INTERNATIONAL RESEARCH JOURNAL OF MANAGEMENT SOCIOLOGY & HUMANITIES



ISSN 2277 – 9809 (online)
ISSN 2348 - 9359 (Print)

An Internationally Indexed Peer Reviewed & Refereed Journal

www.IRJMSH.com
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Published by iSaRa Solutions

"The study of psycho-medico mentally challenges and physical challenge child parents"

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INTRODUCTION

A psycho-medico, or child and adolescent psychiatrist, is a medical doctor who specializes in the mental health of children and adolescents. They can diagnose and treat a wide range of mental health conditions, including: Anxiety disorders Depression Attention deficit hyperactivity disorder (ADHD) obsessive-compulsive disorder (OCD) Image of Child with Depression Opens in a new window post-traumatic stress disorder (PTSD) Eating disorders Psychotic disorders.

A physically disabled child is a child who has a physical impairment that limits their ability to perform certain activities. Physical disabilities can range from mild to severe, and they can be congenital (present at birth) or acquired (developed later in life). Some common types of physical disabilities include: Cerebral palsy, Spina bifida Muscular, dystrophy Arthritis Amputation.

How a Psycho-Medico Can Help a Physically Disabled Child

A psycho-medico can help a physically disabled child in a number of ways, including: Helping the child to cope with the emotional challenges of their disability, Teaching the child coping mechanisms for dealing with stress, anxiety, and depression Helping the child to develop a positive self-image Improving the child's social skills Working with the child's family to provide support and education.

The Role of a Psycho-Medico:

Children are constantly navigating a complex world, and those with physical disabilities face additional challenges. A psycho-medico, also known as a child and adolescent psychiatrist, plays a crucial role in supporting these young individuals. They possess a unique skillset that bridges the gap between mental health and physical well-being. Here's what makes a psycho-medico special for physically disabled children: Understanding the Intersection: Unlike a general psychiatrist, a psycho-medico has a deep understanding of child development, factoring in the emotional and social aspects influenced by a physical disability. They can assess how the disability interacts with typical childhood challenges like anxiety, depression, or social interaction. Treating the Whole Child: A psycho-medico doesn't just address mental health concerns. They consider the physical limitations and how they might contribute to emotional difficulties. This holistic approach ensures treatment addresses the specific needs of the child. Collaboration: Psycho-medicos often collaborate with other professionals, like physical therapists, occupational therapists, and pediatricians. This collaborative approach creates a Comprehensive support system for the child, ensuring various health aspects are addressed in unison. Physical Disabilities and Mental Health:

Children with physical disabilities are more susceptible to experiencing mental health challenges. Here's why: Pain Management: Chronic pain associated with some disabilities can lead to anxiety, depression, and difficulty sleeping. Social Isolation: Physical limitations might hinder participation in activities and social interactions. This can lead to feelings of isolation and loneliness. Frustration and Low Self-Esteem: Difficulty performing everyday tasks due to the disability can cause frustration leading to low self-esteem and anger management difficulties.

How Psycho-Medico Care Helps: Empowerment and Coping Mechanisms: Psycho-medicos equip children with coping mechanisms to manage emotional challenges related to their disability. This could involve relaxation techniques, cognitive-behavioral therapy (CBT) to address negative thoughts, or social skills training. Self-Image and Body Positivity: A psycho-medico can help the child develop a positive self-image and accept their body. This can involve focusing on abilities and strengths instead of limitations. Family Support: The psycho-medico can also work with families to provide support and education. This empowers parents and caregivers to better understand the child's needs and create a positive and supportive environment.

Operational Definition

Hysteria-Hysteria is a term used to describe a temporary state of mind or emotion. It can also refer to behavior that exhibits an overwhelming or unmanageable fear or emotional excess. For example, someone who responds in a way that seems disproportionately emotional for the situation might be described as being "hysterical". Hysteria can also refer to a psychoneurosis marked by emotional excitability and disturbances of the psychogenic, sensory, vasomotor, and visceral functions.

Neurasthenia- The term neurasthenia has a long history, and before Freud was essentially an amorphous concept covering all neurotic disorders. It remains a diagnosis in ICD-10 to describe a syndrome of chronic fatigue. In DSM-IV, however, chronic fatigue enjoys no special status and simply falls into the residual category of undifferentiated somatoform disorder (with fatigue as the symptom).

Anxiety neurosis- Anxiety neurosis is a mild mental illness that causes extreme distress and agitation, often without an obvious cause. Symptoms include: Repeatedly reliving trauma in dreams or intrusive memories A feeling of numbness and emotional blunting

Reactive depression- Reactive depression, also known as situational depression, is a less severe, temporary type of depression that can arise from a specific life situation. In modern diagnostic language, this is technically called a "stress response syndrome".

Obsessions and compulsions-Obsessions and compulsions are both parts of obsessive-compulsive disorder (OCD). Obsessions are unwanted, repetitive thoughts, images, or urges that cause anxiety, disgust, or unease. They can also be stress-inducing and persist despite efforts to ignore or confront them. Compulsions are repetitive behaviors or mental acts that people with OCD feel they need to do to temporarily relieve the unpleasant feelings brought on by the obsessive thought. Compulsions can be mental or physical responses or behaviors to obsessions. For example, a person may have intrusive thoughts about germs or contamination. In response, they

may feel the urge to wash their hands unnecessarily. In this case, the thoughts are the obsession, while the handwashing is the compulsion.

OCD is due to genetic and hereditary factors. Chemical, structural, and functional abnormalities in the brain are the cause.

SIGNIFICANCE OF THE STUDY:

Working at a government hospital, I've witnessed the pervasive worry and stress among parents of physically disabled children. This prompted me to consider researching the anxiety and hysteria experienced by parents of both mentally and physically challenged children. The study aims to explore factors contributing to parental distress, including the daily care giving demands, navigating healthcare systems, financial strain, and societal stigma. It will assess the psychological toll, examining symptoms like chronic worry, panic attacks, and sleep disturbances. Additionally, the research will identify coping strategies utilized by parents, such as seeking social support and engaging in self-care. Ultimately, by shedding light on the mental health challenges faced by these parents, the study seeks to advocate for more comprehensive support services and foster a more compassionate healthcare environment.

J Ben Thabet 1, R Sallemi, I Hasïri, (2012) Care for a child with a disability is a stressful experience for parents. It triggers a range of emotions and feelings that require a set of behaviors and attitudes to manage daily life. To face this situation, parents use coping strategies. The purpose of this study was to assess the psychological reactions (depression and anxiety) of parents and the impact of a child's disability on their quality of life (QOL), and to determine their coping strategies. A survey of 50 parents of handicapped children, treated in the neurology department at the Sfax Teaching Hospital in Tunisia, was conducted in September 2010. The Beck Depression Inventory (BDI), the State Trait Anxiety Inventory (STAI), the SF-36, and the Brief COPE were used to assess, respectively, depression, anxiety, QOL, and coping strategies in parents. Among the group of parents studied, the anxiety and depression rates were, respectively, 68% and 52%. Depression was more frequent among mothers and was correlated with low educational and socioeconomic levels. Anxiety was found in 70.7% of mothers and 55.6% of fathers with no significant correlation. There was a correlation between anxiety and increased family burden related to the presence of a similar case in the family. The range of coping strategies used includes religion (16%), active coping (16%), planning (16%), acceptance (20%), focus and venting of feelings (10%), and seeking emotional social support (10%). Parents used emotion-focused coping in 68% of cases and problem-centered coping in 32% of cases. The coping strategy choice was significantly correlated with gender. Mothers preferentially used emotion-focused coping. Depressed or anxious parents more frequently used emotion-focused strategies. Religious faith was correlated with a strategy centered on religious coping. The length of follow-up (more than 2years) was correlated with a strategy focused on acceptance. Emotion-focused coping was also correlated with low levels of education and socioeconomic status. We found correlations between depression and different types of emotion-focused coping such as emotional support. Impaired QOL was higher among mothers (58.5% versus 33.3%). It was correlated with depression, anxiety,

and the use of emotional coping. Also, it was correlated with low educational and socioeconomic levels and increased family burden related to the presence of a similar case in the family. The size most commonly impaired in mothers was limited due to mental health (56.9% versus 44.4% for fathers). Social functioning (D6) was significantly correlated with the presence of a mental disability, the functional dependence of the child, and increased family burden related.to the presence of a similar case in the family. Impaired QOL was found in 66.8% of parents dissatisfied with the explanations given by the medical team. More problem-focused coping was found in parents satisfied with the information given by the medical team compared to those inadequately informed (42.1% versus 25.8%). The presence of a disabled child causes profound changes in the family. The impact of anxiety and depression on parents and on their QOL are considerable. This is a situation that involves an adaptation process. At first, parents may be tempted to use coping strategies focused on religion, a choice related to Arab-Muslim fatalism. Parents should be encouraged to use active coping strategies to support their disabled child better. In addition, adequate information given by the healthcare staff would help them to deal with the child's handicap and would contribute to improving their QOL.

Jan L. Wallander, James W. Varni, Lina Babani, etl (1988) Advances in biomedical science have resulted in dramatic improvements in the medical care of chronically ill and handicapped children. Past measurement problems have resulted in a lack of clarity regarding the psychological adjustment of these children. The mothers of 270 chronically ill and handicapped children were administered the Child Behavior Checklist in an attempt to identify patterns of behavioral functioning across six pediatric chronic disorders: juvenile diabetes, spina bifida, hemophilia, chronic obesity, juvenile rheumatoid arthritis, and cerebral palsy. In general, it was found that children in all chronic disorder groups were perceived by their mothers as evidencing on the average more behavioral and social competence problems than expected based on norms for children in general. However, their behavioral and social adjustment was reported as better than that of a normative sample of children referred to mental health clinics. There were essentially no differences between children with different chronic disorders in terms of behavior problems and social competence. The results were taken to support the view that these children were as a group at risk for adjustment problems. They were also discussed in terms of the noncategorial approach, which suggests that similar psychosocial challenges are faced across pediatric chronic physical disorders.

Wind, William M. MD; Schwend, Richard M. MD; Larson, Judy (March 2004.) Participation in sports is important for the physical and emotional health of the physically challenged child. Sports can improve strength, endurance, and cardiopulmonary fitness while providing companionship, a sense of achievement, and heightened self-esteem. With interest in such participation increasing, it is necessary for the physicians, therapists, and families of children with special needs to understand the preparticipation evaluation, athletic options, specialized equipment, and sportspecific risks. Recommendations that provide guidelines for safe, effective participation in sports are currently available for common congenital and developmental

disabilities such as Down syndrome, cerebral palsy, myelodysplasia, hemophilia, congenital amputations, and arthritic disorders.

Author links open overlay panel NAOMI BRESLAU PH.D. etl (1985) Psychiatric disorder in 304 children with four congenital conditions was compared with that of 360 normal children and across conditions, three that involve the brain and one that does not. Children with physical disability were at increased risk for psychiatric disturbance. Those with conditions involving the brain had greater psychopathology than children with cystic fibrosis. Severity of physical disability had little effect on psychopathology. The risk of psychiatric disturbance in children with conditions involving the brain varied directly with level of mental retardation. In addition, brain involvement conferred a risk of social isolation independent of mental retardation. The unique feature of severe psychopathology secondary to physical disorder was marked social isolation accompanied by a low level of aggressive behavior outside the home.

Thomas Reinehr, Prof. Dr. med., Michael Dobe etl A total of 38 relevant articles were identified. All studies agreed that the prevalence of overweight and obesity in children with disabilities was almost twice that in their non-disabled peers. No effective, long-lasting interventions for obesity in disabled children and adolescents have been published.

Since a high proportion of disabled children and adolescents are overweight or obese, effective strategies for preventing and managing excess weight need to be developed so as not to further endanger their social participation. Moreover, risk factors for overweight in disabled children and adolescents should be identified and their weight status carefully monitored. Children and adolescents with neuromuscular and neurological disorders often have eating disorders in the sense of underweight and malnutrition, especially if these are associated with problems in chewing and swallowing (e1– e3). This article aims to find out whether children and adolescents with disabilities are also often overweight (1). The authors conducted a literature search using the search terms "(children /OR/ adolescents) /AND/ disability /AND/ (overweight/OR/ obesity)". The literature search aimed to describe overweight in children and explain the available therapeutic options. Of 140 hits in the search, 24 articles dealt with the subject matter under investigation (14 review articles, 6 prevalence studies, 3 articles on the sequelae of obesity in patients with disabilities, and 1 article on treatment). The literature search was complemented by selected literature from specialty journals in the fields of pediatrics, neurology, and obesity (1 review article, 5 prevalence studies, 4 on the sequelae of obesity in people with disabilities, 4 on therapeutic approaches).

METHODOLOGY

AIM OF THE STUDY

To study the difference in Hysteria, Anxiety, Neurasthenia, Reactive depression, OCD in physically disable children than in Intellectual children.

OBJECTIVIES

1. To Study Hysteria among Mentally challenge and physically challenge child parents
2. To Study Neurasthenia among Mentally challenge and physically challenge child parents

3. To Study Anxiety Neurosis among Mentally challenge and physically challenge child parents
4. To Study Reactive Depressive among Mentally challenge and physically challenge child Parents
5. To Study obsession compulsions Disorder among Mentally challenge and physically challenge child Parents
6. To Study Psycho Medico among Mentally challenge and physically challenge child Parents

HYPOTHESIS

1. There will be significant difference between mentally challenge and physically challenge child parents on Hysteria
2. There will be significant difference between mentally challenge & physical challenge child parents on Neurasthenia.
3. here will be significant difference between mentally Challenge and physical challenge child parents on Anxiety Neurosis
4. There will be significant difference between mentally Challenge & physical challenge child parents on Reactive Depressive
5. There will be significant difference between mentally challenge & physical challenge child parents on obsession compulsions
6. There will be significant difference between mentally challenge physical challenge child parents on psycho medico

SAMPLE DESIGN

parents		
Mentally challenge	Physically challenge	TOTAL
30	30	60

Data collection: - Purposive sampling method is used for data collection from Maharashtra state. The total sample was 60, Mentally challenge child parents 30 Physically challenge child parents 30

Sampling Method – Purposive sampling method

TOOLS:

The test of psycho medico The Medico-Psychological Questionnaire (MPQ) is a standardized psychological assessment tool developed by Dr. J. Bharat Raj in 1992. It is designed to identify neurotic trends and general psychological distress in the general population. Structure: Consists of 50 self-administered items. Time to Complete: Typically takes about 15 minutes. Target Age Group: Suitable for adults (generally ages 17 to 57). Core Domains: Evaluates five major neurotic dimensions: Obsessive-compulsive traits, Reactive depression, Anxiety neurosis, Neurasthenia (chronic fatigue and weakness), Hysteria.

Reliability: The reliability of MPQ has been obtained by the test-retest reliability method. A group of 25 college students studying at the All-India Institute of Speech and Hearing were given the test and subsequently, the same group was given the test after a gap of one year. The obtained scores on two occasions were correlated. The correlations turned out to be+0.71, the value being significant at .06 and at 01 levels of probability. However, the reliability has to be worked out on much larger groups with intervals to be more certain about the reliability of the test. Split half method of reliability has not been worked out.

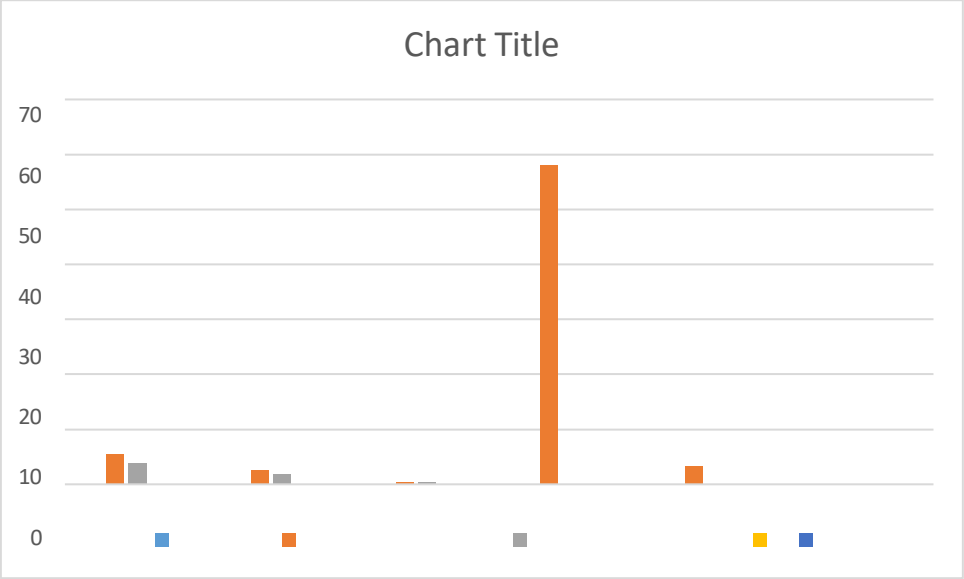
Validity: The earlier use of a test in the psychology Department in the clinical appraisal where the clinical appraisal where the clinical Impression obtained of neurotics were corroborated with independent test administration had pointed out that the test would be valid. Administering the Eysenck Personality Inventory and the Medico-Psychological Questionnaire to a group of 120 normal, the obtained scores on the two tests were correlated. The value of the correlation turned out to be + 0.68, being significant at the .05 and 0.1 levels of probability. This points out the good validity of the test.

STATISTICAL ANALYSIS

HYPOTHESIS 1.

1. There will be significant difference between mentally challenge and physically challenge child parents on Hysteria

Hysteria	N	Mean	Std. Deviation	Std. Error Mean	Df	t	Significant
Mentally challenge	30	5.60	2.581	.471	58	3.20	.05
Physically challenge	30	3.87	1.795	.328			

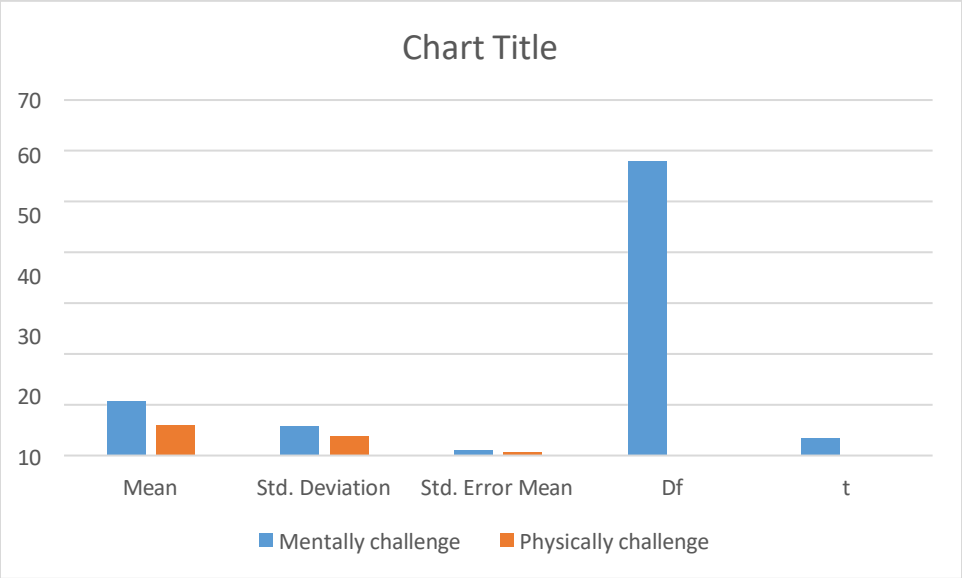


The Mean for Hysteria in Mentally Challenge Parents is 5.60 while for physically Challenge Parents is 3.87. SD is 2.581 and 1.795 and t Score is 3.20. There is Significant difference in Hysteria among Mentally Challenge and Physically Challenge child parents.

HYPOTHESIS 2.

There will be significant difference between mentally Challenge and physical challenge child parents on Anxiety Neurosis

Anxiety	N	Mean	Std. Deviation	Std. Error Mean	Df	t	Significant
Mentally challenge	30	10.60	5.787	1.057	58	3.576	.05
Physically challenge	30	6.10	3.745	.684			

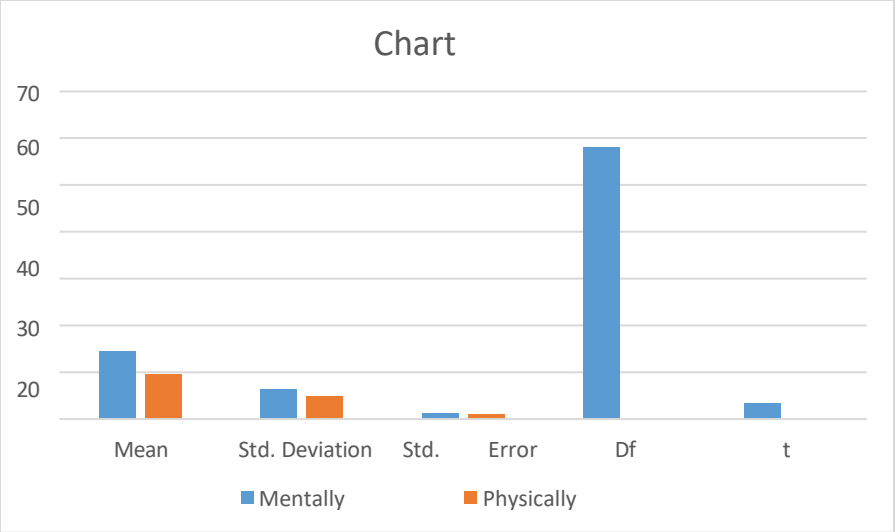


The Mean for Anxiety Neurosis in Mentally Challenge Parents is 10.60 while for physically Challenge Parents is 6.10. SD is 5.787 and 3.745 and t Score is 3.576. There is Significant difference in Anxiety Neurosis among Mentally Challenge and Physically Challenge child parents.

HYPOTHESIS 3.

There will be significant difference between mentally challenge & physical challenge child parents on Neurasthenia.

Neurasthenia	N	Mean	Std. Deviation	Std. Error Mean	Df	t	Significant
Mentally challenge	30	14.50	6.458	1.179	58	3.369	.05
Physically challenge	30	9.53	4.848	.885			

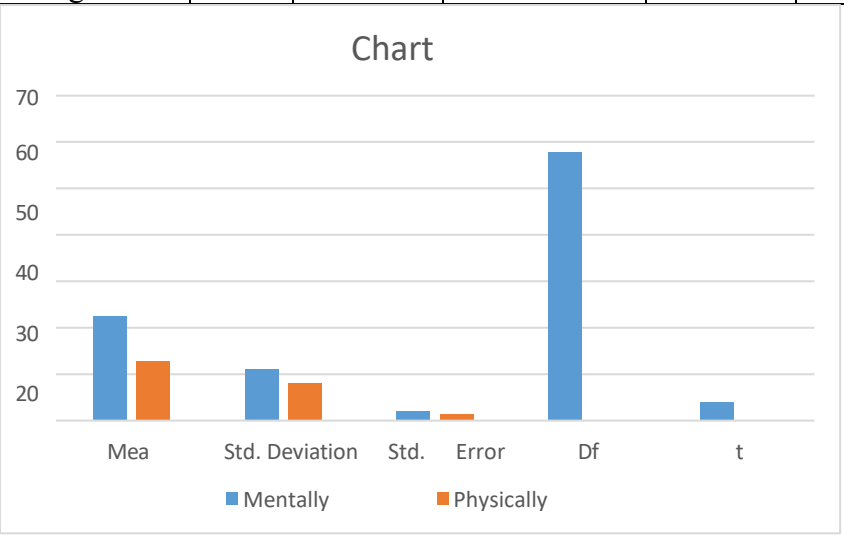


The Mean for Neurasthenia in Mentally Challenge Parents is 14.50 while for physically Challenge Parents is 9.53. SD is 6.458 and 4.848 and t Score is 3.369. There is Significant difference in Neurasthenia among Mentally Challenge and Physically Challenge child parents.

HYPOTHESIS 4.

There will be significant difference between mentally Challenge & physical challenge child parents on Reactive Depressive

Reactive depression	N	Mean	Std. Deviation	Std. Error Mean	Df	t	Significant
Mentally challenge	30	22.57	11.082	2.023	58	3.921	.01
Physically challenge	30	12.80	7.959	1.453			

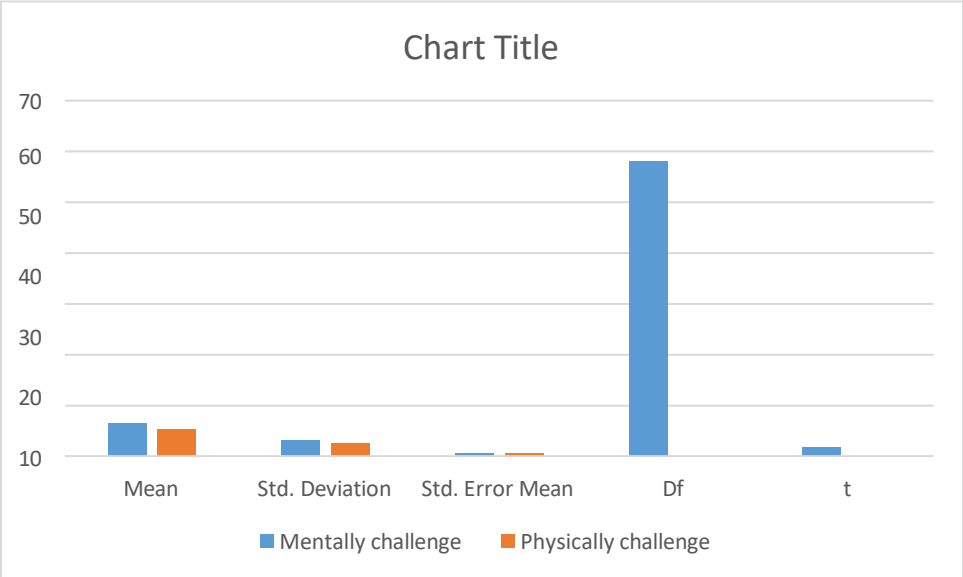


The Mean for Reactive depression in Mentally Challenge Parents is 22.57 while for physically Challenge Parents is 12.80. SD is 11.082 and 7.959 and t Score is 3.921. There is Significant difference in Neurasthenia among Mentally Challenge and Physically Challenge child parents.

HYPOTHESIS 5.

There will be significant difference between mentally challenge & physical challenge child parents on obsession compulsions.

OCD	N	Mean	Std. Deviation	Std. Error Mean	Df	t	Significant
Mentally challenge	30	6.43	3.115	.569	58	1.656	NS
Physically challenge	30	5.23	2.459	.449			

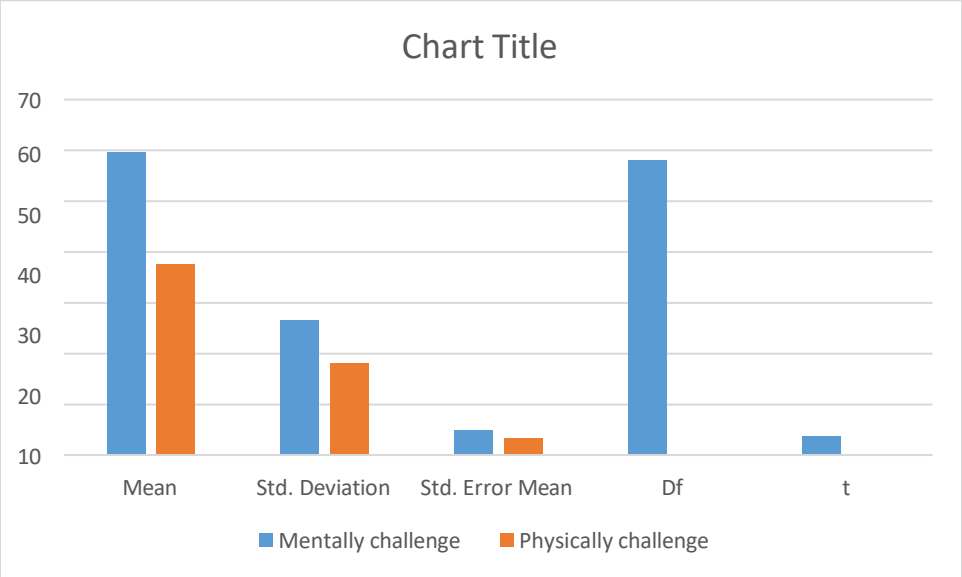


The Mean for obsession compulsions in Mentally Challenge Parents is 6.43 while for physically Challenge Parents is 5.23. SD is 3.115 and 2.459 and t Score is 1.656. There is no Significant difference in obsession compulsions among Mentally Challenge and Physically Challenge child parents.

HYPOTHESIS 6.

There will be significant difference between mentally challenge physical challenge child parents on psycho medico

Gen overall	N	Mea n	Std. Deviatio n	Std. Error Mea n	Df	t	Signific ant
Mentally challenge	30	59.60	26.439	4.827	58	3.784	.01
Physically challenge	30	37.53	17.925	3.273			



The Mean for psycho medico in Mentally Challenge Parents is 59.60 while for physically Challenge Parents is 37.53. SD is 26.439 and 17.925 and t Score is 3.784. There is Significant difference in psycho medico among Mentally Challenge and Physically Challenge child parents.

DISCUSSION-

The test developed by Dr. J. Bharath Raj. In this test H,N,A,R,O Five components of H – Hysteria N- Neurasthenia A-Anxiety Neurosis R- Reactive Depression O- Obsession Compulsion All this measured in this test. There are 90 statements and both options are correct or not.

CONCLUSSION:-

1. There is a significant difference in Hysteria among mentally Challenge & physical challenge child parents. Hypothesis is accepted.
2. There is a significant difference in Neurasthenia among mentally challenge & physical challenge child parents. Hypothesis is accepted.
3. There is a significant difference in Anxiety Neurosis among mentally challenge & physical challenge child parents. Hypothesis is accepted.
4. There is a significant difference in Reactive Depressive among mentally challenge & physical challenge child parents. Hypothesis is accepted.
5. There is a no significant difference in obsession compulsions among mentally challenge & physical challenge child parents. Hypothesis is not accepted.
6. There is a significant difference in Psycho medico among mentally challenge & physical challenge child parents. Hypothesis is accepted.

SUGGESSTIONS:

1. This research can be done on the larger sample
2. This can be done in any states of India.

LIMITATIONS:

1. Only 60 samples were taken.

2. The sample is collected only from state of Maharashtra

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