ORIGINAL PAPER

The Dark Cartoon: Intrusive Imagery Secondary to Childhood Sexual Abuse

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Ir J Psych Med 2012; 29 (3): 171-175

Abstract

We report on the case of a middle-aged woman with a complex psychiatric history in whom atypical intrusive imagery identified in the mental status examination appeared to represent an emergence of childhood dissociative phenomena. These new symptoms led to the reappraisal of her clinical presentation and a diagnostic re-evaluation that they represented a re-emergence of childhood post-traumatic stress disorder secondary to sexual abuse. We discuss the phenomenology identified in our patient with the aim of increasing awareness of unusual symptoms in adults with a history of childhood sexual abuse and the importance of the mental state examination in eliciting and classifying such phenomena.

Key words: Intrusive imagery, post-traumatic stress disorder (PTSD), childhood PSTD, childhood sexual abuse

Introduction

Childhood sexual abuse has profound manifestations in adult psychopathology.[1] The range of clinical sequelae is diverse including depression, substance abuse, self-abusive behavior, somatization disorder, dissociative disorders, borderline personality disorder, conversion reactions, and PTSD.[1,2] These disorders are modulated in severity by variables such as duration, invasiveness and type of sexual abuse, as well as age and sex of victim.[1] Three main models exist regarding the psychopathogenesis of symptoms in victims of childhood sexual abuse.[1] First is the psychoanalytical model proposed by Freud that symptoms arise from the repression of unacceptable thoughts; the second, regarded collectively as Sexual Abuse Accommodation Syndrome, postulates that symptoms arise from the child's attempt to accommodate to sexual abuse; lastly, neurophysiologic changes secondary to trauma have been associated with the evolution of symptoms.[1]

The wide array of psychological sequelae of childhood sexual abuse, and the fact that patients may be reluctant or unable to reveal specific details about the trauma itself, necessitates close attention to clinical symptoms. Special care must be given particularly to post-traumatic symptoms, as these are often overlooked by clinicians.[3] These symptoms consist of increased arousal, avoidance of stimuli associated with the event, numbing of responsiveness and persistent reliving of experiences either in dreams or intrusive memories.[4] One of the challenges may be that of understanding and classifying phenomena that present in the mental status examination, which may not easily fit into traditional categories of adult PTSD. Intrusive images have been a particular focus of study within syndromes of childhood sexual abuse and PTSD.

Intrusive images are contents of consciousness that possess visual qualities and tend to be recurrent, uncontrollable and distressing[5] and are distinct from verbal intrusive cognitions (ruminations).[6,5] They are regarded as a hallmark of PTSD and generally consist of reliving experiences from intact memory of trauma.[7,4]

Nonetheless, pathology of memory is also commonly associated with PTSD.[8] In cases of post-traumatic amnesia, a traumatic event fails to assimilate into memory schemata due to its overwhelming effect on mental processing.[8] In such cases, clear intrusive imagery may still manifest in various forms,[1,8] but the diagnostic criteria for PTSD are not fully met (because the patient cannot recollect or experience traumatic memories). Thus, intrusive imagery remains difficult to classify within the clinical definition of PTSD in amnestic states. In this report, we explore the aetiology and classification of unique intrusive images as they presented in a patient who had been sexually abused as a child.

Case history

XX, a 48-year-old divorced, unemployed woman with three children and a long and complex psychiatric history, presented to the outpatient review clinic with ongoing complaints of constant worry, agitation, frustration and suicidal ideation. Her background included multiple diagnostic co-morbidities including recurrent depressive disorder, generalised anxiety disorder, mixed personality disorder and recovering alcohol and benzodiazepine dependence. She had several acute in-patient admissions resulting from episodes of self-harm as well as periods of home-based treatment, ongoing anti-depressant pharmacotherapy and out-patient attendance with addiction counselling and clinical psychology. There had been little evidence, to date, of significant benefit from any clinical interventions.

During a recent outpatient clinic visit, a medical student conducted a detailed history and mental state examination uncovering symptoms, which until that time had not been recorded in the clinical file. This interview differed from that normally conducted in the setting of a review clinic in that it was not time restricted and was performed under the explicit declaration that the interviewer was a medical student and not therefore in a position to provide any actual clinical intervention. Also, the approach to the interview was formulaic and detailed - adopting the standard headings and sub-headings recommended for an initial diagnostic assessment in psychiatry. Consequently, it is likely that specific areas were addressed - particularly regarding thought content and perceptual abnormalities - that may not have been explored in detail since the initial assessment interview years earlier.

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Submitted: 16th January 2012
Accepted: 13th April 2012

https://doi.org/10.1017/S0790966700017201 Published online by Cambridge University Press

In the interview, XX described experiencing recurrent intrusive images of "dark scary cartoons". These images would appear to her in dreams and then recur throughout the day causing her great distress. She described them as "funny but terrible and strange images" reminiscent of "cartoons she has seen, such as Mickey Mouse and Desperate Dan, but appearing twisted and ruined". These images would force themselves into her mind and torment her throughout the day. Importantly, XX recognised these images as products of her imagination and not emanating from the external space. They had been bothering her constantly for the previous two years.

In further discussion of the intrusive images XX revealed how learning that her father had sexually abused her son could have precipitated her current mental state. When her son had told her about his own abuse experiences three years previously, she described experiencing déjà vu. She stated that her son had told her how her father had "gotten close to him in a strange way" and that she distinctly remembered experiencing something comparable. Her son's account to her seemed to unlock a faint memory that her father had also abused her in a similar way. Nonetheless, she was unable to elaborate on any other specific details or memory of the abuse other than that it would have occurred when she was very young. When asked frankly if her father had abused her, XX nodded affirmatively, but seemed unable to make a verbal response. Critical to this discussion is that although sexual abuse had been suspected previously, it had never been so openly discussed in prior visits to the clinic.

Of note in her past medical history, XX described that she had been prescribed diazepam for insomnia at age ten years and that she had been hospitalised for what she called a "mini-stroke" at the age of 16 when she experienced a complete right-sided hemiparesis, which resolved spontaneously in a matter of days.

Apart from the intrusive imagery, detailed above, on mental state examination XX presented as disheveled and poorly groomed with dirt and tar on her hands and under her fingernails. The volar surfaces of her forearms were covered with self-inflicted scratch marks bilaterally. She was cooperative with reasonable eye contact. Speech was both coherent and relevant with a normal tone and rate. She appeared agitated and distraught, with subjectively low mood. She doubted whether life was worth living, but denied any specific plans of suicide or self-harm. There was no evidence of passivity phenomena or of thought insertion, withdrawal or broadcast. Similarly, XX denied hallucinations in all perceptual modalities. She was well oriented, showed no short or long-term memory deficit, and scored 27/30 on the Mini Mental State Examination.

Discussion

The development of PTSD involves exposure to an extreme traumatic stressor followed by the development of characteristic symptoms, namely persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the event, hyperarousal, and numbing of general responsiveness.[4]

The DSM IV lists "developmentally inappropriate sexual experiences without threatened or actual violence" as a cause of PTSD in children. Nonetheless, the symptomatic features of PTSD in adult and children victims must be differentiated

Classification syndromes have been proposed to globally assess the child and adult survivor of sexual abuse. Goodwin et al proposed a syndrome encompassed by the mnemonic FEARS to designate the various categories of post-traumatic symptoms in child incest victims (Table 1).[3,1] In this mnemonic, F stands for fears (i.e. phobias associated with the abuse); E represents ego constriction where there is a loss of developmental gains; A stands for anger dyscontrol in which victims repress and have difficulty expressing anger; R stands for repetition of thoughts or images of the trauma and S represents sleep disturbance including nightmares and sadness.

This mnemonic was modified to differentiate the moderate syndrome, which is more common in children compared to the severe syndrome present more often in adult victims.[1] In this

Table 1. Moderate and severe post-traumatic symptoms in adult incest victims constituting the five cardinal signs of PTSD.[1,3]

Moderate syndrome	Severe syndrome
Fears • Hyperalert • Nervous	**F**ugues • Dissociative symptoms • Multiple Personality
Ego constriction • Sexual inhibitions • Social inhibitions	**E**go fragmentation • Borderline personality • Multiple personality
Anger Dyscontrol • Continuing anger • Afraid of anger	**A**ntisocial acting- out • Alcohol, substance abuse
Repetition • Flashbacks • Nightmares	**R**eenactments • Rape or other victimisation
Sleep disturbance • Nightmares	**S**omatization • Medical problems
Sadness • Guilt • Depression	**S**uicidality • Suicidal thoughts • Suicidal attempts

https://doi.org/10.1017/S0790966700017201 Published online by Cambridge University Press

severe syndrome F represents fugues where high intensity fear and anxiety are relieved by retreating into amnesia and derealisation[3,1]; E is ego fragmentation resulting in multiple personality disorder or borderline personality disorder; A represents antisocial acting out, where victims are unable to repress their anger or impulses; R for reenactments where victims will subconsciously seek out abusive partners or partners who incestuously abuse the victim's children in addition to repetitions experienced in the moderate syndrome and S is suciadality and somatization.

Reviewing XX's case in light of these criteria, many of her symptoms and co-morbidities are congruent with a severe post-traumatic sexual abuse syndrome (i.e. alcohol dependence, self abuse, borderline personality disorder and dissociative amnesia of the trauma itself). Yet, a critical part of the diagnostic criteria of adult PTSD - a specific traumatic memory on which the patient fixates - is lacking. When questioned about the abuse perpetrated by her father XX was unable to comment on any concrete memory, but stated that she experienced déjà vu when she learned of the nature of her son's abuse. Thus it would seem the knowledge of her son's abuse caused the resurfacing of a distant memory or sense of the event.

Whether repressed memories exist at all or are part a disorder known as false memory syndrome (in which a dependent patient fabricates memories in order to prolong the therapeutic relationship) has been a topic of much debate[9] and deserves further consideration in this case. It is possible to argue that XX's vague sense of déjà vu does not correspond with evidence of sexual abuse at all, and is instead an artifact of the interviewing process. Proponents of false memory syndrome Ofshe and Waters argue that memory recovery therapy is a product of overzealous, feministic therapists who coerce patients to remember their supposed childhood abuse.[10] Of critical importance in XX's history is that the information regarding her childhood sexual abuse was freely given in her first presentation to medical student, with no prior therapeutic relationship - making the possibility of a false memory syndrome less likely.

A further hypothesis in relation to the intrusive images our patient experienced is that they represented an unconscious guilt or self-punishment response to the tragic news of her son's sexual abuse, rather than a direct manifestation of herself being abused in the past. However, XX's long psychiatric history, associated with multiple co-morbidities pre-dating the revelation of her son's abuse as well as the childhood history suggestive of conversion symptoms are compatible with a sexual abuse syndrome. Nonetheless, while the presentation and course of XX's psychiatric symptoms as well as her own admission of her own abuse in the interview, strongly support the likelihood of a history of childhood sexual abuse, the news of her son's abuse certainly destabilised her already fragile coping mechanisms, and compounded what was already a complex clinical picture.

While a syndrome of sexual abuse seems clear in XX's case, repression of the memory of the event in a dissociative amnesia precludes a pure adult form of PTSD. Nonetheless, as stated above the psychological manifestations of childhood PTSD differ from that of the adult, namely in experiencing frightening dreams. While posttraumatic nightmares typically are associated with specific elements of the trauma, which includes sexual imagery[1], they may not have specific trauma-related contents in children.[11,2,4] Such dreams in children often contain images of monsters, rescuing others, or threats to self.[11,4]

Therefore, the intrusive images of dark cartoons XX experienced could represent a manifestation of childhood PTSD because they appeared to her as nightmares, even though they lack the concrete nature of memories typically associated with PTSD flashbacks. This presentation raises a further question as to why, despite being an adult, XX presents with diagnostic criteria closer to that of a child. Unable to work through this adversity as a child, the psychopathology of XX's may have been incubated for an extended period but re-emerged in middle age through a number of possible mental processes including:

- the resurfacing of the fractured, immature traumatic memory manifests as a residuum of childhood presentation of PTSD,
- a regression state where subconsciously XX retreated to an earlier developmental period to better cope with the traumatising memory, and /or
- a chronic form of childhood PTSD that occurred before her repression/obliteration of the memory.

Green et al report similar instances of PTSD being triggered in adult victims following disclosure of the sexual abuse of their daughters.[12] Furthermore, Goodwin et al report that symptoms expressed in therapy often regress to styles of expression appropriate to the age at which the trauma occurred.[3] Nonetheless, as the remainder of XX's symptoms were suggestive of an adult post-traumatic presentation the argument that her presentation represents a regression state appears less cogent. In addition, because XX's symptoms were triggered in adulthood, a chronic form of childhood PTSD also becomes less likely. We suggest that the isolated memory of abuse, fractured and all but obliterated, triggered a childhood presentation of PTSD, as the specific memory elements were not present to initiate an adult form of the disorder.

When further questioned about the nature of the "scary cartoons" that haunted her, XX conjured a vague yet disturbing picture of funny, terrible images reminiscent of the work of artist Todd Schorr, or any other number of macabre cartoonists. For many, cartoons represent a core element of childhood as parents increasingly utilize them as a central form of entertainment and education during the developmental years.[13] Nonetheless, early media exposure from infancy to adolescence has been associated with delayed cognitive development and poor behavioral outcomes.[14,15] Media exposure has a particularly negative impact on children from poor socioeconomic groups.[16] For these reasons, the American Academy of Pediatrics recommends that no child under the age of 2 should have media exposure of any kind.[17] Thus, while images and memories from childhood cartoons remain linked with emotional recollections of a time of innocence, they have potential pathological consequences in the developing mind. Although violent cartoons have been linked specifically with increased aggression,[18] whether early exposure to cartoons predisposes to the development of intrusive images is unknown. However, because cartoons often represent an exaggeration or distortion of normal physical appearances and emotional expressions, artists can translate them into powerful depictions of the monstrous. The work of Todd Schorr exemplifies this fact as his paintings render

https://doi.org/10.1017/S0790966700017201 Published online by Cambridge University Press

familiar characters as perverted figures personifying loss of innocence. In this sense, the scary cartoon may serve as the vessel of the distorted image of the abuser, who in a real sense has transformed from protector to monster in the mind of the abused.

In this sense, the intrusive images of dark cartoons that tormented XX seem an entirely appropriate manifestation of her childhood. Her father, a presumably once-trusted figure in her life, destroyed that confidence through sexual abuse. Arguably, this was such an abhorrent experience that the memory was repressed in her subconscious only to be triggered years later by learning that her son has suffered a similar experience. Even to this day she lacks a full memory of any abuse, but her multiple psychiatric sequelae may represent, in part, a consequence of psychological repression of memories from a turbulent childhood as diagnostic complexity and, atypicality, are more commonly found in victims of childhood sexual abuse.[1,2]

The intrusive images reported in our case do not fit into any of the traditional major descriptive categories within the standard mental status examination, yet raise the importance of recognising similar phenomena in adult patients, whether or not they report memories of childhood sexual abuse. The psychopathogenesis associated with childhood sexual abuse is complex and this case highlights the importance of thorough and serial mental state examinations even in long-term patients, especially if they have been refractory to treatment. Discovery of these symptoms led to the reappraisal of what was largely considered a refractory case and opened the door to possible new treatment options. Eliciting such phenomena as mental imagery may be particularly productive in patients likely to have experienced childhood trauma. However, in routine clinical encounters the thought content section of the mental state examination may frequently be limited in practice to the exclusion of psychotic symptoms and suicidal ideation. Time constraints in busy clinical settings may justify the priority of eliciting mental phenomena associated with obvious clinical risk. However, there is also a case to be made for more attention to be focused on other phenomena, including mental imagery, in the training of psychiatry trainees and other mental health professionals so that their presence is not overlooked and their potential diagnostic significance is realised.

Why it was possible for a junior healthcare team member to elicit new clinical features in this case raises questions about the potential pitfalls in long-term psychiatric management. As noted in the case description, there were several differences in the approach to the interview from those previously used. Of specific importance to this case may have been the fact that the patient was aware that while the interviewer was still part of the health care team, he was unable to dispense psychotropic medication. During previous interviews, XX was felt to have established a good rapport with her treating clinicians and did not tend to fail appointments. However, she had been preoccupied with seeking medication, notably benzodiazepines and while this was firmly resisted when the extent of her propensity for misusing medications was realised, it nonetheless tended to result in somewhat repetitive, stereotypical conversations about the limitations of medication and the need for psychological approaches to her problems. We suggest therefore that the changed dynamic in the interview with the medical student, in combination with the detailed approach to the mental status examination as referred to above, may have acted in combination to facilitate XX in simply discussing openly what was going on in her mind

In this regard our case would seem to offer a salutary lesson regarding the risks of stagnation in the diagnostic formulation and of unproductive patterns of communication developing between clinicians and long-term patients attending mental health services. Secondly, it underscores the importance of re-visiting periodically both the history and mental status examination in a detailed, structured and comprehensive manner in patients who present ongoing diagnostic complexity and treatment challenges.

As a follow-up to our case report the clinical team felt that the immediate challenge was to gently build on the conversation XX had with the medical student, to include the senior clinicians and then to gradually try to establish new avenues of treatment. It remains to be seen to what extent this results in an improved, long-term clinical and functional outcome for the patient.

Conclusion

Here we report the case of XX, a 48-year-old woman with a long and complex psychiatric history largely refractory to a range of interventions in whom intrusive visual images appeared to represent the emergence of childhood dissociative phenomenon. The recognition of these symptoms led to the re-evaluation of her clinical presentation and the revelation of a past history of childhood sexual abuse. The memory of the sexual abuse appears to have been almost entirely erased through dissociative phenomena, yet global evaluation of the case is highly suggestive of a severe syndrome of childhood sexual abuse. We discuss the phenomenonology of the intrusive images experienced by the patient in light of previous literature, and argue that there may be a need for greater awareness of the importance of recognising intrusive images whether or not they are associated with a specific traumatic event, or a concrete memory of sexual abuse exists. We also suggest that there may be training implications for developing systematic approaches to the mental state examination in adult patients suspected of childhood sexual abuse.

Conflict of Interest

None.

Consent

Written consent was obtained from patient.

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