International Journal of Homoeopathic Sciences

E-ISSN: 2616-4493
P-ISSN: 2616-4485
www.homoeopathicjournal.com
IJHS 2023; 7(1): 464-470
Received: 01-08-2022
Accepted: 03-09-2022

Dr. Justina M Steefan
Assistant Professor, Department of Psychiatry, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

Dr. Siddesha G
Assistant Professor, Department of psychiatry, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

D Lovanya
Intern, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

M Priyanka
Intern, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

M Sai Surya
Intern, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

NS Safa
Intern, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

Corresponding Author:
Dr. Justina M Steefan
Assistant Professor, Department of psychiatry, MNR Homoeopathic Medical College and Hospital, Sangareddy, Telangana, India

Common behavioral disorders in children and homeopathic approach

Dr. Justina M Steefan, Dr. Siddesha G, D Lovanya, M Priyanka, M Sai Surya and NS Safa

DOI: https://doi.org/10.33545/26164485.2023.v7.i1h.790

Abstract
Behavioural disorders are one of the most concerning disorders of children for parents and teachers. They include ADHD, ODD and Conduct Disorder. There are various factors that can cause these disorders, like genetic, environmental, neuro-biological, and developmental are some to mention. Even though the symptoms of these disorders seem to be similar they differ in their main core. Homoeopathy has shown wonders in treating pediatric patients and behavioural disorders are not an exception.

Keywords: Behavioural disorders, attention-deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, homoeopathy

Introduction
As per Wood Worth, the term "behaviour" refers to all motor or conative actions, such as swimming or dancing, cognitive activities, such as thinking, reasoning, and visualizing, and affective behaviours, such as feeling joyful, sad, or furious. The operations of the human mind and conscious, subconscious, and unconscious behaviour are also included [1].
Behaviour disorders are defined as any disturbance in these regular conative, cognitive, or emotional processes.
Typical behavioral issues in children include:
1. ADHD.
2. Disruptive behaviour and dissocial disorder
i. Oppositional defiant disorder.
ii. Conduct disorder.

Attention-deficit/hyperactivity disorder
According to the Synopsis of Psychiatry by Kaplan and Sadock Attention-deficit/hyperactivity disorder (ADHD) is a neuropsychiatric syndrome that mostly affects preschoolers, children, adolescents, and adults worldwide. ADHD is characterized by a decreased capacity for sustained attention and an increase in impulsive or hyperactive behaviour. Moreover, it can lead to impulsivity and hyperactivity [2-4].
There are three varieties of ADHD, and the diagnosis will depend on which signs the child exhibits most frequently. Subtypes include:
1. Inattentive type.
2. Hyperactive-impulsive type.
3. Combined type.

Causes
1. **Heredity/Genetic predisposition:** Genetic heritability of 80-90% is observed. If one person in the family is diagnosed with ADHD there is greater probability of ADHD in another direct blood relation which suggests a genetic basis to ADHD.
2. **Neuro chemical Factors:** Many neurotransmitters are postulated to be associated with ADHD symptoms; however, dopamine is a major focus of clinical investigation, and the pre- frontal cortex has been implicated based on its role in attention and regulation of impulse control. Catecholamines also play a major role. There is depressed activity of dopamine and nor- epinephrine.

3. **Neurophysiology factors:** Possible chemical imbalance that inhibits the efficiency of the neurotransmitter of certain portions of brain.
4. **Neuroanatomical Aspects:** Researchers have hypothesized networks within the brain for promoting components of attention including focusing, sustaining attention, and shifting attention. Single photon emission computerized tomography (SPECT) suggests that populations of children with ADHD show evidence of both decreased volume and decreased activity in prefrontal regions, anterior cingulated, globus pallidus, caudate, thalamus, and cerebellum.
5. **Developmental Factors:** Higher rates of ADHD are present in children who were born prematurely and whose mothers were observed to have maternal infection during pregnancy. Perinatal insult to the brain during early infancy caused by infection, inflammation, and trauma may, in some cases, be contributing factors in the emergence of ADHD symptoms.
6. Food additives, coloring agents, preservatives, and sugar.
7. Prolonged emotional deprivation, and stressful life events may initiate or perpetuate ADHD [2-4].

Symptoms

A child with inattentive type ADHD may

1. Find it difficult to pay attention.
2. Become easily distracted.
3. Have difficulty focusing on tasks, particularly long tasks such as reading.
4. Start tasks but forget to finish them.
5. Appear not to listen to instructions or to forget them.

A child with hyperactive-impulsive type ADHD might

1. Have trouble sitting still or remaining in one place.
2. Move about a lot in their seat or fidget by tapping their hands or feet.
3. When it's not acceptable, rush around or climb on furniture.
4. Find it tough to wait their turn.
5. Find it difficult to converse or play quietly.

A child with combined ADHD will exhibit a mixture of the above behaviours. Some other features of such a child are

- Fidgetiness
- Trouble staying sitting when necessary.
- Easy diversion, trouble with turns, blurting out replies even before the inquiry is finished.
- Switching from one unfinished task to another.
- An excessive need to converse.
- A lack of attention to detail and a propensity to misplace things.
- Impulsivity, which is the act of doing something risky with little thought to the prospective repercussions [2, 3, 5, 6].

Diagnostic criteria

According to ICD 10 and DSM5 child must exhibit core symptoms of inattention, hyperactivity, and impulsivity.
Symptoms start in early childhood (<7 years of age).
Symptoms are exhibited at least in 2 locations (home, school etc.). Evidence of impaired function.
Symptoms are unrelated to other mental health disorders [2-7].

General managemen

Psych education: Children, their parents and teachers should be informed about the symptoms of ADHD and different treatment options.

School-based intervention: Schools may have special educational needs coordinator who can help to provide support at school. The child should be assessed for any co-morbid learning difficulties.

Behavioral therapy: It is useful to help younger children cope with their symptoms more effectively.

Cognitive behavioral therapy: Beneficial for adolescents with ADHD, especially those with low self-esteem/ co-morbid anxiety and depression.

Social skill training: Helps children to learn social norms; good evidence for improving peer relationships in long term.

Parental training and educational courses: First-line intervention for mild to moderate ADHD. Taught courses are the most effective way of delivering psych education and training in behavioral techniques to parents. The groups provide support by allowing parents to meet other families coping with ADHD [2, 3].

Prognosis

The progression of ADHD varies. In 60% to 85% of instances, symptoms last throughout adolescence; in 60% of cases, they last into adulthood. The other 40% of instances come to an end in adolescence or the early stages of adulthood. In certain circumstances, the ADHD may go away but the issues with poor impulse control and short attention span persist. Usually, hyperactivity is the first symptom to go away, followed by inattention. Often, ADHD persists throughout middle childhood. Persistence can be predicted by a family history of the condition, traumatic life experiences, and comorbidities with behavioral symptoms, depression, and anxiety. Remission often happens between the ages of 12 and 20. A prosperous youth and adulthood, fulfilling relationships, and a lack of major sequelae may accompany remission. Nonetheless, most individuals with this condition [2-4].

Disruptive behaviour and dis-social disorder

It is characterized by persistent behaviour problems ranging from markedly and persistently defiant, disobedient, provocative or spiteful behaviour to those that persistently violate the basic rights of others or major age-appropriate societal norms, rules or laws [2-7].

Oppositional defiant disorder

Oppositional defiant disorder is characterized by persistent patterns of negativism, disobedience, aggressive behaviour towards authoritative figures, and failure to take responsibility for mistakes, hence casting blame on others, according to Kaplan and Saddock's synopsis of psychiatry. They struggle in the classroom and in peer relationships, but they often avoid physical aggressiveness and harmful behaviour [2-4].

Causes
Normal oppositional behaviour peaks between 18&24 months.
Among the criteria included in ODD, irritability appears to be one of the predictors of later psychiatric disorders.

In Children
Children can have a variety of temperamental tendencies, like strong preferences, strong will, or high assertiveness. Parents who provide an example of more severe means of expressing and imposing their own will may encourage their kids to engage in ongoing conflicts with other adults. An infant's early attempts at developing independence might end up developing into exaggerated patterns of behaviour.

In Late Childhood
In late childhood, environmental trauma, illness, or chronic incapacity, such as mental retardation, can trigger compositionality as a defense against helplessness, anxiety, and loss of self-esteem.

In Adolescence
In adolescence as an expression of the need to separate from the parents and to establish an autonomous identity [2-6].

Symptoms
In Children: Children with oppositional defiant disorder: Frequently argue with grownups, act out, and express their rage, resentment, and annoyance at others at a degree and frequency that are excessive for their age and stage of development. Despite excellent intelligence, individuals may do badly or fail in school, due to their lack of collaboration, poor involvement, and refusal to accept aid. - Low self-esteem, a low threshold for irritation, depression, and temper outbursts come in second to these problems.

In Adolescence: Adolescents who are ostracized may turn to alcohol and illegal substances as a modality to fit in with peers [2-6].

Diagnostic criteria
DSM-5 has divided oppositional defiant disorder into three types.
A child may meet diagnostic criteria for oppositional defiant disorder with a 6-month pattern of at least four symptoms from the three types below.
A child with Oppositional defiant disorder has:

1. Angry/Irritable children: often lose their tempers, are easily annoyed, and feel irritable much of the time.
2. Argumentative/Defiant children display a pattern of arguing with authority figures, and adults such as parents, teachers, and relatives. Children with this type of oppositional defiant disorder actively refuse to comply with requests, deliberately break rules, and purposely annoy others. These children often do not take responsibility for their actions, and often blame others for their misbehavior.
3. Children with the vindictive type of oppositional defiant disorder are spiteful and have shown vindictive or spiteful actions at least twice in 6 months to meet diagnostic criteria [2-6].

Management
Parents are directly trained in child management techniques as part of a family intervention, which also includes a comprehensive analysis of how the family interacts. The intention is to simultaneously promote greater prosocial behaviour and reduce undesirable behaviour. The focus of cognitive behavioral therapy is on changing the behaviour by discouraging oppositional behaviour in children by paying less attention to it and promoting good behaviour by praising and selectively rewarding it.
The child gains benefits from individual psychotherapy through role-playing and practices with better adapted answers. In social circumstances with classmates and families, it aids in the development of a sense of mastery and achievement. The child may learn that he can act less offensively. Positive reactions may frequently result from regained self-esteem. It could be beneficial to replace harsh, punishing parenting with more loving parent-child interactions [2-4].

Prognosis
A child's prognosis for the oppositional defiant disorder is partially influenced by how well their family is doing and whether they are developing concomitant psycho-pathologies.
There is a higher risk of conduct disorder and subsequent drug use disorders in kids who have a strong history of aggressiveness and oppositional defiant disorder. Parental psychopathologies, such as antisocial personality disorder and drug abuse, increases the chance of a volatile and disturbed home environment more than it does in the general population [2-5].

Conduct disorder
Definition
According to the Synopsis of Psychiatry by Kaplan and Sadock - A persistent pattern of behaviours in a child or adolescent known as conduct disorder develops over time and is typically characterized by violence and violating the rights of others. Children with conduct disorders frequently exhibit the four types of behaviours listed below: Violation of age-appropriate standards, physical assault or threats of damage to others, destruction of their own or others' property, stealing, or other dishonest behaviour [2-4].

Causes
A meta-analysis of longitudinal studies indicates that the most important risk factors that predict conduct disorder include impulsivity, physical or sexual abuse or neglect, poor parental supervision and harsh and punitive parental discipline, low intelligence quotient (IQ), and poor school achievement.

Parental factors
The evolution of children's maladaptive aggressive behaviours is linked to harsh, authoritarian parenting that involves severe physical and verbal abuse. Although divorce itself may not be a risk factor for maladaptive behaviour, it may be more significant to consider the continuation of anger, resentment, and bitterness between separated parents. Conduct disorder is frequently caused by parental psychopathology, child abuse, and child neglect.

Genetic factors
A study of more than 6,000 male, female, and opposite sex

twins found that genetic and environmental factors accounted for proportionally the same amount of variance in males and females.
The sex-specific effects on antisocial behaviour in youth along with the replicated finding of a potential role for the X-linked monoamine oxidase A gene in the aetiology of antisocial behaviour leads to the need for further genetic investigation of conduct disorder on the X chromosome and for analyses of these behaviours to be done separately by gender.

Sociocultural factors
Youth residing in geographic areas with greater population density report increased rates of aggression and delinquency. Unemployed parents, lack of a supportive social network, and lack of positive participation in community activities seem to predict conduct disorder.

Psychological factors
Poor emotion regulation among youth is associated with higher rates of aggression and conduct disorder. Emotion regulation is associated with social competence and can be observed even in children of preschool age.

Neurobiological factors
Neuroimaging studies utilizing MRI have used voxel-based morphometry methods to compare structural brain differences between children with conduct disorder compared to normal controls. Studies have reported that children with conduct disorder had decreased grey matter in limbic brain structures, and in the bilateral anterior insula and left amygdala compared to healthy controls.
Neurotransmitter studies in children with conduct disorder suggest low level of plasma dopamine B-hydroxylase, an enzyme that converts dopamine to norepinephrine, leading to a hypothesis of decreased noradrenergic functioning in conduct disorder [2-5].

Clinical features
Conduct disorder does not develop overnight, instead, many symptoms evolve until a consistent pattern develops open that involves violating the rights of others.
The average age of onset of conduct disorder is younger in boys than in girls. Boys most commonly meet the diagnostic criteria by 10 to 12 years of age, whereas girls often reach 14 to 16 years of age before the criteria are met.
Symptoms

Symptoms in children
- Aggressive antisocial behaviour: bullying, physical aggression, and cruel behaviour toward peers. Children may be hostile, verbally abusive, impudent, defiant, and negativistic toward adults.
- Persistent lying, frequent truancy, and vandalism are common. In severe cases, destructiveness, stealing, and ting physical violence often occur.
- Impaired social attachments, evinced by their difficulties with peer relationships.
- Poor self-esteem
- Lack the skills to communicate in socially acceptable ways and appear to have little regard for the feelings, wishes, and welfare of others.

According to ICD11 conduct disorders and oppositional defiant disorders are classified under Disruptive behaviour or dissocial disorder (Block L1-6C9) [2-7].

Diagnostic criteria
According to DSM-5 Diagnostic Criteria for Conduct Disorder child must exhibit symptoms like:
Aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules.
The child shows at least one symptom of conduct disorder prior to age 10 years.
Mild: conduct problems in are few and they cause minor harm to others (lying, staying out after dark without permission, other rule-breaking).
Moderate: The number of conduct problems and the effect on others are intermediate between those specified in "mild" and those in "severe" (e.g., stealing without confronting a victim, vandalism).
Severe: Many conduct problems in excess of those required to make the diagnosis are present, or conduct problems cause considerable harm to others (e.g., physical cruelty, use of a weapon, stealing while confronting a victim, breaking and entering).
At least 3 symptoms should be displayed for a period of 12 months [2-6].

Management
Psychosocial Interventions
When given beginning while a child is in kindergarten, early persistent preventative treatments can change the trajectory and prognosis of violent behaviour.
According to a meta-analysis of CBT program-related controlled trials, CBT can significantly lessen the symptoms of conduct disorder in children and adolescents. The following CBT therapy methods have been shown to be effective.
Children that participate in Kazdin's Problem-Solving Skills Training (PSST), a 12-week sequential programme, learn how to solve problems when confronted with conflict. Children can practice these strategies in vignette circumstances by completing "super-solver" assignments.
Treatment programmes have generally been more successful in lowering overt signs of behaviour, like aggression, and covert signs, like lying or stealing.
Children's treatment plans that emphasize fostering social skills can bring down the aggressive behaviour [2-4].

Prognosis
The prognosis for children with conduct disorder is uncertain in those who have symptoms at a young age, exhibit the greatest number of symptoms, and the severe ones, and express them frequently. The best prognosis is predicted for mild conduct disorder in the absence of coexisting psychopathology and the presence of normal intellectual functioning. If left untreated it may lead to incarceration later in life, due to assaultive behaviour [2-4].

General behavioral assessment
The direct measuring of a specific behaviour is a component of behavioral evaluation. Strict behavioral measurement concentrates on the direct measurements that can be observed, like the number of temper tantrums per unit of time, the duration and frequency of episodes of hyperventilation, or the number of cigarettes smoked per 24-hour period, rather than on human characteristics like

repression, ego strength, or self-esteem (vague terms to a behaviorist).

Direct Counting of Behaviour

Overt behaviour may be directly measured by the patient, a family member, or an unbiased observer since it is straightforward.

These metrics are used by cognitive behaviour therapists to create baselines of a certain unwanted behaviour (i.e., violent thoughts that the patient may wish to reduce). Follow-up actions for the same behaviour evaluate development and analyze improvement [2-4].

Homeopathic approach

A holistic approach to healing is one of the tenets of the homoeopathic system of medicine. It involves not only the child's physical, mental, and emotional development but also the environment in which the child is raised and the mother's emotional condition throughout pregnancy. According to homoeopathic philosophy, every person is a unique individual who has evolved to be significantly distinct from every other human from the moment of creation. Prescriptions for medicines are made depending on how closely a person's symptoms match those of the medicine [8-10].

Table 1: Rubrics for behavioral disorders in different repertories from chapter mind

ADHD Complete repertory Absentminded Abstraction of mind Restlessness [11] **Boricke Repertory** Mood and disposition-impatient, impulsive Mood and disposition- restlessness, mentally, physically. Propensity -to be aimlessly busy [12] **Murphy Repertory** Absentminded Attention deficit disorder. Busy-fruitlessly Hyperactive Overactive Restlessness-children in [13] **BBCR** Absentminded Active fruitlessly Restlessness [14] **Kent** Absentminded [15] **Synoptic key** Hurry, impatience Restlessness, anxious [16]	**ODD Complete Repertory** Anger Defiant Dictatorial Haughty Quarrelsome Rage [11] **Boricke Repertory** Mood, disposition–stubborn, obstinate, self-willed [12] **Murphy Repertory** Anger, children in Anger, trifles at Contradict to others Defiant. Dictatorial Domination – children in Haughty Obstinate [13] **BBCR** Fretful Obstinate Headstrong Defiant Stubborn Peevish [14] **Kent** Defiant [15] **Synoptic key** Stubborn, obstinate [16]	**Conduct Disorder:** **Complete Repertory** Abuse Abusive Attack others desire to Censorious Contemptuous Contradict Cruelty Deceitful Disobedient Haughty Impulses, morbid Kleptomania Liar Malicious Mischievous Obstinate Quarrelsome Rage Rudeness Violence, children in [11] **Boricke repertory** Mania, monomania, kleptomania Mood and disposition, obstinate, stubborn Propensity, to be abusive, curse, swear Propensity, to be cruel Propensity, to be destructive [12] **Murphy Repertory** Abusive, ailments from Abuse Antisocial Attack others desire to Brutality. Cheating behaviour Contemptuous Cruelty Cunning Cursing, children in Deceitful Depravity Destructive behaviour, children in Disobedient Escape, attempts to Fire, wants to set things on Harshness Haughty Impolite Impulsive Insult Others Lies Malicious Mischievous Mocking Quarrelsome Rage, children in Rudeness Striking, children in Vindictive Violent behaviour [13] **BBCR** Abusive Anger Destructive Disobedience Homicidal Impulses, morbid Malicious Quarrelsome Raving, raging Rude. Violence [14] **KENT** Abusive Anger Censorious Destructiveness Disobedience Desire to leave home Insolent. Malicious Quarrelsome Rudeness Violent [15] **Synoptic Key** Abusive, scolding, quarrelsome. Anger, irritability Cruelty. Impulses horrid [16]

Commonly indicated homeopathic remedies in behavioral disorders with indications

Anacardium

- Easily angered, up to blows for the least offence.
- Disposition to become angry and to object.
- Hopelessness with silly manners, awkwardness.
- Disposition to laugh at serious things and seriousness when there is something to laugh.
- Impunity, hard-hearted, cad, deprived, perversity, villainy, curses.
- Disbelieves his own power and discouraged [12, 16-21].

Belladonna
- Indifference, apathy; nothing impresses him; impossibility to enjoy; silent and serious.
- Disposition of taking offence while one is smiling.
- Fury and anger with fixed look, with great deceit.
- Likes to torture men and animals.
- Impulses to set fire, to theft.
- Deranged, mad, spoiled persons [12, 16-21].

Chamomilla
- Speaks and replies only when he is forced, obstinate to speak a word.
- Bad moods with complaints of insomnia.
- Believes to be offended.
- Tendency to become angry and dispute.
- Very much choleric and quarrelsome humour.
- Excessive irritation, extremely sensitive to external impressions.
- Irritable persons, bad humour, disposed to become very angry, quarrel, wicked children, sensitive to pain.
- Quarrelsome and angry; tendency to weep and become angry [12, 16-22].

Hyoscyamus
- He believes himself very strong and very wealthy which he is not.
- Alternate fury and calmness.
- Imprecation, quarrels, rows, reproaches, and complains about imaginary injustice.
- Tendency to being offended and injures others.
- He raises his hand against others and throws himself against others with knife in hand.
- He wants to strike and assassinate everyone he meets.
- Cruelty.
- Jealousy of man towards women and vice-versa [12, 16-21].

Lycopodium
- Grudging persons.
- Bad tempered, especially in the evening.
- He is grave, calm, imperious, arrogant, majestic even when he is angry.
- Head full of ideas of defiance and jealous.
- Great irritability to become angry and afraid.
- Stubbornness sometimes with suppressed anger, which he can hardly express.
- Child becomes disobedient.
- Will full and obstinate character.
- Violence with irritability and easily excited to become angry.
- Least contradiction makes him angry and out of himself.
- Mad fury manifested by envious words, reproaches by ordeal or by imprecations and desire to strike person with whom he disputes.
- Propensity to strike.
- Pride, egoism, envy, jealousy, stubbornness [12, 16-21].

Nux Vomica
- Physical and mental irritability.
- Silent mood, self-centered.
- Restlessness and lamentations which force him to walk in open air.
- Opinionated and obstinate opposition in everything that others desire.
- He cannot bear least contradiction.
- Irascibility, quarrelsome, he is offended by everything.
- Great disposition to criticize and to reproach.
- Injures out of jealousy with shameless expressions, quarrels and reproaches.
- Carried off by violent anger.
- He looks at everybody with a wicked eye, as if he wished to whip them.
- Tendency to run away.
- Pride, quarrels, wicked, liar, guile and theft
- Jealousy of child towards another child.
- Jealous and obscene words [12, 16-21].

Stramonium
- Tendency to run away.
- Fit of fury with development of great force, so much so that one cannot hold him.
- Wants to kill people or himself.
- Arrogance and pride with fear [12, 16-21].

Lachesis
- Believes to be offended by everybody.
- Disbelief and suspicion.
- Insane jealousy.
- Tendency to doubt everything, even for the truth.
- Great dispute.
- Tendency to find fault with others and reproaches them.
- Quibbler and tendency to quarrel for sheer love of contradiction.
- Passionate of anger even without being contradicted.
- He injures others while on ambush and all his thoughts are full of evil.
- Hastiness and restlessness must do everything fast.
- Great irritability: simple touch puts him in fury.
- Envy, pride, jealousy, cruelty, wicked, satiric.
- Opposition and contradicting nature [12, 16-21].

Tarentula
- Impulsive and egotistical.
- Sudden swings in mood.
- Hatred, skilful, clever, destructive, or deficient.
- Throws objects.
- Malingering.
- Kleptomania.
- Furious, dejected.
- Aggression, suddenness, agitation, squirming, and haste.
- Restless arms and legs, picking at fingers; want to move about [12, 16-21].

Conflict of Interest
Not available

Financial Support
Not available

References
1. Mangal SK. Advanced Educational Psychology. 2nd Ed. New Delhi, India: PHI Learning; c2012. p. 3.
2. Sadock, Benjamin J, Virginia A Sadock, Pedro Ruiz.

Kaplan & Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry. Eleventh edition. Philadelphia: Wolters Kluwer. 2015;608-615(1169-1181):1242-1247.
3. McKnight, Rebecca, Jonathan Price, John Geddes. Eds. Psychiatry. Fifth edition. New York, NY: Oxford University Press; c2019. 188, 189, 229, 492-499.
4. Harrison PJ. Philip Cowen, Tom Burns, and Mina Fazel. Shorter Oxford Textbook of Psychiatry. Seventh edition. Oxford: Oxford University Press; c2018. p. 450-456.
5. American Psychiatric Association. American Psychiatric Association, eds. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. 5th ed. Washington, D.C: American Psychiatric Association. 2013;59-66:461-476.
6. ICD-10-CM 2022: The Official Codebook with Guidelines. Chicago: American Medical Association; c2021. p. 338-340
7. ICD-11. The ICD 11 Classification of mental and behavioral disorders diagnostic criteria for research: World Health Organisation, Geneva. Chapter-6; c2018. p. 338- 340.
8. Behavioral Disorders of Chilhood | National Health Portal of India. Accessed February 17, 2023. https://www.nhp.gov.in/Behavioral-disorders-of-chilhood_mtl.
9. Behavioural Disorders Symptoms, Causes, & Homeopathic Treatments – Welcome Cure. Accessed; c2023 Feb 18. https://www.welcomecure.com/diseases/behavioural-disorders/overview.
10. Childhood Behavioral Disorders and Homeopathy; c2018 Jul 26. https://www.ayurclinic.com.au/childhood-behavioural-disorders/.
11. Zandvoort, Roger Van. The Complete Repertory: Mind-Generalities. Leidschendam: Institute for Research on Homeopathic Information and Symptomatology; c1996.
12. Boericke, William, Oscar E, Boericke. Pocket Manual of Homœpathic Material Medical: Comprising the Characteristic and Guiding Symptoms of All Remedies (Clinical and Pathogenetic). 9th ed., Revised and Enlarged with the addition of a repertory. New Delhi: Indian Books & Periodicals Publishers; c2004. p. 48-50, 110-115, 187-189, 336-338, 387-390, 409-413, 473-478, 612-613, 633.
13. Robin Murphy. Homoeopathic Medical Repertory: A Modern Alphabetical and Practical Repertory, B Jain Publishers, Third Revised Edition, Tenth Impression; c2021.
14. Boger, Cyrus Maxwell, Bradford, Thomas Lindsley, Tiwari, Shashi Kant. Boenninghausen's Characteristics Materia Medica & repertory with word index with corrected & Revised Abbrrevations & Word Index. B Jain Pub Pvt Ltd; c2008.
15. Kent JT, Clara Louise Kent. Repertory of the Homœopathic Material Medical. Reprint edition: New Delhi: Indian Books & Periodicals Publishers; c2008 Apr.
16. Boger CM. Synoptic Key of the Material Medical: A Treatise for Homeopathic Students. Rearranged & Augmented edition. New Delhi: B. Jain; c2015. p. 120, 137, 162, 210, 229, 235, 236, 262, 263, 309, 318.
17. Allen HC. Allen's Keynotes Rearranged & Classified: With Leading Remedies of the Material Medical & Bowel Nosodes. Tenth edition. New Delhi: B. Jain; c2018. p. 28-30, 63-66, 111-114, 194-196, 230-233, 241-245, 289-293, 370-372, 383-385.
18. Kent JT. Lectures on Homoeopathic Material Medical: Together with Kent's "New Remedies" Incorporated & Arranged in One Alphabetical Order. New Delhi: B. Jain; c2015; 79-81, 193-218, 363-374, 529-538, 620-633, 643-654,740-747, 898-901, 937- 942.
19. Gallavardin, Jean-Pierre. Psychiatry Remedies: Materia Media and Repertory. Edited by Emm Gallavardin. Translated by Rajkumar Mukerji. 9th impression. Noida, U.P., India: B. Jain Publishers (P) Ltd; c2019.
20. Farrington EA. Clinical Material Medical. B. Jain Publishers; c2013. 33-62, 73- 84,177-198, 217-223, 246-251, 399-423, 439-447.
21. Murphy, Robin. Lotus Material Medical. Third edition. New Delhi: B. Jain; c2022; 141- 143, 318-326, 512-516, 955-960, 1112-1120, 1191-1201, 1403-1411, 1846-1850, 1903-1913.
22. Borland, Douglas M. Children's Types. London: British Homeopathic Association; c1997;3:4.

How to Cite This Article
Steefan JM, Siddesha G, Lovanya D, Priyanka M, Surya MS, Safa NS. Common behavioral disorders in children and homeopathic approach. International Journal of Homoeopathic Sciences. 2023;7(1):464-470.