



CASE REPORT

AYURVEDIC MANAGEMENT OF ATTENTION DEFICIT HYPERACTIVITY DISORDER- A CASE REPORT.

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Abstract

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most frequent neurodevelopmental disorders in childhood, diagnosed in childhood characterized by persistent hyperactivity, impulsivity and inattention which significantly affects the scholastic performance, and affect the daily living. The prevalence of ADHD in India falls approximately 6–11% of children. In Ayurvedic medicine, psychiatric and behavioral problems are linked to the vitiation of *Dhi* (intellect), *Dhriti* (retention), and *Smriti* (memory), a state referred to as *Prajnaparadha*. This case report explores the clinical management of a 6-year-old male child presenting with a neurobehavioral profile, including increased hyperactivity, frequent temper tantrums, inattention, echolalia, and inappropriate laughter. Using the diagnostic framework of the DSM-5, the patient was subjected to a comprehensive one-month therapeutic protocol involving internal Ayurvedic medications, In-Patient (IP) procedural treatments, done behavioral and speech therapy. Clinical progress was rigorously monitored using the ADHD T2 scale, Vanderbilt parent Assessment Scale, and the Clinical Global Impression (CGI) scale. Here the clinical symptoms were correlated to the *unmada* spectrum disorders. The results indicated a significant reduction in hyperactive symptoms and an improvement in attention span. These findings suggest that addressing the cognitive triad of *Dhi*, *Dhriti*, and *Smriti* through traditional Ayurvedic interventions can lead to remarkable clinical improvements in such kinds of neurobehavioral disorders, providing promising results.

Introduction

ADHD is a neurodevelopmental condition that typically appears in childhood and affects an estimated 1.4–3.0% of children, with higher prevalence observed among boys[1]. Its primary symptoms—inattention, hyperactivity, and impulsivity—can significantly impact a child's social and family relationships. Reduced attention span, does not listen when spoken to directly, unable to follow instructions, and fails to focus on schoolwork, etc., which is inappropriate for the individual's age or developmental stage. Hyperactivity and impulsivity are marked by excessive activity, fidgeting, difficulty remaining seated, interrupting or intruding on others, and blurting out answers before questions are completed, etc., are the symptoms that exceed what is typically expected for the person's age or developmental level. ADHD is commonly associated with comorbid conditions such as oppositional defiant disorder, anxiety, and depression. Among these, learning disability is one of the most frequent comorbidities linked with ADHD and is often associated with poor school performance and academic underachievement. Academic deficits,

school-related difficulties, and peer neglect are more strongly associated with symptoms of inattention, whereas peer rejection and, to a lesser extent, accidental injuries are more commonly related to prominent symptoms of hyperactivity and impulsivity. [3]

Attention Deficit Hyperactivity disorder is inherited and multifactorial disorder.[4] Both genetic and environmental factors contribute to its development. Various prenatal and perinatal factors have been identified as underlining risk factors; however, the exact etiology remains unclear. [5]

Different types of evidence-based treatment approaches are available for managing ADHD and its associated comorbidities. Clinical practice guidelines recommended a multimodal approach that includes stimulant and nonstimulant medications, behavioral therapies, routine lifestyle interventions to reduce symptoms and improve overall functioning

Recommendations for the use of medication and behavior therapy are age specific. Behavior therapy in the form of parent training is recommended as the first-line treatment for children younger than 6 years, the guideline suggests the use of FDA-approved medications for ADHD, together with parent training in behavior management (PTBM) and/or behavioral classroom intervention (preferably both). [6] In addition to parent training, behavioral classroom management, behavioral peer interventions, and organizational training have demonstrated well-established effective methods. There are hundreds of trials involving the ADHD drugs; all of the stimulant and non-stimulant medications have adverse effects predominantly including disturbed sleep, neurological conditions (headache, dizziness, insomnia, seizures), psychiatric effects (mood/anxiety, tics) and gastroenterological effects including poor appetite and overlapping with possible growth restriction. [7]

In *Ayurveda*, ADHD we see the aggravated activity of *vata* and *pitha dosha* affect *manovahasrotas* exhibit hyperactivity symptoms like excessive talk, squirming in seat, fidgeting, climbing on windows, etc. which all represent as *atipravrtti* of the *cheshta*, *vak*, and *manas*. The impulsivity is the action without thinking due to impairment of the *buddhi* associated with the impairment of *Dhriti* with child blurts out answers at wrong places, unable to wait for turn, often intrude on others, aggressive nature etc.

Case History

A 6-year-old male child presented to the outpatient department with a clinical-features characterized by increased hyperactivity, frequent temper tantrums, and communication deficits, echolalia, irrelevant speech, and inappropriate laughter. Clinical observations revealed profound restlessness, poor attention, and difficulty with impulse control, along with bruxism and tactile hypersensitivity over the right cheek. The antenatal period was complicated by hyperemesis gravidarum and gestational hypertension, the latter of which required management with antihypertensive medication. The child is the firstborn of a non-consanguineous marriage, delivered via LSCS (3.3 kg) due to maternal bronchial asthma, his antenatal history was significant with hyperemesis gravidarum, low lying placenta, maternal stress due to familial conflicts while his

postnatal history was significant for neonatal jaundice requiring phototherapy on 1st day of life. His bowel, appetite, micturition, and sleep remained normal, and while his developmental milestones gross motor like crawling were timely achieved but fine motor, social and language had early delayed. Family history is significant for paternal speech-language delay and familial alcohol use. At around 10 months of age, the mother noticed long episodes of excessive crying. By one and a half years of age, the child was speaking only in disyllables and had a vocabulary of only one to two meaningful words. The child had earlier acquired the ability to count from 1 to 10 and backwards and to recite the alphabet from A to Z and backwards.

Gradually the mother noticed that the number and alphabet counting skills was regressed at the age of 2 years. Same time the excessive screen exposure was noticed. His communication was mainly by making sounds and pointing towards objects to fulfill his needs. Mild improvement in interaction and communication was noted after the child joined in playschool. By age 3, he e On medication such as risperidone and, exhibited mild poor eye contact and sound intolerance, associated inattention and hyperactivity. On medication such as risperidone and clonidine tablets for 2yrs and conventional speech and occupational therapies, no improvements were seen and the child recently developed hallucinatory episodes, specifically seeing cartoon characters accompanied by intense fear in darkness. He showed improvements in the out-patient treatment, so they took admission here for further evaluation and better management.

Clinical findings

The 6-year-old child presented with core clinical features suggestive of Attention-Deficit Hyperactivity Disorder (ADHD) alongside symptoms of mild ASD in the early period. Inattention was evidenced by a reduced attention span, difficulty concentrating, frequent careless mistakes, and an inability to finish tasks or retain study material. Hyperactivity and impulsivity were further noted through reduced sitting tolerance, persistent wandering, restless, on-the-go nature and solitary play. The child exhibited difficulty waiting for his turn, frequently interrupted others, and acted impulsively before receiving directions. Additionally, he exhibited increased temper tantrums, irrelevant speech and laughter, bruxism, and tactile sensory hypersensitivity over the right cheek.

Ashta sthana pareeksha is as follows:

Nadi: sadarana

Mootram-peetham

Malam –Pinditham

Jihwa –Anupaliptham

Sabdham-Aspashtam & Avyaktham

Sparsha-Anushnam

Drik-Anavilam

Akruti-krusha

Asta sthana pareeksha infers that the vitiated doshas are Pitha and Vatha.

Dasavidha Pareeksha is as follows

Dooshyam:

Dosha-Pitta, Vata, Dhatu-Rasa, Srotas-Rasavaha srotas, Manovaha srotas

Desham:

Deha desha -Sarvangam, Bhumi desha-Jangalam

Balam

Rogi Balam -Avaram

Roga Balam -Pravaram

Kaalam:

Kshanaadi-Sisisram

Vyadhi avastha-Pravaram

Agni -Madyamam

Prakruthi: Vatapitta

Vaya: Baala

Therapeutic interventions

The treatment protocol was structured within an Ayurvedic framework to address a *Sannipathika dosha dushti* (imbalance of all three *doshas*), with a specific clinical focus on the predominance of *Pitta* and *Vata*. This approach was tailored to the patient's *vaya* (age), *dehabala* (physical strength), *agnibala* (metabolic capacity), and the specific *dushya* (affected tissues) involved.

The therapeutic objective was to manage the patient's symptoms as manifestations of *Bala Unmada*. The management strategy utilized the principles to correct digestion and metabolism, *Srotoshodhana* for systemic detoxification and channel clearing, and specific *Pitha-Vata samana* therapies to restore internal equilibrium.

Initially, the patient received outpatient treatment consisting of *Rajanyadhi choorna* (5g twice daily after food) and *Kalyanaka Ghrita* (5ml two times) for one month, *saraswatha choornam* 2.5gm twice daily after food and *Hridya virechana* one teaspoon at bed time with lukewarm water. Upon inpatient admission, this regimen was continued with the addition of *Balarishtam* (5ml twice daily after food), *Gandha Tailam* 3 drops mixed with *Arishtam*, *Gulashundi* one teaspoon twice daily.

Table 1. Internal medications

Sl. No	Internal medicine	Dose	Remarks
1.	<i>Rajanyadi Choornam</i> ^[8]	1 tsp twice daily (BD) with hot water	<i>Agnideepana</i>
2.	<i>Saraswatha Choornam</i> ^[9]	1/4 tsp twice daily (BD) with ghee and rock candy.	Improving clarity of speech
3.	<i>Kalyanaka Ghritam</i> ^[10]	After attaining the <i>Deepana</i> start 1 tsp twice daily before food	Reduce behavioral manifestations, improve scholastic performance
4.	<i>Balarishtam</i>	5ml twice daily after food	Maintenance of general health.
5.	<i>Gandha Tailam</i>	3 drops mixed with <i>Arishtam</i>	Maintenance of general health.
6.	<i>Gulashundi</i> ^[11]	1 tsp twice daily	Maintenance of general health.
7.	<i>Hridyavirechanam</i>	1 tsp at bedtime (HS) with hot water	<i>Indriyaprasadanam</i>

Table 2: External procedures

Sl. No	External treatment	Duration	Remarks
1.	<i>Utsadanam</i> with <i>Triphala Choornam</i> & Milk	3 Days	Improve Agni
2.	<i>Abhyangam</i> with <i>Sudhabala Tailam</i>	7days	Attention improved.
3.	<i>Ksheeradhara</i> with <i>Panchatiktakam kashayam</i> <i>Abhyangam</i> with <i>Vatasini Tailam</i> ^[12]	7days	Hyperactivity slightly reduced.
4.	<i>Navadhanya Lepam</i> in <i>balaksheeram</i>	7 days	Hyperactivity reduced, improve nourishment.
5.	<i>Sirodhara</i> with <i>sudhabala</i> and <i>lakshadhi thaila</i>	7 days	Sitting tolerance improved, reduce temper tantrums.
6.	<i>Bala sohaladhi sirolepa</i> ^[13]	7 days	Attention improved, hyperactivity reduced
7.	Face massage with <i>dhanwanthara thaila</i>	During the course of treatment at hospital	Improve the clarity of speech
8.	<i>Mukha prathisananam</i> with <i>kalyana avaleha choornam</i> ^[14]	During the course of treatment at hospital	Reduce tactile hypersensitivity over the right cheek.

Over a treatment period of one month, the therapy was initiated with *Rukṣaṇa* in the form of *Utsadanam* with *Thriphalachoornam* with milk. After achieving a state of mild *Rukṣaṇa*, *Abhyanga* with medicated oil was performed, followed by *Kṣheeradhara* using *Pancatiktakam ksheera Kaṣaya*. Subsequently, *Snigdha Pralepa*, *sirodhara*, and facial massage were administered continuously for seven days. *Bala Sohaladi sirolepa* was also applied for a duration of seven days. Throughout the treatment period, facial massage with medicated oil and *Mukha Pratisaraṇam* were continued regularly.

Psychosocial intervention

Behavioral therapy sessions were conducted three times per week. Initially, long-term goals were established, including improvement in attention span, waiting behavior, social and cognitive skills. Short-term goals were also defined, such as improving attention, reducing hyperactivity, and minimizing temper tantrums during therapy sessions. Several structured activities of ball-passing activities, bead-sorting tasks based on color, and picture-naming tasks. Positive reinforcement techniques such as reward systems and star-charting were used to encourage appropriate behavior. [15] These interventions were to improve the attention, reduce the hyperactivity and other maladaptive behavior. In addition, parental training and counseling were provided during all sessions to help care givers to understand behavioral management strategies.

Result

1.Attention-Deficit/Hyperactivity Disorder Test (ADHDT2) [16]

Items	Pre assessment	Post assessment
Inattention	27	13
Hyperactivity	34	20
ADHD index	89	71
Probability	Likely	possible

2.Vanderbilt Assessment scale 3rd edition- parental assessment [17]

Items	Pre assessment	Post assessment
Inattention	2	0.9
Hyperactivity	2.3	1.2
Fear and Anxiety	0.85	0.57
Academic performance	2.7	2.4

3. Clinical global impression scale [18]

Clinical global impressions	Pre assessment	Post assessment
Severity of illness	4(moderately ill)	3(Mildly ill)
Global improvement		2(Much improved)
Therapeutic effect		3(Decided improvement- partial remission of symptoms)
Side effect		3 (none)

The patient underwent comprehensive clinical evaluations, including the ADHDT2 scale, Vanderbilt Assessment scale 3rd edition- parental assessment, Clinical Global impressions rating scales.

Post-treatment, significant improvements were observed in attention, hyperactivity, academic performance and the overall quality of life. After treatment the patient demonstrated remarkable recovery, reduced echolalia and inappropriate laughing. Attention and focus improved, temper tantrums and hyperactivity reduced significantly. His hallucination and fear to darkness was reduced. He obeys commands. Considering the overall treatment assessment, decided improvement was noticed along with partial remission of symptoms and no treatment side effect was noticed.

Discussion

The patient came to the OPD with complaints of reduced attention span, difficulty concentrating in studies, frequent careless mistakes, inability to finish tasks, hallucinatory episodes specifically seeing cartoon characters accompanied by intense fear in darkness. Additionally, he had affected with increased temper tantrums, irrelevant speech and laughter, and tactile sensory hypersensitivity over the right cheek. In Ayurveda, Attention Deficit Hyperactivity Disorder (ADHD) can be understood as a manifestation of *Unmada*, characterized by disturbance of the mental functions. It results in *Prajnaparadha* (intellectual blasphemy), where the coordination between the mind, intellect, and memory is lost, leading to abnormal behavior.

Unmada in this case is rooted in *heena satwa* (a weak psychological constitution), which makes the individual highly susceptible by both *Sharirika* and *Manasika dosha* imbalances. This vulnerability is compounded by *Bija Dushti* (hereditary factors), evident in the paternal history of speech-language delays and excess alcohol use. Furthermore, *Garbhpaghatakara Bhavas* for prenatal factors has played a significant role, the maternal history included a prior abortion, psychological stress, hyperemesis gravidarum.

Postnatally, these underlying vulnerabilities were triggered by improper dietary habits and environmental stress in mother. This *garbhpaghatakarabhava* along with *heena satwa* in child leads to *rasa dhatu dusti* and *rajo tamovagunya*. This is accelerated by increased screen time and less peer group interaction opportunity gives to *vata pradana tridosha dusti* in child and *sthana samsraya* in *manovaha srotas* manifesting *vathapitha prakopa*. Resulting decline in mental function like *dhee*, *driti*, *smriti* that eventually manifests as *Bala Unmada*. Because of these factors resulting loss of intellect, knowledge, and memory, the individual starts to have hyperactivity, impulsivity and inattention.

This case demonstrates the potential of Ayurvedic protocols in the management of ADHD child, especially when conventional treatments showed limited results. ADHD are predominantly attributed to the vitiation of *Vata Pitha Dosha* and *srotorodha*. Therefore, the primary objective of treatment is to restore and maintain the normalcy of *Vata* and *Pitha dosha*, *srodhosodhana* by different therapeutic measures.

Treatment began with *Agni-deepana* and *Vata-anulomana* using *Rajanyadhi Choornam*. *Kalyanaka Ghritha* improve *drithi* by its *srothoshodhana* property and very effective in *vata paithika unmada*. *Saraswatha choornam* improves the speech clarity and improve *buddhi*, *dhriti* and *smriti*. Upon inpatient admission, this regimen was continued with the addition of *Balarishtam*, *Gandha Tailam* 3 drops mixed with *arishtam* for improved the general health. *Gulashundi* is prepared with *thila*, *shundi* and palm jaggery that's rich in iron and calcium which improve the general health. *Hridya virechana* 1teaspoon daily at bed time with lukewarm water for *mridushodhana* and the repeated *shodhana* gets clean the *koshta*, *hridaya*, *indriyas* which refreshed the mind gradually.

Over one month, the external treatment started with *Utsadanam*, with *Triphala Choornam* and milk for *Rukshana*. As *chalatwa* and *anavasthitatwa* is the quality of *vata*, *abhyangam* with *Sudhabala Tailam* helps to reduce *vata*, which is responsible for hyperactive behavior in ADHD patients. This has also been shown to increase serotonin levels which might help to modulate elevated dopamine levels in children with ADHD. *Ksheeradharā* with *Panchatiktakam Kashaya choornam* and mild *abhyangam* with *Vatasinithailam*^[17] which reduces tantrums and hyperactivity. *Navadhanya Lepam* in *balaksheeram* which is *Snigdha pralepa* and are nourishing in nature. As *Shira* is considered to be *uttamanga* in which controls the functions of body, we planned for *Shirodhara* with *sudhabala* and *lakshadhi thaila*, having *vata pitta hara* property which helps to reduce the hyperactivity. Also it is *indriyaprasadana* and pacifies *vata* which is responsible for the impulsive behaviour, and helps in decreasing the visual and auditory reaction time thereby increasing the attention span. *Balasohaladhi sirolepa* is the special *sirolepa* which indicated in *unmada chikithsa* to reduce the hyperactivity, temper tantrums and improve the sleep quality. Face massage with *dhanwanthara thaila*, *Mukha prathisananam* with *kalyana avaleha choornam*¹ together helps to increase the clarity of speech, chewing ability, and reduce the hypersensitivity of cheeks.

Conclusion

The management of Attention-Deficit Hyperactivity Disorder (ADHD) requires a comprehensive approach that addresses its central symptoms as they persist from childhood into adulthood. While conventional interventions—such as behavioral, occupational, and speech therapies—provide foundational support, they often fall short of achieving optimal clinical outcomes when used in isolation. This case demonstrates that integrating *Ayurvedic* principles, specifically those related to *Unmadam*, offers a more holistic and effective strategy. Considering the patient's *prakrithi* and *koshta* along with the treatment more favorable prognosis can be achieved.

Declaration and Patient Consent

Authors certify that they have obtained a patient consent form, where the caregiver has given consent for reporting the case in the journal. The caregiver realized that his name

and initials will not be published, and efforts will be made to cover the identity, but obscurity cannot be guaranteed.

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