



NPTEL ONLINE CERTIFICATION COURSES

Course Name **Mental health and basics of Clinical Psychiatry**
Faculty Name **Dr Sumit Kumar**
Department Name **Psychiatry**
TATA MAIN HOSPITAL

Lecture 16 : Mood Disorders - 2

Topics Covered

- Bipolar Disorder
- Etiology & pathophysiology & Treatment
- Dysthymia
- Cyclothymia
- Seasonal affective disorders

Bipolar Affective Disorder (BPAD)

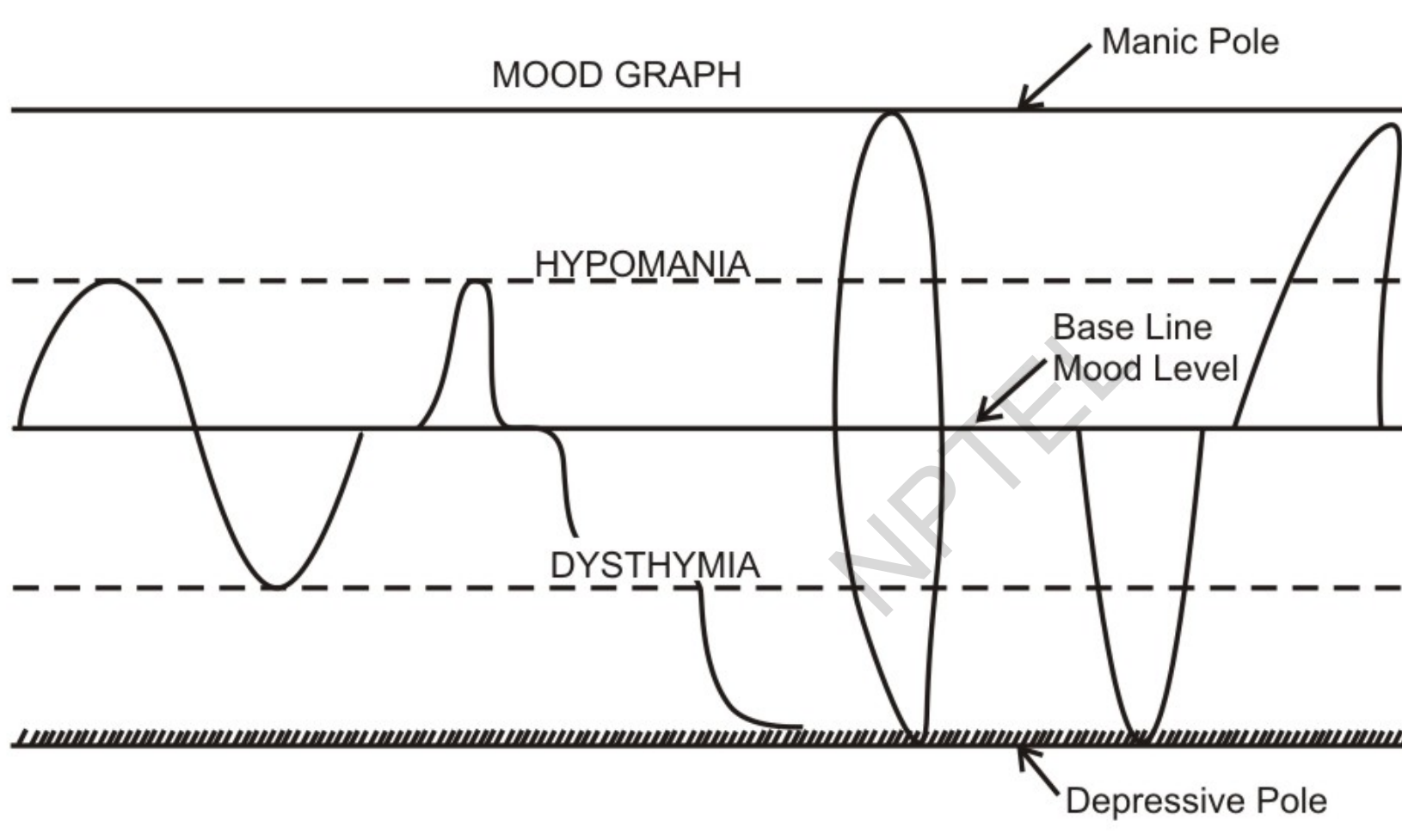
BPAD is characterized by periods of prolonged and profound **depression** alternate with periods of excessively elevated and irritable/Jocular mood, known as **mania**.

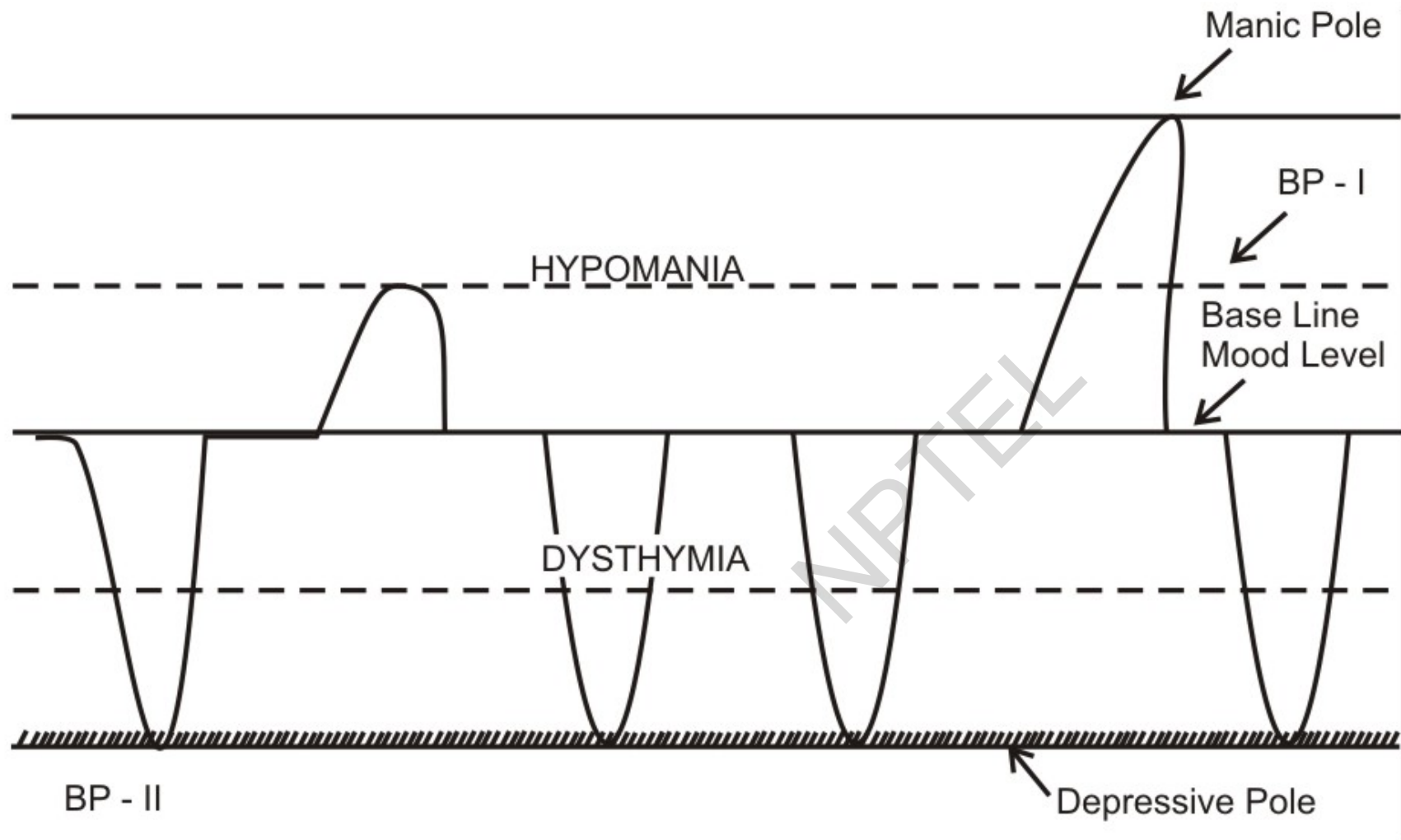
At least two mood episodes before a bipolar diagnosis can be considered, with complete recovery in between the episodes. (ICD)

The **depressive episode** must be present at least for **2 weeks**; mania for **7 days** (fewer if hospitalized)(ICD)

Hypomania for **4 days** and **mixed episodes for 2 weeks** before they can be diagnosed using (ICD)

Bipolar disorder can be diagnosed even with a single manic episode (DSM)





Psychotic symptoms:

In bipolar disorder, mood symptoms are prominent.

In severe form, mania may be associated with psychotic symptoms (usually mood-congruent/ incongruent).

Delusions and hallucinations are often 'changeable' in their quality.

Grandiose and persecutory delusions are common in psychotic mania.

Auditory hallucinations are usually the **second person in nature** and are often consistent with the patient's mood (e.g. religious revelations).

Mixed states are cases where manic and depressive symptoms occur simultaneously.

The occurrence of both manic/hypomanic and depressive symptoms in a single episode, present every day for at least 1 week (DSM-IV) or 2 weeks (ICD-10).

Rapid cycling: Patients with BPAD have **more than 4 episodes per year**; they are called rapid cyclers.

Substance abuse related with more manic relapses

Anxiety disorders related with depressive relapses.

Antidepressants switch occurring within 2 months of onset

Factors associated with the rapid cycling

a) Tricyclic anti-depressant b) low thyroxine level, c) Female patient d) Bipolar type 2 e)

Neurological disease

Ultra-rapid cycling refers to the situation when fluctuations are over days or even hours.

Postpartum onset refers to the onset of mania, hypomania or depression within 4 weeks of childbirth.

BPAD is divided into two main broad types;

Type 1 is characterized by full-blown mania or mixed mania and depression.

Type 2 is characterized by recurrent depression and hypomania without episodes of either mania or mixed states.

The natural course of mood episodes suggests that mania lasts for 4 months while depression for 6 months.

Mood episodes becomes longer in the elderly who show shorter periods of inter episodic remissions and more frequent episodes, which are considerably longer than those seen in working age adults.

- ✓ BPII > I in terms of clinically severity and role impairment .
- ✓ Suicide rate is 15-18 % more than the general population.
- ✓ Risk of recurrence is 50 % in 1 year and 70 % in 4 year.
- ✓ Comorbidity : anxiety, substance and impulse control disorders.

SI NO	Bipolar Type II	Bipolar Type I
1.	Patients suffer more	Patients suffer less
2.	Patients are having increased depressive episodes	Less depressive episodes
3.	More Unstable Switch from II → I Poor functional recovery	More Stable
4.	More suicidality	Less suicidality
5.	More exposed to Antidepressants	More exposed to Antipsychotics
6.	1/3 rd cases of Bipolar	1/4 th cases of Bipolar



Relapse indicators:

1. Residual symptoms - (insomnia, fatigue, painful physical complaints, problems concentrating, and lack of interest.)
2. Index Phase - Depressive episodes (65%) have longer recovery time as compared to manic episodes (47%)
3. Sleep Disturbances - Circadian and social rhythms disruptions are strong indicators for bipolarity.

Diagnosis of Mania

DSM Mania

- Duration: at least 1 week or any duration if hospitalized.
- Criterion A: Abnormally and persistently elevated, expansive, or irritable mood.

ICD 10 Mania

- Duration: Sustained for at least a week (unless it is severe enough to require hospital admission).
- A mood that is predominantly elevated, expansive or irritable and definitely abnormal for the individual concerned.

- (1) Inflated self-esteem or grandiosity
- (2) Decreased need for sleep
- (3) More talkative than usual or pressure to talk
- (4) Flight of ideas or subjective racing of thoughts
- (5) Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
- (6) Increase in goal-directed activity (either socially, at work or school or sexually) or psychomotor agitation
- (7) Excessive involvement in pleasurable activities that have a high potential for painful consequences

At least three of the following must be present

- (1) Increased activity or physical restlessness;
- (2) Increased talkativeness ('pressure of speech');
- (3) Flight of ideas or the subjective experience of thoughts racing;
- (4) Loss of normal social inhibitions resulting in behaviour which is inappropriate to the circumstances;
- (5) Decreased need for sleep;
- (6) Inflated self-esteem or grandiosity;
- (7) Distractibility or constant changes in activity or plans;
- (8) Behaviour which is foolhardy or reckless and whose risks the subject does not recognize e.g. spending sprees, foolish enterprises, reckless driving;

A manic mood episode is also operationally defined in ICD and DSM.

ICD states-

Mania/manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood, with 3 (or more) characteristic symptoms of mania.

The disturbance must be **sufficiently severe** to impair occupational and social functioning. Psychotic features may be present

Secondary Mania:

Occur as a result of misuse of alcohol or illicit drugs, prescribed drugs such as Levodopa and corticosteroids.

The drug induced state wanes with the clearance of the drug responsible.

It can also occur in certain organic conditions such as thyroid disease, multiple sclerosis and lesions involving cortical and or subcortical areas of the brain.

Hypomania/hypomanic episode- ICD

- Hypomania shares symptoms with mania, but these are evident to a lesser degree, not severe enough to interfere with social or occupational functioning or require admission to hospital, or include psychotic features.
- It includes mildly elevated, expansive, or irritable mood, increased energy and activity, increased self-esteem, talkativeness, over-familiarity, reduced need for sleep and difficulty in focusing on one task alone.

Bipolar Depression



Already on treatment

Not on treatment

Valproate,
Olanzapine,
Risperidone,
other
atypicals

Lithium
Lamotrigine
Antipsychotics

First line therapy:

- **Monotherapy/combination:** Lithium, lamotrigine, quetiapine, olanzapine-fluoxetine combination, valproate+lithium, valproate+ antidepressant
- **Combination:** mood stabiliser/antipsychotics+ antidepressant
- **Psychosocial intervention:** if depression is mild to moderate
- **ECT:** may be considered with monotherapy or combination therapy as per the indication

Optimise the
dose

Optimise the
dose

- Add antidepressant – bupropion, SSRI
- Add or change to lithium, lamotrigine or quetiapine
- Consider changing from one agent (lithium/lamotrigine/quetiapine) to other
- Consider Valproate along with lithium or antidepressant
- Consider combinations
- Consider psychosocial intervention if the depression is mild to moderate
- Consider ECT as per the indication
- Consider rTMS, tDCS

Bipolar Hypomania/Mania/Mixed Episode



Currently on treatment (Breakthrough episode/switch in presence of antidepressants)

- Stop antidepressant- if patient is getting the same
- Optimize the dose of the mood stabilizer which the patient is on
- If the symptoms do not respond to optimisation of the dose or are severe, consider adding an antipsychotic medication
- Benzodiazepines may be used depending upon the need

Currently not on treatment

First line therapy:

- **Monotherapy:** Lithium, valproate, antipsychotics
- **Combination:** Lithium+ antipsychotic/ valproate+antipsychotic
- **Use Benzodiazepines as per the need**
- **Use of depot antipsychotic may be considered if patient is not willing to take oral medications**
- **ECT:** may be considered with monotherapy or combination therapy as per the indication

Failure of adequate trial of first line treatment

Failure of adequate trial of first line treatment

Second line therapy:

Monotherapy: Change lithium to lamotrigine or vice versa

Combination:

- Add antipsychotic if not used
- Change from Lithium+ antipsychotic to valproate+antipsychotic medication
- Change from Valproate+antipsychotic to lithium+antipsychotic medication
- Continue lithium/valproate and change the antipsychotic medication
- Consider changing lithium/valproate to carbamazepine

Dysthymia/Persistent Depressive

- Chronic, mildly depressed mood and diminished enjoyment, not severe enough to be considered a depressive illness.
- Insidious in onset low grade chronicity for atleast 2 years

Prevalence :

F>M

preferentially in 20's

Coexistent with substance abuse, anxiety (panic),borderline personality disorder.

- Clinical features :

Depressed mood (< 2yrs) Reduced/increased appetite, Insomnia/hypersomnia, reduced energy/fatigue, Low self-esteem, Poor concentration, thoughts of hopelessness.

Treatment:

No Pharmacological intervention is required according to guidelines

Insight oriented Psychotherapy is treatment of choice for Dysthymia.

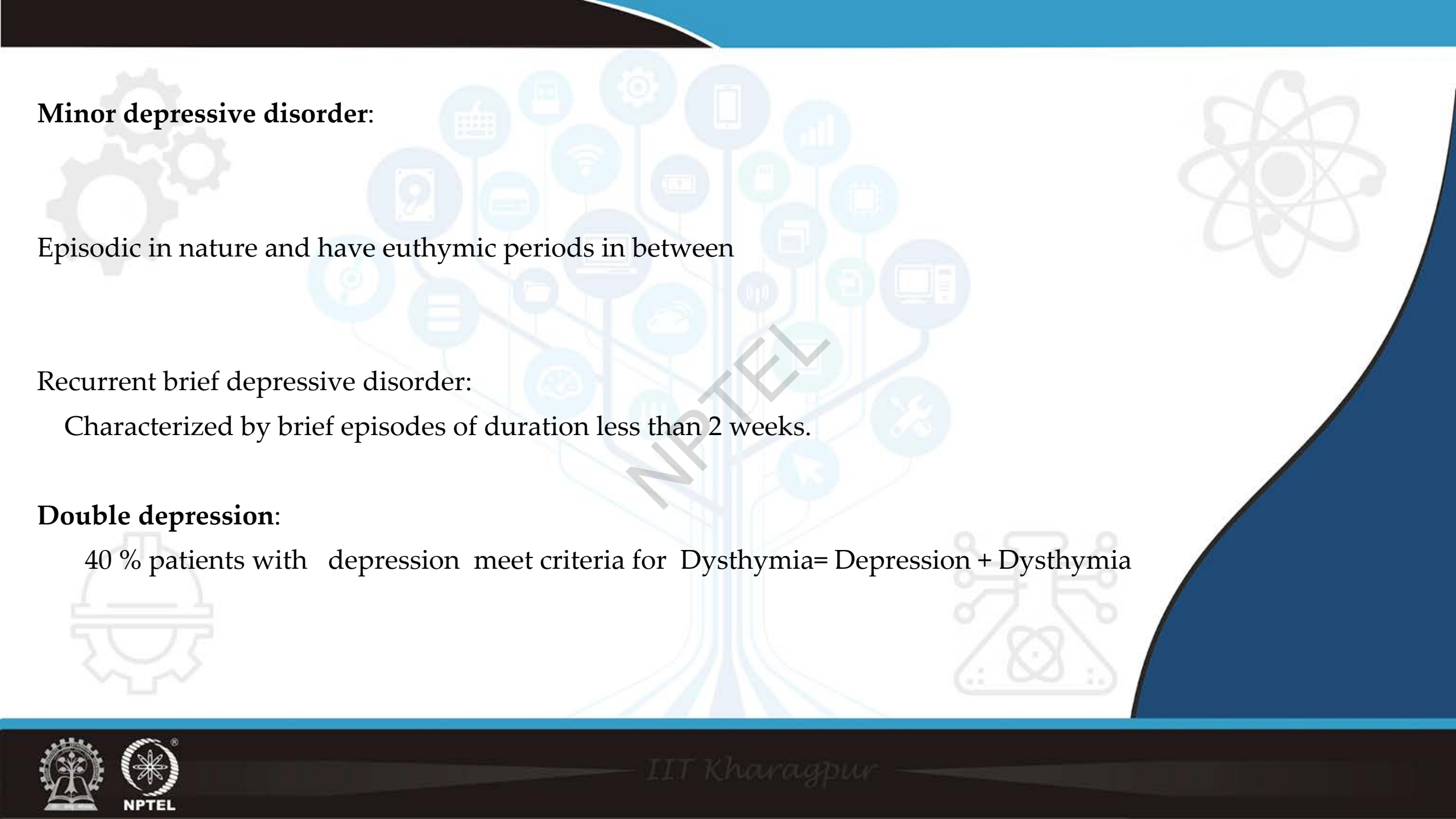
However combination treatment of pharmacological + Psychological may be effective.

Dysthymia progresses to develop

Major depression-20 % cases

BD I - 15 %cases

BD II - 5 % cases



Minor depressive disorder:

Episodic in nature and have euthymic periods in between

Recurrent brief depressive disorder:

Characterized by brief episodes of duration less than 2 weeks.

Double depression:

40 % patients with depression meet criteria for Dysthymia= Depression + Dysthymia

Cyclothymia

Cyclothymia in which an individual may experience oscillating high and low moods, without ever having a significant manic or depressive episode

These episodes of mild depression and mild elation are not sufficiently severe or prolonged to fulfill the criteria for bipolar affective disorder or recurrent depressive disorder for the **last 2 years**

Prevalence 3%-5% M:F - 3:2

An individual usually perceives these mood swings as being unrelated to life events

Depressive phase is commonly seen during which patient seeks treatment.

Patients frequently coexists with Borderline personality disorder

Family members of cyclothymic disorder often have substance related history.

Unpredictable nature of mood produces great stress.

Patients with adaptive coping strategies have good outcome than patients with poor coping strategies.

Rx

Mood stabilisers and antipsychotics forms the mainstay of treatment pharmacologically along with benzodiazepines for counteracting agitation

Psychotherapy directed towards increasing patients awareness of their condition helping them develop coping mechanism for mood swings

Seasonal Affective disorder

The classical presentation is depression with reversed biological features in winter.

Diagnosis

AS PER →

ICD-10

3 or more affective episodes , with onset within the same 90 day period of the year, for 3 or more consecutive years.

Remissions should occur within a defined **90-day period** of the year.

Seasonal episodes substantially outnumber any non-seasonal episodes that may occur.

Affective episode is most **commonly depressive** in nature

Atypical features like **hypersomnia, increased appetite, carbohydrate craving** and **weight gain** are common.

Onset is in autumn/winter when daylight is less

Resolution is in spring/summer when daylight is more

Rx- Phototherapy

Bright light (10,000 lux)

Daily for 2 hours

REFERENCES

1. Comprehensive Text Book Of Psychiatry (Kaplan & Sadock)
2. Oxford Text Book OF Psychiatry
3. Tasman & Leibermann (Text Book Of Psychiatry)
4. Clinical practice guidelines 2017; bipolar depression
5. Clinical practice guidelines 2017; bipolar /mania

CONCLUSIONS

- In this lecture we have learned regarding the concepts of bipolar disorder ,its types, severity, relapse indicators related to bipolarity. Diagnosis of Hypomania , mania .
- Dysthymia , cyclothymia and its related concepts.
- Seasonal Affective disorders in brief



**THANK
YOU !**



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Course Name

Basics of Mental Health & Clinical Psychiatry

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TATA MAIN HOSPITAL

Lecture 17 : Anxiety Disorders-I

CONCEPTS COVERED

- Concept regarding anxiety, differentiate between worry and fear
- Types of anxiety disorders
 - i) Generalised anxiety disorder ii) Social anxiety disorder iii) Panic disorder iv) Post traumatic stress disorder
- Obsessive compulsive disorder
- OCD related disorder

Anxiety Disorder-I

Anxiety

Diffuse unpleasant ,vague sense of apprehension often accompanied by autonomous symptoms such as headache , perspiration , palpitations , tightness in the chest , mild stomach discomfort and restlessness indicated by an inability to sit or stand still for long.

According to Epidemiological data

Specific phobia >> **Substance use Disorders** >> **Major Depressive disorders (MDD)** >> **OCD**

Most Common (1st)

2nd

3rd

4th

Fear

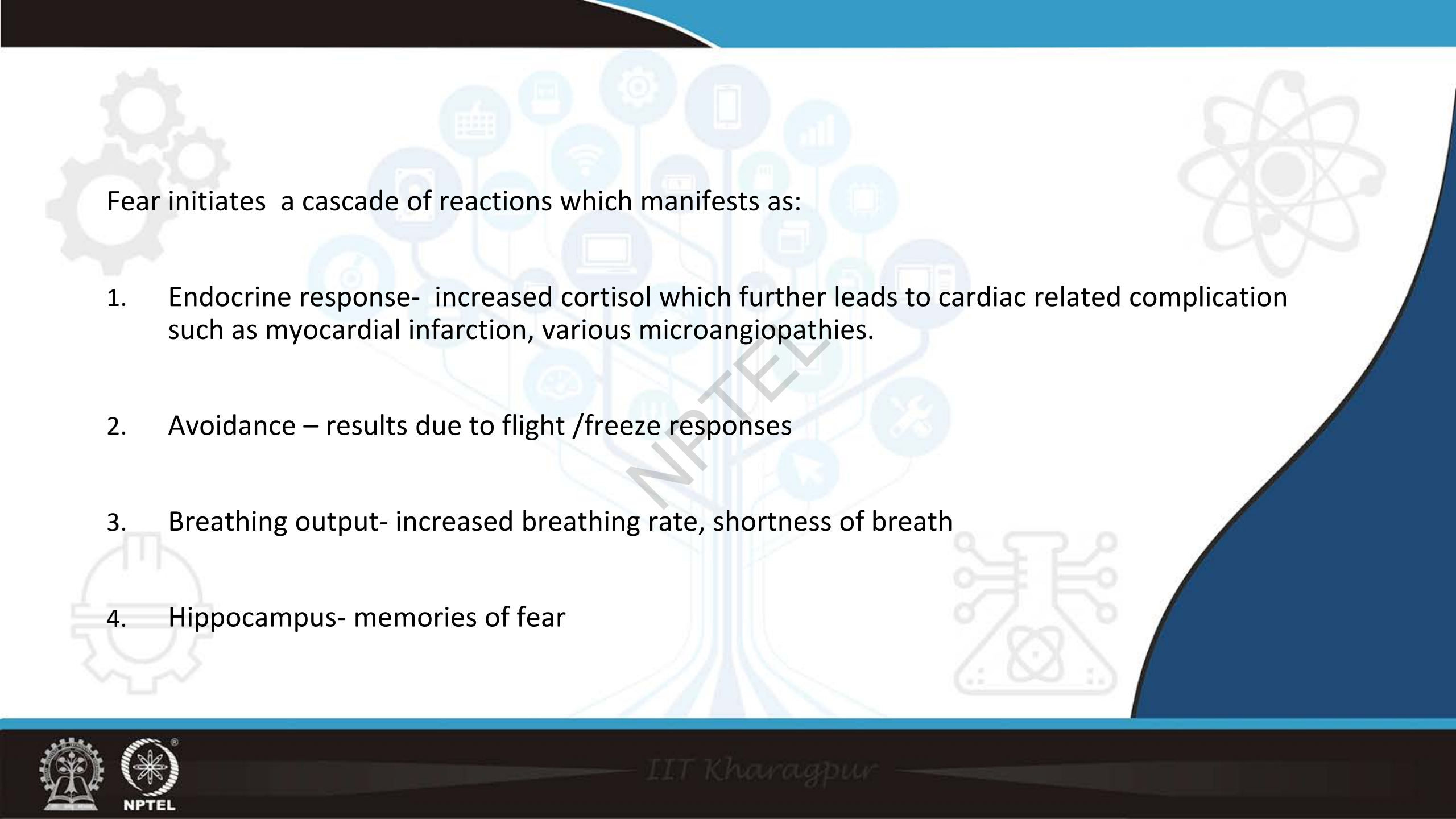
No known stimulus

Phobias, Panic

Worry

Known Stimulus

Obsessions

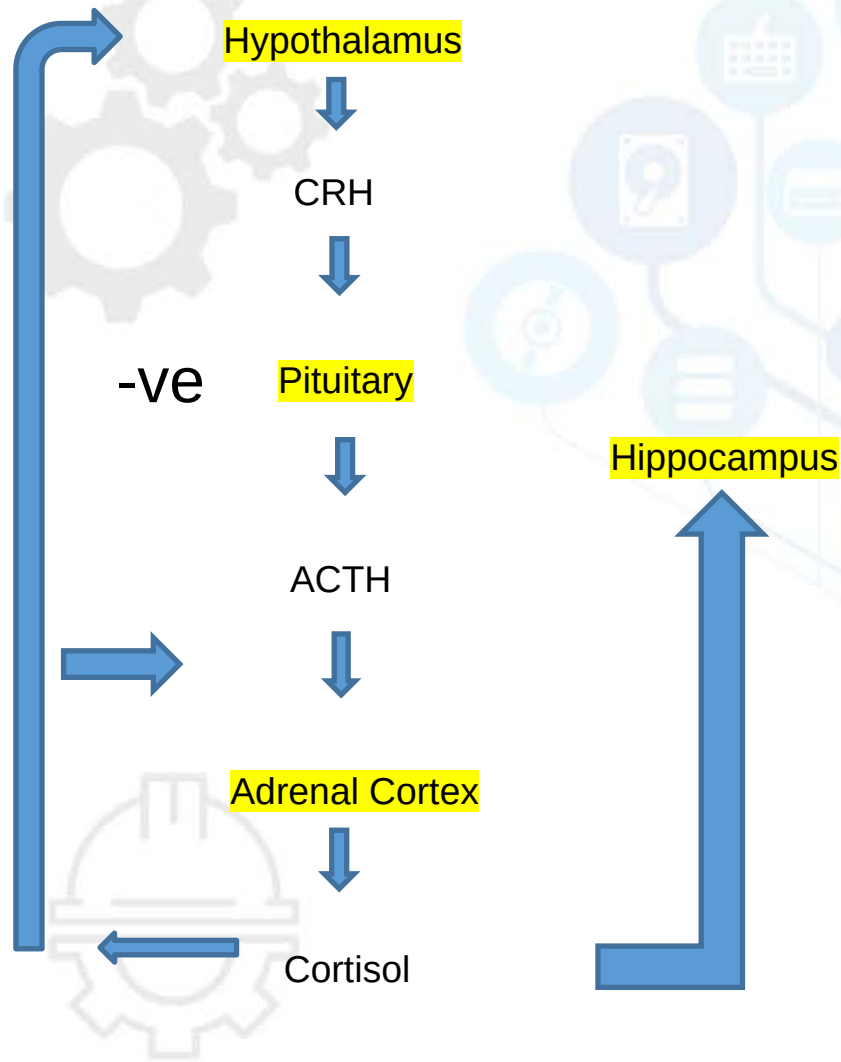


Fear initiates a cascade of reactions which manifests as:

1. Endocrine response- increased cortisol which further leads to cardiac related complication such as myocardial infarction, various microangiopathies.
2. Avoidance – results due to flight /freeze responses
3. Breathing output- increased breathing rate, shortness of breath
4. Hippocampus- memories of fear

Neuroendocrine

During Normal Stress



During Chronic stress



No feedback Inhibition

Excess of cortisol leads to

- a) Decreased hippocampal neurogenesis
- b) Atrophy of Hippocampal dendrites.
- c) Shrinkage of Hippocampus.
- d) Disruption of Long term potentiation
- e) Impairment of memory performance
- f) Compensatory increase in dendritic arborisation of neurons in basolateral Amygdala.

Generalised Anxiety Disorders (GAD)

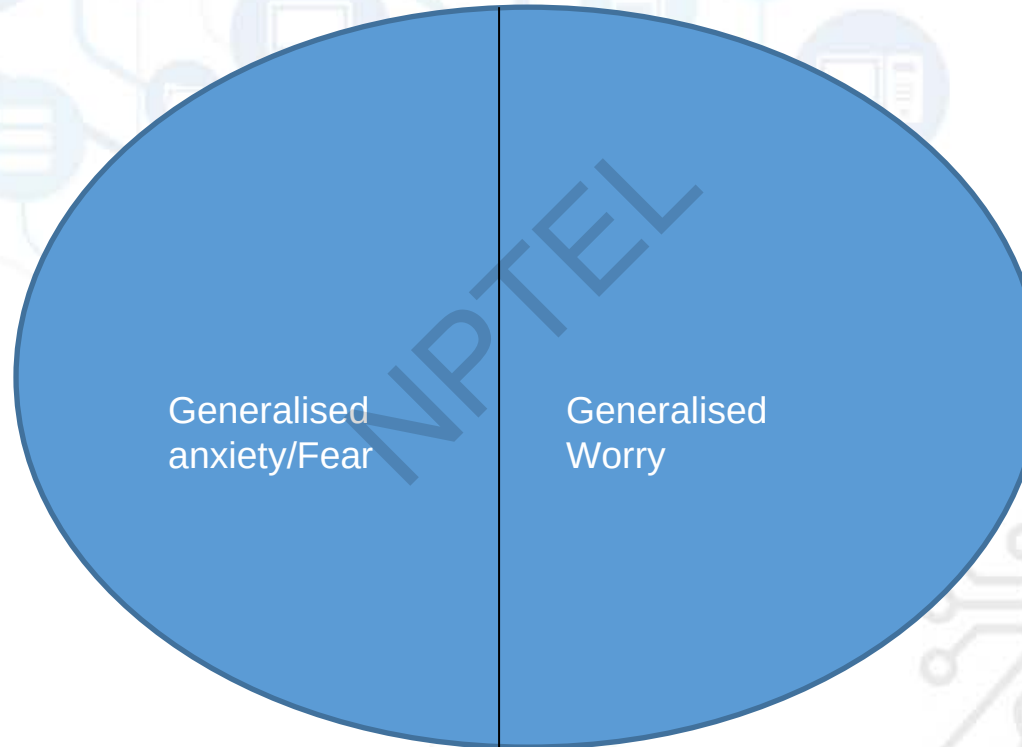
Generalized anxiety disorder, ICD-10 requires duration of at least 6 months and the symptoms should have been present on most days during 6 months.

Atleast 4 (with at least 1 from 'autonomic arousal')

1. Symptoms of autonomic arousal: palpitations/tachycardia; sweating; trembling/shaking; dry mouth.
2. 'Physical' symptoms: breathing difficulties; choking sensation; chest pain/discomfort; nausea/abdominal distress.
3. Mental state symptoms: feeling dizzy, unsteady, faint or lightheaded;
Derealization / depersonalization; fear of losing control, going crazy, passing out, dying.
4. General symptoms: hot flushes/cold chills; numbness or tingling sensations.
5. Symptoms of tension: muscle tension/aches and pains; restlessness/ inability to relax; feeling keyed up, on edge, or mentally tense; a sensation of a lump in the throat or difficulty swallowing.
6. Other: exaggerated responses to minor surprises/being startled; concentration difficulties/mind going blank due to worry or anxiety; persistent irritability; difficulty getting to sleep due to worrying

Generalised Anxiety disorder

- Sleep
- Concentration
- Fatigue
- Arousal
- Irritability
- Muscle Tension



- Risk factors include

- i) exposure to civilian trauma
- ii) Bullying or peer victimization a higher number of life events
- iii) Being a first---- degree relative of a GAD patient and female gender.

Assessment:

Hamilton anxiety scale -14 item scale

Treatment

SSRIs: escitalopram, paroxetine, sertraline.

TCAs: imipramine.

Benzos: alprazolam and diazepam (not suited for long----term therapy).

Venlafaxine, duloxetine & Buspirone

CBT

Social anxiety disorder/ Social Phobia

Fearful of embarrassing themselves in social situations like social gatherings , oral presentations meetings

They have specific fears about performing specific activities such as eating or speaking in front of others or they may experience vague, non specific fear of embarrassing oneself.

Social phobia occurs more in **small group settings** where close scrutiny is possible.

Fear of **vomiting & Blushing** in public is seen in some with social phobia.

The condition usually begins between the ages of 17 and 30.

The fear of **humiliating or embarrassing** oneself as an important feature with **recognition that the fear is excessive or unreasonable**.

Treatment

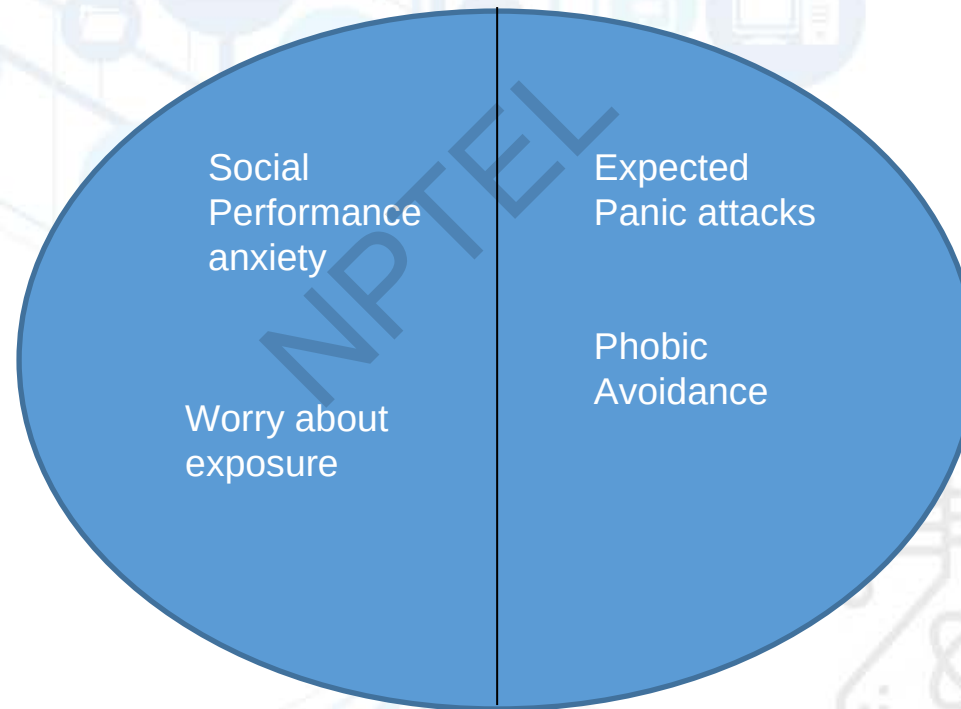
- Selective serotonin Reuptake inhibitors
- Selective Norepinephrine reuptake inhibitors
- Beta Adrenergic antagonist
- Behaviour Therapy

Prevalence – 3-13 %

M > F

Duration- 6 months

Social Anxiety disorder



Panic Disorder

According to **ICD-10**, for a definite diagnosis of panic disorder several severe panic attacks should have occurred within a period of about 1 month:

- (1) In circumstances where there is no objective danger;
- (2) Without being confined to known or predictable situations; and
- (3) With comparative freedom from anxiety symptoms between attacks (although anticipatory anxiety is common).

Panic Attack- An abrupt surge of intense fear or discomfort” reaching a peak within minutes.

Four or more of a specific set of physical symptoms accompany a panic attack.

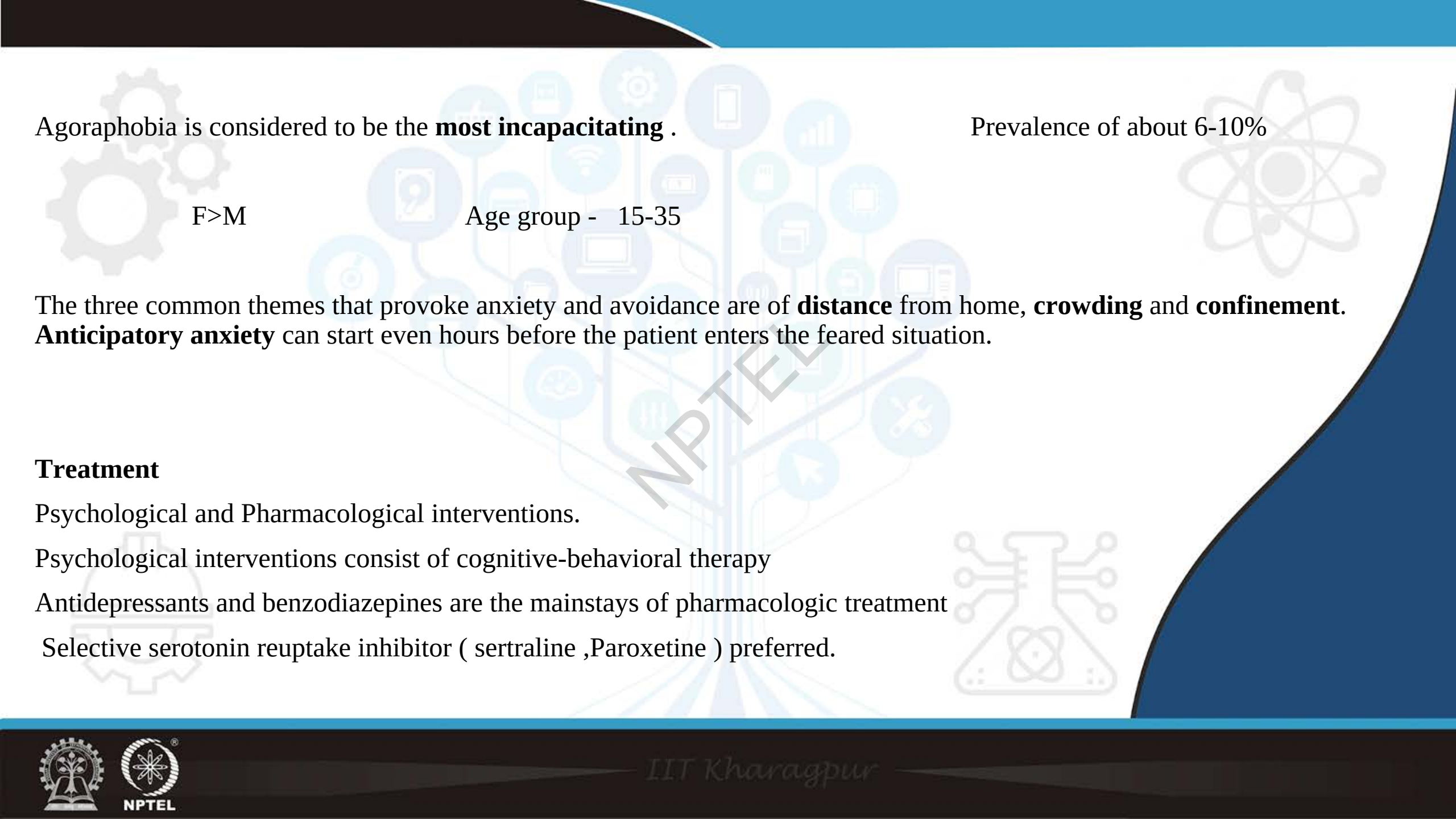
Panic attacks occur as often as several times per day or as infrequent as only a few attacks per year.

- i) Palpitations or accelerated heart rate.
- ii) Sweating, trembling or shaking, sensations of smothering
- iii) Chest pain or discomfort
- iv) Dizzy, unsteady, light-headedness
- v) Faint, chills or heat sensations
- vi) Paraesthesias (numbness or tingling sensations)
- vii) Derealization (feelings of unreality) or depersonalization (being detached from oneself)
- viii) Fear of losing control or "going crazy", and fear of dying.

A hallmark feature of panic disorder is that attacks occur without warning.

Panic Disorder





Agoraphobia is considered to be the **most incapacitating** .

Prevalence of about 6-10%

F>M

Age group - 15-35

The three common themes that provoke anxiety and avoidance are of **distance** from home, **crowding** and **confinement**. **Anticipatory anxiety** can start even hours before the patient enters the feared situation.

Treatment

Psychological and Pharmacological interventions.

Psychological interventions consist of cognitive-behavioral therapy

Antidepressants and benzodiazepines are the mainstays of pharmacologic treatment

Selective serotonin reuptake inhibitor (sertraline ,Paroxetine) preferred.

Specific Phobia

Strong persisting fear of an object or situation.

Arousal of severe anxiety when patients are exposed to specific situations

Or objects when patients even anticipate exposure to the situations or objects.

Exposure to phobic stimulus or anticipation of it almost invariably results in panic attack.

Starts in early age group predominantly as Animal Phobia

Adulthood peak for situational phobia

Defence Mechanism:

Repression → Displacement → Symbolization → Avoidance

Treatment

Behaviour Therapy

Insight Oriented Psychotherapy

Social Phobia-
Fear in the
situation not of the
situation

Acrophobia-	Fear of heights
Agarophobia-	Fear of open places
Hydrophobia-	Fear of water
Claustrophobia-	Fear of closed spaces
Cynophobia-	Fear of dogs
Mysophobia-	Fear of Dirt & Germs
Xenophobia-	Fear of Strangers

Adjustment disorder

- Is a condition that refers to the **psychological reactions** arising in relation to adapting to new circumstances and occurs in divorce, separation etc., which is **not catastrophic** in nature.
- The usual presentations include anxiety, depression, poor concentration, irritability, anger, etc. with
- Physical symptoms caused by autonomic arousals such as tremor and palpitations , someone who has been exposed to a psychosocial **stressor** like
- Onset must be within **1 month** in ICD-10 and **3 months** according to DSM-IV.
- Individual **vulnerability** plays a greater role in adjustment disorder than any other neurotic disorder
- The onset is **more gradual** than that of acute stress reaction, and the course is **more prolonged**. Social functioning is usually impaired

Treatment: Psychotherapy, Crisis Intervention, No FDA approved medicines

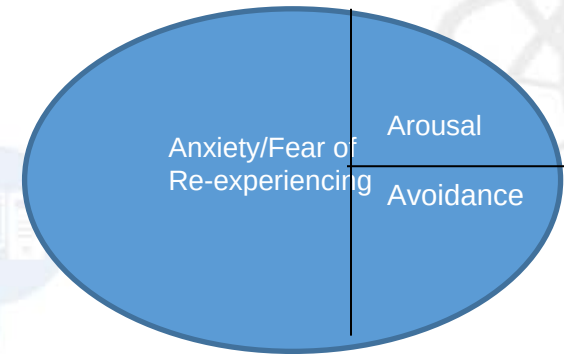
Post Traumatic Stress disorder

The essential features are **hyperarousal**, **re-experiencing of aspects of the stressful event** and **avoidance** of reminders.

The principal symptoms of PTSD include

Hyperarousal

Persistent anxiety Irritability Insomnia Poor concentration



Hypervigilance due to re-experiencing and enhanced startle response , Intrusions , Recurrent distressing dreams Intensive intrusive imagery (flashbacks, vivid memories) ,Difficulty in recalling stressful events at will

Avoidance

Avoidance of reminders of the events- Efforts to avoid thoughts, feelings, or conversations associated with the trauma. Efforts to avoid activities, places, or people that arouse recollections of the trauma . Detachment-Feeling of detachment or estrangement from others Emotional numbness, Diminished interest in activities (anhedonia)

Require 2 or more persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) to diagnose PTSD.

F > M

PTSD should start within **six months of the trauma**.

When the onset is delayed i.e. **after six months** – termed as '**probable PTSD**'; in others the course may be chronic > 6 months.

Etiology

- i) Experiencing a traumatic event such as a severe threat or a physical injury
- ii) A near-death experience, combat-related trauma
- iii) Sexual assault
- iv) Interpersonal conflicts
- v) child abuse,
- vi) After a medical illness.

Treatment

Treatment

Pharmacological

1. Beta blockers
2. SSRI's
3. TCA's

Newer drugs proposed mechanism

Opioid agonists-blocks reconsolidation

Glycine antagonists -strengthen fear extinction.

Psychotherapy

1. Behavioural therapy
2. Cognitive therapy
3. EMDR Eye movement desensitization reprocessing
4. Group therapy
5. Family therapy

Dissociative disorders

Dissociative disorders refer to a set of conditions that involve disruptions or breakdowns of memory, identity, or perception.

ICD----10 classifies Conversion Disorder as a dissociative disorder.

Types:

Dissociative Identity Disorder -the distinct alternation of two or more distinct personality states with impaired recall among personality states

Dissociative Amnesia -The temporary loss of recall memory, specifically episodic memory, due to a traumatic or stressful event.

Dissociative Fugue - Reversible amnesia for personal identity, usually involving unplanned travel or wandering, sometimes accompanied by the establishment of a new identity.

Dissociative Convulsions/ Pseudoseizures:

Dissociative movement disorders :

Prevalence: Some surveys estimate that 10% of the adult population F>M

Etiology

Childhood sexual abuse (57----90%), Emotional abuse (57%), Physical abuse (62----82%) Neglect (62%).

Treatment:

The aim is to integrate feelings, perceptions, thoughts and memories.

Individual psychotherapy

Acceptance and Commitment Therapy

Coping skills

REFERENCES

- 1 Oxford Text book Of Psychiatry
- 2 Comprehensive Text book Of Psychiatry Kaplan & Sadock
- 3 Text book Of psychiatry (Tasman & Leibermann)
4. Stephen Stahl's Textbook Of Psychopharmacology

CONCLUSIONS

-In this lecture we have discussed regarding the concepts of Anxiety and its various types namely panic disorder, Generalized anxiety disorder, social anxiety disorder , specific phobia , post traumatic stress disorder and dissociative disorder

Management of various types of Anxiety disorders in brief



**THANK
YOU !**



NPTel ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental Health & Clinical Psychiatry

Faculty Name Dr Sumit Kumar

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Lecture 18 : Anxiety Disorders-II

CONCEPTS COVERED

- Concepts regarding Obsessive compulsive disorder and its treatment
- Concepts regarding OC related disorder namely , skin picking disorder, hoarding disorder, compulsive `buying, body dysmorphic disorder and trichotilomania along with its treatment in brief

Anxiety disorders - II



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Obsessive Compulsive Disorders

OCD is characterized by obsessional thinking, compulsive behaviour and often associated with marked anxiety and depression.

Diagnosis according to ICD 10 obsessions (thoughts, images, or ideas) and compulsions share the following features, all of which must be present:

- (1) Acknowledged as originating in the mind of the patient
- (2) Repetitive and unpleasant; at least one recognized as excessive or unreasonable
- (3) At least one must be unsuccessfully resisted (although resistance may be minimal in some cases)
- (4) Carrying out the obsessive thought or compulsive act is not intrinsically pleasurable

Obsessions can occur in several forms such as thoughts, ruminations, doubts, impulses and phobias.

Obsessional **slowness** can occur as a result of Obsessional doubts or compulsive rituals.

According to ICD-10, either obsessions or compulsions (or both) present **on most days** for a period of at least **two successive weeks**.

Common symptoms:

Checking (63%)

Washing (50%)

Fear of contamination (45%)

Doubting (42%)

Bodily fears (36%),

Counting (36%), Insistence on symmetry (31%),

Aggressive thoughts (28%)

Symmetry obsessions tend to be chronic and treatment resistant.

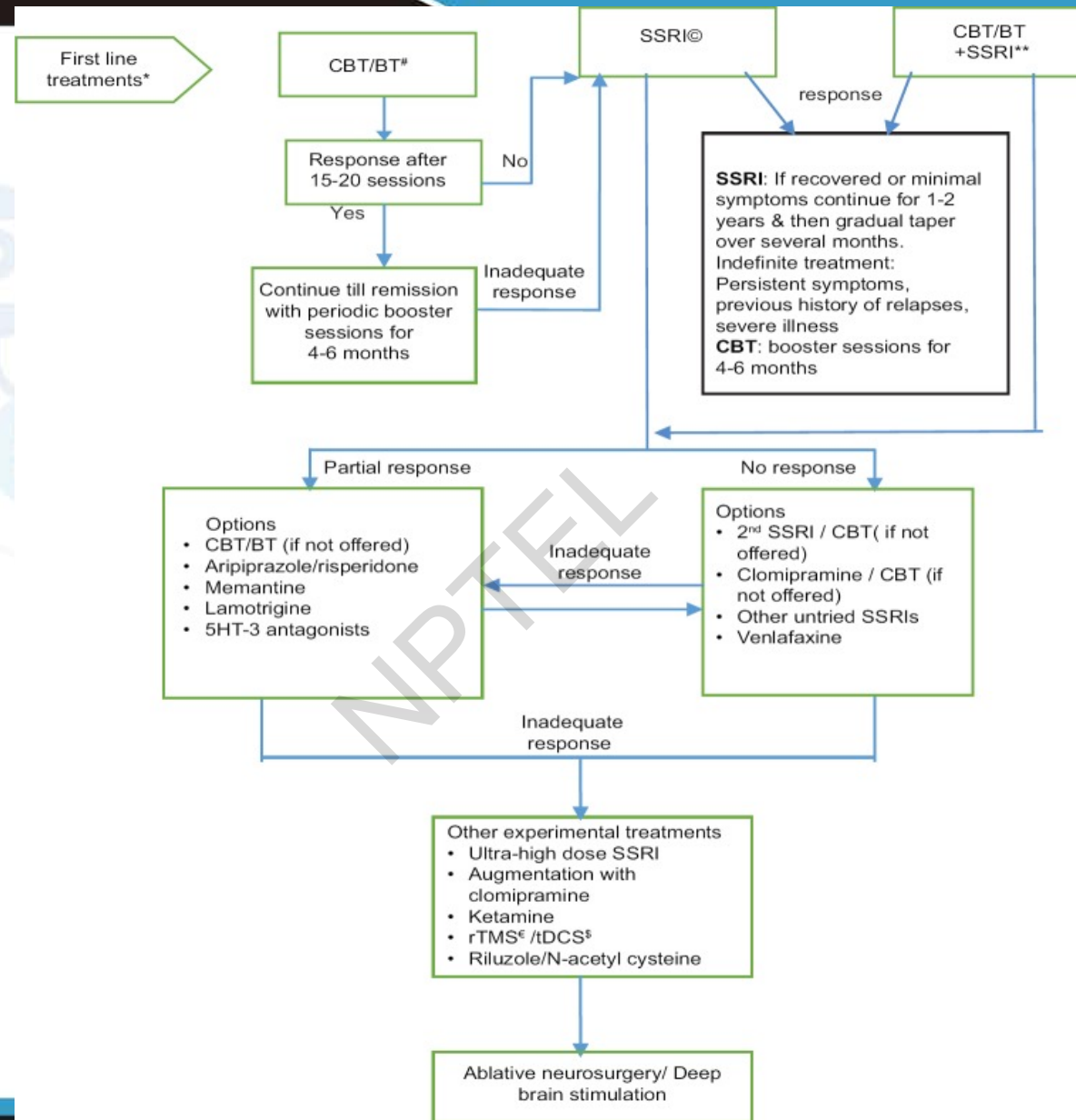
Prevalence : 2-5%

M>F

Radioimaging: Decrease size of B/L caudate

Assessment : YBOCS scale

Treatment



OCD Related Disorders



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Compulsive buying/ Oniomania

Categorization of this psychopathological condition in international classification systems continues to be debated and consensus on diagnosis criteria has yet to be reached.

It is defined as a problematic buying behaviour that is:

- (1) Uncontrollable
- (2) Markedly distressing, time-consuming, and/or resulting in family, social, vocational, and/or financial difficulties;
- (3) Not occurring only in the context of hypomanic or manic symptoms”(). An estimated prevalence of compulsive buying traits has been noted in 2-8% with >80% female cases in survey samples.

A lifetime prevalence of any affective disorder of 68%, predominantly depression, has been noted in people with compulsive buying disorder.

Treatment

SSRIs have been evaluated.

Cognitive-behavioural therapy with self-monitoring.

Body Dysmorphic disorder

A patient with body dysmorphic disorder (BDD) (dysmorphophobia) is **convinced that part of their body has a defect or is flawed in some way.**

The patient engages in repetitive behaviours or mental acts in response to preoccupations with perceived defects or flaws.

2 variants

- i) Psychotic and
- ii) Non----psychotic variants.

Etiology: low self-esteem , critical parents and significant others , early childhood trauma
unconscious displacement of emotional conflict

Treatment:

High----dose SSRIs used for a longer duration than the usual antidepressant trial period can be effective

Fluoxetine has RCT evidence in this regard.

Antipsychotics have also been studied with variable success.

Trichotillomania/Hair pulling disorder

- Before engaging in the behaviour patient experience an increasing sense of tension and achieve a sense of gratification or relief from pulling of hair.
- Trichotillomania cannot be attributed to another medical or mental condition.
- All areas of the body are affected but preferentially scalp, eyebrows ,eyelashes, beard pubic area,arm pits are commonly involved.
- Age group- before 17 years F>M Prevalence: 0.6-3.4%

2 types of Hair pulling

- i) Focussed Pulling
- ii) Automatic Pulling

Etiology

1. Disturbances of Mother & Child relation
2. Fear of being left alone
3. Recent object loss

Hair Loss characterized by short ,broken strands together with normal strands.

Trichophagy , mouthing of hair follow compulsive hair pulling episodes but the patient altogether denies experiencing it.

Treatment

No FDA approved medicines available

Evidences available for

SSRI's, Lithium , Naltrexone and Atypical Antipsychotics

Non pharmacological : Habit Reversal, Desensitization



Skin Picking/Excoriation

Recurrent skin picking resulting in skin lesions and repeated attempts to decrease or stop picking.

The skin picking must cause clinically relevant distress or impairment in functioning.

The skin picking behaviour cannot be attributed to other medical or mental condition

Most common site being face preferentially , other areas are legs, arms, hands, fingers, scalp .

It leads to physical disfigurement and embarrassment which further adds to medical consequences if not addressed properly.

Mean age of onset : 12-16 yrs F>M Prevalence: 1-5 %

Treatment

No FDA medicines available

Evidences are suggestive of

SSRI's

Opioid Antagonist (Naltrexone) , Non pharmacological : Habit Reversal , brief CBT

Hoarding Disorder

Characterized by

- i) Acquiring of and failure to discard a large amount of possessions that are deemed useless or of little value.
- ii) Greatly cluttered living areas precluding normal activities.
- iii) Significant distress and impairment in functioning due to hoarding.

Fear of losing items that patient believes will be needed later or an emotional attachment to possession.

Hoarding items include newspaper , magazines, old clothes , books .

M=F

Prevalence : 2- 5 %

Treatment

SSRI's

Cognitive restructuring

REFERENCES

Oxford Test book Of Psychiatry

2 Comprehensive Text book Of Psychiatry Kaplan & Sadock

3 Text book Of psychiatry (Tasman & Leibermann)

4. Stephen Stahl's Textbook Of Psychopharmacology

5 . Clinical Practice guidelines OCD 2017 (Y.C Reddy , Suresh Badamath)

CONCLUSIONS

-In this lecture we have discussed regarding concepts of obsessive compulsive disorder and its treatment

Concepts related to OC related disorders namely hoarding disorder, skin picking disorder, trichotillomania , compulsive buying , body dysmorphic disorder along with its treatment.



**THANK
YOU !**



NPTEL ONLINE CERTIFICATION COURSES

Course Name Basics Of Mental Health & Clinical Psychiatry
Faculty Name Dr Sumit Kumar
Department Name Psychiatry
TATA MAIN HOSPITAL

Lecture 19 : Eating Disorders

CONCEPTS COVERED

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorders
- Comparison Between Anorexia vs Bulimia

Eating Disorders

Anorexia Nervosa

1. Individual voluntarily reduces and maintains an unhealthy degree of weight loss or fails to gain weight proportional to growth.
2. Fear of becoming fat / drive for thinness despite medical starvation.
3. Individual experiences starvation related medical problems
hypothermia , bradycardia , orthostasis, reduced body fat stores.
4. Behaviours present for atleast 3 months

Refuse to eat at public places, high carbohydrate diet

F > M Prevalence : upto 5% Age group- 14-18 years

2 Types

Restricting Type

Purging Type

Associated with OCD, Depression ,anxiety

Delayed psychosocial sexual development.

Complications in the form of Hypothermia ,oedema , bradycardia , hypotension , lanugo

Amenorrhoea occurs before weight loss is noticeable

ECG changes suggestive of T wave flattening , ST segment depression , lengthening of QR interval, superior mesenteric artery syndrome

Treatment:

Hospital Management

Cognitive Behavioural Therapy

Dynamic Psychotherapy

Family therapy

Pharmacotherapy : SSRI's & Benzodiazepines

Bulimia Nervosa

- 1 . Episodes of binge eating occurs relatively frequently **once a week for atleast 3 months.**
- 2 . **Compensatory behaviours practised immediately after binge eating** to prevent weight gain :

Vomiting primarily , laxative abuse, enemas , diuretics , less commonly exercises, dieting.

3. Weight not severely lowered as in Anorexia

4. Patient has morbid fear of fatness.

F > M

Prevalence : 1-4 %

Etiology : Social , Psychological , biological

More than half of the cases have anorexia in the past.

Two Types

- a) Purging
- b) Non Purging

Purging type has more complications :

Hypokalemia , Hypochloremic alkalosis , Gastric and esophageal tears in those who vomit.

Treatment :

Cognitive Behavioural therapy

Dynamic Psychotherapy

Binge eating disorder (BED)

ICD-10 this falls under atypical bulimia

DSM-V Eating disorder not otherwise specified (EDNOS)

Binge eating disorder is characterized by recurrent episodes of binge eating in the absence of extreme weight-control behaviour.

Background of a general tendency to overeat.

BED is associated with obesity

Patients typically present in 40s.

More males compared to other eating disorders.

There is a high degree of spontaneous remission noted and stressed associated overeating is a common phenomenon.

Treatment

Self-help, behavioural weight loss programmes and CBT/IPT can help.

Comparison

Anorexia

19/100000 per year

Age group- Teenagers

65%- Depression

34%- Social phobia

26%- OCD

More complications associated

OCD traits common in Anorexia

Treatment:

Cognitive restructuring

Bulimia

29/100000 per year

Age group- 16 -35 years

Substance abuse common in Bulimia

More prevalent than Anorexia

Treatment:

20 Sessions over 5 months

CONCLUSIONS

-In this lecture we have discussed regarding concepts of Eating disorders like Anorexia Nervosa , bulimia nervosa and Binge eating disorders and its management.

REFERENCES

1. Comprehensive Text Book Of Psychiatry (Kaplan & Sadock)
2. Oxford Text Book OF Psychiatry
3. Tasman & Leibermann (Text Book Of Psychiatry)
4. Stephen Stahl's Psychopharmacology



**THANK
YOU !**



NPTEL ONLINE CERTIFICATION COURSES

Basics of Mental Health & Clinical Psychiatry

Dr. Arijita Banerjee

**Dr B.C. Roy Multi-speciality Medical Research Centre
IIT KHARAGPUR**

Lecture 20: Physiology of sleep

CONCEPTS COVERED

- (1) Sleep and coma .
- (2) Neural basis of sleep .
- (3) What is meant by NREM (non-rapid eye movement, sws) and REM (rapid eye movement) sleep .
- (4) NREM and REM sleep are distributed.
- (5) Describe the behavioral and autonomic features associated with nrem and rem sleep .
- (6) EEG , as a physiological tool to delineate stages of sleep.
- (7) How the total sleep duration and different sleep stages vary with different ages in normal humans.

Sleep is temporary physiological state of unconsciousness from which the person can be aroused (awaken) by sensory stimuli.

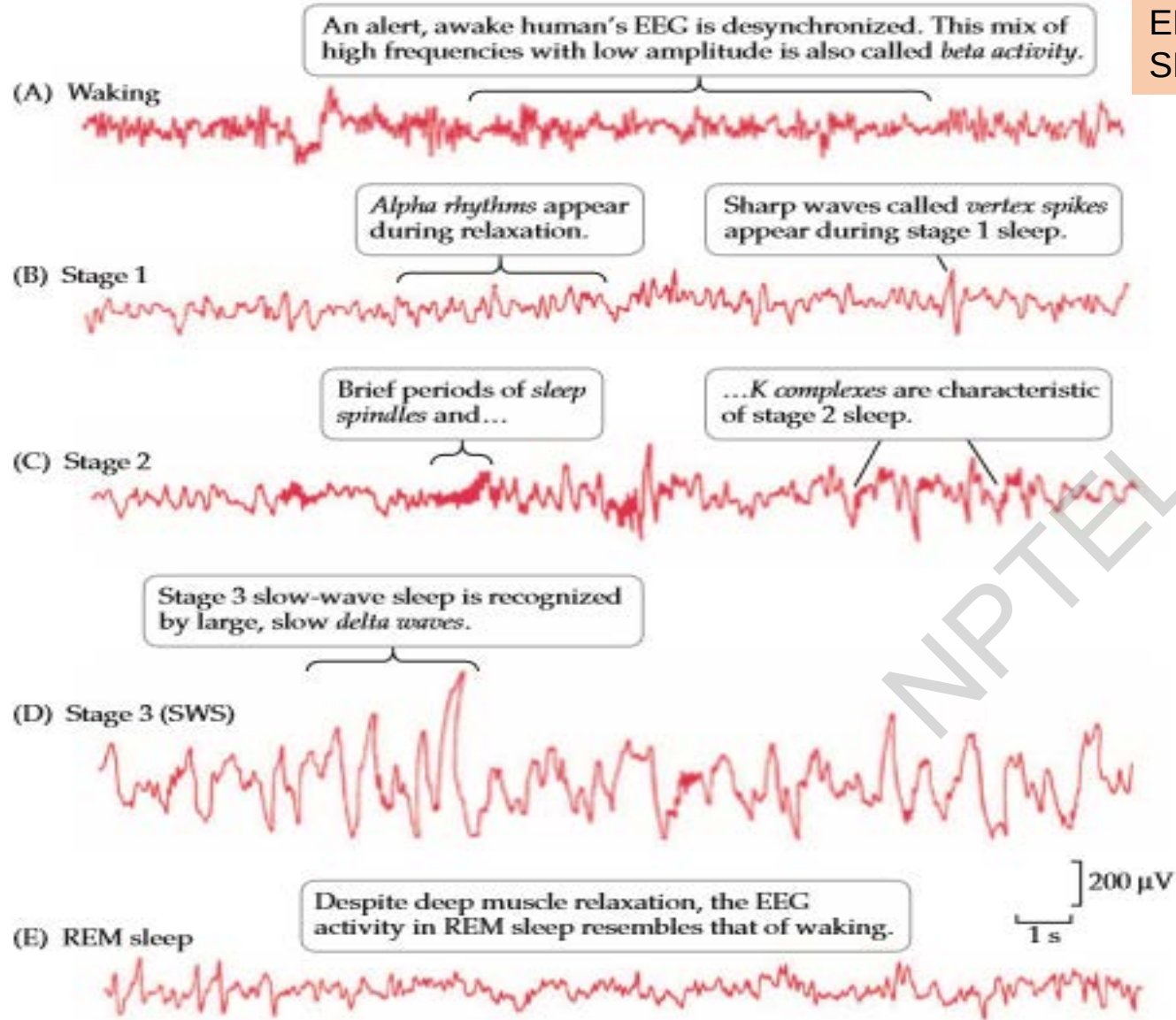
- Lying down posture
- Increased threshold to sensory stimuli
- Low level of motor output
- Dreaming

Coma, on the other hand, is a state of loss of consciousness (LOC) from which the person cannot be aroused

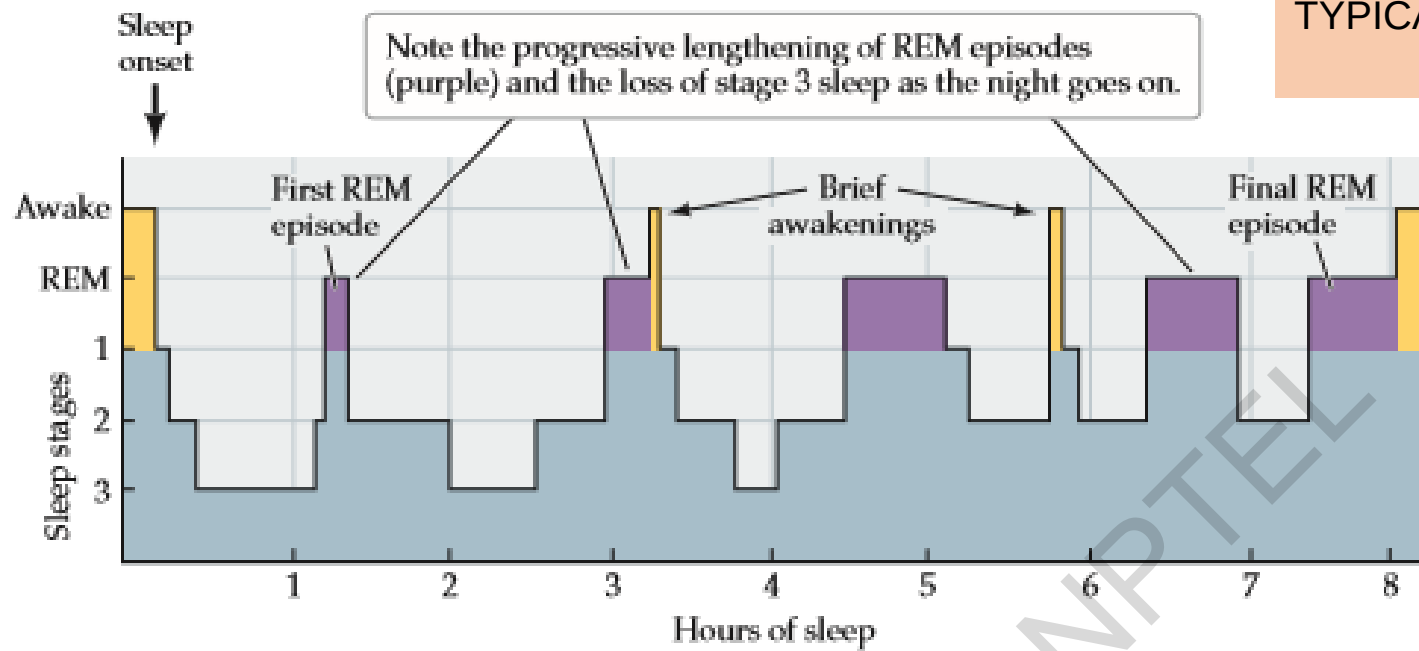
commonest EEG pattern of coma is continuous slow waves

- Experimenters found that brain potentials recorded from electrodes on the scalp by electroencephalography (EEG).
- Polysomnography- EOG
EMG
EEG
- Electrophysiological measurement led to the groundbreaking discovery that there are two distinct classes of sleep: rapid-eye-movement sleep, or **REM sleep**, and **non-REM (NREM) sleep**
- **REM-R** **NREM-1,2,3,4** later on **N1,N2,N3**

ELECTROPHYSIOLOGICAL CORRELATES OF SLEEP AND WAKING



SWS (Slow-Wave Sleep), because in this type of sleep EEG waves are generally of low frequency

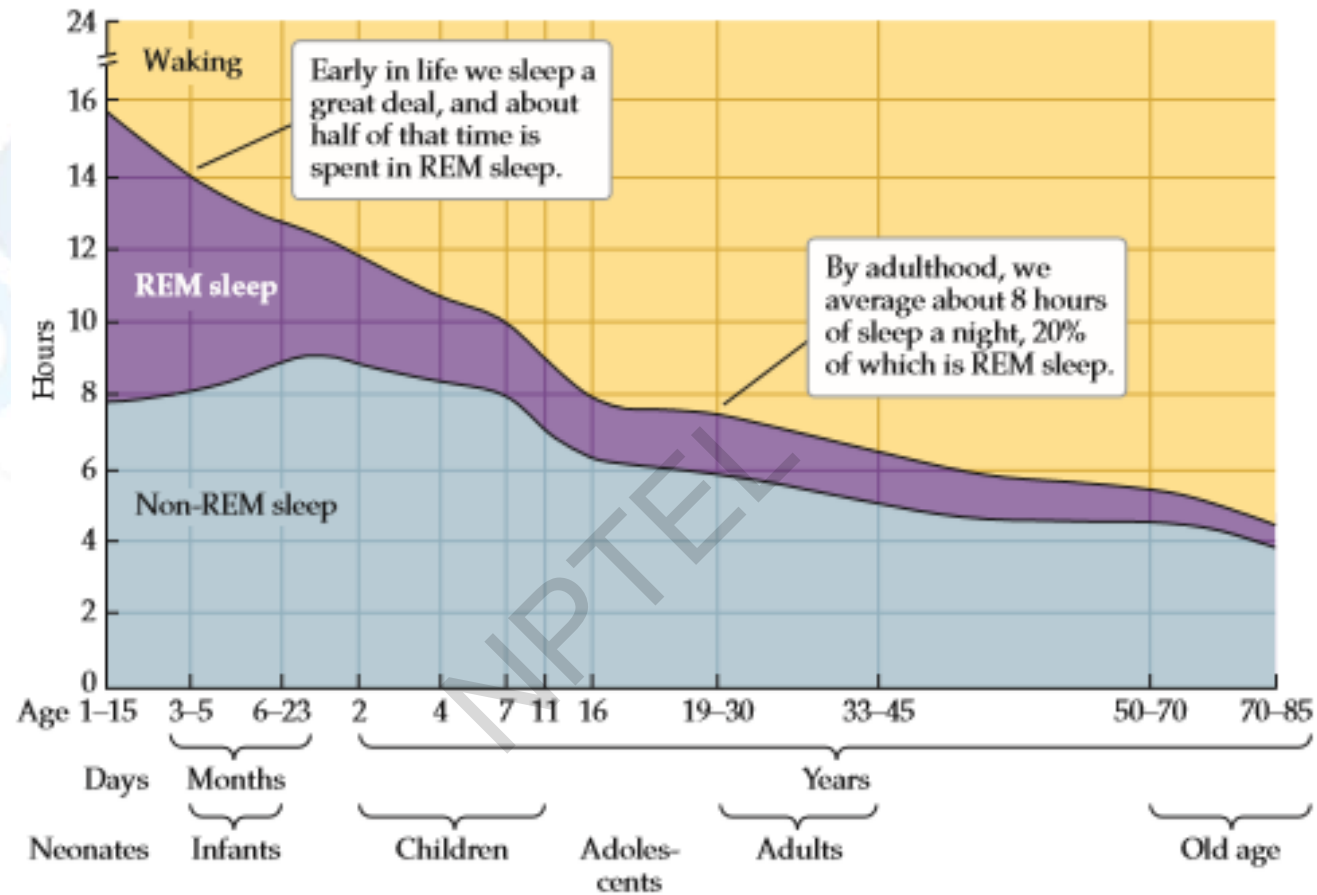


TYPICAL NIGHT OF SLEEP IN AN YOUNG ADULT

NREM-75%
REM-20-25%

REM increases
in morning

90 TO 110MINS



HUMAN SLEEP PATTERNS CHANGE WITH AGE

Properties of NREM & REM Sleep

PROPERTY	NREM SLEEP	REM SLEEP
AUTONOMIC ACTIVITIES		
Heart rate	Slow decline	Variable with high bursts
Respiration	Slow decline	Variable with high bursts
Thermoregulation	Maintained	Impaired
Brain temperature	Decreased	Increased
Cerebral blood flow	Reduced	High

Properties of NREM & REM Sleep

	NREM	REM
SKELETAL MUSCULAR SYSTEM		
Postural tension	Progressively reduced	Eliminated
Knee jerk reflex	Normal	Suppressed
Phasic twitches	Reduced	Increased
Eye movements	Infrequent, slow, uncoordinated	Rapid, coordinated
COGNITIVE STATE		
	Vague thoughts	Vivid dreams, well organized
HORMONE SECRETION		
Growth hormone secretion	High	Low

Neural basis of sleep

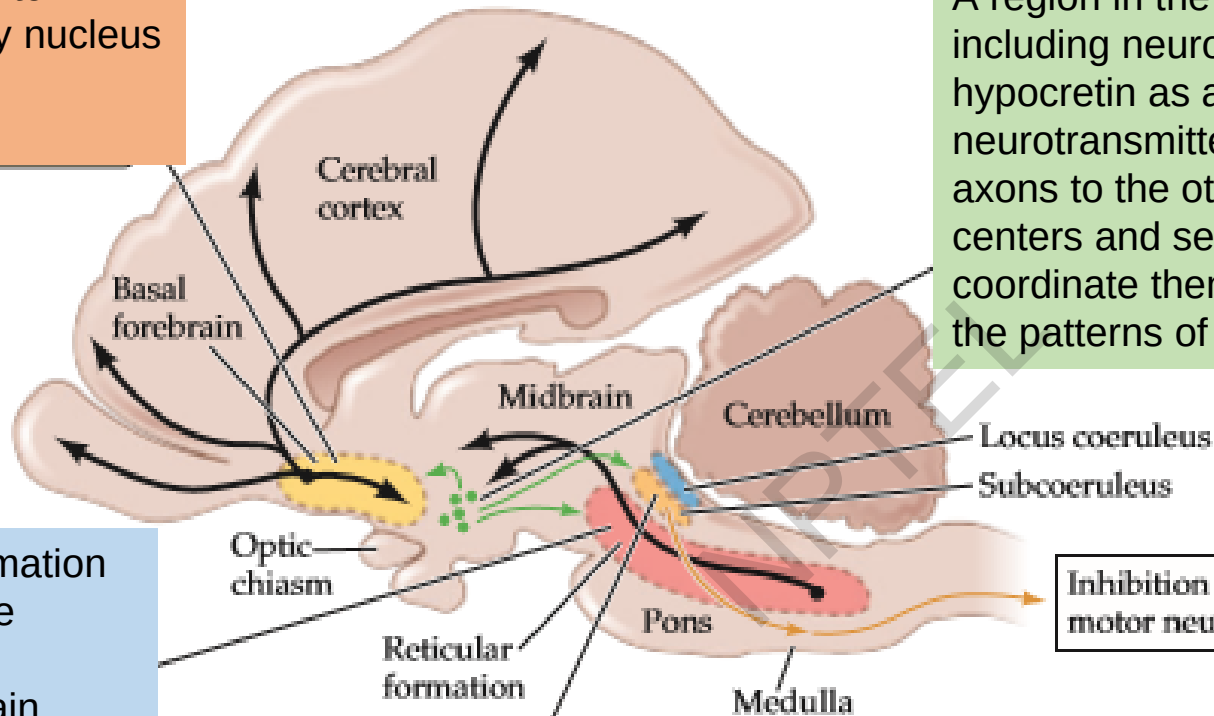
Basal forebrain –SWS
Releases GABA into
Tuberomammillary nucleus
Of hypothalamus

A region in the hypothalamus,
including neurons that use
hypocretin as a
neurotransmitter, sends
axons to the other three sleep
centers and seems to
coordinate them, enforcing
the patterns of sleep.

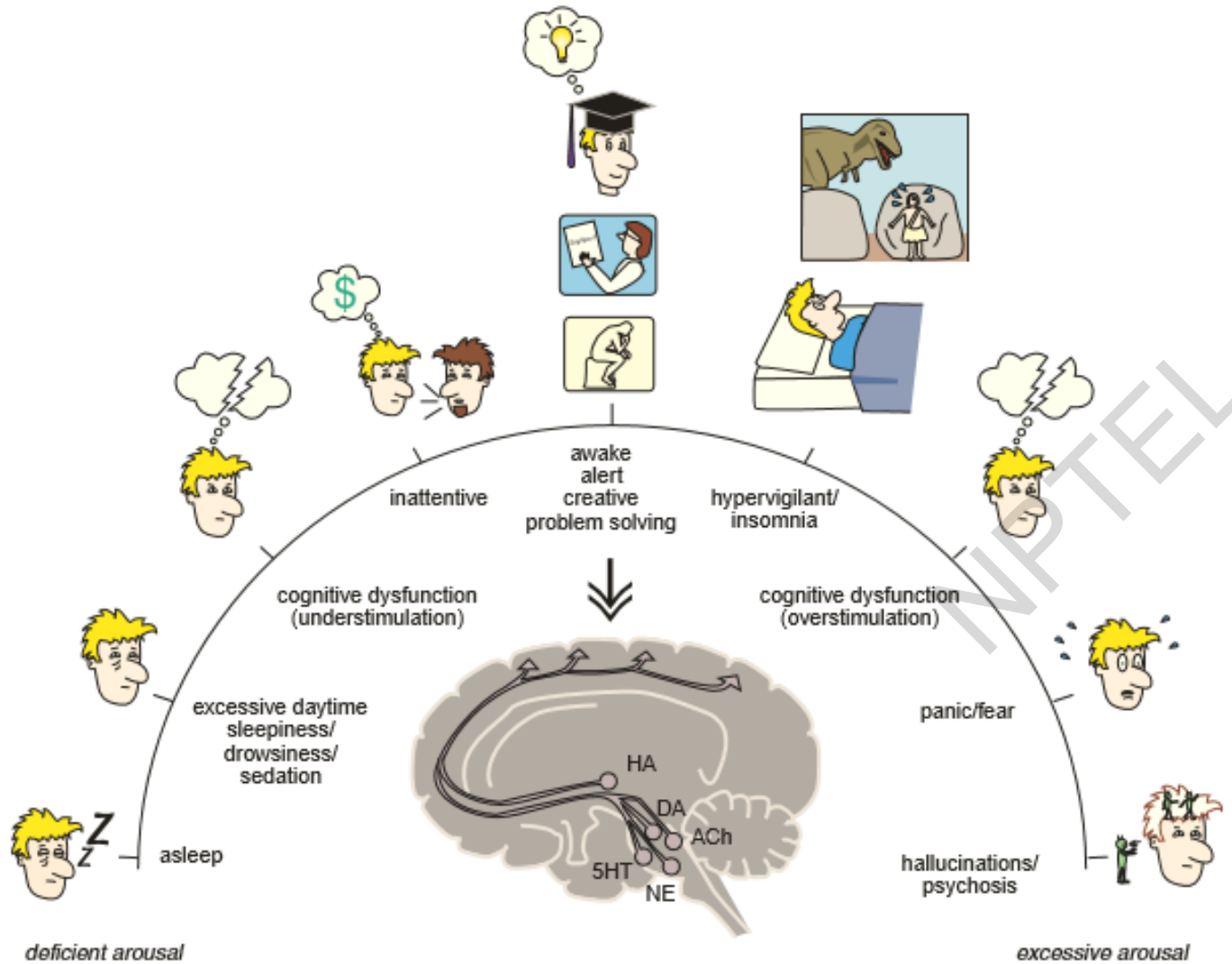
Reticular formation
Wakes up the
cortex,
Basal forebrain
imposes
Sleep by inhibiting
RF

Subcoeruleus ventral to locus coeruleus promotes
REM sleep.

Inhibition of
motor neurons

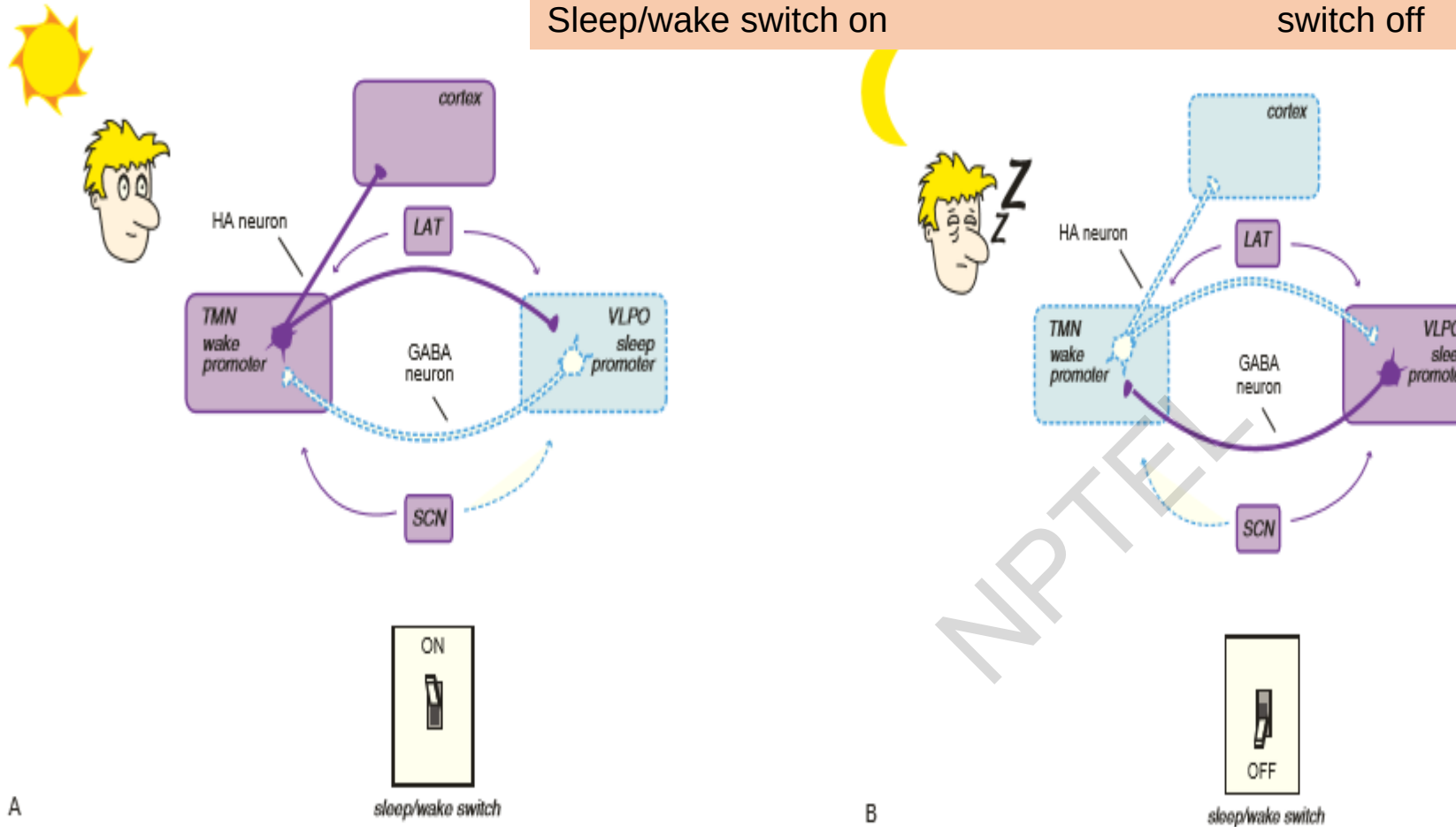


Arousal Spectrum of Sleep and Wakefulness

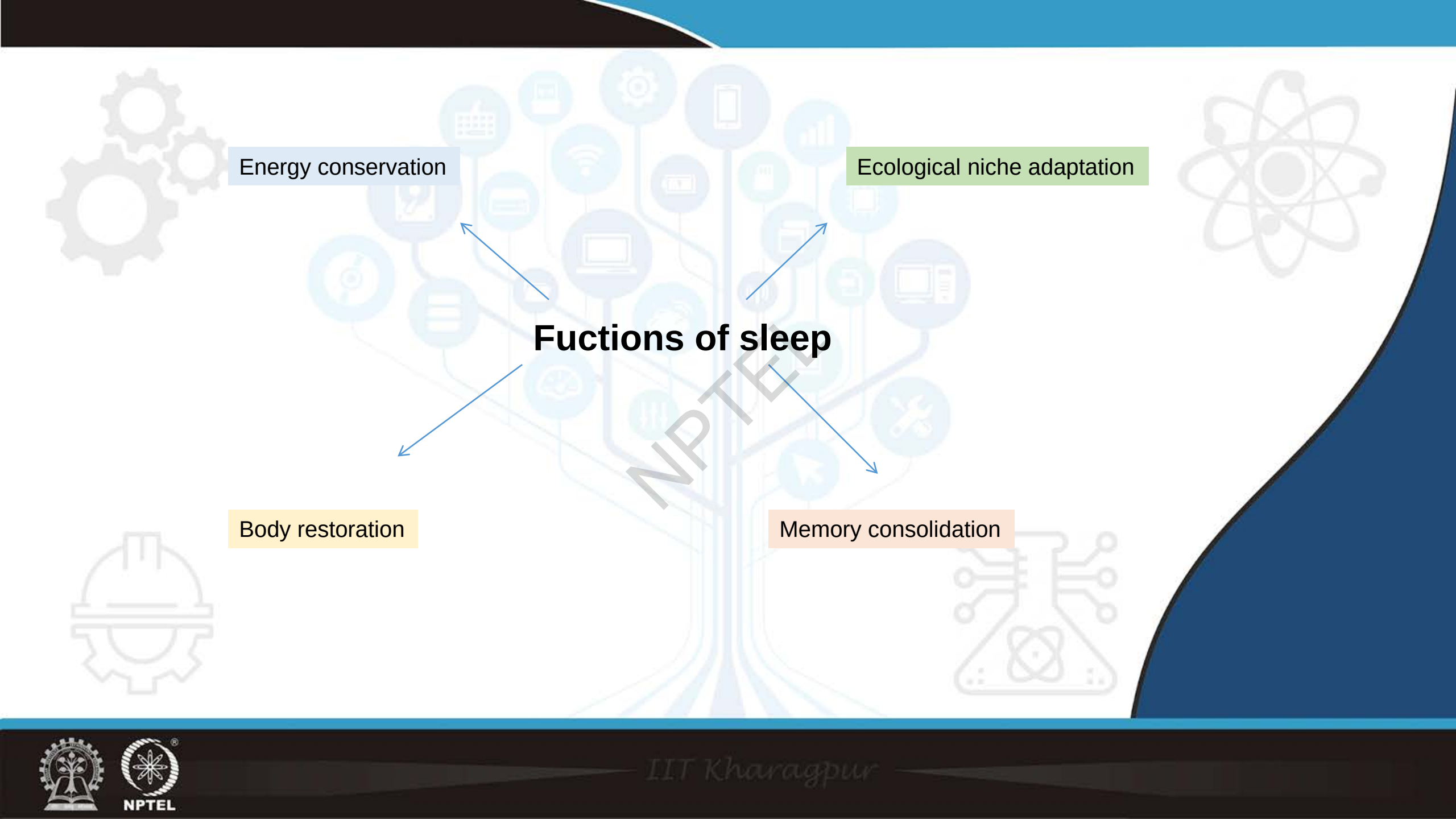


-cognitive disturbance is the product of both too little and too much arousal.

-five neurotransmitters histamine, dopamine, norepinephrine, serotonin, and acetylcholine



The sleep/wake switch is also regulated by orexin/hypocretin neurons in the lateral hypothalamus (LAT), which stabilize wakefulness, and by the suprachiasmatic nucleus (SCN) of the hypothalamus, which is the body's internal clock and is activated by melatonin, light, and activity to promote either sleep or wake.

A conceptual diagram showing the functions of sleep. At the center is the text "Fuctions of sleep" (note the typo). Four blue arrows radiate from this central text to four colored boxes: "Energy conservation" (top-left, light blue), "Ecological niche adaptation" (top-right, light green), "Body restoration" (bottom-left, light orange), and "Memory consolidation" (bottom-right, light orange). The background features a stylized tree with a circuit-like trunk and branches, each ending in a circular icon representing various concepts like technology, science, and nature. Decorative elements include gears in the top-left, an atom symbol in the top-right, a hard hat in the bottom-left, and a circuit board with an atom symbol in the bottom-right.

Energy conservation

Ecological niche adaptation

Fuctions of sleep

Body restoration

Memory consolidation

Keypoints

- Animals show circadian rhythms of activity that can be entrained by light.
- Lesions of the suprachiasmatic nucleus (SCN) abolish activity rhythms in constant conditions.
- Almost all mammals show two sleep states: rapid-eye-movement (REM) sleep and non-REM sleep (NREM). Human NREM has three distinct stages (stages 1, 2, 3) defined by electroencephalography (EEG).
- REM sleep is characterized by rapid, low-amplitude EEG (almost like an EEG while awake) but also by profound muscle relaxation.
- The basal forebrain promotes SWS, the brainstem reticular formation promotes arousal, the subcoeruleus of the pons triggers REM sleep, and hypothalamic neurons releasing hypocretin regulate these three centers.

REFERENCES

1. Guyton and Hall Textbook of Medical Physiology, John E. Hall, 13e
2. Stahl's Essential Psychopharmacology, 4e
3. Behavioural Neuroscience, Breedlove, 6e



**THANK
YOU !**