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August 22, 1984

Robert Brown, Esq.
c/o Swords to Plow Shares
710 "C" St. #320
San Rafael, CA 94901

RE: George Ojala

Dear Mr. Brown:

George Ojala sent me a letter recently about my report (written in September, 1977) concerning his mental condition. I am a psychiatrist and had worked with him about his mental and emotional problems from May to September, 1977. My diagnosis of him was that he suffered from chronic schizophrenia which had subsided into a latent phase, but from which he had many residuals. Prior to my contact with him he had been in VA Hospitals and had been diagnosed as having an anxiety neurosis and was rated at 50% disability. In my report, especially in the paragraph under mental status I presented details of his symptomatology which clearly indicates a more ominous illness then anxiety neurosis had occurred and from which serious residuals remained. According to his recent letter to me he hasn't improved since I saw him 7 years ago, further indicating the fixed, chronic aspect to his mental illness.

However, he now feels my diagnosis of him as having a latent type of schizophrenia did him a great disservice in that the VA tends to minimize this label and he thought it was due to my diagnosis that his disability was set at 50%, but I have it in my notes that at the time he came to me he was getting 50% because he was rated as having an anxiety neurosis. In any case, I agreed with George that I would clarify this aspect of my report and hence this letter. Also in the last 7 years the classification of mental illness has been revised and now in the DSM III revision latent schizophrenia is not used. As classified currently I would have labeled his condition as "Schizophrenia, chronic, residual type". As such he should be considered for an increase in his disability classification.

If my report is regarded as outdated since it is 7 years old then a current clinical evaluation should be carried out and it should include a battery of psychological tests which usually are clarifying if there are doubts

Approved exception to SF 502

PATIENT'S NAME	AGE	SEX	RACE	SOCIAL SECURITY NO.	CLAIM NO.	NAME OF HOSPITAL
OJALA, George P.	33	M	Cau		c- SSN	VAMC, American Lake, WA

DIAGNOSES *(List in numerical order: first, the established clinical diagnosis responsible for the major part of patient's stay; then, in order of clinical importance, other established diagnoses for which treatment was given. Place letter "N" before diagnosis (es) responsible for Nursing Care placement. List Problem numbers after diagnosis.)*

ICDA CODE

1. Neuresthenic neurosis. 300.5
2. Immature personality. X Not service connected 301.89
3. Schizophrenia, paranoid type, by history; in good remission. 295.69
4. Drug dependence - psycho-stimulants (amphetamines) X not true
5. History of drug dependence - opium and derivatives (hallucinogens) X not true
6. ~~Post traumatic stress syndrome.~~

PERTINENT CLINICAL DIAGNOSES NOTED BUT NOT TREATED *(Include autopsy diagnoses not listed as clinical above)*

OPERATIONS/PROCEDURES PERFORMED AT THIS HOSPITAL DURING CURRENT ADMISSION	DATE
	MAY 30 1980

SUMMARY *(Brief statement should include, if applicable, history; pertinent physical findings; course in hospital; treatment given; condition at release; date patient is capable of returning to full employment; period of convalescence, if required; recommendations for follow-up treatment; medications furnished at release; competency opinion when required; rehabilitation potential; and name of Nursing Home, if known.)*

The veteran was admitted to the American Lake VAMC with complaint of "extreme exhaustion," experiencing "everything as a stress" feeling, "headache all the time, uptight in the body." He feels distressed about the change in his disability status (75% to 40%) which was "unjust."

The history revealed that his present difficulties began, by his description, during the time when he was in Viet nam, as the result "of stress and exposure to stress suffered while in Viet nam." He felt that "sudden call of duty" to Viet nam was "unexpected stress after a long, pleasant experience in South America." He described in great details some of the "frightening experiences" while in Viet nam, adding later that "most of the living there was frightening." He felt that he was "beat ... , got himself hooked on any available drugs, living in constant fear of being attacked."

He was a part of the flight crew "concerned with saving the lives." He described his job as being extremely "dangerous; and many times flew stoned." On one such occasion, "he just cracked up, went crazy, and never recovered since." Since that time he feels that any change is "distress," any uncertain situation "distress" that leaves him "exhausted and helpless."

After the discharge from the service, he attempted to get a job, but has failed to stay with any, feeling "not able to meet the expectations or being physically exhausted." He feels distressed, "paranoid" about people "when walking through the supermarket, sometimes feels like exploding or attacking." Before entering the hospital, he was living with his parents. He had been asked by his father "an alcoholic" to "move out" although his mother did not feel the same way. He is continuing "to smoke grass but he has almost given up all other drugs." At this time he experiences considerable headache, which he implies is the result of the motorcycle accident that he suffered in 1973.

(Cont on SF 507)

ADMISSION DATE	DISCHARGE DATE	TYPE OF RELEASE	INPATIENT DAYS	ABSENCE DAYS	WARD NO.	SIGNATURE OF PHYSICIAN
9/26/79	5/16/80	OPT/SC	161	11	61C	See Page 3

Standard Form 507

CLINICAL RECORD

Report on HOSPITAL SUMMARY Pg 2
or
Continuation of S. F. VA 10-1000
(Strike out one line) (Specify type of examination or data)

(Sign and date)

...chiatric evaluation he was found to be a well-developed, white male, with no ...arent physical deficits, in good contact, oriented three times. He related, in ...ful and anxious manner, conveying the impression of urgency, and distress, that ...sponded to reassurance and support, and he obviously needed a great deal of it. ...speech was somewhat accelerated, as if he was in a great hurry to communicate ...is preoccupation at once. Thought process was goal oriented, organized, ...onally circumstantial and evasive, at times over-inclusive, but spontaneously ...ns to the original thought. The content conveyed distress about Viet nam, depri-...ion, and injustices suffered from the war, problems in adapting following the ...charge from the service, particularly sensitivity to stress, which seems to be ...ything and anything, regardless of circumstances. No frank delusions or halluci-...ns were elicited, but transient paranoid-like preoccupations are experienced. ...ffect reflected sudden shifts between extremes of sadness and anger, the changes ...ring in exaggerated fashion. The impulse control was tenuous, at best marginal. ...tellectual function appeared to be well preserved, though the concentration and ...tion fluctuated with the rise and fall of the experienced anxiety. The multiple ...ic complaints of chronic weakness, fatigability, and exhaustion, headache, and ...ointestinal problems are experienced as genuine distressing difficulties, seem-... also relevant to the level of experienced anxiety.

...al examination by the admitting physician noted hyporeflexia and questionable ...ia, however subsequent observation did not substantiate the find. Laboratory data ...mission indicated slight elevation of CPK of 88, otherwise laboratory work was ...mal. Chest x-ray revealed no active disease. Initial diagnostic evaluation was ...owed by psychological consult which essentially supported the impression of immature ...ality with narcissistic and hysterical features. ~~Significant comments in the~~ ...ogical assessment were centered around underlying personality structure, and ...al interpretation that he is likely to report feelings of depression, and ...es multiple somatic complaints that will increase under stress. Under stress, ... felt he also may present psychotic experiences, delusions, hallucinations, ...ersonalization, etc. (For additional details, reader is advised to refer to ...ve psychological assessment). Due to a recurrent complaint of headaches, x-ray was obtained, which was normal. EEG also was normal.

...italization was initially characterized by the extreme flucuations between ...ive compliance and periodic escapades that, on occasion, were accompanied by ...d alcohol abuse, and fairly consistent demands that his discomfort be alleviated ...ne drugs (the preference being Valium). The limits were set; this behavior ...ly subsided, but as the acting-out declined, a number of somatic complaints ...ssive preoccupations with physical and emotional "inabilities" went up.

(Continue on reverse side)

(OVER)

...IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)	REGISTER NO.	WARD NO.
...orge P.		61C

... Jr., Wn D:5/21/80 T:5/23/80 kh

REPORT ON ______ or CONTINUATION OF 10-1000

In addition to Thorazine 600mg BID, and Benadryl 50mg PO for EPS QID, he was treated with individual and group therapy, (large and small group), milieu, and rehab-oriented activities, that were used as an extension of therapeutic endeavors initiated in individual and group psychotherapy, placing emphasis on resocialization and reality oriented activities.

Gradually he improved, and a review of the progress notes indicated that by the end of March he stabilized, but it was felt that the level of functioning was never high enough to guarantee self-sufficient existence, and the question was raised whether this can be achieved in the foreseeable future, or ever. The impression was that his overall immaturity, and his dependency needs will remain in conflict with the demands of reality, and the possibility of recurrent disintegration of psychotic proportion, or return to drugs, or whatever other means are available to avoid distress, are to be anticipated, if deprived of a reliable support system.

There is indeed a reality in his "complaint" that his difficulties can be related to the Viet nam war, the reality being that precipitating stresses contributed to the dissipation and disintegration of rather vulnerable psychic structures that would have possibly survived, or maintained more efficient equilibrium, without the exposure to the trauma of war. He, "this may be an assumption," could have gone through life remaining on the edge of the events as a contented observer, adequately equipped to survive as long as the door "to get away" from the stress, was open. The war, and the service, needed the participant, not the observer, and the role of participant was above his resources.

The impression, at the time of his discharge, was consistent with the impression obtained earlier that "recovery" that will ascertain a full self-reliable existence is remote, and probably unrealistic. He hasn't worked since 1975, existing by relying on "service connected disability" which insured the survival, but reinforced the dependency . At this point the most that one can hope for is that he would learn to use the remaining resources in more prudent and economical fashion that would lead towards some degree of rehabilitation, probably always remaining dependent on "service-connected disability" as the source that will guarantee basic survival.

In addition to the above described therapy, he was also referred to the behavioral shaping clinic, receiving twice-weekly biofeedback, helping cope with tensions, the various complaints of "pain, depression, feeling of being dejointed, etc." He responded to this with some alleviation of symptoms as he did to any form of therapy that offered support and reassurance. He also was evaluated by the Podiatrist, who found that he has third and fourth toenail deformity on the right foot, in addition to having fungal infection, and suggested excision for permanent removal. The planned surgical procedure was not done due to his failure to return from the pass on time, to obtain the necessary preliminary laboratory work. In case of additional difficulties, the procedure can be done on the outpatient basis.

On 5/15/80 he was given an OPT/SC discharge, with one month's supply of medication, consisting of Thorazine 500mg BID; Diocytl Sodium Sulfosuccinate 240mg Q. HS; and Benadryl 50mg PO for EPS, QID. He is considered competent for VA purposes. The veteran will be living with his parents in Port Angeles. His next follow-up outpatient appointment was arranged for 6/5/80 at 1 PM; our Outpatient facility,

M. R. YOKAN, M.D./5/21/80

Approved exception to SF 502

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OJALA, GEORGE P.	32	M	C		C-SSU	VAMC SEATTLE WA

DIAGNOSES *(List in numerical order: first, the established clinical diagnosis responsible for the major part of patient's stay; then, in order of clinical importance, other established diagnoses for which treatment was given. Place letter "N" before diagnosis (es) responsible for Nursing Care placement. List Problem numbers after diagnosis.)*

ICDA CODE

1. Adjustive reaction with anxiety and depression
2. Chronic drug abuse
3. Headaches

PERTINENT CLINICAL DIAGNOSES NOTED BUT NOT TREATED *(Include autopsy diagnoses not listed as clinical above)*

OPERATIONS/PROCEDURES PERFORMED AT THIS HOSPITAL DURING CURRENT ADMISSION — DATE

SUMMARY *(Brief statement should include, if applicable, history; pertinent physical findings; course in hospital; treatment given; condition at release; date patient is capable of returning to full employment; period of convalescence, if required; recommendations for follow-up treatment; medications furnished at release; competency opinion when required; rehabilitation potential; and name of Nursing Home, if known.)*

HISTORY: The patient is a 32 y/o Caucasian male who is admitted with vague complaints of depressed mood, sleep disturbance and decreased energy with fleeting thoughts of suicide. He claims to have had these symptoms for 10 years but is most concerned about having tried many different psychotropic drugs without relief. He has been in outpatient therapy for at least the past year with some minimal response. Patient states he believes he has post-traumatic stress syndrome and needs evaluation for this. He does, however, give a history of drug abuse prior to his Vietnam experiences and interpersonal problems dating to this time also. He also has a history of paranoid schizophrenia in the past which has poor substantiation. He has also carried the diagnosis of drug abuse, post-traumatic stress syndrome, neuresthenic neurosis, and immature personality. He states that no medications, either neuroleptics or antidepressants have helped him in the past. He states the best he has done is with Lithium. Right now he feels there is a "short circuit" in his head and a feeling of pressure or vise around his head recently. He has had chronic headaches for many years without any exacerbation. Patient has been unemployed for most of his life, has no real interest in working but has made various attempts at vocational training without follow through in the past. Patient is currently living with his mother in a retirement home trailer court in Port Angeles area. He is 100% service connected until recently when his benefits were cut to 50%. This appeared to be somehow related to his recent admissions to this hospital.

MENTAL STATUS EXAM: Patient was casually dressed, somewhat disheveled young man in need of hygiene and grooming. He was generally cooperative and non-agitated but hunched in his chair and acting rather guarded and suspicious. His speech was normal rate without pressure, increased volume, or latency. He denied any hallucinations or delusions. He did have some preoccupation with feeling of injustice against him due to decrease of his service connected disability. His affect was somewhat constricted with subdued mood. He expressed some suicidal ideation with

ADMISSION DATE	DISCHARGE DATE	TYPE OF RELEASE	INPATIENT DAYS	ABSENCE DAYS	WARD NO.	SIGNATURE OF PHYSICIAN
9/22/81	11/19/81	REGULAR	58	0	7W	/// ///

VA FORM MAR 1972 10-1000 EXISTING STOCK OF VA FORM 10-1000, JAN 1971 WILL BE USED. HOSPITAL SUMMARY

D:11/19/81 T:11/25/81 pw #3

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