Volume I, Issue V
5th August, 2025

NEURODIVERGENT TIMES

Monthly Magazine on Neurodivergence

" A Publication from Holding Hope
Centre for Speech & Hearing"

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Neurodivergent Times
Magazine!

We are excited to announce Neurodivergent Times – a magazine dedicated to amplifying voices, sharing experiences, and addressing the challenges faced by the neurodivergent

WE INVITE

SCHOOLS, ADVOCATES, PARENTS, HEALTHCARE PROFESSIONALS, NEURODIVERGENT INDIVIDUALS

to contribute articles on any issue, perspective, or solution related to neurodiversity. Your insights can educate, inspire, and create meaningful change!

■ Send your submissions to: goswamineha9348@gmail.com

Let’s work together to build awareness, acceptance, and support for the neurodivergent community.
Your words can make a difference!

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EDITORIAL

Therapy Is Not a Shortcut —It's a Journey

At Holding Hope Centre for Speech & Hearing, we celebrate every child's progress—whether it's a new word spoken, a new movement learned, or a new skill mastered in class. But as professionals committed to long-term developmental outcomes, we often encounter a disheartening pattern: parents discontinuing therapy after just a glimpse of improvement. Or, in some cases, switching therapists too quickly when progress appears "too slow."

We understand that therapy is a financial, emotional, and time-intensive commitment. And it's natural for parents to want quick, visible results—especially when they're investing so much. However, we must ask: Are we evaluating therapy through the lens of long-term developmental goals, or only short-term gratification?

The Allure of "Quick Fixes"

In many cases, a child begins therapy and shows early signs of improvement—perhaps clearer speech sounds, better attention, or more coordinated motor responses. At this point, some parents feel the job is done. They pull the child out of therapy, thinking, "He's improved. Why continue spending money?" Others, expecting rapid change, grow frustrated when improvements are incremental. They may switch therapists or centres prematurely, believing, "Maybe someone else can fix this faster." In doing so, they unknowingly disrupt a therapeutic relationship built on trust, understanding, and consistency.

The Reality of Neurodevelopmental Progress

The truth is,therapy is rarely linear. Especially for children with developmental delays, autism, cerebral palsy, or speech-language disorders, progress can be slow, uneven, and sometimes invisible in the short term. But under the surface, critical neural rewiring is taking place. Small improvements today—like following a two-step command, sustaining attention for ten minutes, or imitating a new sound—lay the foundation for larger developmental leaps in the future.

Discontinuing therapy too soon can undo this foundational work. Children may regress, plateau, or develop compensatory behaviors that are harder to address later. Therapy, much like education, builds on itself—it requires time, patience, and consistency.

When Is a Change Warranted?

Of course, there are genuine situations where a change in therapist may be necessary—if the child is not comfortable, if the approach isn't suited to the child's needs, or if there is a breakdown in communication with the professional. In such cases, seeking a second opinion or exploring another approach is completely valid.

However, decisions should be made with clinical insight, not frustration, and always in partnership with your child's therapy team. Therapists are not miracle workers—they are facilitators of growth. And growth, by its nature, takes time.

The Financial Perspective

Therapy is indeed a financial investment, and families deserve transparency and accountability in how it delivers value. But therapy is also an investment in your child's independence, academic readiness, and social-emotional wellbeing. Discontinuing therapy after minor improvements may save short-term costs, but could lead to higher long-term needs—in education, behavior management, or even medical care.

In Conclusion: Therapy Is a Marathon, Not a Sprint

We urge our parent community to reframe how they view therapy: not as a temporary service to "fix" a child, but as an ongoing support system that helps the child thrive at their own pace.

Every child deserves the chance to reach their potential—not just to show improvement, but to sustain and build upon it. Let us walk this journey together—with trust, patience, and commitment.

-Editorial Board
Neurodivergent Times

Autism and Multidisciplinary team work

Dr.Pooja Singh Tomar

A multidisciplinary team plays a vital role in supporting individuals with Autism Spectrum Disorder (ASD). The team typically includes early interventionist, occupational therapists, speech-language pathologist, paediatrician, physical therapists, psychologists, paediatric rehabilitation specialist (combined approach of PT and OT), special educators and Vocational trainers.

Occupational Therapists:
They help individuals with ASD with various techniques that includes sensory integration, primitive reflex integration, neuro developmental approach, gross and fine motor skills development, motor planning, oral motor stimulations for feeding issues and developing daily living skills like feeding, dressing, grooming etc. They also help in evaluating child's sensory, motor and cognitive abilities using various assessment tools. OTs also recommends adaptive equipment or technology for sensory-motor needs.

Speech-Language Pathologist (SLP'S):
Focus on improving communication skills, including speech, language, and social interaction. They use techniques like augmentative and alternative communication (AAC) devices, picture communication symbols to support individuals with autism who struggle with verbal and non-verbal communication. Speech-language pathologists work on social skills training, such as initiating and maintaining conversations, understanding social cues, and developing relationship required for social life.

Medical Practitioners:
Developmental Paediatricians, Neurologist help in recovering from symptoms like hyperactivity, sleep disorder, gastro-intestinal issues, anxiety and depression. Diet can be modified with the help of Nutritionist/ Dietician.

Physical Therapists:
They work on gross motor skills and strengthening required for activities like walking, running etc. and improves balance, and coordination.

Psychologists:
Theyprovide behavioural support and counselling and provides behavioural interventions, such as Applied Behaviour Analysis (ABA). Behavioural therapists also use CBT approach to improve behaviour and thought process for symptoms like tantrums or self-injurious behaviour. They perform various assessments to understand child's cognitive and chronological age and performance.

Special Educators:
They develop and implement individualized education plans (IEPs) to enhance academic and functional skills, such as reading, writing, and social skills.

Vocational Trainers:
They play a crucial role in supporting individuals with autism spectrum disorder (ASD) in developing skills for employment. They provide particular job skills training according to person's capabilities, workplace adaptation, career exploration and soft skills development for team work. Vocational trainers focus on developing essential skills, such as communication and work-related management. By providing these services, vocational trainers can help individuals with ASD achieve employment goals, gain independence, and build confidence in their abilities.

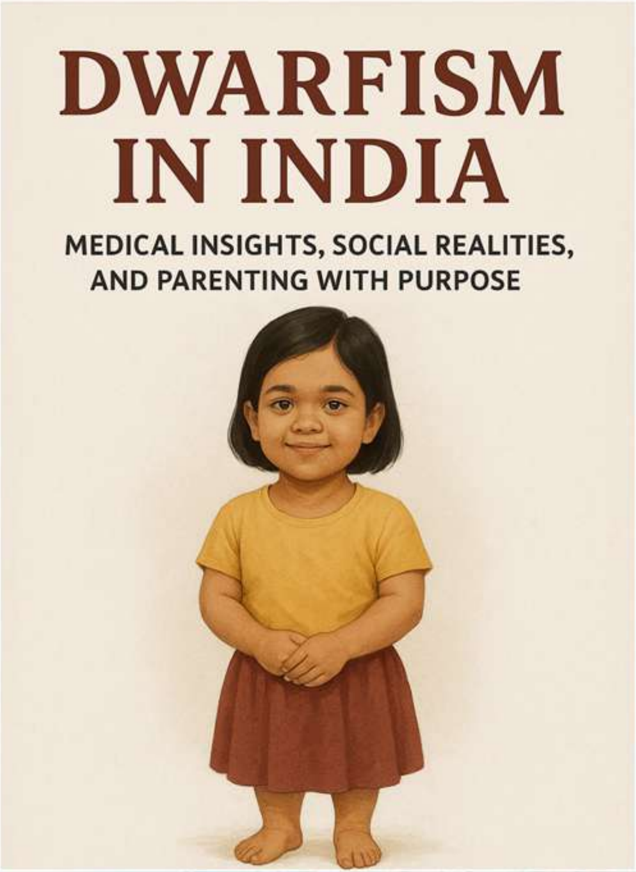
Rehabilitation teams may work with individuals with autism and their families to develop transition plans from high school to post-secondary education or employment. Therapists may work with parents to develop strategies for supporting their child's communication, social, and behavioural development.

Together, the rehabilitation team provides comprehensive support to help individuals with ASD enhance their quality of life.

Dwarfism in India:

Medical Insights, Social Realities, and Parenting with Purpose

Dr.Sudeshna Goswami



DWARFISM IN INDIA

MEDICAL INSIGHTS, SOCIAL REALITIES, AND PARENTING WITH PURPOSE

Dwarfism, a condition characterized by short stature due to genetic, hormonal, or medical reasons, affects thousands of individuals across India. While the medical understanding of dwarfism continues to evolve, societal awareness and acceptance often lag far behind. In India's diverse and often traditional cultural landscape, dwarfism presents a unique set of challenges and opportunities that span across healthcare, social inclusion, education, and family life.

Understanding Dwarfism in the Indian Context

Dwarfism is typically defined as an adult height of 4 feet 10 inches (147 cm) or shorter due to a medical condition. The most common cause is achondroplasia, a genetic disorder affecting bone growth. Other types include spondyloepiphyseal dysplasia, diastrophic dysplasia, and growth hormone deficiency. Turner syndrome, which affects females, is also a known contributor.

In India, late diagnosis is common, especially in rural areas where specialized pediatric endocrinology and genetic counseling services are limited. Many cases are initially misattributed to poor nutrition or delayed growth, leading to missed windows for early intervention. Diagnostic confirmation may involve genetic testing, hormonal assessments, and imaging studies such as X-rays or MRI.

While growth hormone therapy is available in India and can be effective in certain conditions like Turner syndrome and growth hormone deficiency, it has no significant benefit in most skeletal dysplasias. Access to this therapy is also limited by cost, which can be prohibitive for many families.

Therapeutic and Rehabilitative Support

Effective management of dwarfism requires a multidisciplinary approach. Physical therapy plays a critical role in improving strength, balance, and mobility. Occupational therapy helps individuals navigate everyday environments that are not designed for shorter stature—offering adaptations for clothing, kitchen use, and school or workplace furniture.

Surgical intervention may be required for spinal issues, bowed legs, or other orthopedic complications. Although limb-lengthening surgeries are available, they are complex, controversial, and not medically necessary in most cases.

Unfortunately, pediatric rehabilitation services are unevenly distributed in India. While some metro cities have advanced child development and orthopediccenters, smaller towns and rural areas often rely on general physicians with limited training in genetic or developmental conditions. As a result, therapy is often delayed or inconsistent, impacting long-term outcomes.

Social Stigma and Cultural Misconceptions

In India, societal attitudes toward individuals with dwarfism are heavily influenced by deep-seated myths and misconceptions. Dwarfism may be wrongly associated with karmic punishment or bad omens in some communities. People with dwarfism are often subjected to name-calling, ridicule, or treated as comic figures in media and public life.

The Indian entertainment industry has historically played a damaging role in reinforcing stereotypes. Characters with dwarfism are rarely seen in serious roles or depicted as professionals, students, or parents. Instead, they are frequently used for visual humor or as sidekicks—further marginalizing their social standing.

These attitudes filter down to everyday life. Children with dwarfism may face bullying at school, exclusion from peer groups, or lowered academic expectations. Adults often encounter discrimination in employment, with assumptions made about their physical or intellectual abilities. Basic infrastructure—such as public transportation, restrooms, and workplace furniture—is often inaccessible or unsafe.

Legal Protections and Policy Framework

India's Rights of Persons with Disabilities (RPWD) Act, 2016 recognizes dwarfism as a benchmark disability. This inclusion provides individuals the right to obtain a disability certificate and access various government benefits including education and job reservations, transportation concessions, and income tax rebates.

However, awareness of these provisions is low, and implementation remains uneven. Many eligible individuals remain unaware of their rights or are discouraged by bureaucratic red tape. Disability inclusion is still an emerging concept in India, and true accessibility—physical, educational, or social—requires systemic change across sectors.

Parenting a Child with Dwarfism in India

For parents, receiving a diagnosis of dwarfism in their child can be emotionally complex. In India, where extended families often play a strong role in child-rearing, parents may face pressure, stigma, or unsolicited advice based on superstition rather than science.

Early and accurate information is key. Parents are encouraged to consult specialists such as developmental pediatricians, pediatric endocrinologists, and occupational therapists. Developmental delays may occur, but many children with dwarfism have normal intellectual abilities and can thrive in inclusive educational environments.

Building self-esteem is critical. Parents should avoid using labels or pet names that reinforce size as a defining trait. Celebrate the child's interests, abilities, and unique personality. Schools should be made aware of the child's condition, with requests for appropriate accommodations such as lower benches, accessible toilets, and exemption from physically strenuous activities.

Open conversations within the family are essential to counter shame or silence. Grandparents and relatives must be sensitized to avoid pity or overprotection, which can hinder independence. Encouraging the child to participate in sports, arts, or social clubs fosters inclusion and self-confidence.

Connecting with support groups like the Little People of India can provide families with guidance, resources, and a sense of belonging. These groups often organize conferences, skill-building workshops, and community events that affirm identity and offer practical coping strategies.

Building an Inclusive India

Progress for individuals with dwarfism in India requires a shift in both policy and perception. Media must move beyond stereotypes and showcase diverse stories of success and resilience. Public and private institutions should adopt universal design principles to ensure accessibility for all body types and physical abilities. Schools and workplaces need inclusive policies, awareness training, and monitoring systems to prevent discrimination. Medical and paramedical education should include content on genetic disorders and disability-sensitive practices.

Ultimately, dwarfism should not be viewed solely through the lens of medical treatment. It is a lifelong condition with social, psychological, and identity implications. With early intervention, loving support, and systemic change, individuals with dwarfism can lead empowered, fulfilling lives.

Conclusion

In India, addressing dwarfism goes beyond genetics or growth charts. It demands empathy, education, and equity. From parenting a child with love and dignity to advocating for policy implementation, every step counts. The goal is not to "fix" the person but to fix the systems and mindsets that limit them. By reshaping narratives and making society more accessible, we create a country where height is not a barrier to humanity, opportunity, or respect.

Dr. Michael Ain:

A Trailblazing Orthopedic Surgeon

by Debashis Borpuzari

Introduction

Dr. Michael Craig Ain, a renowned pediatricorthopedic surgeon, stands as a beacon of resilience and achievement. Born with achondroplasia, the most common form of dwarfism, Dr. Ain faced significant barriers in his journey to become a leading figure at Johns Hopkins Hospital in Baltimore, Maryland. Standing at 4 feet 3 inches, he overcame rejection from multiple medical schools and societal prejudices to become one of the few doctors with dwarfism in the United States, specializing in skeletal dysplasias. This article explores his life, career, and lasting impact on medicine and society.

Early Life and Challenges

Born in 1962 in a middle-class Jewish family, Dr. Ain grew up with achondroplasia, a genetic condition characterized by short limbs, an average-sized torso, and an enlarged head. His early experiences as a patient, including time spent in a body cast, sparked an interest in medicine. However, pursuing this dream was fraught with obstacles. Dr. Ain applied to 20 to 30 medical schools, candidly disclosing his condition in each application, stating, “Because I am [a little person], it shaped me.” Despite his academic qualifications, he faced repeated rejections, with interviewers expressing doubts about his ability to reach patients’ bedsides, his physical strength, or his capacity to earn respect from peers and patients.

Undeterred, Dr. Ain persisted. After initial rejections, he was accepted into Albany Medical College in New York, graduating in 1989. His determination carried him through a transitional internship at the University of California, Irvine (1989–1990), a year in a pediatrics residency in California, and a five-year orthopedic surgery residency at Albany Medical Center (1990–1995).

Career and Contributions

Dr. Ain’s career took a pivotal turn when he joined Johns Hopkins Hospital in 1995 as a full-time surgeon, later becoming an Associate Professor of Orthopaedic Surgery and Neurological Surgery, as well as Director of the Residency Training Program in the Department of Orthopedic Surgery. Initially, he aimed to specialize in hand and joint surgery, but a transformative moment came when he learned he had inspired a family with a child who had achondroplasia. This experience led him to focus on skeletal dysplasias, conditions affecting bone growth, including achondroplasia.

As one of the few orthopedic surgeons with dwarfism, Dr. Ain brought a unique perspective to his practice. He spent about 20% of his time treating children of short stature, addressing conditions like scoliosis, bone fractures, and joint issues. His expertise extended to procedures such as spinal arthrodesis for thoracolumbar kyphosis in pediatricachondroplasia and total hip arthroplasty in skeletal dysplasias. His research contributions include publications on medical malpractice in pediatricorthopedics, external fixation for cervical spine injuries, and spinal decompression in achondroplastic patients, enhancing treatment protocols for these conditions.

Patients praised Dr. Ain for his empathy, humor, and straightforward approach. One patient, who underwent surgery for a broken femur in 2000, credited him with exceptional care, while another with scoliosis appreciated his ability to preserve spinal flexibility during surgery.

His office at 601 N. Caroline St., Baltimore, was a hub for patients seeking specialized care, and his affiliation with Johns Hopkins Medical Institute solidified his reputation as a top-tier surgeon.

Overcoming Adversity

Dr. Ain's path was marked by resilience. After being denied entry to two orthopedic surgery residencies, he continued to advocate for himself, eventually securing a fellowship at Johns Hopkins, where the orthopedic surgery department was expanding its focus on skeletal dysplasias. His ability to confront ableism head-on—addressing concerns about his height with practical solutions, such as using a step-stool in the operating room—demonstrated his capability and determination.

Social media discussions on platforms like Reddit highlight public admiration for his perseverance, with users noting the injustice of his initial rejections and celebrating his success as a rebuke to ableist biases.

Dr. Ain's story resonates beyond medicine. He became a role model for others with dwarfism, including a Western High School student who cited him as an inspiration in 2019. His visibility challenged stereotypes, proving that physical stature does not limit professional excellence.

Legacy and Impact

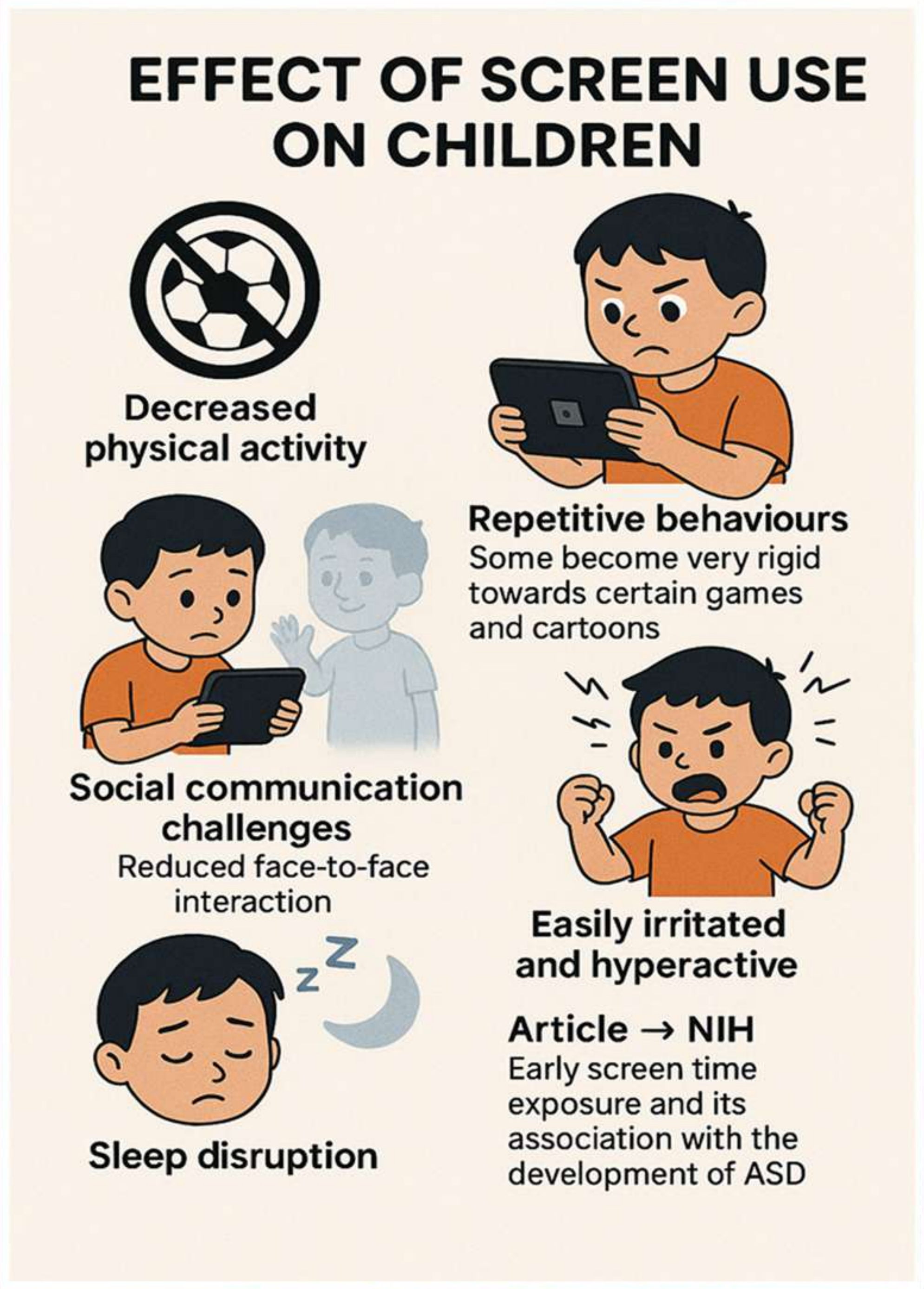
Dr. Ain's contributions extend beyond his surgical practice. By excelling in a physically demanding field, he shattered misconceptions about what individuals with dwarfism can achieve. His work at Johns Hopkins helped elevate the institution's reputation as a leader in treating skeletal dysplasias. His publications, co-authored with colleagues like Adam Margalit and Jaysson T. Brooks, have advanced the understanding of pediatricorthopedic conditions, benefiting both patients and practitioners.

Conclusion

Dr. Michael Ain's journey from facing rejection to becoming a leading orthopedic surgeon at Johns Hopkins Hospital is a powerful narrative of overcoming adversity. His expertise in skeletal dysplasias, coupled with his personal experience with achondroplasia, made him a uniquely empathetic and skilled physician. Through his work, he not only transformed lives but also challenged societal prejudices, proving that determination and talent transcend physical limitations. Dr. Ain's legacy continues to inspire medical professionals and individuals with dwarfism alike, reminding us that the sky is indeed "big enough for us all."

Effect of Screen Use on Children

By Dr.Shafqat Ashraf



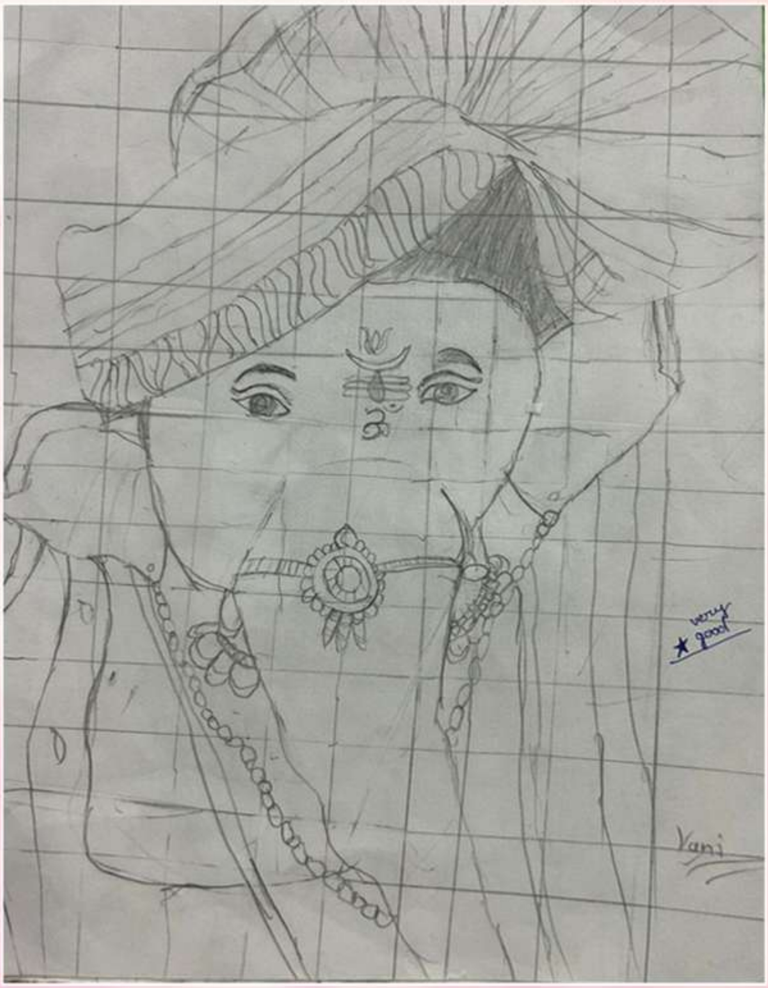
- ***Decreased physical activity.***
- ***Repetitive behaviours: Some people become very rigid towards certain games and cartoons, and show less interest in other activities.***
- ***Social communication challenges: A child with excessive screen time may show reduced face-to-face interaction; they often don't want to get socially involved.***
- ***A child who has more screen time can become easily irritated and hyperactive.***
- ***There is sleep disruption; the sleep pattern also becomes very disturbed.***
- ***Article → NIH: Early screen time exposure and its association with the development of ASD.***
- ***There are three studies that reported this relationship between early exposure to different screens and the risk of developing ASD. These studies found that early exposure to screens is associated with an increased risk of developing ASD compared to those who are never exposed or are exposed later in life.***
- ***This may be because, at a younger age, the brain is more prone to genetic variables that affect development later—unlike in a 3-year-old, where the brain has already achieved some developmental milestones.***
- ***Lin et al., a study that examined the risk of neurodevelopmental conditions in relation to screen exposure, found that early exposure leads to sleep disturbances among those children.***

Vani: The God’s Child

Sandhya Devi, Special Educator

Meet Vani, a 13 yr old artist with a unique spark! Despite facing challenges with cerebral palsy & stammering, Vani’s talents shine bright. Her portraits breathe life with precision and passion. Yeah, she makes generally God’s portraits and that’s shows she is truly a God child. Academics may not be her strength, but art is her canvas. Vani’s observation skills and understanding make her a keen learner. Her determination & creativity inspire us all. Vani’s story celebrates individuality, resilience& the power of inclusion. Let’s embrace her differences & recognise the beauty in her uniqueness. Vani’s journey reminds us that everyone has a special gift & with support anyone can achieve their dreams.


**
Vani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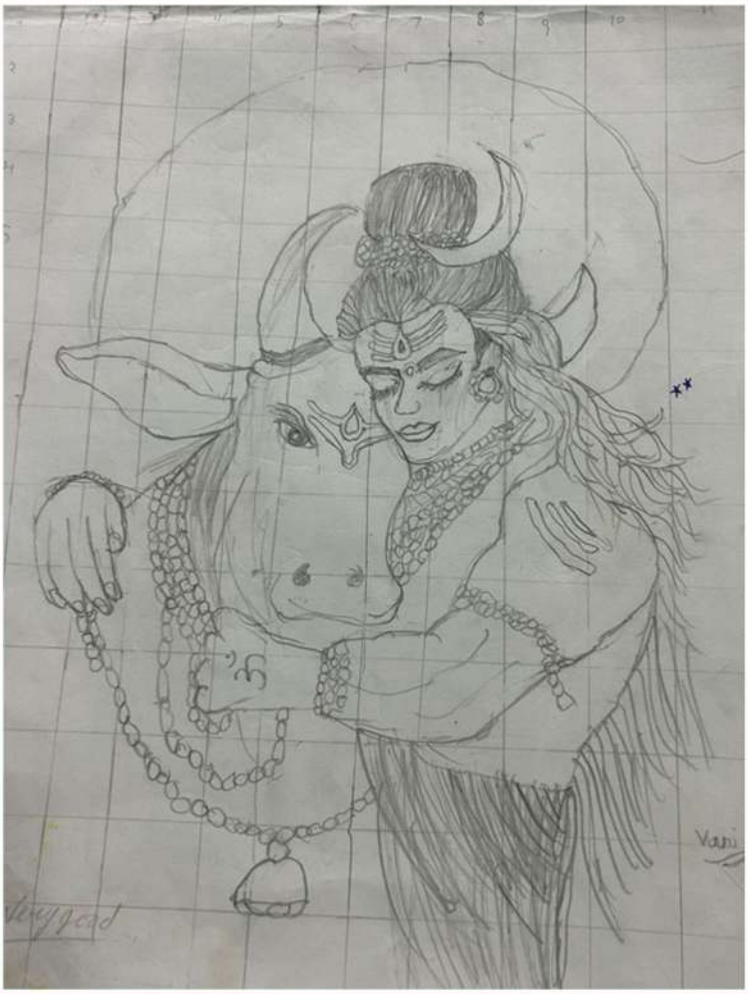
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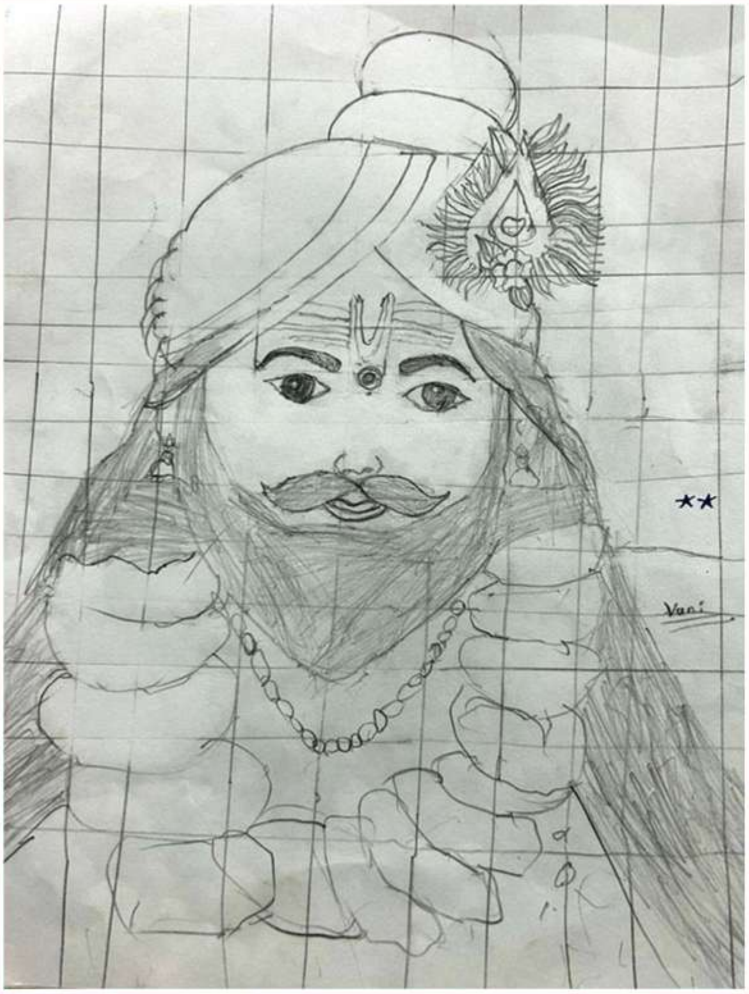
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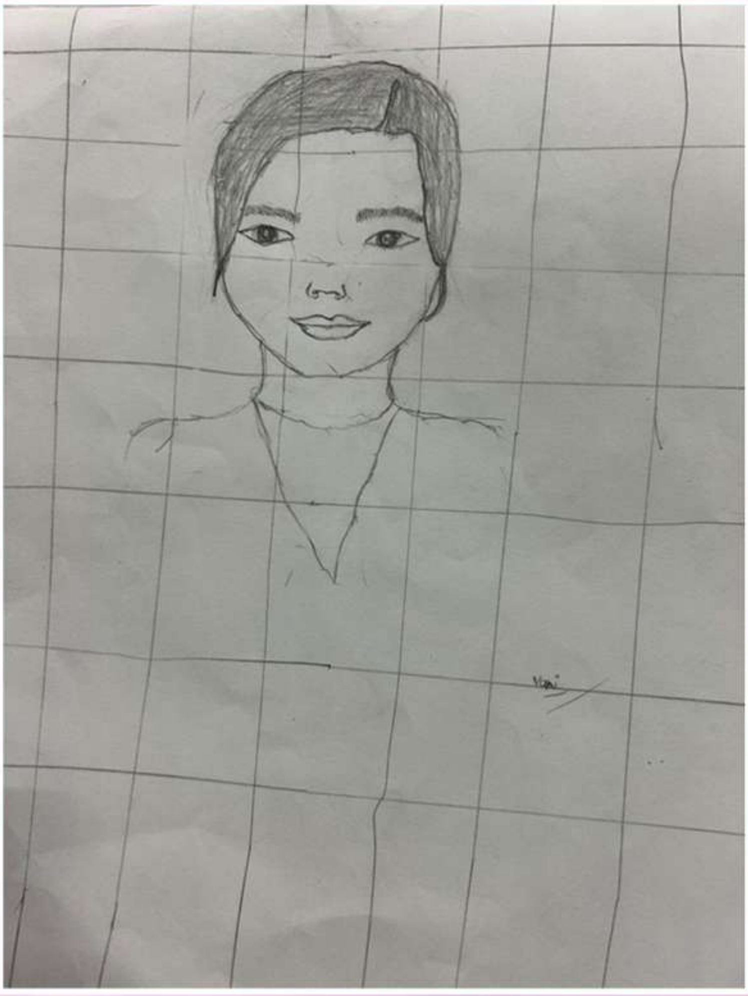
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