0023

Scanned 11/6/16

243-5816 **REQUEST FOR PHYSICAL EXAMINATION**

NOTE: Shaded Items not for rating board completion.

1. NAME	2. FILE NUMBER	3. YR. OF BIRTH	4. SEX	5. PERIOD OF SERVICE EOD	RAD	6. CONTROL DATE
	[redacted]	47	M	8/69	8/77	

7A. FIRST NAME - MIDDLE INITIAL - LAST NAME OF VETERAN

George P. OJALA.

7B. ADDRESS OF VETERAN (Street, City, State and ZIP Code)

15458-42nd AV SO

Seattle, Wa 98188

8. REGIONAL OFFICE

VARO Seattle

9. RECEIVING STATION ONLY

A. DATE OF RECEIPT	B. DATE SCHED. OR AUTH.	C. DATE COMPLETED
OCT 4 1977		NOV. 21 1977

10. PRIORITY OF EXAMINATION (Check appropriate boxes)

- [ ] TERMINAL
- [ ] ORIGINAL (S.C.)
- [x] INCREASE OR REOPENED
- [ ] REVIEW
- [ ] POW
- [ ] ORIGINAL (N.S.C.)
- [ ] OTHER (Specify)

D. PLACE OF EXAMINATION

- [x] CLINIC
- [ ] FEE
- [ ] OTHER STATION

E. NAME OF FEE EXAMINER OR OTHER STATION

OPC, Seattle

11. PLEASE CONDUCT:

- [ ] A. A COMPLETE GENERAL MEDICAL EXAMINATION WITH SPECIAL ATTENTION TO DISABILITIES LISTED IN ITEM 13.
- [x] B. EXAMINATION LIMITED TO DISABILITIES CHECKED IN ITEM 12 AND/OR LISTED IN ITEM 13.

12. SERVICE CONNECTED DISABILITIES

DIAG. CODE	(✓)	CHECK DISABILITIES FOR WHICH EXAMINATION IS NEEDED
	✓	Chr. anxiety Reaction

11-2-77 9:00

13. OTHER DISABILITIES (List diagnoses or symptoms for which examination is requested)

14. REQUIRE MEDICAL DETERMINATION OF

- [ ] COMPETENCY
- [ ] NEED FOR AID AND ATTENDANCE OR HOUSEBOUND (Provide VA Form 21-2680)

15. SPECIALIST EXAMINATIONS

- [x] (Check box if required, specify and give reasons for requests in Item 16. REMARKS)

16. REMARKS

NP - make C File available to Examiner - Note Report from DR C. Glenn Clements Dated 9-22-77

17. CLAIMANT REPRESENTED BY

- [ ] AL
- [x] VFW
- [ ] DAV
- [ ] ARC
- [ ] AMVETS
- [ ] OTHER (Specify)

18. DATE	19. SIGNATURE OF AUTHORIZING OFFICIAL	20. SYMBOL AND BOARD NO.
10/3/77	SF Mitchell	3

VA FORM 21-2507

11/07/77 dm

Special psychiatric examination.

Ojala, George P. 11/02/77

0023

This is a 30 year old veteran, whom I examined in January of 1977, and diagnosed as suffering from a chronic anxiety reaction. Since that time, there has been a psychiatric evaluation and a report by Dr. Glenn Clements, who documents a diagnosis of schizophrenia, latent type. I have reviewed that report, and essentially agree with it. This morning Mr. Ojala states that he is not good. His condition remains much the same as it was in January. He says he never really feels healthy. He either has the flue, or other body aches. He also complains of having a felt a good deal of depression, and several times has considered suicide. He has grave financial concerns, and says he does not have enough money to live on. He is in therapy with Dr. Clements, whom he sees twice a month, and he does take Haldol. He complains that his thoughts are pretty disjointed. He recently remembered an explosion in Viet Nam, in which he was blasted against a wall, and he got his back pain again.

He lives with a brother, but spends a week a month with his parents. His daily routine has very little structure. He does attend group therapy weekly, which he finds quite supportive. He feels unable to work, and uncoordinated muscularly. He is on public assistance.

Mental status examination: He is a rather good looking young man. He was alert, well oriented and cooperative. He is anxious. He, this time, admits to hearing voices. He also has ideas of reference. When walking down the street, he fears people will attack him. He has some difficulty with abstractions.

Conclusions: I will change my diagnostic impression from that of an anxiety reaction, to schizophrenic reaction, latent type. This does not represent a change in his basic condition, but only a change in diagnosis. He is competent.

DIAGNOSIS: Schizophrenic reaction, latent type.

C. Richard Johnson, M. D.

APPROVED

E.K. C[illegible] M.D.

C. GLENN CLEMENTS, M.D.
201 BROADWAY, SUITE 830
SEATTLE, WASHINGTON 98122

MA 4-0296

September 22, 1977

Albert L. Nelson
Service Officer, VFW
400 Boren Avenue
Seattle, Washington 98104

RE: GEORGE OJALA

Dear Mr. Nelson:

I had George Ojala in psychotherapy since May of this year and have had some reports from other agencies such as the VA Hospital where George was both in outpatient and inpatient therapy in 1976.

Although Mr. Ojala had a difficult childhood, he completed High School essentially without any overt signs of mental problem. In 1969, he married precipitously, got a divorce, and enlisted in the Army all in the same year. He was in the service from 1969 to 1973 and was in Viet Nam for one year in 1971. He had a good rating Stateside, but in Viet Nam he felt he was discredited on several occasions and got discouraged, gave up trying, and got heavily into drug use (psychedelic not narcotic).

On returning to the States, many things did not work out for him in the service and at one time he was depressed enough to be hospitalized. He was considering blowing up a helicopter and himself in the process. He was assigned to helicopter units. (This sounded delusional when he reported it to me.) He was hospitalized for approximately one week, but couldn't stand being in the hospital so he put up a front of being okay and was discharged. He was discharged from the service in 1973 without clarifying his medical status. However, in the next year he experienced considerable anxiety and returned for evaluations and at that time a diagnosis of Anxiety Neurosis was made and he was given a 50 percent disability by the VA examiners.

DATE of claim

He attended community colleges on the GI bill for several years and was apparently able to complete tasks in this setting until Spring of 1975 when he decompensated. At that time he could not complete his school work, experienced mental problems of being unable to concentrate, and being "wired." He reports hallucinatory, delusional-type ideation, which seriously interfered with his concentration. He recuperated over the summer and then attended college again in the Fall Quarter of 1975. He reports that at this time he really fell apart. He stayed at home through the winter and finally in the Spring of 1976 he sought help at the VA Hospital in Seattle where he was treated for some three months. He felt no one really understood him there. He was given quite a series of medications including Navane, Trilifon, and Thorazine up to 800 mg/day. On discharge to outpatient status he was on Thorazine 400 mg/day and this was continued for some six months. The VA records supplied me are incomplete, but on one sheet I note a differential diagnosis was made of 1) Depression, 2) Anxiety Neurosis, and 3) Latent Schizophrenia. The medication indicates that the doctors there treated him as being schizophrenic and not simply depressed or anxious.

Since discharge from the VA program, Mr. Ojala has not been able to work. He has attempted jobs on two occasions but never lasted more than a day. He has stayed mainly with his brother or with his parents and he has managed by virtue of going from one doctor to another since he was not in regular consultation at the VA. He continued in this pattern until May of 1977 at which time he began therapy with me. I attempted to work with many of his symptoms as well as his life situation. Medication ranged, at first, from some of the mild tranquilizers until finally I have placed him on Haldol.

MENTAL STATUS:

George is very cooperative. He relates his history in what appears to be a logical sequential pattern. There is no pressure of speech. He reports his mind feels as if it is "wired." His face feels tense at times and at times it is as if there is a snarl on his face. Eyelid blinking will appear as if it is out of his control. He reports hallucinatory experiences during the day in which he will hear music strong enough to cause him to go to the next room to see if he has turned off the stereo. He complains of hearing gibberish in his head which interferes with his concentration. He reports feeling a tight

band or container surrounding his brain as if there is a barrier for thoughts going between him and whomever he is talking to. He reports that at times he is quite depressed and dispares of any progress being made. When he is out on the streets he is apt to be anxious and quite paranoid. He fears being attacked. He has weird sleep patterns. His physical energy is unreliable and he doesn't know whether to agree to invitations or not because he doesn't know how he will feel. To get energy enough to come to an appointment with me or in order to attend a seminar may require a day's rest prior to and after the meeting. He complains of arthritic-like pains through all the joints of his body and especially if he does work. He tried to fix his sister's clutch (car) recently and had this kind of pain for several days. Otherwise, there is no distortion of time, place, or situation.

In summary, I diagnose the above as pointing toward a schizophrenic reaction. There are paranoid elements and there are many psuedo-neurotic patterns operating which do incapacitate Mr. Ojala at this time.

Psychiatric Diagnosis: APA 295.5, Schizophrenia, latent type.

My recommendation is that Mr. Ojala continue in psychotherapy and receive anti-psychotic medication. I feel he is incapacitated for work at this time, due to his mental illness. As to prognosis, this is difficult in this situation and in this type of illness. Mr. Ojala is seeking help, but he is on public assistance and he is unwilling to return to the VA clinic. Certainly his condition has been chronic and incapacitating for two years and that doesn't auger well for a speedy recovery.

I trust this will be of use in your evaluation of Mr. Ojala.

Yours sincerely,

C. Glenn Clements M.D.

C. Glenn Clements, M.D.

CGC/js

REPORT OF ACTION TAKEN

TO:

DATE: December 7, 1979

VETERAN OTALA, George P.
C or

The following action has been taken on a claim/inquiry submitted by you:

HR, Par. 29 eval.

The hospital did not certify that the vet was admitted and treated for his SC psychosis for a 21 day period. The evidence of record shows that he had unpaid bills and is in a financial dilemma. It is the opinion of this Board that the vet presented for admission and exaggerated his symptoms remaining hospitalized just long enough to create possible eligibility for a Par. 29 eval. The care provided this vet in the hospital could have been as easily provided on an OP basis. The HR is negative for psychosis. Entitlement is found not to exist for a 100% eva. under Par. 29.

Rating of 1/9/79 and 6/7/79 are confirmed.

V.F.W. Service Division
Dept. of Washington

The above statement was received from the VA Ajudication as to why I would not get an increase in disability benifets. The VFW in Seattle was representing me at that time.

NORMAN F. PETERSON M.D.
932 CAROLINE
PORT ANGELES WASHINGTON 98362

TELEPHONE 452 8991

March 24, 1981

Mr. Al Nelson
V.F.W. - Service Division
400 Boren Avenue - P.O. Box C14111
Seattle, WA 98114

RE: George Ojala

Dear Mr. Nelson,

I have been working with Mr. Ojala since July 25, 1980. We have had thirty (30) therapy sessions to date. George is suffering from a Delayed Stress Syndrome that was precipitated by his combat experiences in Vietnam. Current symptoms include depression (sometimes with suicidal ideation), paranoia, intermittent auditory and visual hallucinations, generalized dysphoria and extreme social isolation.

The treatment program includes weekly individual psychotherapy and medications. Currently I am prescribing Lithium Carbonate (for the depressive mood) and Loxitane C, an antipsychotic drug designed to alleviate the auditory and visual hallucinations.

I feel that George is currently 100% disabled by his symptoms. He will require prolonged treatment before he will be ready for even part-time employment. He has been making gains in therapy, his moods are starting to brighten, and he is starting to make some social outreach to neighbors and old friends, but clearly he is not ready for competitive employment. I feel the next step will have to be Vocational Rehabilitation. George may be ready in 6 to 8 months for this kind of a program. However, he is now unable to tolerate close personal contact on a daily basis kind of contact one must be able to tolerate in order to function on even the most routine undemanding jobs. Also, he has considerable impairment of concentration and memory - so much so that these factors, coupled with the distracting auditory and visual hallucinations render him unemployable at this time.

Indeed, I feel that it will take all my skills as a therapist, and considerable effort by George to maintain the progress we have made to date.

My clinical observations coupled with past V.A. Hospital records lead me to the diagnosis of Delayed Stress Syndrome caused by combat experiences in Vietnam. According to my understanding of the V.A. criteria, George is now 100% disabled by his symptoms, and has been continuously so since his symptoms first began in 1975. I don't feel there was an improvement, and then a worsening of symptoms that warrant the conclusion that he went from 100% disability to 50% disability, and now back to 100% disability.

If I can provide any further information re Mr. George Ojala, please feel free to contact me.

Sincerely yours,

Norman F. Peterson M.D.

Norman F. Peterson, M.D.

NORMAN F. PETERSON, M.D.

Member of Academy of
Psychosomatic Medicine

.9 Georgiana
-t Angeles, WA 98362
.lephone: 452-8991

April 11, 1988

To Whom It May Concern:

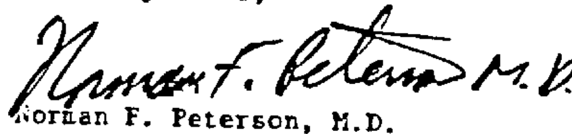
RE: George P. Ojala

I am writing at the request of Mr Ojala to comment on my report of March 24, 1981 (enclosed) as it relates to his Post Traumatic Stress Disorder claims, especially the date of onset of his disorder. I have examined the evaluation by Dr. Kormos dated August 28, 1984. Certainly all the signs and symptoms that Dr Kormos observed on that date were present when I was treating Mr Ojala starting in July 1980. My letter of February 27, 1981 (also enclosed) and my letter of March 24, 1981 refer to my observations of these signs and symptoms of Post Traumatic Stress Disorder.

In retrospect it appears that Mr Ojala was suffering from Post Traumatic Stress Disorder when I first started treating him in July of 1980. The symptoms of social olation, extreme depression, generalized dysphoria, distrubed sleep, and problems .h concentration and memory, and avoidant behavior were all present at that time and ntioned in my letters.

I hope this letter and the enclosures will be of assistance to you in your deliberations.

Sincerely Yours,



Norman F. Peterson, M.D.

C. GLENN CLEMENTS, M.D.
801 BROADWAY, SUITE 830
SEATTLE, WASHINGTON 98122
TELEPHONE 624-0296

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.	32	M	C		C-SSA	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	Ø	7W	/// ///

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

D:11/17/81 T:11/25/81 pw #3

U.S. Government Printing Office: 1981—341-427/4139

Standard Form 507

CLINICAL RECORD

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

(Sign and date)

..o plans or commitment to this. There is no homicidal ideation. His intellectual status showed an average intelligence with clear sensorium.

PHYSICAL EXAMINATION except for obesity was essentially within normal limits.

LABORATORY: Screening laboratories were obtained: thyroid studies, CBC, SMA 12, Dexamethasone suppression test, urinalysis, chest x-ray which were all within normal limits.

PSYCHOLOGICAL TESTING: The patient showed average verbal and abstract problem solving skills on intellectual evaluation. There were no signs of organic impairment on this testing. He showed no interest in superficial social activities but does want close relationships and wants us to like him. He does value independence. He does not want others telling him what to do and has a great deal of difficulty with authority. He is likely to misinterpret other's intentions and expectations when he feels stressed. He showed considerable anger, especially with women. He did have symptoms of depression and disordered thinking on the MMPI and was evaluated as likely to experience physical symptoms related to his psychological distress. There was no indication of frank thought disorder or other endogenous depression.

..SPITAL COURSE: The patient was admitted to the ward and observed for several days. He showed a superficial interaction with patients on the ward which generally increased to a productive interaction over the next several weeks. The patient generally took a very passive stand and showed no insight into his problems. He was virtually unwilling to approach problems from another point of view and was mostly interested in getting some sort of medication intervention. There was absolutely no sign of post-traumatic stress syndrome in this patient. He was not happy with this evaluation but took it fairly well. Patient was started on a trial of Nardil .. mg qd and his Lithium carbonate was discontinued after the first week. Patient reported no improvement from the Nardil and wanted to stop it and stated he would do so. He was encouraged to continue this for at least a two month trial. During the course of his one month hospitalization no significant improvements were made which could be attributed to the Nardil.

The patient did make a good friend apparently with one other patient on the ward and made arrangements to take him back to his mother's retirement home with him.

During this hospitalization the patient was reviewed for his chronic headaches and hypoglycemia and no organic basis for either of these could be substantiated. It should be noted the patient has a long, long history of drug abuse, approximately ..-400 LSD dosages in the past. He denies current significant use of drugs and was

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) | REGISTER NO. | WARD NO. 7W

..LA, GEORGE P.
.. SEATTLE WA

REPORT ON ____ or CONTINUATION OF 11/19/81

STANDARD FORM 507
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.80 6-8
October 1975 507-106

H. R. KORMOS, M. D.
1806 GROVE STREET
BERKELEY, CALIFORNIA 94709

PSYCHIATRIC EVALUATION.

Re OJALA, George,
Date of Birth: January 29 1947.

August 28 1984.

IDENTIFYING DATA: This is a 37 years old white married male, the father of one child. The patient was seen on four occasions. Furthermore, his mother and his wife were interviewed and available medical records, mostly originated by the U.S.Veterans Administration were consulted.

CHIEF COMPLAINT: "What goes on within me is more than I can handle."

PRESENT ILLNESS: There is no evidence of mental illness until 1971. At that time, the patient, as an Air Force flight engineer in a helicopter in Vietnam was exposed to particularly heavy enemy fire. He responded to this fear in the same manner many of his colleagues did, namely by increasing his use of marijuana and whatever else was available. It was his perception that the combination of fear and drug effcts set in motion an alteration of his mind which has in essence remained present ever since.

Subsequently he lost a significant number of his buddies in combat. Since he was assigned to an Air Rescue and Recovery unit, he often had to fly particularly dangerous missions for the purpose of rescuing aircrews downed in enemy territory. It took him in fact several years before he was able to talk about his experiences on those missions. Even now it is difficult for him to do so.

He received several decorations, including the Distinguished Flying Cross.

Following the completion of his year of duty in Vietnam, he served the remainder of his military obligation out in the continental United States. Like many Vietnam combat veterans, he continued marijuana use after leaving the theatre of war. This eventually led to conflicts with his superiors and thereafter he was discharged.

At first he seemed to do well but within a year he began to experience a multitude of symptoms. Also, his family and friends had noticed definite pesonality changes in him. He began to isolate himself, felt often in a daze, had anxiety attacks and had diffi-

to page -2-

MENTAL STATUS: The patient is a well-built, well developed white male, appearing perhaps a little younger than his stated age. Dress is conventional. He is oriented and alert, with no evidence of intoxications.

He speaks in a low monotone. Form of thought is loose, with many tangential thought sequences. He denies hallucinatory and delusional perceptions but does have "flashbacks" to Vietnam scenes. These can be provoked by noise and vibration resembling that typically produced by helicopter engines. Likewise, being on a speeding motorcycle reminds him vividly of being in a helicopter and can set off "flashbacks". There are significant violent fantasies of retaliation against people in general but none are directed against specific individuals.

Content of thought is thoroughly dominated by a perception of self as suffering, sick, incapacitated and not receiving the kind and amount of help required. There is also a strong feeling of "alienation" in that patient feels different from others and unable to fit in anywhere.

Affect is depressed and fearful of the future.

Intelligence is judged to be constitutionally above average. However, his depression and preoccupation with his emotional turmoil interfere with the full use of his capabilities.

Concentration and attentionspan are diminished. Memory is likewise impaired, both for remote and for recent material.

No abnormal motor phenomena or other gross evidence of neurological illness was observed.

CONCLUSIONS: There does not seem to be much question but that patient suffers from a disabling illness. His depressed affect, his ever present anger and retaliatory fantasies, his intolerance of other human beings, his combat memories and flashbacks and his physical pain together make it inconceivable that he could be gainfully employed in any way at the present time.

Likewise, there is no question at all but that he is in need of longterm psychotherapy; the only treatment modality that could reasonably be expected to be of help to him. The fact that past efforts to treat him have not been succesful in no way negates the need for psychotherapy but it does underscore how difficult the case is. The need for treatment is likely to persist for the foreseeable future.

Diagnostically the issues are less clear. The medical records reflect a long list of different diagnoses, arrived at by clinicians at the various facilities where he has been seen.

to page -4-

AUG 28, 1984

Certain observations can at this time be made with confidence. His response to the various antipsychotic medications he has been given is quite atypical for schizophrenia. Whereas, classically, the schizophrenic patient has a high tolerance for the side effects of antipsychotics and derives benefit from these agents, the patient's response has been the exact opposite.

The abnormal perceptions patient has on occasion reported in the past also are not characteristic for schizophrenia.

The family history is entirely devoid of mental illness in so far as can be determined, again an unusual finding in schizophrenia.

All of the above observations are on the other hand consistent with a diagnosis of Post Traumatic Stress Disorder. There was no evidence of psychopathology prior to combat. There was unquestionable exposure to traumatic events outside of the range of usual human experience. There was a typical latent period immediately after combat during which no symptoms were evident. There are recurrent painful and intrusive recollections of combat scenes. Estrangement from others, following the patient's return from Vietnam was much in evidence. Impaired concentration remains a problem. Irritability and violent fantasies also are clearly present.

The diagnosis reached is therefor that of Post Traumatic Stress Disorder, Chronic, DSM-III 309.81

The patient is totally disabled as far as gainful employment is concerned. The prognosis is guarded, much will depend on the treatment he will receive in the future. The patient has been informed of the above findings and he shows good understanding of the issues, in particular of the need for treatment, in so far as it pertains to impulse control. While the patient currently is in fact able to contain violent impulses, he is under considerable pressure and this issue should be a focal point of future treatment efforts.

H.R.Kormos M.D.,
Diplomate, American Board of Psychiatry and Neurology,
Asst. Clinical Professor of Psychiatry, U. of California, San Francisco.
Commander, M.C., U.S.N.R.

not interested in further treatment for this. Patient was rather manipulative and negative throughout his hospital stay but with no significant behavioral or ward problem.

DISPOSITION: Patient discharged after six weeks of hospitalization to his mother's retirement home in Port Angeles. He was encouraged to remain in the Seattle area and to seek appropriate treatment for his ongoing problems. However, the patient seemed unable to separate from his mother at this time.

MEDICATIONS ON DISCHARGE: Nardil 50 mg qd.

Patient will be followed by Dr. Norman in the Port Angeles area.

The patient may return to his prehospital activities immediately.

The patient is competent for VA purposes and was not suicidal or homicidal at the time of discharge.

KATHLEEN MYERS, MD
Resident in Psychiatry

Dr. Norman Peterson
532 Caroline
Port Angeles WA 98362

(Continue on reverse side)

☆ U.S. Government Printing Office: 1981—341-468/4251

COPY 1 in medical files
1 to UFW-al 19 NOV 81

extra
~~tensions~~ came into hospital

nightmares - flashbacks
depression dulling - no joy in life.
anxiety
trouble getting motivated
fatigue
isolation from others - alienation
chronic headache
sleep disturbance
difficulty in concentrating
despair - am I ever going to break it
lack of interest in everything
Suicidal thoughts
fantasies of retaliation
memory impairment
hopelessness
TM syndrome

TO AL Nelson