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Anorexia Nervosa Following Torture in a Young African Woman

A case of weight loss from food avoidance and vomiting in a young Ethiopian torture victim is described, and possible aetiological factors discussed.

Although a wide variety of psychological and physical sequelae occur in torture victims, a life-threatening eating disorder resembling anorexia nervosa has not previously been reported.

Case report

A 22-year-old African torture victim was admitted for investigation of an eating disorder after referral by the Medical Foundation for the Care of Victims of Torture (a London-based body providing specialist multidisciplinary care for victims of torture). She had been vomiting after most meals and was losing weight. She was 157 cm in height and weighed 39 kg on admission. She had started vomiting when she was aged 16 years, at which time she was imprisoned in Ethiopia and interrogated about the political activities of her father and brother. During a 6-month period in prison, she was beaten about the arms, chest, and legs with electric cables. On one occasion, a blood-stained rag was stuffed into her mouth to prevent her screaming. Following this incident, she vomited blood-streaked material and when she attempted to eat, vomited repeatedly. She said that at the time, eating had reminded her of the rag in her mouth. During the course of imprisonment, her weight fell from 64 kg to 45 kg. Following her release, she spent 6 months in hospital, where she failed to gain weight, continuing to vomit after meals. Over the following 4.5 years, this bizarre eating pattern continued. She said that the vomiting was involuntary and that it was preceded by an unpleasant acid taste in her mouth. Her weight remained low at 35–45 kg, and she survived on small snacks and liquids only. Following her imprisonment, she began to menstruate less frequently and irregularly, approximately once every 3 to 6 months. After her release, she was depressed and preoccupied with memories of her experience as a prisoner.

She was born in Africa, an identical twin. Her father was executed during the patient's imprisonment. Her parents were Christians and placed a high value on academic success. An elder brother died when the patient was 16 years old, also the victim of a politically motivated execution. One elder brother and one elder sister are in good health, as is the twin sister. She was a healthy child and a bright student. Following her imprisonment, she attended a pharmacy course at the University and passed her examinations, apparently without difficulty. Because of their status as ex-prisoners, she and a few class mates were segregated from the majority of their fellow students. After qualifying, she worked with missionaries in the famine regions of the country. Her abnormal eating and vomiting attracted the attention of her colleagues, and arrangements were made through a religious order for her to be sent to Ireland for investigations. After a short period in Ireland, she joined her two cousins in the UK and applied for political asylum. Soon after her arrival in the UK, she was charged with shop-lifting a tin of cat food from a supermarket. She claimed that she remembered very few details of this incident and it was thought possible that the alleged offence had taken place in a fugue state. She described herself as a shy person, having difficulty making friends, and had had no sexual relationships. There was no history of contact with the psychiatric services. Her cousins confirmed the above history.

Investigations

On physical examination, extensive scarring was found across both her breasts. There were scars on her elbows and dorsal surfaces of the feet from previous lash-injuries.

Results of barium meal and follow-through, and gastro-duodenoscopy, were normal. A computerised tomography head scan showed prominent superficial sulci with normal ventricles. A scintigraphic examination of gastric emptying, using a mixed solid meal containing egg white labelled with ^{99}technetium, demonstrated delayed emptying and marked gastro-oesophageal reflux on admission. The test was repeated prior to discharge and showed improvement in gastric emptying with no evidence of reflux.

Psychometric assessment showed the subject to be of average intelligence, using culture-fair tests. The patient scored 10, 13, and 4 on the Eating Attitudes Tests (EAT-26) (Garner *et al*, 1982) administered at 2-monthly intervals, all within the normal range, which has a cut-off score of 30.

Mental state and progress

On admission, she was a thin, tense, young woman who preferred to spend her time alone. Her spoken English was good. Her mood was depressed and anxious, and she complained of early-morning wakening and diurnal mood variation, although she denied suicidal thoughts. There were no phobic symptoms or nightmares. Although emaciated, she claimed that she was only a little underweight at 38 kg, suggesting an ideal weight for herself of 41 kg. She felt that her arms and legs were thin, but that her buttocks and thighs were of an adequately large size. There was no evidence of cognitive impairment.

She was treated with dothiepin and there was an improvement in her depressed mood. However, she remained very anxious. A refeeding programme was gradually introduced. At first the patient vomited after most snacks, sometimes attempting to conceal her vomit, but on

occasions vomiting at the communal dining table. There followed a more intensive nursing regime of a kind formulated for patients with anorexia nervosa, but in this case beginning with a liquid diet. As a result, she lost 4 kg during her first 6 weeks on the ward. After this she began to eat more, vomited less, and began to gain weight after 8 weeks of in-patient treatment. She attended groups for anorectic patients as well as relaxation classes. After 16 weeks in hospital, her weight reached 46 kg and she menstruated. Her periods became regular subsequently.

During her admission, she expressed concern about her increasing weight. At 42 kg she thought that she was beginning to look fat, and sought reassurance repeatedly from the nursing staff. She bought slimming magazines on several occasions.

Prior to her discharge, the antidepressant treatment was stopped at the request of the patient, and her mood remained stable. She was discharged to the care of her cousin. Follow-up care was given by the psychiatric outpatient department and the Medical Foundation for the Care of Victims of Torture. Intensive supportive care from the Foundation's multidisciplinary team was made available. She lost a small amount of weight following discharge, but in the next 6 months her condition remained stable, and she did not have a recurrence of vomiting. She also resumed full-time studies, hoping to qualify to practise pharmacy in this country.

Discussion

The patient we have described suffered psychogenic vomiting in association with severe weight loss. She did not suffer prolonged amenorrhoea or bulimic episodes, although she did manifest a disturbance of body image consistent with the diagnosis of anorexia nervosa. We regarded her as having an atypical eating disorder allied to anorexia nervosa.

Acute and chronic psychological sequelae are common among victims of torture and extreme stress (Eitinger, 1980). Studying a group of torture victims, Lunde (1982) found that mental symptoms were present in 75%, depressive symptoms in 19%, fear and anxiety in 24%, and irritability in 30%. Rasmussen & Marcussen (1982) report that 32% of victims suffer from gastrointestinal complaints, most commonly irritable spastic colon. There are no accurate reports available of the incidence of dissociative states among torture victims. However, impaired memory, impaired concentration, and vertigo, are common complaints in the absence of any neurological deficit (Somnier & Genefke, 1986).

The association between the preceding torture and the presenting symptoms appears to be clear-cut in this patient. The commencement of the eating disorder coincided with the combined traumas of torture, imprisonment, and the death of the patient's father. The vomiting may be accounted for, using a classical conditioning model, by the episode of gagging during torture. To explain the continuance of the symptom, a more complex interpretation is called for. Russell (1979) has drawn attention to the frequency with which hysterical dissociation mechanisms are found in bulimia nervosa. Torem (1986) has reported two cases of binge-eating and self-induced vomiting where the underlying mechanism was thought to be dissociative. In our case, there was a history suggestive of a fugue state during a shoplifting episode, possibly indicating a tendency towards dissociation. The patient stated that she sometimes felt strange, "as though in a dream" when vomiting, and she showed no evidence of distress during the episodes.

Other factors that may have accounted for the tenacity of the symptoms include the increasing ease of vomiting due to the spontaneous gastro-oesophageal reflux demonstrated. The patient viewed the onset as leading inevitably to vomiting. The return towards normal functioning, evident on stomach-emptying tests, coincided with a reduction in the frequency of vomiting and may have contributed to the continued absence of vomiting after discharge from hospital.

An intriguing aspect of the case is the patient's acquisition of 'anorectic attitudes', especially her fear of becoming fat. The weight she suggested for herself was significantly less than her premorbid weight, and also less than the minimal acceptable healthy weight of 46 kg. She appeared unusually preoccupied with her body shape and expressed a complex interpretation of it. As she gained weight, she demanded regular reassurance from the nursing staff that she was not becoming overweight, and she started to buy slimming magazines. By this stage she had spent a good deal of time among the anorectic in-patients. Their influence on her attitudes may have accounted for some of this behaviour. The significance of the patient's normal scores on the Eating Attitudes Tests is of limited relevance, since this test has not, to the best of our knowledge, been validated in an African population.

Owing to the range of difficulties faced by the torture victim, including medical and psychological sequelae, educational needs and social problems, a multidisciplinary approach is an essential requirement. In some centres this can best be organised through specialist institutions for the care of torture victims.

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Post-Partum Psychosis in Adult GM_2 Gangliosidosis

A Case Report

Adult hexosaminidase A deficiency is a form of GM_2 gangliosidosis with autosomal recessive inheritance. Only 35 cases (mostly among Ashkenazic Jews) have been reported worldwide. Symptoms include, in a third of the cases, psychosis. A 27-year-old sufferer with no prior psychiatric history, developed a post-partum psychosis, with affective and hebephrenic components, 3 days following her first delivery. She responded to lithium within 10 days of initiating treatment; the full episode lasted 1 month. We conclude that lithium is the preferred treatment for psychosis in such adult patients, especially in light of possible long-term neurological deterioration caused by phenothiazines. Ashkenazic Jews with atypical neurological syndromes presenting with psychosis should be tested for hexosaminadase A deficiency.

Adult GM_2 gangliosidosis is a rare autosomal recessive disorder caused by a deficiency of hexosaminidase A, leading to the accumulation of GM_2 gangliosides in neurons (O'Brien, 1983). Total absence of this enzyme occurs in Tay–Sachs disease, which leads to death in late infancy. A juvenile form of GM_2 gangliosidosis, usually leading to death in the second decade, has also been diagnosed.

Hexosaminidase A deficiency was first discovered in adults by Navon *et al* (1973). Thirty cases have subsequently been reported in the literature (reviewed by Navon *et al*, 1986). The disorder is apparently inherited as an autosomal recessive gene, with the highest frequency found among Ashkenazic Jews (disease prevalence of 1:67 000 in the USA, Greenberg & Kaback, 1982; and 1:14 000 in Israel, Navon & Adam, 1985). Age of onset varies from the first to the third decades of life. Clinical manifestations also vary, even within the same family, and include pyramidal, lower-motor-neuron (especially of proximal lower limbs), and cerebellar signs, often suggesting amyotrophic lateral sclerosis, spinocerebellar, and spinal muscular atrophy-like syndromes (Argov & Navon, 1984; Navon *et al*, 1986). Sensory impairment is not found.

In 9 of 33 reported cases, psychosis developed in the course of the disease (Navon *et al*, 1986). The clinical picture usually reported is one of hebephrenic schizophrenia, with long-term decline, sometimes leading to an incapacitating dementia.