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## Life, Death, and IQ: It's Much More than Just a Score: Understanding and Utilizing Forensic Psychological and Neuropsychological Evaluations in Atkins Intellectual Disability/ Mental Retardation Cases

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**LIFE, DEATH, AND IQ: IT’S MUCH MORE THAN  
JUST A SCORE: UNDERSTANDING AND  
UTILIZING FORENSIC PSYCHOLOGICAL AND  
NEUROPSYCHOLOGICAL EVALUATIONS IN  
ATKINS INTELLECTUAL DISABILITY/MENTAL  
RETARDATION CASES**

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In 2002, the U.S. Supreme Court held in *Atkins v. Virginia*<sup>1</sup> that the Eighth Amendment forbids the execution of anyone who suffers from mental retardation. The presentation of *Atkins* claims is a detailed and ambitious undertaking for attorneys, but a necessary one. It requires tremendous preparation involving many hours of consultation with your expert forensic psychologists, neuropsychologists, and/or psychiatrists. If, as the lawyer, you do not truly understand what the psychologist has to offer, you cannot properly present this information. Moreover, failure to possess an intricate understanding of every facet of the psychologist's effort will hamper your ability to properly challenge the competing opinion advanced by the state's psychologist. Success lies in obtaining fully committed expert witnesses.

<sup>1</sup> *Atkins v. Virginia*, 536 U.S. 304 (2002).

Trial judges and jurors have (typically) no formal training in the area of mental retardation (“MR”), now referred to as Intellectual Disability (“ID”). As fact-finders, they can fall prey to the same misconceptions about mental retardation found in the general public. Contrary to popular belief, one cannot tell if someone is intellectually disabled merely by looking at them. Upon first glance, they do not necessarily look different, act different, or talk different. Those with mild MR blend into society and appear to function normally in the community as compared to the more severe forms of MR, who will always “stand out” because of their physical anomalies and severely global intellectual and adaptive behavior deficits.<sup>2</sup> Those suffering from ID possess strengths along with limitations. Some can live independently, drive a car, and maintain gainful employment, even graduate from high school. They can engage in meaningful interpersonal relationships, sell drugs, and join gangs. Thus, it is imperative that the judge and/or jury be educated about ID and relieved of their false preconceptions about those so afflicted.

There are five categories of ID, being: mild, moderate, severe, profound, and unspecified.<sup>3</sup> Of persons suffering from MR, 85% of those fall in the “mild mental retardation” category.<sup>4</sup> Most criminal defendants who have ID will function in the upper end of these five categories and will be mild MR.<sup>5</sup> Those with mild MR can acquire academic skills up to approximately the level of a sixth grader.<sup>6</sup> By adulthood, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance and assistance, especially when under stress. With appropriate support, individuals with mild MR can usually live successfully in the community, either independently or in supervised settings.<sup>7</sup>

As difficult as it is for judges and juries to learn the truths about ID, it is the duty of the attorney to educate the fact-finder. It is imperative judges and juries become educated about ID and relieve themselves of their own false preconceptions about those with ID. In order for attorneys to do so, attorneys must first be educated to *Atkins* and its progeny, the psychological standards for assessing ID found in the AAIDD, and the standards and practices for potential defense and prosecution expert witnesses.

This article highlights best practices for assessing MR and ID in capital cases with an emphasis on *Atkins* trial preparation and potential problems the authors have noted through experience. These best practices in *Atkins* hearings concern issues for the lawyers, forensic psychologists, and neuropsychologists, which include:

1. Practice effects and IQ testing

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<sup>2</sup> Frank M. Gresham, *Interpretation of Intelligence Test Scores in Atkins Cases: Conceptual and Psychometric Issues*, 16 APPLIED NEUROPSYCHOLOGY, 91-97 (2009).

<sup>3</sup> AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 42-44, (4<sup>th</sup> ed. 2000).

<sup>4</sup> *Id.* at 43.

<sup>5</sup> See USER’S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 18 (American Association on Intellectual & Developmental Disabilities ed., 10<sup>th</sup> ed. 2007).

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

2. Consistency of IQ scores over time
3. Flynn Effect
4. Malingering versus cognitive suboptimal effort
5. Lack of records indicating pre-age 18 diagnosis of MR/ID
6. Retrospective assessment of adaptive behaviors
7. Death row trends of increasing IQ over the years while incarcerated
8. Maladaptive behaviors versus symptoms of conduct disorder and antisocial personality disorder
9. There need be no nexus between an *Atkins* finding of mental retardation and the adaptive behavioral aspects of criminal and homicidal behavior
10. Potential bias of collateral informants
11. Cultural issues inherent in IQ and adaptive testing
12. Considering the utilization of different experts within a particular case, i.e., assessment of adaptive functioning versus assessment of intelligence
13. Videotaping assessments
14. Litigation strategies expanding MR/ID findings

Due to the length requirement of this article, some of these issues will be addressed and not to the extent of their respected complexities. The terms “intellectual disability” and “mental retardation” will be utilized interchangeably throughout this article. Finally, we will utilize the terms “forensic and clinical psychologist,” “forensic and clinical neuropsychologist,” and “forensic psychiatrist” as experts utilized in *Atkins* cases. Our primary focus will be on the first two due to their assessment skills and training in intellectual and adaptive testing and neuropsychological testing.

## I. STANDARDS FOR *ATKINS* HEARINGS

### A. *The Definition of MR/ID*

The American Association on Intellectual and Developmental Disabilities distributes a manual known as the AAIDD 11<sup>th</sup> Edition (2010). This manual, known as “the green book,” is standard text for which ID is assessed, diagnosed, and treated. The AAIDD defines ID as “a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18.”<sup>8</sup> Under the DSM-IV-TR (2000), MR diagnosis includes three criteria:

1. Significantly sub-average general intellectual functioning;
2. Significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety;

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<sup>8</sup> THE AAIDD AD HOC COMMITTEE ON TERMINOLOGY AND CLASSIFICATION, INTELLECTUAL DISABILITY: DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 5 (11<sup>th</sup> ed. 2010).

3. Onset must occur before age 18.<sup>9</sup>

A more thorough discussion of these three criteria is discussed below.

*B. The Legal Standard is the Psychological Standard*

Forensic psychologists, forensic neuropsychologists, and forensic psychiatrists evaluate a myriad of psycholegal issues such as insanity, diminished capacity, and competency to stand trial. These legal referral questions reflect statutory criteria that is legally based, being – insanity, the wrongfulness and inability to appreciate or conform behavior to the requirements of the law, as well as competency – the ability to understand the nature and the objectives of the legal proceedings and ability to assist in one’s defense. The expert is asked to assess the defendant’s psychiatric, cognitive and neuropsychological functional abilities and apply these deficits and impairments to legal criteria.

In contrast, an *Atkins* claim is unique, as the legal determination reflects the diagnostic requirements of MR/ID pursuant to the American Association of Mental Retardation (AAMR), now American Association on Intellectual and Developmental Disabilities (AAIDD), and the American Psychiatric Association’s (APA) Diagnostic & Statistical Manual (DSM-IV) for mental disorders.<sup>10</sup> As a consequence, a defendant’s IQ, adaptive functioning scores, and ultimate psychiatric diagnosis will determine the defendant’s fate, rather than an application of psychiatric diagnoses to legal terms such as “mental abnormality,” “rational,” “wrongfulness, and “appreciate.” Accordingly, forensic psychologists, forensic neuropsychologists, and psychiatrists play even a more profound role in the evaluations and ultimate legal dispositions of these MR/ID capital claims.

*C. Evolving Standards of Practice*

An *Atkins* evaluation, similar to a capital mitigation evaluation, has literal life and death consequences. The AAIDD and DSM policies, manuals, and recommendations primarily concern the clinical assessment of mental retardation with goals of assessing an individual’s needs and supports, not sentencing determinations. With this said, an *Atkins* evaluation brings the fields of clinical psychology, forensic psychology/neuropsychology, and psychiatry together. Therefore, an *Atkins* expert should be competent in both the clinical assessment of mental retardation and the forensic psychological legal arena.

Few expert witnesses have specialized training and education in the fields of forensic psychology, forensic neuropsychology, and mental retardation for example. Instead, clinical and educational psychologists specializing in the assessment of ID will testify in an *Atkins* hearing with little courtroom experience, and similarly, many forensic psychologists/neuropsychologists will be requested to evaluate ID cases with less career clinical experience in the assessment of ID. It is extremely important to fully scrutinize the educational and professional experience of the so-called expert(s). You may well find that the state’s expert has spent the majority of his or her career doing work unrelated to the determination of ID. Moreover,

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<sup>9</sup> AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4<sup>th</sup> ed. 2000).

<sup>10</sup> *Id.*; AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4<sup>th</sup> ed. 2000).

competent defense counsel requires a review of any and all peer reviewed publications and prior testimony attributed to the expert psychologist regarding ID evaluations. You may encounter statements in such articles and/or testimony which are at odds with opinions offered in your case. Such inconsistencies are areas for cross-examination.

Whenever possible, the defense should employ psychologists possessing board certification in forensic psychology and/or neuropsychology, and appreciate the significance of board certification by the American Board of Professional Psychology (ABPP). ABPP Board Certification is not a mere honorary designation, but a status earned through the psychologist's investment of substantial time and effort. Similarly, defense counsel must investigate whether any expert has affiliation with "vanity boards" taking the appearance of board certification but are simply dues paid to an organization that provide meaningless status. Finally, the defense team should consider multiple culturally competent experts suited to effectively evaluate the unique needs of individual intellectually disabled clients.

*Atkins* hearings should ensure fairness in the evaluation and adjudication of ID in capital cases. Therefore, the experts must strive to provide the most ethical, evidence based, and high quality mental retardation evaluations. Ideally, differences in expert opinion may be resolved justly and with reasonable accuracy based primarily on the science and secondarily on clinical judgment. On the other hand, it would be naïve to believe certain experts employed by the state are incapable of approaching their work with a particular mindset supporting the position of the state. As will be discussed later, opportunities present themselves whereby the psychologist(s) make subjective choices which impact upon his or her ultimate opinion.

Competent presentation of an *Atkins* claim is a work intensive proposition. The defense lawyer must understand the role and methods of the forensic psychologist/neuropsychologist(s) and have a working knowledge of all collateral material and testing data. The full commitment of your expert to the case is an absolute necessity. The forensic psychologist and neuropsychologist is not an advocate for the client, but is an advocate for his or her opinion. A good expert is only worth his or her weight when they can assist the attorney in the presentation of an *Atkins* claim through direct testimony *and* through cross-examination of the state's psychologist. Once an expert's report is submitted it is difficult for the witness to vary from the formal report during testimony. The report, in effect, becomes a prior statement from which testimony cannot significantly vary without consequence for the witness.

#### *D. Thoroughly Defining ID/MR in Light of Atkins*

The U.S. Supreme Court left the psychological assessment and legal procedure related to *Atkins*' claims as an open question for the states to decide, resulting in potentially different diagnostic criteria across jurisdictions.<sup>11</sup> However, the Supreme Court intended for the states to adhere to the clinical definition of ID as a clinically

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<sup>11</sup> Kay B. Stevens and J. Randall Price, *Adaptive Behavior, Mental Retardation and the Death Penalty*, 6 JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE, no. 3, 2006, 1-29.

diagnosable disorder rather than a legally constructed definition such as insanity, which assesses functional impairments and diminished responsibility.<sup>12</sup>

Of the eighteen state statutes outlined in *Atkins*, seventeen of them exclusively use clinical definitions of MR from the AAMR and DSM-IV.<sup>13</sup> However, a recent survey noted that out of the thirty-five states that permit the death penalty, only eleven of them define ID using accepted clinical standards.<sup>14</sup> For example, many of the states do not provide specific cut-off IQ scores and adaptive functioning limitations requirements, whereas some do. This means a defendant could be found ID in one state and not another. It is the first author's experience that the courts are inclined to follow the clinical definitions of mental retardation outlined by the AAIDD and DSM-IV-TR, as well as respective state supreme court case law when determining whether a particular defendant qualifies for ID.

While most states follow the three prong MR/ID criteria laid out by the AAIDD and DSM-IV-TR (significant sub average intellectual functioning; significant sub average adaptive functioning; and onset before age eighteen), central to this paper is the fact that these legal/clinical definitions of mental retardation (and the subsequent case law) often do not address the real complicated nuances of ID assessment. These nuances, which are essential issues in an *Atkins* hearing include the following: practice effects, error of measurement, lack of records and definitive diagnosis before age eighteen, assessment of maladaptive behaviors, retrospective assessment of adaptive behaviors, cognitive effort and malingering assessment, etc.

*Atkins* claims are driven by the creative litigation of defense teams who are thinking outside the box. They are doing so by exploring the disabilities in reasoning, judgment, verbal and language skills, memory, attention, and impulse control that affect many defendants who are on the cusp of the criteria for a diagnosis of MR/ID. For example, the California Supreme Court upheld a lower court's decision that mental retardation is not measured according to a fixed intelligence score or a specific adaptive behavior deficiency, but rather an individual's overall capacity based on the consideration of all of the relevant evidence.<sup>15</sup> Specifically, the lower court emphasized the Verbal IQ scores as carrying more weight than the Full Scale IQ score because verbal skills are especially related to issues of premeditation, deliberation, appreciation of concepts of wrongful conduct, ability to think and weigh reasons for doing things, logic, and foresight.

#### *E. Utilizing Neurology and Neuropsychological Testing in Atkins Hearings*

Neurological disorders and neuropsychological in *Atkins* claims can add dimensional aspects to the assessment of the defendant's global mental functioning,

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<sup>12</sup> Richard J. Bonnie and Katherine Gustafson, *The Challenge of Implementing Atkins v. Virginia: How Legislatures and Courts Can Promote Accurate Assessments and Adjudications of Mental Retardation Cases*, 41 U. RICH. L. REV. 811 (2007).

<sup>13</sup> For a detailed discussion on state's legislation defining mental retardation, see David DeMatteo, Geoffrey Marczyk, and Michele Pich, *A National Survey of State Legislation Defining Mental Retardation: Implications for Policy and Practice After Atkins*, 25 BEHAVIORAL SCIENCES & THE LAW, no.4, 2007, 781-802.

<sup>14</sup> *Id.*

<sup>15</sup> *People v. Vidal*, 155 P.3d 259, 260 (2007).

which is relevant to ID, but may also transcend the assessment of ID. When considering the former field of neurology, one can argue that other underlying brain-based disorders that leave an offender with cognitive and social vulnerabilities should be litigated as alternative *Atkins* claims.<sup>16</sup>

When considering the neuropsychology discipline, intelligence testing is one area of neuropsychological functioning as well as the required assessment procedure for the examination of ID. In fact, neuropsychological tests are correlated with IQ tests as both types of instruments measure cognitive functioning in a multitude of areas. Simplistically, the Wechsler Adult Intelligence Scale – (4<sup>th</sup> Edition) assesses verbal comprehension, perceptual reasoning, working memory, and processing speed.<sup>17</sup> These are all neuropsychological and brain/behavior functions. Similarly, traditional neuropsychological assessment instruments and batteries assess executive neurocognitive functioning, including problem solving, planning, abstract thinking; language and oral comprehension skills; visuospatial perception; auditory and visual attention; auditory and visual immediate and delayed memory; motor and sensory perception skills; and emotional/social intelligence. Further, research informs us that those with ID have a variety of neuropsychological deficits including executive/frontal dysfunction, attention, processing speed, visuospatial, planning, motor speed, grip strength, and sensory deficits.<sup>18</sup> In fact, those with ID/MR do not form a homogeneous group with respect to neuropsychological development or adaptive functioning, and their patterns of neurocognitive and adaptive functioning deficits differ as a function of the causative mechanism.<sup>19</sup>

We recommend that defense attorneys educate the jury on the capital defendant's global and vast neurocognitive profile of functioning in addition to intelligence. Recent advances in neuropsychology suggest an individual's capacity to acquire critical skills necessary to function as a full moral agent is dependent on the successful integration of *both* cognitive and emotional brain systems, which is influenced significantly by the healthy development of an individual's prefrontal cortex and limbic system.<sup>20</sup> The limited cognitive tests (IQ and adaptive tests) utilized to diagnose MR provide scant information about an individual's capacity to both experience emotion and to assimilate successfully the cognitive and emotional processes necessary to appreciate moral norms and be able to consistently control and conform their conduct. In essence, the restricted tests used in *Atkins* hearings

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<sup>16</sup> Stephen Greenspan and Harvey N. Switzky, *Execution Exemption Should Be Based on Actual Vulnerability, Not Disability Label*, 13 ETHICS & BEHAVIOR 1, 19-26 (2003).

<sup>17</sup> Wechsler Adult Intelligence Scale (WAIS-IV).

<sup>18</sup> Tara L. Victor and Kyle B. Boone, *Identification of Feigned Mental Retardation, in ASSESSMENT OF FEIGNED COGNITIVE IMPAIRMENT: A NEUROPSYCHOLOGICAL PERSPECTIVE* 31-45 (Kyle Brauer Boone, ed., 2007).

<sup>19</sup> See Marget Pulsifier, *The Neuropsychology of Mental Retardation in 2 J. INT'L NEUROPSYCHOLOGICAL SOC'Y* 159 (1996); Katherine A. Loveland & Belgin tunali-Kotoski, *Development of Adaptive Behavior in Persons with Mental Retardation in HANDBOOK OF MENTAL RETARDATION AND DEV.* 521, 541 (Robert Hodapp & Jacob Burack eds., Cambridge University Press 1998).

<sup>20</sup> See P. Sasso, *Implementing the Death Penalty: The Moral Implications of Recent Advances in Neuropsychology*, 29 CARDOZO L. REV. 765 (2007).

inform us little about the extent to which a defendant should be held morally accountable for his conduct. Because a defendant can exhibit a level of reasoning capacity in an IQ test, that does not indicate whether he has the requisite capacity to both synthesize and coordinate these cognitive functions and incorporate them into a course of action that he can successfully execute in the face of environmental influences.

Along the lines of the inclusion of neuropsychology to *Atkins* claims, the AAIDD defines intelligence as a general mental ability that includes one's ability to make "sense of things," comprehend "surroundings," "organize," "understand complex ideas," "to learn from experience," and "to engage in various forms of reasoning."<sup>21</sup> Further, the AAIDD refers to the World Health Organization's definition of intellectual functions including "general mental functions required to understand and constructively integrate the various mental functions, including all cognitive functions and their development over the life span."<sup>22</sup> The Court in *Atkins* recognized neurocognitive impairments in those with MR that could be considered for offenders with other neurological disorders and evidence of brain damage.<sup>23</sup> These impairments include: understanding and processing information, communicating, abstracting from mistakes and learning from experience, engaging in reasoning, controlling impulses, and understanding the reactions of others. The important point is while neuropsychological testing should not take the place over the IQ and adaptive testing requirements for the assessment of ID, it can offer rich information into a defendant's overall neurocognitive functioning and should be utilized in these claims.

## II. IMPERFECT LAW AND IMPERFECT SCIENCE

Experts and lawyers working *Atkins* cases must be aware of the many nuances that potentially complicate and muddy the ID diagnostic waters and could lead to lethal injection or life in general population. The following section addresses some of these issues within an evidence-based practice framework.

### A. How to Demonstrate "Age of Onset Prior to Age 18"

The AAIDD and DSM-IV-TR require age of onset of ID prior to age eighteen because it is a developmental disorder. The purpose of age of onset is to distinguish ID from other disabilities occurring later in life. Usually ID originates prenatally, at birth, or shortly after birth. However, in many cases, the etiology of mental retardation is progressive and may be due to exposure to environmental toxins, or due to traumatic brain injury and infection that may originate later on. The intellectual disability *does not have to have been formally diagnosed, but it must have originated during the developmental period.*

#### 1. Don't Give Up Hope if The Offender Has Not Previously Been Diagnosed MR

Capital defendants often lack a formal diagnosis of ID or MR before the age of eighteen. The AAIDD recognizes a number of reasons why offenders lack formal

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<sup>21</sup> AAIDD, *supra* note 8, at 15.

<sup>22</sup> World Health Organization, *International Classification of Functioning, Disability, and Health (ICF)* (May 22, 2001).

<sup>23</sup> User's Guide, *supra* note 5, at 20.

ID diagnoses before age eighteen.<sup>24</sup> First, many of the schools that defendants attend are in poor areas with limited school resources for the assessment of developmental disorders and do not offer special education programming for students with ID. In other cases, the person may be given no diagnosis or an alternative diagnosis (learning disability) for political purposes – protection from stigma or teasing, avoidance of assertions of discrimination, parental concerns about labels, the schools’ concerns about over-representation for data reporting purposes, or lack of resources. Other plausible reasons include the fact that many individuals with MR display minimal academic and behavioral delays/impairments in the preschool and early elementary school years, but are not identified as developmentally disabled or MR. In some cases, children’s IQ’s are malleable and fluctuate in and out of ID range, and while exhibiting marked cognitive and behavioral deficits, the child may be placed in learning disabled classes, special education classes, and/or severe behavioral handicapped type classes and labeled as low functioning learning disordered and/or attention deficit hyperactivity disordered (ADHD) youth, but are never red-flagged as MR/ID.

*Atkins* claims, just like other areas of capital litigation, are not perfect. More often than not, especially with older defendants, school records in *Atkins* claims can be absent, incomplete, or lacking in substance. Because a defendant does not carry a formal diagnosis of mental retardation prior to age eighteen, this does *not* mean he is not developmentally and currently mentally retarded. It is necessary to identify evidence of the developmental disability by identifying sources of information to shed light on the disability’s presence in the defendant’s childhood. While test results and specific data may not be available, persuasive evidence may be gleaned from collateral sources found in prior juvenile delinquency adjudication court files such as pre-sentence investigation reports. Placements in facilities tailored to those who are ID can provide the disability’s onset before age eighteen. This type of background information tends to be repeated as part of the defendant’s ongoing history and, therefore, may be referenced in more recent reports.

For example, in *Davis*,<sup>25</sup> the defendant was a thirty-eight year old who had never before been diagnosed with mental retardation. Despite no previous diagnosis, the district court found *Davis* to be mentally retarded after the defense’s psychologist testified that schools have a strong bias against classifying a student as mentally retarded and are hesitant to diagnose students with low IQs as having mental retardation, but more often classify them as having learning disabilities.<sup>26</sup>

In capital cases, mitigation specialists, attorneys, and psychologists investigating mental retardation must investigate evidence of limitations in intellectual functioning and adaptive behavior during the defendant’s developmental period. It is also recommended the defense team investigate potential etiological and causative factors of developmental impairments and disability in the defendant’s life. Proof of causation is *not required* for a diagnosis of ID, but it is useful in illustrating the complete picture of a defendant’s developmental disability.

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<sup>24</sup> AAIDD, *supra* note 8, at 102.

<sup>25</sup> *United States v. Davis*, 611 F. Supp. 2d 472, 475-77 (D. Md. 2009).

<sup>26</sup> *See id.* (citing AAMR at 31-32).

## 2. Are The Offender's Impairments Due to MR or a Learning Disorder?

It should be noted a common issue in *Atkins* cases is the potential overlapping and confusion of ID and learning disorders. The prosecution may try to blur the line between the two, but ID and learning disorders are substantially different. To fail to recognize the differences between the two can have dire consequences on a viable *Atkins* claim. Learning disorders are characterized by difficulties in learning basic academic skills – currently or historically – that are not consistent with the person's chronological age, educational opportunities, or intellectual abilities. In essence, learning disabilities are seen when the person's academic skills in a particular area (e.g., math, reading) are below age/grade level but the IQ is not significantly impaired. In *Davis*, the Court found the defendant's academic deficits were not solely attributable to a learning disability.<sup>27</sup> The district court stated,

Significant global impairments in conceptual and abstract thinking ability are generally not seen in learning disabilities, in which the primary problem is typically a focused deficit in one or more aspects of academic functioning (e.g. reading, math, written expression) . . . In other words, an individual with [mild mental retardation] will have generalized deficits, whereas a person with [a learning disability] will exhibit underachievement limited to specific areas.<sup>28</sup>

The *Davis* court's differentiation between specific academic deficits and global limitations is a critical point. When a defendant has deficits in one or two of educational areas, a learning disorder can be the cause of the deficits; however, when a defendant has impairments in multiple educational areas, ID is the more likely cause.

## 3. Psychiatric Comorbidity

When someone has ID as well as psychiatric or behavioral disorders, this is referred to as "co-morbidity" and it a common occurrence; it is not the exception, it is the rule.<sup>29</sup> Presence of a psychiatric or behavioral disorder does not rule out MR. In fact, youth with ID have rates of ADHD (21.1%), Autistic and Pervasive Developmental Disorders (11-14%), and Dyslexia (14%), as well as other disorders including psychotic and mood disorders, epilepsy, and personality disorders.<sup>30</sup> Some experts tend to explain symptoms of ID as being not a function of ID but proof of other psychiatric conditions. A dual diagnosis or evidence of a contributory cause

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<sup>27</sup> *Davis*, 611 F. Supp. 2d at 475-77.

<sup>28</sup> *Id.* at 482-83.

<sup>29</sup> User's Guide, *supra* note 5, at 15; See E. Rose et al., *Neuropsychological Characteristics of Adults with Comorbid ADHD and Borderline/Mild Intellectual Disability*, 30 RES. IN DEVELOPMENTAL DISABILITIES 496 (2009); Kiriakos Xenitidis et al., *ADHD Symptom Presentation and Trajectory in Adults with Borderline and Mild Intellectual Disability*, 54 J. INTELL. DISABILITY RES. 667 (2010).

<sup>30</sup> See Bart Oeseburg et al., *Prevalence of Chronic Diseases in Adolescents with Intellectual Disability*, 31 RES. IN DEVELOPMENTAL DISABILITIES 698 (2010); Santo F. Di Nuovo & Serafino Buono, *Psychiatric Syndromes Comorbid with Mental Retardation: Differences in Cognitive and Adaptive Skills*. 41 J. PSYCHIATRIC RES. 795 (2007).

does not negate the possibility of the presence of mental retardation.<sup>31</sup> It is imperative that the expert be aware of psychiatric comorbidity with ID and assesses it according to the case.

#### 4. Conducting a Retrospective Diagnosis for ID

The fact remains that many individuals who currently function in the ID range for both IQ and adaptive functioning will lack a formal diagnosis prior to age eighteen. Consequently, attorneys and experts must attempt to assess for a diagnosis from past information; this is called a “retrospective diagnosis.” Retrospective diagnosis should not only be based on the consideration of various collateral information at different developmental periods and evaluating not only past tests scores, but also on descriptive information of everyday life and adaptive living skills. This investigation should include, but is not limited to: interviewing family members, gathering school records, employment records, and prison records. As an attorney preparing the presentation of this information as well as cross-examination of the state’s expert, it is imperative to possess a vast working knowledge of this material. This is not a time to merely turn the information over to your psychologist(s) to let them interpret. The significance of factual information in the formulation of opinions cannot be overlooked and must be highlighted when examining your expert(s) and in cross-examination of the state expert.

When investigating *Atkins* claims, it is recommended that prior to engaging expert(s) assistance, the defense lawyers and investigators should conduct a thorough life history investigation to obtain insight into various litigation issues, i.e., insanity, diminished capacity, and mitigation. Additional discussion of a retrospective diagnosis is detailed in the section on adaptive functioning.

#### 5. Etiological Factors as Evidence of ID

One last developmental MR question is whether mental retardation is a dynamic diagnosis. As the AAIDD specifically indicates, “contextual factors include environmental factors and personal factors that represent the complete background of an individual’s life.”<sup>32</sup> For example, personal factors such as motivation, lifestyle, race, gender, educational level, coping skills, past and current life experiences, and psychological assets may play a role in the manifestation of a disability. Environmental factors such as the physical, social, and attitudinal environment in which people conduct their lives interact with personal factors which ultimately impact human behavioral and cognitive functioning. Therefore, MR is a dynamic, changeable, flexible, and malleable condition. MR is a biopsychosocial condition with many causes and impacting factors across the lifespan. More to the point, a defendant can grow into, out of, and back into ID/MR over time. Consequently, certain defendants will have test scores and functioning that fluctuate in and out of the ID range over time. *Atkins* hearings will typically involve defendants on the cusp of mental retardation, meaning evidence of any fluctuation becomes ever more

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<sup>31</sup> See John H. Blume et al., *Of Atkins and Men: Deviations from Clinical Definitions of Mental Retardation in Death Penalty Cases*, 18 CORNELL J.L. & PUB. POL’Y 689, 726, 728-29 (2009) (citing *Holladay v. Campbell*, 463 F. Supp. 2d 1324, 1344 (N.D. Ala. 2006), *Rivera v. Dretke*, No. Civ. B-03-139, 2006 WL 870927 (S.D. Tex. Mar. 31, 2006), *Lambert v. State*, 126 P.3d 646, 651 (Okla. Crim. App. 2005)).

<sup>32</sup> AAIDD, *supra* note 8, at 17.

meaningful. Finally, in some ID cases in which there is questionable developmental data and a lack of consistent MR diagnosis or absence of it, the defense team should consider investigating etiological and causative factors for ID and developmental disability.

This investigation as to etiology of mental retardation is perfectly aligned with a mitigation investigation as to the constellation of risk factors that breed neuropsychological and neurological impairment.<sup>33</sup> The information can be very useful in a “. . . ‘totality of the circumstances’ type investigation” for ID, as defense teams must often relentlessly search for records and information that adds to the developmental outline of a defendant’s life and functioning. For example, a failure of a defendant to meet normal milestones of development – e.g., lifting head, rolling over, smiling, crawling, pulling to stand, standing, walking, toileting, talking (difficulty later in childhood including speech impairments) trouble learning to feed and dress himself, or acquiring motor skills such as tying shoe laces, skipping, and riding a bicycle – any of these characteristics may be associated with a developing onset of ID.<sup>34</sup> In *Nelson*, the district court relied on the defendant’s etiological risk factors, such as his mother’s parenting skills and drinking while pregnant, in assessing the defendant’s deficits for mental retardation.<sup>35</sup>

The defense team must investigate neurodevelopmental issues including birth traumas causing anoxia-related brain damage, in utero exposure to diseases, alcohol and other substances, Fetal Alcohol Syndrome, near drownings, use of inhalants, early motor vehicular accidents and subsequent brain injury, exposure to neurotoxins (lead, mercury, pesticides, chemical waste, alcohol and drugs), physical abuse, meningitis and encephalitis, convulsions and seizures.<sup>36</sup> Table 1 outlines the AAIDD etiological risk factors for intellectual disability that should be investigated.<sup>37</sup>

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<sup>33</sup> See John Matthew Fabian, *Neuropsychological and neurological correlates in violent and homicidal offenders: A legal and neuroscience perspective*, 15 *AGGRESSION AND VIOLENT BEHAV.* 209 (2010).

<sup>34</sup> The International Justice Project, *A Practitioner’s Guide to Defending Capital Clients Who Have Mental Retardation* (2006), available at [http://www.nofsw.org/Defending\\_Clients\\_Who\\_Have\\_Mental\\_Disorders\\_and\\_Impairments.pdf](http://www.nofsw.org/Defending_Clients_Who_Have_Mental_Disorders_and_Impairments.pdf).

<sup>35</sup> *United States v. Nelson*, 419 F. Supp. 2d 891, 897 (E.D. La. 2006).

<sup>36</sup> See Shruti S. B. Desai, *Effective Capital Representation of the Mentally Retarded Defendant*, 13 *CAP. DEF. J.* 251 (2001).

<sup>37</sup> AAIDD, *supra* note 8, at 60.

**Table 1**

<b>Time</b>	<b>Biomedical</b>	<b>Social</b>	<b>Behavioral</b>	<b>Educational</b>
Prenatal	1. Chromosomal disorders 2. Single-gene disorders 3. Syndromes 4. Metabolic disorders 5. Cerebral dysgenesis 6. Maternal illnesses 7. Parental age	1. Poverty 2. Maternal malnutrition 3. Domestic Violence 4. Lack of access to prenatal care	1. Parental drug use 2. Parental alcohol use 3. Parental smoking 4. Parental immaturity	1. Parental cognitive disability without supports 2. Lack of preparation for parenthood
Perinatal	1. Prematurity 2. Birth injury 3. Neonatal disorders	1. Lack of access to prenatal care	1. Parental rejection of caretaking 2. Parental abandonment of child	1. Lack of medical referral for intervention services at discharge
Postnatal	1. Traumatic brain injury 2. Malnutrition 3. Meningoencephalitis 4. Seizure disorders 5. Degenerative disorders	1. Impaired child-caregiver interaction 2. Lack of adequate stimulation 3. Family poverty 4. Chronic family illness 5. Institutionalization	1. Child abuse and neglect 2. Domestic violence 3. Inadequate safety measures 4. Social deprivation 5. Difficult child behaviors	1. Impaired parenting 2. Delayed diagnosis 3. Inadequate early intervention services 4. Inadequate special education services 5. Inadequate family support

*B. Assessing Intelligence: A Crash Course in IQ Testing and Practice Tips*

The AAIDD requires significant limitations in intellectual functioning pursuant to a diagnosis of ID as an IQ score that is *approximately two standard deviations below the mean, considering the standard error of measurement for the specific instruments used and the instrument's strengths and limitations.*<sup>38</sup> This language is key because no IQ score is perfect or void of error in measurement. Errors of measurement are environmental and may include personal issues such as variation in test performance, environmental factors such as prison noise affecting the examinee's performance, the examiners' behavior and scoring, and cooperation and effort in the test-taker. A Full-Scale IQ of 70 on the test is two standard deviations

<sup>38</sup> *Id.* at 35 (emphasis added).

below the mean (100) and represents the bottom 2.5 percent of the standardization sample which is in the ID range. Although, attorneys should not use an IQ of 70 as the threshold for *Atkins* claims; the standard error of measurement (typically 3 to 5 points<sup>39</sup>) allows full scale IQ scores of 70 to 75 to qualify for an ID diagnosis.<sup>40</sup> The AAIDD and APA do not intend for there to be a fixed cut-off score for making the diagnosis of ID because it is not justified psychometrically. Therefore, an IQ standard score is best interpreted as bounded by a range that would be about three points above and below the obtained score. As stated in *Atkins*, “[i]t is estimated that between 1 and 3 percent of the population has an IQ between 70 and 75, which is typically considered the cutoff IQ score for the intellectual functioning prong of the mental retardation definition.” A number of federal courts have held there is no fixed cut-off IQ score for making the diagnosis of ID.<sup>41</sup>

### 1. Distinguish the Right IQ Test From the Wrong One

Attorneys and experts must also be aware of the most current versions of IQ tests. In 2011, many psychologists consider the WAIS-IV to be the gold standard IQ test, but some neuropsychologists are more satisfied with the validity of the WAIS-III due to its vast empirical literature over the WAIS-IV. However, the WAIS-IV is the most *current* version of the WAIS tests and should be used in *Atkins* evaluations. The use of the most current version of a particular test with the most current norms available is advocated for by the AAIDD.<sup>42</sup> When competing reports are generated by psychologists employed by court psychiatric clinics, there is a distinct possibility (possibly to due to budgetary constraints) more current versions of tests have not been utilized, abbreviated IQ tests (Wechsler Abbreviated Scale of Intelligence – WASI) are given, or select subtests are utilized due to time resources. These are all issues that need to be investigated on cross-examination of the prosecution’s expert.

While the WAIS-IV is the gold standard IQ test, the Stanford Binet is also an acceptable IQ test. However, there are other tests that are typically utilized in *Atkins* proceedings that should not be granted equal weight or much weight at all. The Revised Beta Examination has often been used as a screening IQ in prisons. The Beta is a non-verbal group administered intelligence test. Similarly, the General Ability Measurement for Adults (GAMA) is another nonverbal IQ screen assessing areas of matching, sequences, analogies, and construction. Both the GAMA and the Beta should never be equated with the WAIS-IV, especially because these tests do not have verbal components, which are critical to the theoretical constructs of intelligence. Further, IQ screening tests such as the WASI and the Kaufman Brief Intelligence Test (K-BIT) are just that (screening tests) and should not be granted equal weight as to the WAIS-IV.

The defense attorney must also access the raw data relied upon by the state’s expert relating to IQ testing and seek the original test along with any and all notes composed in connection with its administration, as well as any raw psychological/neuropsychological testing data for that matter. Psychologists are

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<sup>39</sup> *Id.* at 36.

<sup>40</sup> *Atkins v. Virginia*, 536 U.S. 304, 309 n.5 (2002).

<sup>41</sup> AAIDD, *supra* note 8, at 38.

<sup>42</sup> USER’S GUIDE, *supra* note 5, at 20.

typically reluctant to provide this information, as they are aware that any mistake in calculation or questionable notation creates fodder for cross-examination.

It should be noted that not all scores obtained on intelligence test administered to the same person will be identical over time.<sup>43</sup> In fact, IQ scores are not expected to be the same across tests, editions of the same test or time periods.<sup>44</sup>

## 2. The Flynn Effect

When an IQ test is developed, but before its release for general use, it is given to a large group of people in order to create a standardized norm. Those who then take an IQ test have their scores based on comparison to the standardized norm. "IQ tests are periodically revised and reformed to ensure the content appropriate to current cultural contexts, embrace the demographics of the normative reference group, and to maintain an average score of 100."<sup>45</sup> In the 1980s, Dr. James Flynn noticed that IQ tests scores steadily increase over time. Essentially, the "Flynn Effect" shows the general population gets smarter over time and older IQ tests must be corrected in order to accurately assess intelligence.<sup>46</sup> "The person's overall intelligence has not changed, rather, the actual norms by which to judge the person's IQ have increased since the test was last normed."<sup>47</sup> IQ tests with aging norms may be obsolete and representative of inaccurate estimates of intelligence. In *United States v. Hardy*, the court held an IQ score of 73 that was not adjusted for the Flynn Effect was not the "best estimate" of intelligence.<sup>48</sup> Such enhancements in scores could be due to cultural changes, improved nutrition, testing experience, changes in schooling and child-rearing practices, and the advent of technology (e.g., the Internet). Flynn has suggested that IQ scores should be adjusted about 0.31 points per year for each year the test was administered after the standardization was completed.

Any expert assessing an *Atkins* case should consider the Flynn Effect.<sup>49</sup> Recognition of this enhancement is critical in *Atkins* cases not only for current testing, but for past tests. The AAIDD states that recognition of a potential Flynn Effect on an IQ score is "best practices."<sup>50</sup> Flynn also supports deducting an additional 2.34 points from all WAIS-III IQ scores due to the test's normative sample as having too many low scoring subjects which resulted in inflated norms. When considering professional practice, the AAIDD best practices require

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<sup>43</sup> AAIDD, *supra* note 8, at 38.

<sup>44</sup> Ian M. Evans, *Testing and Diagnosis: A Review and Evaluation*, in CRITICAL ISSUES IN THE LIVES OF PEOPLE WITH SEVERE DISABILITIES 25-44 (L.H. Meyer et al. eds., Brookes 1991).

<sup>45</sup> Cecil R. Reynolds et al., *Failure to Apply the Flynn Correction in Death Penalty Litigation: Standard of Practice Today Maybe, but Certainly Malpractice of Tomorrow*, 28 J. PSYCHOED. ASSESSMENT 477, 478 (2010).

<sup>46</sup> *United States v. Lewis*, No. 1:08-CR-404, 2010 WL 5418901, at \*6 (N.D. Ohio Dec. 23, 2010).

<sup>47</sup> *Id.*

<sup>48</sup> *United States v. Hardy*, 762 F. Supp. 2d, 849, 857 (E.D. La. 2010).

<sup>49</sup> James R. Flynn, *Tethering the Elephant: Capital Cases, IQ, and the Flynn Effect*. 12 PSYCHOL. PUB. POL'Y & L. 170, 184 (2006).

<sup>50</sup> AAIDD, *supra* note 8, at 37.

recognition of a potential Flynn Effect when older editions of an intelligence test (with older norms) are used in the assessment or interpretation of an IQ score.<sup>51</sup> It should be acknowledged that the first author has found that when comparing current WAIS-IV IQ testing to a defendant's prior WAIS-III testing, after calculating the Flynn Effect, the IQ scores between the WAIS-IV and the WAIS-III are usually very consistent, more so than if the Flynn Effect was not calculated.

The adversarial system dictates attorneys' and experts' stances on the Flynn effect. Prosecutors and their experts question and often detest its use while defense attorneys and their experts often embrace the Flynn effect. Concerning the former, state experts contest the alteration of IQ scores due to insufficient research, lack of legal authority, and absence of prevailing standards of practice.<sup>52</sup> Despite prosecutors' attempts to erode the Flynn Effect, a number of federal and state courts have applied the Flynn Effect in *Atkins* hearings.<sup>53</sup> A number of psychologists have published journal articles endorsing IQ scores corrections for the Flynn Effect in capital cases.<sup>54</sup> One article even suggests that a defense attorney's failure to

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<sup>51</sup> See Gresham, *supra* note 2.

<sup>52</sup> Leigh D. Hagan, Eric Y. Drogin & Thomas J. Guilmette, *IQ Scores Should Not Be Adjusted for the Flynn Effect in Capital Punishment Cases*, 28 J. PSYCHOED. ASSESSMENT 474, 474-46 (2010).

<sup>53</sup> See, e.g., *United States v. Lewis*, No. 1:08 CR 404, 2010 WL 5418901, at \*11 (N.D. Ohio Dec. 23, 2010) ("The Court recognizes the Flynn Effect as a best practice for an intellectual disability determination."); *Thomas v. Allen*, 607 F.3d 749, 753 (11th Cir. 2010) ("An evaluator may also consider the 'Flynn effect,' a method that recognizes the fact that IQ test scores have been increasing over time. . . . Therefore, the IQ test scores must be recalibrated to keep all test subjects on a level playing field."); *Holladay v. Allen*, 555 F.3d 1346, 1350 n.4, 1358 (11th Cir. 2009) (crediting the psychologist that concluded the IQ scores needed to be adjusted for the Flynn Effect); *Walker v. True*, 399 F.3d 315, 322-23 (4th Cir. 2005) (remanding for an evidentiary hearing in part because the district court "refused to consider relevant evidence, namely the Flynn Effect evidence."); *Hardy*, 762 F. Supp. 2d at 864, 866 ("[T]here is in fact published, peer-reviewed research supporting the existence of the Flynn Effect for the test Hardy took and the IQ range in which his score fell" and "correcting for the Flynn Effect is a 'best practice' in the field and therefore should be done."); *Wiley v. Epps*, 668 F. Supp. 2d 848, 894 (N.D. Miss. 2009) (in evaluating the defendant's intellectual functioning, the Court will take into account the obsolescence of the test's norms); *United States v. Davis*, 611 F. Supp. 2d 472, 486, 488 ("Corrections for the Flynn Effect . . . allows for fair comparisons between scores obtained at different times . . . In conclusion, the Court finds the defendant's Flynn effect evidence both relevant and persuasive, and will, as it should, consider the Flynn-adjusted scores in its evaluation of the defendant's intellectual functioning."); *Thomas v. Allen*, 614 F. Supp. 2d 1257, 1278 (N.D. Ala. 2009) ("It also is undisputed that Professor Flynn's recommendation – i.e., 'deduct 0.3 IQ points per year [three points per decade] to cover the period between the year the test was normed and the year in which the subject took the test'—is a generally accepted adjustment."); *Green v. Johnson*, No. CIVA 2:05CV340, 2006 WL 3746138, at \*45 (E.D. Va. Dec. 15, 2006) ("Considering all of the case law and evidence, this Court concludes that the Flynn Effect should be considered when determining whether Green's scores fall at least two standard deviations below the mean. There is sufficient evidence in the record to show the Flynn Effect is recognized throughout the profession.").

<sup>54</sup> Jack M. Fletcher, Karla K. Stuebing, & Lisa C. Hughes, *IQ Scores Should Be Corrected for the Flynn Effect in High-Stakes Decisions*, 28 J. OF PSYCHOEDUCATIONAL ASSESSMENT 469, 473 (2010); Cecil R. Reynolds *et al.*, *Failure to Apply the Flynn*

recognize the Flynn Effect constitutes legal malpractice.<sup>55</sup> As another article mentions, given the fact that death is different and irrevocable as punishment, and if there remains a doubt about the accuracy of IQ testing as an objective measurement of ID, “what possible justification could there be for issuing estimates of general intelligence in a death penalty case that are less than the most accurate estimates obtainable?”

Even if both sides uniformly agree the Flynn effect is an empirically proven statistical fact, they may disagree on the extent to which an individual test subject’s IQ score should be adjusted to take this phenomenon into account. However, the AAIDD’s language provides a blueprint for *Atkins* evaluations as it recommends that clinicians take into account the Flynn effect *and* the standard error of measurement when performing retrospective diagnoses in less than optimal circumstances. The AAIDD communicates that the most current norms of an intelligence test should be used at all times and in cases where a test with aging norms is used, a correction for the age of the norms is warranted.<sup>56</sup>

### 3. Practice Effect: Too Many Tests Inflate IQ Scores

A defendant who is tested multiple times by various experts can be susceptible to IQ test practice effects. Simply, the more times the defendant takes the same or similar test(s) within short retesting periods (especially nonverbal tasks), the more likely he or she will learn how to perform the tasks and store knowledge in memory, jeopardizing the accuracy of true intelligence and leading to an increase in the defendant’s IQ scores over time. The improvement in scores is due to the practice of taking the test, not an improvement in intelligence. In fact, various studies have demonstrated increases in intelligence scores up to 6 months after former testing (up to 11 points for performance IQ and 6 points for full scale IQ scores).<sup>57</sup>

No state statute mandates that a forensic examiner communicate with prior evaluators to avoid multiple assessment of a defendant’s intelligence using identical tests. However, the APA Ethics Code (9.06) establishes that psychologists should consider various test factors that might affect their judgment or reduce their assessment accuracy.<sup>58</sup> Therefore, experts must ethically consider prior IQ testing when performing their own assessments. Some courts, familiar with the inherent

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*Correction in Death Penalty Litigation: Standard of Practice Today Maybe, But Certainly Malpractice of Tomorrow.* 28 J. OF PSYCHOEDUCATIONAL ASSESSMENT 477, 481 (2010).

<sup>55</sup> Cecil R. Reynolds et al., *Failure to Apply the Flynn Correction in Death Penalty Litigation: Standard of Practice Today Maybe, But Certainly Malpractice of Tomorrow.* 28 J. OF PSYCHOEDUCATIONAL ASSESSMENT 477, 481 (2010).

<sup>56</sup> AAIDD, *supra* note 8, at 37 (quoting USER’S GUIDE, *supra* note 5, at 20-21).

<sup>57</sup> Michael R. Basso, Francine D. Carona, Natasha Lowery & Bradley N. Axelrod, *Practice Effects on the WAIS-III Across 3- and 6-Month Intervals*, 16 CLINICAL NEUROPSYCHOLOGIST 57 (2002); Gary Groth-Marnat, HANDBOOK OF PSYCHOLOGICAL ASSESSMENT (4th ed. 2003); Alan S. Kaufman, *Practice Effects*, in 2 ENCYCLOPEDIA OF HUMAN INTELLIGENCE 828 (Robert J. Sternberg ed., 1994).

<sup>58</sup> Julie C. Duvall & Richard J. Morris, *Assessing Mental Retardation in Death Penalty Cases: Critical Issues for Psychology and Psychological Practice*, 37 PROF. PSYCHOL.: RES. & PRAC. 658, 663 (2006).

problems with practice effect, may order concurrent testing performed by the defense psychologist and state psychologist in unison. As a joint effort, it becomes difficult to question the integrity of the administration of testing instruments when both experts have participated in the assessment.

Research indicates that practice effects have more impact on individuals with higher IQ's and older people show smaller retest gains than younger people. Defendants with other conditions in addition to MR, such as dementia and traumatic brain injury, may not be as susceptible to IQ practice effects. However, given the narrow margin for error in *Atkins* proceedings, the expert must consider practice effects for *all* cases. When practice effects are at issue in an *Atkins* case, the expert should consider using a different intelligence test at the time of retesting, utilizing the same IQ test at least 9-12 months after first administration, utilizing other non-administered optional subtests from the IQ test used in the first evaluation, and considering the defendant's age and the time interval between testing.

Finally, the comparability of IQ scores from different tests should be considered by the examining expert. Notably, IQ scores are not expected to be the same across tests, editions of the same test, or time periods.<sup>59</sup> Many individual capital defendants in the first author's experience have multiple IQ scores that fluctuate up to 10 to 15 points across thirty or more years. While the construct of intelligence is thought to be rather stable over time, the use of various tests in diverse settings may yield different results. Again, MR is a dynamic and malleable condition, and the expert must consider all factors related to such a diagnosis in addition to the results of IQ testing. Specifically, in evaluating past IQ tests, the expert should consider the following:

1. The purposes for which the test was administered;
2. The properties of the test;
3. Non-standardized administration of the test;
4. Test content across different scales and between different age levels on the same scale;
5. Scores obtained on verbal versus nonverbal tests;
6. Differences in the standardization samples;
7. Changes between different editions of the same scale/test;
8. Use of an alternative scale as an individual's age increases;
9. Variations in the person's abilities/performance.

Finally, the expert should adhere to the AAIDD and APA standards providing that there is no fixed cut-off point to be established for a diagnosis of ID, and the use of clinical judgment is important to interpret possible measurement error. The expert should never average IQ scores over time to obtain a "true score" as this violates basic statistical theory. Finally, the expert should never "clinically adjust" IQ scores due to issues such as culture or perceived suboptimal effort on the part of the examinee.

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<sup>59</sup> IAN M. EVANS, *Testing and Diagnosis: A Review and Evaluation*, in CRITICAL ISSUES IN THE LIVES OF PEOPLE WITH SEVERE DISABILITIES 25 (Luanna H. Meyer, Charles A. Peck & Lou Brown eds., 1991).

#### 4. Full Scale IQ is the Most Appropriate Measure of Intellectual Functioning

Intelligence Quotient (IQ) tests contain a number of different sub-tests, the conglomeration of which adds up to make a full-scale IQ score. Prosecution experts may argue a defendant's full scale IQ score is not the most representative of intelligence and instead will argue individual sub-test scores are more indicative of intelligence for an *Atkins* evaluation.<sup>60</sup> This opinion is not supported by the AAIDD. In fact, full scale IQ is the most important criteria in assessing intellectual functioning. The AAIDD manual specifically states, "[u]ntil more robust instruments based upon one or more of the multifactorial theories of intellectual functioning are developed and demonstrated to be psychometrically sound, we will continue to rely on a global (general factor) IQ as a measure of intellectual functioning."<sup>61</sup> In both *Davis* and *Lewis*, the district court rejected the government expert's attempts to use the sub-test scores instead of full scale IQ. The respective courts specifically stated there is no authority for the government's contentions.<sup>62</sup>

Most capital defendants have a long criminal record dating back to their teenage years. In line with such a criminal history, they also have a history of poor school performance, poor school attendance, and significant drug abuse. The prosecution may claim a low IQ score (as well as low conceptual adaptive functioning skills) is a product of the defendant's school absences as well as substance abuse.<sup>63</sup> In *Wiley*, the government claimed the defendant's poor academic performance was due to his absences and alcohol use, and not his intellectual functioning limitations because Wiley demonstrated his best academic performance in the 6<sup>th</sup> grade, when he also had the fewest number of school absences. The defendant's experts countered this argument by testifying, "an examiner must be careful not to draw a direct cause and effect between numerous absences and failing grades, as an individual's difficulty with schoolwork can affect how regularly one attends school."<sup>64</sup> The district court rejected the government's argument, and agreed with the defendant's expert, stating, "from the beginning of his formal education, Petitioner struggled academically . . . In reviewing all of the information in the record, the Court finds that collateral information supports a determination that Petitioner's limited formal education and school absences alone cannot account for the limitations in his intellectual functioning and adaptive behavior skills."<sup>65</sup> Therefore, experts and defense attorneys must be vigilant in identifying a complete timeline of the defendant's academic performance, school absences, and drug use, for example.

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<sup>60</sup> See *United States v. Davis*, 611 F. Supp. 2d 472, 484-85 (D. Md. 2009); *United States v. Lewis*, No. 1:08 CR 404, 2010 WL 5418901, at \*9-10 (N.D. Ohio Dec. 23, 2010).

<sup>61</sup> AAIDD, *supra* note 8, at 47.

<sup>62</sup> *Davis*, 611 F. Supp. 2d at 485; *Lewis*, 2010 WL 5418901, at \*10.

<sup>63</sup> See *Wiley v. Epps*, 668 F. Supp. 2d 848, 914 (N.D. Miss. 2009).

<sup>64</sup> *Id.*

<sup>65</sup> *Id.* at 914-15.

### 5. Malingering Does Not Equal Suboptimal Effort

*Atkins* overruled *Penry v. Lynaugh*<sup>66</sup> and held that the evolving standards of decency prohibit the execution of defendants with mental retardation. In dissent, Justice Scalia predicted that this holding would promote sport litigation where defendants would malinger MR in order to make frivolous *Atkins* claims.<sup>67</sup> Justice Scalia's prediction is unfounded given this first author's experience as most criminal defendants do not intentionally fake low cognitive functioning. However, the issue of assessing effort and malingering is necessary to consider in *Atkins* claims like any other forensic psychological/neuropsychological evaluation.

The practicing forensic psychologist and forensic neuropsychologist in both mitigation and *Atkins* MR claims should assess the defendant's cognitive effort and motivation in order to assure that the testing results hold validity. The expert and attorney should understand the differences between malingering and suboptimal effort. In the former, the defendant will intentionally exaggerate cognitive deficits to achieve a goal (avoid prosecution or death penalty), ultimately affecting the validity of the test results. With the latter, a defendant may put forth varied effort compromising the test results without formally intending on manipulating the test results for a desired gain. Importantly, some individuals with a history of brain injury and/or attention deficits may legitimately have global neurocognitive deficits and put forth suboptimal effort. Such suboptimal effort may truly be due in part to impairment rather than unwillingness to engage in the assessment process.

The modern day cognitive effort tests are not well normed with MR samples, but there is growing evidence of the accuracy of neurocognitive malingering tests with the assessment of those who are MR.<sup>68</sup> Importantly, the extent of global neuropsychological deficits with MR individuals suggest that standard effort test cutoffs may not be appropriate for use with this population, and greater caution must be used in effort testing interpretation with MR individuals as the likelihood of false-positive errors are probably high.<sup>69</sup> The expert should be aware of the limited studies with MR populations and should also consider administering more than one effort test in order to obtain convergent validity as to effort. Forensic experts should never attempt to assess for cognitive effort and malingering of cognitive deficit with personality tests, such as the MMPI-2, which offers valuable data on malingering mental illness, but not MR. Further, assessments using the SIRS for malingering of mental illness, or the Hare Psychopathy Checklist-Revised (Hare PCL-R) to assess for psychopathy, are also not indicated in an *Atkins* mental retardation evaluation and would be considered unethical practice.

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<sup>66</sup> *Penry v. Lynaugh*, 492 U.S. 302 (1989).

<sup>67</sup> *Atkins v. Virginia*, 536 U.S. 304 (2002).

<sup>68</sup> Lili Graue et al., *Identification of Feigned Mental Retardation Using the New Generation of Malingering Detection Instruments: Preliminary Findings*, 21(6) THE CLINICAL NEUROPSYCHOLOGIST 929-42 (2007); Karen L. Salekin & Bridget M. Doane, *Malingering Intellectual Disability: The Value of Available Measures and Methods*, 16 APPLIED NEUROPSYCHOLOGY, 105-13 (2009).

<sup>69</sup> TARA L. VICTOR & KYLE BRAUER BOONE, *Identification of Feigned Mental Retardation, in ASSESSMENT OF FEIGNED COGNITIVE IMPAIRMENT: A NEUROPSYCHOLOGICAL PERSPECTIVE* 310-39 (Kyle Brauer Boone ed., Guilford Press: New York 2007).

As a practical consideration, the defense attorney should examine the manner in which certain testing instruments have been administered. State employed psychologists typically struggle with caseload demands and may well be employed on a part-time basis. As such, they may cram many hours of testing into a single day, which increases the risk of the defendant giving less than optimum effort. If a test goes for too long, it is not unusual for defendants, particularly those with intellectual deficits, emotional dysfunction, and mental illness, to give up and become disinterested and apathetic, thereby affecting their effort. This outcome affects the validity of the assessment and the state's expert's opinion. Ideally, the practicing forensic expert in *Atkins* cases should administer tests in such a way that the defendant remains engaged and willing to work, thereby enhancing the credibility of their test results and subsequent interpretations.

### C. Assessing Adaptive Behaviors

Federal courts have defined adaptive functioning as “how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.”<sup>70</sup> The AAIDD defines adaptive behavior as “the collection of conceptual, social, and practical skills that have been learned and are performed by people in their everyday lives.” To qualify as ID, a defendant must exhibit significant deficits in one of these three areas. Under the DSM-IV, there are 11 domains of adaptive functioning to be measured, deficits in two or more of these areas meets the definition for ID.

Attorneys and experts must be aware in the assessment of limitations in adaptive behavior, limitations often coexist with strengths. Individuals may have capabilities and strengths in either social or physical capabilities and strengths in some adaptive skill areas.<sup>71</sup> In a number of federal *Atkins* cases, the defendant possessed strengths but still possessed deficits amounting to ID. In *Davis*, the government presented evidence the defendant was able to: manage his own finances, use money orders and debit cards, open bank accounts, and had lived outside the family home since he was a teenager.<sup>72</sup> In *Wiley*, the state tried to argue the defendant could not be deemed mentally retarded based on the credible testimony of an expert because he “often provided money to help pay household bills, possessed skill repairing vehicles and frequently helped friends and neighbors with auto repairs, provided transportation for others, volunteered for military service, and was a reliable worker who quit school to go to work to provide for his family.”<sup>73</sup> The Fifth Circuit rejected the argument, noting the expert testimony in the case indicated that all those abilities were still consistent with mild mental retardation.<sup>74</sup> Consequently, the assessment is what the defendant cannot do rather than what he can do. As one psychologist has

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<sup>70</sup> *Wiley v. Epps*, 625 F.3d 199, 216 (5th Cir. 2010). *See also* *United States v. Hardy*, 762 F. Supp. 2d 849, 879-81 (E.D. La. 2010).

<sup>71</sup> AAIDD, *supra* note 8, at 47.

<sup>72</sup> *United States v. Davis*, 611 F. Supp. 2d 472, 503 (D. Md. 2009).

<sup>73</sup> *Wiley*, 625 F.3d at 217.

<sup>74</sup> *Id.* at 217-18. *See also Hardy*, 762 F. Supp. 2d at 853-54 (noting that people with mild mental retardation “are generally able to fulfill all expected adult roles.”).

stated, assessing adaptive behavior deficits is like looking at a movie, not like looking at a snapshot.

Adaptive functioning assessment is the most underrated issue in *Atkins* determination. Most attorneys, judges, and even psychologists, traditionally appear to weigh intelligence and IQ as the core of a mental retardation diagnosis. Most *Atkins* evaluations involve offenders who are in the borderline range of intelligence with mild cognitive limitations based on IQ scores. Individuals who land in this sometimes “grey IQ area” often demonstrate variable levels of adaptive behavior skills making an MR diagnosis difficult. This is the prong of the MR determination that affords trial judges the most discretion in their interpretation of the facts presented. As such, it is the area that creates the most concern for the defense.

### 1. The Difficulties in Assessing Adaptive Behaviors

Perhaps the most important issue to consider in the assessment of adaptive functioning in *Atkins* claims is the fact that what matters are the adaptive deficits and limitations of the claimant, rather than his strengths. Prosecutors tend to cherry-pick what they interpret as “skills” thereby inflating the adaptive abilities of the defendant. Moreover, state psychologists, potentially influenced by the need to produce opinions to serve the state’s purpose, can interpret abilities in such a way so as to create an impression that your client has greater adaptive skills. For example, a state psychologist may determine that your client has the ability to handle his own money, inferred from the fact that he maintained a savings account. In reality, it is the case that a family member opened the account and had to assist the client whenever he sought to make a deposit or withdrawal. Concurrently, the defendant having been a drug dealer in the past, shows he has handled money, but provides no foundation he handled money correctly. The ultimate assessment issue becomes not whether they were afforded the opportunity to do the skills, but whether they can in fact *functionally* perform them. There is also the risk that because your client possesses skill in one particular area of adaptive behavior that the court may infer a greater general level of skill than is warranted.

Prosecutors and prosecution experts tend to latch onto the defendant’s own statements from the clinical evaluation in order to assess adaptive functioning. This reliance on the defendant’s “self-rating” is when the assessor asks the person what they can and cannot do, and the 2007 AAMR User’s Guide states this methodology has a high risk of error in determining adaptive functioning.<sup>75</sup> Self-ratings should not be relied on because the person may have communication difficulties, the person may not understand their impairments, or if they do, they may not be willing to explain their impairments and instead try to portray themselves in a favorable way. The User’s Guide even warns that self-ratings should only be used “with caution” even when in conjunction with multiple informants or respondents.<sup>76</sup>

There have been various problems with the assessment of adaptive functioning (historically and currently) that may result from the ambiguous language in the AAMR and the AAIDD. One of the problems with the assessment of adaptive behavior is that no adaptive behavior rating scale measures all 10 adaptive behavior skills, and no guidelines exist for using instruments to assess impairments in 2 of the 10 skill areas. The AAMR and AAIDD state that significant limitations in adaptive

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<sup>75</sup> User’s Guide, *supra* note 5.

<sup>76</sup> User’s Guide, *supra* note 5, at 20-21. *See also Davis*, 611 F. Supp. 2d at 491.

behavior should be established through the use of standardized measures normed on the general population, including people with and without developmental disabilities. An emerging consensus categorizes adaptive behaviors into three areas, not 10, those being conceptual, social, and practical skills. A person must have significant limitations in adaptive behaviors two standard deviations below the mean in one of these three adaptive domains. It is incumbent on the expert to align adaptive behavior domain deficits on testing instruments with the AAIDD's three adaptive domains, and this is not an easy task. It is critical to the assessment of ID for experts to utilize appropriate objective standardized adaptive functioning instruments. Too many prosecutorial experts fail to utilize these instruments and fall short in the diagnosis of ID for *Atkins* hearings. In fact, a number of federal courts have endorsed the practice of both interviewing respondents and administering adaptive functioning instruments in *Atkins* hearings.<sup>77</sup>

Adaptive behaviors are more easily detected in individuals who are severely and/or profoundly disabled as compared to higher functioning intellectually disabled people. Determining the threshold for a diagnosis of mild mental retardation encourages the investigation for precise definitions and assessment practices due to its diagnostic dependence on adaptive behavior measures.<sup>78</sup>

*a. Retrospective Adaptive Functioning Assessment*

Another consideration in the assessment of adaptive behaviors is that many of the collateral informants must provide a retrospective judgment of the defendant's behaviors at different times in his life. While the AAIDD provides no standardized methods for a retrospective evaluation of a defendant's prior adaptive behaviors, it does endorse the practice when supported with clinical judgment. A concern is that the respondent must recall from memory the individual's actual performance years ago.<sup>79</sup> However, it is the stance of the authors of this article that retrospective interviews with family members and other collateral informants (through either an

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<sup>77</sup> See e.g., *Hardy*, 762 F. Supp. 2d at 882 (citing the User's Guide as requiring both the administration of adaptive functioning instruments and the use of multiple informants); *Davis*, 611 F. Supp. 2d at 493 (Government expert criticized defense expert because he used the ABAS II instrument instead of the more reliable SIB-R and testified that he did not use any instruments himself because they were subject to being feigned; in crediting defense expert, court concluded that "nearly all methods of assessing an individual's adaptive functioning – particularly in a retroactive analysis – are imperfect. Even if ABAS-II scores from the defendant's friends and family would not have been . . . 100% reliable, it would have been of much greater assistance to the Court to have the data, and allow experts to argue what weight should be given to that data, than to not have any data at all."); *Wiley v. Epps*, 668 F. Supp. 2d 848, 913 (N.D. Miss. 2009) ("Dr. Swanson is the only professional who administered standardized adaptive functioning assessments and interviewed collateral informants to corroborate her findings with regard to this issue. As an assessment into an individual's adaptive behavior . . . the Court finds it important that it be provided with evidence that vague or ambivalent responses by interviewees were probed to substantiate or discount reports of Petitioner's ability to perform a given skill totally independent of support.").

<sup>78</sup> See generally Kay B. Stevens & J. Randall Price, *Adaptive Behavior, Mental Retardation, and the Death Penalty*, 6 JOURNAL FORENSIC PSYCHOLOGY PRACTICE, no. 3, 2006, 1-29.

<sup>79</sup> Marc J. Tassé, *Adaptive Behavior Assessment and the Diagnosis of Mental Retardation in Capital Cases*, 16 APPLIED NEUROPSYCHOLOGY 114, 120-21 (2009).

adaptive test or an interview) is critical, as it provides information necessary to the defendant's historical adaptive functioning. In *Hardy*, the Court stated the ideal informant would be one who has extensive experience with the defendant in all relevant domains, and knew him prior to the age of 18.<sup>80</sup> Many prosecution experts disagree with employing retrospective evaluations and simply do not contact any family members regarding the adaptive skills of the defendant. In *Hardy*, the Court endorsed using a retrospective analysis in *Atkins* hearings, stating:

Unlike in a medical, educational, or social services context, the law is concerned with what was rather than what is. The point of an *Atkins* hearing is to determine whether a person was mentally retarded at the time of the crime and therefore ineligible for the death penalty, not whether a person is currently mentally retarded and therefore in need of special services. . . . Mental retardation in the *Atkins* context must therefore be diagnosed, if it is to be diagnosed at all, retrospectively in every sense of the word.<sup>81</sup>

When evaluating adaptive behavioral skills and the intellectual functioning of a defendant retrospectively, the expert should do the following:

1. Conduct a thorough social history investigating development, environmental risk factors for offspring neurocognitive impairment, functioning, relationships, and family;
2. Explore possible reasons for the absence of data or differences in data (i.e., poorly trained examiners, selection of inappropriate assessment instruments, improper interpretation of test scores, lack of sensitivity or awareness of the impact of changing norms and practice effects);
3. Conduct a thorough review of records throughout the entire lifespan of the defendant's and their family members;
4. Map out the grades earned across school years looking for consistency of low grades in core academic areas;
5. Indicate any grade levels failed or repeated;
6. Summarize teacher, social, and behavior ratings;
7. Identify teacher comments to student or parents and parent-teacher conferences;
8. Identify periodic academic achievement testing;
9. Identify results of hearing and vision and other screenings;
10. Search for failure or learning deficit patterns that would trigger teacher parent intervention;
11. Identify the outcome of any eligibility assessment and whether there was an individualized education plan (IEP), identify special education history and note the diagnosis if any, the years given, type of placement (resource room, self-contained, separate school) and other supports;

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<sup>80</sup> *Hardy*, 762 F. Supp. 2d at 897.

<sup>81</sup> *Id.* at 881 (footnotes omitted).

12. Note any services that could be considered substitutes to special education which could indicate difficulties in cognitive adaptive behavior;
13. Look for difficulties in practical adaptive skills, i.e., inability to tell time or count change; utilize public transportation and fill out job applications, etc.;
14. Look for difficulties in social adaptive skills, i.e., following others, lack of self-direction, few friends, inability to understand social cues.

Finally, the AAIDD demands that a clinician assess adaptive behavior functioning in light of the context of community environments typical of the individual's peers and culture. This requirement is challenging to meet in cases in which an offender has lived in juvenile detention and/or adult prison for most of his life. While it is necessary to compare the adaptive functioning test results with normative data pertaining to individuals within the population at large (non-intellectually disabled people), some argue that prison is an artificial environment and adaptive tests should not be administered to collateral informants when a defendant has been incarcerated for lengthy periods. It is the first author's recommendation that the expert should utilize the adaptive functioning instruments in a retrospective fashion with collateral informants who rate the defendant's adaptive behaviors prior to incarceration. The forensic examiner's objective is to provide the most thorough information about the defendant's adaptive functioning at specific time period(s) as indicated by the collateral informant.

## 2. The Necessity of Using Informants to Assess Adaptive Functioning

Adaptive behavior rating scales require collateral informants to rate the individual's actual performance in their environment rather than their ability to perform certain behaviors. The expert should consider performing some of the adaptive behavior questions on the instruments with the defendant in order to obtain a partial hands-on assessment of functioning. Further, the expert psychologist can examine the individual's adaptive functioning on specific adaptive testing instruments that require the assessment of skills such as utilizing transportation, making change, signing checks and money orders, navigating maps, and using a phone book. The expert must also examine another area of adaptive functioning (academic achievement) with academic achievements tests. Academic functioning in fact is the adaptive area most often successfully proven by successful *Aktins* claimants.<sup>82</sup>

It is necessary when possible to obtain multiple family members and/or significant others in the defendant's life as collateral informants to provide information as to adaptive skills. It is imperative for the expert to interview numerous potential informants in order to secure an informant who knows the defendant well, can rate his behavior across a period of time in multiple settings, and who can be objective without significant bias in favor of the defendant. In addition to utilizing adaptive tests, the expert is encouraged to conduct an extended "open question" clinical interview with the family and friends of the defendant in order to

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<sup>82</sup> John H. Blume, Sheri Lynn Johnson, & Christopher Seeds, *An Empirical Look at Atkins v. Virginia and its Application in Capital Cases*, 76 TENN. L. REV. 625, 634 (2009).

obtain further information as to adaptive skills that might not be covered by adaptive functioning instruments. It is often helpful for the collateral informants to be interviewed individually and administered more than one adaptive instrument in order to provide convergent validity.

Prosecution experts often fail to interview *any* collateral informants in retrospective evaluations because they question the validity of the results. This, however, is no excuse to neglect interviewing family members to obtain necessary data on the defendant's historical adaptive skills. A number of federal courts have criticized the prosecution for failing to interview any respondents in *Atkins* hearings.<sup>83</sup>

Prior to the expert's interview, the defense attorney should engage in a screening process of possible respondents who could provide adaptive behavior information. The psychologist should not be left to interview multiple informants who might provide inconsistent and unreliable information rendering fodder for the prosecution. All individuals who the psychologist interviews should be interviewed by the defense team as part of mitigation preparation. When seeking individuals who may have first-hand knowledge of the defendant's deficiencies, one cannot simply walk into the room and ask a sister, "Hey, is your brother mentally retarded?" Such inquiry requires a level of trust between the attorney and the defendant's family, which cannot be established during a single interview, as well as patience for developing "context."

Correctional officers are not preferred informants for adaptive assessment instruments due to negative bias against the defendant and often a lack of knowledge about adaptive behaviors. Critically, prison institutional adaptation is not declarative of adaptive functioning in the community because the offender has less opportunity to display evidence of social, conceptual and practical skills on a regular basis in a correctional setting. Further, a thorough investigation into an offender's prison life is critical to uncover truths about what he is capable of doing; yet experts and attorneys may not be able to definitively discern whether a particular offender in fact filled out his administrative forms, prison kites and requests, etc. Again, the experts must focus on limitations rather than strengths of the offender in all contexts including prison life.

Similarly, an expert should not rely on a defendant's verbal behavior, such as recordings of the defendant's phone calls in jail, in assessing adaptive functioning. The User's Guide advises clinicians to not use verbal behavior to make inferences about an individual's adaptive behavior.<sup>84</sup> In *Davis*, the district court held the

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<sup>83</sup> See e.g., *United States v. Davis*, 611 F. Supp. 2d 472, 497-99 (D. Md. 2009) ("reject[ing] the conclusions of Dr. Spector as unsupported by the evidence and contrary to the accepted practices in the field" because the government's expert did not speak or interview any of the defendant's family, friends, or teachers); *Holladay v. Allen*, 555 F.3d 1346, 1362 (11th Cir. 2009) (crediting the defendant's psychologist's assessment over the government's psychologist's assessment on adaptive functioning because the government's expert failed to interview any respondents who knew the defendant prior to the age of 18).

<sup>84</sup> *Davis*, 611 F. Supp. 2d at 494 (citing Am. Ass'n. on Intellectual and Developmental Disabilities, *USER'S GUIDE* 22 (Robert L. Schalock et al. eds., 10th ed., 2007)).

telephone calls relied on by the government's experts were "largely irrelevant to the assessment of the defendant's adaptive functioning."<sup>85</sup>

Another issue with adaptive functioning is whether impairments in adaptive behaviors are directly related to and caused by subaverage intellectual functioning. The expert does not have to answer whether the adaptive behavior is caused by MR or something else. The impairments in adaptive functioning can be the result of many different biopsychosocial interactions in one's life, and they are at least in part connected to intellectual impairments.

One final area that should be considered in the assessment of adaptive behaviors is social and emotional intelligence. While the traditional adaptive tests used for assessing ID assess a number of skills rated by a collateral informant (social interaction, interpersonal relationships, coping skills, and use of play and leisure time), other assessment instruments can be administered to the claimant to assess emotional intelligence for ID evaluations. For example, the defendant's ability to perceive emotions, use and feel emotional information, understand emotions, and manage, modulate, and control emotions are all relevant to emotional adaptive behaviors. Deficits in social judgment, behavior, and social victimization are often indicated in the lives of *Atkins* petitioners.<sup>86</sup>

In summary, all relevant assessment information (adaptive testing, collateral informant information, psychosocial history records, and intellectual/academic achievement testing) should be considered for potential evidentiary value. Of note, there does *not* exist one single standardized adaptive behavior scale that captures the entire spectrum of adaptive behaviors across all age groups, but an expert must consider all this information in assessing the offender's adaptive functioning.

### 3. Maladaptive Behaviors: Street Smarts vs. Antisocial Personality

Some offenders who qualify for ID may also possess antisocial personality disorder. Intellectual limitations underlying ID are not disproved by an offender's coexisting personality disorder traits or evidence of maladaptive behaviors. Many prosecution experts will describe any maladaptive behavior or evidence of street smarts in a defendant's life as a product of a criminal personality rather than as an intellectual limitation. Challenging the prosecution in this area is sometimes overlooked by defense attorneys and defense experts.

The diagnoses of conduct disorder or antisocial personality disorder are relevant to a defendant's developmental criminality. An individual may possess street smarts and engage in criminal activity, but this fact does not diminish the point that he could also possess significant limitations in adaptive behavior. A reasonable clinician must diagnose ID when applicable even if he also meets a diagnosis of antisocial personality disorder (APD).<sup>87</sup>

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<sup>85</sup> *Id.* See also Stephen Greenspan & Harvey N. Switzky, *Lessons from the Atkins Decision for the Next AAMR Manual in AAMR in WHAT IS MENTAL RETARDATION? IDEAS FOR AN EVOLVING DISABILITY IN THE 21ST CENTURY*, 283, 291 (Harvey N. Switzky & Stephen Greenspan eds., 2006).

<sup>86</sup> Stephen Greenspan, *Homicide Defendants with Intellectual Disabilities: Issues in Diagnosis in Capital Cases*, EXCEPTIONALITY (forthcoming 2011).

<sup>87</sup> John Blume, Sheri Johnson & Christopher Seeds, *Of Atkins and Men: Deviations from Clinical Definitions of Mental Retardation in Death Penalty Cases*, 18 CORNELL J. L. & PUB. POL'Y., 689, 689-92 (2008-09).

When considering maladaptive behaviors, studies of children and adolescents with ID have found 30-50% also exhibit clinically significant behavior problems.<sup>88</sup> Frequently, a defendant with legitimate MR may display developmental negative and maladaptive behaviors, i.e., aggression, impulse control problems. These maladaptive behaviors are often misconstrued as evidence of conduct disorder and antisocial personality disorder. While a minority of individuals with MR also have antisocial personality, it is crucial for the examiner to adequately differentiate maladaptive from antisocial behaviors. Behaviors that interfere with an individual's daily activities are problem/maladaptive behaviors rather than the absence of adaptive behavior. Further, maladaptive behaviors may be utilized by the individual as a means to communicate their needs and can be considered adaptive.

When examining the criteria of APD – *impulsivity and failure to plan ahead* – are qualities often seen in those with MR as they may be prone to: low frustration tolerance, inability to restrain impulses, vulnerability to victimization, poor socialization skills; and deficient abilities in reading social cues. *Having a reckless disregard for self or others* is common among those with MR as they have difficulties taking care of themselves and maintaining a safe environment. The APD symptom of *consistent irresponsibility as indicated by repeated failure to sustain consistent work behavior or honor financial obligations* are frequent adaptive deficits consistent with MR. The APD symptom of *lack of remorse*, may also be displayed by those with MR as they have deficient social skills, lack sensitivity, and lack empathy to how their behaviors affect others. The APD symptom of *failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest*, can be seen in some individuals with MR as they may not readily learn from punishment or appreciate consequences of their acts. The APD symptom of *irritability and aggressiveness*, may be displayed by those with MR due to their difficulties with poor impulse control, vulnerability to victimization, poor communication skills, and inability to read social cues. In summary, depending upon the expert's point of view, such behavior is subject to interpretation.

#### 4. Experts Must Not Assess Homicidal Behavior as Adaptive Behavior

When considering the assessment of adaptive behaviors, the expert witness should not utilize the facts of the instant offense. Prosecution witnesses often will rely on evidence of: planned, premeditated, manipulative (rational) criminal behavior and leadership role in the crime as an assessment of the defendant's adaptive skills. However, this provides little evidence as to adaptive functioning.<sup>89</sup> Fabian (2009) noted that experts are not equipped to dissect the behavioral contexts of a defendant's alleged crimes when considering adaptive versus antisocial functioning.<sup>90</sup> The AAMR's User's Guide advises to "not use past criminal behavior

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<sup>88</sup> Bruce Baker, Cameron Neece, Rachel Fenning, Keith Crnic & Jan Blacher, *Mental Disorders in Five-Year-Old Children With or Without Developmental Delay: Focus on ADHD*, 39 J. CLINICAL CHILD & ADOLESCENT PSYCHOL., no. 4, 2010, at 492.

<sup>89</sup> *Ex parte Briseno*, 135 S.W.3d 1, 13 (Tex. Crim. App. 2004).

<sup>90</sup> John Fabian, *State Supreme Court Responses to Atkins v. Virginia: Adaptive Functioning Assessment in Light of Purposeful Planning, Premeditation, and the Behavioral Context of the Homicide*, 6 J. FORENSIC PSYCHOL. PRACTICE, no. 4, 2006 at 18.

or verbal behavior to infer level of adaptive behavior or about having MR/ID.”<sup>91</sup> Finally, the U.S. Supreme Court in *Atkins v. Virginia* and *Tennard v. Dretke* never supported a finding that in order for a capital defendant to be found MR, he needs to establish a nexus with his mental capacity (or lack thereof).<sup>92</sup>

5. It is Professionally Unethical For a Psychologist to Videotape an *Atkins*-Related Interview or Have A Third Party Present During Evaluation

Death penalty litigation is perhaps the most adversarial forum for forensic psychologists and neuropsychologists to practice in criminal cases. As a result, defense and prosecution attorneys will attempt to achieve the upper hand even at the sake of compromising the ethics of the expert witness conducting the evaluation. The expert witness psychologist must consult his/her ethical guidelines through the following organizations (American Psychological Association, American Academy of Clinical Neuropsychology, National Academy of Neuropsychology, and American Board of Forensic Psychology) when considering the recording of a forensic evaluation. Recording psychological/neuropsychological testing is inconsistent with the recommendations of the standards for educational and psychological testing of the APA as well as the published use of standardized instruments.<sup>93</sup> Videotaping and audiotaping the forensic examination (especially if the defendant is aware of the recording) invalidates the testing results. The presence of a third party observer such as an attorney is also inconsistent with the requirements for standardized test administration as set forth by the APA, Ethical Principles of Psychologists and Code of Conduct. As a practical matter, the presence of a defense attorney or other team member would create the impression the entire process has been orchestrated thereby destroying its credibility.

Recently there has been research assessing the effects of third party observers on a test-taker’s performance and multiple studies have shown impaired test performance on a broad range of tasks measuring cognitive and neuropsychological skills.<sup>94</sup> Importantly, the normative samples of the tests not standardized with third party observers, tape recorders, or video-cameras present. Recording an *Atkins* evaluation violates a psychologist’s duty and responsibility to ensure the reliability and validity of their assessment methods. Similarly, the secretive recording of

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<sup>91</sup> USER’S GUIDE, *supra* note 5.

<sup>92</sup> See *Atkins v. Virginia*, 536 U.S. 304, 317 (2002); *Tennard v. Dretke*, 542 U.S. 274, 289 (2004).

<sup>93</sup> Committee on Psychological Tests and Assessment, *Statement on Third Party Observers in Psychological Testing and Assessment. A Framework for Decision Making*, AM. PSYCHOL. ASS’N (2007) (referencing Marios Constantinou, Lee Ashendorf & Robert McCaffrey, *When the Third Party Observer of a Neuropsychological Evaluation is an Audio-Recorder*, 16 THE CLINICAL NEUROPSYCHOLOGIST, no. 3, 2002, at 407, 411-12).

<sup>94</sup> See e.g., Julie Horwitz & Robert McCaffrey, *Effects of a third party observer and anxiety on tests of executive function*, 23 ARCHIVES OF CLINICAL NEUROPSYCHOLOGY 409, 415 (2008); Marios Constantinou, Lee Ashendorf & Robert McCaffrey, *When the Third Party Observer of a Neuropsychological Evaluation is an Audio-Recorder*, 16 THE CLINICAL NEUROPSYCHOLOGIST, no. 3, 2002, at 407, 411; Constance Kehrer, Phyllis Sanchez, Ulya Habif, J. Gail Rosenbaum & Brenda Townes, *Effects of a Significant-Other on Neuropsychological Test Performance*, 14 THE CLINICAL NEUROPSYCHOLOGIST, no. 1, 1999, at 67, 70.

neuropsychological testing and interviewing, which may ameliorate possible invalidation of testing, is also unethical because it is deceptive and inconsistent with the APA ethical principles for psychologists.<sup>95</sup>

When an expert witness is court ordered to videotape or audiotape his evaluation, and/or to have any attorney or third party present to witness the evaluation, it is imperative for the expert to communicate with the lawyer the ethical and professional ramifications. The expert and lawyer should prepare an affidavit citing the professional literature in the fields of neuropsychology, psychology, and forensic psychology that consistently rejects this practice. The attorney should also request a hearing pertaining to this issue.

### III. THE ROLE OF DEFENSE ATTORNEYS IN *ATKINS* CASES

In conclusion, the criminal defense attorney practicing in *Atkins* capital litigation must consider the following roles to best represent his/her client:

1. Early on in the investigation process, consider mitigation themes relevant to neurocognitive impairment even if the defendant is below the *Atkins* MR threshold;
2. If the defendant does not meet *Atkins* ID/MR finding, the team may wish to consider a comprehensive neuropsychological evaluation of the defendant for mitigation or other litigation;
3. The lawyer should consult with experts concerning other legal issues that are relevant to a MR client, i.e., competency to stand trial and waive Miranda rights;
4. Investigate possible etiological and causative factors that lead to MR and neurodevelopmental impairments. Just because the defendant may have not been formally assessed as MR prior to age 18, does not indicate he is not MR;
5. Early on, the defense team must maintain close contact with family and significant others of the defendant and assess the appropriateness of these individuals as collateral informants;
6. Comprehensive school records should be collected including special education, individualized education placement, special behavioral programming and placements, and intellectual, adaptive, and academic testing results;
7. All prison records must be obtained which offer information on work skills, GED attainment, IQ and academic testing, and other adaptive skills information;
8. All employment and military records must be obtained;
9. Consider expert witnesses who have experience in the criminal forensic setting, have evaluated juvenile criminal defendants and have experience with developmental cognitive disorders and conduct disorder, and who have experience with neuropsychological testing and cognitive effort/motivation testing;

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<sup>95</sup> Shane Bush et al., *Secretive Recording of Neuropsychological Testing and Interviewing: Official Position of the National Academy of Neuropsychology*, 24 ARCHIVES OF CLINICAL NEUROPSYCHOLOGY, no. 1, 2009, at 2.

10. If resources permit, consider utilizing more than one expert to assess relevant issues, i.e., adaptive functioning versus intelligence;
11. Learn the AAIDD standards so the prosecution cannot litigate there is a nexus between the defendant's mental capacity, adaptive behaviors, and the crime;
12. Insure *Atkins* forensic examinations are not videotaped, audiotaped, or conducted with third party observer(s) present;
13. Experts are not to assess psychopathy, psychiatric malingering, and other irrelevant conditions outside the scope of the assessment of MR;
14. The attorney must be well versed with the AAIDD, AAMR, and DSM-IV-TR mental retardation definitions, standards, and considerations.

On a final note, any practicing criminal defense attorney should care deeply if his client is a person with ID/MR as this condition drastically affects the following issues throughout a criminal procedure:<sup>96</sup>

1. Client's level of involvement in the crime itself (they are often used by other criminals to assist in illegal activities without their understanding of the significance of their actions or their consequences);
2. Whether your client's statements are viewed as voluntary (a suspect's statements are not excluded without evidence of impermissible coercive conduct, the threshold of showing coercive conduct is lower if the defendant is ID);
3. Your client's ability to knowingly and intellectually understand and appreciate his Miranda rights is affected by ID;
4. The reliability of your client's statements are in question with ID (they often say what they think law enforcement wants to hear, they are suggestible and gullible, easily led and prone to acquiesce to manipulative police interrogation methods);
5. Your client's ability to understand the court proceedings, make legal decisions, prepare for trial, and rationally assist in his defense is affected by ID;
6. Your client's ability to remember and recall events is affected by ID (attention and memory skills are most likely impaired with ID).

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<sup>96</sup> OPENING THE DOOR: JUSTICE FOR DEFENDANTS WITH MENTAL RETARDATION: A HANDBOOK FOR ATTORNEYS PRACTICING IN TEXAS (TX Appleseed, 1st ed. 2005).