Military Trauma's Unusual Appearance

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In my clinical and forensic practices, I have encountered histories of military trauma on many occasions, in various contexts, and, of course, often long after the traumatic event. Recent personal experience led to my reflections on a prior veteran patient and his military trauma's intrusion in his life in a setting that could hardly have been dreamed about when he suffered his trauma.

After I had had two equivocal transient ischemic attacks (TIAs) within a few days, I wanted to confirm my assumption with our senior-aged discussion group that such rare events were just part of normal aging. None of them had had similar experiences, not even those several years older than I. One of the psychiatrists at the table amiably confronted, "You're in denial!" I then hurriedly and worriedly proceeded with an evaluation. The magnetic resonance imaging (MRI) portion of that led to the reflections that follow.

My MRI was preceded by telephone screening, one question of which was whether I was claustrophobic; I am not. This is a problem currently affecting some two percent of patients undergoing the study,[1] but earlier the incidence may have been twice that or more.[2] When I went for my test, the technician advised me of the MRI's confined space, the need to lie motionless for several minutes, and the machine's noisiness. She then placed headphones on my ears and said that I had a choice of what to listen to, but whatever it was, it would be played at high volume. I chose a classical radio station, which at test-time broadcast the Andante and Scherzo of Bruckner's Symphony number 4. During my immobility, the music partially masked the machine's clamor. At times it seemed as if the symphony was incorporated into, and indistinguishable from, the MRI's sounds.

While in the MRI apparatus, I reflected on my former veteran patient. (My psychiatric colleague might have appropriately suggested that maybe these thoughts were more comfortable than my personal apprehensions!) I had seen this man in an outpatient clinic over several months for treatment of alcohol dependence, part of which treatment included his active involvement in Alcoholics Anonymous (AA). During our therapy, he had spine problems. These were evaluated by an orthopedist, who recommended an MRI. But, because of claustrophobia, the study could not be completed.

During his service many years before, a night combat exercise had gone badly. He was with an infantry squad on shore, while tanks were being disembarked from special landing craft not far off in the water. Some of the tanks went fatally "belly up"; chaos ensued. In the darkness and confusion, he heard the clamor of the tanks that were reaching shore. Suddenly, one of the rackety monstrosities was right in front of him. He fell to the ground and lay as flat, straight, and motionless as he could, parallel to the approaching machine's treads. He was terrified between the tracks as the tank clanged over him, thankfully without causing physical injury.

Years later, the beach trauma with its confinement, immobility, deafening clamor, and terror, was too similar to a constricted, noisy, MRI space to allow the test to be tolerable for him. Although I do not recall this part of our discussion, similar to my experience where the external symphony seemed to have become embedded in the MRI's loud sounds, his

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traumatic memory may have become part of the MRI's clamor in the nature of a flashback.

Despite his intolerable claustrophobic symptoms in the MRI, he wanted to complete the study. In view of how we proceeded, because of his alcoholism he was probably hesitant to use an anxiolytic to deal with his claustrophobia while undergoing the test. This stance is against such drugs that some AA participants take, fearing that they could be substituting prescribed drugs for alcohol and not adequately confronting their alcoholism, which usually includes significant denial. While limited use of these drugs, such as for a medical procedure, is not part of a "slippery slope," or "substituting one drug for another," some "recovering alcoholics," as they call themselves, still are apprehensive about such drug use compromising AA's basic Step One: "We admitted we were *powerless* over alcohol—that our lives had become unmanageable" (emphasis added).[3]

With these concerns about an anxiolytic, we discussed how he might manage otherwise. To work on desensitizing him, I devised an inelegant procedure that was an available approximation to his wartime trauma and the MRI situation, a procedure influenced by my prepsychiatric training in psychology. This exercise was to have him lie on his back on his kitchen floor in such a way that he could place his head on a cushion under the sink, which had a garbage disposer with its on/off switch nearby under the counter. He was then to turn the noisy, grinding disposer on for brief, then longer, periods of time to try to adapt to the confinement and the noise.

Reflecting on this story these decades later I recall his congeniality, including his willingness to try this bizarre desensitization regimen. But in those earlier days of the MRI, when less was known about its claustrophobic potential, the technicians were likely less supportive than mine was, including that he may not have had the use of noise-blocking headphones. Nonetheless, I am also not optimistic that his merely listening to a symphony, or even hard rock, while in the MRI would have protected him from his mililtary trauma.

It was not easy for him to do the desensitizing exercise, but he managed some sessions. The exercises seemed to decrease his MRI apprehension, but not nearly enough to allow him to face the test unsedated. Subsequently, with the help of diazepam, he completed his examination. Enough sedation alone initially, without knowing the apparent etiology of the veteran's claustrophobia, and without the desensitization exercises, might have sufficed to allow the completion of his test at that time.

Often we do not easily know how, where, or when anyone's trauma may surface years later. I was fortunate that my testing was not intruded on by adverse military experience. When we physicians become patients, memories of our work experiences accompany us, and often much more unpleasantly than my anecdote here. Thankful to say, my MRI was unremarkable, and since then, no equivocal, or unequivocal, TIAs have made their appearance.

References

1. Eshed I, Althoff CE, Hamm B, *et al*: Claustrophobia and premature termination of magnetic resonance imaging examinations. J Magn Reson Imaging 26:401–4, 2007
2. Kilborn LC, Labbe EE: Magnetic resonance imaging scanning procedures: development of phobic response during scan and at one-month follow-up. J Behav Med 13:391–401, 1990
3. Alcoholics Anonymous World Services: Twelve Steps and Twelve Traditions. Alcoholics Anonymous World Services, New York, 1952