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Clinical Definitions of Mental
Retardation in Death Penalty Cases

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OF ATKINS AND MEN¹: DEVIATIONS FROM CLINICAL DEFINITIONS OF MENTAL RETARDATION IN DEATH PENALTY CASES

John H. Blume, Sheri Lynn Johnson & Christopher Seeds

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Under Atkins v. Virginia, the Eighth Amendment exempts from execution individuals who meet the clinical definitions of mental retardation set forth by the American Association on Intellectual and Developmental Disabilities and the American Psychiatric Association. Both define mental retardation as significantly subaverage intellectual functioning accompanied by significant limitations in adaptive functioning, originating before the age of 18. Since Atkins, most jurisdictions have adopted definitions of mental retardation that conform to those definitions. But some states, looking often to stereotypes of persons with mental retardation, apply exclusion criteria that deviate from and are more restrictive than the accepted scientific and clinical definitions. These state deviations have the effect of excluding from Atkins's reach some individuals who plainly fall within the class it protects. This article focuses on the cases of Roger Cherry, Jeffrey Williams, Michael Stallings and others, who represent an ever-growing number of individuals inappropriately excluded from Atkins. Left unaddressed, the state deviations discussed herein permit what Atkins does not: the death-sentencing and execution of some capital defendants who have mental retardation.

In 2002, following a consistent wave of state legislative action prohibiting the use of the death penalty on defendants with mental retardation, the Court overruled its thirteen-year-old decision in *Penry v. Lynaugh*,² and declared a categorical exemption from the death penalty for defendants who have mental retardation.³ In doing so, the Court recognized that defendants with mental retardation are less culpable because they have diminished capacities to understand and process information, to communicate, to learn from mistakes and from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.⁴ The Court defined the exemption supported by national consensus by embracing two clinical definitions – one provided by the American Association on Mental Retardation (AAMR) (now the American Association on Intellectual and Developmental Disabilities (AAIDD)) and the other by the American Psychiatric Association in its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).⁵ State measures for ascertaining mental retardation in capital cases, the Court suggested, would be “appropriate”—or “constitutional”—so long as they “generally conformed” to these clinical definitions.⁶ Thus, under *Atkins v. Virginia*, the Eighth Amendment protects

¹ John Steinbeck, *Of Mice and Men* (1937).

² 492 U.S. 302 (1989).

³ *Atkins v. Virginia*, 536 U.S. 304 (2002).

⁴ *Id.* at 318.

⁵ *Id.* (citing American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 41 (4th ed. text rev. 2000); AAMR, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 5 (9th ed. 1992)). The AAMR 1992 definition has since been redrafted in a 2002 revision but is substantially the same. See AAMR, MENTAL RETARDATION DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 13, 14, 17, 58 (10th ed. 2002); see also AAIDD, USER'S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 12 (10th ed. 2007).

⁶ *Id.* at 309 n.3; see *id.* at 317 n.22 (noting that “[t]he statutory definitions of mental retardation are not identical, but generally conform to the clinical definitions set forth in n. 3, *supra*”).

individuals who meet the AAIDD/AAMR criteria or the virtually identical criteria of the DSM-IV-TR.

The three-part clinical definitions set forth by the AAIDD and DSM-IV-TR define mental retardation as significantly subaverage intellectual functioning accompanied by significant limitations in adaptive functioning, originating before the age of 18.⁷ Since *Atkins*, most jurisdictions have adopted definitions of mental retardation that conform to those definitions. Some states, however, have taken *Atkins*'s statement that lower courts and state legislatures may define their own procedural rules for "enforcing the constitutional restriction,"⁸ as license to apply methods that deviate from and are more restrictive than the accepted scientific and clinical definitions. Some of these states, such as Texas, are among those that the Court identified as holdouts to the national consensus in *Atkins*.⁹ These deviations have the effect of excluding from *Atkins*'s reach some individuals who plainly fall within the class it protects—persons whom no reasonable clinician would exclude from a pool of subjects with mental retardation.

In *Cherry v. Florida*, for example, the state argued that the defendant's IQ score of 72 disqualified him under *Atkins*'s intellectual functioning requirement because the Florida statute refers to an IQ score of "70 or below." Cherry argued that the statistical concept of the standard error of measurement should apply, and that applying that concept his score was best understood as within a range of scores from 67 to 77. The court ignored statistics, imposed a 70 cutoff, and dismissed Cherry's *Atkins* claim, without considering adaptive functioning or onset.¹⁰ According to the scientific and clinical definitions of mental retardation, however, Roger Cherry's IQ score did not defeat his *Atkins* claim. Contrary to the Florida courts' rulings, the definitions recognized in *Atkins* entitled Cherry to a fair assessment of adaptive functioning.

In *Williams v. Quarterman*, the petitioner, who had a full scale IQ score of 70, faced a different problem. Denying Williams's *Atkins* claim, the Fifth Circuit Court of Appeals interpreted evidence of social and practical skill deficits—including an inability to live on his own, an inability to cook, an inability to hold a job, poor hygiene, becoming homeless, an inability to dress appropriately for weather, and an inability to follow the rules of games in school—as "bizarre and antisocial conduct," evincing characteristics that "are just as easily seen as attention-getting behaviors as they are evidence of mental retardation," traits that "could be explained by

⁷ The clinical definitions of mental retardation approved in *Atkins* provide:

Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.

American Association of Mental Retardation, *Mental Retardation: Definition, Classification, and Systems of Supports* (9th ed. 1992) (hereafter AAMR 9th ed.).

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning that is accompanied by 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.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 2000) (hereafter DSM-IV-TR).

⁸ *Atkins*, 536 U.S. at 317 (quoting *Ford v. Wainwright*, 477 U.S. 399 (1986)).

⁹ See *id.* at 316 n. 20.

¹⁰ *Cherry v. State*, 959 So.2d 702 (Fla. 2007).

anti-social personality rather than mental retardation.”¹¹ Contrary to the Fifth Circuit’s opinion, the scientific and clinical definitions emphasize that individuals with mental retardation often have mental disorders as well. No reasonable clinician would have determined that Jeffrey Williams did not have mental retardation merely because the evidence also supported a diagnosis of antisocial personality disorder.

In *State v. Stallings*, Ohio courts accepted that Michael Stallings had significantly subaverage intellectual functioning as well as significant limitations in adaptive functioning, but nevertheless rejected his *Atkins* claim because no defense expert could “definitely conclude” that onset of these impairments occurred before the age of 18; the experts testified only that mental retardation could not be ruled out.¹² In federal habeas review, the district court questioned whether the state court’s demand for a standardized test score pre-dating Stallings’s eighteenth birthday exceeded what *Atkins* requires, imposing in effect an “impossible burden” of proof on a petitioner not tested as a child or adolescent. Nevertheless, the court “reluctantly” affirmed, concluding that the state court’s prerequisite, if novel, was not unreasonable.¹³

The constitutional concerns these divergent approaches raise are readily apparent. This troubling array allows a defendant who would be ineligible for execution in one state to be eligible for execution in another.¹⁴ This state of affairs, in which factually similar *Atkins* claims generate different results by jurisdiction, is intolerable under the Eighth Amendment, which demands consistency and non-arbitrary application of punishment.

Atkins’s directive is straightforward. In applying the Court’s mandate, the States, while free to establish procedural rules, must adhere in substance to the scientific and clinical definitions of mental retardation set forth by the AAIDD and the DSM-IV-TR. Leaving “to the State[s] the task of developing appropriate ways to enforce the constitutional restriction upon its execution of sentences,”¹⁵ the Court gave states authority over the procedures used to implement the categorical exemption, such as whether determinations of mental retardation should be made by a judge or by a jury, whether determinations should occur before or after guilt-innocence trials, which party bears the burden of proof, and what entitles a mental retardation claim to an evidentiary hearing or bars it by procedural default.¹⁶ And the Court anticipated case-by-case dispute over the fact-intensive determination of whether a particular defendant has mental

¹¹ *Williams v. Quarterman*, 2008 WL 4280315, *13 (5th Cir. 2008).

¹² CR 1997 05-111(A), 2004 WL 5457509, slip op at 6 (Ohio Ct. Common Pleas Jan. 16, 2004).

¹³ *Stallings v. Bagley*, 561 F. Supp.2d 821, 885-86 (N.D. Ohio 2008) (applying 28 U.S.C. 2254(d)).

¹⁴ See, e.g., Dennis Olvera et al., *Mental Retardation and Sentences for Murder: Comparison of Two Recent Court Cases*, 38 *Mental Retardation* 228, 231 (2000) (finding that in factually similar cases, different courts reached different results). See generally Lois A. Weithorn, *Conceptual Hurdles to the Application of Atkins v. Virginia*, 59 *Hastings L. J.* 1203, 1231 (2008) (“[A]s the comparison between Florida’s and California’s use of standardized IQ tests suggests, there are noteworthy inconsistencies in the ways in which state courts are using these tests. This result is disturbing in light of the dramatic real-world consequences of the application of these tests in the *Atkins* context. A defendant with Full Scale IQ scores ranging from 68 to 86 was determined to be eligible for the death penalty in Florida, while a defendant with Full Scale scores of 81 to 96 was found to be ineligible in California.”).

¹⁵ *Atkins v. Virginia*, 536 U.S. 304, 317 (2002) (citing *Ford v. Wainwright*, 477 U.S. 399 (1986)).

¹⁶ For a general discussion of state procedures for determining mental retardation following *Atkins*, see Steiker & Steiker, *Atkins v. Virginia: Lessons from Substance and Procedure in the Constitutional Regulation of Capital Punishment*, 57 *DePaul L. Rev.* 721, 724-30 (2008); *id.* at 731-37 (focusing on the use of procedures to circumvent the constitutional exemption).

retardation.¹⁷ But the Court did not give the States license to narrow the class of persons who fall within the constitutional prohibition.

Roger Cherry, Jeffrey Williams, and Michael Stallings represent an ever-growing number of individuals who are inappropriately excluded from *Atkins*'s reach based on distortions or novel amendments inconsistent with the scientific and clinical definitions. These deviations have a significant impact on the adjudication of mental retardation claims in capital cases. Left unaddressed, they ultimately permit what *Atkins* does not: the death-sentencing and execution of some capital defendants who have mental retardation.¹⁸

I. The Framework: *Atkins* and the Scientific and Clinical Definitions

Both the AAIDD and DSM-IV-TR define mental retardation in three parts, as a disability characterized by [1] significantly subaverage intellectual functioning (represented by an IQ score two standard deviations below the mean, usually 70) and [2] significant limitations in adaptive behavior or functioning as expressed in conceptual, social, and practical adaptive skills [3] originating before the age of 18.¹⁹ Significantly subaverage intellectual functioning is most accurately defined not strictly by IQ scores, but as intellectual performance that is at least two standard deviations below a societal mean. Over ninety-seven percent of all people fall within two standard deviations, or thirty points, of the mean; the class of individuals with mental retardation, in other words, includes less than three percent of the population. Eighty-five percent of persons with mental retardation—and most capital defendants with mental retardation—fall in the “mild” classification, the highest level of functioning to meet the clinical definitions, which “typically describes people with an IQ level of 50-55 to approximately 70,”²⁰ and in terms of mental age is similar intellectually in many ways to an average ten-year-old, or a fifth or sixth grade student.

Because most capital defendants with mental retardation fall in this upper boundary, any factor that introduces unreliability into the procedure and renders a defendant's test score erroneously high is dangerous. Courts and advocates must therefore be aware that not all IQ tests are equal, vigilant that the tests are scored properly²¹ and are current, and in all cases account for

¹⁷ 536 U.S. at 317 (“Not all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus.”).

¹⁸ Many issues confronting mental retardation assessments under *Atkins* mirror ongoing debate in scientific forums, on issues such as whether certain standardized instruments properly measure adaptive functioning and whether intelligence should be defined by labeled groups or by standard deviations below the mean, or even whether “assessment methods used to evaluate ‘mental retardation’ in educational and social service settings can be employed in the death penalty context without modification, reservation, or additional scrutiny.” See generally Lois A. Weithorn, *Conceptual Hurdles to the Application of Atkins v. Virginia*, 59 Hastings L. J. 1203 (2008). These questions are not the concerns of lower courts under *Atkins* and they do not concern us here.

¹⁹ Id. (citing AAMR, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS (9th ed. 1992) at 5; DSM-IV-TR (4th ed.) at 41. The AAMR 1992 definition has since been redrafted in a 2002 revision but is substantially the same. See AAMR, MENTAL RETARDATION DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 13, 14, 17, 58 (10th ed. 2002); see also AAIDD, USER'S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 12 (10th ed. 2007).

²⁰ 536 U.S. at 309 n.3 (quoting DSM-IV).

²¹ See *Hall v. Quarterman*, 534 F.3d 365 (5th Cir. 2008) (holding state court unreasonably denied *Atkins* claim in part because decision based on a misreading of defendant's IQ as 72 instead of 67); *Lewis v. Quarterman*, 2008 WL 3319698 (5th Cir. 2008) (holding district court erred in refusing to consider affidavit

standard statistical concepts of measurement error, practice effect, and an effect unique to intelligence testing known as the Flynn effect. These requirements are incorporated by the AAIDD definition of significantly subaverage intellectual functioning, as “[p]erformance that is at least two standard deviations below the mean of an appropriate assessment instrument,²² considering the standard error of measurement for the specific assessment instruments used and the instruments’ strengths and limitations.”²³ Unfortunately, courts have uniformly adhered to these requirements, even though the clinical definitions stress them.

The two clinical definitions of mental retardation recognized in *Atkins* also have nearly identical requirements for adaptive functioning. At the time of *Atkins*, both clinical definitions required significant limitations in adaptive behavior in two of ten (AAMR) or two of eleven (DSM-IV-TR) skill areas. After *Atkins*, the AAMR revised the definition of adaptive functioning according to three rather than ten skill areas, as “the collection of conceptual, social, and practical skills that have been learned by people in order to function in their everyday lives.”²⁴ As the use of multiple skill areas suggests, assessing adaptive functioning deficits is an intensive task that involves taking into account the testimony of family members, teachers, employers, friends, family, correctional officers, and more. It is also a sensitive task in which one must look closely for clients putting on a “cloak of competence”—“passing” as normal or faking as though they do not have certain deficits—and for clients “cheating to lose,” who would rather die, literally, than be diagnosed with mental retardation. The clinical definitions guide this complex assessment with several operational principles.²⁵ Two of these principles—that “limitations in present

of the author of Stanford-Binet test stating that the psychologist who administered the test to the defendant did not follow proper procedures).

²² An appropriate assessment instrument is an intelligence test that is generally accepted in the field (the most common are the Wechsler Adult Intelligence Scale (WAIS-III) and the Stanford-Binet Intelligence Scale (SB5)), is properly normed on a sample that represents the defendant’s age and cultural and linguistic background, and is current. The mean of a properly normed and current test is generally 100; two standard deviations below that mean is an IQ score of 70. This is presently true for the WAIS-III and the SB5. For a general discussion of appropriate intelligence tests, see AAMR 2002 at 59-71. Bonnie & Gustafson, 41 U. Rich. L. Rev. at 826-29, provides an excellent discussion of issues concerning intelligence testing and establishing the first prong of the clinical definitions of mental retardation under *Atkins*. For a discussion of the possibility of means other than 100, and accordingly situations in which two standard deviations below the mean registers as something higher than 70, see Bonnie and Gustafson, 41 U. Rich. L. Rev. at 842-43.

²³ AAIDD, USER’S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 12 (10th ed. 2007); AAMR, MENTAL RETARDATION DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 13, 14, 15, 17, 58 (10th ed. 2002).

²⁴ AAMR 10th ed. at 73. The 2002 AAMR, which reduced the skill areas to three, requires significant limitations in only one area. AAMR 10th ed. at 20-23 (table) (chronicling historical development of the current definition. The definitions of adaptive behavior, while following developments in consensus in the clinical field, have retained a consistent core meaning. See AAMR 10th ed. At 21-23.

²⁵ The shift to measuring adaptive functioning by skill areas was “contingent on” several “assumptions” or principles of application. These are part of the AAMR “application of the definition” or “operational definition” of mental retardation:

- (1) Limitations in present functioning must be considered within the context of community environments typical of the individual’s age peers and culture.
- (2) Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor, and behavioral factors.
- (3) Within an individual, limitations often coexist with strengths.
- (4) An important purpose of describing limitations is to develop a profile of needed supports.

functioning must be considered within the context of community environments typical of the individual's age peers and culture" and "within an individual, limitations often coexist with strengths"—factor significantly in capital cases.²⁶

The third criterion for establishing mental retardation under the clinical definitions is that the functional limitations associated with mental retardation develop before the subject is eighteen years of age. Evidence of onset is usually established through a social history investigation, which includes a thorough inventory of school records, medical records, and interviews with witnesses (most importantly teachers and school peers) who knew the defendant in the community environment – including the individual's age peers and culture – in which he or she grew up.²⁷ The clinical definitions neither specify nor require that onset be established by a standardized test score.²⁸

Overall, none of the diagnostic criteria for mental retardation "include an exclusion criterion."²⁹ This is because of the well-accepted understanding that individuals with mental retardation possess a wide variety of "abilities and needs."³⁰ Some individuals with IQ scores between 70 and 75 have mental retardation, while others, lacking significant deficits in adaptive functioning, do not. Some individuals with mental retardation suffer from a concurrent mental disorder, others do not. Some individuals, due in part to social and cultural factors, have taken standardized intelligence or adaptive behavior tests before the age of eighteen, while others have not. Because all individuals with mental retardation are unique, the clinical definitions eschew exclusion criteria. Since *Atkins*, the few state and federal courts have nevertheless applied exclusion criteria, often looking to stereotypes. In these determinations of mental retardation, the science—the "standards of measurement, assessment, and diagnosis at the center of *Atkins* adjudications"—have been betrayed.³¹

II. Roger Cherry and Others Excluded from *Atkins*'s Reach Despite Qualifying IQ Scores

For Roger Cherry, the issue on appeal was whether he could satisfy the first prong of the definition of mental retardation with an IQ test score of 72. The Florida statute referred only to an IQ score of "70 or below," and because of this, the state court determined a strict cutoff should apply and not the standard error of measurement. Without considering adaptive functioning, the court ruled that Cherry did not have mental retardation based on his IQ score.³² *Cherry* illustrates

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- (5) With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

See 10th ed. at 8-9, 13, 27.

²⁶ SHALOCK LUCKASSON, CLINICAL JUDGMENT 39 (AAMR, 2005); see AAMR 10th ed. at 8; DSM-TR-IV at 42, 47.

²⁷ AAIDD User's Guide (2007) at 18-20.

²⁸ Accord Bonnie & Gustafson, 41 U. Rich. L. Rev. at 855.

²⁹ DSM-IV-TR at 47.

³⁰ *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 445 (1985).

³¹ Accord Bonnie & Gustafson, 41 U. Rich. L. Rev. at 816 ("At the very least, the Court must have assumed that expert disagreements would rest on articulable differences in scientific or clinical judgment, rather than on hidden disagreements about whether the offender deserves a death sentence. In this sense, the very soundness of the *Atkins* decision, and the integrity of *Atkins* adjudications, turns on the effort made by the states to implement it in a scientifically satisfactory manner.") (focusing on Va. Code Ann. §§ 19.2-264.3:1.1-1.2 (Repl. Vol. 2004)).

³² *Cherry v. State*, 959 So.2d 702 (Fla. 2007).

a recurring problem after *Atkins*: courts' failure to apply the standard error of measurement and other practice effects to all IQ scores.

A. The Accepted Understanding of Significantly Subaverage Intellectual Functioning Applies Standard Measurement Error and Other Practice Effects to All IQ Scores

When the Court recognized in *Atkins* that “‘mild’ mental retardation . . . typically describes people with an IQ level of 50-55 to *approximately* 70,”³³ the word “approximately” was important. It refers to the standard error of measurement and other known phenomena, such as the practice effect, that impact accurate interpretation of intellectual test scores. “Because all measurement, and particularly psychological measurement, has some potential for error, obtained scores may actually represent a range of several points.”³⁴ This error can obtain from the behavior of the tester or the manner in which the tester provides the test, the environment in which the test is taken and its immediate effect during the test upon the subject, or other factors, such as the properties of the test instrument.³⁵ The concept of the Standard Error of Measurement (SEM), accounts for the threat error poses to test-score reliability. It “describes the band of error surrounding an individual’s theoretical ‘true’ score on that test” and “estimates the standard deviation of an individual’s scores on a test if that person could be tested a large number of times, and effects such as practice and fatigue could be ruled out.”³⁶ On up to date and well-standardized tests, the SEM is between three to five points. “Thus an IQ standard score is best seen as bounded by a range that would be approximately three to four points above and below the obtained score,” and “an IQ of 70 is most accurately understood not as a precise score, but as a range of confidence”³⁷ or as a range of scores that varies with the level of confidence in the

³³ 536 U.S. at 309 n.3 (quoting DSM-IV) (emphasis added).

³⁴ AAMR, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS (10th ed. 2002).

³⁵ See James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues*, 27 MENTAL & PHYSICAL DISABILITY L. REP. 11, 13 (2003) (“As much as the criminal justice system might prefer to have a hard-and-fast limitation measureable by a single IQ score, it is simply impossible to exclude consideration of other factors about the testing performed on the individual, or to ignore the need for clinical judgment by experienced diagnosticians.”). Scoring errors are also a prominent problem. See, e.g., Joseph J. Ryan, *Scoring Reliability on the WAIS-R*, 51(1) J. CONSULTING AND CLINICAL PSYCHOLOGY 149 (1983). Ryan’s study asked 19 psychologists and 20 graduate students to score two completed WAIS-R protocols. The study obtained significantly different results, which demonstrated that “scoring error has a significant impact on the accuracy of WAIS-R summary scores. . . . Inspection of the individual protocols by the authors revealed that IQ variability resulted from mechanical errors in scoring, such as incorrectly converting scaled scores to IQs, giving incorrect credit to individual items, and calculation errors in adding raw scores of subtests.” *Id.* He concluded that this lack of scoring precision, along with “other sources of unreliability that are known to influence performance, such as test administration, examiner-examinee characteristics, and the psychometric properties of the instrument . . . underscore[] the need to report IQ values in conjunction with a precision range based on the standard error of measurement of the test.” *Id.*

³⁶ DAVID WECHSLER, WAIS-R MANUAL: WECHSLER ADULT INTELLIGENCE SCALE – REVISED 31 (1981); see THE PSYCHOLOGICAL CORPORATION, WAIS-III – WMS-III TECHNICAL MANUAL 53 (1997) (“The standard error of measurement is used to calculate the confidence interval, or the band of scores, around the observed score in which the individual’s true score is likely to fall. . . . The examiner can use confidence intervals to report an individual’s score as an interval that is likely to contain the individual’s true score. Confidence intervals also serve as a reminder that measurement error is inherent in all test scores and that the observed test score is only an estimate of true ability.”).

³⁷ *Id.* at 57. See J. P. GUILFORD, PSYCHOMETRIC METHODS (2d ed. 1936, 1954). Guilford notes that with the SEM, “for any given obtained score, then, we can draw conclusions concerning the probable limits of corresponding true scores.” *Id.* Where the SEM of a test is X, “[w]e may say that for any particular true

desired result. Accordingly, both clinical definitions include measurement error in the definition of intellectual functioning:

Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below. It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior.³⁸

Therefore, as the WAIS-III Manual describes, “[i]t is clear that neither of [the clinical definitions] intends for a fixed cutoff point for making the diagnosis of mental retardation.”³⁹ The Court recognized the same in *Atkins*, noting that “[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.”⁴⁰ The bottom line is that a person can have an IQ score (or scores) over 70 – and as high as 75 – and still have mental retardation.⁴¹ This is universally recognized in clinical practice⁴², as legal commentators have noted.⁴³

score the odds are two to one that the obtained score will not deviate more than one [x] from it.” *Id.* at 389. “A departure of [2X] from the true score would be expected in one case in about twenty.” *Id.* See GUILFORD & BENJAMIN FRUCHTER, *FUNDAMENTAL STATISTICS IN PSYCHOLOGY AND EDUCATION* 337 (6th ed. 1978, 1942) (notes that using a SEM enables scientific investigators to “say something definite concerning how trustworthy [their] predictions are – about how much error one should expect in the phenomenon predicted”); Henry E. Garret, *STATISTICS IN PSYCHOLOGY AND EDUCATION* 320 (2d. ed., 1926, 1937) (stating SEM measures the “effect of variable or chance errors in producing divergences of an obtained score from its theoretically true value”); FREDERIC M. LORD & MELVIN R. NOVICK, *STATISTICAL THEORIES OF MENTAL TEST SCORES* 66-67 (1968) (explaining that the standard error of measurement is “a measure of the discrepancy between the estimate and the actual value of the true score” that illustrates “the relative magnitude of these errors”). The SEM at a level of 95% confidence for the WAIS-III is generally plus or minus 5 points, which “[i]n effect . . . expands the operational definition of mental retardation to 75. *Id.* at 57.

³⁸ DSM-IV-TR at 41-42; see AAMR, *MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS* 14 (9th ed. 1992) (defining significantly subaverage intellectual functioning as “approximately 70 to 75 or below” The AAMR 10th edition adjusted this language in response to confusion over whether a 75 IQ score would also be subject to an SEM range, but the definition did not change. AAMR 10th ed. at 28.

³⁹ AAMR 10th at 58.

⁴⁰ 536 U.S. at 309 n. 5.

⁴¹ The integral nature of the SEM as a reliability measure to the intelligence prong of MR diagnosis and classification is also exemplified by the 1992 AAMR definition of significantly subaverage intellectual functioning as “approximately 70 to 75 or below.” As the 2002 Manual explains, this definition explicitly applied the standard error of measurement in the definition rather than stating it, as the current definition does. The 2002 manual explains that “[b]y defining significantly subaverage intellectual functioning as ‘approximately 70 to 75 or below,’ the authors of the manual intended to provide increased clarity, but not to change the cutoff.” AAMR 2002 at 28.

⁴² See THE PSYCHOLOGICAL CORPORATION, *WAIS-III TECHNICAL MANUAL* (1997) (describing the standard error of measurement as one of the “psychometric properties that are critical for the interpretation of scores.”).

⁴³ See, e.g., David DeMatteo, et. al., *A National Survey of State Legislation Defining Mental Retardation: Implications for Policy and Practice After Atkins*, 25 *BEHAV. SCI. LAW* 781, 791 (2007) (arguing against using cut-offs when measuring intellectual functioning and noting that “the most commonly used measures of intellectual functioning have a five-point measurement error, which means that an IQ measured at 75 may actually be as low as 70”); John M. Fabian, *Life, Death, and IQ: It’s Much More Than Just a Score:*

Two other phenomena occur in IQ testing that are widely recognized as scientifically legitimate and which must be taken into account to obtain a reliable score. One of these is the practice effect. Taking an IQ test more than once during a short period of time—within six to twelve months—may result in an artificially high score.⁴⁴ As the AAIDD explains, “[p]ractice effect gains occur even when the examinee has not been given any feedback on his performance.”⁴⁵ Effects are measured according to each IQ test, and the WAIS-III manual notes an increase of approximately five points when the test is given more than once within a period of two to twelve weeks.⁴⁶ Therefore, a score on the WAIS-III of 75 with a strong practice effect could mask a “true” IQ score of 70. Plainly, taking the practice effect into account could make the difference between an MR or non-MR diagnosis. Accordingly, the AAIDD warns that “clinicians need to be sensitive to these practice effects and best practices in intellectual assessment recommends against administering the same intelligence test to someone within the same year.”⁴⁷ Consequently, when looking at multiple IQ scores, it is imperative to know how the tests stand in relationship to one another in time.

A second clinically recognized effect in IQ test measurement is known as the Flynn effect. The Flynn effect identifies the gradual increase of IQ scores on a particular instrument over time. James Flynn, after whom the effect is named, has recognized different quantum of effect in different countries. For the United States, Flynn has measured that overall IQ scores rise at a rate of 3 points every 10 years, or a rate of 0.33 points per year since the test was normed or renormed. Thus, depending on the length of time a test has been in effect—due to rising IQ scores—the test mean will often be higher than 100. As the AAIDD notes, a WAIS-III test normed in 1995 with a mean of 100 would have a mean of 103 in 2005, ten years later.⁴⁸ Accordingly, two standard deviations below the mean would be higher than 70, it would be 73. It is for this reason that IQ tests are periodically renormed, which mutes the Flynn effect. Due to the Flynn effect, IQ scores must be adjusted to take into account when the IQ test was taken in relation to when the test was re-normed. As with the practice effect, failure to take the Flynn effect into account results in an artificially high IQ score. When looking at any IQ score therefore, it is imperative to know when the test was issued and when it was renormed. The AAIDD recognizes the Flynn effect and the practice effect as necessary for reliability, particularly when conducting retrospective diagnoses, those “when the individual with mental retardation did not receive an official diagnosis of mental retardation during the development period.”⁴⁹ Many courts have held that the Flynn effect must be accounted for.⁵⁰ But others have erroneously dismissed the Flynn effect as an “unexamined scientific concept”⁵¹ or as a concept

The Dilemma of the Mentally Retarded on Death Row, 5(4) J. FORENSIC PSYCHOLOGY 1 (2005) (recognizing that the AAMR criteria require consideration of a 5 point standard error of measurement). Accord Bonnie & Gustafson, 41 U. Rich. L. Rev. at 836 (“[T]he SEM must always be taken into account when interpreting scores on IQ tests; failing to do so would be a clear departure from accepted professional practice in scoring and interpreting any kind of psychological test, including IQ tests.”).

⁴⁴ AAIDD, USER’S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 21 (10th ed. 2007); WAIS-III Manual at 56.

⁴⁵ AAIDD, User’s Guide (2007) at 21.

⁴⁶ WAIS-III (1997) at 56.

⁴⁷ AAIDD User’s guide (2007) at 21.

⁴⁸ AAIDD User’s Guide (2007) at 21.

⁴⁹ AAIDD (2007) at 17.

⁵⁰ See, e.g., *Walker v. True*, 399 F.3d 315, 322 (4th Cir. 2005).

⁵¹ *Neal v. State*, 256 S.W.3d 264 (TCCA 2008).

that is only used in capital litigation.⁵² The importance that the AAIDD places upon the Flynn effect and practice effect as necessary for assessing the first criterion for mental retardation of the clinical definitions shows otherwise.

B. Some Jurisdictions Ignore the Fundamental Role of the SEM and Practice Effects in IQ Assessment

The Florida court in *Cherry* justified enforcing a bright-line cutoff at a full scale IQ score of 70 by distinguishing the clinical definitions, which expressly allow for scores over 70, from a less explicit state rule.⁵³ This is one of several ways in which courts since *Atkins* have failed to account for the standard error of measurement in measuring IQ and refute the clinical definitions.⁵⁴ A second errant approach dismisses the standard error of measurement if a subject tests in a similar range on two or more tests within a short period of time. In Texas, Jose Garcia Briseno presented full-scale IQ scores on the WAIS-III of 72 and 74, from examinations administered approximately one year apart. The defense expert asserted that, taking the SEM associated with the WAIS-III into account, a score as high as 75 could suffice to meet the intellectual functioning prong. The state's witness, psychologist testified that the SEM did not apply because there were two proximate test IQ scores on the WAIS-III within a year. Although the state's witness cited no source supporting this conclusion, the state courts adopted his point of view.⁵⁵ But in the event of two proximate scores on the same test within a short period of time, confidence in the result does not increase and the SEM does not correspondingly diminish. Because the SEM exists uniquely in every test circumstance it does not dissipate simply because several IQ tests are given.⁵⁶

⁵² *Ledford v. Head*, 2008 WL 754486 (N.D. Ga.). See *Green v. Johnson*, 515 F.3d 290, 300 n.2 (4th Cir. 2008).

⁵³ See, e.g., *Jones v. State*, 966 So.2d 319, 329 (Fla. 2007) (“Under the plain language of the statute, ‘significantly subaverage general intellectual functioning’ correlates with an IQ of 70 or below.”).

⁵⁴ See *Howell v. State*, 151 S.W.3d 450, 458 (Tenn. 2004) (interpreting statute demanding “significantly subaverage general intellectual functioning as evidenced by a functional intelligence quotient (I.Q.) of seventy or below” to impose a “bright line” cutoff at 70); *Bowling v. Com.*, 163 S.W.3d 361, 374-75 (Ky. 2005) (noting that “*Atkins* did not discuss margins of error” and interpreting statute defining “significantly subaverage general intellectual functioning” as “an intelligence quotient (I.Q.) of seventy (70) or below” to impose a “bright line cutoff” at 70); see also *Green v. Johnson*, 515 F.3d 290, 300 n.2 (4th Cir. 2008) (“[N]either *Atkins* nor Virginia law appears to require expressly that [SEM] be accounted for in determining mental retardation status.”); cf. *State v. Lott*, 779 N.E.2d 1011, 1014 (Ohio 2002) (applying rebuttable presumption that defendant is not mentally retarded if IQ is over 70); see also Bonnie, *The American Psychiatric Association’s Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. AM. ACAD. PSYCHIATRY LAW 304, 305-06 (2004) (stating that the American Psychiatric Association’s Council on Psychiatry and Law takes the position that “incorporation of a specific cutoff score is inappropriate, not only because different tests have different scoring norms, but also because designating a specific score ignores the standard error of measurement and attributes greater precision to these measures than they can support.”); Bonnie & Gustafson, 41 U. Rich. L. Rev. at 844 (“[A] cut-off score for intellectual functioning would only be plausible if it were defined as 70 or below on a specific test with a mean of 100 and a standard deviation of 15 and if it incorporated some way of taking individualized factors such as the Flynn effect and practice effects into account. This is not an advisable approach.”).

⁵⁵ See State Habeas Court Findings of Fact and Conclusions of Law, at 2 (quoted in *Briseno v. Dretke*, 2007 WL 998743 at *9); accord *Ledford v. Head*, 2008 WL 754486, *8 (N.D. Ga. 2008) (finding 77 FSIQ on WAIS-R in 1992 and 79 FSIQ on WAIS-III in 2007 “corroborate each other, and thus reduce the likely impact of the standard error of measurement”).

⁵⁶ A letter by the author of a chapter on the WAIS-III devoted to serial testing of IQ scores, submitted to the TCCA by Briseno’s attorneys, offered the proper clinical approach: “[Briseno’s] second test score of 74 is

Further, some courts correctly recognize that the SEM and IQ produce a range rather than a number nevertheless dismiss downward adjustment as “speculative” because the SEM “could as likely increase as reduce the IQ score.”⁵⁷ This perspective was summed up by the district court in *Briseno*, which observed in affirming the state court’s determination that “[b]ecause measurement error could as easily raise a petitioner’s scores otherwise falling below 70 above that threshold, federal courts are reluctant to grant habeas relief based on an IQ score falling within the borderline area.”⁵⁸ Pointing to diversity in state approaches, the district court concluded that “no decisive consensus exists among the States, [so] the Texas courts did not unreasonably apply *Atkins* with respect to its consideration of *Briseno*’s IQ score.”⁵⁹ This refutes the clinical definitions and violates *Atkins* in precisely the same way as a cutoff score does: it fails to take into account the SEM.⁶⁰

The district court’s statement in *Briseno* emphasizes an additional point. Federal habeas review of state court determinations under the AEDPA commands federal courts to uphold state court applications of law that are not unreasonable, even if incorrect. Under this standard of review, federal courts are shy to overturn state court determinations rejecting downward adjustment based on the SEM; the courts are “reluctant” to reverse on what appears to be a judgment call by the state court on how accurate the court thinks the IQ test actually is. The same problem exists with dismissing the SEM where multiple proximate tests exist. One may readily argue that with life or death on the line, it makes little sense not to err on the side of inclusion of downward adjustment.⁶¹ But more, federal courts should recognize that the state court is exercising discretion where *Atkins* left none, unreasonably refusing to apply the standard error of measurement in assessing intelligence that the clinical definitions and *Atkins* require. This is particularly troublesome because of the place of the intelligence criterion in determining mental retardation.

C. The Place of the Intelligence Criterion in Determining Mental Retardation

For those functioning in the “upper boundary of mental retardation,” as most capital defendants with mental retardation do, “IQ scores alone cannot precisely identify an individual’s

consistent with his initial score of 72, and his estimated true IQ score is 95 times out of 100 likely fall within the range of 67-79.” See Davis S. Tulskey (ed.), *Clinical Interpretation of the WAIS-III and WMS-III* (2003). In addition, the practice effect, see *infra*, would increase.

⁵⁷ *Ledford v. Head*, 2008 WL 754486 at *8; see *Green v. Johnson*, 515 F.3d at 300 n.2.

⁵⁸ 2007 WL 998743 at *10.

⁵⁹ *Id.* (citing 28 U.S.C. § 2254(d)(1)); see *id.* at *7-9 (“[P]recise tracking of the AAMR’s approach is not ‘clearly established’ federal law,” the district court held in *Briseno*, observing that states are all over the map on the use of a cutoff.”).

⁶⁰ See Robert G. Knight, *On Interpreting the Several Standard Errors of the WAIS-R: Some Further Tables*, 51(5) JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY 671 (1983) (describing three methods of SEM for WAIS). Alfred L. Brophy, *Confidence Intervals for True Scores and Retest Scores on Clinical Tests*, 42(6) J. OF CLINICAL PSYCHOLOGY 989 (1986).

⁶¹ Bonnie & Gustafson, 41 U. Rich. L. Rev. at 836 (“If courts consider it desirable to err on the side of finding mental retardation in *Atkins* cases in order to avoid the risk of mistakenly executing a defendant who actually qualified for Eighth Amendment protection, perhaps they would decide only to use SEM to decrease a score. If so, SEM could only be used to put a defendant into the mentally retarded range but not to take a defendant out of that range.”); Weithorn, *Conceptual Hurdles to the Application of Atkins v. Virginia*, 59 Hastings L. J. at 1206 (arguing that given the “severity and finality of the death penalty, state policies should err on the side of casting a net that is too wide rather than one that is too narrow in defining ‘mental retardation’”).

functioning . . . and thus an upper range of 70 to 75 is typically suggested.”⁶² It is erroneous to rule out mental retardation simply because a person has an IQ just above 70 without first considering context and deficits in adaptive functioning.⁶³ The intelligence measurement performed by IQ testing is, in other words, a gateway or “a guideline [that] could be extended upward through IQ 75 or more, depending on the reliability of the intelligence test used.”⁶⁴ For an individual with an IQ on the border of the 70 range, the diagnosis is ultimately determined by whether the individual has significant adaptive behavior deficits.⁶⁵ Cases like *Cherry* deny defendants whose scores fall within a qualifying range an opportunity to establish adaptive functioning limitations. *Cherry* was entitled to a fair assessment of adaptive functioning before being excluded from *Atkins*’s pool.

II. The Case of Jeffrey Williams, and Other Exclusionary Interpretations of Adaptive Functioning

In contrast to Roger *Cherry*, Jeffrey Williams scored 70 or below. The denial of Williams’s *Atkins* claim turned on the courts’ interpretation of evidence of Williams’s adaptive functioning. In *Atkins*, the Court recognized that deficits in adaptive behavior reduce the personal culpability of a defendant charged with a crime because they contribute to a “diminished capacit[y] to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.”⁶⁶ Williams presented evidence showing an inability to live on his own, an inability to cook, an inability to hold a job, an inability to maintain a stable home, an inability to dress appropriately for weather, and an inability to follow the rules of games. Adhering to the skill areas identified by the clinical definitions, the defense expert, who concluded that Williams had mental retardation, and the state expert, who concluded he did not, both identified adaptive functioning limitations in social skills. The defense expert found the evidence also showed significant limitations in practical skills. According to the clinical definitions, these findings supported a diagnosis of mental retardation.

The federal courts in *Williams*, however, found that other evidence, including achievement tests, the opinions of multiple lay witnesses that Williams did not have mental

⁶² AAIDD, USER’S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 24 (10th ed. 2007). “IQ scores alone cannot precisely identify an individual’s functioning in the upper boundary of mental retardation.” USER’S GUIDE at 24 (suggesting an upper range of 75).

⁶³ Caroline Everington & J. Gregory Olley, *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8(1) JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE 1, 6 (2008) (“There is no finite score that can represent one’s intellectual functioning with 100% accuracy. There is always a measurement error . . . Furthermore, this score does not stand in isolation but must be considered with other evidence [(adaptive behavior)].”); Kay B. Stevens & J. Randall Price, *Adaptive Behavior, Mental Retardation and the Death Penalty*, 6(3) J. FORENSIC PSYCHOLOGY PRACTICE 1, 21 (2006) (“Limiting the determination of mental retardation to a specific IQ score is unacceptable due to multiple factors such as measurement error and cultural bias.”).

⁶⁴ AAMD, MENTAL RETARDATION DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 11 (8th ed. 1983).

⁶⁵ The original purpose of the concept of adaptive behavior in the clinical definitions was to check false positives—it first appeared in the AAMR definition of mental retardation in 1959, with the intent “to better reflect the social characteristics of the disability, to reduce the reliance on IQ scores, and to decrease the number of ‘false positives,’ or individuals falsely identified as having mental retardation.” AAMR 10 at 24; see *id.* at 34 (quoting MacMillan et al. (adaptive behavior is “a bulwark against false positives that would occur if IQ was used as the sole determinant of mental retardation”)).

⁶⁶ *Atkins*, 536 U.S. at 318.

retardation, and evidence of Williams’s adaptive strengths “overrode” the evidence of adaptive limitations.⁶⁷ The federal district court pointed to “substantial adaptive strengths, finding that Williams rented an apartment, bought at least two vehicles, [and] washed his clothes.” And the Fifth Circuit further characterized Williams’s adaptive deficiencies as “bizarre and antisocial conduct,” evincing characteristics that “are just as easily seen as attention-getting behaviors as they are evidence of mental retardation” and “could be explained by anti-social personality rather than mental retardation.”⁶⁸ Focusing on adaptive strengths, and dismissing the deficits that Williams experienced as symptoms of antisocial personality disorder, the federal courts held that Williams failed to establish *Atkins*’s second prong.

The courts were wrong on both counts. Persons with mental retardation often have mental disorders as well. And because individuals with mental retardation, even those with intelligence scores at the same level, vary widely in what they can do, science does not prescribe a list of abilities that exclude mental retardation, but rather defines mental retardation by what an individual cannot do. No reasonable clinician would have determined that Williams did not have mental retardation merely because he also met a diagnosis of antisocial personality disorder. And no reasonable clinician would have excluded Williams simply because he was able to buy a car, purchase an apartment, and wash his clothes—particularly when other evidence showed that after Williams bought the car, he failed to maintain it; that after he purchased his apartment, he lost it and became homeless; and that, even if able to wash his clothes, Williams did not manage his own hygiene. Williams’s case is representative of scientifically unsound and *Atkins*-violative assessments of adaptive functioning.

A. Prioritizing Limitations, Not Strengths.

The use of skill areas to define adaptive functioning is “contingent” on a handful of principles, which help to form the “operational definition of mental retardation.”⁶⁹ Most important in criminal proceedings are the principles that limitations often coexist with strengths and that limitations in functioning must be assessed in the context of community environments. The AAIDD explains:

Within an individual, limitations often coexist with strengths. This means that people with mental retardation are complex human beings who likely have certain gifts as well as limitations. Like all people, they often do some things better than other things. Individuals may have capabilities and strengths that are independent of their mental retardation. These may include strengths in social or physical capabilities, strengths in some adaptive skill areas, or strengths in one aspect of an adaptive skill in which they otherwise show an overall limitation.⁷⁰

[M]ental retardation is not something you have, like blue eyes or a bad heart. Nor is it something you are, like being short or thin. It is not a medical disorder, although it may be coded in a medical classification of diseases; nor is it a mental disorder, although it may be coded in a classification of psychiatric disorders. Mental retardation refers to a particular state of functioning that begins in childhood, is multidimensional, and is affected positively by individualized

⁶⁷ Williams, 2008 WL at 4280315 at *11.

⁶⁸ Williams v. Quarterman, 2008 WL 4280315, *13 (5th Cir. 2008).

⁶⁹ AAMR 10th ed. at 8-9, 13, 27.

⁷⁰ Id. at 8.

supports. . . . [A] comprehensive and correct understanding of the condition of mental retardation requires a multidimensional and ecological approach that reflects the interaction of the individual and his or her environment, and the person-referenced outcomes of that interaction related to independence, relationships, contributions, school and community participation, and personal well-being.⁷¹

Knowing these principles and applying them are critical to avoid the stereotyping that has historically led to misunderstandings of the adaptive abilities of individuals with mental retardation. Because limitations define mental retardation, adaptive strengths are relevant only insofar as they offset particular adaptive weaknesses, understanding that limitations coexist with strengths requires a particularized balancing of skill-area-specific strengths versus weaknesses, balancing *within skill areas*, rather than a general assessment of overall adaptive behavior, which occurred in Williams.⁷²

1. Legacy of Stereotype.

While adaptive strengths within skill areas are relevant insofar as they offset evidence of a corresponding deficit, strengths in adaptive behavior can never establish mental retardation. “The diagnostic criteria for mental retardation do not include an exclusion criterion”⁷³ Strengths and weaknesses thus may coexist, but strengths have no value independent of weaknesses.⁷⁴ Nevertheless, since *Atkins*, numerous courts have dismissed mental retardation claims, finding no adaptive behavior limitations, without mentioning the alleged deficits or balancing them against the alleged strengths—relying, rather, entirely upon alleged adaptive abilities.⁷⁵

The consequence is that some courts, failing to engage in the careful and thorough analysis called for by the definitions, resort to stereotype. Stereotyping has long been a problem with regard to mental retardation. From early legal codes defining the criminal defense of “idiocy” for “a person who cannot account or number twenty pence,” to the turn-of-the-twentieth-

⁷¹ 2002 AAMR Red Book at 48. This point is also well put by George S. Baroff, *Establishing Mental Retardation in Capital Cases: An Update*, 41(3) MENTAL RETARDATION 198, 199 (2003):

Another way of illustrating the artificiality of IQ 70, or any other single IQ, is to compare the distribution of IQs to the color spectrum. The latter ranges its colors in a series of very small steps, such that the transition from one color to another (e.g., yellow to orange) is so gradual that it is only at the extreme of one color that its difference from the other is obvious. The point is that we are asked to draw a diagnostic distinction that treats mental retardation as distinctly different from borderline intelligence. In fact, like the color spectrum, they really overlap. The point of this discussion is that rendering a decision as to mental retardation by IQ alone would be even more arbitrary if the scores are either at the ceiling of one range or at the floor of the next. Of course, the diagnosis is also based on adaptive behavior, and it can be expected that this criterion will assume added significance when scores are at the boundary of the IQ ranges.”

⁷² See *Lambert v. State*, 126 P.3d 646 (Okla. Crim. App. 2005), discussed *infra*; *Holladay v. Campbell*, 463 F.Supp.2d 1324 (N.D. Ala. 2006), discussed *infra*.

⁷³ DSM-IV-TR at 47.

⁷⁴ See *Lambert*, 126 F.3d at 651 (recognizing that unless evidence of an adaptive strength corresponds to an adaptive deficit upon which the defendant relies, evidence of the strength is irrelevant to the proceedings, and should not even be admitted).

⁷⁵ For example, see *Rodriguez v. State*, 919 So.2d 1252 (Fla. 2005), which relies solely on the defendant’s outbursts during trial to refute mental retardation, even though the defendant’s impulsiveness and inappropriate behavior suggested adaptive behavior limitations consistent with mental retardation.

century view that “every imbecile . . . is a potential criminal,” the “mentally retarded” have been regarded as a group both incompetent and dangerous.⁷⁶ One would hope that a positive byproduct of the clinical shift from generalized assessment of adaptive behavior to a focus on the inability to perform particular core skills would have been acknowledgement that “[m]entally retarded people are individuals” and that “[a]ny attempt to describe them as a group risks false stereotyping and therefore demands the greatest caution.”⁷⁷ But despite scientific advances and evolving social perspective, stereotype still pervades adaptive behavior assessment in capital cases.

Several years ago, the Mississippi Supreme Court rejected expert reports and standardized test results showing adaptive behavior limitations, and denied an evidentiary hearing on mental retardation, because the evidence was at odds with the court’s and the state’s understanding of what “retarded people cannot do”

These reports, affidavits and testimonies do not paint the picture of a retarded person. Simply because *retarded people do not* operate heavy machinery, retarded people do not drive tractors, retarded people do not hold jobs for much longer than a year at a time, much less work two jobs at a time, retarded people are not admitted to the radio operator school of the Army, retarded people do not get drivers licenses, buy cars and drive cars. Further, retarded people do not support families and see to it that all the bills are paid, retarded people do not see to the care of others and make sure they have enough money, a nice house, and school clothes.⁷⁸

The Mississippi court likely would not have used the phrase “retarded people do not” if the court possessed a more realistic perspective about what suffering from mental retardation actually means.⁷⁹ Even prior to the court’s decision in *Wiley*, it was estimated that “eighty-nine percent of all persons with mental retardation ‘can usually acquire the vocational and social skills necessary for independent living.’”⁸⁰ Individuals with mental retardation can drive, can hold jobs, can make

⁷⁶ Ellis & Luckasson, *Mentally Retarded Defendants*, 53 Geo. Wash. L. Rev. 414, 416-20 (1988); see *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 454-55 (1985) (Stevens, J., concurring) (“The discrimination against the mentally retarded that is at issue in this case is the city’s decision to require an annual special use permit before property in an apartment house district may be used as a group home for persons who are mildly retarded. The record convinces me that this permit was required because of the irrational fears of neighboring property owners, rather than for the protection of the mentally retarded persons who would reside in respondent’s home.”); see also *Buck v. Bell*, 274 U.S. 200 (1927) (discussing sterilization of “feeble-minded”).

⁷⁷ Ellis and Luckasson at 427.

⁷⁸ *Wiley v. State*, 890 So.2d 892, 897 (Miss. 2004) (emphasis added), aff’d, *Wiley v. Epps*, 2007 WL 405041, *34 (N.D. Miss.).

⁷⁹ *Accord Hughes v. State*, 892 So.2d at 215 (discussing *Wiley*, 890 So.2d at 896) (“This Court found [the expert’s] affidavit in [*Wiley*] insufficient to warrant an evidentiary hearing [in part] because . . . the record indicated that Wiley possessed significant adaptive skills, i.e., sustained employment, military service, and school attendance without special education classes.”); see, e.g., *Brown v. State*, 959 So.2d 146, 150 (Fla. 2007) (acknowledging that 68 FSIQ qualified, but finding mental retardation diagnosis “was contradictory to the evidence that Brown was engaged in a five-year intimate relationship prior to the crime, that he had his driver’s license and drove a car, and that he was employed in numerous jobs including as a mechanic”).

⁸⁰ Note, *Evolving Standards of Decency in Mississippi: Chase v. State, Capital Punishment and Mental Retardation*, 25 Miss St. C. L. Rev. 221 (2006) (quoting Martha A. Field & Valerie A. Sanchez, *Equal Treatment for People with Mental Retardation* 32 (1999)). The commentator points to an individual with mental retardation who was awarded a Mayoral Service Award in DC, noting that “[t]he Thorntons’ lives

money, and can operate heavy machinery.⁸¹ In cases such as *Wiley*, classic stereotyping of individuals with mental retardation prevails, over evidence and expert testimony showing significant limitations in adaptive skills.⁸²

More often, the nod to stereotype is less obvious than it was in *Wiley*. The Fifth Circuit opinion in *Clark v. Quarterman* provides an unfortunate example. Responding to a challenge that the lower courts erred in relying “exclusively upon the court’s own interpretation of testimony about Clark’s adaptive strengths” and solely on “evidence of strengths and not limitations,”⁸³ the court dismissed the petitioner’s argument as “incorrect,” concluding that “evidence of a strength in a particular area of adaptive functioning necessarily shows that the defendant does not have a weakness in that particular area.”⁸⁴ “Even if adaptive limitations rather than strengths often define mental retardation,” the court added, “the evidence in this case shows primarily adaptive

dramatically illustrate the potential dangers when judges--or anyone else other than trained mental health professionals--make decisions about who does and who does not have mental retardation.” *Id.* at 253.

⁸¹ See *Lambert*, 126 P.3d at 657.

⁸² Just as stereotype ought not trump expert opinion, courts must look for stereotype in lay opinion. Reliance on stereotype, again in denying an evidentiary hearing on mental retardation, was criticized by a dissenting Texas Court of Criminal Appeals justice:

Lay persons often have unrealistic ideas about what mentally retarded persons look like and how they act. There is a wide range of abilities encompassed by the term ‘mentally retarded’; the term applies equally to those whose are able to live successful independent lives and to those who live and die in a vegetative state. Mr. Tatum attested that he ‘knew some kids in school with Down’s syndrome’ and that appellant is not retarded. It is well known that Down’s syndrome creates a distinctive physical appearance. If Down’s syndrome is Mr. Tatum’s standard for diagnosing mental retardation, then of course, appellant is not retarded in his eyes.

Ms. Prosperie claimed to know that appellant is not retarded because her neighbor’s daughter is retarded. We do not know the extent of that child’s retardation or how it manifests in appearance and behavior.

Mr. White said that appellant is not retarded because his uncle is retarded, and appellant is not like his uncle.

Mr. Boles, looking back to the time of the offense, says that appellant is not retarded, and the state asserts that Boles is qualified to make that judgment because he now works with mentally challenged children.

Each of these lay witnesses appear to have judged appellant’s mental capacity by personal standards formed by personal experience with a very small number of retarded persons. Given the wide range of manifestations of mental retardation, these witnesses, although sincere, do not have the experience or training to make any assessment of the mental abilities of appellant. . . . I am loathe to find that appellant is not mentally retarded when that finding is based largely on the lay opinions of a store supervisor, a waitress, a bag boy, and five prison guards, and the expert opinion of a psychologist who could not reach a definite conclusion, especially when all had limited contact with appellant.

Hall at *43-44 (Johnson, J., dissenting). The court relied solely on evidence from a sentencing proceeding that took place before *Atkins*. The Northern District of Texas upheld the state court’s rejection of Hall’s mental retardation claim. *Hall v. Quarterman*, 443 F.Supp.2d 815 (N.D. Tex. 2006). [update]

⁸³ See *Clark v. Quarterman*, 457 F.3d 441, 446-47 (5th Cir. 2006), *aff’g*, *Ex parte Clark*, 2004 WL 885583 (TCCA 2004).

⁸⁴ *Id.* at 447.

strengths and does not show limitation in any significant area.”⁸⁵ Evidence of an adaptive strength or strengths *may* disprove a deficit, but not *necessarily*. Further, limitations rather than strengths do not “often” define mental retardation – they *always* do.⁸⁶ As in *Wiley* and *Clark*, the result in *Williams* was fueled by the erroneous belief that because an individual can *do* certain things, he or she cannot have mental retardation. The true measure of adaptive functioning is what an individual *cannot* do.

2. The Glass Half-Full Perspective: *Briseno*.

Accordinging dispositive weight to strengths not only strays from the clinical definitions, it alters the landscape of a mental retardation hearing. If a strength, regardless of its affiliation to a limitation, can refute a claim of mental retardation, the proceeding takes on a different and less stable character than if the only relevant issue is proof of limitations. When alleged limitations are the focus, the limitations provide a foundation upon which to measure the evidence.⁸⁷ Without that foundation, courts understandably may feel adrift amidst disconnected facts (some supporting adaptive behavior and some countering, not necessarily within the same skill areas) from which they are asked to divine a conclusion. This unmoored perspective amplifies the extent to which courts may view the adaptive behavior determination as a subjective battle of experts. It thrives on the (mis)perception that *Atkins* gives courts precious little, if any, guidance on how to distinguish and make determinations between expert diagnoses.

In Texas, this perspective is the norm. And it has spurred judicial addendum to the *Atkins*-approved clinical definitions. Texas state and federal courts, including the courts in *Williams*, complain that determining adaptive behavior is a “highly subjective” choice between “dueling diagnosticians” in dire need of additional structure.⁸⁸ They see mental retardation as attuned to the eye of the beholder, depending ultimately upon whether one views the metaphorical glass as half-empty or half-full.⁸⁹ From this perspective, “uniform application” of clinical definitions of mental retardation is “impractical[], if not impossible[].”⁹⁰

This perceived “quagmire”⁹¹ pushed the Texas Court of Criminal Appeals to articulate “evidentiary factors which factfinders in the criminal trial context might also focus upon in

⁸⁵ *Id.*

⁸⁶ Similar challenges to adjudications of mental retardation claims have repeatedly lost in Texas federal and state courts. *See, e.g., Webster, 421 F.3d at 313 n.15; Briseno, 2007 WL at *15; but see Lambert.*

⁸⁷ *See Lambert.*

⁸⁸ This statement in *Rodriguez* provides an example:

The current unavailability of a Supreme-Court-sanctioned, uniform, legal definition of “mental retardation,” along with the highly subjective nature of current clinical definitions of that term, has created a situation in which the determination of whether a particular criminal defendant or convicted capital murderer is “mentally retarded” often becomes a battle between dueling diagnosticians. . . . The dueling diagnosticians who have disagreed in petitioner’s case have been talking past each other, i.e., discussing whether they believed petitioner was mentally retarded without first agreeing upon a single definition of that term

Rodriguez at * 13.

⁸⁹ *See Briseno, 135 S.W.3d at 13.*

⁹⁰ *Id.* (emphasis added).

⁹¹ *Rivera v. Dretke, 2006 WL 870927 (S.D.Tex. 2006)* (“As anyone who reads *Atkins* readily realizes, each side of a capital case will have to retain an expert, both of whom should be prepared to cover the intellectual functioning and adaptive abilities of the petitioner. This places the finder of fact in the position

weighing evidence as indicative of mental retardation or of a personality disorder.”⁹² The *Briseno* factors present an array of divergences from the clinical definitions in applying *Atkins*. For one, as the court’s statement indicates, *Briseno* erroneously pits mental retardation against disorders in an either-or dichotomy. Further, the factors by turns adhere to stereotype or label (such as factor 1, which asks whether people who knew the defendant thought he was “mentally retarded”) and focus solely on adaptive strengths (such as factor 7, which asks whether the crime required forethought and planning, and factor 6, which asks whether the defendant is able to lie and hide facts). Even the factors that do point to traits that “occur with sufficient frequency to warrant certain limited generalizations”⁹³—for instance, people with mental retardation often have limited communication skills and may not be able to provide coherent responses⁹⁴, have poor impulse control⁹⁵, are more often followers than leaders—fail to address significant qualifications to these generalizations. Individuals with mental retardation often cannot focus on the specifics of what an interviewer is asking and therefore “may appear deviously to steer away from certain lines of testimony”⁹⁶, and thus may appear to hide facts or lie. Many individuals with mental retardation will say what they think the interviewer wants to hear, regardless of its accuracy⁹⁷ and will overrate their skills and mask their limitations.⁹⁸ What resembles coherence, therefore, may actually be feigned. Overall, the *Briseno* factors narrow the scope of relevant behaviors to a limited group of questions from a universe of possibilities,⁹⁹ and as such fail to fully address all skill areas set out in the clinical definitions: areas such as home living and self care, for instance, are ignored. Thus, a factfinder applying all the factors will not necessarily have assessed the full

of having to sift through the quagmire of conflicting testimony inherent in cases that involve “dueling experts.”).

⁹² *Ex parte Briseno*, 135 S.W.3d 1, 13 (Tex. Crim. App.). There are seven *Briseno* factors:

- Did those who knew the person best during the developmental stage – his family, friends, teachers, employers, authorities – think he was mentally retarded at that time, and, if so, act in accordance with that determination?
- Has the person formulated plans and carried them through or is his conduct impulsive?
- Does his conduct show leadership or does it show that he is led around by others?
- Is his conduct in response to external stimuli rational and appropriate, regardless of whether it is socially acceptable?
- Does he respond coherently, rationally, and on point to oral or written questions or do his responses wander from subject to subject?
- Can the person hide facts or lie effectively in his own or others' interests?
- Putting aside any heinousness or gruesomeness surrounding the capital offense, did the commission of that offense require forethought, planning, and complex execution of purpose?

Id. at 8-9.

⁹³ Ellis & Luckasson at 427-28; see *id.* at 428-32.

⁹⁴ *Id.* at 428.

⁹⁵ *Id.* at 429.

⁹⁶ *Id.* at 429.

⁹⁷ *Id.* at 429-30, 431.

⁹⁸ See *id.* at 430.

⁹⁹ See *Holladay* at 1343 (“It is important, in determining whether a person is or is not mentally retarded, not to pick and choose so as to over-emphasize certain characteristics” and cited in full the AAMR principle emphasizing that limitations often coexist with strengths.”).

possibility of adaptive deficits, and cannot therefore rule out the possibility of significant limitations in adaptive functioning.

Texas courts see *Briseno* as resolving who decides the legal issue of mental retardation, the factfinder or the clinician.¹⁰⁰ But the image of dueling diagnosticians at the decision's core is out of proportion. In reaching its conclusion, the court overlooked a difference between clinical judgment and mere "subjectivity." While an expert's opinion as any opinion, by definition, is somewhat subjective, it is worthy of respect because it is grounded in the clinician's training, experience with clients, knowledge of data, and adherence to accepted methods and principles.¹⁰¹ The AAIDD warns that clinical judgment "should not be thought of as a justification for abbreviated evaluations, a vehicle for stereotypes or prejudices, a substitute for insufficiently explored questions, [or] an excuse for incomplete or missing data."¹⁰² The state's expert in *Briseno* used "clinical judgment" incorrectly in all of these ways. It is not necessary to resolve differences between experts where one expert applies methodology that does not generally conform to the clinical definitions.¹⁰³

One might view the *Briseno* factors as a not-too-distant relative of the Fifth Circuit nexus requirements for mitigating evidence that the Supreme Court has repeatedly rejected. In *Smith* and *Tennard*, for example, the Fifth Circuit demanded that mitigation make a difference in *certain* ways that the court deemed important. In overruling these decisions, the Supreme Court held that all mitigation offered by a defendant is relevant, a defendant need not establish any nexus to the crime or fit into any other box manufactured by a court to have mitigating evidence considered by a jury. Like the *Tennard* nexus requirement, the *Briseno* factors create their own world of relevance, redefining the questions that make up the constitutional determination.¹⁰⁴

¹⁰⁰ See the Southern District of Texas opinion, affirming *Briseno*:

Nothing in federal law authorizes habeas relief based on an alleged misapplication of professional psychological standards alone. Admittedly, clinical methodology informs the mental retardation review, but the Court of Criminal Appeals correctly understood that the Constitution, not differing opinions by qualified experts, defines the class of those mentally retarded offenders excluded from execution.

Although experts may offer insightful opinions on the question of whether a particular person meets the psychological diagnostic criteria for mental retardation, the ultimate issue of whether this person is, in fact, mentally retarded for purposes of the Eighth Amendment ban on excessive punishment is one for the finder of fact, based upon all of the evidence and determinations of credibility.

See also Rodriguez v. Quarterman, 2006 WL 1900630 (W.D. Tex. 2006) at *11 ("Like most clinical definitions drawn from the medical and biological sciences, the foregoing definitions cited, but not specifically adopted, by the Supreme Court do not transfer easily into the realm of law, where legally valid distinctions and classifications must necessarily be based on more than a subjective choice between the conflicting testimony of differing diagnosticians.").

¹⁰¹ SHALOCK & LUCAKSSON at 1.

¹⁰² *Id.* at 91.

¹⁰³ There are cases applying *Briseno* in which defendants have been found to have mental retardation. *See Ex Parte Modden*, 147 S.W.3d 293 (TCCA 2004) (finding unanimous expert agreement supports MR; strong dissent says facts don't meet *Briseno* factors); see also *In re Hearn*, 376 F.3d 447 (TCCA 2004) (majority finding MR; dissent disputing IQ and AF), *aff'd*, 418 F.3d 444 (5th Cir. 2005).

¹⁰⁴ It follows that defense counsel should be challenged as ineffective who consent to constitutionality of *Briseno* factors. See Defendants must not acquiesce to use of *Briseno* factors. This has happened. *See*

Undoubtedly, this gives courts more direction. But the *Briseno* factors focus on a few facts, which portray stereotype, strength-first or strength-only reasoning, at best a handful of itemized weaknesses, and are satisfied by the answers to those questions alone. Once the adaptive behavior determination is properly viewed as on reliant on proof of limitations, the scope of the proceedings narrows and focuses appropriately on the particular limitations the defendant alleges.¹⁰⁵

B. Focus on Skill Areas

If a court follows the clinical definitions and the operational principles, an assessment of adaptive functioning “generally conforming” to *Atkins* must focus on (1) deficits claimed by the defendant (2) in the context of the skill areas the definitions set forth and (3) balance the evidence supporting the alleged adaptive limitations against evidence of adaptive strengths that offset those deficits.¹⁰⁶ Skill areas and the assumption of coexisting strengths and weaknesses within and between skill areas necessitate particularized balancing. Particularized balancing, in turn, helps to clarify the relevance of all evidence.¹⁰⁷

A good example of particularized balancing is *Holladay v. Campbell*.¹⁰⁸ In *Holladay*, the petitioner alleged limitations in all skill areas. The court, emphasizing that limitations coexist with strengths¹⁰⁹, grouped the evidence relevant to adaptive behavior into two categories: that “tend[ing] to show limitation(s) in adaptive functional behavior” and that “tend(ing) to show the absence of limitations in adaptive functional behavior.”¹¹⁰ Within those two categories, the court further allocated the evidence according to skill area, itemizing each evidentiary fact as relevant to one or more of the following areas: home living, self-care, health and safety, social skills, self-direction, communication, work, functional academics, and community use. The court then factored in the results of a standardized test administered to two of the defendant’s relatives and expert testimony.¹¹¹

Both parties in *Holladay* agreed that the defendant had significant limitations in functional academic skills. The “remaining question” for the court, therefore, was simply whether *Holladay* had significant limitations in any other skill area.¹¹² Balancing the facts tending to show a limitation against those tending to show the absence of a limitation in each skill area, the court found significant limitations in five areas (communication, social skills,

Moreno v. Dretke, 450 F.3d 158, 164 (5th Cir. 2006) (“Moreno does not dispute that these are correct definitions of MR.”).

¹⁰⁵ See *Lambert*.

¹⁰⁶ See also, e.g., *Walker v. True*, 399 F.3d 315, 321 (4th Cir. 2005), on remand, *Walker v. True*, No. 03-0764 (E.D. Va. Aug. 30, 2006) (no MR found because no adaptive deficits by ppe); *Com. v. Graham* (Pa. Ct. Common Pleas, Dec. 18, 2003); *Com. v. Pirela* (Pa. Ct. Common Pleas April 30, 2004).

¹⁰⁷ At this point, nearly every jurisdiction has formally or implicitly adopted the skill area model. See *Murphy v. State* (Okla. Ct. Crim. App.). Yet some courts and some states still rely on a generalized determination of adaptive behavior. See A.R.S. § 13-703.02(K)(1), (K)(2) (Ariz.); see *State v. Grell*, 135 P.3d 969 (Ariz. 2006) (“The DSM-IV definition of mental retardation, however, while similar in overall meaning, is not the same as the statutory definition. The statute requires an overall assessment of the defendant’s ability to meet society’s expectations of him. It does not require a finding of mental retardation based solely on proof of specific deficits or deficits in only two areas. . . .”). *Id.* at 709.

¹⁰⁸ 463 F.Supp.2d 1324 (N.D. Ala. 2006).

¹⁰⁹ *Id.* at 1343.

¹¹⁰ *Id.* at 1334.

¹¹¹ See *id.* at 1336-40.

¹¹² *Id.* at 1343.

community use, functional academics, and work) of the AAMR 9th edition.¹¹³ Applying the AAMR 10th ed. skill areas, the court found significant limitations in all three areas: conceptual, practical, and social.¹¹⁴

An equally thorough and even more efficient approach was taken by the Oklahoma Court of Criminal Appeals in *Lambert v. State*, where the defendant alleged significant limitations in only certain skill areas.¹¹⁵ The court fine-tuned its adaptive functioning analysis to focus only on skill areas in which Lambert alleged deficits:

Unless a defendant's evidence of particular limitations is specifically contradicted by evidence that he does not have those limitations, then the defendant's burden is met no matter what evidence the State might offer that he has no deficits in other skill areas. In fact, the State need not present any evidence that a capital defendant can function in areas other than those in which a deficit is claimed. In capital mental retardation proceedings, the State's first response must always be to counter the evidence presented by the defendant.¹¹⁶

The defendant presented proof of deficits in four of the nine skill areas: health and safety, academics, communication, and social and interpersonal skills.¹¹⁷ The state accepted the existence of these skill-area deficits, but offered alternative explanations: the state argued that the defendant did not have mental retardation because his limitations were better described by, or caused by, antisocial personality disorder, schizophrenia, conduct disorder, and drug abuse.¹¹⁸ The OCCA correctly dismissed this argument, finding that “[b]y accepting Lambert's assertions that he had limitations in these skill areas, the State failed to contradict his claims.”¹¹⁹ By

¹¹³ Id. at 1346. For example, with respect to the “work” category, the court noted the following supported adaptive limitations: that Holladay did not function well in a painting job, would grow frustrated and leave the site, was not capable of buying paint, and didn’t know a screwdriver from a scraper; he could not work machines at a tire store; none of his jobs requires significant intellectual ability; Holladay never found work on his own initiative. Id. at 1336. The court found that the following tended show an absence of limitations with respect to work skills: he did not have trouble following directions at his tire store job; he also worked at a chicken plant. Id. at 1336-40.

¹¹⁴ Id. at 1346 n.29.

¹¹⁵ 126 P.3d 646 (Okla. Crim. App. 2005). In *Lambert*, the Oklahoma Court of Criminal Appeals applied a definition of mental retardation the court adopted in the wake of *Atkins*. 126 P.3d at 650; see *Murphy v. State*, 54 P.3d 556, 567-68 (Okla. Crim. App. 2002), overruled on other grounds, *Blonner v. State*, 127 P.3d 1135 (Okla. Crim. App. 2006) (overruling procedures set forth in *Murphy* but leaving substantive definition of mental retardation intact). The definition mirrored the AAMR 9th ed. definition, requiring as one prong that the defendant show significant limitations in adaptive functioning, and for that requiring a showing of significant limitations in two of nine skill sets. See id.

¹¹⁶ Id. at 651.

¹¹⁷ Id. at 652. Specifically, the court recognized that: “Lambert received very little parental supervision as a child. He was often unclean, hungry and inappropriately dressed. He lay in the street in traffic, ran under a moving train, cut and burned himself, and swallowed wire. Lambert left school after the 7th grade, when he was fifteen. Until that point, he made poor grades or failed in each class since kindergarten. He repeated first grade. He was placed in educably mentally handicapped (EMH) classes in elementary school; testimony indicated those classes at Lambert's school housed students with mental retardation. The known examples of Lambert's writing in the record show poor printing, very poor spelling, and lack of organized thought. He had few friends, preferred the company of younger children, and was easily manipulated.” Id. at 652.

¹¹⁸ Id. at 652-53; see id. at 655, 659.

¹¹⁹ Id. at 653.

grounding the assessment in alleged limitations, *Lambert* and *Holladay* applied *Atkins* without the need for additional factors such as *Briseno*.

The approach taken in cases like *Lambert* and *Holladay* follows the clinical definitions.¹²⁰ It also helps to guide courts through some of the difficult questions in adaptive behavior assessment, including: To what extent should a petitioner's behavior in prison impact the adaptive behavior determination? And what role do the circumstances of the crime play?

C. Prison Behavior is Not a Reliable Measure of Adaptive Functioning

A familiar argument confronting capital defendants who assert mental retardation is that their behavior in prison shows otherwise. Participation in prison programs, having magazine subscriptions, studying for or acquiring a GED while in prison, filling out a grievance form, are all examples of activities that have been offered to disprove mental retardation. Consider this position, adopted by the Fifth Circuit in *Clark v. Quarterman*:

Our review of the evidence of Clark's behavior in prison casts serious doubts on his claims of adaptive limitation, as evidence collected from his cell along with his handwritten requests include:

- [*] complaints that he needed a technician to fix his television as it had been several "weeks now of no reception via my coaxial cable hooked up to the jack on the wall;
- [*] a handwritten diet plan entitled "Eat to Beat Stress" noting that he should "eat small meals and snacks several times a day to keep blood sugar from fluctuating" as well as notes about the effects of various chemicals such as folic acid, pyridoxine, and thiamine;
- [*] handwritten puzzles including the decipherment of several extremely complicated codes; and
- [*] complaints about delays in approving his request for a legal visit with another inmate in which Clark planned to assist the inmate in obtaining parole.¹²¹

In the same way that the testimony of a former employer may make the point that the defendant was a good worker and could follow directions, in the same manner that a court may look to a defendant's prior testimony or taking notes during the trial or a coherent allocution at sentencing, these arguments focus on strengths.¹²² Following the clinical definitions focus on limitations,

¹²⁰ Accord *State v. White*, 885 N.E.2d 905, 915 (Ohio 2008) (reversing trial court's finding of no mental retardation because the trial court erred in focusing on whether White exhibited behavior that was "bizarre" or "out of the ordinary").

¹²¹ *Clark v. Quarterman*, 457 F.3d 441, 447 (5th Cir. 2006).

¹²² Take for example the Florida Supreme Court's decision in *Rodriguez v. State*, 919 So.2d 1252 (Fla. 2005). En route to finding the defendant had no significant limitations in adaptive behavior, the court rejected the results of standardized test scoring the defendant two standardized deviations below the mean, and relied instead on the defendant's behavior at trial:

none of this should matter—unless the defendant has alleged adaptive limitations that behavior in prison disproves, none of it is relevant.

A thorough investigation is critical to uncover the truth about what an individual is actually capable of doing. Aside from taking into account the defendant's active attempt to wear a "cloak of competence" counsel and courts are well advised to take a close look at whether the asserted strengths are more than mere appearances. For example, is the defendant actually reading the books or magazines in his cell? Did he actually fill out the administrative forms?¹²³ Greenspan and Switzky have reported that "[g]iven the amount of time that a condemned prisoner has to think about his life, and to discuss his case with attorneys and others, it is not surprising that an *Atkins* applicant, even one who clearly has MR, might be able to show some surface sophistication in discussing what he would and should have done differently to avoid his current predicament."¹²⁴ Several examples from *Lambert*, in which assertions of prison behavior as strengths were refuted, illustrate the importance of thorough inspection:

"Prosecutors offered evidence from prison employees who had frequent but brief contact with Lambert, had received his requisition slips, and did not believe he was retarded. *However, those employees could not say that Lambert himself filled out all his requisitions, as they were not present when the slips were written. They could not say Lambert read the books he checked out. While they disagreed on many issues, these witnesses could not contradict Lambert's cellmates' testimony. . . .* [that they often filled out prison requisition slips for Lambert, and that he checked out books for other inmates to read since he did not read books]."

Rodriguez's behavior throughout the trial proceedings indicated his awareness and understanding about what was happening in the courtroom. He variously made comments about the prosecutor's statements and the evidence presented, even denying his presence at the murder scene during one witness's testimony. Rodriguez's subsequent conversations with Dr. Haber, particularly one in which he recited the State's plea offer in detail, also indicate an understanding of the situation. These incidents support the trial court's finding that Dr. Haber's opinion was not only adequate, but also completely supported by the evidence.

But this impulsive and inappropriate behavior also supports a diagnosis of mental retardation. Indeed, it resembles some of the characteristics of individuals with mental retardation that the *Atkins* opinion found jeopardized possibility of fair trial and sentencing proceedings where MR defendants are involved. Incredibly, the Florida court simultaneously held that "there was no evidence at all that the defendant had any memory impairments or problems of impulsivity."

¹²³ See Ellis & Luckasson at 430-31. See *Hall* at 44 (Johnson, J., dissenting) ("I am unpersuaded that bragging or using big words and claiming to read classic literature establishes that appellant is not retarded. If appellant is, in fact, retarded, his statements may establish only that he, like many retarded persons, wishes to be regarded as "normal" and "smart" and that he will behave in ways that he thinks will cause others to regard him as such, just as persons with normal intelligence will behave in ways that are perceived as producing acceptance. As Dr. Church noted in her affidavit, appellant "had difficulty with the requirements of doing the work of a 'stocker' and was demoted to bagging groceries." She also stated, "His main motivation is not to appear to be a 'dummy' in order to mask his deficits. He tends to say what he has heard others say and/or to say what he thinks others expect him to say. This is not at all unusual as a coping mechanism for the mentally retarded population.").

¹²⁴ Stephen Greenspan & Harvey N. Switzky, Lessons from the *Atkins* Decision for the Next AAMR Manual in WHAT IS MENTAL RETARDATION? IDEAS FOR AN EVOLVING DISABILITY IN THE 21ST CENTURY 283 (Switzky and Greenspan eds., 2006).

“The State’s same institutional witnesses testified that they had little or no trouble communicating with Lambert, that he was not a discipline problem in prison, and that he seemed to understand the routines and procedures expected of him. *None of these witnesses testified to long or complex conversations which required an exchange of ideas or feelings. In addition, all the expert witnesses agreed that mentally retarded persons adapt very well to institutional settings such as prison, and are unlikely to exhibit problems with impulse control in those settings.*”¹²⁵

But there is more at stake with respect to reliance on prison behavior than issues of evidentiary relevance. The operational principle that “[l]imitations in present functioning must be considered within the context of community environments typical of the individual’s age peers and culture” means that the “individual’s functioning must be measured [in] typical community-based environments, not environments that are segregated by ability.”¹²⁶ Death row is an atypical, segregated, structured, and regulated community, and presents circumstances of “legal restraint,” in which adaptive behavior assessments are “less than optimal.”¹²⁷ In this structured circumstance, “the role of the person’s immediate environment [must be] integrated into the assessment.”¹²⁸

Members of the scientific community note that “[c]onducting adaptive behavior assessments in prison makes it impossible to assess “adaptive behavior within the context of community environments as required by the 2002 AAMR standards.”¹²⁹ In part, this is because “[p]rison officials . . . do not have the experience with the individual in community contexts to provide a valid assessment of skills.”¹³⁰ Others have stressed that prison assessments are suspect because “[m]any ‘real-world’ adaptive behaviors (e.g., transportation skills) are not possible in this setting and therefore cannot be measured”; “certain adaptive behaviors (e.g., grooming) may appear better due to the structure”; and “some adaptive behavior deficits (e.g., inability to read) can be masked by the appearance of reading (i.e., looking at reading material such as a newspaper

¹²⁵ *Lambert v. State*, 126 P.3d 646, 652 (Okla. Ct. Crim. App. 2005).

¹²⁶ AAMR 10th ed. at 8.

¹²⁷ USER’S GUIDE at 14.

¹²⁸ *Id.* at 15.

¹²⁹ Caroline Everington & J. Gregory Olley, *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8(1) JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE 1, 12 (2008).

¹³⁰ *Id.* at 12. See Bethany Young, et. al., *Four Practical and Conceptual Assessment Issues that Evaluators Should Address in Capital Case Mental Retardation Evaluations*, 38(2) PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 169, 174 (2007) (“Although prison employees can be valuable sources of information about functioning in the prison environment, they will not have observed the offender outside of the secure setting, may have little knowledge about the adaptive behavior of persons with mild to moderate mental retardation, and may feel pressured by peers to report a high level of functioning.”); John M. Fabian, *Life, Death, and IQ: It’s Much More Than Just a Score: The Dilemma of the Mentally Retarded on Death Row*, 5(4) J. FORENSIC PSYCHOLOGY 1, 13-14 (2005) (noting problems with correctional staff as source of information about adaptive functioning because they “may be plagued by certain biases for or against the defendant,” “there may be a consensus among staff that experts are coming to death row to ‘get the prisoner off the hook,’” “officers may have their own lay opinions on what retardation is and may also not believe these defendants are retarded because they are criminals and function fairly well in some areas,” and some officers are likely “to have experienced conflicts with the defendants which may cause bias against the defendant in an evaluative setting”); Kay B. Stevens & J. Randall Price, *Adaptive Behavior, Mental Retardation and the Death Penalty*, 6(3) J. FORENSIC PSYCHOLOGY PRACTICE 1, 16 (2006) (“Correctional officers are sometimes selected as informal informants, yet they may be biased regarding the death penalty, inhibited by institutional policies or peer pressure, and/or poorly informed.”).

but instead of actually reading merely looking at the pictures or sports scores).”¹³¹ Accordingly, it has been suggested that, because “few measures of adaptive functioning have been designed or normed for use with institutionalized correctional populations,” “[t]he immediate best professional choice appears to base adaptive functioning evaluations of capital case and death row inmates on a clinical synthesis of both preincarceration functioning and current functioning.”¹³²

D. The Limited Probative Value of the “Sophistication” of the Crime.

Some courts have found that a defendant failed to establish significant adaptive functioning limitations based solely on evidence of the defendant’s conduct during the crime. One of the *Briseno* factors is “whether the commission of the offense required forethought, planning, and ‘complex execution of purpose.’”¹³³ The Texas Court of Criminal Appeals is not the only court to emphasize the circumstances of the crime as a factor in assessing adaptive behavior deficits.¹³⁴ Other courts have expressed skepticism about the relevance of crime circumstances.¹³⁵ Legislatures, too, have debated this point.¹³⁶

A recent article in the Texas Bar Journal emphasizes that when “assessing a person’s level of adaptive functioning, it is important to look at every aspect of the defendant’s life including what some experts describe as “criminal adaptive functioning,” or “street smarts,” or the ability to “think on [one’s] feet.”¹³⁷ “While most defense experts will attempt to emphasize subaverage results of either IQ or other psychological testing,” the author states, “most jurors are quite capable of assessing the credibility of such evidence when confronted with credible evidence of a planned, premeditated crime, and evidence of a defendant who has functioned independently in society.”¹³⁸ Minimizing the significance of expert testimony on mental retardation, the author concludes, “in many instances the facts of the crime will be the *best* evidence of a defendant’s level of adaptive functioning.”¹³⁹

¹³¹ James R. Patton & Denis W. Keyes, *Death Penalty Issues Following Atkins*, 14 (4) EXCEPTIONALITY 237, 249 (2006). Accord Bethany Young, et. al., *Four Practical and Conceptual Assessment Issues that Evaluators Should Address in Capital Case Mental Retardation Evaluations*, 38(2) PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 169, 171 (2007) (noting that using typical methods of assessment of adaptive functioning in capital cases may be inappropriate because the subject has little opportunity to display social, conceptual or practical skills on a routine basis in nonrestricted settings compared with people who provided normative data and because “behaviors that are considered to be adaptive in the general population may not be adaptive in prison environments or within certain peer groups.”).

¹³² Stanley L. Brodsky & Virginia A. Galloway, *Ethical and Professional Demands for Forensic Mental Health Professionals in the Post-Atkins Era*, 13(1) ETHICS & BEHAVIOR 3, 7 (2003); see Kay B. Stevens & J. Randall Price, *Adaptive Behavior, Mental Retardation and the Death Penalty*, 6(3) J. FORENSIC PSYCHOLOGY PRACTICE 1, 19 (2006) (“[F]orensic evaluators should consider adaptation to prison incarceration as *one* factor of many in their assessment of adaptive behavior.”).

¹³³ 135 S.W.3d at 9.

¹³⁴ See, e.g., *Neal v. State*, 256 S.W.3d 264 (TCCA 2008) (finding no adaptive behavior deficits where the defendant’s criminal acts showed “that he was capable of planning elaborate criminal ventures and attempting, albeit unsuccessfully, to conceal the evidence”).

¹³⁵ *Holladay*, *supra*.

¹³⁶ Compare, e.g., Bill Analysis, S. 3, 2003-2004 Sess. (Cal. 2003), with, e.g., Bill Analysis, S. 51, 2003-2004 Sess. (Cal. 2003); see Peggy Tobolowsky, *Atkins Aftermath: Identifying Mentally Retarded Offenders and Excluding Them From Execution*, 30 J. Legis. 77, 98 (2003).

¹³⁷ William Lee Hon, *Feature: Expert Witness, Claims of Mental Retardation in Capital Litigation*, 69 Tex. B. J. 742, 743-44 (Sept. 2006).

¹³⁸ *Id.* at 744.

¹³⁹ *Id.* at 744 (emphasis added).

In a prominent case, the Tennessee Court of Criminal Appeals relied predominantly on crime evidence in its adaptive behavior assessment.¹⁴⁰ The court rejected the results for Vineland and Independent Living Scale tests scores of two standard deviations below the mean,¹⁴¹ because it questioned whether the standardized measures could measure someone like the defendant who was raised in Vietnam and spoke little to no English and had been incarcerated for more than ten years before the tests were administered. The court also rejected expert testimony finding the defendant had deficits in five of the ten DSM-IV skill areas. Instead, the court relied solely on the facts of the crime to support its finding that the defendant did not suffer from significant limitations in adaptive behavior. The court explained:

In the legal setting, the court must not become so entangled with the opinions of psychiatric experts that we lose sight of the nature of the criminal offense itself. We must also not turn a blind eye to the defendant's ability to use society to better his needs. There are mentally retarded persons who are criminals, but they tend to commit fairly primitive crimes, impulsive crimes, and sudden acts of violence. The more complex the crime, however, the less likely that the person is mentally retarded. Thus, the court cannot forget to examine the nature of the criminal conduct and the circumstances involved in that conduct when determining whether a person is mentally retarded.¹⁴²

Within this passage, are traces of stereotype (“there are mentally retarded persons who are criminals, but they tend to commit fairly primitive crimes, impulsive crimes, and sudden acts of violence”) and a focus on strengths regardless of weaknesses (“the more complex the crime . . . the less likely that the person is mentally retarded”). Finally, despite acknowledging skill sets and that a defendant need only show significant limitations in one or two, the court applied the Briseno factors as well.¹⁴³ The result was a *mélange* in which the court ultimately relied on nothing but the circumstances of the crime:

The circumstances of the Petitioner's crime belie any assertion that the Petitioner suffered from any deficit in intellectual ability or adaptive skills. The Petitioner had previously been employed by the victims of his crime. He knew the layout of the restaurant and knew that jewelry was kept on the premises. The Petitioner did the talking with one of the victims at the onset of the crime. The Petitioner was the person that went into the office to collect the jewelry. After the crime, the Petitioner escaped with two of his co-defendants to Houston, Texas, where it was the Petitioner who arranged to sell the jewelry to a Vietnamese man for \$4,000. It

¹⁴⁰ *Van Tran v. State*, 2006 WL 3327828 (Tenn. Crim. App. 2006). The post-conviction petitioner presented results of two standardized adaptive behavior tests (Independent Living Scales and Vineland) on which he scored more than two standard deviations below the mean. *Id.* at 5, 10. These scores met the criteria for significant deficits in adaptive behavior under the AAMR. *Id.* A psychologist specializing in neuropsychology, who administered additional tests, found that the defendant had deficits in frontal lobe functioning, deficits in language and verbal communication, in memory, and in motor speed, all of which would negatively impact his adaptive functioning. *Id.* at 8. She found that the petitioner showed limitations in five of the DSM-IV-TR skill areas (language-communication; functional academics; conceptual reasoning; health and safety; and social and interpersonal skills) and overall limitations in at least the one of the three AAMR skill areas (conceptual). *Id.* at 11. The expert also described environmental risk factor that contributed to the petitioner's deficits. *Id.* at 11.

¹⁴¹ 2006 WL 3327828 (Tenn. Crim. App. 2006) at 16.

¹⁴² *Id.* at 24-25.

¹⁴³ See *id.* at 23-24.

was also the Petitioner who paid this man from the proceeds and divided the money with his two co-defendants. The Petitioner's active participation and planning in the offense is the "opposite end of the spectrum from [the] behavior of mentally retarded offenders."¹⁴⁴

The implication that crime evidence can override the other evidence regarding mental retardation because it is the "best evidence" of adaptive functioning must be rejected. There are several reasons for this. One reason courts should "avoid basing diagnostic inferences about a defendant's level of adaptive functioning, and about having MR, on information about his or her past criminal acts" is that "not enough information is typically available (on a precise microlevel) regarding the exact situational demands and the level of cognitive skills required to navigate those demands."¹⁴⁵ For example, "we do not typically know about is the extent to which the defendant may have been coached and trained by a less impaired 'robbery coach,' as opposed to figuring out these things for himself."¹⁴⁶ Further, "when establishing standards for assessment of adaptive skills, it is important to note that maladaptive skills should not be used as indications of adaptive deficits" because "some items that are associated with maladaptive behavior, such as social behavior, are actually adaptive skills areas that are important to establishing adaptive skills deficits."¹⁴⁷ Further, because the focus must be on the specific areas of adaptive functioning identified by the clinical definitions,¹⁴⁸ the truth about the relevance of crime facts to the diagnosis is, it depends. It depends on what evidence of adaptive limitations the defendant presents, and the extent to which the crime facts offset that evidence. Evidence of the crime, like any evidence offered by the prosecution, is only relevant to the mental retardation determination if it corresponds to a skill area in which the defense has presented evidence of a deficit.¹⁴⁹ In *Lambert*, the prosecution emphasized the crime circumstances, which showed that the defendant could drive, give and understand directions, and use a weapon.¹⁵⁰ But as the OCCA astutely recognized, "[n]one of the evidence of criminal activity went to any of Lambert's claims of

¹⁴⁴ *Van Tran*, 2006 WL 3327828 (quoting *Atkins*, 536 U.S. at 319-20).

¹⁴⁵ Stephen Greenspan & Harvey N. Switzky, *Lessons from the Atkins Decision for the Next AAMR Manual* in WHAT IS MENTAL RETARDATION? IDEAS FOR AN EVOLVING DISABILITY IN THE 21ST CENTURY 283, 291 (Switzky and Greenspan eds., 2006) ; see Caroline Everington, PhD. & J. Gregory Olley, PhD., *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8(1) JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE 1, 11 (2008) ("[M]ost important, adaptive behavior is the individual's typical performance in his/her community setting. The details of the crime cannot be considered to be a sample of typical behavior.").

¹⁴⁶ Stephen Greenspan & Harvey N. Switzky, *Lessons from the Atkins Decision for the Next AAMR Manual* in WHAT IS MENTAL RETARDATION? IDEAS FOR AN EVOLVING DISABILITY IN THE 21ST CENTURY 283, 291 (Switzky and Greenspan eds., 2006).

¹⁴⁷ Caroline Everington, PhD. & J. Gregory Olley, PhD., *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8(1) JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE 1, 11 (2008) ("The distinction between adaptive skills and maladaptive behavior is particularly germane to criminal justice cases where there is a tendency to use the facts of the crime as evidence of adaptive skills.").

¹⁴⁸ Bethany Young, et. al., *Four Practical and Conceptual Assessment Issues that Evaluators Should Address in Capital Case Mental Retardation Evaluations*, 38(2) PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 169, 173 (2007); Caroline Everington, PhD. & J. Gregory Olley, PhD., *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8(1) JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE 1, 11 (2008).

¹⁴⁹ See *Lambert*, 126 P.3d at 651. Similarly, the causation of an individual's adaptive functioning deficits does not negate the diagnosis of mental retardation when deficits are present.

¹⁵⁰ *Id.* at 656.

adaptive function limitations.”¹⁵¹ And therefore, “none of it was relevant” (and its probative value significantly outweighed by its prejudicial impact).¹⁵²

In *Holladay*, too, the prosecution argued that the crime facts were the strongest evidence of the absence of adaptive functioning limitations. The court, having found that the defendant had deficits in conceptual, social and practical skills, recognized that “[t]he main legal/medical issue in this case may be whether the ability to commit a crime and temporarily avoid capture forecloses a determination of mental retardation.”¹⁵³ The court, however, was “at a loss to see which of the ten factors this bears on. It would appear that such criminal conduct would indicate at least social limitations.”¹⁵⁴ The *Holladay* court noted that *Atkins*, rather than finding the heinous facts of the crime refuted mental retardation, saw the defendant’s criminal behavior and impulsive behavior as potentially indicative of adaptive behavior limitations and consequently reduced culpability. As *Lambert* noted, an individual can be “‘street smart’ and survive outside an institution.”¹⁵⁵ Choosing a “life of crime” as the prosecution asserted in *Lambert*, “shows that he is a bad person,” but it does not make the defendant any more likely to have mental retardation.¹⁵⁶ The *Atkins* majority recognized that “[t]here is no evidence that [people with mental retardation] are more likely to engage in criminal conduct than others.”¹⁵⁷ Perhaps most important, as with prison evidence, courts should be cautious of crime evidence and measure its value according to the level of detail in which the behavior and events alleged to represent adaptive abilities are explained.

In sum, in assessing criminal conduct including the facts of the crime, courts must ask what relevance criminal conduct has to the adaptive behavior determination in general. This requires careful analysis of (a) whether the stressed strengths involved in the criminal activity actually correlate to the asserted deficits, (b) the level of detail of adaptive limitations provided by the evidence, and (b) ensuring that strengths are not wrongly given dispositive weight by uncaredful use of stereotype.

E. Mental Retardation and Mental Disorders Coexist

Fortunately for Jeffrey Williams, the courts did not look incorrectly to prison behavior or crime evidence. The courts did, however, make another error, positing a false dichotomy between mental retardation and mental disorders. state and federal courts have interpreted a

¹⁵¹ *Id.* at 656.

¹⁵² *Lambert*, 126 P.3d at 655-56 (“None of the evidence of criminal activity went to any of Lambert's claims of adaptive function limitations. Thus, strictly speaking, none of it was relevant to disprove those claims.”).

¹⁵³ *Holladay* at 1346.

¹⁵⁴ *Id.*

¹⁵⁵ *Lambert*, 126 P.3d at 656.

¹⁵⁶ *Id.* at 656. This has long been recognized in the field: “[A]daptive behavior is a term of art, which is not synonymous with maladaptive behavior.” Ellis and Luckasson at 422 (discussing AAMD, 1983). In their *Atkins* dissents, Justice Scalia and Chief Justice Rehnquist criticized the majority for allowing committers of brutal and heinous crimes to avoid the death penalty. *Atkins*, for example, had 16 prior felony convictions and shot the victim in question eight times. Accord *Rivera* at 47 (finding mental retardation despite finding that “[t]he underlying crime for which Rivera was given the death penalty is one of the most senseless and brutal crimes that this Court has ever encountered”).

¹⁵⁷ *Atkins*, 536 U.S. at 318. Learning disabilities and inclination to impulsive behavior, the Court recognized, also enhanced the risk that offenders with mental retardation offenders will not receive a fair and individualized sentencing proceeding. *Id.*

mental disorder.¹⁵⁸ The courts distinguished evidence as explained by mental retardation or another disorder, antisocial personality disorder, but not both. The courts described what Williams presented as evidence of adaptive deficits as “bizarre and antisocial conduct,” evincing characteristics that “are just as easily seen as attention-getting behaviors as they are evidence of mental retardation” and “could be explained by anti-social personality *rather than* mental retardation.”¹⁵⁹ The *Briseno* court accepted this same dichotomy, citing it as a motivating reason for the need to enunciate its novel additional evidentiary factors.¹⁶⁰ These are representative of other courts’ that have found it a challenging puzzle to assess whether certain traits reflect mental retardation *or* something else.¹⁶¹

Yet it is well recognized by clinical professionals that mental retardation and mental disorders coexist¹⁶² and may even be interrelated.¹⁶³ The characteristics that the Court identified in *Atkins* that make defendants with mental retardation less culpable—diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others¹⁶⁴—overlap with the criteria for some mental disorders.¹⁶⁵ Accordingly, “[w]hen a defendant’s behavior, whether criminal or other, is associated with certain characteristics (such as impulsivity, recklessness, or low frustration tolerance), it can be difficult to determine whether the behavior is attributable to mental retardation, antisocial personality disorder, some combination of both, or another diagnostic issue entirely (e.g., substance use, neurological impairment, other mental illness).”¹⁶⁶

¹⁵⁸ See, e.g., *Lambert; Briseno*.

¹⁵⁹ *Williams v. Quarterman*, 2008 WL 4280315, *13 (5th Cir. 2008) (emphasis added).

¹⁶⁰ *Id.* at 13.

¹⁶¹ See, e.g., *Green v. Johnson*, 2006 WL 3746138 at *59 (E.D. Va. 2006). See also *Simpson v. Quarterman*, 2007 WL 1008193 at *15 (E.D. Tex. 2007) (citing 136 S.W.3d at 664-65)). For more recent examples, see *Neal v. State*, 256 S.W.3d 264 (TCCA 2008) (finding no adaptive behavior deficits where experts diagnosed him with conduct disorder and antisocial personality rather than MR); cf. *Brumfield v. Cain*, 2008 WL 2600140 (M.D. La. 2008) (same, affirming reasonableness of trial court determination based on evidence before the trial court, but granting evidentiary hearing based on new evidence related to “risk factors” for mental retardation (family history of MR, low birth weight, mother’s use of drugs during pregnancy, abuse)).

¹⁶² See AAIDD, User’s Guide at 15 (“In general, mental health disorders are more prevalent among individuals with MR/ID than the general population.”). See, e.g., *Handbook of Mental Illness in the Mentally Retarded* (Frank J. Menolascino & Jack A. Stark eds., 1984).

¹⁶³ See *Bonnie*, 32 J. Am. Acad. Psych. & Law 304-08 (2004), Holladay, 463 F.Supp.2d at 1344 (referring to Appendix B); see *id.* at 1346.

¹⁶⁴ See 536 U.S. at 318.

¹⁶⁵ Characteristics of mental retardation overlap, for example, with the diagnostic criteria for antisocial personality disorder, which is defined by factors including “failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest”; “impulsivity or failure to plan ahead”; “consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations”; and “lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another. . . .” DSM-IV-TR at 706. See Irving Phillips & Nancy Williams, *Psychopathology and Mental Retardation: A Study of 100 Mentally Retarded Children*, 132(12) AM. J. PSYCHIATRY 1265 (1975) (in study of 100 children with mental retardation, finding largest categories of co-morbidity were behavioral disorders followed closely by personality disorders).

¹⁶⁶ Bethany Young, et. al., *Four Practical and Conceptual Assessment Issues that Evaluators Should Address in Capital Case Mental Retardation Evaluations*, 38(2) PROFESSIONAL PSYCHOLOGY: RESEARCH AND PRACTICE 169, 173 (2007). See also John M. Fabian, *Life, Death, and IQ: It’s Much More Than Just a Score: The Dilemma of the Mentally Retarded on Death Row*, 5(4) J. FORENSIC PSYCHOLOGY 1, 27 (2005) (“Adaptive issues such as poor social skills, gullibility, reckless and antisocial behaviors may be due to both adaptive functioning deficits pursuant to mental retardation as well as other psychiatric disorders.”).

One study, noting that “one common theme in the literature concerns the difficulties associated with the diagnosis of personality disorder in people who have intellectual disabilities,” explains that while there is “overlap between intellectual disability and personality disorder (allowing others to make most of one’s important life decisions, undue compliance with other’s wishes, self-injury, impulsivity, affective lability),” “[i]t is clear that for people with severe disabilities whose communication is impaired, the inability to make their needs known is likely to increase the probability of [challenging] behaviours.”¹⁶⁷ “[D]evelopmentally handicapped persons have had (in many cases) life experiences that would negatively affect *anyone’s* personality.”¹⁶⁸ In short, environmental circumstances experienced by individuals with intellectual disability can prompt development of personality disorder, “[f]or example, an individual might have adapted to institutional social norms by developing dependent features or aspects of Antisocial Personality Disorder as a result of oppositional behavior.”¹⁶⁹

Using a clinical approach, therefore, a diagnosis of mental retardation is multifactorial. In *Lambert* and *Holladay* the courts were able to dispel the false dichotomy. In *Lambert*, accepting the existence of deficits in four skill areas, the state argued that the defendant did not have mental retardation because his limitations were better described by, or caused by, antisocial personality disorder, schizophrenia, conduct disorder, and drug abuse.¹⁷⁰ The OCCA dismissed this argument, finding that “[a]n alternative explanation for an agreed condition is not a negation of that condition.”¹⁷¹ The court went farther, taking issue with the relevance of the state’s evidence concerning the diagnoses and the drug use.¹⁷² Because in the court’s view, neither the drug abuse evidence nor the evidence concerning mental disorders offset the alleged limitations, it was irrelevant to the mental retardation determination and improperly admitted.¹⁷³ *Holladay* reached the same conclusion, faulting the prosecution’s expert for “look[ing] upon inappropriate conduct as something separate from mental retardation, rather than as indicating a lack of support

¹⁶⁷ Jessica Moreland, et. al., *The Validity of a Personality Disorder Diagnosis for People with an Intellectual Disability*, 21 J. OF APPLIED RESEARCH IN INTELLECTUAL DISABILITIES 219, 220 (2008). See Lindsay et al., at 314-17. See Louise F. Eaton, M.D. & Frank J. Menolascino, M.D., *Psychiatric Disorders in the Mentally Retarded: Types, Problems, and Challenges*, 139(10) AM. J. PSYCHIATRY 1297 (1982) (studying 114 community-based individuals diagnosed as having both mental illness and mental retardation and finding that 27.1% of the subjects had personality disorders). See John M. 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(4) JOURNAL OF FORENSIC PSYCHOLOGY PRACTICE 1, 14 (2006) (“[S]ome offenders may have both antisocial personality traits and mild mental retardation . . .”).

¹⁶⁸ Lawrence Dana, *Personality Disorder in Persons with Mental Retardation: Assessment and Diagnosis* in MENTAL HEALTH ASPECTS OF MENTAL RETARDATION: PROGRESS IN ASSESSMENT AND TREATMENT 130, 131 (1993) (noting “link between depressed mood, low social support, and poor social skills was found among mildly retarded persons[,] further found to be associated with inept social interactions [which are] among the key diagnostic criteria for personality disorders”); id. at 153 (noting that antisocial personality disorder is one of the six personality disorders that exists most often among individuals with mental retardation).

¹⁶⁹ William R. Lindsay, et. al., *Personality Disorders in DIAGNOSTIC MANUAL-INTELLECTUAL DISABILITY: A CLINICAL GUIDE FOR DIAGNOSIS OF MENTAL DISORDERS IN PERSONS WITH INTELLECTUAL DISABILITY* (National Association for the Dually Diagnosed in Association with the APA) 313, 314-17 (2007).

¹⁷⁰ Id. at 652-53; see id. at 655, 659.

¹⁷¹ Id. at 653. Specifically, with regard to drug abuse, the *Lambert* court noted that because “[m]ental retardation is a condition present at birth . . . subsequent drug abuse makes it no more nor less likely.” Id. at 655.

¹⁷² 126 F.3d at 659.

¹⁷³ Id. at 659; see *Rivera*.

which has impeded adaptation.”¹⁷⁴ The *Holladay* court’s finding that adverse home environment (parental physical abuse; alcoholism by parents) may have contributed to mental retardation underscores the importance, stressed in the clinical definitions, of identifying environmental risk factors and supports or lack thereof as a means of diagnosing mental retardation.

When dual diagnoses are appropriate there is always a risk of “diagnostic overshadowing,” of “under-recognition of intellectual among individuals with depression, psychosis, or anxiety disorders.”¹⁷⁵ Deficits in adaptive behavior are neither burdened by a particular cause or etiology nor disproved by concurrent or coexisting mental disorders. The clinical definitions provide, without reservation, that a diagnosis of mental retardation is not dependent on cause. “Mental retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.”¹⁷⁶ Forty percent of the time there is no clear etiology.¹⁷⁷ The test is between the individual and their environment: if the individual functions at a significantly deficient level in certain skills, they have mental retardation, regardless of the etiology of their limitations. A defendant seeking to prove adaptive functioning deficits, therefore, “is not required to show that mental retardation is the cause of his limitations in these skill areas.”¹⁷⁸ As the DSM-IV-TR states, “[t]he diagnostic criteria for mental retardation do not include an exclusion criterion; therefore, the diagnosis shall be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder.”¹⁷⁹

It may seem wrong for self-induced causes, such that the defendant is in part or whole responsible for the limitation, to support exclusion. In *Rivera v. Dretke*, the court could not identify particular causes of the functioning deficits, finding it “impossible in hindsight to separate out what may be ‘true’ MR (existing before age of 18) from whatever damage Rivera may have done to himself from his continual use of inhalants, cocaine, and marijuana.”¹⁸⁰ Finding the defendant had mental retardation, the court was nevertheless “troubled by the notion that one can “fry” his own brain by using illegal drugs and then be excused from some of the possible consequences of committing a gruesome and murderous act.”¹⁸¹ But the rationale of *Atkins* is not that mental retardation absolves a defendant of criminal responsibility, rather that it lessens his moral culpability to a level where the death penalty is no longer an appropriate

¹⁷⁴ *Holloday*, at 1343; see *id.* at 1345 (“This court rejects the argument that willful and antisocial behavior excludes an MR determination. To the contrary, it suggests that a person whose IQ tests strongly indicate MR has not adapted.”).

¹⁷⁵ AAIDD User’s Guide at 16. See, e.g., Steven Reiss & J. Szyszko, *Diagnostic Overshadowing and Professional Experience with Mentally Retarded Persons*, 87 Am. J. Mental Deficiency 396 (1983).

¹⁷⁶ DSM-IV-TR at 41. The major predisposing factors include: “heredity, early alterations of embryonic development, environmental influences, mental disorders, pregnancy or prenatal problems, general medical conditions acquired in infancy or childhood.” See DSM-IV-TR at 45-46.

¹⁷⁷ See DSM-IV-TR at 45.

¹⁷⁸ *Lambert v. State*, 126 P.3d 646, 651 (OCCA 2005); see *Rivera*.

¹⁷⁹ DSM-IV-TR at 47; *id.* at 42 (“Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social or vocational opportunities, and the mental disorders and general medical conditions that may coexist with mental retardation.”); DSM-IV-TR at 45 (“Individuals with mental retardation have a prevalence of comorbid mental disorder that is estimated to be three to four times greater than in the general population.”); DSM-IV-TR at 44 (stating that an individual may have mental retardation with another mental disorder or with a general medical disorder (e.g., Down syndrome)).

¹⁸⁰ 2006 WL 870927 (S.D.Tex. 2006), at 24, 26.

¹⁸¹ *Id.* at *23.

punishment. The court recognized that it was compelled under *Atkins* to accept that the cause of the subaverage functioning was not dispositive to the mental retardation determination.¹⁸²

Thus, the bottom line with regard to evidence of concurrent or contributory disorders is that circumstances, both present and historical, can make significantly subaverage functioning more or less likely.¹⁸³ But a dual diagnosis or evidence of a contributory cause does not negate the possibility of the presence of mental retardation. A defendant need not disprove an ASPD diagnosis to prove mental retardation. If the defendant has adaptive limitations, even if evinced by characteristics that overlap with conduct disorder, and the requisite intellectual limitations, he may have mental retardation even if other diagnoses apply.

III. The Novel Onset Prerequisite Applied to Michael Stallings

The third criterion for establishing mental retardation under the clinical definitions is evidence of development of the functional limitations associated with mental retardation before the subject is eighteen years of age. The clinical definitions neither specify nor require that evidence of onset be established by a standardized instrument testing intelligence or adaptive behavior.¹⁸⁴ Most often, individuals with mental retardation have not taken standardized assessments of intelligence or adaptive functioning prior to the age of eighteen. Often, despite indications of mental retardation, tests are not performed for charitable reasons, for instance where institutions do not want to stigmatize a child, or financial reasons, if institutions do not want to pay benefits or have services' responsibility. This may be particularly true in schools or other institutions serving lower socioeconomic neighborhoods.¹⁸⁵ In some districts IQ testing has been forbidden for race discrimination reasons. Some foreign nationals may not have grown up in an environment where standardized intelligence testing was available. The AAIDD recognizes this, identifying "[a] number of reasons might explain the lack of an earlier, official diagnosis of mental retardation":

- the individual was excluded from a full school experience
- the person's age precluded his or her involvement in specialized services such as special education programs
- the person was given no diagnosis or a different diagnosis for 'political purposes' such as protection from stigma or teasing, avoidance of assertions of discrimination, or related to conclusions about the potential benefits or dangers of a particular diagnosis
- the school's concern about over-representation for data reporting purposes of specific diagnostic groups within their student population
- parental concerns about labels
- contextual school-based issues such as availability or nonavailability of services and potential funding streams at that time; and
- the lack of entry referral into the diagnostic referral process due to cultural and linguistic differences.¹⁸⁶

¹⁸² See *id.* at n.55.

¹⁸³ See *Holladay* at 1345 ("It is obvious that negative influences such as parental physical abuse, excessive drinking of alcohol, etc., can have a negative effect [on adaptive functioning].").

¹⁸⁴ Accord *Bonnie & Gustafson*, 41 U. Rich. L. Rev. at 855.

¹⁸⁵ See *Bonnie & Gustafson*, 41 U. Rich. L. Rev. at 855 ("Such a requirement would be unconstitutional because it would amount to discrimination against people whose need for special education was overlooked and who did not have access to adequate clinical or social services as a child.")

¹⁸⁶ AAIDD User's Guide (2007) at 18

The AAIDD also states, specifically with respect to the context of criminal proceedings, that “some criminal defendants fall at the upper end of the MR/ID severity continuum (i.e., people with mental retardation who have a higher IQ) and frequently . . . have a history of academic failure and marginal social and vocational skills [and] their previous and current situations frequently allowed formal assessment to be avoided or led to assessment that was less than optimal.”¹⁸⁷

Michael Stallings was one such defendant. The Ohio courts accepted that Stallings presented I.Q. test scores and evidence of adaptive functioning limitations sufficient to satisfy the first two prongs of the clinical definitions, but denied his *Atkins* claim for lack of evidence of onset, based on the testimony of Stallings own experts.¹⁸⁸ When asked about onset, one expert testified that Stallings was described by family members, teachers and mental health professions, as a child, as having characteristics associated with mental retardation, namely, that he was a concrete thinking, impulsive, immature, a follower, who did not understand personal relationships and had difficulty adjusting to new situations.¹⁸⁹ The expert also noted that Stallings was in “special education classes and developmental handicapped classes.”¹⁹⁰ The expert concluded that, based on this information, he could not “rule out mental retardation, although he could not state with 100 percent certainty that Stallings was mentally retarded.”¹⁹¹ A second expert concurred. Acknowledging that “there was no actual testing for mental retardation . . . prior to age 18,” the expert stated that Stallings’s “school records and family reports support the conclusion that his functional limitations and severity were not new.”¹⁹² The court was unimpressed with this testimony because neither would “definitely conclude” that onset preceded 18; in the courts view neither said that Stallings had mental retardation, “only that it is possible.”¹⁹³ Stallings is not the only capital defendant whose *Atkins* claim was wrongly denied for failure to present “concrete evidence” of onset in the form of standardized testing.¹⁹⁴

While the Ohio Supreme Court recently reversed another Ohio trial court’s decision that a defendant failed to establish mental retardation simply due to the lack of a standardized test prior to eighteen, correctly holding that evidence of onset of adaptive functioning limitations prior to eighteen did not necessarily have to be proven by standardized test,¹⁹⁵ Stallings was not so fortunate. And the state courts’ demands for “definite proof” of onset in the form of a standardized test posed additional problems for him in the federal habeas context. Even if a

¹⁸⁷ AAIDD User’s Guide (2007) at 18 (citing secondary sources).

¹⁸⁸ 561 F.Supp.2d 821, 883-84.

¹⁸⁹ Id. at 882.

¹⁹⁰ Id.

¹⁹¹ Id. (quoting Trial Transcript).

¹⁹² Id. at 883.

¹⁹³ Id. at 884.

¹⁹⁴ See, e.g., *Rosales v. Quarterman*, 2008 WL 3858466 (5th Cir. 2008) (rejecting merits of *Atkins* claim in part because petitioner failed to “present any concrete evidence of adaptive behavioral deficits that had onset before the age of 18”); see also *Pizzuto v. State*, 2008 WL 466568 (Idaho 2008) (finding that lack of pre-18 IQ test in combination with present seizure disorder provides reasonable basis to infer lack of pre-18 onset and that IQ decreasing and MR increasing over time).

¹⁹⁵ *State v. White*, 885 N.E.2d 905, 917 (Ohio 2008); see id. at 9156 (“Although White had taken neither an IQ test nor an adaptive-skills test before age 18, Drs. Hammer and Fabian were able to review White’s academic records. These records strongly support the experts’ conclusion that White’s intellectual and adaptive deficits had their onset before age 18.”). The court properly looked to White’s grades in school, his achievement test scores, and the deficiencies indicated there corroborated by interviews with family members.

federal court agrees that no proof of standardized testing is necessary to establish onset, they may not find that a state court was “unreasonable” in dismissing a mental retardation claim on that basis. In *Stallings v. Bagley*, a Northern District of Ohio judge did just that. While the federal district court expressly disagreed with the state court’s demand for “definite proof” of pre-18 onset in the form of a standardized test, the Court, “reluctantly,” was not ready to say that the state court’s demand was an objectively unreasonable interpretation of *Atkins*.¹⁹⁶

IV. Conclusion.

In defining mental retardation, the AAIDD and the APA have endeavored to present definitions approved by a consensus of the scientific community. Like the American Bar Association standards for defense counsel in capital cases¹⁹⁷, the AAIDD and APA definitions of mental retardation reflect prevailing norms in the field. They do not set hard and fast rules that predetermine the outcome in every case, but they provide a normative guide to which courts, following *Atkins*, must adhere. Deviations from the clinical definitions disrupt consistency between jurisdictions in the application of *Atkins*’ categorical bar. Defendants in some states are being held to a different and stricter standard than defendants elsewhere. This creates a risk of arbitrary application that the Eighth Amendment cannot accept. But worse, some individuals who should be exempt from the death penalty under *Atkins* are not.

¹⁹⁶ *Stallings v. Bagley*, 561 F.Supp.2d 821, 884-85 (N.D. Ohio 2008).

¹⁹⁷ See *Wiggins v. Smith*.