Role of Homoeopathic in Common Neuropsychiatric Disorder- Adhd in Children

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1. Background

All of us are aware of the significant age-shift in the population distribution throughout theWorld making our country today as one with a very large proportion of the young- a young Country giving us a tremendous advantage. The challenge to bring up a young country is manifold. Parents, Educationists, Sociologists, Physicians-all are enjoined with the responsibility of carrying through the nurturing and caring process of the body and the mind. Homoeopathy, we claim, scores over other systems as it has preventive, promotive and curative properties and hence is a whole system of medicine. What better field can we hope for than working with growing children and especially those who are at risk? As we are aware, the challenge is being taken up on a very stressful field. Not only have our children been under the strain of the scourge of numerous stresses at the physical level (anemia, malnutrition, infections) but the last few years have seen mental stress increasing multifold. Children are made to face the competitive world at a very early age. They are the major victims in this rat race and are like a shuttle cock tossing between the demands from school/Parents/and society and of course, of the self! This competitive world has taken away the childhood of many. We are witnessing a striking contrast between gross indulgence in the superrich, over protectiveness in the urban middle class and gross neglect in the rural regions. While globalization, migration and urbanization proceed at breakneck speed,children become the helpless victims of this juggernaut of change.

This scenario has shown a definite impact on child behaviour and in turn many children end up with psychological maladjustment. There is a need of a counselor in all schools now. The incidence of Childhood Depression, ADHD, Nocturnal enuresis, Anxiety disorder etc. has increased noticeably. As Homoeopaths we have no choice but to stand for the claims of our science and explore the role of this ‘Pathy’ (which is dubbed by the westerners as witchcraft!) in improving the lives of the children in this young country.

Knowledge of Psychology and Psychiatry is not the only need but Knowledge of Materia Medica is equally vital. Our M.M images are best and frequently expressed at the adult level Rather than in children. Though there are very well proved Homoeopathic drugs indicated in Disorders in children (Children Types), it becomes difficult to utilize this information in clinical Practice. The demands from parents/school/ society also need handling which requires a Special skill withHomoeopathic Materia Medica. Community awareness on paediatric issue is also vital.

2. Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) refer to a range of problem behaviors associated with poor attention span. ADHD refers to a chronic behavioral disorder that initially manifests in childhood and is characterized by hyperactivity, impulsivity, and/or inattention. Not all of those affected by ADHD manifest all three behavioral categories. It is the most common psychiatric disorder of childhood affecting 3-5% of children. There is sufficient evidence to

say that the incidence of ADHD has been rising due to a multitude of causes, the chief being the intrusion of multimedia early in the life of the growing child and the inability of the neurophysiological mechanisms to cope with the rapidly changing stimuli,the brain becomes, so to say, to the rapid changes and cannot handle itself when the speed reduces.

ADHD occurs two to four times more commonly in boys than girls (male to female ratio 4:1for the predominantly hyperactive type vs. 2:1 for the predominantly inattentive type).
Three sub types of ADHD are described (1) Predominantly inattentive,(2) Predominantly hyperactive and impulsive,(3) Combined.Early diagnosis and treatment makes a world of difference in the period when learning is Crucial to development. The brain is growing both in size and in connectivity and it is crucial that the attention component is taken care of optimally so that the stimuli are registered and integrated at the right time. Since this time is lost, it cannot be got back again.

One can classify the symptoms on the basis of the three variables, namely, inattention, Hyperactivity and impulsivity. One can classify the symptoms based on the three areas of difficulty, which are inattention, hyperactivity and impulsivity.

3. Diagnosis and Clinical Features

The symptom heterogeneity exhibited by children diagnosed with ADHD is considerable. The variability in behavioral profile within groups of children with ADHD is colored by many factors: Age, symptom subtype, cognitive deficit, co morbidity. Inconsistent behavior and poor academic performance are the hallmarks of ADHD.There is a constellation of symptoms associated with this syndrome: Inattention, Restlessness, Impulsivity, Noisiness, Disorganized Behaviour, High Activity Level, Distractibility Level, and Learning and Academic Difficulties. Having gone through the diagnostic criteria, it would be useful to understand the manner in which the ADHD patient will be brought to the clinician. Referrals are most commonly through the school since that is the structured situation where the disturbance is manifest.

1. Difficulty in remaining seated in structured situations e.g. Classroom, dinner table.
2. In unstructured situations he is more active than peers
3. Fails to pay attention to instruction in academic and social situations
4. Difficulty in withholding a response of any kind until the appropriate moment
5. Difficulty in interrupting an inappropriate course of action once initiated
6. Difficulty in adjusting incorrect or maladaptive responses
7. ADHD behavior is highly context dependent (colored by perception of different persons)

4. Management of Adhd

Treatment depends on a child¡¦s exact diagnosis. Take into account any specific difficulties and those strengths that may aid their improvement. Treatment starts with understanding the child well about his/her strengths and limitations which will aid in making an individualized plan that will fit the needs of the child The strength can be used to enhance the difficult areas which means I need to know him or her well.Along with this they may need specialist support and advice. E.g.- psychologist or a Behavioral therapist. Avoid all stimulants and precipitating factors especially T.V .should be avoided
Yoga and hypnosis plays major role. Dietary advice is necessary especially to avoid packed food, food with preservatives, aerated drinks.

5. Homoeopathic Holistic Point of View of ADHD

Trying to understand the child¡¦s temperamental qualities and shaping up of personalities through various environmental influences helps a better approach in the complete understanding of the evolution of the presentation of the child. Each child with behavioral disorder is unique in him, represents individualization. Though hyperkinetic child revolves around hyperactivity, impulsivity & inattention; the presentation of each child gives a varied & peculiar picture. This picture makes each

child unique and individualistic. This individualization is represented in our Materia Medica which can be seen through repertory after erecting an appropriate totality which represents the essence of each child considering the temperament. The background miasm needs understanding in terms of the Fundamental & Dominating **Miasm.** The disease predominantly falls in the Tubercular Zone. The other co morbid association needs to be understood before finalizing the anti miasmatic remedy.

6. CASE :1

Shri Bhailalbhai Amin Anand Bal Marg Darshan Kendra

{Family and child guidance and counseling centre}

PSYCHOMETRIC ASSESSMENT REPORT

Name: R B DOB: 1/7/2001 CA: 7 yrs 2 months
School: Bright day school – Vasna Grade: 2
Date tested: 15/9/2008

6.1 Background information and referral complaint

Rahil is a pre-term born at 8 months through CS. The amniotic sac had ruptured. Cry followed immediately. He was kept in the incubator for a day. The developmental milestones were slightly delayed. He learned to sit around 8 months; walk at 18 months and speech started at 2 yrs. In the preschool in the initial period he took some time to adjust to new surrounding and learning. It was in higher K.G. he was gaining confidence to learn.

The present problems are although he is a friendly child and is good in creative art, he behaves restless; has short attention span, has difficulty reading and writing. He has mirroring problems. This has partly affected his self-esteem. So it was felt necessary to assess his cognitive strengths and weakness. At home he is found to be a finicky eater – prefers roti and banana; junk food and potato vegetable only.

6.2 Test administered and results

BKT: MA- 7-10 Yrs	IQ: 109 average	Average range
VSMS: SA- 7-7 yrs	SQ: 105 average	90-109
SFB: ST- 8-6 YRS	TT: 7-3 yrs	
BVMGT: age appropriate		
HTTP: HFD MA is 6-0 yrs		
WRAT-R1 Reading GE- 1M		
Spelling GE- 1M		
Arithmetic GE- 2B		

6.3 Observation and test and interpretation

Rahil is a bespectacled boy who appears slightly short. He came accompanied by both parents. He was found to correct and disrupt the conversation during the clinical intake. He had difficulty spelling his surname. He displayed appeasing behavior. He over did things not expected/asked of. When asked t draw human figure he drew a house instead while drawing human figure he rotated the paper to draw curves. Often he was lost in thoughts, and demanded questions be repeated. Although he preferred Gujarati language he tried hard to reply in English. At times he had difficulty comprehending the question however simple it was revealing some thought lock. He has clear speech.

The general test of intelligence finds his social intelligence, numerical reasoning and nonmeaningful memory at 8 yrs; meaning memory and vasomotor function at 7 yrs; nonverbal reasoning at 6 yrs; language at 5 yrs; while conceptual thinking at 4 yrs. He has not developed classification of common objects; identification of colors, knows blue as orange etc. he missed the salient feature in the picture card.

The achievement test finds he is slightly better in decoding and tries to use gestalt approach. He is weak in analysis. He makes bizarre mistakes in writing, he wrote boy/ dog; will/iue; him/ g km; cut/kta; cook/oot; light/lat; must/sqe; dress/ tases etc. he just looks at a letter and assumes the rest. In the mathematic section he attempted simple addition and subtraction.

Rahil was prompt and cooperative in the Seguin Form Board test. He improved speed in the subsequent trials. He copied the geometrical designs from the stimulus cards of the Bender test what comforted his mind. He test finds he suffers mental confusion, organizational difficulties, poor motor coordination; emotional instability, acting out behavior, anxiety, immaturity, neuroses, fearfulness, mental deficiency and reading problems. Organicity is a suspect.

The house-tree-person drawing personality additionally finds he is and overtly aggressive boy. He has been a poor school beginner which could be due to developmental lag or neurological impairment. He has a poorly integrated personality. In fact he has a precarious personality. On one and he desires help, the other hand he may behave hostile and blunt. He likes to receive warmth but is reluctant to permit access to self. He feels he is striving hard but the goal is relatively unattainable. So he seeks Name : Mast R age : 8 yr male, jain pure veg. Baroda.

LOCATION	SENSATION	MODALITY	CONCOM
MIND Since 2 yrs of age	Irritable3 Clenching of fist2 Tantrums	< scolding3 < sweet2	
2 ½ yrs	Restless3 Jumping Running here and there Breaking of things3 Spoiling things3 Useless activity2 Killing of ants and frogs Rough language3 Abusive2 Concentration poor3-	> watching cartoon and TV3	
Since Jr. KG	Writing difficulties3 mistakes in writing, he wrote boy/ dog; will/iue; him/ g km; cut/kta; Memory poor diagnosed Dyslexia in Nov 08		

satisfaction in fantasy, behaves intratensive, keeps self aloof and inaccessible. He desires to see as little as possible. There is a need to make more refined adjustments in interpersonal relations. (His paternal grandmother lives with him. She suffers HBP, diabetes and occ becomes incontinent. Rahil finds her a nuisance at home.) He suffers feelings of intellectual inadequacy which leads to feeling of inferiority and low self esteem.

The VSMS finds him an average functioning boy, helpful at home. He prefers to play either with small children or bigger boys.

DIAGNOSIS: Dyslexia. Attention deficit hyperactive disorder

RECTUM Immediately after birth Since 1 year >2 Daily Abdomen i/f/ related to food.	Constipation Desire absent for weeks Strain3 Stool hard3 Ball like Blackish, yellowish Fissure+ Pain2	➢Enema+ purgatives < bournvita2 < bread2	

6.4 Patient as person

Lean spacs,Appearance: whitish, restless3.Perspiration : profuse forehead2/neck2/ - dribbles.Thirst : freeze water ½ glass ½ hour.Cr: pastry2,choclate2, icecream2, sweet3.
Mo : obst history : menstrual irregularities on hormonal tab. Later on conceived on its own. See life space for detail for state & complaints.
Over all : suppressed anger2/anxiety2 & fear2 of BIL. Resulted in to headache & increased stool.
Sudden decision of ceaser because of less amniotic fluid. Premature 1 month & 11 days.
Birth weight : 2.25. mental state after preg: not prepared, why it was early.
Cried immediately, lactation: slow in sucking, poor lactation.
Dentation : 8 – 9 months, sitting – 7 months, walking – 1 year, speech sentence – 2 yr.
Sleep : good, sun averse, bath : hot averse, ac pref. overall C2 H2.
Odours: prefers sp of perfumes2

6.5 Life Space

Pt's M came for her 7 years old son's c/o ADHD and dyslexia.

Pt belongs to Jain Bhavsar fly of Baroda consisting of GM, paternal uncle and aunty, F and M. pt's M had difficulty in conception due to menstrual irregularity. But ultimately she conceived after 3 yrs of marriage. The overall pregnancy remained stressful for her, both mentally and physically. She had GI infection and fever 2-3 times during pregnancy. Mentally also she remained tensed because of EBIL's nature. He would switch off the fan even when pt felt hot. When she would be sleeping at night, she would be anxious about what if she wakes up late in morning. Her H used to displace his anger on her if anything happens with EBIL. So pt always remained tense throughout the day hoping that no problem occurs because of her. Because of this tension, she had to go to toilet. Many a times she had irritation also which she used to suppress because if once she starts speaking than it would be worst for opposite person- ek var bolvanu chalu karu to samevalanu aavi bane. When angry her communication decreases to a great extent and sometimes her BP increases. After whole day's tension she used to feel relaxed when her H would take her out of home. As it was her first pregnancy, she wanted to go to maternal place for delivery but she couldn't as her maternal place is far from here, her parents were aged and also their financial condition was not so good. So she had to mentally prepare herself for this. After "shrimant" at 7 months she went to stay at her friend's place where she had constant tension what if someone needed her at her in law's place? And in such tension she lost 2 kg weight. Ultimately she went back to in law's house at 8^{th} month. Here she developed some infection due to which CS had to be done. Now she was prepared for normal delivery and not for early CS which created tension for her. Because of this stress she had difficulty in feeding also and she had to give top feed to pt. she didn't find any difficulty in upbringing as her MIL and SIL were also there with her and she remained

at home all the time. Yet her tension continued. So ultimately they separated off on JULY 15th, 2004 when pt was 2 ½ yrs old.

Pt's mother came to know about her problem when he used to play with his cousin of same age and used to beat him if became angry. She found his irritation abnormal but avoided it. He used to beat his cousin if he didn't give him what he wanted. But his behavior was limited up to his cousin only. Right now he becomes angry when he is scolded or asked not to see TV or things don't go his way. He would express his anger by tightly closing eyes, making fists and shaking of whole body or will throw things whatever comes in his hands or he would be abusive even with elders. When scolded, he would keep anger within and would not talk to that person again. He would remember it for long time. Generally he is mischievous also. He would break toys or would throw oil from bottle all over the house or would melt soap in water etc. he would kill ants, frogs etc.

He is also hyperactive and would not sit quietly at one place and would run and jump all the time. The only time when he is quiet is while watching cartoon on TV. Even in school he would get up from his seat and take a round after writing for sometime when the class is still going on. Along with this he has difficulty in recognizing alphabets also. He used to forget every thing if he didn't go to school for 1-2 days which persists even today. As far as maths is concerned, he has no difficulty but he has difficulty in English and Hindi.

He is sensitive3. Whenever there is any problem between his parents, he asks his mother to do whatever his father says, so that there would be no problem. He perceives if his mother is having some problem and asks whether she is OK- puchhe tane kai dukh chhe? He likes doggies and wants to bring them to the house. Same way he also asks mother to bring plants home. He easily gives his things to others. Earlier he was shy but now he can easily mix with others. He was fond of going out but now he doesn't go out much with parents. When asked whether his hyperactivity decreases when he is our, she denied and said he would demand to go back home soon as there is no TV over there.

He neither prepares his school bag on his own nor he wears socks himself but would get ready if he has to go for movie, playing badminton and skating. He likes drawing and clay moldings. He is fond of perfume and grooming nicely.

Date	1	2	3	4	5	6	7	8	9	10	Action.
11.02.09	S	S	S	S	?			?	Pt ab.	-	Taremtula 200 1p HS
17.2.09	S	S	S	S	Av. study	?			Pt ab	-	Ct all
24.2.09	S	S try to beat GMO	S	>	>	Sincere trying	?	?	Pt ab	-	Tarantula 200 3p.HS
3.3.09	s	?	s	>	>	?	?				Ct all
18.3.09	>		>	>	>	>					Ct all
	Talk with clinical psychologist: he is much better in academic. Span/irritability is much better. Constipation : 0										
1.4.09	No report. Irritability/Hyperactivity with contradicts only. It increases with seeing T.V.2nd std. good marks in CBSE. Pt appears better & communicative.										Ct all
18.4.09	>2	>	>2	>2	>2				>2		s.l

	Over all > 50 to 60 % at all the level.										s.l
19.5.09	0	g	s	g	g	>2		G	-	-	s.l
	Relation cordial with all. Performance in community.										s.l
11.6.09	Relatives: he is totally changed, good rel with GMO. Occ. Irritable with jetix TV show.										s.l
11.5.10	Received B +, occasional irritable, adv. Psych evaluation. During vacation aggression increased because of watching fighting cartoons.										

When asked how family members react to his hyperactivity, his mother said earlier she used to throw her anger on him but now she explains him calmly. If he demands for anything, first she would explain him the condition and if he doesn't understand even after that than she brings him that thing. Her H remains out of the house most of the time and so he also behaves nicely with him. Her MIL has still not understood his problem and so many times she advices or interrupts in his work on which he gets irritated and asks his M to tell GM not to talk to him. He himself tells his mother that he would do everything if he would be explained calmly but would not do anything if scolded. Nowadays his behavior has improved and after 1 month's sitting with psychologist, has also developed interest in Hindi and English.

6.6 Follow up Criteria

1. Irritability/Violence, 2. Pt == G Mo relations 3.Restlessness/hyperactivity
4. Concentration-attention span. 5. Academic input 6. Writing difficulty
7. Reading difficulty. 8. Pt = social interactions. 9. Observation of child
10. Input: clinical psychologist.

: 1Constipation 2. Cold in general
20.1.09 treatment started

7. Case -2

Priliminery information
Mast J age 8 yrs. Male , veg, Resi: amdavad.
Fa : Mr. P 34 yrs. Mo : Mrs.P 33 yrs. Br. : 12 yrs.

NO	LOCATION	SENSATION	MODALITIES	ACOOMP.
1	*MIND*	Memory poor+3, Could not recollect lesson		
	Since Schooling	Name of person giving wrong name. Identify wrong—MASHI-MAMI, MAMI-MASHI. Speaking wrong word, writes wrong name.		
		RESTLESS+3 Concentration poor Could not sit in one place for one minute. Running here and there. Throw various items. Never violence. Frequently changes toys for playing.		

	Since 2yrs.-4yrs.	Sit quietly. " GENGA JEVO HATO"		
	MIND Since 2-3 years of age.	Speech stammering+3 R/T/R Even in simple sentence.		

7.1 Associated Complaints

LOCATION	SENATION	MODALITIES	ACCOM.
URT Since 8months Once 15 to 18 days remains continues Up to 3years, once/ year AKT	Recurrent URTI. Nose block+2, cough bouts+2, Rattling and watery cough. Temp.- medium.	COW+3 Dentition+2 Cold bath+2 Allo. Rx	
SKIN Since 6months Armpit Arm/ elbow/ Around umbilicus	Dryness+2 Itching+2, Scaless+2-sticky, dirty white. Discolouration-black pigmentation.		
CNS 3 year of age	Sudden shrieks, crying+2 Eyes closed+3 Redness+2 Fever. Next day morning diagnosed as FEBRILE Convulsion.	>3 after 2-3 months Rx.	

7.2 Patient as Person

CRAVING:- Chocolate+2, Spicy+2, Sour+3, Rae+2.
THIRST:- Small and frequently.THERMAL:- C4H
MOTHER'S OBSTRETIC HISTORY:- Abortion: Induced after elder child
Pregnancy unplanned as elder son was small but accepted.
Morning sickness:-3- 4 months.
Mental state:- Conflict with neighbour, Thoughts+, Tension, internal burning, Could not speak, why doing like this?
Labour:-1st child bleeding at 3rd and 7th month. Amniotic fluid flow before one day.
Delivery:- F.T.N.D- Home village.BIRTH WT.:- 1.7 Kg., Crying immediately.
LACTATION:- 7 Months.
DEVELOPMENTS LAND MARKS AND PROBLEM:-
MENTAL DEVELOPMENT:- Not recognised mo. and fa.
SOCIAL SMILE:- Limited. DENTITION:- Delayed at one year.
SITTING:- After one year.CRAWLING:- 1YRS 2Month.WALKING:- 2 YEARS. WORDS:- 2 ½ years.STAMMERING:- ++
PAST HISTORY:- Typhoid one year back.
FAMILY HISTORY:- PG. Fa—D.M, MG.Mo—Asthma, Maternal uncle-- Asthma

7.3 Interview with mother

Mother was anxious about the pt and felt there was something "abnormal" in pt but family members/relatives did not agree. Grandparents & other relatives considered it as a normal behavior. Gradually his complaints increased. Parents were confused whether to consult any doctors for child behavior?

Basically family hails from Saurashtra. They are belonging to kadva Patel community. Father is a 12th pass businessman. He has been described as COOL & CALM. Mother is 7th pass; home maker described self as irritable3. If any of the children do not obey or perform well in studies, she would beat them with stick/belt or anything that comes in hand. Pt received beating almost daily, He weeps & forgets. Elder one becomes more irritable & throws things. At the same time Mo is anxious3 about patient's future. Grandparents are staying at village. Both are caring3 & fulfill all of patient's demands. Patient is also attached3 to G.P

Mother's state during pregnancy- it was not a planned pregnancy. Her elder son was 3 ½ year old & mischievous by nature. Mother wanted more gap between the 2 children. She accepted the unplanned pregnancy well. There was a quarrel on trivial matters with the neighbor which Mo. did not like & she continues to brood/worried about why this happened? At the end of 8th month she delivered pt at parent's home.

Elder brother is irritable3/dominating3. He has his own way. He does not share his toys. He often interferes or irritates master J. pt. hardly responds to all this.

Mother described pt as cool3, calm, and fearful3. He has fear of police3/dark2/mother2.

Since beginning he was not interested in mixing/ home work etc. He could not sit at one place. He was constantly moving – restles3. Teachers often complained about his restlessness & about him disturbing other students in class by doing mischief. He forcefully eats breakfast of other children. He was not aware what he was doing.

His memory is poor he cannot recollect simple things nor can identify relatives by name (see chief complaints).

He likes to play games but does not understand rules/regulation. He does not take care of things. He would like to break all the things. He would like to snatch other people's things. Usually no one plays with him because he does not know how to play a simple game. He tried to beat other children & he receives a beating.

He is an obstinate3 child. He is fond of new things. Father fulfilled majority of his demands. Otherwise he throws tantrums & takes things by any means.

He does not like if guests stay at home. He takes care of mother when she falls sick. He massages & presses her legs. He likes to watch TV. esp music shows & FIGHTING movies.

7.4 Observation

Master J appeared lean, thin, restless++ with constant blinking3 of eyes & poor eye contact. He was stammering2 while talking & biting his nail. His skin was absolutely dry3

7.5 Shri Bhailalbhai Amin Anand Bal Marg Darshan Kendra

{Family and child guidance and counseling centre}

Psychometric Assessment Report
Name:-J PD.O.B:-18/12/2001CA:-7YEARS 9 MONTHS
School: - Vikas {Guj. Medium}-AhmadabadGrade: - 2
Referred By:-Dr. Hitesh PurohitDate Tested:-9/10/2009

7.6 Background information and Referral Complaints
Jay is a pre-term born [8 month]. It was a normal delivery with immediate birth cry. His birth wt. was 1.7 kg only. He is a home delivered child. On the seventh day he has hospitalized. All his developmental milestones were delayed. He learnt to sit at 21 months, walk and talk after 30 months. At around 3 years he suffered febrile seizure in sleep state. No treatment was offered and event has not reputed till date. He suffers dry skin. It affects the epidermis layer, and the skin peels off. In February '09 he suffered Typhoid.

The present problem are he has weak memory in academics, confuses names of relatives, behave excessively restless, talks meaninlessly, can not copy from the blackboard properly, is nocturnal enuretic and although eats home cooked food, he eats even when he is not hungry. So it was felt necessary to assess his cognitive abilities.

7.7 Tests Administered and Result
BKTMA-5.4 yearsIQ - 69 Mild MR**Average Range** 90-109
VSMSSA – 5.4 yearsSQ - 69 Mild MR
SFBST – 5.0 yearsTT - 4.0 years

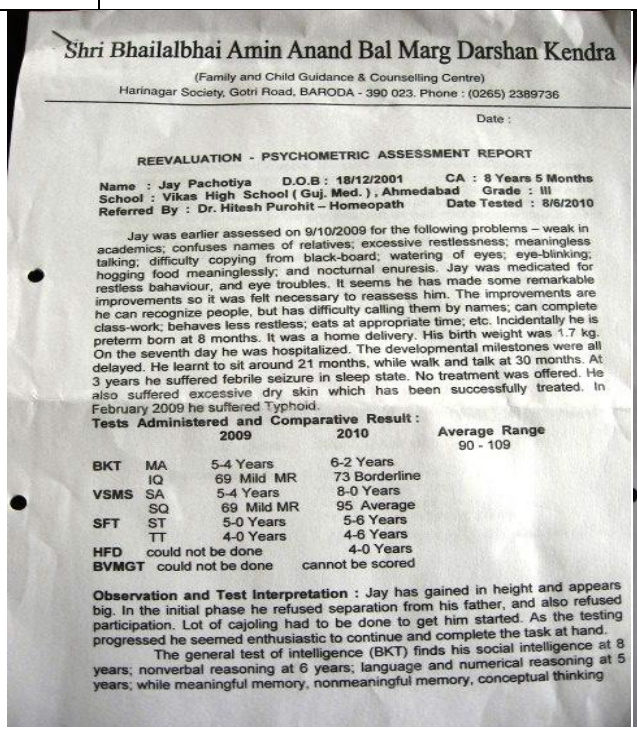
7.8 Observation and Test Interpretation
Jay appears small for his age. He has curly hair. His eyes were reddish and he often blinked. He behaved ill-at-ease. He had difficulty separating from his parents. So his father was allowed to be present. He has poor comprehension, and behaved very disruptive and often wanted to snatch things.
The general test of intelligence [BKT] finds his language and numerical reasoning at 5 years, while meaningful memory, no meaningful memory, conceptual thinking, visulomotor function and social intelligence at 4 years. Jay has not yet developed laterality, coin recognition, esthetic sense, color recognition (knows red and yellow as "white", and blue as "black"), can't say days of the week says the seasons, and cannot identify missing details revealing he has perceptual difficulties.

The perceptual difficulties were further noticed in the Seguin Form Board test. He has part whole recognition difficulty. But with practice effect he can improve. In the test initial trial he placed the shapes haphazardly, but with re demonstration he improved and was totally successful in the final trial.

7.9 The profiles of VSMS are as under
Self-help General – 4yearsLocomotion – 4 years
Self-help Eating – 6 yearsCommunication – 5 years
Self-help Dressing – 7 yearsSocialization – 4 years
Self Direction – NDOccupation – 5 years
He has difficulty playing cooperatively with peer mates. H e beats them and gets beaten. He has difficulty watching TV or concentrating on objects foe long. Cannot take by himself. He has tendency to waste water. He merely pours on himself.
Diagnosis:→ ADHD with Enuresis, Eye Problem and Perceptual-motor problem
Recommendation:→ Regular Eye Check-Up, Play Therapy
Occupation Therapy, Sensory Integration Therapy
Medicine to continue, Parent Counseling
A: 1.Memory. 2. Identification.3 concentration 4. Restlessness 5. Stammering speech
6. Eye blinking 7. Socialization 8. Nail biting 9 enuresis 10 dryness of skin.

B : 1. Observation of child 2. Report of therapist 3. URTI in general.
Treatment started: 5.10.2009

date	1	2	3	4	5	6	7	8	9	10	Action
2.11.09	>	>?.	>?	>?	>	?	?	?	Once/15 days	s. itching2	Baryt carb 200 1p/wkly
Pt ab	Acc. to fa : > able to identify & recollect MAMI.										
25.11.09 Pt.	>	>	>	>	>3	0	?	0	occ	s. itching 0	Ct all
	Acco . to fa "appears cool ,able to identify person. Regularly going at Spandan Foundation (run By PM Barvelia foundation) - Amdavad for 1 hour.										
25.12.09 Tele report	Over all better by 25 to 30 %. Stammering , nail biting, blinking enuresis : 0										Ct all
22.1.2010 Tele report	Over all improving. Memory & identifying > name recollection : poor. Acute cold with fever >3 with ars.alb 200. Talk with Dr. At foundation : improvement + to ++										Baryta carb 200 3p.hs/weekly
19.2.10 tele	Regular medicine. gradual better										Ct all
29.3.10 pt	S	G	Poor	>2	0	0	0	0	occ	Increased	C all
	Fa: able to recollect names, restless +, able to give answer of common questions										
27.4.10	Cold > 3 ars alb.										
31.5.10 pt	g	G	>90 %	>90 %	0	0	0		Occ	>2	B.C. 1m 1 does
	Good improvement. During vacation relatives noticed good change at behaviour.										
14.6.2010	2nd psychometric report.										



Shri Bhailalbhai Amin Anand Bal Marg Darshan Kendra

(Family and Child Guidance & Counselling Centre)
Harinagar Society, Gotri Road, BARODA - 390 023. Phone : (0265) 2389736

Date :

REEVALUATION - PSYCHOMETRIC ASSESSMENT REPORT

Name : Jay Pachotiya D.O.B : 18/12/2001 CA : 8 Years 5 Months
School : Vikas High School (Guj. Med.) , Ahmedabad Grade : III
Referred By : Dr. Hitesh Purohit – Homeopath Date Tested : 8/6/2010

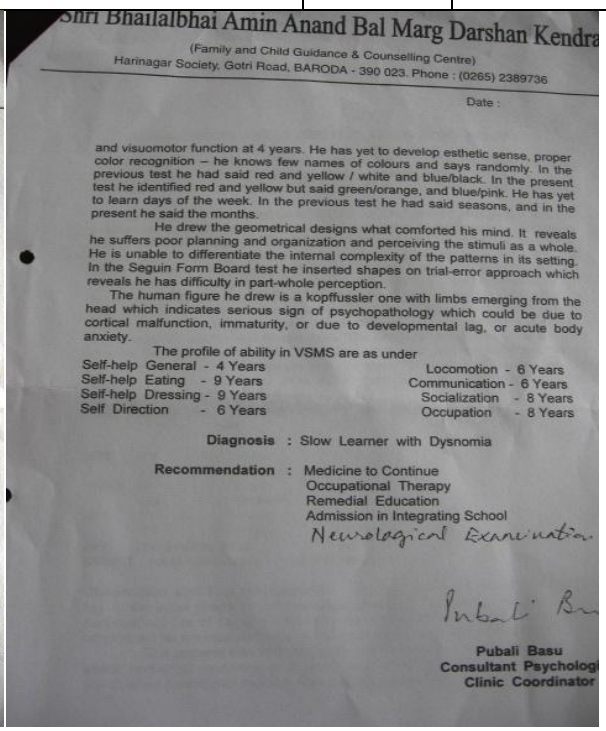
Jay was earlier assessed on 9/10/2009 for the following problems – weak in academics; confuses names of relatives; excessive restlessness; meaningless talking; difficulty copying from black-board; watering of eyes; eye-blinking; hogging food meaninglessly; and nocturnal enuresis. Jay was medicated for restless bahaviour, and eye troubles. It seems he has made some remarkable improvements so it was felt necessary to reassess him. The improvements are he can recognize people, but has difficulty calling them by names; can complete class-work; behaves less restless; eats at appropriate time; etc. Incidentally he is preterm born at 8 months. It was a home delivery. His birth weight was 1.7 kg. On the seventh day he was hospitalized. The developmental milestones were all delayed. He learnt to sit around 21 months, while walk and talk at 30 months. At 3 years he suffered febrile seizure in sleep state. No treatment was offered. He also suffered excessive dry skin which has been successfully treated. In February 2009 he suffered Typhoid.

Tests Administered and Comparative Result :

		2009	2010	Average Range 90 - 109
BKT	MA	5-4 Years	6-2 Years	
	IQ	69 Mild MR	73 Borderline	
VSMS	SA	5-4 Years	8-0 Years	
	SQ	69 Mild MR	95 Average	
SFT	ST	5-0 Years	5-6 Years	
	TT	4-0 Years	4-6 Years	
HFD	could not be done		4-0 Years	
BVMGT	could not be done		cannot be scored	

Observation and Test Interpretation : Jay has gained in height and appears big. In the initial phase he refused separation from his father, and also refused participation. Lot of cajoling had to be done to get him started. As the testing progressed he seemed enthusiastic to continue and complete the task at hand.

The general test of intelligence (BKT) finds his social intelligence at 8 years; nonverbal reasoning at 6 years; language and numerical reasoning at 5 years; while meaningful memory, nonmeaningful memory, conceptual thinking



Shri Bhailalbhai Amin Anand Bal Marg Darshan Kendra

(Family and Child Guidance & Counselling Centre)
Harinagar Society, Gotri Road, BARODA - 390 023. Phone : (0265) 2389736

Date :

and visuomotor function at 4 years. He has yet to develop esthetic sense, proper color recognition – he knows few names of colours and says randomly. In the previous test he had said red and yellow / white and blue/black. In the present test he identified red and yellow but said green/orange, and blue/pink. He has yet to learn days of the week. In the previous test he had said seasons, and in the present he said the months.

He drew the geometrical designs what comforted his mind. It reveals he suffers poor planning and organization and perceiving the stimuli as a whole. He is unable to differentiate the internal complexity of the patterns in its setting. In the Seguin Form Board test he inserted shapes on trial-error approach which reveals he has difficulty in part-whole perception.

The human figure he drew is a kopffussler one with limbs emerging from the head which indicates serious sign of psychopathology which could be due to cortical malfunction, immaturity, or due to developmental lag, or acute body anxiety.

The profile of ability in VSMS are as under

Self-help General - 4 Years	Locomotion - 6 Years
Self-help Eating - 9 Years	Communication - 6 Years
Self-help Dressing - 9 Years	Socialization - 8 Years
Self Direction - 6 Years	Occupation - 8 Years

Diagnosis : Slow Learner with Dysnomia

Recommendation : Medicine to Continue
Occupational Therapy
Remedial Education
Admission in Integrating School
Neurological Examination

Pubali Basu
Consultant Psychologi
Clinic Coordinator

Conclusion: scientific Homoeopathic treatment with proper integration helps for cure.