Declaration of Xavier F. Amador, Ph.D.

Nov. 16, 1997

I, Xavier Amador, Ph.D., decare as follows:

1. I am a clinical psychologist licensed to practice in the state of New York. I received a B.A degree in psychology from the State University of New York in 1982, a Masters degree in Clinical Psychology from New York University in New York City in 1987, and a Ph.D. degree in Clinical Psychology from New York University in 1989. I completed a clinical internship at the St. Luke's/Roosevelt Hospital Center in New York City in 1989, immediately after which I was appointed to the medical school faculty at Columbia University College of Physicians and Surgeons in New York City.

2.1 am currerttly an associate professor of psychology in the department of psychiatry at Columbia University College of Physicians and Surgeons, an adjunct associate professor of psychology in the doctoral program in clinical psychology at Columbia University's Teachers College and a Research Scientist at the New York State Psychiatric Institute. I am also the Director of the Diagnosis and Evaluation Center for Psychotic Disorders at Columbia University College of Physicians & Surgeons and Chief Division of Diagnosis and Assessment in the Department of Clinical Psycho-Biology at the New York State Psychiatric Institute. From 1989 to 1993 I was the Associate Science Director of the Schizophrenia Research Unit at the New York State Psychiatric Institute and Columbia University.

3. I am a standing member of a National Institute of Mental Health grant review committee (the Clinical Psychopathology Initial Review Group) that evaluates grant applications submitted by investigators studying schizophrenia and other mental disorders.

4. Since 1989 I have been the principal investigator on twelve research grant awards. These grants have been given by non-profit foundations and the National Institute of Mental Health. The studies supported by these awards have focused on improving the diagnosis of schizophrenia and illuminating the nature, causes and treatment of unawareness of illness in this disorder. I have also been a co-investigator and consultant on over 15 other schizophrenia research studies. In 1990 I received a grant from the American Psychiatric Association to support my work on the revision of the criteria for schizophrenia and related psychotic disorders in the Diagnostic and Statistical Manual for Mental Disorders, fourth edition (DSM IV). I was an expert schizophrenia consultant and a Field Trial Coordinator for the DSM lV revision. Also, I have been a consulting editor for sixteen scientific journals in the fields of psychiatry and psychology including several which are published by the American Medical Association, American Psychiatric Association and the American Psychological Association. I review papers almost exclusively in the area of schizophrenia and the common problem

of treatment refusal and unawareness of illness.

5. I supervise both clinical and research activities of medical students, psychiatric residents and post doctoral research fellows in the department of psychiatry at Columbia University College of Physicians and Surgeons in New York City. I also supervise doctoral psychology students conducting clinical and research work at the New York State Psychiatric Institute.

6. I have over fifteen years of hands on clinical experience working with patients with schizophrenia, first as an inpatient mental health therapy aid and outpatient counselor from 1982 through 1985 at the University of Arizona Health Sciences Center and at the Southern Arizona Mental Health Center, then as a student therapist in the doctoral program at New York University from 1985 through 1989 and finally, as an attending psychologist at the New York State Psychiatric Institute from 1989 to today. I am a New York State licensed psychologist in private practice.

7. Counsel for Theodore J. Kaczynski have requested that I convey to the court the information I have provided them about schizophrenia as well as the relevant research on unawareness of illness as this information relates to Mr. Kaczynski's inability to submit to an examination by government psychiatrists. They have also asked that I convey to the court my opnion on the nature, presence and severity of the mental disorder suffered by Mr. Kaczynski as it explains the reason he has refused the government's mental examination while allowing himself to be evaluated by defense mental health experts. I have formulated an opinion on these matters based on documents including numerous excerpts of Mr. Kaczynski's writings, the declaration of Dr. David Foster, the government pleading and exhibits filed 11/14/97 and the unredacted version of the exhibits filed with the government pleading, all of which were provided to me by his counsel over the last 72 hours.

8. First, with regard to Mr. Kaczynski's illness, he is typical of the hundreds of patients with schizophrenia that I have personally evaluated. The documented history of his illness is also consistent with reports in the clinical and research literature which involve tens of thousands of patients with schizophrenia. Like the overwhelming majority of males with schizophrenia, the prodromal phase of his illness began in his mid-twenties and was manifested by a significant degree of neglect in his grooming and hygiene and increased withdrawal from social relations. His writings show unambiguous evidence of delusions, another hallmark symptom of schizophrenia. From the material I have reviewed he clearly exhibits delusions of reference, bizarre delusions and paranoid delusions. The organization of his delusional beliefs and his well organized behavior in response to these delusions are consistent with the additional diagnosis of paranoid

subtype.

9. It is not necessary to have paranoid delusions to have paranoid schizophrenia. What is necessary is that the delusions are systematized: i.e., organized around a central theme. Or, that the patient is preoccupied with one or more delusions. Some patients with schizophrenia have delusions that are not thematically related to one another. For example, a patient of mine had a delusion that he was a Colonel in the Green Berets, that his rank was a government secret and that he had instant access to the president of the United States anytime he wanted. In addition to this grandiose delusion he also had a delusion of thought broadcasting. He believed that anyone could hear his thoughts as if they had been spoken aloud. He also insisted that he was once a tnember of a well known Rock and Roll band. One delusion had no obvious link to the others in his mind. In addition, he was extremely disorganized in his behavior. For example, at times he would shout out loud incoherently, he twice lit his apartment on fire accidently while smoking cigarettes and used to post notices on telephone poles in his neighborhood warning the public about his sister who he believed was a witch. In this instance the patient received a disorganized subtype diagnosis.

10. Mr Kaczynski, is capable of being extremely organized as evidenced by his journals and behavior. His symptoms and behavior are typical of patients with schizophrenia, continuos course, paranoid subtype. Mr. Kaczynski's symptom picture and behavior is not unique. Another patient of mine with the same diagnosis (schizophrenia, continuos course, paranoid subtype) had several delusions centered on the belief that the Central Intelllgence Agency was monitoring his every move because he was exceptionally intelligent and they wanted to study his intellect. In fact, this MIT graduate was very intelligent, but like Mr. Kaczynski, he had been incapable of maintaining social contact and had actually survived on the streets of Washington D.C. for over two years while homeless. Nearly anyone that he met would be incorporated into his delusional belief system which was elaborate but centered on the paranoid belief that he was being watched and might be abducted by government forces at any time. Research on delusions shows that certain major themes are common in patients vulnerable to this cognitive defect. When delusions turn to the paranoid type, the themes commonly involve government agencies and spiritual deities.

11. In most clinical settings the diagnosis of schizophrenia can be made with minimal direct patient interview. Usually, oniy about one to two hours of direct patient interview are required when other sources of information are available. In acute care clinical settings, the diagnosis is typically made with less than two hours of direct patient interview whenever sufficient written materials that speak to the patient's mental status and history of social and occupational functioning (e.g. medical records or patient journals) are available. State of the art research diagnoses typically involve no mare than four hours of direct patient contact. Instead, researchers rely on collateral information

from relatives, friends and others who have observed the subject for long periods of time, on written materials the subject may have produced over the course of months or years and on previous medical, work and school records.

12. Indeed, in patients like Mr. Kaczynski who present with paranoid thought content, direct patient interview longer than an hour or two may offer little if any additional information that is relevant to making the diagnosis. Because schizophrenia is a longitudinally based diagnosis, other sources of information such as a patient's writing's and work history can carry more weight than information gleaned from direct clinical interview. In other words, observations of the patient over the course of years is often necessary to make certain schizophrenia diagnoses. For example, a patient presenting with the exact same symptoms as Mr. Kaczynski could not be given the diagnosis of Schizophrenia, Continuous, Paranoid subtype if be had not evidenced these signs of illness for at least six months. Such a patient would more likely receive the diagnosis of Psychotic Disorder, Not Otherwise Specified or Schizophreniform disorder.

13. Second, as someone who conducts research in the area of schizophrenia, and in particular, on the common problem of unawareness of illness and treatment noncompliance, the most parsimonious explanation for Mr Kaczynski's refusal to submit to the Court's order for psychiatric evaluation is that he suffers from severe deficits in awareness of illness.

14. The government's suggestion in its 11/14/97 pleading - that Mr. Kaczynski has willfully defied the Court's order - demonstrate that the fact of Mr. Kaczynski's disease and his predictable resistance to being evaluated have not been understood in light of what those of us who conduct research on schizophrenia know to be true about this disorder.

15. Many people suffering from schizophrenia do not believe they have an illness and are unaware of the specific deficits caused by the disorder. Indeed, many of these individuals feel that the only thing they really suffer from is pressure from relatives, friends, doctors and courts to accept evaluation and treatment. Lack of insight frequently obstructs treatment, as disagreement that treatment is even necessary leads to patients feeling coerced to accept care for an illness they don't believe they have. Large scale studies have suggested that from fifty percent to more than eighty percent of all patients with schizophrenia do not believe they have an illness. These are not people who would be expected to agree to an insanity defense. Owing to its prevalence and disruption of the therapist-patient relationship, this type of discrepancy in perspective, or what is commonly labeled "poor insight" has become integral to our conception of schizophrenia.

16. My own research and that of others has demonstrated that a majority of patients

with the diagnosis of schizophrenia are not only unaware of illness generally, but also unaware of many of the specific signs and symptoms of schizophrenia that they currently have. Research shows that this type of unawareness results in medication noncompliance in patients who have been prescribed antipsychotic medications and in refusal of psychiatric evaluation by patients not currently in treatment. In fact, the research indicates that the majority of schizophrenia patients who are involuntarily hospitalized and receiving court ordered treatment evidence this type of awareness deficit.

17. On the face of it, schizophrenia patients who are unaware of their illness appear to be in denial or simply afrald of psychiatrists. Like Mr. Kaczynski, such patients are described as fearful of mental health professionals. Such descriptors are simply that, descriptions of behavior. They do not explain what we now know to be true about the causes of such behavior. Research shows that unawareness of illness in schizophrenia actually involves a deficit in one's capacity to become aware of changes in one's ability to function psychologically, socially and even physically.

18. Schizophrenia patients with severe deficits in unawareness are said to have an Anosognosia syndrome. Patient's with anosognosia usually believe that they do not have the illness that their doctors tell them they have.

19. Like Mr. Kaczynski, who is painfully aware of his severe social deficits and problems with insomnia, but unaware of his schizophrenia, patients with anosognosia will go to great lengths to preserve the self-concept they hold. Typically, their concept of themselves is literally stranded in time. They believe that they have many of the same capacities and abilities that they possessed prior to the onset of the illness. When observations are made by others that contradict the patients self concept (e.g. "you have schizophrenia"), the Anosognosia patient can become agitated, angry and vigorously refute the claim. It is the same type of reaction that most people would give when confronted with propositions that are experienced as insulting, threatening and/or ludicrous.

20. In stroke patients, this aspect of anosognosia is easier to understand. One stroke patient who I evaluated had suffered a stroke to the nondominant hemisphere of the brain. He was paralyzed on the left side of his body and had memory impairments. This patient was aware that he had problems with his memory but claimed that he was in the hospital because of compilcations from a hip replacement surgery he had undergone six months ago. At the time of the evaluation he did not know that his left arm and leg were paralyzed but did recognize that he was in the hospital and that his memory was not what it used to be. When asked to move his arm he became angry and said that he would not. He insisted that there was nothing wrong with his arm and leg and said that he didn't feel like it and that the request was absurd. This type of response is called a confabulation and is typical of patients with anosognosia.

Confabulations occur whenever a patient is confronted with information about himself that is grossly at odds with his self-concept. Eventually, this patient angrily demanded that the examiner leave the room.

21. Particular brain areas implicated in anosognosia in stroke patients provided psychiatric researchers like myself, with a practical starting point for generating hypotheses about neuropsychological contributions to anosognosia in schizophrenia. Dysfunction of the frontal lobes and the non-dominant hemisphere temporal parietal system, specifically implicated in anosognosia in stroke, have been demonstrated in many patients with schizophrenia. Three published studies have found various aspects of unawareness of illness to be strongly correlated with poorer performance on neuropsychological tests sensitive to frontal lobe dysfunction. We have data which replicate these findings.

22. Dr. Karen Froming completed an extensive neuropsychological evaluation of Mr. Kaczynski. My initial review of the summarized results of the testing revealed mild frontal lobe impairment and nondominant hemisphere dysfynction. This pattern of neuropsychological test results is consistent with anosognosia in schizophrenia. In addition, Mr. Kaczynski evidenced significant deficits in his ability to perceive affect. Recent studies have shown a strong relationship between deficits in the ability to process affect and anosognosia in schizophrenia.

23. The government's assertions in the pleading filed 11/14/97, do not offer any clinically defensible basis for disputing either the fact of Mr. Kaczynski's schizophrenia, or that his inability to submit to an examination is a function of the illness. Mr. Kaczynski suffers from anosognosia and that is the primary reason he has refused the court ordered evaluation. His refusal to submit to the court ordered evaluation is typical of patients with schizophrenia who will nevertheless endure circumscribed evaluation by other doctors for specific aspects of the illness (e.g. insomma, depression, social isolation) that the patient recognizes.

24. This type of seemingly contradictory behavior is a hallmark of anosognosia in schizophrenia. It reflects brain dysfunction rather than a calculated plan to manipulate authority for personal gain. Indeed, it appears from the government's motion that Mr. Kaczynski's refusal to submit to the ordered evaluation has worsened his legal situation considerably. If the patient with anosognosia does not perceive the evaluation as a challenge to his self-concept (his understanding of his innate capacities and abilities), he will usually submit without argument. Undoubtedly, that is likely the reason that Mr. Kaczynski submitted to a neuropsychological evaluation. It did not threaten his self-concept.

25. Compounding the problem is the fact that Mr. Kaczynski's delusional system is classically paranoid both in its organization and content. As I mentioned above, it is

common for paranoid delusions to be constructed around fear of government agencies. It is not at all surprising, in my experience, that Mr. Kaczynski with his paranoid delusions would refuse an evaluation demanded by a government agency that seeks his death. Given the number and type of paranoid delusions held by Mr. Kaczynski it is my opinion that he would be incapable of trusting the truthfulness and moral integrity of anyone representing the government.

26. Although schizophrenia is caused by brain dysfunction, it is not the same pattern or type of dysfunction that leads to other central nervous system disorders like mental retardation or Alzheimer's disease. The brain areas affected are unique. Patients with schizophrenia can have above average intelligence. More generally, one can have brain impairment, deficits in certain functions, without evidencing general cognitive deterioration. The main point here is that high IQ is not mutually exclusive with either the diagnosis of schizophrenia or anosognosia.

27. In summary, reluctance to submit to psychiatric evalutions and treatment are a hallmark of schizophrenia. Mr. Kaczynski's willingness to seek help with his insomnia and social deficits has no bearing on his capacity to submit to a psychiatric evaluation. It is like comparing apples to oranges.

The foregoing is true and correct and executed under peaalty of perjury under the laws of the United States of America on this 16th day of November, 1997.

XAVIER F. AMADOR, Ph.D
(signature)

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