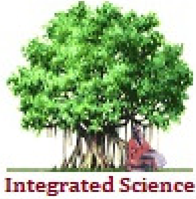

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Case Report

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Ensuring inclusion into the school of a girl child through Social Case Work intervention

Kamlesh Kumar Sahu,[1*] Martina Nongmin[2]

1 Assistant Professor, 2 M.Phil. PSW Trainee,

Department of Psychiatric Social Work, Institute of Psychiatry, Kolkata, India

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ABSTRACT

Borderline mental functioning/disability is technically a cognitive impairment; however, this group have not a diagnosable mental disability to be eligible for specialized services even though they comprise a greater percentage of the population than do children with the diagnosable developmental delays. Parenting of a child with special need particularly of a child with borderline disability can be more challenging apart from that there are various issues and concerns including inclusion in school, where psychosocial intervention is required; social case work interventions might be a good choice for a better outcome. This case report is a demonstration of the same.

Keywords: borderline mental functioning, disability, inclusion, social case work, intervention, inclusive education

INTRODUCTION

Borderline mental functioning/disability is a categorization of intelligence wherein a person has below average cognitive ability (generally an IQ of 71-84),[1, 2] but the deficit is not as severe as intellectual disability (below 70). This is technically a cognitive impairment; however, this group have not a diagnosable mental disability to be eligible for specialized services[3] but they comprise a greater percentage of the population than do children with diagnosable developmental delays.[4] In the DSM-IV-TR codes borderline intellectual functioning as V62.89,[2] which is generally not a billable code.

During school years, individuals with borderline intellectual functioning are often "slow learners."[3] Although slow learners comprise up to 7% of the school-going population but large percentage of this group fails to complete high school[4-6] and can often achieve only a low socioeconomic status, most adults in this group blend in with the rest of the population.[7]

It is well known that intelligence (measured as IQ) has an important role in the academic achievement of children.[8] This group of slow learners children lag behind in the regular classroom since they are not able to learn with the speed and methods of teaching adopted which is unsuitable for their learning ability.[6] It is well known that many slow learners attending regular mainstream schools are able to achieve adequate academic competence if they receive “additional individualized education”.[8,9] Unfortunately, in our country, most regular mainstream schools do not have resource rooms to provide additional individualized education to slow learners.[8,9] In a classroom of 40 or 50 students, the teacher is unable to provide individual attention to those who lag behind in studies.[8,9] Consequently, slow learners most often do not get sufficient attention in regular mainstream schools, having poor performance, fail repeatedly in examinations, and become school dropouts.[6,8,10] Slow learners have been reported to experience severe emotional distress, lose their self-esteem and by adolescence age they are at risk to develop mood and conduct disorders.[11] Many time they are excluded from the school or they and their parent have to face various challenges to be in the mainstream school.

Parenting is tough and challenging in today’s rapidity changing lifestyle and shifting life goals. Parenting requires maturity, learned skills and planned workout. Parenting of a child with special need particularly of child with a borderline disability can be more challenging. Children with borderline intelligence are at heightened risk for maladaptive outcomes.[12] Research suggests that parenting may be particularly influential for children who are vulnerable or at risk. A study of externalizing behavior problems from early to middle childhood by Denham and colleagues[13] found that relations between parenting and externalizing problems were strongest for children who exhibited clinically significant behavior problems, suggesting that parenting had the greatest impact on children

*Corresponding Author
Email: withkamlesh@gmail.com

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already exhibiting deviant developmental trajectories. Similarly, studies of preterm infants have shown that parent and family variables bear a much stronger relationship with child outcomes for children at risk than for typically developing children[14] suggesting that evidence of maladaptive family processes may have significant implications for future intervention and prevention efforts.[7]

Expecting parents usually have an ideal image of a baby, any discrepancy between the perfect child of their fantasy and the real child may be the cause for negative attitudes and parenting stress.[15,16] Apart from this there are various issues and concerns where psychosocial intervention is required; social case work interventions might be a good choice for better a outcome.

Inclusion is a term used by people with disabilities and other disability rights advocates for the idea that all people should freely, openly and without pity accommodate any person with a disability without restrictions or limitations of any kind.[17] India has made tremendous efforts to make its education system more inclusive. Under the Right to Education Act[18] all children have the right to go to school without any barred. Though, to accommodate a greater number of children with disabilities, further progress is needed.[19] The majority, 31 million of the 58 million out-of-school children, were girls. India has 58.81 million girls and 63.71 million boys of primary school age. As of 2011, 1.4 million children of primary school age did not go to school in India, with 18 per cent girls out of school and 14 per cent boys. Out of 2.9 million children with disabilities in India, 990,000 children aged 6 to 14 years (34 per cent) are out of school. The percentages are even higher among children with intellectual disabilities (48 per cent), speech impairments (36 per cent) and multiple disabilities (59 per cent).[20] This data have not included borderline mental functioning/disability and similar conditions for disability since it does not qualify technical definition of requirements for inclusion into a particular category of disability. So these groups are not eligible for specialized services even though they have the similar needs which are applicable in inclusion in the school also.

Social case work is ''a process …….. to help individuals to cope more effectively with their problems in social functioning''.[21] It is a primary method of Social Work is concerned with the adjustment and development of individual towards more satisfying human relations. It is one of the direct methods of social work which uses the case-by-case approach for dealing with individuals or families as regards their problems of social functioning. Case work aims at individualized services in the field of social work. Casework method based on systematic and orderly practice experiences which include a process of intake, social study and diagnosis, treatment, termination and follow-up towards problem solution and social functioning among individuals.[21] Various therapies and interventions can be part of social case work based on the needs and suggestibility of the case. There are various approaches and models in social work practice which also implies in psychiatric setting.[22]

Social case work intervention has demonstrated efficacy on tailored services based on the needs of the client.[23-25] So this publication may contribute in reestablishing significance of social work interventions in disability management which is disregarded in India although agood number of social workers are practicing in this field.

Case Introduction

Index client Ms. K. N. 6 years and 8 months old girl child, studying in class I, hailing from lower socio-economic status nuclear Hindu family, from a metropolitan city of India.

Sources of Information

The client herself, her mother, case record file and previous assessment reports were sources of information which were reliable and adequate.

The Reason for Referral

She was referred to the Department of Psychiatric Social Work of a tertiary care teaching institution for parental counselling and psychosocial intervention.

Brief Clinical History

Presented with complaints of:

- Inattentive in studies
- Poor in studies
- Restlessness
- Gets angry very easily
- Self-injurious behaviour

} for the past 3 years

- Problem in inclusion in the school (during the course of the treatment)

with insidious onset, continuous course, improving progress with intervention and medicine. Predisposed by medical conditions (forceps delivery, post natal septicaemia meningitis[26] and seizures since early childhood) precipitated by faulty parenting and perpetuated by unhealthy living patterns, uncongenial family environment and faulty parenting.

Brief clinic history

The client's present complaints were started three years ago when she started going to school (that time she was at the age of three and half years old) though she has a history of delayed developmental milestone and behaviour problems. The child was inattentive in the studies at school as well as at home, gets easily distracted. Due to this her academic performance was very poor. Her school teachers had complained that the child was unable to write without prompting her letter by letter by someone. She was able to recognize the alphabets and can pronounce them orally but refused to write without prompting. It had been reported that she has difficulties in recalling and writing some similar spelling and alphabets. Her mother was so much worried about her poor performance and slow learning in studies. The client's mother was making tremendous efforts to teach and care her best but she reported that the child was not bothering her instructions or following her guidance for studies. The father was pampering the child to such an extent that even

if the mother tries to discipline her, the father would scold the mother in the presence of the child. This behaviour of the father has put a negative impression on the child.

The child was restless, was unable to seat in a place or do any activities or studies for a longer time and she was getting angry very easily, with little provocation e.g. asked to write, scolded when didn't write etc. She was not expressing her anger verbally but bitten her fingers till she has satisfied herself. Sometimes it was bleeding or had amark on her fingers.

Past History

The child became senseless on the 2nd day of her birth. She was immediately shifted to the hospital and was admitted in the pediatric department. She was diagnosed with septicaemia meningitis[26] and after 19 days of treatment, was released from the hospital. After that, she was perfectly alright till she was 11 months old. Then she was given the booster dose of a vaccine, after that she started having episodic convulsion and frothing from her mouth. She was again admitted and treated in the same hospital and was released on the next day. Since then, she was perfectly alright till the age of three and half years. After that, she started having the same symptoms of episodic convulsion and was suffering from the same, till the date she was referred. Which was treated by a neurologist and convulsion was stopped in few months but was on regular antiepileptic medication.

FAMILY HISTORY

Family History of Illness: There is no family history of any major physical/psychiatric illness or substance abuse.

Family Composition: The family consisted of three members (figure 1).

Father is 37 years old, a responsible gentleman educated up to class VI and driver by profession.

Mother is 32 years old, educated up to graduation and a house wife. She is a good lady by nature, very responsible towards her family.

The client herself is the third member of the family. She is three years eight months old studying in class I.

The attitude of the family Members towards client's Illness was very supportive.

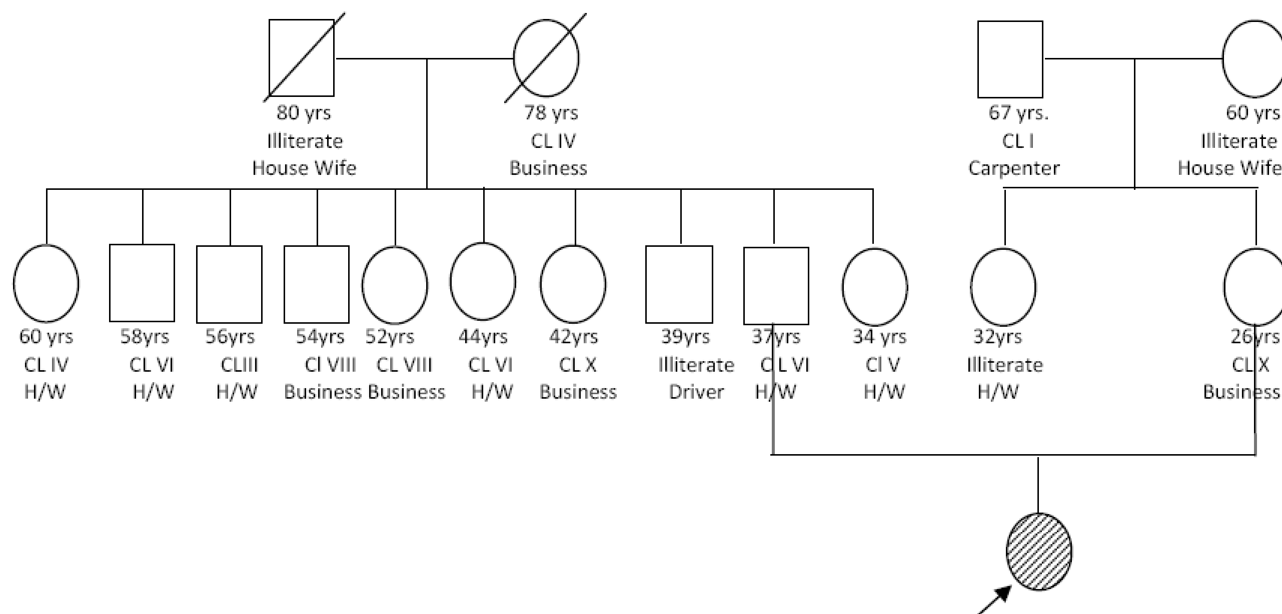
Family Interaction Pattern

Interaction between the parents: The interaction between the parents was reported to be very cordial. The client's parents shared a very good and healthy relationship towards each other. The client father used to come home alternative day due to his work schedule in different places. However, after returning from work he used to spend time with others especially with her daughter. The client's father used to discuss everything with the client's mother before he takes any decision.

Interaction between the client and her mother: The interaction between the client and the mother were reported to be cordial. The client was getting full support and love from the mother. But at the same time she was strict with the client to discipline her. She tries to discipline her but it was over ruled by the father's intervention. So, she didn't fear for the mother because she is aware of the fact that her father will protect her.

Interaction between the client and her father: The client's father loves the client very much. He used to pamper and overprotect her very much which led to the client's behaviour problems worsens. The client's father would scold her mother

Figure 1: Genogram



infront of the client if he witnessed that she is beating or scolding the client for her misbehaviour. So, the client does not feel scared or follow the instruction of the mother.

Family Dynamics

Boundaries: Clear and open boundaries. Parental sub-system is well defined.

Leadership: The client's father is the nominal and functional head of the family. He used to consult and discuss with the client's mother before he take any decision. So, he used to take decision democratically.

Role structure and function: The role of the client's parents was well allocated and they were functioning well accordingly but the child was unable to perform her role as expeted by the parents. At time famther's poor understanding about child's problems and his over protative behaviours made the child's problem more critical leading to disagreement or at time conflict with the mother.

Communication: Open and direct communication is used in the family.

Reinforcement: The client's mother used to criticise whenever the client was misbehaved with the others or was not following the instruction given to her but she was apreciating or rewarding the child for her good performance. On the other hand, the client father's was used to support the client and pampered her. He even scolded his wife for being disciplined the client behaviour. So, reinforcement pattern spesifically from the father side waspoor.

Cohesiveness: From the beginning the in the family we feeling was present. The emotional bonding is very strong among each other.. They shared meals, participarted in family rituals and family functional together and missinging others absaces whenever theyare away from them. Therefore, cohesiveness among the family members is adequate

Adaptive pattern: If any misunderstanding or conflict arises in the family. They used to solved the problems among themselves tactfully and make use to restore peace immediately. Hence, adaptive pattern in the family is adequate.

Social Support Systems

Primary support: All family members are very supportive towards the client.

Secondary: Social and emotional was receiving from the aunt, relative and friends.

Tertiary support: Family has receiving care from the IOP and the support from the community and other tertiary care institutions whenever needed.

Family Burden: The client mother expresd subjective burden as main the burden of the family was the client illness as she is the only child in the family.

Economic burden: Economic burden was present in the family because the client's father was the only earning member of the family and thatsalso not very sound.

Emotional burden: The client parents are very emotional towards the client illness. So they felt lots of infiriourity (stigma) about her problems and poor studies andsocial behavious.

Express Emotion: Critical comment and dissatisfaction is present from the mother. Emotional over involvement was present in the family from father side.

General pattern of living. The client famiy had their own house one bed room and a kitchen but bath room and toilet was shared among the family members in the compus. There are four paternal uncles with their family were living in the same housing campus which was their family propertity. Though their fooding and finicial arrengemts were sapareted but they werefunctionally attachedvery closesly not only in terms of household infrastuctur but also emotionally. So, the child (client) grown up with many cusines uncles and aunts. Since she had some illness at time she was pampered or over cared by some of them and at time faced critical comment from the paternal aunts. There were some obvious issues with other childrens but overall she liks and washappy in that living. They maintained good relationship among the relatives and also with the neighbourhood. Initially the child was living happily with her own parents over there but during the course of the treatment when she started showing problems in her studies her mother decided to shieft to her mother's (the client's marnal grandmother) place which was in the city. She uses to go to her ownhouse every week end that is Saturday and Sunday. When she was coming on week ends she was much pampered by her fathers and others relatives and nowat all seating forstudies.

PERSONAL HISTORY

Birth & Early Development: Client was born out of non-consanguineous marrage with full term forceps delivery in the hospital. Delayed birth cry was reported. Post-natal medical history suggestive of neonatal meningitis[26] and episode of fits as diecribed in past histoty. Delayed speech development was reported speech therapy was given and improvement was reported. The child is inattentive and easily distractable.

Breast feed: Breast fed up to 1 year. The child was given supplementary food and rice since 7 months of age.

Early development: She was started talking after 2 years of age.

Toilet training: Toilet training was achieved at the age of three and half years.

Behavior problem: Night terror, bed wetting and nail biting was reported.

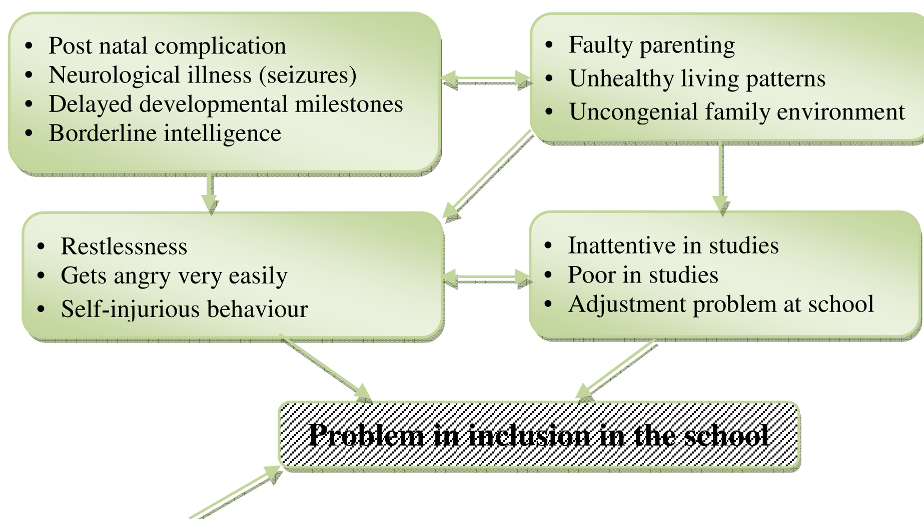
Temperament as a child: Restless but friendly with the friends was reported.

Cognitive development: The child reading, writing and arithmetic was not achieved as the child was inattentive in her studies. Intellectual level was below avarage IQ was 76. **Educational history**: The client started going to school at the age of three and half years. Pre-nursery, nursery and KG were studied in the private English Medium school. Later, her parents shifted to her in a Bengali medium government school from class I. The client academic performance was poor as she does not want to read and write. There was a lot of complaints from the class teacher from nursery to class I about her restless behaviour in the class and also inattentiveness in her studies.

After she passed class I but her mother changed her school which was in the city. It was a Christan missonary's school known for good deciplince and eduction. Though the child liked the new school its big ply ground and overall atmosphere but she had the same copmlains here also which was was taken serioulу by the school. She started roaming around the school campous even in class hours, at time refused to seat in the classroom also. Not writing without prompting as before. Use to ran away from the school at lunch break al most every day. So, will allthese complaints the school decided not to allow her to continue and expressed the deficluties they faced to manege her and maintaning their deciplince and studies. They also suggested to send her a special school.

Social Activity: The child had many friends at home and at the schools. She used to play with her friends. However, there were complaints that sometimes the client pushed or slaped them. friend whenever she was angry.

FIGURE 1 SOCIAL ANALYSIS AND DIAGNOSIS



INTERVENTIONS

Goal of the Interventions: Based on the assessment findings to address problems or pathology the following goals were set:

- To Build a worker-client relationship
- To support and educate the family
- To improve the attaintion consantration of the client
- To improve interaction patterns with the client
- To improve reinforcement patterns in the family
- To improve coping straitgies in the mother
- To addres the problems in the schools
- To ensure inclusion in the schools of the client
- To improve the client behaviour
- To improve communication skills of the client
- To address the high perceived burden in the family

Interventions Plan: All intervention was done as OPD basis, initially biweekly session lasting around 45-60 minute then monthly and subsequently once in three months held. The majority of the sessions were individual with the client's mother, few sessions were conducted jointly with father, few sessions with father separately, and many sessions with the client.

- The total number of sessions conducted - 28
- Individual sessions with the client – 10
- Individual sessions with the client's mother - 15
- Joint session with parent - 03
- Individual sessions with the father - 2

Interventions consisted of:

- Rapport Building with the client and the family
- Psychoeducation to the family
- Teaching and coping skills training to mother
- Cognitive exercise and activity scheduling to the client
- Behaviour modification with the client
- Intervention with school

Rapport Establishment: Rapport establishment aims to maintain a good relationship with the client's mother and the client and also to enhance cooperation and participation of the client in the session for better outcome. Initially, all the supportive measures were take – active listing, expression of empathy, reassurance etc. Conversation was started with the client's mother about the client problems, she become very much emotional. She was empathizing difficulties of having only one child and that also with some problem. The case worker listens patiently and facilitates ventilation alonge with collecting relavant informations. Repeated reassurance and positive attitude towards the client illness made the session successful.

Then the worker builds the rapport with the client by offering her play marials, drowing sheets and being plyful with her.

Psychoeducation to the family: It was evident in the family analysis that family has less awerness about the clint's problem leading to unreasonable expectations, inability to deal with her and finally high subjective burden and high express emotion including dissatisfaction. So, psychoeducaion was given to the parent with the suggestion to pass the knoledge to others in the extended family whatsoever is their understanding. Details of possible causes, course, prognosis, treatment options and need to maintain a perticular way in dealing and communicating with the client were dissused and whenever possible examples were cited. The whole process was completed with supportive measures rather critical keeping inview of the family had already undergoing burden and stigma.

The father was surpized to discover the fact behind her child's beaviour and agreed upon certain his own behaviours which reinforced thechild's probllembehaviours. The mother felt happy and relive by getting ackloledgement of her efforts.

Teaching and coping skills training to mother: The case worker assessed the level of motivation in writing skills and it

was found in action stage that the client was trying to do her task slowly which was the major complain and worry of the mother. The case worker appreciated and applause each step she was doing and rewarded her with sweets or candy and encourage the client to write more alphabet. The client mother was happy and the child gets motivated. Gradual step by step procedure was demonstrated and reccomended to mother for pproctices. Initially, pattern based writing practice was suggested without emasizing on sequence of the witting, once the she acheved some steps of writing sequence were thought. It was suggested that not to pester the child all the time to study but be regular about study timings, to start study hours with her favorite study topic or activities. The father was asked to participate but not to interfiars during this hours and never argue or conflict with her mother.

Effective monitoring client's academic: The case worker was asked the client's parents to keep track of the client academic performance by following up in writing, reading practice at home. It was found that the client writing skill was improving gradually and she can write the entire difficult alphabet very well.

Some coping strategies were thought to the mother in order to deal with the client's problem behaviours, to communicat with her and dealing with others in the family including the father.

Cognitive exercise and activity scheduling to the client: The client was asked to do fill the clolour in a drawing sheet in the session in front of the case worker. The client performed well with that. The case worker encourages the client's mother to continue practice in similar tasks filling colour, shorting beads or grains, arrenging blocks etc. with positive reinforcements in order to develop attainsion and consantration on the client and also to devlop setting habits.Which ultimately promotes the client's competencies. After few sessions both the parent was happy that the child is showing interest in her writing and reading and she could write the spelling correctly.

The client mother was reported that the child was spending her time in playing and watching cartoon and not studying. The case worker encouraged and advised the client mother to spend time and give home practice in reading and writing every day for at least 1 hour a day apart from the school hours. Activity scheduling was introduced not only to mentain the punctuallity instudy hours but also keep the child active and to give her time for plying and recreation.

Behaviour Modification: During this session the case worker started the session with the client's inappropriate behaviours like short temper, self-injurious behaviour and pushing or slaping to others.

Some basic tasks were assigned to the mother like be consistaint in rewarding and avoide psysical punishment. Set time-out for punishment if required.

The client's parents were asked to use modification technique provided by the case worker. Both the parents was motivated and encourage to use behaviour modification technique and maintain the a record daily dairy of the client's such behavious. So that progress canbe montored.

Intervention with school: To reduce client's problems in the school, in one hand she was provided actively guided support for studies at home by mother and, on the other hand school autherity were contacted and explained about her behaviour and requsted to give some time to her for improving her studies as well as behaviours. When they showed resistance inclusive educationand right of the children to study were berifed firmly. Parents were also persuaded not to argue or be roude to school but to listenand support them to mentain the dicipline which was the mejor concern of them also to feel greatfull to the school fortaking her inteally and whenevery required apposise for any mischevious behaviou of their child. Several tellephinic conversation and finally with the infuance of an infuancial faher who understood the case workers point she wasensured inclusion into the school. Gradually as she shown improvement she was accepted well.

OUTCOMES

- The family' knowledge and ability to deal with the problem was improved significantly
- Client reading and writing skills was improved
- Client problem behaviour was improving
- Various areas of family phathologies were improved like burden, exppress emotion, interaction with client.
- Parents were satisfied and happy with the progress
- The client settled in good school and improving

FOLLOW UP: The client was on active follow up service for aroun one and half year, actively monitored and continuously encourageed the client's parent and the family presently also family is in touch.

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