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Attention-deficit/hyperactivity disorder: A case report with homeopathic and conventional perspectives

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Abstract
Attention Deficit Hyperactivity Disorder (ADHD) is one of the most frequent neurodevelopmental disorders in childhood and adolescence, which is typically first, diagnosed in childhood and often persists into adulthood. It is one of the most prevalent causes of children being sent to psychology and psychiatric clinics, Children with ADHD may struggle to focus, lack self-control and impulsive behaviors, or exhibit excessive activity. Hyperactivity, one of the main symptoms of ADHD, can lead to a child's psychological and social incompatibility at home, school, and community. This case report presents a 5-year-old boy with delayed milestones, extreme restlessness, marked hyperactivity, and severely disturbed speech limited to a few incomprehensible words. The child was extremely sensitive to noise, exhibited obstinate constipation, had an excessive fear of darkness, and showed peculiar behaviors such as biting and pulling his mother's hair. He constantly desired to go out, refused to remain at one place, and displayed a striking affinity for playing in water. A detailed case-taking and repertorial analysis led to the prescription of SULPHUR 1M/1 DOSE followed by ** Medorrhinum 1M**, which was administered as the constitutional remedy and repeated as required according to the circumstances at different stages of follow-up. Gradual improvement was noted in restlessness, speech expression, attention span, bowel regularity, and reduction of destructive behaviors. This case highlights the importance of individualized constitutional prescribing in homeopathic management of ADHD, demonstrating significant scope in improving behavioral, emotional, and developmental outcomes.

Keywords: Attention Deficit Hyperactivity Disorder (ADHD), hyperactivity, developmental delay, speech disturbance, restlessness, noise sensitivity, fear of dark, behavioral problems, sulphur 1M, homeopathy, medorrhinum 1M, constitutional remedy, case report

Introduction
ADHD is characterized by some combination of hyperactivity, impulsivity and inattention. Children with ADHD may experience functional difficulties in every aspect of their lives, including behavior, academic achievement, and interpersonal relationships with family and peers. In the long term, the combination of frustration, rejection and failure can have a serious detrimental effect on developing self-esteem. with the establishment of more comprehensive diagnostic criteria that identify the various subtypes, estimates now place the childhood prevalence of ADHD at 4 to 8 percent. Once thought to affect boys more than girls, the disorder now appears not to discriminate along gender lines. While, indeed, more boys than girls are diagnosed with ADHD, girls are being identified more often now than in the past, particularly in the inattention subtype. Possibly girls are less likely to be recognized and diagnosed with ADHD because their behavior is generally less overactive and disruptive. ADHD was originally thought to be a condition that resolved in adolescence, but new evidence suggests that this is not the case for the majority of children. For up to 65 percent of patients diagnosed in childhood, the symptoms persist into the teenage years and, for some, into adulthood

Previous studies
Literally thousands of studies have been conducted on Attention Deficit Hyperactivity Disorder (ADHD) and its various predecessors in diagnostic nomenclatures prior to DSM-V (The Diagnostic and Statistical Manual of Mental Disorders-V). Despite this long research history, ADHD is not necessarily well understood among the lay public, given the many

controversies and public misconceptions concerning the disorder. Longitudinal evidence suggests that childhood ADHD persists into young adulthood in 60-70% of the cases when defined relative to same-age peers and in 58% of the cases when DSM-V criteria and parental reports are used. These early studies of childhood hyperactivity excluded many children that would currently meet the criteria.

Causes of ADHD

Scientists have not yet identified the specific causes of ADHD. While there is growing evidence that genetics contribute to ADHD and several genes have been linked to the disorder, no specific gene or gene combination has been identified as the cause of the disorder. However, it is important to note that relatives of individuals with ADHD are often also affected. There is evidence of anatomical differences in the brains of children with ADHD in comparison to other children without the condition. For instance, children with ADHD have reduced grey and white brain matter volume and demonstrate different brain region activation during certain tasks (Pliszka, 2007). Further studies have indicated that the frontal lobes, caudate nucleus, and cerebellar vermis of the brain are affected in ADHD (Tripp & Wickens, 2009). Several non-genetic factors have also been linked to the disorder such as low birth weight, premature birth, exposure to toxins (alcohol, smoking, lead, etc.) during pregnancy, and extreme stress during pregnancy.

Diagnosis

There are three main types of ADHD:

- Predominantly inattentive presentation.
- Predominantly hyperactive/impulsive presentation.
- Combined presentation.

A diagnosis is based on the presence of persistent symptoms that have occurred over a period of time and are noticeable over the past six months. While ADHD can be diagnosed at any age, this disorder begins in childhood. When considering the diagnosis, the symptoms must be present before the individual is 12 years old and must have caused difficulties in more than one setting. For instance, the symptoms can not only occur at home.

Inattentive type

Inattentive refers to challenges with staying on task, focusing, and organization. For a diagnosis of this type of ADHD, six (or five for individuals who are 17 years old or older) of the following symptoms occur frequently:

- Doesn't pay close attention to details or makes careless mistakes in school or job tasks.
- Has problems staying focused on tasks or activities, such as during lectures, conversations or long reading.
- Does not seem to listen when spoken to (i.e., seems to be elsewhere).
- Does not follow through on instructions and doesn't complete schoolwork, chores or job duties (may start tasks but quickly loses focus).
- Has problems organizing tasks and work (for instance, does not manage time well; has messy, disorganized work; misses deadlines).
- Avoids or dislikes tasks that require sustained mental effort, such as preparing reports and completing forms.
- Often loses things needed for tasks or daily life, such as school papers, books, keys, wallet, cell phone and eyeglasses.
- Is easily distracted.
- Forgets daily tasks, such as doing chores and running errands. Older teens and adults may forget to return phone calls, pay bills and keep appointments.

Hyperactive/impulsive type

Hyperactivity refers to excessive movement such as fidgeting, excessive energy, not sitting still, and being talkative. Impulsivity refers to decisions or actions taken without thinking through the consequences. For a diagnosis of this type of ADHD, six (or five for individuals who are 17 years old or older) of the following symptoms occur frequently:

- Fidgets with or taps hands or feet, or squirms in seat.
- Not able to stay seated (in classroom, workplace).
- Runs about or climbs where it is inappropriate.
- Unable to play or do leisure activities quietly.
- Always "on the go," as if driven by a motor.
- Talks too much.
- Blurts out an answer before a question has been finished (for instance may finish people's sentences, can't wait to speak in conversations).
- Has difficulty waiting for his or her turn, such as while waiting in line.
- Interrupts or intrudes on others (for instance, cuts into conversations, games or activities, or starts using other people's things without permission). Older teens and adults may take over what others are doing.

Combined type

This type of ADHD is diagnosed when both criteria for both inattentive and hyperactive/impulse types are met.

ADHD is typically diagnosed by mental health providers or primary care providers. A psychiatric evaluation will include a description of symptoms from the patient and caregivers, completion of scales and questionnaires by patient, caregivers and teachers, complete psychiatric and medical history, family history, and information regarding education, environment, and upbringing. It may also include a referral for medical evaluation to rule out other medical conditions.

It is important to note that several conditions can mimic ADHD such as learning disorders, mood disorders, anxiety, substance use, head injuries, thyroid conditions, and use of some medications such as steroids (Austerman, 2015). ADHD may also co-exist with other mental health conditions, such as oppositional defiant disorder or conduct disorder, anxiety disorders, and learning disorders (Austerman, 2015). Thus, a full psychiatric evaluation is very important. There are no specific blood tests or routine imaging for ADHD diagnosis. Sometimes, patients may be referred for additional psychological testing (such as neuropsychological or psychoeducational testing) or may undergo computer-based tests to assess the severity of symptoms.

Treatment

A multimodality approach to treatment that emphasizes both behavioral interventions and pharmacotherapy is considered optimal. Combined therapy is found to be especially useful

for children with comorbid anxiety, depression or stressed family situations. It may also reduce the medication doses needed for symptomatic control.

Parent-Child Interaction Therapy (PCIT): It is an evidence-based therapy modality to help young children with ADHD and oppositional defiant disorder.

Behavioral therapy most of which relies on a system of positive and negative reinforcements consists of interventions designed to alter a child's behavior at home and school. With time and consistent, repeated application, these interventions are thought to gradually reshape a child's behavior.

Pharmacotherapy: It consists of short-term and long-term stimulants. The active ingredients in the majority of both these formulations are methylphenidate (Concerta, Ritalin) and dextroamphetamine (Dexedrine). It is believed that stimulants work to minimize ADHD symptoms by altering the levels of neurotransmitters in the brain. Eight out of 10 children show improvement on stimulants. For children with inattention alone, low doses are generally sufficient. Higher doses may be required for a diagnosis of combined attention deficit and hyperactivity

Case summery

Name: XYZ

Age/Sex: 5 Yrs old/boy

Address: Gomti Nagar, Lucknow

Present complaints

Personal history: History of obstinate constipation

Family history

Father: Renal calculi

Mother: Repeated coryza

Physical generals

Thermal: Hot

Thirst: Thirsty

Perspiration: More on head and back

Stool: Tight Stool, do not go to stool for many days, has to take enema many times

Sleep: Lying on abdomen

Urine: OK

Mental generals

Sensitive noise to fear from high pitch sound, Likes To play with water, biting others especially mother and hair pulling. Extreme fear from dark, can't sleep with light of very hyperactive and physically restless child. Always wants to go out of the house and travel at different places. But there is no attention in any physical and mental activity. Concentration is very poor. Patients' parents were both working so in their absence he is with their grandparents.

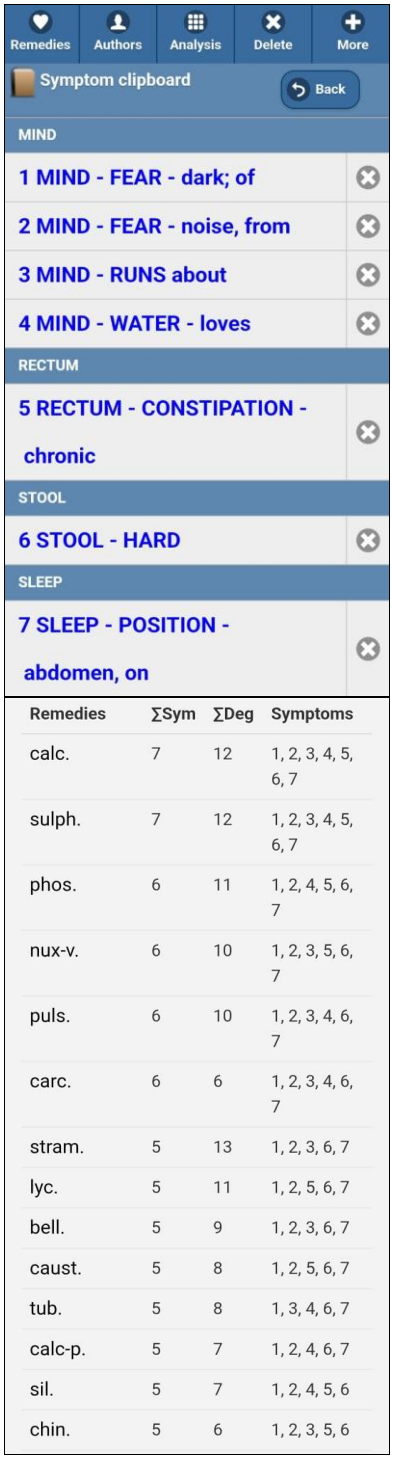
Repertorial totality

Biting others	Mind-biting
Fear -noise from different sources	Mind-fear -noise from
Pulls his mother's hair	Mind-pulling hair
Fear Dark of	Mind-fear -dark of; children in
Tight stool	Stool -hard
Wants to go to different places	Travelling desire for
Likes to sleep on abdomen	Sleep- position- abdomen on

Miasmatic background

Mainly miasm running behind the disease is ''PSORA AND SYCOSIS''. But in family background sycotic miasm was predominant.

Repertorial chart



Remedies	∑Sym	∑Deg	Symptoms
calc.	7	12	1, 2, 3, 4, 5, 6, 7
sulph.	7	12	1, 2, 3, 4, 5, 6, 7
phos.	6	11	1, 2, 4, 5, 6, 7
nux-v.	6	10	1, 2, 3, 5, 6, 7
puls.	6	10	1, 2, 3, 4, 6, 7
carc.	6	6	1, 2, 3, 4, 6, 7
stram.	5	13	1, 2, 3, 6, 7
lyc.	5	11	1, 2, 5, 6, 7
bell.	5	9	1, 2, 3, 6, 7
caust.	5	8	1, 2, 5, 6, 7
tub.	5	8	1, 3, 4, 6, 7
calc-p.	5	7	1, 2, 4, 6, 7
sil.	5	7	1, 2, 4, 5, 6
chin.	5	6	1, 2, 3, 5, 6

Selection of remedy

Calcarea carb - 7/12, Sulphur - 7/12, Phos - 6/11, Nux vomica - 6/10, Pulsatilla - 6/10

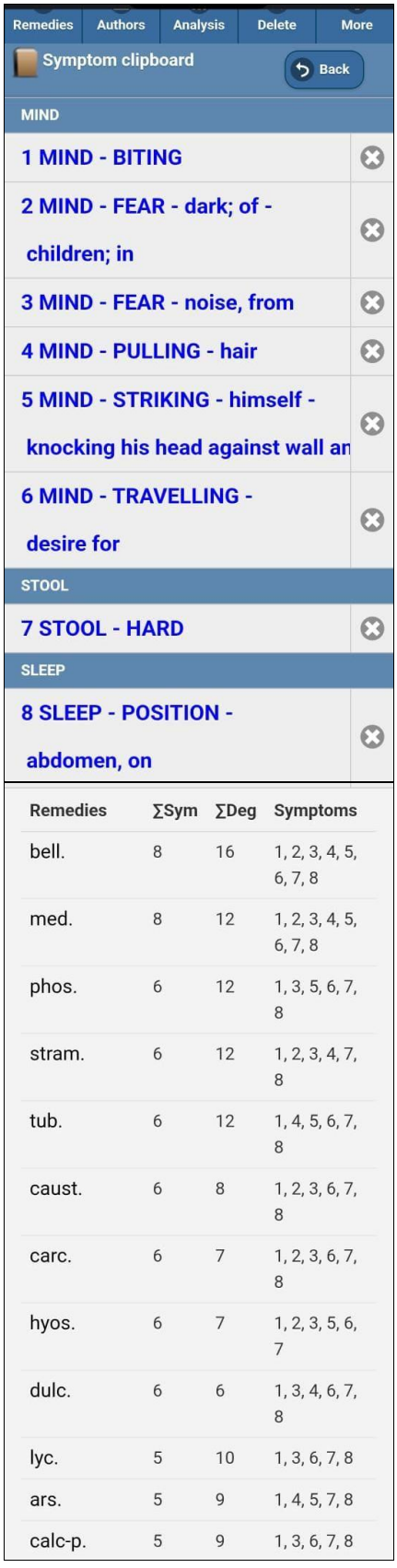
Remedy given and potency

After carefully selecting using synthesis repertory - Sulphur 1M/1 Dose was given on 2 sept 2024

According to swan rating scale used for assessment of ADHD, scoring was - 10

1st follow up - 21/9/2024

Sensitivity towards noise decreased. But rest of the symptoms were same. constipation was very severe patient. patient was going for stool in 3-4 days.



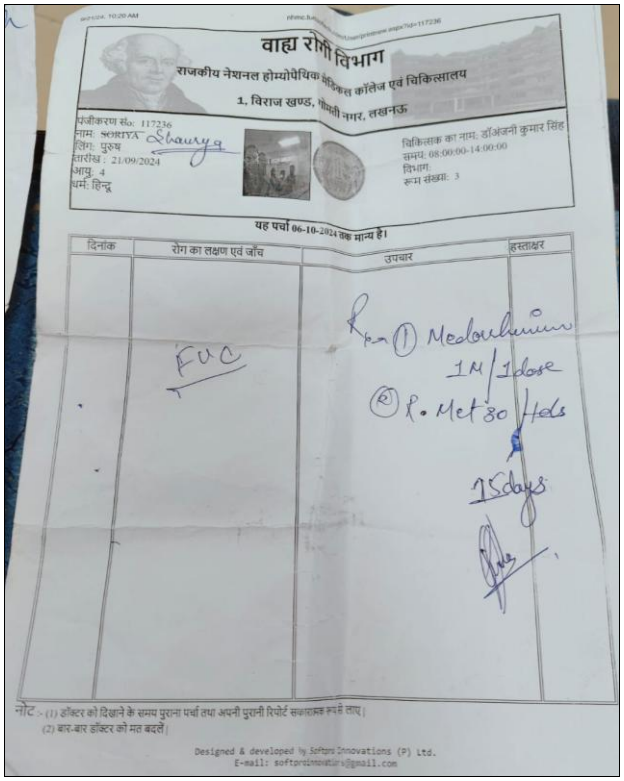
Remedies	∑Sym	∑Deg	Symptoms
bell.	8	16	1, 2, 3, 4, 5, 6, 7, 8
med.	8	12	1, 2, 3, 4, 5, 6, 7, 8
phos.	6	12	1, 3, 5, 6, 7, 8
stram.	6	12	1, 2, 3, 4, 7, 8
tub.	6	12	1, 4, 5, 6, 7, 8
caust.	6	8	1, 2, 3, 6, 7, 8
carc.	6	7	1, 2, 3, 6, 7, 8
hyos.	6	7	1, 2, 3, 5, 6, 7
dulc.	6	6	1, 3, 4, 6, 7, 8
lyc.	5	10	1, 3, 6, 7, 8
ars.	5	9	1, 4, 5, 7, 8
calc-p.	5	9	1, 3, 6, 7, 8

Selection of remedy

Belladona - 8/16, Medorrhinum - 8/12, Phos - 6/12, Stramonium - 6/12, Tuberculinum - 6/12

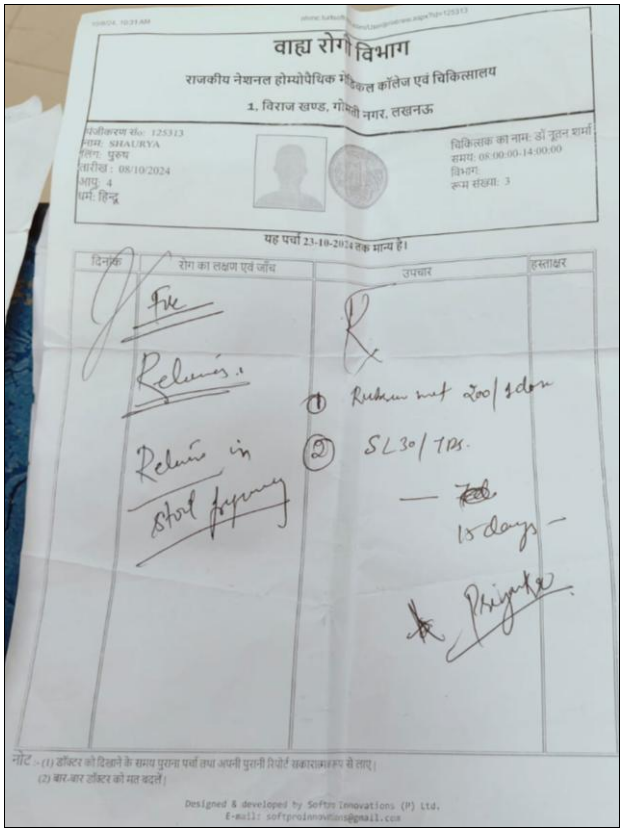
Remedy given

Medorrhinum 1M/1 dose



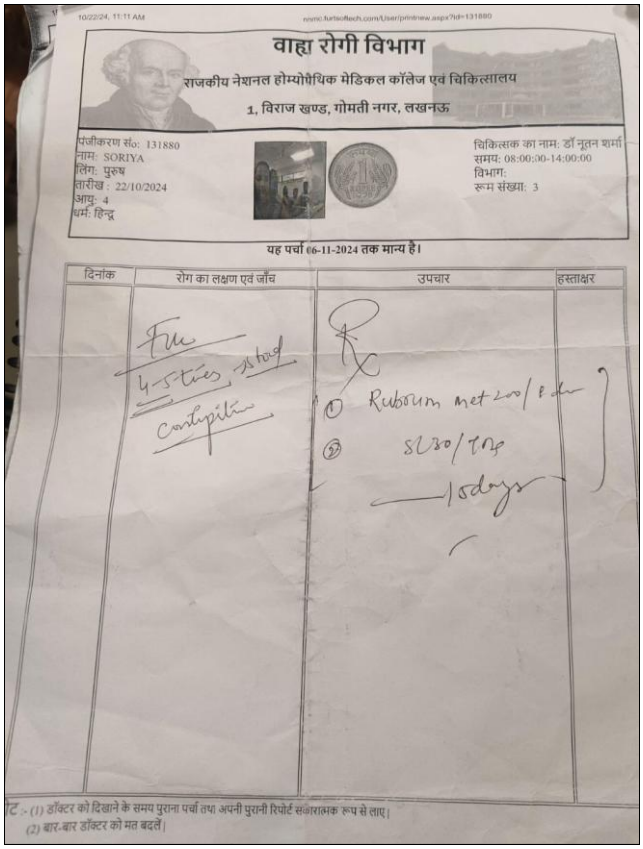
Second follow up-8/10/2024

Constipation was slight decreased. Patient start going for stool on alternate days. Hyperactivity was slight decreased. Fear of noise from sound of vehicles and machines almost reduced. Attention span improved.



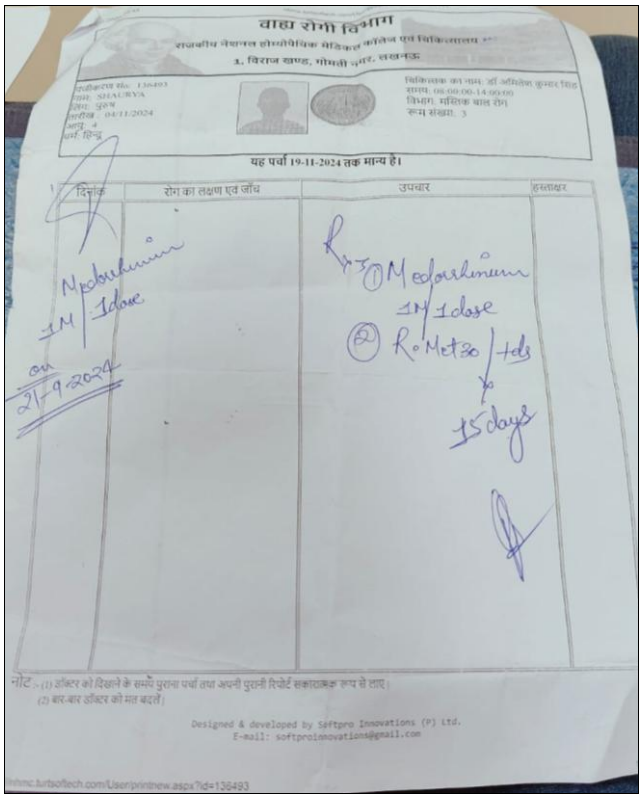
Third follow up-22/10/2024

Urge for stool 4-5 times but unsatisfactory. Hyperactivity was reduced. speech improved. Attention span was increased. Started studying.



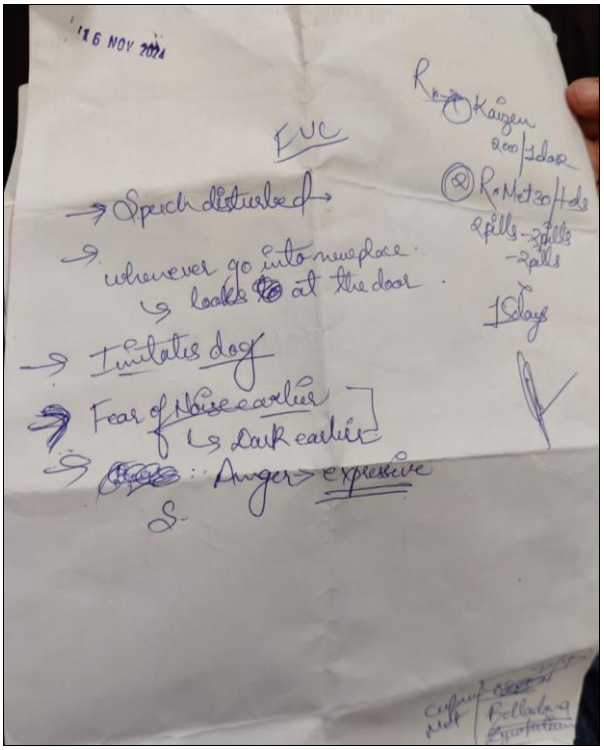
Fourth follow up-4/11/2024

Constipation relieved. Stool frequency becomes normal. Hyperactivity decreased. Started calling Mummy, Papa to their parent's earlier speech was blurred.



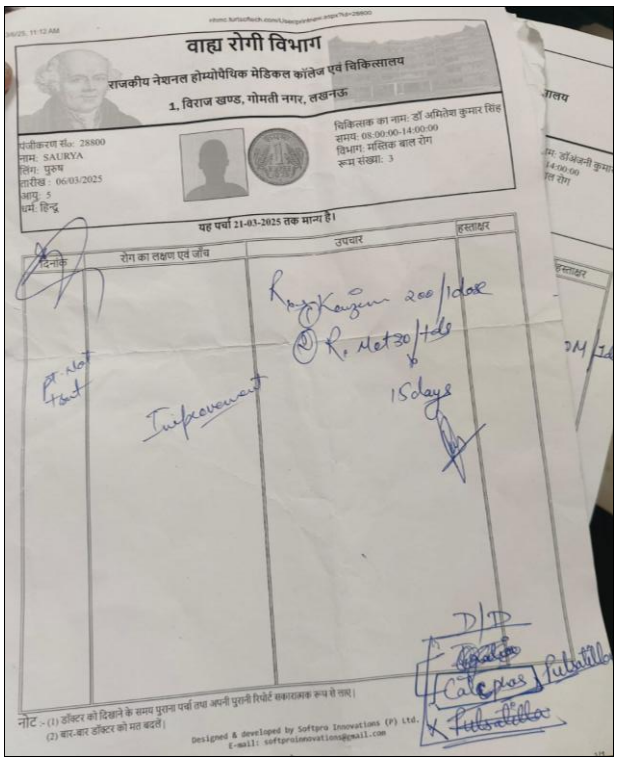
Fifth follow up-16/11/2024

Fear of dark and noise completely cured. Started doing imitation of dog. Anger increased. Anger expressive specially towards mother.



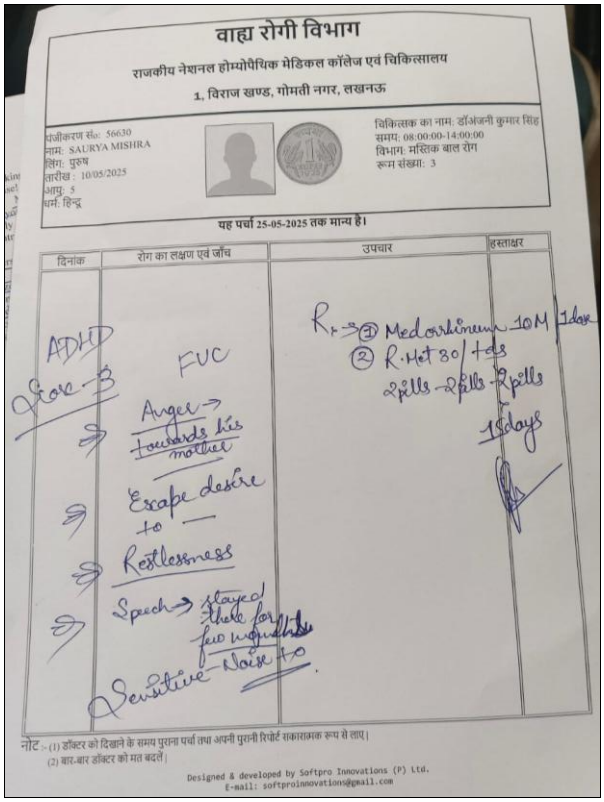
Sixth follow up-6/03/2025

Patient was not present but his father said that patient started sitting for studying for an hour which was great improvement than earlier. Hyperactivity decreased. Concentration and attention span increased.



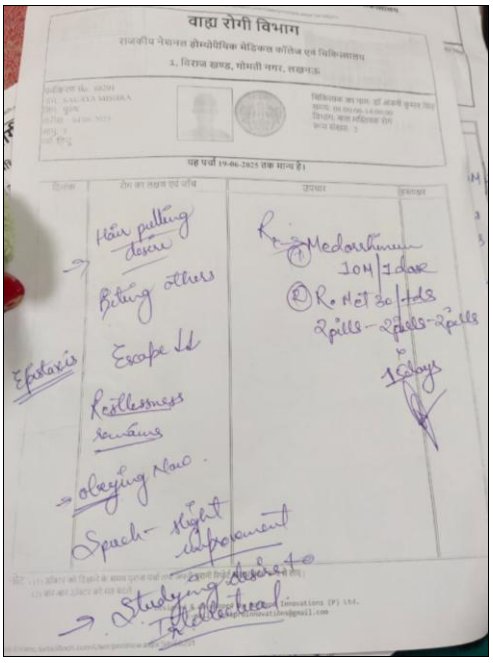
7th follow up-10/5/2025

Anger towards his mother continued. Physical restlessness was present when going outside home. Wants to go out of home. Enjoys watching vehicles, animals now. Speech improved started forming short sentences for asking food and water. He was sensitive to people shouting or fighting Infront of him. Noise of parent's arguments disturbed him.



8th follow up-4/06/2025

Anger towards mother continued he pulls hair of mother sometimes and started biting in anger when she came from office or she shouts on any of his mistake. restless present but not that much. Speech improved. Started forming long sentences but not clear. Desire to go out of the house decreased. Attention span while studying improved and started reading alphabets and writing also.

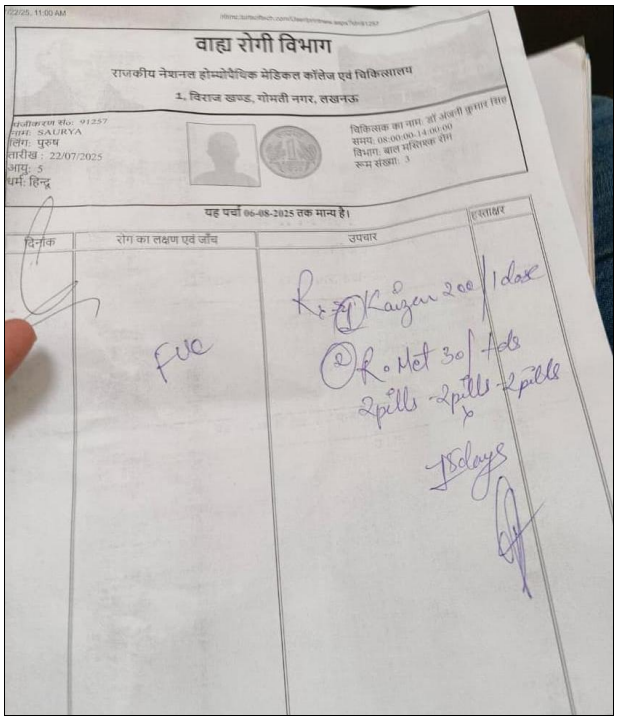


Cut-off threshold for the diagnosis of behavioral disorders and disorders without specific biological markers, such as ADHD.

There are existing scales that have already been standardized and validated to evaluate ADHD in children and adolescents (10-12), for example: Conners (3rd edn.);

Conners Comprehensive Behavior Rating Scales; Conners Early Childhood; the Vanderbilt ADHD Diagnostic Parent/Teacher Rating Scales; ADHD Rating Scale-IV, Swanson, Nolan, Pelham-IV Teacher and Parent Rating Scale (SNAP-IV) ADHD Symptom Checklist-4; ADHD Comprehensive Teacher Rating Scale; Brown Attention Deficit Disorder Scales, Behavior Assessment System for Children (2nd edn.); and Achenbach System of Empirically Based Assessment. These scales are based on categorical assessment; that is, they focus on psychopathology and extreme ADHD symptoms, which could lead to evaluation errors that result in over-diagnosis or, conversely, the failure to identify individuals with mild ADHD symptoms. Since the 1960s, there have been increasing attempts to confront this concern and to examine the problem of bias in categorical scales, with attempts to develop reliable scales that are free from problems such as cultural differences, biases in the selection of reference groups, and lack of objectivity in the definition and evaluation of "deficit" and "behavioral disorder". Among the various existing scales that evaluate the symptoms and signs of ADHD, the Strengths and Weaknesses of ADHD-Symptoms and Normal-Behaviors (SWAN) rating scale is based on observations of normal and abnormal distributions of attention skills in diverse population samples. SWAN has been used in research on diagnostic and therapeutic approaches to ADHD in children and adolescent

9th follow up



Hyperactivity reduced to almost 80 percent. Sits still at one place and study with full concentration. Speech improved patient starts making full sentences. Anger towards mother completely gone and stopped biting and pulling hair.

Diagnostic consideration

There are existing scales that have already been standardized and validated to evaluate ADHD in children and adolescents, for example: Conners (3rd edn.); Conners Comprehensive Behavior Rating Scales; Conners Early Childhood; the Vanderbilt ADHD Diagnostic Parent/ Teacher Rating Scales; ADHD Rating Scale-IV, Swanson, Nolan, Pelham-IV Teacher and Parent Rating Scale (SNAP-IV) ADHD Symptom Checklist-4; ADHD Comprehensive Teacher Rating Scale; Brown Attention Deficit Disorder Scales, Behavior Assessment System for Children (2nd edn.); and Achenbach System of Empirically Based Assessment. These scales are based on categorical assessment; that is, they focus on psycho-pathology and extreme ADHD symptoms, which could lead to evaluation errors that result in over-diagnosis or conversely, the failure to identify individuals with mild ADHD symptoms. Since the 1960s, there have been increasing attempts to confront this concern and to examine the problem of bias in categorical scales, with attempts to develop reliable scales that are free from problems such as cultural differences, biases in the selection of reference groups, and lack of objectivity in the definition and evaluation of "deficit" and "behavioral disorder". Among the various existing scales that evaluate the symptoms and signs of ADHD, the Strengths and Weaknesses of ADHD-symptoms and Normal-behaviors (SWAN) rating scale is based on observations of The SWAN scale was created by Swanson *et al*. and comprises 30 items measuring the full range of behavior, instead of only the pathological signs and symptoms of ADHD. The items measure behavioral characteristics representative of the attention skills of the general population. Raters are asked to evaluate the child/adolescent by comparing them to other children of the same age group, and from the same family and school environment, on skills such as focusing attention, controlling anxiety, and inhibiting impulsive behavior during tasks that require prolonged mental effort and during daily activities. On the complete scale, each item is scored from -3 to +3 (below average to above average), where 0 (zero) is normal and based upon the population average (see Figure 1). These variations result in normally distributed behavioral rates normal and abnormal distributions of attention skills in diverse population samples. SWAN has been used in research on diagnostic and therapeutic approaches to ADHD in children and adolescent.

The SWAN scale was created by Swanson *et al*. and comprises 30 items measuring the full range of behavior, instead of only the pathological signs and symptoms of ADHD. The items measure behavioral characteristics representative of the attention skills of the general population. Raters are asked to evaluate the child/ adolescent by comparing them to other children of the same age group, and from the same family and school environment, on skills such as focusing attention, controlling anxiety, and inhibiting impulsive behavior during tasks that require prolonged mental effort and during daily activities. On the complete scale, each item is scored from -3to+3 (below average to above average), where 0 (zero) is normal and based upon the population average. These variations result in normally distributed behavioral rates.

In our case swan rating scale was

Before treatment - 10

After treatment - 2 with the help of homeopathic medicines.

Dietery restrictions - intake of sugar was prohibited during case taking to avoid it during the course of treatment.

Advise/other instructions

Speech therapy was advised for the child

Conclusion

Being a complex neuromuscular condition, old school medicine offers little help in treatment of ADHD. They don't have cure of it and manage only by the suppression of symptoms not curing it. Homeopathic Antimiasmatic dynamic medicine can help a great deal in this very troublesome medicine along with some dietary restrictions and speech therapy.

Conflict of Interest: Nil

Financial Support: None

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