MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST
Psychology Clinic	52-B	30 July 84

REASON FOR REQUEST (Clinical data and findings)

Patient admitted from CHHS. It has a number of unusual allegations which are compatible with persons paranoid pathology. Will you please examine with complete psychological testing.

Thank you.

PROVISIONAL DIAGNOSIS

Schizophrenia paranoid type.

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	ROUTINE / TODAY / 72 HOURS / EMERGENCY
Gabriel Durand-Hill, MC, USA		☐ BEDSIDE ☐ ON CALL	☐ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

PSYCHOLOGICAL EVALUATION

Patient was interviewed and medical records were reviewed.

Presenting Problem: Patient is a 27 year old single white active duty SP4, referred for testing by Inpatient Psychiatry. The patient was hospitalized after sending a grandiose, paranoid, 25-page letter to the Fort Sam Houston IG..

Background Information: The patient is the third of four children in a "close-knit" family. He claims that after his birth he was incubated for a year due to prematurity, spinal meningitis, jaundice and rheumatic fever. Due to the nature of his father's work the family moved frequently, and the patient claims he lived in forty different homes between age 5 and 18. Although he made friends easily, there were periods when he was a loner and spent time to himself "in scientific pursuits." The patient reported that he was a BS degree in Mechanical Engineering, but on his own has been "doing research in physics", and allegedly invented a weapon based on the laser. He submitted his research data to several journals for publication but was always rejected. He joined the Army in July of 1982 because he was tired of "waiting in soup lines for food." While stationed at White Sands he submitted his invention to top Army officials, but again was rejected. Later he discovered that something similar was being done by the Army, and he felt he was possibly betrayed and that his work was plagiarized. He offered his work to the Israeli government because they were "valued allies," but they too turned him down.

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
JOHN B. POWELL, Ph.D., CPT(P), MSC, Chief, Clinical Psychology Service			30 AUG 1984
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO.	WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first.)

005390[illegible]20
CLARK WILLIAM H SP4
H 2[illegible] CAU 4PRS USA
84209 BAMC

52A/B AFYA 728 84

☆ U.S.GPO:1980-0-311-158/2

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-[illegible])
Prescribed by GSA/ICMR
FPMR 101-11.806-8
513-107

Clinical Psychology Svc
ATTN: HSHE-SYO
Brooke Army Medical Center
Fort Sam Houston, Tx 78234

When his commanders learned what he had done, they "thought he was going to defect", so they had him sent to Fort Sam Houston to work as a chaplain's assistant. He enjoyed this work with "intelligent people" better than being a meteorological observer at White Sands but he was so upset about his project he wrote a 25-page single-spaced letter to the Fort Sam Houston I.G. telling not only about his situation at White Sands, but also about people allegedly using drugs there. He also claimed his life had previously been threat ened by coworkers at White Sands when he had reported their drug use. An interest in catholicism also resulted in a lengthy manuscript in which he "proved" that Jesus was an alien, and that catholics were conspiring with the communists to enslave the free world.

The patient says he enjoys being with any of a half dozen friends, particularly for a hom dinner and cards. He has a girlfriend in Austin, a music teacher four years his senior, who has rejected his marriage proposals. He has dated other women, but found nothing in common with them. He likes to watch sports on TV and used to play racketball and go bicycling until he suffered a knee injury in basic training. The patient claims he rarely gets angry, but expresses his feelings in a "cool, passive manner." He says he feels obliged to correct others' wrongs, so he states his opinion orally or on paper to make himself clear. He stated that he does not act impulsively, and that he "sat on it a few days" before writing the letter which resulted in his being hospitalized.

Mental Status Evaluation: Patient arrived from the psychiatric ward on time for his appointments. He was neatly groomed in hospital garb, friendl cooperative, and helpful during testing. Usually he was responsive to questions during the interview, but did, in a most polite way, refuse to talk about the contents of some o his writings, stating that was what got him into trouble in the first place. He seemed to be aware of why he was hospitalized because he stated that people had just cause to be upset by his letter. He showed little insight into his own behavior or thinking processes, however. The main concern he expressed was what a history of being in a mental hospital would do to his future, as he wants to pursue graduate work in physics, as advanced degrees in this area will give him credibility so other scientists will accept his works more readily.

While interviewed, the patient maintained good eye contact, had appropriate affect, was oriented and explained his plight in a logical methodical way. He also demonstrated a good sense of humor.

Evaluation Results: Psychological evaluation reveals a highly intelligent individual who functions well in most structured areas of intellectual and emotional performance, but who does show clear evidence of a thought disorder. This thought disorder reveals itself both in the highly elaborated, grandiose delusional systems evident in his writings, as well as in his tendency to respond with loose associations, idiosyncratic responses and faulty logical processes in unstructured or emotionally stimulating situations. The patient does not reveal any evidence of hallucinations, inappropriate affect, incoherence, bizarre preoccupations or unusual perceptions. Social behavior was generally appropriate during the assessment period, and there was no clear indication of social isolation, peculiar behavior, impaired personal hygiene or deterioration in role functioning.

The patient is functioning intellectually in the Superior range of intelligence, with a Full Scale WAIS-R IQ of 124 (95th percentile). The Verbal IQ of 122 and Performance IQ of 118 were generally consistent with this overall level of ability, and showed no evidence of major deterioration in intellectual abilities. The lowest score was on the Picture Arrangement subtest, suggesting relative weakness in logical sequencing and social insight. Arithmetic was also unexpectedly low given the patient's interest in

Cont. (Evaluation Results): engineering; this was apparently due to his tendency to reach an answer very quickly without checking his response.

Although he performed well on structured tests with clearly-defined expected responses, he had somewhat more difficulty with projective tests. Responses on the Rorschach were not very numerous and included a high percentage of popular responses. For an individual of his intelligence this suggests some constriction of his fantasy and creativity in an effort to respond in a more recognizably appropriate fashion. Despite these efforts, the intrusion of more primitively impulsive fantasies was occasionally noted (e.g. "two people of the feminine gender trying to pick up a heavy object; their bras are falling off from the exertion"). His efforts at integrating his perceptions reflected a reliance on inappropriate abstract intellectualization to deal with more affectively stimulating cards (brightly colored cards were seen as; "symbol of fire, with red hot, blue cooler, and gray ashes"; "the esophagus , trachea and lungs of a person with smoke and tar deposits"). These responses suggest a tendency to attempt to intellectually distance himself from emotionally stimulating conflicts, but resulting in more impulsive, less appropriate responses which indicate definite impairment in reality testing.

Personality testing in general reflected an anxious, rigid and intellectualized individual, who is oversensitive and self-critical. High levels of outwardly directed anger were also evident, apparently stemming from his ruminatively developed protective grandiosity. These delusional preoccupations are likely to reflect his intellectual defenses against a pervasive underlying sense of inadequacy, failure and social rejection. This combination of defenses suggests a high potential for acting out behavior to assert his beliefs, with little or no insight into the impact of his behavior on others. When these behaviors get him into trouble he may appear remorseful, contrite and overcontrolled. While his apologetic pronouncements may sound sincere, the patient lacks the geniune insight or behavioral controls to prevent further episodes. This behavioral style and the patient's evident psychological defenses appear to be well-established, chronic adaptive styles, and show poor prognosis for efforts at change.

Summary & Recommendations: The patient clearly evidences a complex, highly developed delusional system, although most other evidence of an acute schizophrenic reaction is absent. The patient is highly intelligent and functions well in most structured areas of his life. However, under emotional stress his intellectual functions show signs of loose associations, intrusion of primitive fantasies, impulsivity, and inappropriate reality testing and abstract reasoning. Grandiosity and behavioral acting out appear to defend against underlying feelings of inadequacy, failure and social rejection.

Diagnostically, the patient appears to fall into an area between a clear Paranoid Schizophrenic Reaction or a more conservative Paranoid Disorder. At the time of this testing there was no well documented historial evidence of a more clearly diagnosable decompensation in status, such as hallucinations, incoherence, or fragmented thinking. The patient's level of intelligence may be partially masking any deterioration in role functioning, but without further evidence of a change in status the more conservative diagnosis is recommended.

At best, the patient evidences a chronic thought disorder that is not likely to be treatable. It is also extremely unlikely that he can perform any useful military role, and the risk of recurring delusionally-based behavioral difficulties is very high.

Diagnostic Impression: (DSM III 297.10) Paranoia.

JBP/lrc

JOHN B. POWELL, Ph.D.
CPT(P), MSC
Chief, Clinical Psychology Service

Clinical Psychology Svc
ATTN: HSHE-SYO
Brooke Army Medical Center
Fort Sam Houston, Tx 78234

MEDICAL RECORD | NARRATIVE SUMMARY (CLINICAL RESUME)

DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED
27 July 1984	28 Sep 84 (date forwarded to MEB)	64

(Sign and date at end of narrative)

DIAGNOSES: 1. AXIS I: 2953 Schizophrenia, paranoid type, chronic, severe, in some degree of remission, manifested by persecutory and grandiose delusions, highly developed, complex delusional system, in which he believes that he has found a special formula and the true meaning of religious materials and concepts.

STRESS: Moderate, routine military duties, concerns about his safety after having made revelations about his peers.

PREDISPOSITION: Severe, history of marginal adjustment to personal, family, social, academic, and occupational demands.

IMPAIRMENT: Marked for further military duty.

LD: No, EPTS.

AXIS II: No diagnosis.

AXIS III: None.

2. Compound myopic Astigmatism, bilateral detected by Optometry Clinic on SF 88 corrected to normal vision with glasses.

LD: No, ETPS.

PROCEDURES: None.

COMMENTS/RECOMMENDATIONS: It is the opinion that the individual's schizophrenia renders him medically unfit for retention in the military service. LD is judged No, EPTS on the basis that he had been suffering for several years his well-developed complex systematized delusional illness as clearly documented on his three major manuscripts, all completed before he joined the US Army. Impairment for social and industrial adaptability is judged to an equivalent rating of slight. Upon the patient's discharge from BAMC, he will not require transfer to another hospital but can be released to his own care. He understands that his activity level is full and his diet regular.

(Use additional sheets of this form (Standard Form 502) if more space is required)

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO	ORGANIZATION
GABRIEL DURAND-HOLLIS, LTC MC	D&T: 11 Sep 84		BAMC

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; rank; grade; hospital or medical facility)

REGISTER NO.	WARD NO.
0053908	52B

CLARK, WILLIAM H., SP4
BAMC, FSH, TX

NARRATIVE SUMMARY (CLINICAL RESUME)
Standard Form 502
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806—8
MARCH 1979 502-113
NSN 7540-00-634-4114
U.S. G.P.O. 1980-329-032

MEDICAL RECORD	NARRATIVE SUMMARY (CLINICAL RESUME)		
DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED	
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(Sign and date at end of narrative)

This was the first psychiatric hospitalization for this 27 year old never married Caucasian male US Army active duty SP4 with approximately one year and ten months three weeks continuous active military service when admitted via the CMHS to the (1) BAMC Psychiatry Service arriving on Ward 52B on 27 July 1984 with diagnosis of Rule out Schizophrenia, paranoid type.

(2) SOCIAL AND FAMILY HISTORY: Patient was born in Baton Rouge, LA on 29 October 1956. His father died at the age of 60 of a coronary. He used to work for Exxon Corpora- (3) tion. The mother is alive and is 60 years old. She is a housewife and has not remarried. The patient has four siblings, all sisters and older than him, aged 30, 32, and 33 and one younger brother aged 18. The brother is still at home and attends (5) college. The patient grew up in Baton Rouge, LA but because of his father's work, the family had to move frequently. They resided in Caracas, Venezuela, Germany, Sicily, five years in Spain, two years in Aruba and then returned to the United States. The patient had been residing in Austin since 1976. He started school at the age of five and graduated from high school at 16. He completed 5-6 years of college and has a Bachelor's Degree in Mechanical Engineering from the University of Texas at Austin which he obtained in 1978. He has never been married. His police record is negative. The patient began to work at the age of 14 as a salesman and clerk for a small shop in Baton Rouge, LA. He remained in that type of work for a year. His next job was as a carpenter doing home construction and working for approximately six months. Next he worked as a drilling engineer for Exxon Corporation for a year and a half.

MILITARY HISTORY: Patient was appointed to the US Naval Academy on June 1974. On August 1976, he was forced by circumstances to resign his appointment. He enlisted into the US Army on 5 October 1982 and completed basic training at Ft. Jackson, S.C. AIT was done at Chanute AFB. His initial MOS was 93E, Meteorological Observer. After working as a permanent party at WSMR, NM from 1 June 1983 to 21 May 1984, he was transferred and reclassified to 71M, coming to FSH, TX on 22 June 1984 to work as a Chaplain's Assistant. He allegedly has been able to get along well with his peers He has not had any problems with his officers. He has not received any disciplinary actions or Article 15's. His present ETS is for 5 October 1985.

PAST MEDICAL HISTORY: The patient had the usual childhood diseases. The patient denied any serious adult illnesses. Patient underwent a tonsillectomy at the age of 10. He fractured his right scapula at the age of 21 in an accident while surfing (4) in Florida. He does not have any known drug sensitivities or allergic reactions. He began to smoke at the age of 12 or 13. He quit smoking for a period of 2½ years

(Use additional sheets of this form (Standard Form 502) if more space is required)

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
GABRIEL DURAND-HOLLIS, LTC, MC	D&T:11Sep84		BAMC

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; rank; grade; hospital or medical facility)

CLARK, WILLIAM H., SP4
BAMC, FSH, TX

REGISTER NO.	WARD NO.
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during the time that he was in the Naval Academy. He has returned to smoking and presently consumes about a pack of cigarettes per day. He drinks alcoholic beverages on occasionally and no more than a couple of beers. He experimented with marijuana twice in 1974. He has never used any other illegal drugs.

REVIEW OF SYSTEMS: The patient considers himself at the present time to be in excellent health. He began to wear glasses at the age of 18, primarily for reading. The patient indicated that he had been born as a premature baby - 7 months and 3 weeks gestation. He spent the first year of his life in an incubator. During that year, he allegedly developed spinal meningitis. Later on, he also had rheumatic fever and jaundice. He believes that he recovered from all of those illnesses without sequela.

CHIEF COMPLAINT: "I turned a statement into the IG."

HISTORY OF THE PRESENT ILLNESS: The patient was considered a reliable historian. He stated that he had arrived at FSH,TX on 22 June 1984. He had been reclassified to 71M, Chaplain's Assistant, because his previous job as a 93E, Meteorological Observer had been civilianized. He had been working at the Main Post Chapel at FSH, TX, and apparently had been doing his job relatively well. On 17 July 1984, he had prepared a statement for the FSH IG in which he described in full detail in a 25-page single spaced document, many of the experiences and incidents that occurred to him in his previous assigment at White Sands Missile Range (WSMR). He believed that in that statement he had made accusations about problems that occurred at WSMR and were not given proper attention. He thought that his statement may have created an impression of him trying to get back at some of the people that he had mentioned in his statement. Although the same statement may have made people consider that he could have a mental problem; therefore, a psychiatric evaluation would be considered necessary. He knew that he had been asked by his CO on 27 July 1984 to accompany him to the Troop Medical Clinic where an appointment had been set up for him with the CMHS. After being seen there, his mental status examination revealed some thought confusion, social alienation, impending life threats, multiple ideas in reference to religion and grandiose beliefs of delusional quality, as well as ideas of reference. He also revealed obsessive preoccupation with Biblical interpretations giving evidence to his scientific theories. In his statement, he indicated evidence of tangential thinking and loose associations, making allegations about his importance to the FBI, CIA, NASA and the Israeli government. Under those circumstances, he was recommended for inpatient psychiatric evaluation. When examined at Ward 52B, he corroborated in great detail, most of the above allegations and indicated that he had a copy availabl of his basic equation which had been a bi-product of 2½ years of his own personal

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GABRIEL DURAND-HOLLIS, MAJ, MC	D&T:11Sep84		BAMC

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; rank; grade; hospital or medical facility)

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research. The equation had to do with a theoretical model that could be used to prepare a non-dissipating laser. He also made reference to another work which he titled "Parallel Symbiosis" which he went on to describe as a transliteration of the Book of Job in which each phrase of that biblical epic had been transferred from a gloomy, incomprehensible text into a hopeful, bright phrase. In passing, he made reference to another of his works titled, "The Rainbow Tribunal", which he described as being the trial of Jesus Christ and an evaluation of the effect that his teachings had upon western civilization, all set in a futuristic courtroom where in each item of evidence he brought forth had been quoted from reputable authorities in each topic of inquiry. The language of the "Rainbow Tribunal" was such that a faithful Christian or Catholic might think the author (in other words, the patient) to be some kind of an Antichrist figure. The patient's own mother, after reading the text and estimating the impact that it could have, became sufficiently upset that she proceeded to disinherit the patient and forced him to camp out of the house for several months. At around that same time, the patient suspected his mother of having attempted to poison him.

PHYSICAL EXAMINATION: Height 5'10", weight 150 lbs, temperature 98.3, pulse 83, respirations 18, blood pressure 110/70. This was a well-developed, well-nourished Caucasian male in no acute distress. His sensorium was clear. He was alert, friendly, cooperative, and well-oriented in all spheres. His emotional response appeared flat, at times, clearly inadequate. His thinking processes were characterized by well-concealed, systematized, delusional ideas of a grandiose and paranoid nature. For instance he believed that he discovered some highly technical formula that has to do with the conservation of energy which could be practically applied to the eventual construction of an ultimate weapon. He also believed that he had had special insights into some religious material specifically the Book of Job and Revelation. His speech was, in most areas, relevant, coherent and intelligent, but in dealing with the areas where he had his thinking disturbance, he appeared difficult to follow, somewhat tangential, and not entirely logical or rational. He did not admit to any disturbances of perception. His intellectual functions were considered high above average. His memory was excellent. His judgment, outside his areas of distortion, was considered fair and his insight entirely lacking. The rest of the physical examination was otherwise unremarkable.

LABORATORY STUDIES: Serology, SMAC-20, UA, and CBC were all normal. Chest X-ray was reported as normal.

CONSULTATIONS: Social work provided individual's social and family

(Use additional sheets if more space is required)

history. Occupational therapy enrolled him into a treatment program progressing to a regular work therapy assignment. Psychology Service examined the patient on 30 August 1984. It was their impression that the patient clearly demonstrated a complex, highly developed delusional system. His IQ full scale was reported as 124, placing him in the superior range of intelligence. Diagnostically he was considered to fall into an area between a clear paranoid schizophrenic reaction or a more conservative paranoid disorder. It was considered that his level of intelligence could be partially masking any deterioration in role functioning. Nevertheless, his thought disorder was considered to be chronic and most likely, not treatable. Optometry, as part of a routine final medical examination SF 88, reported compound myopic astigmatism, bilateral. Vision corrected to normal with glasses.

COURSE IN HOSPITAL: The patient was observed on no psychoactive medication for several days. He rapidly adjusted to the ward routine. He was granted escort privileges on 30 July 1984 and responsible status on 2 August 1984. By 6 August 1984 he had completed his psychological testing. His behavior was rather quiet, keeping a very low profile and not sharing with the staff almost any of his thoughts. He was able to handle self privileges and usually received a number of visitors. By 9 August 1984, he began to go out on weekend passes. By 13 August 1984, he appeared well adjusted to the ward routine. He was not reporting any problems or voicing any complaints. He was assigned to work therapy. On 20 August 1984, he appeared comfortable, relaxed, apparently was enjoying his regular work assignment. His behavior on the ward was excellent and he continued to maintain a very low profile. He was often seen occupied in writing without devulging the nature of his work. On 22 August 1984, patient's case was presented to an informal psychiatry board. It was the unanimous opinion that his final diagnosis is schizophrenia, paranoid type. Accordingly, he is to be recommended for medical separation. By 29 August 1984, the patient had a good, functional behavior. He continued to work daily and reported absolutely no complaints By 5 September 1984, his general behavior continued to be appropriate. He was seen very busy writing. On 6 September 1984, the major findings of his psychological testing as well as the proposed final diagnosis and disposition was discussed with the patient. He was given a recommendation for possible placement on medication in an attempt to bring his thinking disorder under control. He requested and was granted a two week period of time in which he will decide which way he wants to go. The rest of his hospitalization was uneventful. He was exposed to milieu, group, occupational and recreational therapy.

PRESENT CONDITION: The individual is alert, pleasant, calm, cooperative without overt delusions, loose associations or other remarkable findings. He has learned to avoid ious id s and writings. He looks entirely comfortable and

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