Defending the Unabomber: Anosognosia in Schizophrenia

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Contents

The use of recent psychiatric research in the defense of the 'Unabomber' (United States vs. Theodore Kaczynski) is a compelling example of how the gap between research and practice can have profound consequences on the practice of forensic psychiatry, psychology and the judicial process. In this case, educating the lawyers and the court about the research on poor insight in schizophrenia changed the defense strategy and ultimately the course of the trial.

Over the last decade, we have been studying poor insight in schizophrenia (1-8). We have conceptualized insight, the patient's unawareness of his illness, as a multidimensional phenomenon, which encompasses both a lack of awareness of having a mental disorder and/or the signs of a mental disorder. The studies have looked at phenomenology, prognostic value, nosological utility and etiology of poor insight in schizophrenia. In particular, recent research has indicated that the etiology of poor insight is not only due to defense mechanisms but also linked to neurological deficits.

This paper will summarize the research on poor insight in schizophrenia that was relevant to the case and describe its application within the particular legal context. Despite the overwhelming evidence against Theodore Kaczynski, with his best alternative being a "not guilty by reason of insanity" defense, he refused to be examined by state psychiatric experts for fear of being declared a "sickie." His refusal to be evaluated resulted in the prosecuting attorneys petitioning the court for sanctions. In particular, they wanted to prohibit the use of any mental illness evidence during the guilt/innocence and mitigation phases of the trial. Given that the evidence against Mr. Kaczynski was overwhelming, a mental illness defense was arguably his only hope of escaping the death penalty. Yet he did not want to be evaluated and was blocking his lawyers attempts to put on an insanity defense. This created several legal quagmires and accusations that Mr. Kaczynski was strategically manipulating the court in order to throw the proceedings into disarray.

His refusal to be evaluated and put on a mental illness defense can more easily be understood in light of the research literature on insight. In most cases involving people with schizophrenia, severe deficits in illness awareness and the irrational compulsion to prove one's 'sanity' despite life threatening consequences, are a consequence of brain dysfunction rather than manipulation or defensiveness. It was anosognosia, a neurological condition that results in the type of unawareness just described, that kept him from complying with the court order to be examined by experts, as opposed to manipulation or a willful violation of the judge's decree.

Anosognosia in Schizophrenia

The high prevalence of unawareness of illness in schizophrenia has been replicated in several studies. This remains true whether insight is viewed as a simple or unitary phenomenon of whether a person believes he/she has an illness or not, or a complex multidimensional phenomenon. The International Pilot Study of Schizophrenia (9), a multinational and cross-cultural study conducted for the World Health Organization found that 81% of 811 patients deny that they had an illness. A second multinational study by Wilson et al. (10) of more chronic patients with schizophrenia found that 89% of the 768 patients denied they had an illness. We replicated the main results of these studies finding that nearly 60% of 221 patients with schizophrenia did not think they were ill (4). Unlike the two previous studies which simply asked patients if they believed they were ill, we used an assessment procedure that measured many of the component dimensions of insight into illness. The Scale to assess the Unawareness of Mental Disorder (SUMD) assesses *unawareness of illness* generally, and unawareness of treatment response and specific signs and symptoms. The scale also measures *attributions* for symptoms. In addition to finding that a large proportion of patients in the sample did not believe they were ill, we also reported that patients showed significant deficits in awareness of their different symptoms. Of note is that insight can be modality specific. In other words, one can have insight into some aspects of the illness while lacking awareness of others. For example, we found that some patients were unaware of hallucinations and flat affect, but aware that they suffered from delusions. Other studies, that examined relationships between unawareness of tardive dyskinesia and unawareness of illness in schizophrenia, add further evidence that insight can be "spotty" (11-14).

In addition to being common in schizophrenia, poor insight is associated with noncompliance with treatment, involuntary commitment and poorer course of illness (1,8,15-17). In a previous paper, we found evidence suggesting that the etiology of poor insight was complex. In most cases involving patients with schizophrenia, psychological defense played a small role, but accounted for very little of the variation in insight. Neuropsychological deficits, on the other hand, were highly correlated with lower levels of insight (18).

Prior to 1990, poor insight in schizophrenia was commonly viewed as a defensive function. As such, it should be associated with positive symptoms of psychosis. However, the empirical research does not support this link even when the relationship between insight and delusions have been examined (4,19,20). More direct evidence of the relations between insight and neuropsychological function exists. Prior to review-

ing these data, a brief word about the proposition that poor insight in schizophrenia is better understood as anosognosia is in order.

Poor insight in schizophrenia bears remarkable similarities to anosognosia in neurological disorders. Patients with schizophrenia who have poor insight, and neurological disorder patients with anosognosia, exhibit the following characteristics: a very severe lack of awareness of their illness, the belief persisting despite conflicting evidence, confabulations to explain the observations that contradict their belief that they are not ill, and a compulsion to prove their self-concept.

Neurological patients with anosognosia of hemi-paresis behave as though they know nothing about the paralysis. They persist, despite irrefutable evidence to the contrary, in the belief that their paralyzed limbs are normal. In one study (7) we evaluated a 71 year old male patient with a right posterior lesion who was unaware of motor impairments, left hemineglect, and left hemi- sensory loss, yet he believed the reason for his hospitalization was a hip replacement. Similarly, a 26 year old man with an 8 year history of chronic schizophrenia was involuntarily committed during a psychotic episode and gives the following reason for his hospitalization in a psychiatric ward, "*I think that's all they have available now, a psychiatric ward because of the heavy drug and alcohol uses that is going on.*" Both patients offer confabulations to explain away the evidence that contradicts their beliefs. Another feature of anosognosia is that patients have varying degrees of insight into different aspects of their illness and symptoms. In the case of the 26 year old schizophrenia patient, he had poor insight about the reason for his hospitalization, yet he displayed insight into his thought disorder.

Most studies find that lesions to the nondominant hemisphere and frontal lobes are implicated in anosognosia (1). Many studies have found that patients with schizophrenia show deficits on tests of frontal lobe function and hypofrontality on functional neuroimaging. At the time of the Unabomber trial, the hypothesis that awareness deficits in schizophrenia stem from frontal lobe dysfunction rather than psychological defensiveness had gained considerable currency. More than a dozen studies using insight measures with demonstrated reliability and validity have been published confirming the hypothesis (21-32). Most, though not all, of these studies have found this relationship to exist independent of variations in I.Q. Only three published studies have not found the hypothesized relationship between level of insight and frontal lobe function. However, because these studies measured very different aspects of unawareness than the studies cited above, and one of the studies had low statistical power, they are not considered failures to replicate.

In summary, the research on poor insight in schizophrenia indicates that it is very common in this disorder, it is complex and multidimensional, predictive of noncompliance, a poorer course of illness, and is linked to front lobe dysfunction. Indeed, it can easily be argued that in most cases the term "poor insight" is a misnomer when applied to individuals with schizophrenia and the diagnosis of "anosognosia" should be used instead.

Applicability of the Research in the Case of United States Vs. Theodore Kaczynski

In this section, we will first outline the basic facts of the case and then illustrate how the defendant's paradoxical behavior exhibited the characteristics of anosognosia in schizophrenia, and how the scientific research was used to elevate the defense attorney's and the court's understanding of the mentally ill defendant they were dealing with.

In November 1997, Theodore Kaczynski, infamously known as the "Unabomber," was being tried for bombings spanning nearly a decade that killed 3 people and injured 23 across the United States. He had a long history of mental illness. The evidence against him was overwhelming, which included his own diaries spanning twenty years that gave details of the bombs and to whom they were destined. He agreed to be evaluated by four defense experts, psychologists and psychiatrists, in order to 'prove' he was sane, but he refused to be evaluated by the state's experts. The judge ruled that he must comply. The prosecutors moved for sanctions against entering any mental illness evidence claiming that Kaczynski was manipulating the court.

The defense initially argued that Kaczynski's phobia of psychiatrists was causing him not to comply. An excerpt from the defense expert's, Dr. Vernon Foster's declaration to the court was as follows, "*An essential component of Mr. Kaczynski's brain disorder is his deeply ingrained fear of being considered mentally ill. The series of meetings I held with Mr. Kaczynski were for the purpose of serving as liaison between him and his counsel to encourage Mr. Kaczynski to explore the mental health issues involved in his case. I approached the meetings mindful from his writings and background that Mr. Kaczynski had expressed a perception of psychiatrists as agents of a science of the brain given to mind control and personality alteration. In Mr. Kaczynski's perception, psychiatrists seek to eliminate free will and personal autonomy by creating a population that is wholly compliant with the needs of an omnipotent system. A significant feature of Mr. Kaczynski's illness is his pathological fear and compulsive aversion to evaluation by psychiatrists.*" The prosecution, to their credit, proceeded to find evidence that Kaczynski did consult with psychiatrists in the past on issues of insomnia and interpersonal relationships with women. They argued that the so called 'phobia' was a manipulation as clearly the defendant was not afraid of mental health professionals as evidenced by letters he had sent to various doctors and therapists over the years.

The judge in the case, according to court documents, was seriously considering granting the prosecution the sanctions requested. Mr. Kaczynski's attorneys would not be able to enter any expert testimony on the defendant's mental illness at any point in the trial. The defense was cornered as they argued that Kaczynski was terrified of psychiatrists yet here was evidence that he had consulted with them in the past.

Upon learning of the legal arguments being made, one of us (XFA) contacted Mr. Kaczynski's lawyers to inform them that there was research they may not be aware of that was highly relevant to their client's behavior. The defense attorneys were contacted, rather than the prosecution, because they were trying to understand and explain their client's refusal to be evaluated. Upon learning of the research on anosognosia in schizophrenia, and how it applied to their client, they changed their argument. They now argued that it was his mental defect that caused him to disobey the Judge's order, not a phobia per se. The Judge appeared persuaded and was considering allowing mental illness evidence when Mr. Kaczynski's anosognosia caused him to throw the proceedings into chaos once again. Upon learning that his lawyers were arguing vehemently for the right to put on an insanity defense, Kaczynski moved to have them fired and asked to be allowed to defend himself. Under no circumstances did he want to be portrayed as mentally ill.

This new impasse was settled when the judge ruled that he could neither fire his lawyers nor defend himself. The court then appointed an independent expert, Dr. Sally Johnson, to examine him. Mr. Kaczynski agreed to this evaluation because he was eager to prove that he was competent to stand trial, competent to defend himself, and not mentally ill. However, Dr. Johnson found that Mr. Kaczynski had paranoid schizophrenia *and* was competent to stand trial. At this point in time, it looked as if the trial would proceed with the original defense counsel in place. An independent expert had diagnosed the defendant with schizophrenia and the judge was still considering the defense argument that Mr. Kaczynski suffered from anosognosia. It was at this point that the prosecutors moved to offer him life in prison. This plea bargain had not been offered previously despite impassioned pleas from Mr. Kaczynski's brother, David Kaczynski, who had alerted authorities that his beloved brother might be the Unabomber.

On January 21, 1998, Theodore Kaczynski agreed to the plea bargain offered by the government. Court documents record that he agreed to the sentence to avoid a capitol trial, but given his feelings and beliefs about being mentally ill, it is probably more accurate to say that he chose life in prison over having to endure an insanity defense. Nevertheless, the press reported what most mental health experts who evaluated him had opined: that he was indeed mentally ill. Having to once again face the specter of being portrayed as mentally ill, Kaczynski asked for a new trial. In October 1999, the 9th U.S. Circuit Court of Appeals said it would consider Kaczynski's appeal that he was coerced into pleading guilty, that he should have been allowed to defend himself without a lawyer, and that he had a right to bar his court-appointed lawyers from presenting a defense based on mental impairment. The appeal was ultimately denied.

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