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HARTFORD, CONNECTICUT 06106

FRONT SHEET

CASE NO. 3 5 3 9 — ADM. DATE — — 74

NAME: 4 Rev. Adamson, Thomas F.
(Title) (Last Name) (First) (Middle Initial)

LEGAL RES: 135 S. E. 11th Avenue
(Street No.) (Street)

Rochester, Minnesota
(City) (State or Country)

55901 | 24 | | 507 | 8-7313
(Zip Code) (State Code) (Ct. Town Code) (Area Code) (Telephone Number)

BIRTH DATE: 07 12 33 — Age: 40 — Birthplace: Minnesota

SEX: M X — MARITAL STATUS: S X

CITIZEN: U.S. X

RELIGION: Cath. X

ADM TO IOL: First X — SIGNED VOL. SLIP: Yes X

LEGAL BASIS FOR ADM.: 1 Vol. X | 2 L.T. Vol. | 3 Phys. 15 Da. | 4 Prob. Court | 5 Other Court | 6 Inf. | 7 Supt's Transfer | 8 Other: | 9 Legal Guardian Appl. For Adm. | 10 Parental Appl. For Adm.

PATIENT COMES FROM: 1 Gen. Hosp. Psy. Ward | 2 Gen. Hosp. Non Psy. Ward | 3 Priv. Psy. Hosp. | 4 Instit. Phys. | 5 Referral Phys. | 6 Home X | 7 VENE | 8 Other

Specify Name of Above Unit:

PREV. PHYS. OR: Curran, J. — 1 2 0 6

ACCOMP. TO IOL BY: Unaccompanied

GROUP: 9A F — Unit: Fuller II — 0 1

PREVIOUS ADM. FOR PSYCHIATRIC CONDITION: No X

Name of Institution — Dates — Prev.

IOL:

Gen. Hosp.:

State Hosp.:

Federal Hosp.:

Other Priv. Hosp.:

Total all Prev. Adm. for Psych. Condition: 0 0

LENGTH OF ILLNESS:

Present Episode: Several Years X — Years X

Total Duration: Several Years X — Years X

FACTS REGARDING PRESENT ILLNESS AND REASONS FOR PRESENT HOSPITALIZATION: Forty year old priest with long-standing psychosexual problem for which he had brief help in 1968 with only short-term success. Problem has continued and within the past two months he has been seen in consultation by a priest-psychologist and the referring psychiatrist, Dr. T—, and recommendation made for treatment here. Exam reveals pleasant, oriented man who appears in no discomfort except that he reports some apprehension about being here. No gross thought disorder. No obsessions or compulsions.

PHYSICAL ILLNESS: None.

DIAGNOSTIC IMPRESSION: Homosexuality.

INTRODUCTOR: Elizabeth Lufkin (Signature) — 1 6 7 7 (Ident. No.)

CHIEF INTRODUCTOR: (Signature) — (Ident. No.)

ADM. PHYS.: John J. Curran M.D.

CONN. LICENSE NO.: 11210 — 1 2 0 6 (Ident. No.)

ljb

Form 211 Rev. B 6-73

PLAINTIFF'S EXHIBIT
319

JK 13101

62-C9-06-0003962

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HARTFORD CONNECTICUT 06101

CLINICAL NOTES

Patient [illegible] Case No. [illegible]

[illegible] June [illegible]

[illegible] DATE: 6-4-74

Ad[illegible]

PSYCHIATRIC HISTORY

1. INFORMANT

Information was obtained primarily from the patient, with a brief summary letter from the referring psychiatrist, Dr. Francis A. Tyce, which, in turn, contained a summary of psychological testing done by Dr. John Hawkinson, although the date of the testing is not indicated. The information appears to be reliable.

2. CHIEF COMPLAINT

Father Ashmore was referred for treatment of a psychosexual problem which he had had for a number of years, with the most recent episode occurring on April 15, 1974.

3. PRESENT ILLNESS

The patient is the second of twelve children of Mennonite-born parents of Irish extraction and was raised on a dairy farm. There may have been some confusion as to authority issues, inasmuch as his paternal grandparents also lived on the farm with them until the patient was 15 years old. There seemed to be nothing particularly remarkable about his early development, except possibly that animal sexuality created in him conflicts about human sexuality. He recalls finding it hard to reconcile the manner of animal breeding with human sexuality as an expression of love and tenderness. He also recalled having a stallion which was high-spirited and somewhat mean as the [illegible] years old. The stallion was put to stud on several occasions [illegible] a foal. Because of his meanness, the stallion was "cut" (that is, castrated) in an effort to produce a more tractable animal. As a gelding, the horse was no more docile than before. The patient did not recall who it was that castrated the horse — whether it was his father or an uncle who bought and sold horses, and it was obvious to him that he should have been aware of how the procedure was carried out and that possibly he was present. He also recalled his identification with the stallion and how a young boy's status reflected whether he owned a stallion, gelding, or a mare.

At puberty, an older boy who worked as a farm hand used to talk a great deal about sex. At the age of 15, the patient was seduced by a 60-year-old man who was a hand on a neighbor's adjacent farm. The relationship continued occasionally over the next two years, following which the man moved away for about two years. The patient had not seen him for about ten or eleven years. For six years while he was studying theology until after ordination, there was no sexual involvement. Since then, he has had close relationships with a few men -- all of whom he has known for a number of years and who see him every six months or so. In 1964, the patient was involved in improper touching of an eighth-grade boy, and when this activity was made known to his bishop, he was seen by him and admonished to control his behavior. There were no further such difficulties until about three years later,

CLINICAL NOTES

Patient [illegible] Case No [illegible]

[illegible] - 2 June 19, 1974

PRESENT ILLNESS (continued):

following which he saw Doctor Tyce for approximately 15 sessions over a 3-month period, and he was also transferred out of the community by his bishop. There was no such tension involving young boys until April of 1974, when, while in a sauna with a 14-year-old boy, he touched him, with no further sexual activity. The young boy apparently talked about the experience to a friend, who, in turn, talked to a priest, and the patient's bishop was brought into the picture again. The patient was seen by Doctor Tyce subsequently on three occasions and hospitalization was suggested. In addition, the patient saw Father Kenneth Pierre, a priest-psychologist, for three sessions, and Father Pierre felt that he could be treated on an outpatient basis. However, on the recommendation of Doctor Tyce, his bishop, the Most Reverend Loras T. Watters, agreed that he should come here for treatment. Father Adamson denied that his behavior is impulsive or compulsive, and it was not manifest under the influence of alcohol, which he does not abuse. He did acknowledge his need for psychotherapy and states that he considers his behavior to be abnormal. There is no history of assaultiveness, destructiveness, or suicidal ideation.

4. FAMILY HISTORY

The family enjoyed middle-class benefits. There do not appear to be any familial diseases or mental disorders. The patient acknowledged that on occasion his father overindulged in alcohol.

Father: Paul E. Adamson, died in 1971 at the age of 5- of carcinoma of the lung. He had been a farmer throughout his life and was born in Minnesota of Irish extraction. He was considered to be easygoing and friendly.

Mother: Mildred Mary Manon Adamson, aged [illegible], in good health. She continues to live on the family farm in Byron, Minnesota. [illegible] to be easygoing and friendly, as was her husband.

Siblings: (1) Elizabeth Prigge (Mrs. David), aged 41, married, mother of five children, living in Byron, Minnesota. She is said to be gregarious and a good organizer, and is close to the patient. (2) The patient. (3) Mary Kesler (Mrs. William), aged 38, mother of six children, living in Rochester, Minnesota. She is described as quiet, a good homemaker, and an all-round helpful person. (4) Alison Greene (Mrs. Maurice), aged 36, mother of two children, living in Rochester. She is said to be a good mother and quiet and unassuming. (5) Robert, aged 35, married, father of four children, living in Austin, Minnesota. He is a foreman for the Bell Telephone Company and described by the patient as "like me" in personality. His first wife suicided in 1961, leaving the four children. He married a nurse three or four years later and has no children by her. (6) Phyllis Vick (Mrs. John), aged 34, mother of three children, living in Minneapolis. She is said to be a maverick. (7) John, aged 31, father of three children, living in Byron, Minnesota. He is said to be easygoing and quite witty. He works for IBM and also takes care of the family farm. (8) Helen Wilde (Mrs. James), aged 29, mother of two children, living in Byron. She is described as easygoing, kindly, and a concerned type of person. (9) Catherine Stephenson (Mrs. Lee), aged 27, mother of four children, living

CLINICAL NOTES

ient Father Thomas [illegible] Adamson Case No. [illegible]

PSYCHIATRIC HISTORY - 3 June 19, 1974

RECENT FAMILY (continued):

St. Charles, Illinois. She is said to be more outspoken than the others. The client claims his mother thinks that Catherine is the best mother of her daughters. (10) Theresa Erickson (Mrs. James), aged 25, living in Byron, the mother of two children. She is said to be high-strung and has marital difficulties. (11) Wayne, aged 23, is the father of two children, living in Byron. Earlier he had a drinking problem, but has since settled down, following his marriage. (12) Ronald, aged 21, single, living in Byron on the farm, and attends Rochester Community College.

Home Atmosphere and Influences: It should be noted that the paternal grandparents lived with the family until the patient was 15. His grandfather was rather strict and the patient recalled some awkwardness for his parents with the older generation living there. The farm originally belonged to his grandfather. The patient's great-grandfather was a schoolteacher, who migrated from County Mayo in Ireland. His maternal grandmother was born in County Mayo. In addition, the patient's paternal aunt, Gertrude Adamson, lived with the family. His maternal grandmother is over 90 years old and living in a rest home.

PERSONAL HISTORY: Father Adamson was born in Byron, Minnesota on July 12, 1933 at home, and to his knowledge, there were no difficulties during his mother's pregnancy or with labor and delivery. He was breast-fed.

Early Development: Unremarkable.

Neurotic Traits: The patient remembered that he was shy -- particularly when he started first grade. Otherwise, he did not recall any difficulties.

Play: Growing up on the farm, the patient was quite active with fishing, horseback riding, and a variety of sports. [illegible] and was also involved in school dramatics.

Education: From grades 1 through 8 he attended District 26 one-room schoolhouse, then where he went to Lourdes High School in Rochester, Minnesota through grade 10. He did well academically. From there he went to St. Mary's College in Winona, studying pre-law, and in his junior year, switched to the seminary at the same college. Then there he went to Catholic University, studying theology, and received his Master's in Educational Administration. He was ordained on May 31, 1958 in Rochester. He has always done well academically.

Attitudes: The patient said he had a rather respectful attitude toward his parents and got along well with his siblings, although some of the younger ones he did not feel as close to, because, by that time, he was away at school himself. He has always had a lot of friends, dated during his younger life, was a member of the 4-H Club.

Occupations: During his growing-up years he worked on the family farm. Following his ordination, he taught at the Cotter High School from 1958 until 1961 and also had parish duties. From 1961 until 1962 he was at Adrian, Minnesota, where he was Assistant Principal at St. Adrian's School. From 1962 until 1964 he was at Caledonia, Minnesota, where he was Principal of a grade and high school there. From 1964 until

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CLINICAL NOTES

Patient: Father Thomas P. Adamson Case No. 38471

PSYCHIATRIC HISTORY - 4 June 19, 1974

FAMILY HISTORY (continued):

1963 he was at Rochester at Lourdes Central as Assistant Principal. From 1968 until 1969 he was at Albert Lea, Minnesota as Newman Chaplain at Lea College. From 1969 until 1971 he was at Fountain, Minnesota as Pastor, with the responsibility of a small mission parish at Wykoff. From 1971 until the present, he has been Pastor at St. Francis of Assisi Church, with the responsibility for running both a grade and a central high school.

Sexual Inclinations and Practices: See Present Illness.

Marital History: Single.

Children: None.

Current Social Situation: The patient is the Pastor of a large church school complex in Rochester, with a number of obvious administrative responsibilities. He has been active in sports, including basketball, golf, etc. He reads a great deal and keeps up with trends in academic administration.

Habits: The patient smoked cigarettes for a few weeks as a college sophomore. He smokes perhaps one cigar a month and inhales. He drinks perhaps as much as two ounces of alcohol a day with a before-or after-dinner drink. He may overindulge on the average of once a year.

Previous Mental Illness: See Present Illness.

TENTATIVE CASE FORMULATION

Father Adamson's problem [illegible] activity involving a consenting adult, and [illegible] involving a young adolescent, with or without his consent. Presumably, it is because of the latter behavior that the patient is here. He acknowledged that his behavior is abnormal, although he seems to lack appropriate concern for the possible consequences of his behavior. This was noticed by the referring psychiatrist, Doctor Tyce, as well as the psychologist, Doctor Hawkinson, who had tested him some time ago. At first sight, Father Adamson does not appear to be appropriately concerned, but I believe he is, and has covered over his feelings reasonably well, although lately he does appear to be apprehensive and slightly depressed. There are other factors involved, such as his concerns about having his family and others find out about his hospitalization, as well as the possibility of his losing his position as Pastor. During my routine questioning about sexual history, I discovered that the patient was very early aware of animal sexuality by his having been brought up on a farm. What did not occur to me or to him until we probed further, was that rather than his having an advantage by this early awareness, it may have disadvantaged him by observing the mating of a cow and a bull with associated violence, such that he could not imagine either his parents or himself involved in such a carnal display. Human sexuality, at least that between the two sexes, could then be seen as a distasteful and threatening experience. There seems to be an aggressive quality about the homosexuality similar to the type described by Wunberg, in which aggression against the father is acted out in the homosexual relationship. It is interesting to note from the history that

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CLINICAL NOTES

Patient ... ...es F. Adamson ... Case No. [illegible]

EARLY HISTORY - 5 June 19, 1970

IVE CASE FORMULATION (continued):

atient could well have developed castration anxiety over displeasing his father etting out of line (his stallion, with which he identified, was castrated for mean and unruly) or for being unable to produce (his stallion was already unto sire a foal when he was "cut"). Either way, Father Adamson, by his homosexual ation, could avoid the castration threat. There is much to be explored in the t's early life, particularly with reference to his relationships with his and mother and oedipal issues. Certainly there is a suggestion of repetitionsion in his touching of the pre-adolescent boy in the face of his having access esenting adult males. It is obvious that the patient requires long-term inve psychotherapy both here and later outside the hospital. In the meantime, I to see him two or three hours a week and to involve him in the full-range of al activities.

John J. Curran, M.D.
Chief of Section

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CLINICAL NOTES

Patient Rev. Thomas F. Adamson Case No. 22[illegible]

June 25, 1974

EVALUATION

The following is the clinical evaluation of Rev. Thomas F. Adamson, age 40, single, who was admitted to the Institute of Living on June 4, 1974, as a voluntary patient.

HISTORY: The patient is the second of twelve children of Minnesota-born parents and was raised on a dairy farm. There may have been some confusion as to authority issues, inasmuch as his paternal grandparents lived on the farm with him until the patient was 15 years old. There seems to be nothing particularly remarkable about his early development, except possibly that animal sexuality created in him conflicts about human sexuality. At puberty, an older boy who worked as a farm hand used to talk a great deal about sex. At the age of 15 he was seduced by a 60-year-old man who was a neighbor's farm hand. The relationship continued occasionally over the next two years. Since that time, except during seminary days, there have been continued relationships with a number of men, which presumably were mutual. However, back in 1964, the patient was involved in touching an eighth-grade boy, for which he was seen by his bishop and admonished to control his behavior. There were no such difficulties until three years later, following which he saw Dr. Francis A. Tyce for approximately fifteen sessions and he was also transferred out of the community by his bishop. The most recent episode occurred on April 15, again with a 14-year-old boy, who presumably mentioned the incident to a friend, who, in turn, talked to a priest about it. He was seen by Doctor Tyce on three occasions and hospitalization was suggested. He was also seen by a priest-psychologist, Father Pierre, who allegedly felt that outpatient psychotherapy would suffice. However, his bishop, on the recommendation of Doctor Tyce, agreed that he should come here. While the patient was a bit apprehensive, he did not appear to be appropriately concerned about his behavior. The patient does not use drugs nor does he abuse alcohol.

MENTAL STATUS: The patient appeared his stated age. He was of athletic build, tall, quite outgoing, and cooperative. On admission he did tend to stay by himself in his room, although he was friendly in approach. There were no disturbances in eating and sleeping. Speech was unremarkable and he was quite open in his discussion of his difficulties and his need for help. He seemed hesitant, however, about agreeing to remain in the hospital for any time on the grounds that he had not realized how long he would need to remain here and that he had a number of pressing problems to take care of in his church and school. There were no delusions, obsessions or compulsions. There were no hallucinations nor disorders of perception, nor could these be elicited. He was oriented in all spheres. Emotionally he appeared somewhat apprehensive and anxious. His memory was intact. Attention and concentration were good. He is of at least superior intelligence and had a good fund of general knowledge. He was able to calculate and abstract. Reasoning and judgment were good for most situations other than that related to his sexual behavior. He has partial insight and he seems fairly well-motivated for psychotherapy, although ambivalent about long-term hospitalization.

PHYSICAL EXAMINATION AND LABORATORY RESULTS: The physical examination was unremarkable. Laboratory results were negative except as follows: a bilirubin of 1.4 and cholesterol of 270 milligrams percent, both with a probability of being normal less than five in a hundred. Skull films were normal. A chest film showed equivocal findings and the radiologist stated that "One cannot be sure, on the basis of a

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CLINICAL NOTES

Patient [redacted] Case No. [redacted]

June [redacted], 1974

EVALUATION -

PHYSICAL EXAMINATION AND LABORATORY RESULTS (continued):

single examination, that there is not some developing or resolving inflammatory process in the lingular segment of the left upper lobe and/or the basilar segment of the lower lobe on the left. One suspects, however, that the abnormality seen represents inflammatory residuals rather than active disease." There is no clinical evidence of respiratory or hepatic disease.

DIAGNOSIS: Homosexuality.

PROGRESS IN HOSPITAL: The patient was admitted to an open convalescent unit for men and was placed on no medication. While friendly on approach, he nevertheless found it difficult to accept the vulgarity of the younger patients. He acknowledged the expertise of the staff and their concern for patients' welfare, but wondered if he needed hospitalization for treatment with his acknowledged problem. He stated repeatedly that he would be willing to get psychotherapy at home, presumably at the counseling service in Minneapolis, where he has seen Father Pierre, a priest-psychologist. Having already committed himself to officiate at his niece's wedding in Rochester, he asked for permission to go home, and this was granted. However, he expected to remain there for additional time in order to speak with his bishop. When it became apparent that he could not abide by my decision that he return here after the wedding, he said he would not come back at all. I subsequently phoned the referring psychiatrist, Doctor Tyce, who, in turn, notified the bishop's office, and it was made clear that the patient indeed must remain in the hospital. He was confronted with this by me and he agreed to come back on June 24, which he did. He was able to speak to his bishop on two occasions during the visit and notified at least his mother that he was "away for a rest" without indicating that he was in a psychiatric hospital. He is still ambivalent about remaining here, particularly in view of my forthcoming vacation. He has stated that he would consider coming back here after I return, [illegible] treatment could certainly continue in spite of my absence.

TREATMENT PLAN: I would anticipate that the patient would need to remain here for at least four to six months, so that he would be given sufficient time to be confronted and to confront himself with the seriousness of his problem. He recognizes it to be a problem but seems fearful of the closeness which therapy would involve, as well as fearful of looking at himself openly and honestly. Certainly uncovering psychotherapy would be indicated and there are some clues from the history as to the genesis of his problem. I would anticipate that he would need to be in a full Occupational Therapy Program and as treatment progressed, he would be given access to the local community -- particularly so that he could celebrate Mass. He will be seen two or three times a week for 50-minute sessions. Follow-up psychotherapy with a therapist of his choice will certainly be recommended.

John J. Curran, M.D.
Chief of Section

JJC:d

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CLINICAL NOTES

Patient Reverend Thomas P. Adamson Case No. 38111

June 11, 1974: Father Adamson continues to reside on Fuller II, an open, convalescent unit, with full grounds privileges. He remains on no psychotropic medications. In the past week I have seen Father Adamson five times in order to obtain historical data. The patient has settled into the hospital routine reasonably well and has been attending some occupational therapy activities, and he has involved himself with fellow patients and with members of the staff. While he recognizes that he has a problem, he is not at all sure how long he can stay in the hospital. Apparently, if he should have to stay beyond August, his bishop would have to reassign him and put another man in his place. This Father Adamson would not want to see happen because he has worked hard to get to his current position, wherein he is pastor of a large church and principal of a school as well. No one but the referring psychiatrist and Father Adamson's bishop knows that Father Adamson is in the hospital. His family knows that he is away; but since he has been accustomed to taking extended trips at this time of year, the family presumes that he is on vacation, visiting with former classmates or other friends. His maternal aunt, who has helped out in the rectory in the past, knows how to get in touch with him but presumably does not know either that he is in Connecticut or that he is in a hospital. Father Adamson recognizes that this is a problem, but he would not handle it any other way. He has a commitment to officiate at the wedding of his niece on June 22 and will have to go home for that purpose. He expects that he might be able to speak to his bishop at that time. My current impression is that Father Adamson will be reluctant to stay in the hospital much longer, unless he is assured that he can be out of here in August, to resume his priestly role. Certainly I would want to encourage him to stay as long as possible, recognizing the reality of his concerns, however.

Thus far I am unable to detect any serious emotional problem with the patient, other than the apparently circumscribed problem with which he presented himself. He recognizes the abnormality and would like help with it. I am beginning to get some clues which will be outlined in the formal psychiatric history.

/
John J. Curran, M.D. /fjt

June 18, 1974: Father Adamson continues to reside on Fuller II, with full grounds privileges; and he remains on no medications. I have continued to obtain historical data from the patient and have explored some of his relationships. Father Adamson has been somewhat reluctant to involve himself in the full occupational therapy program, largely because he does not feel he needs to remain in the hospital much longer. He stated it was not his understanding that he had to be here indefinitely, and he expressed a fear that he might lose his position as pastor if he stays much longer. He is planning to go home this coming weekend to officiate at his niece's wedding, and he hopes to speak with his bishop at that time. What he wanted to do was to remain at home, at least until the end of the month, taking care of accumulated business in the parish. When I informed him that he could not do so, he stated that he would probably not come back to the hospital at that rate. I tried to clarify with him what his attitude was about hospitalization, and he claimed that he came here with the understanding that he would be here only two or three weeks. I told him I would have to speak with Dr. Tyce, the referring psychiatrist, and the patient's bishop and would also want to speak to Father Pierre, a priest psychologist whom he had also seen who presumably recommended outpatient treatment.

I spoke to Dr. Tyce, who was quite concerned about the possibility of Father Adamson's leaving the hospital. He reiterated his concerns about the patient and said he would be in touch with the bishop and relay the information to him. He said that presumably

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CLINICAL NOTES

Patient Reverend Thomas P. Adamson Case No. 36191

June 18, 1974 (continued):

the bishop would be in touch with me. I put a call in to Father Pierre, but he was not immediately available. I left a message for him to return the call. Later in the afternoon of this date, I heard from Father Tighe, who is Chancellor of the Diocese of Winona, Minnesota; and he informed me that the bishop was in Washington and could not be reached. He said, however, that he was speaking in behalf of the bishop and that it was their understanding that Father Adamson would remain at the Institute of Living until he was released by us. He also said it may well be that Father Adamson would be replaced at his parish no matter how long he remained in the hospital. It was arranged that Father Adamson could call the bishop on June 19, prior to his departure for home, and make an appointment to sit down with him and discuss the whole problem. I later informed Father Adamson of my contacts with Dr. Tyce and Father Tighe, and he appeared dejected but left with the understanding that he would go home from June 19 until June 24, when he would resume treatment.

John J. Curran, M.D. /fjt

June 19, 1974: Father Adamson left the hospital today on a therapeutic visit.

J. Curran, M.D. /fjt

June 24, 1974: Father Adamson returned from therapeutic visit today.

J. Curran, M.D. /fjt

June 25, 1974: Father Adamson has now been a patient at the Institute of Living for three weeks, having been admitted voluntarily on June 4, 1974. Accordingly, he has been evaluated clinically; and a written report of this evaluation has been submitted by the undersigned and may be found elsewhere in the chart. For a summary of the patient's history, mental status, diagnosis, his course in the hospital thus far, and plans for his treatment, please see this evaluation report.

John J. Curran, M.D. /fjt

July 2, 1974: Father Adamson continues to reside on Fuller II, an open convalescent unit, with full grounds privileges; and he remains on no psychotropic medication. After much discussion with him, I have not yet established that Father Adamson will remain in the hospital. He is still struggling with dependency issues without realizing it, but there are some issues of reality as well. He will lose out on his position as pastor at St. Francis Church, and he also would not want his family and friends to be aware of his hospitalization here. He intends to speak further to his bishop about what arrangements the bishop can make for him; and if these are favorable, I guess he would consider staying in the hospital. One of the big issues he raises is my being away on vacation for the next three weeks. While I acknowledged that this is a difficult thing for him to accept, I did state, however, that Dr. Hill, whom I have asked to look after him, will be more than able to discuss issues, as would I, regarding his problems which brought him here. Father Adamson acknowledges that so much of our time has been

July 2, 1974 (continued):

spent in discussing whether or not he will remain in the hospital, that many important therapeutic issues have not yet been explored. That is not to say that the whole issue of his ambivalence about remaining in the hospital is itself not important and undoubtedly a part of his personality profile. Even if he stays, I am afraid he will not stay here indefinitely but will rather agitate to leave sometime again in August. He hopes that his bishop will be able to appoint someone to take care of the parish temporarily until he is able to return home, rather than make a permanent reassignment.

John J. Curran, M.D. /fjt

July 4, 1974: Father Adamson informed me that he had since spoken to his bishop and that he has decided to remain in the hospital a bit longer. He signed back into the hospital on this date, having submitted a ten-day notice recently. He thinks that the bishop will be able to appoint someone temporarily, but he did ask if he could go home for the next few days to settle parish matters. I did allow him to leave on this date, to return on Monday, July 8. At that time he will be under the care of Dr. Thomas Hill under my absence on vacation.

John J. Curran, M.D. /fjt

July 5, 1974: Father Adamson left the hospital today on a therapeutic visit.

J. Curran, M.D. /fjt

July 8, 1974: Father Adamson returned from therapeutic visit today.

T. Hill, M.D. /fjt

July 9, 1974: The patient resides on Fuller II and has a daily town pass. He is receiving no medications. The undersigned is following Reverend Adamson in the absence of his regular therapist, Dr. Curran, who is on vacation. During the past week the patient has been on visit, clearing up personal business in his parish and with his superiors. He has been ambivalent about staying in the hospital and only peripherally involved on the unit. He admits to finding it difficult to allow himself to relate other than superficially or diplomatically with other patients. He is making arrangements to celebrate Mass at a nearby church and has requested a monthly town pass for this purpose. The undersigned is seeing the patient two hours each week, attempting to help him uncover some of the underlying feelings and conflicts which may have accompanied the patient's several episodes of homosexual contact with adolescent boys. The patient appears to be relatively indifferent to the social and psychological implications of his behavior and, indeed, relates in a very superficially pleasant, cooperative manner but without feeling and without appearing to be affectively involved. Attempts are being made to discuss his feelings about the priesthood, levels of

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CLINICAL NOTES

nt Reverend Thomas P. Adamson Case No. 38191

9, 1974 (continued):

...onsibility he has had to handle in parish work, and his feelings about the amount support and chronic conflicts which exist between himself, his colleagues, and parishioners.

Thomas M. Hill, M.D. /fjt

16, 1974. The patient resides on Fuller II and has a monthly and daily town s. He is on no medication. The staff reports that the patient continues to ticipate superficially in unit meetings, is polite, and intellectual in his approach day-to-day conflicts. He attends several Department of Educational Therapy ivities, including swimming. In therapy sessions the patient has continued to ate in a cooperative but superficial manner, which appears almost cool. The only e the patient has shown any affect was when he was confronted with the possible ...inistrative consequences of his repeated acts. When he stated he might be asked to ve the priesthood, he looked frightened and shaken. The patient states that he never really felt very involved with people and has seen himself as an arbitrator go-between who keeps things running. He also appears to deal with almost any ...one feeling by avoiding it or the person associated with it. This might in some be a factor in his decision to enter the priesthood, where he felt he could avoid only expressions of sexuality but sexual feelings of all kinds. He appears fused about his own sexual object preferences, as he is not clear about feelings physical attraction, dependency, or aggression. Because of this sense of vagueness the possible serious consequences of the patient's behavior and treatment, ...chological testing has been ordered.

Thomas M. Hill, M.D. /fjt

...y 23, 1974: Reverend Adamson is residing on Fuller II and is on no medication. has been attending unit and other hospital activities consistently. During the ...st week the patient became very upset at the possibility that he might lose his ...ob and even his privileges as a priest, as we discussed the possible consequences his behavior. He became more upset when it became increasingly apparent to the ...esigned that Reverend Adamson is continuing to use his parish responsibilities to ...id dealing with his own emotional problems. On the last visit here, which had to be ...r the expressed purpose of clearing up his affairs and transferring them to some other ...ersonal, he made arrangements to have important paper work and mail here pending his ...turn in two to three weeks. When the undersigned refused to allow Reverend Adamson ...o carry out these plans, the patient became extremely upset, cried bitterly, and ...eeded to go home. There followed a very fruitful discussion and confrontation of ...everend Adamson's behavior, whereby he appeared to be trying to do two things at ...once--keep his job and try to become involved in treatment here at the Institute. ...He tended to be trying to keep all emotional problems and conflicts at arm's length ...and to give the appearances of being seriously involved in psychotherapy. Later on in ...the week he requested permission to visit an elderly aunt who is hospitalized and in very poor health. He appeared to be very close to this person, who, as a religious sister, had functioned as his housekeeper since he was ordained. He likened his ...relationship to her as that of his mother or an older sister. He was allowed to go

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CLINICAL NOTES

Patient: Reverend Thomas P. Adamson Case No. 38191

July 23, 1974 (continued):

home on visit for purposes of seeing this relative but with the clear understanding that further visits should be curtailed to facilitate his involvement in psychotherapy and the treatment program here at the Institute. The results of these somewhat stormy sessions seem to be helping the patient to get in touch with his own feelings and the various defenses he is using to avoid treatment. It was clearly pointed out that this behavior could well be construed by his superiors as a lack of faith on his part.

Thomas M. Hill, M.D. /fjt

July 26, 1974: Reverend Adamson left the hospital today on a therapeutic visit.

Thomas M. Hill, M.D. /fjt

July 28, 1974: Reverend Adamson returned from therapeutic visit today.

John J. Curran, M.D. /fjt

July 30, 1974: Father Adamson continues to reside on Fuller II, an open, convalescent unit, with grounds and town privileges, and remains on no medications. During my vacation absence, Father Adamson was looked after by Dr. Hill. The patient was allowed to return home to visit his ailing aunt for one weekend. In addition, he has been assisting at a local church, to his satisfaction. During his sessions with Dr. Hill, Father Adamson discussed some of the issues which prompted his interest in the priesthood, and presumably his decision was influenced by an avoidance of women. At the present time he is still quite eager to leave the hospital and has been asking how much longer he needs to remain. Presumably a decision must be made regarding who will take over his position if he remains here beyond August, and Father Adamson does not want to risk the possibility of his position being given to someone else if he is to be leaving the hospital sometime shortly thereafter. He has offered that he recognizes he has problems for which he will seek treatment on an outpatient basis if he is allowed to leave the Institute. I left it with him that I would have to give the matter further consideration and certainly would want to speak to his bishop before any decision is made. My own present position is that he has not been very well motivated to remain in the hospital but is motivated for treatment on an outpatient basis. I am not at all sure that he needs inpatient treatment for any prolonged time, now that he is at least willing to acknowledge his need for help. If arrangements can be made for him to continue in his position and at the same time seek psychotherapy, with his bishop's approval, that might be the best course of action.

John J. Curran, M.D. /fjt

CLINICAL NOTES

[illegible] Case No [illegible]

[illegible] August [illegible], 197-

Father Adamson, a [illegible] year-old priest, who was admitted to the Institute of [illegible] on June [illegible], 1974, with a long-standing psychosexual problem, was discharged on [illegible] date to return home. From shortly after his admission here, Father Adamson [illegible] ambivalent about remaining. True, there were some reality factors inasmuch [illegible] feared losing his position as pastor in a large and active parish in Rochester, [illegible] also felt a sense of obligation to the people who worked for him. However, he [illegible] also to be concerned about looking at himself in psychotherapy and developing [illegible] therapeutic relationship. He was allowed to go home on visit on three occa- [illegible]. The first, to officiate at his niece's wedding which he had planned to do for [illegible] and he also was able to speak to his bishop at that time. The second time [illegible] business to take care of, and the third visit was to see his seriously ill aunt [illegible] whom he has had a close relationship. Much of the first four weeks of the patient's [hospit]alization was spent on his deciding whether he would remain in the hospital and [illegible]essed and worried about it. Nevertheless, we were able to get into some issues [illegible] and notably those having to do with his feelings regarding sexuality. At first [illegible] not appear that Father Adamson was at all concerned about his behavior which neces[sitate]d his hospitalization, but later it was evident to me that he was anxious and [illegible]sed about it. Having been brought up on a farm, Father Adamson was quite aware [illegible]mals' sexuality but this was a hindrance rather than a help to him. It did not [illegible] to me or him at the time but as the discussion progressed, he had associated sex [illegible] violence, having seen the mating of cows and bulls, and he could not imagine either [illegible] or his parents involved in such carnal display. Human sexuality, at least [b]etween the two sexes, could then be seen as a distasteful and threatening experi[ence]. Also worthy of note in the same line was his feeling regarding the castration of [illegible] stallion who was mean and unruly and, in addition, was not able to sire a foal. [illegible] [illegible]nness he was "cut" and since he had not been able to produce [illegible] [illegible] Adamson made an identification with that stallion [illegible] and [illegible]ened by the castration. [illegible] [illegible]hreat. In later sessions he realized that among other reasons for becoming a [illegible] he was able to avoid heterosexuality. While I was on vacation for three weeks [illegible] Adamson was able to continue some of this discussion with Dr. Hill, who confirmed [illegible] of the above formulations. Upon my return from vacation, Father Adamson was still [illegible] preoccupied with leaving the hospital, and while I recognize that he needs con[illegible] psychotherapy, I did acknowledge that he could do so on an outpatient basis. I [illegible] touch with Bishop Walters, his superior, and indicated my recommendation that [illegible] Adamson continue in psychotherapy with the therapist of his choice, although he [illegible]ated that he would be interested in seeing Father Kenneth Pierre or someone he would [illegible]ate at the consultation services in St. Paul. For a few weeks before his discharge [illegible] Adamson had a town pass which allowed him to say Mass at one of the local churches [illegible] was of mutual benefit. He seemed quite grateful for the opportunity to leave the [hospi]tal. He felt that by leaving at this time he would inconvenience the parish and [te]aching sisters a great deal less, and that he certainly would take advantage of [out-pa]tient psychotherapy now that he had become aware of some things about himself and [b]een "shocked" by the experience of hospitalization. It should be noted that Father [Adams]on came here without letting his rather large family know that he was being hospi[taliz]ed, and it was only after he had been here and returned on visit that he was able [to le]t any of them know that he was "away for a rest." Certainly he realizes the [pract]ical things he could do to help himself deal with his problem and he knows also that

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CLINICAL NOTES

Patient. Rev. Thomas P. Adamson. Case No. 33192

DISCHARGE SUMMARY - 2 August 9, 1974

his bishop cannot tolerate any further difficulties such as those which precipitated his admission here. I feel that he has every chance to overcome his problem. Physical examination done at the time of admission was within normal limits. Laboratory studies were also within normal limits except for a slightly elevated bilirubin, 1.4 milligrams percent, and a cholesterol of 270 milligrams percent, and the absence of any clinical findings or other liver abnormalities.

DISCHARGE DIAGNOSIS: Sexual orientation disturbance.

CONDITION ON DISCHARGE: Slightly improved.

John J. Curran, M. D./ceb

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CLINICAL NOTES

Patient. Reverend Thomas P. Adamson Case No. 38191

Date Due: June 5, 1974 June 7, 1974

PHYSICAL EXAMINATION

A. The General Physical Examination

Age: 40

Present Medical Complaints: None of significance.

Past Medical History: No significant illnesses. No surgical operations. No accidents or injuries.

System Review: Inquiry of functions by systems reveals no current physical symptoms.

General: The patient is well-developed. Nutrition appears adequate. His body build is primarily athletic. Ht. is 5'11". His usual weight is 190 pounds. His present weight is 193.

Skin: The skin is normal in color and texture. There is no rash, jaundice, cyanosis, or edema.

Head and Face: Hair unremarkable. Skull is normal in shape and non-tender. The face is symmetrical.

Eyes: The color is hazel. There is no exophthalmos, enophthalmos, ptosis, strabismus, or nystagmus. The sclerae are clear and the conjunctivae are normal. The pupils are round and regular, equal and of normal size. The direct and consensual light reactions are active bilaterally, as are the responses to accommodation and convergence. The external ocular movements are full and equal. The fundi show no significant abnormality. There is no diplopia and the visual fields are normal to confrontation testing.

Ears: External configuration, external auditory canals, and tympanic membranes reveal no abnormality. Weber and Rinne tests normal.

Nose: No external deformity. Septum is in the midline and mucous membranes are normal.

Mouth: Lips, gums, tongue, palate, and pharynx are normal. There are no gross dental abnormalities.

Neck: The trachea is in the midline. The thyroid gland is symmetrical, of normal size, and without palpable nodules. There is no cervical lymphadenopathy.

Thorax: The chest is symmetrical. Respiratory movements are full and equal.

Lungs: Clear to percussion and auscultation.

CLINICAL NOTES

Heart: Not enlarged. Rate is 72. Rhythm is regular. Heart sounds are of good quality. No murmurs are heard. Pulses in peripheral vessels are full and equal. There is no abnormality of the venous system. Blood pressure is 124/74.

Abdomen: The abdomen is soft and non-tender. There are no palpable masses or organomegaly.

Genitalia: Normal adult male.

Rectal: Prostate normal. No masses or hemorrhoids.

Orthopedic: The posture is erect and the mobility of the spine is within normal range. Extremities are normal. Joint movements are normal without discomfort.

B. The Neurological Examination

Neurological History: Inquiry into general symptoms, convulsive phenomena, headaches, sensory modalities and motor phenomena reveals no abnormality. There is no evidence of personality disturbances associated with neurological dysfunction. Family history is negative for neurological disease.

Gait and Station: Gait is within normal limits. Heel, toe, forward, backward, and heel-to-toe walking are performed well, and associated arm and trunk movements are present. Romberg test is negative.

Cranial Nerves:
1st: Intact by history.
2nd, 3rd, 4th and 6th: See the general physical examination - "Eyes".
5th - Motor: Masseter and temporalis muscles are of adequate bulk and strength. Lateral thrust of jaw is of adequate strength.
Sensory: Pin-prick and light touch are preserved over the entire face. The corneal reflexes are present.
7th - Motor: Facial movements are of full range and symmetrical.
- Sensory: Taste over anterior 2/3 of tongue is intact by history.
8th - Auditory: Weber and Rinne tests are normal.
- Vestibular branch: No nystagmus. Equilibration is normal.
9th and 10th - Motor: There is no difficulty in swallowing. Gag reflex is active. The uvula elevates normally on phonation.
- Sensory: Taste over posterior 1/3 of tongue is intact by history.
11th: The trapezius muscles are of adequate bulk and strength.
12th: The tongue lies in the midline both in the mouth and on protrusion. There is no atrophy or involuntary movement. Lateral thrust of the tongue is adequate and equal.

Motor Examination: Muscle groups show no evidence of atrophy, hypertrophy, weakness, spasm, involuntary movement or alteration of tonus. The extremities are well maintained in space.

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CLINICAL NOTES

Patient. Reverend Thomas P. Adamson Case No. 38191

 June 7, 1974

Reflex Status: Biceps, triceps, radial, ulnar, periosteal, quadriceps and Achilles tendon reflexes are active and symmetrical. There is no clonus. The superficial abdominal reflexes are present. Hoffmann's sign is not present. Plantar stimulation elicits a flexor response.

Sensory Examination: Light touch, pin-prick, joint position, and vibratory sensation are intact over the entire body. Two-point discrimination, graphesthesia, and stereognosis are unimpaired.

Cerebellar Function: Rapid-alternating movements, heel-to-knee, and finger-to-nose tests are well performed.

Meningeal Signs: No evidence of meningeal irritation.

Apraxias, Agnosias, Aphasias: Not present.

SUMMARY OF GENERAL PHYSICAL AND NEUROLOGICAL EXAMINATION: Normal examination.

DIAGNOSTIC IMPRESSION: Normal examination.

P. G. Stern, M.D./I-2

INSTITUTE OF LIVING

MENTAL STATUS

MR. THOMAS ADAMSON (38191) AGE 42 UNIT - FL 2
INTERVIEWED BY DR. J. CURRAN INTERVIEWED ON JUN 5, 1974

APPEARANCE

MR. ADAMSON APPEARS HIS STATED AGE. HE HAS AN ATHLETIC BUILD, IS TALL, IS WITHIN NORMAL WEIGHT LIMITS AND HAS NO APPARENT PHYSICAL DEFORMITIES. HE STANDS AND WALKS NORMALLY. HIS DRESS AND GROOMING ARE FITTING FOR THE OCCASION. THERE IS NOTHING ABNORMAL ABOUT HIS FACIAL FEATURES. THERE ARE NO DEFECTS IN HIS SPECIAL SENSES WHICH COULD CAUSE A BARRIER IN COMMUNICATIONS.

BEHAVIOR, ATTITUDES AND ACTIVITIES

MR. ADAMSON IS USUALLY COOPERATIVE. HE APPEARS EXTREMELY ALERT AND IS VERY OUTGOING. HIS MOTOR ACTIVITY IS UNREMARKABLE. HIS VOICE ALSO IS CONSIDERED UNREMARKABLE.

HISTORICAL INFORMATION REGARDING PHYSIOLOGICAL FUNCTIONS AND INITIATIVE

MR. ADAMSON REPORTS NO DISTURBANCES IN HIS SLEEPING AND EATING HABITS, INITIATIVE OR SEXUAL ACTIVITY.

MENTAL ACTIVITY, SPEECH AND THOUGHT

THE FORM AND CONTENT OF MR. ADAMSON'S SPEECH ARE UNREMARKABLE. THERE IS NO SUICIDAL IDEATION AND HE HAS NO DELUSIONS.

COGNITIVE FUNCTIONS

THE PATIENT'S ORIENTATION, SENSORIUM AND MEMORY ARE INTACT AND HIS ATTENTION AND CONCENTRATION ARE UNIMPAIRED. HIS DIGITAL SPAN IS 5 DIGITS BACKWARD AND 8 DIGITS FORWARD. HE PERFORMS SERIAL SUBTRACTION BY 7 AT AN AVERAGE SPEED; HE MAKES A FEW ERRORS. HIS INTELLIGENCE IS CONSIDERED TO BE SUPERIOR. THERE IS A MODERATE IMPAIRMENT IN SEXUAL RELATIONS.

DISORDERS OF PERCEPTION

THERE IS NO EVIDENCE OF ANY DISORDERS OF PERCEPTION.

AFFECTS

HIS PREDOMINANT AFFECT IS A MILD DEGREE OF FRIENDLINESS. THIS AFFECT IS CONSISTENT THROUGHOUT THE INTERVIEW AND IS CONSIDERED APPROPRIATE TO THE CURRENT SITUATION. HE IS ALSO SOMEWHAT ANXIOUS.

ADAPTIVE CAPACITY

HE DOES NOT INDICATE ANY DIFFICULTIES WITH HIS OBJECT RELATIONS. ELF-EVALUATION IS CONSIDERED REALISTIC. THERE ARE NO DEFICITS IN MR. DAMSON'S POTENTIAL FOR ADJUSTMENT. THE PATIENT SHOWS FAIR INSIGHT INTO IS ILLNESS AND IS FAIRLY WELL MOTIVATED REGARDING HIS NEED FOR TREATMENT.

J. CURRAN, M.D.

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