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Case Reports

Catatonic and Psychotic Symptoms Owing to the Trauma of Captivity in a Cult Environment

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Introduction

We present the case of a 21-year-old African American female patient, who presented with catatonic and psychotic symptoms after a prolonged traumatic experience associated with being held captive in association with a cult. She showed marked improvement after lorazepam administration and multiple individual and family meetings, in which she had the opportunity to discuss her profound deprivation and abuse, which culminated in the death of her infant. The patient presented provided signed informed consent to have the details of her case disseminated. External verification of the facts was sought from Ms. A's mother and other family members, reliable media sources including interviews with the police department, and conversations with her attorney and Child Protective Services.

Case Report

Ms. A, a 21-year-old cachectic-appearing woman who looked significantly younger than her stated age, was brought to the emergency room of a large public hospital by her family for a medical evaluation because of a continued decline in her functioning since experiencing severe and prolonged physical and sexual trauma, extreme isolation, the death of her 15-month-old daughter owing to starvation, and the loss of her 3-year-old daughter to state custody along with the half siblings of her daughter. On presentation to the emergency room, Ms. A was withdrawn and nonverbal, and thus the history was provided by her family members. Information also was obtained through multiple news media reports.

Approximately 4.5 years before this presentation, Ms. A was lured and coerced by a cult leader. She was then held against her will in a hotel room for more than 4 years by the captor and his daughter. During her captivity, Ms. A experienced severe psychologic, physical, and sexual abuse, including being impregnated and giving birth to 2 children during this time. She was regularly used as a sex slave, tortured, starved, and beaten. The beatings and withholding of food occurred more frequently when she was "disobedient," which was in accord with cult rituals. Her captor also forced her repeatedly to recite and write verses that were in keeping with the principles and beliefs of the cult.

Ms. A was rescued by the police 6 months before this hospital visit, when her captor was arrested, after having brought their deceased second child to a local emergency room. This 15-month-old infant appeared like a newborn, was emaciated and showed signs of

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abuse, and was pronounced dead on arrival owing to malnutrition and starvation. The hospital staff became suspicious and contacted law enforcement, who located Ms. A at a local long-stay motel. After her rescue and that of the 3 remaining children, Ms. A was briefly hospitalized at an outside hospital, and records showed that at the time she weighed 59 pounds and "was extremely withdrawn" and "sometimes babbled incoherently." Her medical workup was unrevealing except for malnutrition, and she was discharged to home with her family and referred to a community-based behavioral health organization.

Ms. A's family reported a continued regression since that time. Her initial symptoms were fear and startle responses on encountering loud stimuli and flashbacks in which she would lose all awareness of her current surroundings and speak about what occurred in the motel as if it were happening to her all over again. Her family interpreted these reactions and behaviors as signs of "brainwashing." At times, she would go to the refrigerator and eat nonstop until she became ill. She repeatedly asked for her deceased child, even though she was informed multiple times about her death. She eventually progressed to a state of "lying in bed all day without talking" approximately 3 months before the current admission. This was in stark contrast to her premorbid level of functioning, which her mother described as "a straight A student, who scored a 1380 on her SAT, and wrote poetry in her free time." There was no report of any previous mental health issues or substance use before the abduction by the cult member.

At the time of the current admission, the patient was nonverbal and nonambulatory and was drooling extensively and regurgitating nondigested food. She was lying in the bed, staring blankly, and demonstrated waxy flexibility. She was essentially nonresponsive and nonreactive to efforts at social engagement, whether verbal or physical. Her vital signs and laboratory test results, including a chemistry panel, complete blood count, and urinalysis, were unremarkable. She had no witnessed episodes of regurgitation, her abdominal examination was benign, and her computed tomography abdomen-pelvis result was normal without signs of obstruction or inflammation. At the recommendation of the psychiatry/psychology consultants in the emergency room, Ms. A was admitted to the inpatient medicine service for further evaluation of her emesis rather than to a psychiatric floor because of concerns that a psychiatric unit would be a further traumatizing environment. Moreover, it appeared essential that her family remain at her bedside at all times and that was only possible on a medical floor.

The Psychiatric Consultation-Liaison (C-L) Service was consulted on hospital day 1. On initial evaluation, Ms. A's Bush-Francis Catatonia Rating Scale score[1] was 16. She demonstrated hypoactivity with virtually no interaction in the examination. She was selectively mute and unresponsive to simple commands but mumbled incoherently at times. Ms. A did not engage in eye contact, her eye movements were saccadic and random, and there was no evidence of smooth pursuit. She exhibited classic waxy flexibility in both arms and general rigidity in her legs, body, and neck.

The interprofessional psychiatry C-L team diagnosed her with posttraumatic stress disorder (PTSD) with dissociative symptoms and major depressive disorder, single episode, severe with psychotic features, with catatonia. A challenge with 1 mg of lorazepam intravenously for her catatonic symptoms was administered on hospital day 2. Over the course of the next hour, a marked change was noticed in Ms. A. Within minutes, her saccadic eye movements began to give way to smooth eye tracking. After 5 minutes, Ms. A began having voluntary movements, and shortly thereafter she wrote a simple sentence in a journal provided to her by a member of the psychiatry C-L team. Further, 40 minutes after the administration of the lorazepam, Ms. A started having a conversation with the team, and within the hour, she ambulated without assistance. Ms. A was placed on intravenous lorazepam 1 mg every 6 hours and citalopram 20 mg daily. Over the next 4 days of the hospitalization, the patient relapsed into catatonia several times, which required additional intravenous doses of lorazepam. To minimize her vulnerability to catatonic symptoms, her lorazepam dose was further titrated, and she achieved a sustained remission from catatonia on intravenous lorazepam 2 mg every 6 hours. This dose was eventually switched to oral lorazepam 1.5 mg every 6 hours.

Initial interviews with the patient revealed a moderate degree of thought disorganization as she had loose associations, tangential thought processes, and would often share bizarre thoughts particularly related to sex and breastfeeding. She endorsed auditory