state in which there is a marked alteration in the individual's state of consciousness and customary sense of personal identity is replaced by an external 'possessing' identity and in which the individual's behavior and movements are experienced as being controlled by the possessing agent as per ICD 11. While lot of theories for such disorder are established, core of each theory lies at an unconscious underlying conflict that is not acceptable by individual's psyche. Here is an interesting case of 30yrs old homosexual female having possession trance disorder.

Objectives: To discuss a rare case of possession trance disorder due to unconscious conflict secondary to unexpressed sexual orientation.

Methods: A 30yrs old married female patient diagnosed with Possession Trance disorder as per ICD-11 was on treatment for the same since 3 yrs without improvement. She used to get possession episodes by a religious leader for few hours and would preach to his followers during such episodes. Later she was admitted in indoor facility to understand and explore her illness so as to provide an effective management. After serial interview with the patient and her relatives it was discovered that she had sexual orientation towards females(homosexual). Later on, during the course it was found that patient was attracted to a female disciple of that religious leader and to spend time with her, she used to get possession episodes. This however was not acceptable socio-culturally and by patient herself. This lead to lot of conflicts and dysfunctional marital life with husband. To begin with, patient was unable to accept this fact and reported intense guilt for the same. After serial psychotherapy sessions and pharmacotherapy, she improved significantly. Family based interventions for comprehensive improvement were carried out and the patient was discharged with significant improvement.

Results: Discussion: Lot of communities still has immense stigma against homosexual orientation, at times upto extent to consider it to be some mental illness or supernatural interference. This leads to severe psychological trauma to the person and gives rise to inner conflicts in accepting the true self. This emphasizes a need to develop awareness amongst the communities.

Conclusions: This was an interesting rare case highlighting the need for community based interventions to normalize issues related to human sexuality. There is a need to bring awareness and involvement of community to improve mental health of individual as well as community.

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Sleep Disorders and Stress

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Consider Early ECT Treatment for Chronic Insomnia-Induced Suicidal Ideation

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Introduction: Insomnia is a prevalent global health problem that affects 11.7% - 36% of the population (Grewal *et al.* Clinical Handbook of Insomnia Int 2017; 13 - 25). It is a risk factor for depression, poor quality of life, and accidents. Increasingly, insomnia has been identified as a suicide risk factor (Lin *et al.* BMC Psychiatry 2018: 18; 117) We present a case report of a 43-year-old male patient with insomnia-induced suicidal ideation (SI).

Objectives:

1. Learn the mechanism of insomnia-induced SI
2. Understand the current insomnia treatments
3. Discuss the possible mechanism of ECT treating insomnia-induced SI

Methods: A 43-year-old single male with past psychiatric diagnoses of social anxiety, borderline personality disorder, chronic SI, and severe recurrent depression was admitted to inpatient due to intractable SI from insomnia. He failed trials on SSRIs/SNRIs, bupropion, trazodone, lithium, vortioxetine, quetiapine, zolpidem, and ketamine. The patient was initiated on electroconvulsive therapy (ECT) three times a week with 20mg vortioxetine and 100mg quetiapine for sleep initiation.

Results: After 6-sessions, the patient's mood, affect and sleep had improved considerably, and his suicidal ideations resolved. The patient was discharged with outpatient follow-up and ECT as rescue therapy. His sleep gradually improved to 4-6hrs/night and his mood was back at baseline.

Conclusions: ECT is an effective treatment for refractory insomnia-induced SI, likely due to persistent REM suppression and reduced dendritic arborization and excitatory synapses in the amygdala (Doghramji *et al.* Sleep 2000; 23 - S16 - S20; Lahmeyer *et al.* Sleep Respiratory 1989; 18 346). Possible mechanisms for insomnia-induced SI include impaired decision-making, abnormalities in 5-HT function, or HPA dysfunction leading to a hyperarousal state and cortisol release (Chatzittofis *et al.* Euro Neuropsychopharmacology 2013; Elmenhorst *et al.* Sleep 2012; 35 1615 - 1623; Keilp *et al.* Psychol Medicine 2013; 43 539-551; Novati *et al.* 2008 Sleep; 31 1579 - 1585). Current insomnia treatments address underlying medical/psychological problems and non-pharmacologic and pharmacologic strategies. The predominant non-pharmacologic approach is Cognitive Behavioral Therapy Insomnia (CBT-I), such as relaxation techniques, sleep hygiene education, cognitive structuring, and sleep restriction (Rossman *et al.* American Journal of Lifestyle Medicine 2019; 13 544 - 547). Pharmacologic options include benzodiazepines, non-benzodiazepine hypnotics, tricyclic antidepressants, trazodone, and antihistamines (Saddichha *et al.* Annals of Indian Academy of Neurology 2010; 13 94-102). ECT should be strongly considered for the treatment of refractory insomnia-induced SI, and its early application may avoid rapid deterioration improving the quality of life.

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