Declaration of Karen Bronk Froming, Ph.D.

Nov. 17, 1997

I, KAREN BRONK FROMING, Ph.D., declare as follows:

1. I am a clinical psychologist licensed to practice in the State of California. I specialize in clinical neuropsychology and neuropsychological assessment. I have received training in this speciality in accordance with the standards of the American Psychological Association (APA), Division 40. I am a member in good standing of the APA, and its subspecialty division of clinical neuropsychology.

2. I am a member of the International Neuropsychological Society, the National Academy of Neuropsychology, American Psychological Society and Division 40 (Clinical Neuropsychology), and the California Psychological Association. I am the former chair of the Education Committee of the Northern Califomia Neuropsychology Forum, a position I held in 1993-1994 and in 1990-1991, and a past president (1991-1992) of that organization as well.

3. In 1979, I received my B.A. degree in psychology from the University of Florida. Shortly after graduation, I received training in neuropsychological assessment at the Shands Teaching Hospital and J. Hillis Miller Center Psychological Clinic. As a trained neuropsychological technician, I administered and scored neuropsychological tests and provided neuropsychological services to over 300 patients.

4. In 1984,I received my M.S. in psychology from the University of Florida. From 1986 through 1987, following two years at Shands Teaching Hospital, I completed my pre-doctoral internship training at the San Francisco Veteran's Administration Center. In 1988, I successfully defended my dissertation and received a Ph.D. in psychology from the University of Florida. I was awarded a post-doctoral fellowship in neuropsychology in the Department of Clinical and Health Psychology at the University of Florida and received advanced training in behavioral neurology, behavioral brain syndromes, neuroanatomy, neurophysiology, memory disorders, and aphasiology or language disorders.

5. My past positions included the following duties: Director, Behavioral Medicine Unit, in the Division of General Internal Medicine at the University of California-San Francisco School of Medicine; Staff Psychologist Ill and Triage Coordinator; Consulting Neuropsychologist with the Langley Porter Psychiatric Institute's Psychological Assessment Unit; Assistant Clinical Professor of Medicine and Psychiatry at the University of California-San Francisco; and Adjunct Faculty Member at the Pacific Graduate School of Psychology.

6. In connection with my duties at the University of California-San Francisco School of Medicine, I was responsible for accepting, evaluating and assigning for treatment patients suffering from organic and/or psychiatric complaints. The department for

which I was responsible handles several thousand patient visits per year. I established the first neuropsychological assessment subspecialty service within our department.

7. l am currently in private practice in San Francisco, California. I have continued faculty appointments in the Department of Psychiatry at the University of California-San Francisco. I continue to teach both at the Langley Porter Psychiatric Institute and at San Francisco General Hospital.

8. I was asked by the attorneys for Theodore J. Kaczynski to evaluate his neuropsychological development and functioning. In order to accomplish these goals, I reviewed voluminous background materials including but not limited to Mr. Kaczynski's correspondence and his journal entries related to his own thoughts, his relationships with others, and his relationships with family members. I also reviewed documents regarding his academic, work, and medical history, including his requests for psychological, psychiatric, and counseling services and information.

9. I met with Mr. Kaczynski on two occasions, once to administer a battery of tests and on a second visit to explain test results to Mr. Kaczynski. Upon an initial introduction, Mr. Kaczynski was unable to acknowledge my presence. He was quite anxious, manifested by pressured speech, focus on those present who were known to him, lack of eye contact, and a total avoidance of the half of the room where I sat. After we were introduced, he still averted his gaze, and became preoccupied and distracted by insignificant details as I explained the testing procedures.

10. Mr. Kaczynski was intent on doing well on the testing and assured me there was nothing wrong with him. He acknowledged that he had limited social contacts in his life and no satisfactory long-term relationships, but explained he had chosen that path and it was not the result of any neurological deficit. The explanations for his chronic social isolation which he offered during the testing were clearly contradicted by Mr. Kaczynski's writings that document his despair over both his inability to establish normal human relationship and his inability to comprehend why he has been unable to do so.

11. The results of the neuropsychological testing revealed deficits of a mild nature in the areas of frontal and cerebellar motor functions, microsomia or smell functions, cognitive processing efficiency, visual memory, and affective processing. In the context of Mr. Kaczynski's superior intellect, these mild deficits are noteworthy, especially in their relation to the significant impairments in his social-emotional processing abilities. In particular, the closer the crucial task came to replicating "real-world" social interaction with its multilayered complexity, the greater difficulty Mr. Kaczynski had

in performing the task.

12. My findings are based solely on the objective data provided by Mr. Kaczynski's test performance. These findings, however, are also consistent with the research data regarding neurologic dysfunction in schizophrenia, my clinical impression of Mr. Kaczynski, his thoroughly documented life history, and personality testing administered during Mr. Kaczynski's late adolescence. Mr. Kaczynski's responses on the Minnesota Multiphasic Personality Inventory while he was still a sophomore at Harvard, show clinically elevated scales of social isolation and an overall profile which has been correlated to a predisposition for schizophrenia.

13. My own testing was authorized by Mr. Kaczynski only because he believed that it would prove that he did not suffer from any neurological deficit impairing his social functioning. He was surprised and dismayed when this examiner provided him with the test results which showed that neurological impairments affected his ability to recognize and interpret the meaning of non-verbal social communication. Mr. Kaczynski stated that he had been hopeful he could use my data to support his assertions that he was neurologically intact, and instead, I had offered contrary conclusions. He informed me in writing the very next day that he would no longer need my professional services.

14. My clinical experience is consistent with Mr. Kaczynski's clinical presentation and his unawareness of his disease. Individuals suffering from pervasive paranoid ideation view the world as a threatening place, and any difference of opinion that is offered, including that the individual might be ill, is viewed as further evidence that the outside world is a dangerous and untrustworthy place. Frequently, it is my experience that patients are unable to acknowledge the most severe aspects of the illness, but may recognize discrete symptoms such as insomnia and depression. Clinical experience and research literature report that insomnia and depression are frequent features of schizophrenia. It is clinically significant that while Mr. Kaczynski has made attempts to seek help for these aspects of his illness (as reflected in his 1988, 1991 and 1993 correspondence), he did not want to meet personally with psychologists or psychiatrists, preferred to be diagnosed after he had reported his perceived symptoms (or self-diagnosed), and wanted to receive therapeutic treatment through the mail.

15. The scientific literature also recognizes the combination of mild to moderate neuropsychological deficits in the domains of frontal/cerebellar motor skills, smell functions, temporal lobe functions of memory, reasoning, and affective processing as a neurologic profile correlated to schizophrenia. More recent neuropsychological studies have isolated the neurological basis for schizophrenia patients' inability to recognize their illness. Mr. Kaczynski's superior intellect should not be confused with sound mental health. while his intelligence enables him to think in more elaborate

and convoluted ways, and to appear verbally intact superficially, his inferences and logic are clinically distorted. A wealth of congruent social and medical historical data support the diagnostic impression that Mr. Kaczynski suffers from schizophrenia, paranoid subtype, and offers a more revealing clinical picture than he is able to disclose in a clinical interview.

The foregoing is true and correct and executed under penalty of perjury under the laws of the United States of America on this 17th day of November, 1997.

KAREN BRONK FROMING, PH.D.
(signature)

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