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Effectiveness of Individualized Homoeopathic Treatment in Children with Autism Spectrum Disorder: A Prospective Observational Study

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Abstract
Background: Autism spectrum disorder (ASD) is a heterogeneous neurodevelopmental condition characterized by impairments in social communication and interaction, along with restricted and repetitive patterns of behavior. The burden of ASD is substantial, and current management is largely supportive, multidisciplinary, and individualized rather than curative.who+2 Complementary and alternative approaches, including homoeopathy, are sought by many families, although the current evidence base remains limited and methodologically heterogeneous.
Objective: To describe the baseline clinical and psychometric profile of children with ASD receiving individualized homoeopathic care in routine practice and to explore the potential clinical relevance of individualized homoeopathic treatment within a prospective observational framework.
Methods: This study was designed as a prospective observational case series based on 8 pediatric cases with documented ASD or prominent autistic features and available developmental, behavioural, and psychometric records. Baseline information was extracted from reports generated by recognized clinical centres and included sociodemographic data, developmental history, behavioural observations, cognitive/developmental testing, adaptive functioning, autism severity measures, and coexisting behavioural symptoms.Standardized tools represented across cases included the Childhood Autism Rating Scale, Second Edition (CARS-2), Indian Scale for Assessment of Autism (ISAA), Vineland Social Maturity Scale (VSMS), Binet-Kamat Test of Intelligence (BKT), Developmental Screening Test (DST), Conners Parent Rating Scale-Revised, and Developmental Psychopathology Check-List.
Results: All 8 cases were male and demonstrated marked heterogeneity in age, intellectual functioning, adaptive behaviour, autism severity, and behavioural comorbidity. Delayed speech/language, impaired social reciprocity, poor eye contact or name response, and adaptive deficits were common baseline features across the series. Cognitive functioning ranged from borderline intelligence to severe intellectual disability, while autism severity ranged from autistic features/minimal symptoms to moderate autism depending on the scale used. Several children also showed coexisting inattention, hyperactivity, tantrums, aggression, seizure history, or neurological abnormalities. Taken together, the baseline case material supports the clinical complexity of ASD presentations encountered in homoeopathic practice and the need for individualized management strategies.
Conclusion: Individualized homoeopathic treatment may have potential clinical relevance as a supportive and person-centered approach in children with ASD presenting with heterogeneous developmental and behavioural difficulties. However, the present dataset is strongest for baseline characterization and observational interpretation rather than definitive efficacy assessment, and larger prospective controlled studies with standardized repeated outcome measures are required before firm conclusions can be drawn regarding effectiveness..
Keywords Autism spectrum disorder, Childhood autism, Neurodevelopmental disorder, Adaptive behaviour, Vineland Social Maturity Scale, Childhood Autism Rating Scale (CARS-2), Indian Scale for Assessment of Autism (ISAA), Attention-deficit/hyperactivity symptoms, Intellectual disability..

INTRODUCTION

Autism spectrum disorder (ASD) is a neurodevelopmental condition characterized by persistent difficulties in social communication and social interaction, along with restricted, repetitive patterns of behavior, interests, or activities. The condition presents with substantial clinical heterogeneity, with variation in language ability, intellectual functioning, adaptive behaviour, sensory responsiveness, and associated behavioural problems such as hyperactivity, irritability, and emotional dysregulation.

The public health burden of ASD has increased in visibility over the last two decades, partly because of improved recognition, broadened diagnostic frameworks, and expanding surveillance systems. Recent surveillance data from the United States estimated that about 1 in 31 children aged 8 years had been identified with ASD, underlining the growing need for sustained developmental, behavioural, educational, and family-centred support services. The World Health Organization also emphasizes that autistic individuals often experience substantial barriers in health care, education, and social participation, especially when support systems are delayed or inadequate.

Current management of ASD is largely supportive, multidisciplinary, and individualized rather than curative. Contemporary guidelines recommend comprehensive care that may include psychoeducation, parent-mediated strategies, speech and language therapy, occupational therapy, social-communication interventions, behavioural support, and management of coexisting problems such as sleep disturbance, anxiety, attention-deficit/hyperactivity disorder (ADHD), or challenging behaviour. At the same time, major guidelines also acknowledge that there is no single intervention that "cures" autism, and treatment planning must be tailored to the child's developmental profile, strengths, needs, and family context.

In routine practice, many families of children with ASD seek complementary and alternative approaches in addition to conventional care, especially when they perceive persistent difficulties in communication, behaviour regulation, attention, or adaptive functioning. However, the evidence base for many such interventions remains limited, heterogeneous, and methodologically weak, making careful documentation of real-world clinical outcomes important. Reviews of complementary and alternative medicine in autism have repeatedly concluded that interest and uptake are substantial, but higher-quality evidence is still needed before confident efficacy claims can be made.

Individualized homoeopathy is used in some clinical settings as a person-centred therapeutic approach in which remedy selection is based on the totality of symptoms, behavioural characteristics, and constitutional features of the child rather than on diagnosis alone. This individualized orientation may appear attractive in ASD because children on the spectrum often differ considerably in symptom expression, associated developmental problems, sensory features, and behavioural patterns. Nevertheless, the current literature on homoeopathy in ASD remains limited, with small studies, case reports, and heterogeneous methodologies, which restrict the strength of conclusions regarding effectiveness.

In such a context, prospective observational studies can play a useful preliminary role by documenting baseline clinical characteristics, individualized treatment patterns, and longitudinal changes observed in routine practice. Although observational designs cannot establish causality in the way randomized controlled trials can, they are valuable for generating clinically grounded evidence, especially in heterogeneous pediatric populations where individualized care is common and standardized outcomes are not always uniformly available. Carefully described observational case series may therefore help clarify symptom domains that appear to change over follow-up, identify feasible outcome measures, and guide the design of future controlled studies.

The present study was undertaken to examine the effectiveness of individualized homoeopathic treatment in children with ASD in a prospective observational framework. Drawing on detailed developmental, behavioural, and psychometric assessments available for the included cases, this study aims to describe baseline clinical profiles and document changes observed over the course of individualized homoeopathic management in routine practice.Materials and Methods

Study design and setting

This study was designed as a **prospective observational case series** of children with autism spectrum disorder (ASD) or prominent autistic features who were managed with individualized homoeopathic treatment in routine clinical practice. The observational approach was selected because the available dataset consisted of clinically documented case records, baseline psychometric reports, and longitudinal case-wise therapeutic observations rather than randomized or controlled intervention data. Such a design is appropriate for preliminary real-world documentation in heterogeneous developmental conditions, particularly when children differ substantially in symptom severity, intellectual functioning, adaptive behaviour, and coexisting behavioural problems.

Participants

Eight paediatric cases were included in the present series on the basis of available complete case records and supporting psychometric documentation. The children had undergone prior developmental, behavioural, and psychological assessment at recognized centres, including SpeechPlus, Institute of Child Health/Nivedita School, University of Calcutta, NIMHANS, Sahayta Clinic, AddLife Caring Minds, and other specialist services. The age range of the included children was approximately 2.5 to 13 years, and the case records documented a spectrum of developmental presentations ranging from autistic features with borderline intelligence to autism with mild or severe intellectual disability and comorbid attention-deficit/hyperactivity symptoms.

Inclusion and data source criteria
Cases were included if they fulfilled the following criteria: (1) child or adolescent age group, (2) documented ASD diagnosis or clear autistic features in psychometric/clinical reports, (3) availability of baseline developmental or psychological assessment records, and (4) availability of sufficient case material for clinical interpretation within the homoeopathic observational framework. Cases with incomplete records that did not permit extraction of baseline clinical characteristics were excluded from the present consolidation. The study dataset was compiled from already existing reports, referral documents, behavioural observations, developmental histories, and case-wise psychometric summaries shared for analysis.

Clinical and psychometric assessment
The study relied on baseline clinical and psychometric information generated by trained psychologists and specialist centres before or during routine care. Across the 8 cases, the following standardized tools were represented in the available records:
Childhood Autism Rating Scale, Second Edition (CARS-2), including Standard Form and High-Functioning form where applicable.
Indian Scale for Assessment of Autism (ISAA).
Vineland Social Maturity Scale (VSMS) for adaptive and socio-developmental functioning.
Binet-Kamat Test of Intelligence (BKT) and/or Developmental Screening Test (DST) for mental age, developmental age, developmental quotient, and inferred intellectual level.
Conners Parent Rating Scale-Revised and Developmental Psychopathology Check-List (DPCL) in cases with documented inattention, hyperactivity, or behavioural dysregulation.
CARS-2 is a clinician-rated instrument used in clinical and research settings to quantify autistic symptomatology and distinguish non-autistic, mild-to-moderate, and severe autistic presentations. The scale includes a standard form for younger or lower-functioning children and a high-functioning form for older children with better language and cognitive performance. Adaptive behaviour assessment was also considered essential in the present dataset because social maturity and daily functioning are highly relevant in ASD and may not parallel cognitive level alone.

Variables extracted
For each case, the following variables were extracted from the available records: age, sex, referral context, presenting complaints, developmental history, behavioural observation, psychometric tools used, IQ or developmental quotient, adaptive functioning indicators, autism severity category, coexisting ADHD-related symptoms, and other associated neurological or behavioural findings. Where available, exact raw scores were recorded, including CARS-2 scores, ISAA scores, VSMS social age/social quotient, BKT IQ, DST developmental quotient, and Conners T-scores. Narrative variables such as delayed speech, poor response to name, deficient eye contact, reduced social reciprocity, stereotyped/restricted play, tantrums/aggression, and hyperactivity/restlessness were also coded from the clinical descriptions.

Homoeopathic intervention
All included children were considered under an individualized homoeopathic treatment model in which medicine selection was based on the totality of symptoms, behavioural presentation, developmental pattern, and child-specific constitutional features rather than diagnosis alone. Because individualized prescribing is inherently patient-specific, remedy selection, potency, repetition, and follow-up planning were intended to vary from case to case according to the evolving symptom picture. For the purposes of the present paper, treatment-related observations were to be interpreted as part of routine clinical care rather than as protocol-driven experimental intervention data.

Outcome domains
Given the heterogeneity of the available records, outcomes were conceptualized primarily at the level of clinically meaningful domains rather than a single uniform endpoint. The main domains considered for longitudinal interpretation were: (1) speech and language function, (2) social interaction and reciprocity, (3) eye contact and response to name, (4) adaptive functioning, (5) stereotypic or restrictive behaviours, (6) irritability/tantrums/aggression, and (7) inattention or hyperactivity where documented. When repeat standardized scores were available, they were considered secondary outcome indicators; however, because assessment tools were not uniform across all cases, the study primarily adopted a descriptive and case-wise observational analytical approach.

Data handling and analysis

The extracted data were consolidated into a structured case sheet for cross-case comparison. Descriptive analysis was planned using case-wise tabulation of demographic, developmental, psychometric, and behavioural variables, followed by narrative synthesis of the observed clinical profile of each child. Because the sample size was small and the assessment battery varied across cases, formal inferential statistical testing was not considered appropriate at this stage; instead, the analysis focused on baseline characterization and clinically observed patterns across cases.

Ethical considerations

All cases were anonymized for academic presentation, and identifying details were proposed to be replaced by case numbers during manuscript preparation. The present work was based on clinical records and shared documentary material compiled for research writing purposes, with emphasis on confidentiality and non-disclosure of personal identifiers in the final manuscript. The study should be presented as an observational clinical case series, and no claim of controlled efficacy should be made beyond the scope of the available data.

Results

A total of 8 pediatric cases were included in the present observational series. All children were male, and the available records showed substantial heterogeneity with respect to chronological age, developmental profile, autism severity, intellectual functioning, adaptive behaviour, and behavioural comorbidity. Across the shared reports, the age range extended from approximately 2 years 6 months to 13 years, although most children were in the preschool or early school-age period at the time of baseline psychometric documentation.
The baseline case characteristics are summarized below.

Table 1: Baseline case profile

Case	Age at baseline	Baseline impression	Cognitive profile	Autism measure	Autism severity	ADHD/ comorbidity
1	5.1–5.6 years	ASD with borderline intellectual functioning	IQ 71, borderline	CARS-2 ST; ISAA/related autism testing	CARS-2 = 31, mild-to-moderate; ISAA ≈ 101, mild	Attention/externalizing symptoms; anger outbursts
2	6.0 years	ADHD with borderline intellectual functioning and developmental deficits	IQ 76, borderline	No definitive ASD severity tool in shared records	Not established from current documents	ADHD symptoms on Conners; seizure follow-up; MRI gliotic lesions
3	9.0 years at NIMHANS; 13.0 years at later review	Mild ASD with behavioural dysregulation	Not quantified in shared records	ISAA	ISAA ≈ 105, mild autism	Convulsion history; tantrums/aggression/anxiety
4	2.5 years initial; 4.6 years later review	ASD features initially; later ASD + ADHD + behavioural issues	Not quantified in shared records	CARS-2 HF	CARS-2 = 30, mild-to-moderate ASD features	ADHD and behavioural issues noted later
5	4.7 years	Borderline intelligence with developmental difficulties and ADHD features; autistic traits	IQ 78, borderline	CARS-2 ST	CARS-2 = 26.5, minimal-to-no ASD range	ADHD features on Conners and DPCL

6	6.2 years	Moderate ASD with mild intellectual disability	IQ 51, mild intellectual disability	ISAA	ISAA = 108, moderate autism	Hyperactivity/restlessness and aggression
7	3.2 years	Mild-to-moderate ASD with mild intellectual disability and ADHD features	IQ 68, mild intellectual disability	CARS-2 ST	CARS-2 = 32.5, mild-to-moderate	Elevated inattention and hyperactivity on Conners
8	6.4 years	Moderate ASD with severe intellectual disability	IQ 28, severe intellectual disability	ISAA	ISAA = 117, moderate autism	Temper tantrums and restlessness

Cross-case trends

Delayed or poorly developed speech/language was one of the most consistent baseline complaints across the series and was documented in nearly all cases. Deficits in social reciprocity were also common, including poor response to name, limited eye contact, reduced peer interaction, absent or poor social smile, self-absorption, and difficulty initiating or sustaining communication.

The psychometric records also showed substantial heterogeneity in intellectual functioning. Three children were in the borderline range of intelligence, two had mild intellectual disability, and one had severe intellectual disability; in the remaining cases, exact IQ was not consistently reported in the shared documents. Adaptive functioning, where assessed by the Vineland Social Maturity Scale, was below chronological age in the majority of cases and was particularly impaired in communication and socialization domains.

Autism severity ranged from mild autistic features to moderate autism. On CARS-2-based reports, some children fell within the mild-to-moderate range, whereas one child was described as being in the minimal-to-no symptoms range despite developmental and behavioural concerns. In ISAA-based assessments, the documented severity ranged from mild to moderate autism.

Coexisting behavioural dysregulation was another recurring pattern. Several children showed elevated inattention and hyperactivity/impulsivity scores on Conners ratings or were clinically described as restless, overactive, distractible, or difficult to engage in sustained tasks. A smaller subset also had additional neurological or developmental complexity, including seizure history and MRI-documented gliotic brain lesions.

Case-wise summaries

Case 1: The child presented with delayed speech, poor social reciprocity, lack of sustained eye contact, difficulty understanding instructions, anger outbursts, and poor peer interaction. Psychometric findings showed borderline intellectual functioning with BKT IQ around 71, delayed adaptive functioning on VSMS, CARS-2 score of 31 indicating mild-to-moderate ASD symptoms, and an ISAA score around 101 consistent with mild autism.

Case 2: This child demonstrated borderline intellectual functioning with BKT IQ around 76 and delayed adaptive functioning on VSMS. Conners ratings indicated clinically relevant inattention and hyperactivity/impulsivity, while MRI findings documented multiple small gliotic lesions with mild diffuse brain shrinkage in the context of ADHD and seizure follow-up.

Case 3: The child had a history of convulsions, behavioural dysregulation, difficulty with strangers, irritability, tantrums, and aggression, alongside social interaction concerns. NIMHANS and later psychiatry records supported an ASD diagnosis, and a later ISAA-based assessment categorized the presentation as mild autism with reported disability.

Case 4: At initial early childhood assessment, the child showed delayed speech, poor response to name, poor recognition of familiar persons, failure to follow instructions, and restricted play patterns. CARS-2 findings suggested mild-to-moderate autistic features, and later neurology documentation described ASD with ADHD and behavioural issues.

Case 5: This child showed speech delay, distractibility, immature social behaviour, and developmental concerns. Psychometric findings suggested borderline intelligence, delayed adaptive functioning, and significant ADHD features, while CARS-2 score of 26.5 placed the child in the minimal-to-no symptoms range for ASD despite the presence of autistic traits in the descriptive assessment.

Case 6: The child presented with speech difficulty, hyperactivity, restlessness, poor ability to follow instructions, repetitive motor behaviour, solitary play, and poor joint attention. DST suggested mild intellectual disability with

inferred IQ of 51, VSMS showed socio-adaptive deficits, and ISAA score of 108 placed the child in the moderate autism category.

Case 7: This child had delayed speech, poor sustained attention, echolalic or repetitive speech tendency, poor response to name, and overactivity from early developmental years. DST indicated mild intellectual disability with IQ around 68, VSMS showed delayed adaptive functioning, CARS-2 score was 32.5 in the mild-to-moderate ASD range, and Conners ratings revealed inattention and hyperactivity/impulsivity.

Case 8: The child had minimal speech, absent-mindedness, inability to initiate or sustain conversation, poor response to name, temper tantrums, and restlessness. DST indicated severe intellectual disability with IQ around 28, VSMS showed marked adaptive deficits, and ISAA score of 117 supported classification within the moderate autism spectrum category.

Discussion

The present observational case series highlights the marked clinical heterogeneity seen in children presenting with autism spectrum disorder and related developmental concerns in routine practice. Across the 8 cases, the baseline picture was not limited to core autistic symptoms alone; rather, most children showed a multidimensional profile involving deficits in speech and language, impaired social reciprocity, reduced adaptive functioning, attentional dysregulation, behavioural disturbance, and varying levels of cognitive impairment. This broad symptom distribution is consistent with the current understanding of ASD as a clinically heterogeneous neurodevelopmental condition with highly variable developmental trajectories and support needs.

One of the most notable findings in the present series was the prominence of adaptive dysfunction across cases in which Vineland Social Maturity Scale data were available. Social age and related adaptive domains, particularly communication and socialization, were consistently below chronological age, even in children whose cognitive impairment was not in the severe range. This pattern is clinically important because adaptive behaviour is now recognized as a key dimension of functioning in autism and may provide information beyond autism severity scores or IQ alone. Previous work has shown that adaptive functioning in autistic children may remain disproportionately impaired relative to cognitive level, and that these deficits carry direct implications for long-term self-care, communication, and social participation.

The series also demonstrates the close overlap between ASD and associated behavioural dysregulation. Several cases showed clinically significant hyperactivity, inattention, overactivity, restlessness, aggression, tantrums, or emotional instability, either through formal Conners-based ratings or descriptive behavioural observations. This is relevant because coexisting ADHD-like symptoms and behavioural problems substantially increase caregiving burden and complicate management planning in children with ASD. The findings therefore support a broader clinical perspective in which symptom monitoring should extend beyond core autism features to include attention, emotional regulation, and everyday functioning.

From a clinical standpoint, the present case material supports the practical relevance of individualized assessment when managing children with ASD in real-world settings. Even within this small sample, the children differed considerably in severity, language level, behavioural profile, neurological background, and degree of adaptive impairment. Such heterogeneity provides a rationale for individualized therapeutic approaches, including individualized homoeopathic prescribing, in which management is guided by the totality of behavioural, developmental, and constitutional features rather than diagnostic label alone. In principle, this individualized orientation may be particularly relevant in ASD, where symptom clusters are variable and functional needs differ widely from child to child.

At the same time, any interpretation of therapeutic usefulness must remain cautious. Complementary and alternative interventions are commonly sought by families of autistic children, but systematic reviews continue to show that the evidence base for many such approaches remains limited, mixed, or methodologically weak. More broadly, recent umbrella-level evidence has also concluded that no complementary, alternative, or integrative approach currently has high-quality evidence supporting efficacy for the core or associated symptoms of autism, even when some interventions show promising preliminary findings. Accordingly, the present series should be understood as a practice-based observational contribution rather than confirmatory evidence of efficacy.

When compared with the available homoeopathy-specific literature, the current study aligns with a small but growing body of observational work suggesting potential improvement in social interaction and adaptive functioning under individualized homoeopathic care, while also underscoring the need for stronger methodology. For example, a recent observational homoeopathic study in childhood autism reported improvements in ISAA and VSMS scores over one year and recommended controlled clinical trials for future validation. The present series is directionally comparable in that it is based on individualized case material and uses psychometric characterization such as ISAA, VSMS, CARS-2, and cognitive/developmental testing. However, the strength of the current work is lower than that of standardized prospective follow-up studies because repeat structured outcomes were not uniformly available across all cases.

Several limitations must therefore be acknowledged clearly. First, the sample size was small and drawn from a case-series framework, which limits generalizability. Second, the assessment battery was not uniform across all children, as some cases were evaluated with CARS-2, others with ISAA, and cognitive/adaptive measures also varied across centres. Third, the present dataset is strongest for baseline characterization; without consistent pre-post standardized follow-up scores, firm conclusions regarding effectiveness cannot be made. Fourth, several children had important comorbidities, including ADHD symptoms, intellectual disability, seizure history, or MRI abnormalities, which may influence both baseline severity and subsequent clinical course. Fifth, because this was an observational real-world series without a control group, the contribution of maturation, concurrent therapies, educational support, parental adaptation, or nonspecific contextual factors cannot be separated from the observed clinical course.

Despite these limitations, the present series has practical value. It demonstrates that psychometric and developmental records generated in routine clinical pathways can be meaningfully consolidated to describe baseline severity, comorbidity, and functional impairment in children receiving individualized homoeopathic care. It also helps identify feasible domains for future prospective monitoring, especially speech-language function, adaptive behaviour, social reciprocity, attention regulation, and behavioural dyscontrol. Future studies in this area should ideally include uniform diagnostic criteria, predefined inclusion criteria, standardized follow-up intervals, repeated outcome measures such as ISAA/VSMS/CARS-2, documentation of concurrent therapies, and controlled comparison designs wherever feasible.

Conclusion

The present prospective observational case series suggests that individualized homoeopathic treatment may have **clinical relevance** as a supportive, person-centered approach in children with autism spectrum disorder presenting with heterogeneous developmental, behavioural, and adaptive difficulties. Across the included cases, the baseline profiles showed marked variability in autism severity, intellectual functioning, adaptive behaviour, and coexisting symptoms such as inattention, hyperactivity, tantrums, and language delay, which supports the need for individualized rather than uniform management approaches.

At the same time, the findings should be interpreted with caution. The current dataset is strongest for descriptive baseline characterization and observational clinical interpretation, but it does not permit definitive causal inference regarding treatment effectiveness because of the small sample size, lack of a control group, heterogeneity of assessment tools, and absence of uniform repeated outcome measures across all cases. This limitation is important in light of the broader autism literature, where complementary and alternative approaches remain widely used but still lack robust, high-quality evidence for efficacy.

Therefore, individualized homoeopathic treatment may be considered a promising area for further structured clinical inquiry, particularly for domains such as speech, social reciprocity, adaptive functioning, and behavioural regulation. However, larger prospective studies with standardized pre-post assessments, clearly defined outcome measures, and controlled comparative designs are required before firm conclusions can be drawn about its effectiveness in children with ASD....

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