently. It shifts from a rigid “one-size-fits-all” approach to flexible, child-centred strategies.

Inclusive practices may include:

Early developmental screening

Teacher training programs

Sensory-friendly classrooms

Flexible seating arrangements

Visual schedules

Collaboration with occupational and speech therapists

Individualized learning strategies

Supporting diversity in learning does not weaken academic standards. Instead, it strengthens institutional credibility and social responsibility.

Inclusive education reflects maturity in educational systems.

Empowering educators is essential.

Professional development programs should include:

Training in early developmental milestones

Awareness of neuro-developmental conditions

Classroom management strategies

Communication skills for parent discussions

Mental health awareness

Well-informed teachers are more confident in identifying concerns and initiating conversations.

Investment in training benefits both staff and students.

Educational policy frameworks increasingly emphasize inclusive education and early intervention.

Institutions should establish:

- ✓ Clear developmental observation protocols
- ✓ Referral guidelines
- ✓ Confidential documentation procedures
- ✓ Parent communication standards
- ✓ Accountability ensures consistency.
- ✓ Schools that adopt structured policies demonstrate commitment to child welfare.

Developmental differences are not moral failures. There are variations in neurological development. Schools can reduce stigma by:

- ✓ Conducting awareness programs
- ✓ Promoting empathy education

- ✓ Encouraging acceptance of diversity
- ✓ Highlighting strengths alongside challenges

When developmental concerns are normalized as part of human diversity, families are more willing to seek support.

Education must remain child-centred. A child-centred philosophy values holistic development, recognizes individual differences, prioritizes well-being over competition, encourages collaboration, and embraces inclusion.

The measure of an institution's success is not merely academic ranking but the quality of support provided to every learner.

Long-Term Benefits of Responsible Identification:

Schools that communicate openly and support developmental needs:

Strengthen parent trust

Improve classroom environments

Enhance student outcomes

Build inclusive reputations

Contribute positively to society

Early identification reduces long-term challenges.

Proactive support reflects institutional integrity.

A child's developmental journey should never be compromised by fear, denial, competition, or institutional hesitation.

Educational institutions hold a powerful and privileged position in children's lives. With this position comes responsibility—to observe carefully, communicate honestly, and act compassionately.

Transparent dialogue, ethical decision-making, and collaborative intervention safeguard children's futures.

The focus must always remain on the child, not reputation, enrolment numbers, or external pressures.

When schools choose honesty over avoidance and partnership over silence,
they honour their true mission: nurturing human potential.

Child welfare must always come first.

Chapter Seventeen – The Impact of Excessive Mobile Use on Child Development

In today's digital era, mobile phones have become an inseparable part of daily life. From communication and work to entertainment and education, digital devices dominate modern routines. While technology has brought undeniable convenience, its excessive use among young children has emerged as a growing developmental concern worldwide.

Many parents introduce mobile phones to children at an early age as a practical solution. Devices are used to feed children, calm tantrums, prevent boredom, or keep them quiet in social settings. What begins as a short-term strategy often becomes a daily habit. Over time, dependence on digital screens may interfere with critical developmental processes.

Early childhood is a sensitive and foundational period for brain growth. During this stage, children require rich sensory experiences, face-to-face interaction, physical movement, and emotional bonding. Replacing these essential experiences with prolonged screen exposure can disrupt natural developmental pathways.

This chapter examines how excessive mobile use affects speech, cognitive development, emotional regulation, behaviour, social interaction, and physical health and highlights the importance of responsible digital habits.

The first five years of life represent a period of extraordinary brain plasticity. Neural connections form rapidly in response to environmental stimulation. Experiences during this period shape attention, language, memory, emotional control, and problem-solving skills.

Healthy brain development depends on:

Face-to-face interaction

Eye contact

Responsive communication

Physical exploration

Sensory experiences

Play-based learning

When a caregiver responds to a child's vocalizations or gestures, neural pathways strengthen. This process, often referred to as "serve and return" interaction, is fundamental to cognitive and emotional growth.

Mobile screens provide stimulation but not meaningful interaction. A screen does not adjust emotionally to a child's needs, interpret subtle cues, or engage in reciprocal communication. Passive consumption of digital content does not activate the same neural networks as human engagement.

Excessive screen exposure during early childhood may reduce opportunities for active learning and sensory integration, both of which are critical for long-term development.

Language develops through social interaction. Children learn to speak by listening, observing facial expressions, imitating sounds, and participating in back-and-forth communication.

When a child spends excessive time watching mobile content:

Verbal interaction decreases

Opportunities for imitation are reduced

Conversational turn-taking is limited

Vocabulary exposure becomes passive

Expressive language development slows

Unlike caregivers, screens do not wait for responses or encourage dialogue. Even educational videos cannot replace live communication.

Research indicates that young children who experience high levels of screen exposure may demonstrate delayed expressive language skills. Reduced eye

contact and limited engagement during device use can further affect social communication.

Speech develops through practice and interaction. Without sufficient real-life conversation, language acquisition may be compromised.

Mobile devices often present rapidly changing images, bright colours, and fast-paced stimulation. While this may capture a child's attention temporarily, it may also condition the brain to expect constant novelty.

Excessive screen exposure has been associated with:

Reduced attention span

Difficulty concentrating on slower-paced activities

Increased distractibility

Challenges in following instructions

Delayed executive functioning skills

Executive functions, including impulse control, working memory, and cognitive flexibility, develop through problem-solving and active play. Passive screen viewing does not adequately stimulate these processes.

Children who become accustomed to highly stimulating digital content may struggle with classroom environments that require sustained attention and patience.

Emotional regulation is learned through experience. Children develop coping skills when caregivers guide them through frustration, disappointment, and excitement.

When mobile devices are frequently used to stop crying or prevent tantrums, children may not learn internal regulation skills. Instead, they may associate emotional discomfort with immediate digital distraction.

Consequences may include:

Increased irritability when devices are removed

Low frustration tolerance

Frequent tantrums

Dependency on screens for calming

Difficulty managing boredom

Over time, digital dependency can resemble behavioural addiction patterns. While not identical to substance addiction, excessive screen reliance may alter reward pathways in the brain.

Emotional resilience develops when children experience manageable challenges and receive supportive guidance, not when discomfort is consistently avoided through digital distraction.

Human interaction forms the foundation of social competence. Through play and conversation, children learn empathy, cooperation, negotiation, and conflict resolution.

Traditional childhood experiences such as:

Outdoor play

Group games

Storytelling

Family conversations

Observing adult behaviour

contribute significantly to social maturity.

When screen time replaces these experiences, children may:

- ✓ Show reduced eye contact
- ✓ Demonstrate limited peer interaction
- ✓ Struggle with turn-taking
- ✓ Prefer solitary digital engagement
- ✓ Exhibit difficulty interpreting social cues

Feeding a child with a mobile device eliminates opportunities for shared conversation and bonding. Mealtime should be a space for communication

and relationship building. When screens dominate, relational development weakens.

Social skills cannot be downloaded; they must be practiced.

One common justification for early mobile exposure is feeding convenience. Parents often state, “Without a mobile phone, my child refuses to eat.”

However, feeding with digital distraction may disrupt:

Hunger and satiety recognition

Mindful eating habits

Self-feeding skills

Emotional connection during meals

When a child eats while focused on a screen, awareness of taste, texture, and fullness decreases. Over time, this may interfere with healthy eating patterns.

In earlier generations, feeding involved storytelling, playful encouragement, and family interaction. Although feeding sometimes required patience, it supported communication and bonding.

Mobile phones may simplify feeding temporarily, but they may weaken self-regulation and relational experiences in the long term.

Adequate sleep is essential for memory consolidation, emotional stability, and physical growth. Excessive screen exposure, particularly before bedtime, can disrupt sleep cycles.

Blue light emitted from screens suppresses melatonin production, delaying sleep onset. Poor sleep may result in:

Daytime irritability

Reduced concentration

Hyperactivity

Mood fluctuations

Additional physical health concerns include:

Eye strain

Reduced blinking

Neck and posture problems

Sedentary behaviour

Increased obesity risk

Physical play supports motor development, bone strength, coordination, and cardiovascular health. Excessive mobile use reduces opportunities for movement.

While mobile use does not directly cause neuro-developmental disorders, excessive screen exposure may mimic or intensify certain behaviours.

Children exposed to prolonged screen time may demonstrate:

Reduced social engagement

Language delays

Hyperactivity

Repetitive viewing patterns

These behaviours may overlap with developmental concerns such as attention difficulties or social communication challenges. Professional assessment is necessary to differentiate cause from correlation.

Responsible digital habits are particularly important for children already at developmental risk.

Professional organizations generally recommend:

Under 2 years: Avoid screen exposure, except for supervised video calls

2–5 years: Limit to approximately one hour per day of high-quality content

Avoid screens during meals

Avoid screens at least one hour before bedtime

Ensure parental supervision and discussion

The quality of content and context of use are as important as duration.

Screens should never replace human interaction.

Parents serve as role models. Children observe adult behaviour closely. When caregivers frequently use mobile devices during family time, children internalize this pattern.

Healthy digital habits include:

Creating device-free zones (such as dining areas)

Scheduling screen-free family time

Encouraging outdoor play

Reading books regularly

Engaging in conversation during daily routines

Allowing boredom to stimulate creativity

Limiting screen exposure does not mean rejecting technology. Rather, it involves mindful and balanced usage.

Children require attention, not constant entertainment.

Replacing screen time with enriching experiences strengthens development.

Alternatives include:

Storytelling sessions

Music and singing

Art and drawing

Building blocks

Pretend play

Outdoor exploration

Sports activities

These experiences stimulate imagination, coordination, language, and social interaction.

Unstructured play fosters creativity and independent thinking—skills which are essential for lifelong success.

Excessive mobile use during early childhood may influence long-term outcomes, including:

Academic performance

Emotional resilience

Social competence

Physical health

Behavioural regulation

Habits established during early childhood often persist into adolescence. Encouraging balanced digital habits early reduces the likelihood of problematic media use later.

Development is cumulative. Small daily choices shape future outcomes.

Mobile phones are powerful tools, but they are not substitutes for human interaction. Excessive and unregulated use during early childhood can interfere with speech development, cognitive growth, emotional regulation, social skills, and physical health.

The early years establish the foundation for learning, behaviour, and personality. Replacing real-world experiences with digital screens may weaken that foundation.

Parents and caregivers must recognize that convenience today should not compromise development tomorrow. Responsible technology use, combined with rich human interaction, supports healthy growth.

Healthy habits begin at home. Balanced guidance today ensures stronger developmental outcomes in the future.

Chapter Eighteen – My Vision for the Next 10 Years: A Promise to Tripura and Beyond

My dream is simple, but it is not small. I do not dream of buildings alone.

I do not dream of numbers alone. I do not dream of fame.

I dream of standing beside every parent in Tripura who feels confused, afraid, or alone after hearing the word autism.

I dream of building systems where no parent has to search blindly for help.

I dream of centres where children are treated with dignity.

I dream of transparency that builds trust, not doubt.

Today, our New Hope team has grown to 40 committed members. Each individual carries more than professional responsibility; they carry emotional accountability. We are not simply therapists, coordinators, or administrators, we are partners in families' journeys.

We are not just running a centre. We are building trust. And trust, once broken, is difficult to rebuild. That is why I believe it must be protected from the beginning.

From the first day, I asked myself one question: Why should transparency be optional in autism care?

Parents hand over their most precious responsibility—their child—to a therapy centre for several hours a week. They deserve clarity about what happens inside those rooms.

At our centre, we introduced live CCTV viewing facilities. Parents can observe therapy sessions through a TV screen system. They are not forced to imagine what is happening. They are not required to rely only on verbal reports. They can see.

This does not mean interfering with therapy. It means accountability.

Transparency changes the atmosphere. It creates:

Parental confidence

Therapist responsibility

Structured professionalism

Emotional reassurance

When parents see progress, they feel hopeful.

When they see challenges, they understand them realistically.

When they see effort, they feel respected.

Why should this not be standard practice everywhere?

When you demand higher standards, resistance appears. Some centre owners do not appreciate the push toward transparency. Some interpret it as criticism. Some perceive it as competition. A few may even attempt to undermine your reputation.

But I have learned something important:

If you challenge mediocrity, mediocrity fights back.

My intention is not to attack anyone. My intention is to raise the bar.

If other centres are doing excellent work, why not showcase it openly? Why not give parents confidence? Why not strengthen the entire ecosystem?

The real issue is not competition; it is comfort.

Some systems become comfortable with “average.” But when children’s futures are involved, average is not enough.

I am not fighting individuals.

I am fighting secrecy.

I am fighting complacency.

I am fighting systems that forget that children come first.

There are moments when standing firm feels lonely. Advocacy often requires isolation before it receives acceptance.

But I ask myself one honest question:

What do I love more: approval or the future of these children?

The answer is always clear.

I love their future more than I fear criticism.

When that clarity exists, opposition becomes smaller.

Autism is not a trend.

It is not a temporary issue.

It is a lifelong condition requiring structured support, awareness, and dignity.

If we compromise standards today, children pay the price tomorrow.

I am not comfortable with that.

New Hope began as a centre. It has now become a vision.

With 40 team members, we have already built a multidisciplinary approach—structured therapy, emotional commitment, and transparent practice. But this is only the beginning.

My vision is not limited to one city.

Tripura deserves world-class standards.

India deserves accessible, ethical autism care.

And the world needs scalable, transparent models.

Autism is not regional. It is global.

The challenges parents face in Tripura are similar to those faced in Delhi, Mumbai, London, or New York—confusion, stigma, misinformation, and inconsistent service quality.

If we can build a model rooted in:

Transparency

Accountability

Structured intervention

Continuous training

Emotional empathy

Then that model can grow beyond geographical boundaries.

Expansion does not mean multiplying buildings. It means multiplying standards.

In the next ten years, I envision:

Training more therapists

Establishing structured certification programs

Creating mentorship systems

Encouraging ethical practice guidelines

Integrating technology responsibly

Quality must expand alongside quantity.

An autism centre without trained professionals is a room.

An autism centre with trained professionals is a life-changing environment.

We must build people first.

Leadership alone cannot create a movement. A team transforms vision into reality.

Dr Naisha has stood beside me through every challenge. In moments of doubt, she says something simple yet powerful:

“You keep moving forward. Whether others stand beside you or not—I am with you.”

Support like this strengthens resilience.

Leadership requires belief. But it also requires companionship.

And then there is Jaya.

She works in a stable government position. One day, she said to me, “I will leave my job for you.”

I asked her why she would consider such a step.

Her answer was not about salary or security.

She said, “Because you are fighting autism—not only for Tripura, but for the world.”

When someone is willing to sacrifice stability for a mission, you realize the mission is larger than yourself.

Movements are not built on infrastructure.

They are built on conviction.

The coming decade will not be easy. Growth always attracts scrutiny.

There will be criticism, resistance, misinterpretation, institutional obstacles, and policy challenges.

But there will also be progress.

My roadmap for the next ten years includes:

- Expanding transparent centres - Every new centre must maintain visibility and accountability.
- Creating parent education programs - Parents must understand autism, therapy goals, and home-based strategies.
- Establishing professional training modules - Therapists require ongoing development and supervision.
- Collaborating with schools - Inclusive education must become stronger and more structured.
- Advocating for policy awareness - Government and policymakers must prioritize early intervention systems.
- Encouraging research and data collection - Evidence-based practice strengthens credibility.

Vision without structure becomes imagination. Vision with structure becomes impact.

- From Tripura to India - Tripura is my starting point, not my boundary. Small states often receive limited resources and attention. Yet, children here deserve the same quality of support available in metropolitan cities. I want autism support in Tripura to become a benchmark, not an afterthought. When parents across India hear about Tripura, I want them to say: “That is where standards changed.” Growth must be strategic, sustainable, and ethical. Rapid expansion without quality control weakens credibility. Therefore, expansion must follow principles, not popularity.
- From India to the World - Autism does not recognize borders. Cultural contexts differ, but developmental principles remain consistent. If New Hope can demonstrate transparent therapy models, parent-inclusive systems, structured documentation, and ethical accountability, then international collaboration becomes possible.

The dream is not to dominate markets.

The dream is to standardize integrity.

Global presence must represent global responsibility.

- Redefining Competition

Competition in healthcare and therapy sectors can be destructive when it prioritizes numbers over quality.

My approach is different.

I am not competing against centres.

I am competing against mediocrity.

I am competing against opacity.

I am competing against low expectations.

If all centres raise their standards, children win.

The goal is collective elevation, not individual dominance.

- A Movement, Not Just an Organization

With 40 team members today and many more in the future, New Hope represents more than employment.

It represents belief. It represents accountability. It represents the refusal to compromise when children's futures are involved.

Movements are built when:

Standards remain consistent.

Values remain firm.

Leadership remains transparent.

Teams remain united.

I envision a time when families say:

"Autism support in Tripura changed because someone refused to lower standards."

That sentence alone would justify every challenge.

- Preparing for Challenges

Optimism must be realistic.

The next decade will require:

Financial planning

Human resource development

Emotional resilience

Legal awareness.

Community engagement.

Criticism will not disappear. It may increase.

But criticism often signals visibility. And visibility creates an opportunity for dialogue.

As long as our focus remains child-centred, we remain grounded.

- A Personal Commitment

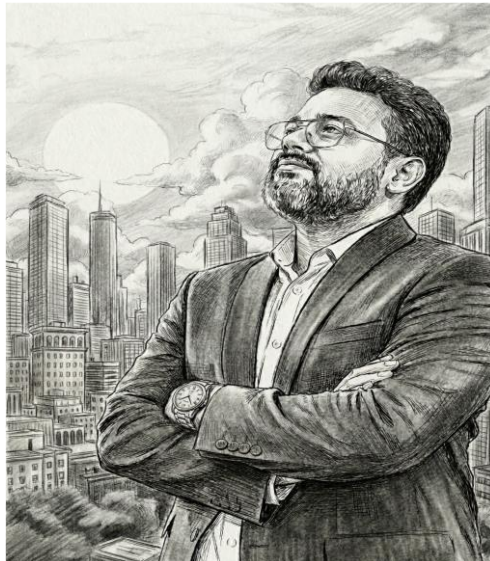
This vision is not built on ambition alone. It is built on responsibility.

I have seen parents cry in uncertainty. I have seen children misunderstood. I have seen potential hidden behind lack of support. These experiences shape commitment. Leadership in developmental care is not about authority. It is about accountability. I am accountable to the children, the parents, and the professionals who trust this vision.

The future generation requires courage and accountability. A promise forward--the journey ahead will test strength. There will be resistance. There will be attempts to slow momentum. There will be disagreement. But there will also be more trained professionals, more transparent centres, more aware parents, and more confident children.

New Hope is not merely an institution. It is a promise. A promise to Tripura. A promise to India. A promise to every family seeking dignity and structured support.

From Tripura to India and from India to the world, the movement continues. And I am ready.



Chapter Nineteen – Event Diaries

SYANDAN-44

অর্থ, বিভিন্ন প্রকল্প বাস্তবায়নের লক্ষ্যে সময়ে সময়ে লগ্নির তালিকে প্রদান করে কেন্দ্রীয় সরকার। লগ্নির তালিকাতে একটা নির্দিষ্ট সময়ের মধ্যে প্রদত্ত অর্থবাণী স্বরূপ করে প্রকল্পের বাস্তবায়ন ঘটতে হয়। কিন্তু বিভিন্ন সময়ে বেশা যাহ নানাবিধ কারণে নির্ধারিত সময়ে টাকা ব্যয় করতে পারেনা লগ্নির তালিকা। সেফেরে প্রদত্ত টাকা কেন্দ্রকে ফেরত দিতে হয়। এবার এই ব্যবস্থার কিছুটা পরিবর্তনের দাবি জানিয়ে সংসদে প্রস্তাব রাখলেন পশ্চিম ত্রিপুরার সাবেক বিধায়ক কুমার বে। বিভিন্ন প্রকল্প থেকে অব্যাহিত অর্থবাণী নির্ধারিত সময়ের পর ফেরতের কারণে উত্তর-পূর্বাঞ্চলীয় রাজ্যগুলির ক্ষেত্রে বিভিন্ন প্রকল্পের মাধ্যমে ব্যবহারের দাবিতে লোকসভায়

অবতরণ করেন সাংসদ বিজয় কুমার বে। সংসদে বিজয় কুমার বেকে আশঙ্ক করে উত্তর-পূর্বাঞ্চল উন্নয়ন মন্ত্রী জ্যোতিবাবিন্দা এম সিংহিয়া জানান, কেন্দ্রীয় ৫৪টি মন্ত্রণালয়ের অধীনে ১০ শতাংশ গ্রস ব্যাজেটের সাপোর্ট (জিবিএস) সমস্ত কার্যবিধির উপরে নজর রাখে। উত্তর পূর্বাঞ্চলীয় রাজ্য গুলির সার্বিক বিকাশে একটি সম্মিলিত প্রচেষ্টা থাকে কেন্দ্রীয় সরকারের। বিগত ৩ বছরে কেন্দ্রীয় সরকারের ৫৪টি লগ্নির বরাদ্দ পরিচালনায় থেকে স্পষ্ট যে উত্তর পূর্বাঞ্চলের ক্ষেত্রে ১০৬ শতাংশ অর্থিক বিনিয়োগ করা হয়ে গেছে। তিনি আরও জানান, প্রধানমন্ত্রী নরেন্দ্র মোদীর লিখ নিদেশনায় উত্তর পূর্বাঞ্চলের কল্যাণে শুধুয়ে ডেনার মঞ্জুর নয়, সমগ্র কেন্দ্রীয় সরকার এই

শুধু নয়, আরও অতিরিক্ত বিনিয়োগের লক্ষ্যে ইতিমধ্যেই উত্তর পূর্বাঞ্চলের সার্বিক উন্নয়নে কাজ করছে। দুই দশক তুলে ধরে তিনি বলেন, বিগত অর্থ বছরে ৫৪টি মন্ত্রকের ৫১ হাজার কোটির ব্যাজেট ছিল, কিন্তু ব্যয় করা হয়েছে ১ লক্ষ ২ হাজার ৩৭৪ কোটি। এব থেকেই প্রমাণিত টাচিং পূর্ণ করাই শুধু নয়, এর অতিরিক্ত বরাদ্দের বিশাল কাজ করছে কেন্দ্রীয় সরকার। তবে কেন্দ্রীয় মন্ত্রী দাবি অনুযায়ী সব কাজই যদি সময়ে হয়ে থাকে বা বরাদ্দকৃত অর্থবাণীর সবটাই যদি ব্যয় হয়ে থাকে তবে কি সংসদের প্রস্তাব অযৌক্তিক। না জেনেই কি সংসদ এ ধরনের দাবি জানানো, শুধু রাজনৈতিক বিশ্লেষণে মনোযোগ



বুধবার "বিশ্ব অজিজন দিবস" উদযাপন উপলক্ষ্যে আয়োজিত কর্মসূচিতে উপস্থিত শিশু বিশেষজ্ঞ ডা. নীলরতন মল্লিকদার। ছবিঃ নিজস্ব





New HOPE

7 Apr 2025 · 🌐

On World Health Day, Tripura Institute of Paramedical Sciences have extended their support to New Hope in the form of Souvenir distribution. We express our heartfelt gratefulness to the team from TIPS for visiting our unit ,recognising our initiative and supporting us.



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Presence of Padma Shri Dipa Karmakar, a true legend in gymnastics in
World Disability Day at New Hope

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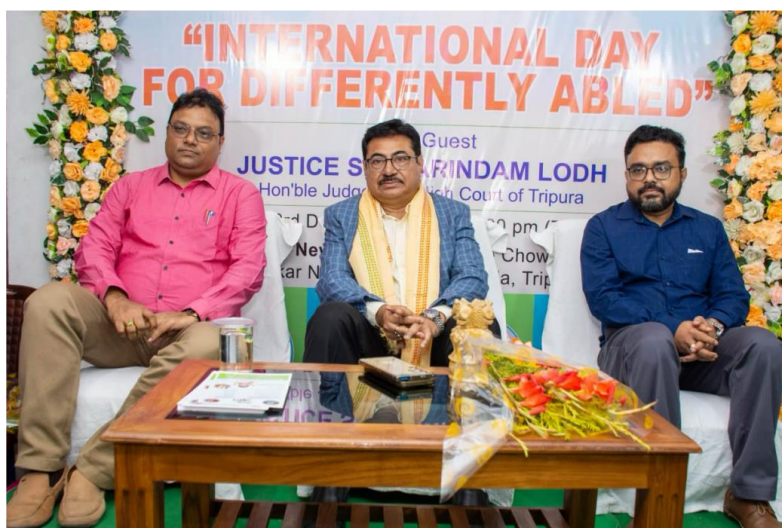
চা-বাগানটি রাজ্য সরকার অধিগ্রহণ
করার ফলে বাগানের প্রায় ৯০০
ভোটার কর্মহীন হয়ে পড়েছেন।
বাগানটি বর্তমানে পরিভ্রমণ
অবস্থায় রয়েছে।

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অভিযোগের ফলস্বরূপ মামলা
চলানো হয়। তদন্তকারী অফিসার করা
হয় ইজপেক্টর অপর্ণা দেবনাথকে।
মোকদ্দমটির দায়িত্ব হাতে পাওয়ার

শিক্ষামূলক ভ্রমণ



সান্দন প্রতিনিধি, আগরতলা, ৯ নভেম্বর।। শনিবার আগরতলার নিউ
হোপ মাল্টিডিসিপ্লিনারি রিহাবি-লিটেশান সেন্টারের এর পক্ষ থেকে
স্কুলের শিশুদের নিয়ে একটি শিক্ষামূলক ভ্রমণে আগরতলা রাজবাড়ি নিয়ে
যাওয়া হয়। শিশুদের মানসিক বিকাশে অনেকটাই সহায়তা করবে।
পাশাপাশি শিশুদের মনোস্তাত্ত্বিক পরিবর্তনেও সাহায্য করবে। শিশু ও
অভিভাবকরা এই ভ্রমণ খুব আনন্দের সহিত করেছে। এখানে তারা সমস্ত
ত্রিপুরার নানা ঐতিহাসিক জিনিস পরিদর্শন করেছে। প্রতিষ্ঠানের পক্ষ থেকে
বলা হয়, আগামীদিনে এই ধরনের শিক্ষামূলক ভ্রমণ আরও করা হবে।



Presence of Chief Justice of Tripura High Court and other dignitaries on International Day for Differently Disabled People at New Hope.



Presence of Senior Paediatrician Dr Nilratan Majumder on awareness program regarding Autism with New Hope.





Respected Director General of Police (DGP) Sri Anurag Dhankar Sir sharing his valuable time with our autistic children and presenting gifts to them.



Lecture on early-stage identification of intellectual disability in children program at group centre CRPF, Agartala. The program was graced by Chief Guest Smt. Preeti Rajput, President, W/o Shri Y. K. Rajput, DIGP, GC CRPF Agartala. Other honoured guests included Smt. Sudha Sandwar, Vice President; Shri Hardeep Kumar, Secretary; and Smt. Neha Chaudhury, Honorary Treasurer.



A memory with our team and children



Distribution of certificates at Annual Day Program



Campus recruitment for Speech Therapist at AYJNISHD, Banahoo gly, Kolkata



Educational tour at Tripura State Museum



Drawing competition at New Hope

Acknowledgments

I am so grateful to all the people in my life and the New Hope Team who have decided to be around me and encourage me to do what God wants me to do.

Thank you to my wife for her constant support through all my ups and downs. Thank you to my near and dear friends and partners for encouraging me to put my life journey into this book.

Thank you to my son for giving me the inspiration to think about autism.

Thank you to my Mom and Dad for believing in me and my potential.

Thank you to my publishers for your guidance and timely help.

And lastly, I would like to thank all the parents and people who have been part of my journey and believed in me. Their support has shaped the person I am today.

Thank you, God, for this beautiful life, and the glory belongs to you alone.

About the Author

Dr (Hon.) Sukanta Nath Bhowmik is an educationist, social entrepreneur, and child development advocate dedicated to transforming the lives of children with special needs.

He holds an MBA from Visva-Bharati University, a Central University in Santiniketan, West Bengal, and has completed Strategic Management studies from the Indian Institute of Management, Kashipur. His academic journey further includes specialized training in supporting children with special needs from AGM Institute, as well as certification in Managing ADHD, Autism, Learning Disabilities, and Concussion in Schools from the University of Colorado.

He is currently pursuing an Executive Diploma in Child Psychology from the Centre for Health Management and Research Institute, Government of India.

Dr Bhowmik is the Founder and Secretary of AWS (NGO) and the driving force behind multiple educational and healthcare initiatives. He is the Founder and Director of SHRC LLP, SI Pvt. Ltd., Sukanta Foundation, NEW HOPE, and Sukanta International School. He is also the proprietor of Sree Industry.

Through NEW HOPE, he has been actively working in the field of autism, ADHD, and learning disabilities, with an upcoming international expansion of the NEW HOPE Autism Unit in Qatar and Singapore. His ongoing vision includes the establishment of NEW HOPE College, aimed at creating inclusive higher education opportunities.

Driven by personal experience, professional expertise, and an unwavering mission, Dr Bhowmik continues to advocate for awareness, inclusion, and structured intervention for children with neuro-developmental differences. His work reflects a lifelong commitment to building a society where every child is understood, supported, and empowered to thrive.