

Of Atkins and Men: Deviations from Clinical Definitions of Mental Retardation in Death Penalty Cases

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

*John H. Blume,** Sheri Lynn Johnson*** & Christopher Seeds*****

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.

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* See generally JOHN STEINBECK, *OF MICE AND MEN* (Penguin Books 1993) (1937); see also *infra* notes 210 & 211 and accompanying text.

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INTRODUCTION

In 2002, following a consistent wave of state legislative action prohibiting the use of the death penalty on defendants with mental retardation, the Supreme Court overruled its thirteen-year-old decision in *Penry v. Lynaugh*,¹ and declared a categorical exemption from the death penalty for defendants who have mental retardation.² 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 experience, to engage in logical reasoning, to control impulses, and to understand the reactions of others.³ The Court defined the exemption 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))⁴ and the other by the

¹ 492 U.S. 302 (1989).

² *Atkins v. Virginia*, 536 U.S. 304 (2002).

³ *See id.* at 318.

⁴ The clinical field increasingly employs the term "intellectual disability." We refer to "mental retardation," since *Atkins* used that term. *See* Robert L. Schalock et al., *The Renaming of Mental Retardation: Understanding the Change to the Term Intellectual Disability*, 45 INTELLECT. & DEVELOPMENTAL DISABILITIES 116 (2007) (explaining that change in terminology within AAIDD involves no change in definition).

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 individuals who meet the AAIDD/AAMR criteria for mental retardation 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 to “enforce 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—

⁵ *Id.* at 308 n.3 (citing AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 41 (4th ed. 2000) [hereinafter DSM-IV-TR]; AAMR, MENTAL RETARDATION: DEFINITION, CLASSIFICATION, AND SYSTEMS OF SUPPORTS 5 (9th ed. 1992) [hereinafter AAMR 9th ed.]). 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) [hereinafter AAMR 10th ed.]; see also AAIDD, USER’S GUIDE: MENTAL RETARDATION DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS 12 (10th ed. 2007) [hereinafter AAIDD 10th ed.].

⁶ See *Atkins*, 536 U.S. at 317 n.22 (noting that “[t]he statutory definitions of mental retardation are not identical, but generally conform to the clinical definitions . . .”).

⁷ The clinical definitions of mental retardation approved in *Atkins*, 536 U.S. at 308 n.3, provide:

Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly subaverage intellectual functioning, existing concurrently with related limitations in one 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. AAMR 9th ed., *supra* note 5, at 1.

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 DSM-IV-TR, *supra* note 5, at 41.

⁸ *Atkins*, 536 U.S. at 317 (quoting *Ford v. Wainwright*, 477 U.S. 399, 405, 416–17 (1986)).

⁹ See *id.* at 316 n.20.

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, applying the statistical concept of the standard error of measurement, his score should be considered to be within a range of scores from 67 to 77. The court ignored statistics, imposed a cutoff of 70, 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 United States Court of Appeals for the Fifth Circuit interpreted evidence of social and practical skill deficits—including poor hygiene, homelessness, and the inability to live on his own, cook, hold a job, dress appropriately for weather, or 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 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,

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

¹¹ *Williams v. Quarterman*, 293 Fed. Appx. 298, 312 (5th Cir. 2008).

¹² See *State v. Stallings*, No. CR 1997 05 1118(A), 2004 WL 5457509, at *11–12 (Ohio Ct. Com. Pl. Jan. 16, 2004).

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, 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 [their] 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 The Court also anticipated case-by-case dispute over the fact-intensive determination of whether a particular defendant

¹³ See *Stallings v. Bagley*, 561 F. Supp. 2d 821, 885–86 (N.D. Ohio 2008) (applying 28 U.S.C. § 2254(d) (2000)).

¹⁴ See, e.g., Dennis R. 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). Professor Weithorn also observes:

[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.

Lois A. Weithorn, *Conceptual Hurdles to the Application of Atkins v. Virginia*, 59 HASTINGS L.J. 1203, 1231 (2008).

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 Carol S. Steiker & Jordan M. Steiker, *Atkins v. Virginia: Lessons from Substance and Procedure in the Constitutional Regulation of Capital Punishment*, 57 DEPAUL L. REV. 721, 724–30 (2008). See also *id.* at 731–37 (focusing on the use of procedures to circumvent the constitutional exemption).

has mental retardation.¹⁷ But the Court did not give 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 of mental retardation. 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 sentencing to death and execution of capital defendants who have mental retardation.¹⁸

I. THE FRAMEWORK: *ATKINS* AND THE SCIENTIFIC AND CLINICAL DEFINITIONS

The AAIDD and DSM-IV-TR define mental retardation in three parts, as a disability characterized by (1) significantly subaverage intellectual functioning; 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 the societal mean.²⁰ An IQ score of around 70 generally corresponds to such performance.²¹ Approximately ninety-seven percent of all people fall within two standard deviations, or thirty points, of the mean.²² In other words, the class of individuals with mental retardation 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 . . . describe[s] people with an IQ level of 50-55 to approximately 70,"²³ and in

¹⁷ *Atkins*, 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 Weithorn, *supra* note 14, at 1232. These questions are not the concerns of lower courts under *Atkins* and they do not concern us here.

¹⁹ See AAMR 10th ed., *supra* note 5, at 8; DSM-IV-TR, *supra* note 5, at 41.

²⁰ See AAMR 10th ed., *supra* note 5, at 57-59; DSM-IV-TR, *supra* note 5, at 41-42.

²¹ See AAMR 10th ed., *supra* note 5, at 57-59; DSM-IV-TR, *supra* note 5, at 41-42.

²² See AAMR 10th ed., *supra* note 5, at 57.

²³ *Atkins*, 536 U.S. at 308 n. 3 (quoting DSM-IV-TR, *supra* note 5, at 42-43).

terms of mental age is similar intellectually in many ways to an average ten-year-old, or a fifth or sixth grade student.²⁴

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, and they must be vigilant to ensure that the tests are scored properly,²⁵ are current, and account for standard statistical concepts of measurement error, practice effect, and an effect unique to intelligence testing known as the Flynn effect.²⁶ 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, considering the standard error of measurement for the specific assessment instruments used and the instruments' strengths and limitations."²⁷ Unfortunately, courts have failed to uniformly adhere 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

²⁴ See DSM-IV-TR, *supra* note 5, at 42-43.

²⁵ See *Hall v. Quarterman*, 534 F.3d 365 (5th Cir. 2008) (holding state court unreasonably denied *Atkins* claim in part because the decision was based on a misreading of defendant's IQ as 72 instead of 67); *Lewis v. Quarterman*, 541 F.3d 280 (5th Cir. 2008) (holding district court erred in refusing to consider affidavit of the author of Stanford-Binet test stating that the psychologist who administered the test to the defendant did not follow proper procedures).

²⁶ See James R. Flynn, *Massive IQ Gains in 14 Nations: What IQ Tests Really Measure*, 101 PSYCH. BULL. 171, 171-91 (1987).

²⁷ AAIDD 10th ed., *supra* note 5, at 12; AAMR 10th ed., *supra* note 5, at 13. 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 10th ed., *supra* note 5, at 59-71. See also Richard J. Bonnie & Katherine Gustafson, *The Challenge of Implementing Atkins v. Virginia: How Legislatures and Courts Can Promote Accurate Assessments and Adjudications of Mental Retardation in Death Penalty Cases*, 41 U. RICH. L. REV. 811, 826-29 (2007) (discussing 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 *id.* at 842-43.

learned by people in order to function in their everyday lives.”²⁸ 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.²⁹ Two of these principles—that “limitations in present functioning must be considered within the context of community environments typical of the individual’s age peers and culture” and that “within an individual, limitations often coexist with strengths”—factor significantly in capital cases.³⁰

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.³¹ The clinical definitions neither specify nor require that onset be established by a standardized test score.³²

²⁸ See AAMR 10th ed., *supra* note 5, at 5. The 10th edition of AAMR, which reduced the important skill areas to three, requires significant limitations in only one area. *Id.* at 20–23 tbl.2.1 (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 *id.*

²⁹ 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.
- 5) With appropriate personalized supports over a sustained period, the life functioning of the person with mental retardation will generally improve.

Id. at 8–9, 13 tbl.1.2.

³⁰ ROBERT L. SCHALOCK & RUTH LUCKASSON, *CLINICAL JUDGMENT* 39 (2005); see AAMR 10th ed., *supra* note 5, at 8; DSM-TR-IV, *supra* note 5, at 42, 47.

³¹ See AAIDD 10th ed., *supra* note 5, at 18–22.

³² See Bonnie & Gustafson, *supra* note 27, at 855.

Overall, none of the diagnostic criteria for mental retardation “include an exclusion criterion.”³³ This is because of the well-accepted understanding that individuals with mental retardation possess a wide variety of “abilities and needs.”³⁴ 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*, however, a 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”—has been betrayed.³⁵

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 instead of the standard error of measurement. Without considering adaptive functioning, the court ruled that Cherry did not have mental retardation based on his IQ score.³⁶ *Cherry* illustrates a recurring problem after *Atkins*: the failure of courts 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 approxi-

³³ DSM-IV-TR, *supra* note 5, at 47.

³⁴ *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 445 (1985).

³⁵ See *Bonnie & Gustafson*, *supra* note 27, 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)).

³⁶ See *Cherry v. State*, 959 So.2d 702 (Fla. 2007).

mately 70,”³⁷ 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.”³⁸ 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.³⁹ 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.”⁴⁰ On up to date and well-standardized tests, the SEM is between three to five points.⁴¹ Accordingly, both clinical definitions include measurement error in the definition of intellectual functioning:

³⁷ *Atkins v. Virginia*, 536 U.S. 304, 309 n.3 (2002) (quoting DSM-IV-TR, *supra* note 5, at 42–43) (emphasis added).

³⁸ AAMR 10th ed., *supra* note 5, at 12.

³⁹ 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 measurable 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 J. CONSULTING AND CLINICAL PSYCHOL. 149, 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.*

⁴⁰ DAVID WECHSLER, WAIS-R MANUAL: WECHSLER ADULT INTELLIGENCE SCALE – REVISED 31 (1981); see THE PSYCHOLOGICAL CORPORATION, WAIS-III – WMS-III TECHNICAL MANUAL 53 (1997) [hereinafter WAIS-III] (“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.”).

⁴¹ See J. P. GUILFORD, PSYCHOMETRIC METHODS 352 (2d ed. 1954) (1936). Guilford notes that with the SEM, “[f]or 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

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.⁴²

Therefore, according to the AAIDD, “[i]t is clear that neither of [the clinical definitions] intends for a fixed cutoff point for making the diagnosis of mental retardation.”⁴³ 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.”⁴⁴ 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.⁴⁵ This is universally recognized in clinical practice,⁴⁶ as legal

X, “[w]e may say that for any particular true score the odds are 2 to 1 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 JOY PAUL GUILFORD, FUNDAMENTAL STATISTICS IN PSYCHOLOGY AND EDUCATION 337 (6th ed. 1978) (1942) (noting 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. GARRETT, STATISTICS IN PSYCHOLOGY AND EDUCATION 290 (6th ed. 1966) (1926) (stating SEM measurements “enable[] us to estimate the probable divergences of an obtained score on a test from its corresponding true score”); 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”).

⁴² DSM-IV-TR, *supra* note 5, at 41–42; see AAMR 9th ed., *supra* note 5, at 28 (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. See AAMR 10th ed., *supra* note 5, at 24.

⁴³ AAMR 10th ed., *supra* note 5, at 58.

⁴⁴ *Atkins v. Virginia*, 536 U.S. 304, 309 n.5 (2002).

⁴⁵ The integral nature of the SEM as a reliability measure to the intelligence prong of mental retardation diagnosis and classification is also exemplified by the 1992 AAMR definition of significantly subaverage intellectual functioning as “approximately 70 to 75 or below.” AAMR 9th ed., *supra* note 5, at 28. 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 10th ed., *supra* note 5, at 24.

⁴⁶ See WAIS-III, *supra* note 40 (describing the standard error of measurement as one of the “psychometric properties that are critical for the interpretation of scores”).

commentators have noted.⁴⁷

Two other phenomena that occur in IQ testing are widely recognized as scientifically legitimate and 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.⁴⁸ As the AAIDD explains, “[p]ractice effect gains occur even when the examinee has not been given any feedback on his performance.”⁴⁹ 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.⁵⁰ 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 a mental retardation (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 recommendations against administering the same intelligence test to someone within the same year.”⁵¹ 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.⁵² James Flynn, after whom the effect is named, has recognized different quantum of effect in different countries.⁵³ 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.⁵⁴ Thus,

⁴⁷ 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: The Dilemma of the Mentally Retarded on Death Row*, 5(4) J. FORENSIC PSYCHOL. 1, 7 (2005) (recognizing that the AAMR criteria require consideration of a 5 point standard error of measurement). See Bonnie & Gustafson, *supra* note 27, 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.”)

⁴⁸ AAIDD 10th ed., *supra* note 5, at 21; WAIS-III, *supra* note 40, at 56-57.

⁴⁹ AAIDD, *supra* note 5, at 21.

⁵⁰ WAIS-III, *supra* note 40, at 56-57.

⁵¹ AAIDD, *supra* note 5, at 21.

⁵² See Flynn, *supra* note 26.

⁵³ See *id.*

⁵⁴ See James Flynn, *The Mean IQ of Americans: Massive Gains 1932 to 1978*, 95 PSYCH. BULL. 29 (1984).

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.⁵⁵ Accordingly, a score of 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, thereby muting 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 renormed. 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 developmental period.”⁵⁶ Many courts have held that the Flynn effect must be accounted for.⁵⁷ But others have erroneously dismissed the Flynn effect as an “unexamined scientific concept,”⁵⁸ or as a concept that is only used in capital litigation.⁵⁹ The importance that the AAIDD places upon the Flynn effect and practice effect in assessing the first criterion for mental retardation, however, shows otherwise.

B. Some Jurisdictions Ignore the Fundamental Role of the SEM and Practice Effect 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.⁶⁰ 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 refuted the clinical definitions.⁶¹ A second errant approach dismisses the

⁵⁵ See AAIDD, *supra* note 5, at 21.

⁵⁶ *Id.* at 17.

⁵⁷ See, e.g., *Walker v. True*, 399 F.3d 315, 322 (4th Cir. 2005).

⁵⁸ See *Neal v. State*, 256 S.W.3d 264, 273 (Tex. Crim. App. 2008).

⁵⁹ See *Ledford v. Head*, No. 1:02-CV-1515-JEC, 2008 WL 754486, at *7 (N.D. Ga. Mar. 19, 2008); *Green v. Johnson*, 515 F.3d 290, 300 n.2 (4th Cir. 2008).

⁶⁰ See *Cherry v. State*, 959 So.2d 702 (Fla. 2007); see also *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.”).

⁶¹ See *Bowling v. Commonwealth*, 163 S.W.3d 361, 374-75, 388 (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); *Howell v. State*, 151 S.W.3d 450, 457 (Tenn. 2004) (interpreting statute demanding “significantly subaverage general intellectual function-

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 of 72 and 74 on the WAIS-III from examinations administered approximately one year apart. The defense's 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 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 psychologist cited no source supporting this conclusion, the state courts adopted his position.⁶² However, two proximate scores on the same test within a short period of time do not increase confidence in the result, 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.⁶³

Further, some courts correctly recognize that the SEM and IQ produce a range rather than a number, but nevertheless dismiss downward adjustment as "speculative" because the SEM could as likely increase as decrease the IQ score.⁶⁴ This perspective was summed up by the district court in *Briseno*, which, in affirming the state court's determination, observed that "[b]ecause measurement error could as easily raise a peti-

ing as evidenced by a functional intelligence quotient (I.Q.) of seventy or below" to impose a "bright line" cutoff at 70); *see also Green*, 515 F.3d at 300 n.2 ("[N]either *Atkins* nor Virginia law appears to require expressly that [SEM] be accounted for in determining mental retardation status."); Richard J. Bonnie, *The American Psychiatric Association's Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. AM. ACAD. PSYCHIATRY L. 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, *supra* note 27, 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."); *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).

⁶² *See Briseno v. Dretke*, No. L-05-08, 2007 WL 998743, at *9 (S.D. Tex. Mar. 29, 2007) (quoting State Habeas Court Findings of Fact and Conclusions of Law, at 2); *accord Ledford*, 2008 WL 754486, at *8 (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).

⁶³ A letter by the author of a chapter on the WAIS-III devoted to serial testing of IQ scores, submitted to the Texas Court of Criminal Appeals by Briseno's attorneys, offered the proper clinical approach: "[Briseno's] second test score of 74 is consistent with his initial score of 72, and his estimated true IQ score is 95 times out of 100 likely to fall within the range of 67-79." CLINICAL INTERPRETATION OF THE WAIS-III AND WMS-III (Davis S. Tulsky et al. eds., 2003). In addition, the practice effect would increase. *See supra* Part II.A.

⁶⁴ *See Ledford*, 2008 WL 754486, at *8; *Green*, 515 F.3d at 300 n.2.

tioner'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."⁶⁵ 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."⁶⁶ This conclusion 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.⁶⁷

The district court's statement in *Briseno* emphasizes an additional point. Federal habeas review of state court determinations under the Antiterrorism and Effective Death Penalty Act of 1996 (AEDPA) commands federal courts to uphold state court applications of law that are not unreasonable, even if incorrect.⁶⁸ 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 what appears to be a judgment call by the state court on the accuracy of an IQ test score. 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.⁶⁹ Federal courts should recognize that state courts are exercising discretion where *Atkins* left none, unreasonably refusing to apply the standard error of measurement that the clinical definitions and *Atkins* require. This is particularly troublesome because of the place of the intelligence criterion in determining mental retardation.

⁶⁵ *Briseno*, 2007 WL 998743, at *10.

⁶⁶ *Id.* (citing 28 U.S.C. § 2254(d)(1)).

⁶⁷ See Alfred L. Brophy, *Confidence Intervals for True Scores and Retest Scores on Clinical Tests*, 42(6) J. OF CLINICAL PSYCHOL. 989 (1986); Robert G. Knight, *On Interpreting the Several Standard Errors of the WAIS-R: Some Further Tables*, 51(5) J. OF CONSULTING AND CLINICAL PSYCHOL. 671 (1983) (describing three methods of SEM for WAIS).

⁶⁸ See, e.g., *Schiro v. Landrigan*, 550 U.S. 465, 474 (2007) ("The question under AEDPA is not whether a federal court believes the state court's determination was incorrect but whether that determination was unreasonable—a substantially higher threshold.") (citing AEDPA, 28 USC §§ 2254(d)(1)-(2) (2006)).

⁶⁹ Bonnie & Gustafson, *supra* note 27, 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, *supra* note 14, at 1206 ("[I]n light of 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.'").

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 functioning . . . and thus an upper range of 70 to 75 is typically suggested.”⁷⁰ 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.⁷¹ For an individual with an IQ on the border of 70, *Atkins*’s first prong serves as a gateway to a consideration of adaptive behavior. The diagnosis is ultimately determined by whether the individual has significant adaptive behavior deficits.⁷² 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.

III. THE CASE OF JEFFREY WILLIAMS, AND OTHER EXCLUSIONARY INTERPRETATIONS OF ADAPTIVE FUNCTIONING

In contrast to Roger *Cherry*, Jeffrey Williams scored 70 or below on his IQ test. The denial of Williams’s *Atkins* claim turned on the courts’ interpretation of evidence of Williams’s adaptive functioning. In *Atkins*, the Supreme 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

⁷⁰ AAIDD 10th ed., *supra* note 5, at 24. “IQ scores alone cannot precisely identify an individual’s functioning in the upper boundary of mental retardation . . .” *Id.* (suggesting an upper range of 75).

⁷¹ See Caroline Everington & J. Gregory Olley, *Implications of Atkins v. Virginia: Issues in Defining and Diagnosing Mental Retardation*, 8(1) J. FORENSIC PSYCHOL. 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 PSYCHOL. 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.”).

⁷² 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 10th ed., *supra* note 5, at 24; see *id.* at 34 (adaptive behavior is “a bulwark against false positives that would occur if IQ was used as the sole determinant of mental retardation”).

understand the reactions of others.”⁷³ Williams presented evidence showing that he was unable to live on his own, cook, hold a job, maintain a stable home, dress appropriately for weather, or follow the rules of games. Adhering to the skill areas identified by the clinical definitions, the defense’s expert—who concluded that Williams had mental retardation—and the State’s expert—who concluded he did not—both identified adaptive functioning limitations in social skills. The defense’s 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 retardation, and evidence of Williams’s adaptive strengths—overrode the evidence of adaptive limitations.⁷⁴ The federal district court pointed to “substantial adaptive strengths, finding that Williams rented an apartment, bought at least two vehicles, [and] washed his clothes.”⁷⁵ 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.”⁷⁶ 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

⁷³ *Atkins v. Virginia*, 536 U.S. 304, 318 (2002).

⁷⁴ See *Williams v. Quarterman*, 293 Fed.Appx. 298, at 310-14 (5th Cir. 2008).

⁷⁵ *Id.* at 312 (citing district court findings).

⁷⁶ *Id.*

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.⁷⁷ 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 limitation⁷⁸

[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 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.⁷⁹

⁷⁷ AAMR 10th ed., *supra* note 5, at 8-9, 13, 27.

⁷⁸ *Id.* at 8.

⁷⁹ *Id.* at 48. See also George S. Baroff, *Establishing Mental Retardation in Capital Cases: An Update*, 41(3) MENTAL RETARDATION 198, 199 (2003) (“Another way of illustrat-

Knowing and applying these principles is 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 *within skill areas*, rather than a general assessment of overall adaptive behavior, which occurred in *Williams*.⁸⁰

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 negate a finding of mental retardation. “The diagnostic criteria for [m]ental [r]etardation do not include an exclusion criterion”⁸¹ Strengths and weaknesses thus may coexist, but strengths have no value independent of weaknesses.⁸² 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.⁸³

The consequence is that some courts, failing to engage in the careful and thorough analysis called for by the various definitions of mental retardation, 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 early twentieth-century view that “every imbe-

ing 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.”).

⁸⁰ 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*.

⁸¹ DSM-IV-TR, *supra* note 5, at 47.

⁸² 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).

⁸³ See, e.g., *Rodriguez v. State*, 919 So.2d 1252 (Fla. 2005) (relying 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).

cile . . . is a potential criminal,” the “mentally retarded” have been regarded as a group both incompetent and dangerous.⁸⁴ 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.”⁸⁵ 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.⁸⁶

The Mississippi court likely would not have used the phrase “retarded people do not” if the court possessed a more realistic understanding of what suffering from mental retardation actually means.⁸⁷ Even

⁸⁴ See James W. Ellis & Ruth A. Luckasson, *Mentally Retarded Defendants*, 53 GEO. WASH. L. REV. 414, 416-20 (1988); see also *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.”); cf. *Buck v. Bell*, 274 U.S. 200 (1927) (discussing sterilization of the “feeble-minded”).

⁸⁵ Ellis & Luckasson, *supra* note 84, at 427.

⁸⁶ *Wiley v. State*, 890 So.2d 892, 897 (Miss. 2004) (emphasis added), *aff’d*, *Wiley v. Epps*, No. 2:00CV130-P-A, 2007 WL 405041 (N.D. Miss. Feb. 2, 2007).

⁸⁷ *Accord 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

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."⁸⁸ Individuals with mental retardation can drive, hold jobs, make money, and operate heavy machinery.⁸⁹ Nevertheless, in cases such as *Wiley*, classic stereotyping of individuals with mental retardation prevails over evidence and expert testimony showing significant limitations in adaptive skills.⁹⁰

mechanic"); *Hughes v. State*, 892 So.2d 203, 215 (Miss. 2004) (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.").

⁸⁸ Alexander Kassoff, Note, *Evolving Standards of Decency in Mississippi: Chase v. State, Capital Punishment, and Mental Retardation*, 25 MISS. C. L. REV. 221, 254 (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 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.

⁸⁹ See *Lambert v. State*, 126 P.3d 646, 657 (Okla. Crim. App. 2005).

⁹⁰ 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 v. State 160 S.W.3d 24, 43–44 (Tex. Crim. App. 2004) (Johnson, J., dissenting). Denying an evidentiary hearing on *Atkins*, the court relied solely on evidence from a sentencing proceeding that took place before *Atkins*. The United States District Court for the Northern Dis-

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,”⁹¹ 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.”⁹² “Even if adaptive limitations rather than strengths often define mental retardation,” the court added, “the evidence in this case shows primarily adaptive strengths and does not show limitation in any significant area.”⁹³ Evidence of an adaptive strength or strengths *may* disprove a deficit, but does not *necessarily* do so. Further, limitations rather than strengths do not “often” define mental retardation—they *always* do.⁹⁴ 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*

According dispositive weight to strengths not only strays from the clinical definitions, it also 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.⁹⁵ 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

trict 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), but the Fifth Circuit vacated and remanded, holding that Hall was entitled to an evidentiary hearing. *See Hall v. Quarterman* 534 F.3d 365 (5th Cir. 2008).

⁹¹ *See Clark v. Quarterman*, 457 F.3d 441, 446-47 (5th Cir. 2006), *aff’g Ex parte Clark*, No. 37288-02, 2004 WL 885583 (Tex. Crim. App. Mar. 3, 2004).

⁹² *Id.* at 447.

⁹³ *Id.*

⁹⁴ Similar challenges to adjudications of mental retardation claims have repeatedly lost in Texas federal and state courts. *See, e.g., United States v. Webster*, 421 F.3d 308, 313 n.15 (5th Cir. 2005); *Briseno v. Dretke*, No. L-05-08, 2007 WL 998743, at *15 (S.D. Tex. Mar. 29, 2007). *But see Lambert v. State*, 126 P.3d 646 (Okla. Crim. App. 2005).

⁹⁵ *See Lambert*, 126 P.3d 646.

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.⁹⁶ 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.⁹⁷ From this perspective, “uniform application” of clinical definitions of mental retardation is “impractical[], if not impossib[le].”⁹⁸

This perceived “quagmire”⁹⁹ pushed the Texas Court of Criminal Appeals to articulate “evidentiary factors which factfinders in the criminal trial context might also focus upon in weighing evidence as indicative of mental retardation or a personality disorder.”¹⁰⁰ The *Briseno*

⁹⁶ This statement 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 v. Quarterman, No. Civ. SA-05-CA-659-RF, 2006 WL 1900630, at *12 & n.70 (W.D. Tex. July 11, 2006).

⁹⁷ See *Ex parte Briseno*, 135 S.W.3d 1, 13 (Tex. Crim. App. 2004).

⁹⁸ *Rodriguez*, 2006 WL 1900630, at *12.

⁹⁹ *Rivera v. Dretke*, No. Civ. B-03-139, 2006 WL 870927, at *7 (S.D. Tex. Mar. 31, 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 of having to sift through the quagmire of conflicting testimony inherent in cases that involve ‘dueling experts.’”).

¹⁰⁰ *Briseno*, 135 S.W.3d at 8. 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?

factors present an array of divergences from the clinical definitions. First, as the court's statement indicates, *Briseno* erroneously pits mental retardation against personality disorders in an either-or dichotomy. Furthermore, the factors adhere by turns 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”¹⁰¹—for instance, people with mental retardation often have limited communication skills and may not be able to provide coherent responses,¹⁰² have poor impulse control,¹⁰³ and 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 to steer away deviously from certain lines of testimony,”¹⁰⁴ 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 accuracy,¹⁰⁵ and will overrate their skills and mask their limitations.¹⁰⁶ Therefore, what resembles coherence 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,¹⁰⁷ and as such fail to fully address all skill areas set out in the clinical definitions—areas such as home living and self-care are ignored. Thus, a factfinder applying all the factors will not necessarily have assessed the full possibility of adaptive deficits, and therefore cannot rule out the possibility of significant limitations in adaptive functioning.

Texas courts see *Briseno* as resolving the question of who decides the legal issue of mental retardation, the factfinder or the clinician.¹⁰⁸

Id. at 8–9.

¹⁰¹ Ellis & Luckasson, *supra* note 84, at 427, 428–32.

¹⁰² *Id.* at 428.

¹⁰³ *Id.* at 429.

¹⁰⁴ *Id.*

¹⁰⁵ *See id.* at 429–30, 431–32.

¹⁰⁶ *See id.* at 430.

¹⁰⁷ *See* Holladay v. Campbell, 463 F.Supp. 2d 1324, 1343 (N.D. Ala. 2006) (“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 citing in full the AAMR principle emphasizing that “limitations often coexist with strengths.”).

¹⁰⁸ *See* *Briseno v. Dretke*, No. L-05-08, 2007 WL 998743, at *15 (S.D. Tex. Mar. 29, 2007):

Nothing in federal law authorizes habeas relief based on an alleged misapplication of professional psychological standards alone. Admittedly, clinical methodology in forms [sic] the mental retardation review, but the Court of Criminal Appeals cor-

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—like any opinion—is by definition 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.¹⁰⁹ 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."¹¹⁰ 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.¹¹¹

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. For example, in *Smith and Tennard*, the Fifth Circuit demanded that mitigation make a difference in *certain* ways that the court deemed important.¹¹² 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.¹¹³ Like the *Tennard* nexus requirement, the *Briseno* factors create their own world of relevance, redefining the ques-

rectly 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.

(quoting *Ex parte Briseno*, 135 S.W.3d 1, 9 (Tex. Crim. App. 2004)).

See also *Rodriguez v. Quarterman*, No. Civ. SA-05-CA-659-RF, 2006 WL 1900630, at *11 (W.D. Tex. July 11, 2006) ("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.").

¹⁰⁹ SCHALOCK & LUCKASSON, *supra* note 30, at 1.

¹¹⁰ *Id.* at 91.

¹¹¹ There are cases applying *Briseno* in which defendants have been found to have mental retardation. See *Ex Parte Modden*, 147 S.W.3d 293 (Tex. Crim. App. 2004) (finding unanimous expert agreement supports mental retardation; dissent arguing facts do not meet *Briseno* factors); see also *In re Hearn*, 376 F.3d 447 (5th Cir. 2004) (majority finding mental retardation; dissent disputing IQ and adaptive functioning), *aff'd*, 418 F.3d 444 (5th Cir. 2005).

¹¹² See *Smith v. Cockrell*, 311 F.3d 661, 680-81 (5th Cir. 2002); *Tennard v. Cockrell*, 284 F.3d 591, 597 (5th Cir. 2002).

¹¹³ See *Tennard v. Dretke*, 542 U.S. 274, 287 (2004).

tions that make up the constitutional determination.¹¹⁴ 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 reliant upon proof of limitations, the scope of the proceedings narrows and focuses appropriately on the particular limitations the defendant alleges.¹¹⁵

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 consider the deficits claimed by the defendant in the context of the skill areas the definitions set forth and balance the evidence supporting the alleged adaptive limitations against evidence of adaptive strengths that offset those deficits.¹¹⁶ 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 evidence.¹¹⁷

A good example of particularized balancing is found in *Holladay v. Campbell*.¹¹⁸ In *Holladay*, the petitioner alleged limitations in all skill areas. The United States District Court for the Northern District of Alabama, emphasizing that limitations coexist with strengths,¹¹⁹ grouped the evidence relevant to adaptive behavior into two categories: that “tend[ing] to show limitation(s) in adaptive functional behavior” and that

¹¹⁴ It follows that defense counsel who consent to the constitutionality of the *Briseno* factors should be challenged as ineffective. Defendants must not acquiesce to use of the *Briseno* factors. However, this has happened. See *Moreno v. Dretke*, 450 F.3d 158, 164 (5th Cir. 2006) (“Moreno does not dispute that these are correct definitions of mental retardation.”).

¹¹⁵ See *Lambert v. State*, 126 P.3d 646 (Okla. Crim. App. 2005).

¹¹⁶ See, 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 mental retardation found because no adaptive deficits).

¹¹⁷ At this point, nearly every jurisdiction has formally or implicitly adopted the skill area model. See, e.g., *State v. Frazier*, 873 N.E.2d 1263, 1291-92 (Ohio 2007) (“Moreover, neither Dr. Forgac nor Dr. Smalldon found that Frazier has ‘significant limitations in adaptive functioning in at least two skill areas,’ as *Atkins* requires.”); *Murphy v. State*, 54 P.3d 556, 567-68 (Okla. Ct. Crim. App. 2002), *overruled on other grounds* by *Blonner v. State*, 127 P.3d 1135 (Okla. Crim. App. 2006). Yet some courts and some states still rely on a generalized determination of adaptive behavior. See, e.g., ARIZ. REV. STAT. ANN. §§ 13-703.02(K)(1), (K)(2) (2008); *State v. Grell*, 135 P.3d 969, 709 (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.”).

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

¹¹⁹ See *id.* at 1343.

“tend[ing] to show the absence of limitations in adaptive functional behavior.”¹²⁰ 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.¹²¹ The court then factored in the results of a standardized test administered to two of the defendant’s relatives and expert testimony.¹²²

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.¹²³ 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 of the AAMR 9th edition—communication, social skills, community use, functional academics, and work.¹²⁴ Applying the AAMR 10th edition skill areas, the court found significant limitations in all three areas—conceptual, practical, and social.¹²⁵ Affirming the district court’s decision, the Eleventh Circuit emphasized that “[i]ndividuals with mental retardation have strengths and weaknesses, like all individuals [and] [i]ndeed, the criteria for diagnosis recognizes this by requiring a showing of deficits in only two of ten identified areas of adaptive functioning.”¹²⁶ The State’s expert’s “predominant focus on Holladay’s actions surrounding the crime,” the circuit court noted, “suggests that she did not recognize this.”¹²⁷

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.¹²⁸

¹²⁰ *Id.* at 1334.

¹²¹ *See id.* at 1336-39.

¹²² *See id.* at 1340.

¹²³ *See id.* at 1343.

¹²⁴ *See 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 required significant intellectual ability; Holladay never found work on his own initiative. *Id.* at 1337-38. 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 1338.

¹²⁵ *Id.* at 1346 n.29.

¹²⁶ *Holladay v. Allen*, 555 F.3d 1346, 1363 (11th Cir. 2009).

¹²⁷ *Id.*

¹²⁸ *See Lambert v. State*, 126 P.3d 646, 652 (Okla. Crim. App. 2005) (finding significant deficits in four of the nine adaptive-functioning skill areas). In *Lambert*, the Oklahoma Court of Criminal Appeals applied a definition of mental retardation the court adopted in the wake of *Atkins*. *Id.* at 650; *see also* *Murphy v. State*, 54 P.3d 556, 567-68 (Okla. Crim. App. 2002),

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.¹²⁹

The defendant presented proof of deficits in four of the nine skill areas: health and safety, academics, communication, and social and interpersonal skills.¹³⁰ 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 caused by antisocial personality disorder, schizophrenia, conduct disorder, and drug abuse.¹³¹ The Oklahoma Court of Criminal Appeals 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."¹³² By grounding the assessment in alleged limitations, *Lambert* and *Holladay* applied *Atkins* without the need for additional factors such as those listed in *Briseno*.

overruled on other grounds by *Blonner v. State*, 127 P.3d 1135 (Okla. Crim. App. 2006). *Blonner* overruled procedures set forth in *Murphy* but retained the definition of mental retardation as a three-prong test:

- (1) If he or she functions at a significantly sub-average intellectual level that substantially limits his or her ability to understand and process information, to communicate, to learn from experience or mistakes, to engage in logical reasoning, to control impulses, and to understand the reactions of others;
- (2) The mental retardation manifested itself before the age of eighteen (18); and
- (3) The mental retardation is accompanied by significant limitations in adaptive functioning in at least two of [nine] skill areas

(footnotes omitted). 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 areas. *See id.*

¹²⁹ *Lambert*, 126 P.3d at 651.

¹³⁰ *Id.* at 652.

¹³¹ *See id.* at 652–53, 655, 659 (presenting and rejecting these arguments as separate from the evidence of mental retardation, as drug abuse does not affect mental retardation, which is present from birth, and mental illnesses, which are also separate from mental retardation).

¹³² *Id.* at 653.

The approach taken in cases like *Lambert* and *Holladay* follows the clinical definitions.¹³³ It also helps to guide courts through some of the difficult questions in adaptive behavior assessment, including: what impact should a petitioner's behavior in prison have on the adaptive behavior determination, and how should the circumstances of the crime affect the determination?

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, and filling out a grievance form are all examples of activities that have been offered to disprove mental retardation.¹³⁴ 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[:]

[C]omplaints 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;

[H]andwritten puzzles including the decipherment of several extremely complicated codes; and

[C]omplaints about delays in approving his request for a legal visit with another inmate in which Clark planned to assist the inmate in obtaining parole.¹³⁵

The Fifth Circuit focused on strengths in the same way that the testimony of a former employer may make the point that the defendant was a

¹³³ *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, when considering White's adaptive functioning, in focusing on whether White exhibited behavior that was "bizarre" or "out of the ordinary").

¹³⁴ *See, e.g., Clark v. Quarterman*, 457 F.3d 441, 447 (5th Cir. 2006).

¹³⁵ *Id.*

good worker and could follow directions, or a court may look to a defendant's prior testimony, note-taking during the trial, or coherent allocution at sentencing to prove an absence of limitation.¹³⁶ If courts follow the clinical definitions' focus on limitations, 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 an individual's capabilities. Aside from taking into account the defendant's active attempt to wear a "cloak of competence,"¹³⁷ 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?¹³⁸ Greenspan and Switzsky 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

¹³⁶ See, e.g., *Rodriguez v. State*, 919 So.2d 1252, 1266 (Fla. 2005). En route to finding the defendant had no significant limitations in adaptive behavior, the court rejected the results of a standardized test scoring the defendant two standardized deviations below the mean, and relied instead on the defendant's behavior at trial:

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.

Id. 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 the possibility of fair trial and sentencing proceedings where mentally retarded 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." *Id.* (citing the trial court's decision).

¹³⁷ See James R. Patton & Denis W. Keyes, *Death Penalty Issues Following Atkins*, 14(4) EXCEPTIONALITY 237, 252 (2006).

¹³⁸ See Ellis & Luckasson *supra* note 84, at 430–31; see also *Hall v. State* 160 S.W.3d 24, 44 (Tex. Crim. App. 2004) (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.'").

should have done differently to avoid his current predicament.”¹³⁹ 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].*¹⁴⁰

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.*¹⁴¹

But there is more at stake with 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 [against] typical community-based environments, not environments that are segregated by ability.”¹⁴² Death row is an atypical, segregated, structured, and regulated community, and presents circumstances of “legal restraint,” in which adaptive behavior assessments are “less than opti-

¹³⁹ 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, 293 (Harvey N. Switzky & Stephen Greenspan eds., 2006).

¹⁴⁰ *Lambert v. State*, 126 P.3d 646, 652 (Okla. Crim. App. 2005) (emphasis added).

¹⁴¹ *Id.*

¹⁴² AAMR 10th ed., *supra* note 5, at 8.

mal.”¹⁴³ In this structured circumstance, “the role of the person’s immediate environment [must be] integrated into the assessment.”¹⁴⁴

Members of the scientific community note that prison’s limited opportunities “[make] it impossible to assess ‘adaptive behavior within the context of community environments . . .’ as required by the 2002 AAMR standards.”¹⁴⁵ 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.”¹⁴⁶ Others have stressed that prison assessments of adaptive behavior 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 but instead of actually reading merely looking at the pictures or sports scores).”¹⁴⁷ Accordingly, it has been suggested that, because “few measures of adaptive functioning have been designed or normed for use

¹⁴³ See AAIDD 10th ed., *supra* note 5, at 14 (stating that assessment in a less than optimal conditions “necessitate[s] considering assessment purposes and specific guidelines to enhance the precision, accuracy, and integrity of the clinician’s diagnosis”).

¹⁴⁴ *Id.* at 15 (stating that in “challenging diagnostic conditions,” assessment must consider the role of the immediate environment).

¹⁴⁵ Everington & Olley, *supra* note 71, at 12.

¹⁴⁶ See *id.* (noting this presents difficulties because “standardized assessments require informants who have observed the individual perform a broad range of skills in community contexts”); see also Bethany Young et al., *Four Practical and Conceptual Assessment Issues That Evaluators Should Address in Capital Case Mental Retardation Evaluations*, 38(2) PROF. PSYCHOL.: RES. AND PRAC. 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.”) (citations omitted); John M. Fabian, *supra* note 47, at 13–14 (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 “more likely to have experienced conflicts with the defendants which may cause bias against the defendant in an evaluative setting”); Stevens & Price, *supra* note 71, at 16 (“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.”).

¹⁴⁷ Patton & Keyes, *supra* note 137, at 249 (stating that prison assessments should be avoided for these reasons); accord Young et al., *supra* note 146, at 171 (noting that using typical methods of assessment of adaptive functioning in capital cases may be inappropriate because, due to length of time spent in restrictive settings, the subject “may have had 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”).

with institutionalized correctional populations [the] 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.”¹⁴⁸

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 on evidence of the defendant’s conduct during the crime. *Briseno* suggested consideration of numerous factors, including whether “the commission of the offense require[d] forethought, planning, and complex execution of purpose.”¹⁴⁹ While the Texas Court of Criminal Appeals has emphasized the circumstances of the crime as a factor in assessing adaptive behavior deficits,¹⁵⁰ other courts have expressed skepticism about the relevance of crime circumstances.¹⁵¹ Legislatures, too, have debated this point.¹⁵²

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,’” colloquially known as “‘street smarts’ . . . [or the ability] to ‘think on [one’s] feet.’”¹⁵³ “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.”¹⁵⁴ Minimiz-

¹⁴⁸ Stanley L. Brodsky & Virginia A. Galloway, *Ethical and Professional Demands for Forensic Mental Health Professionals in the Post-Atkins Era*, 13(1) ETHICS & BEHAV. 3, 7 (2003); see also Stevens & Price, *supra* note 71, at 19 (“[F]orensic evaluators should consider adaptation to prison incarceration as *one* factor of many in their assessment of adaptive behavior.”).

¹⁴⁹ *Ex parte Briseno*, 135 S.W.3d 1, 8–9 (Tex. Crim. App. 2004).

¹⁵⁰ See, e.g., Neal v. State, 256 S.W.3d 264, 275 (Tex. Crim. App. 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”).

¹⁵¹ See e.g., *Holladay v. Campbell*, 463 F. Supp. 2d 1324, 1347 (N.D. Ala. 2006) (rejecting the suggestion that “Petitioner’s extremely violent conduct and later temporary avoidance of capture forecloses a determination of mental retardation”).

¹⁵² See Peggy Tobolowsky, *Atkins Aftermath: Identifying Mentally Retarded Offenders and Excluding Them From Execution*, 30 J. LEGIS. 77, 98–99 (2003). Compare Bill Analysis, S. 3, 2003–2004 Sess. (Cal. 2003), with Bill Analysis, S. 51, 2003–2004 Sess. (Cal. 2003) (suggesting a determination of mental retardation without consideration of the facts of the case at one time and then omitting such a suggestion in subsequent analysis, while reiterating that mental retardation determinations require an “historic view” of the individual’s life).

¹⁵³ William Lee Hon, *Feature: Expert Witness, Claims of Mental Retardation in Capital Litigation*, 69(8) TEX. B. J. 742, 743–44 (Sept. 2006).

¹⁵⁴ *Id.* at 744.

ing the significance of expert testimony on mental retardation, the author concludes that, "in many instances the facts of the crime will be the *best* evidence of a defendant's level of adaptive functioning."¹⁵⁵

In one prominent case, the Tennessee Court of Criminal Appeals relied predominantly on crime evidence in its adaptive behavior assessment.¹⁵⁶ The court rejected the results for Vineland and Independent Living Scale test scores of two standard deviations below the mean because it questioned whether the standardized measures could measure someone like the petitioner who was raised in Vietnam, spoke little to no English, and had been incarcerated for more than ten years before the tests were administered.¹⁵⁷ The court also rejected expert testimony that the defendant had deficits in five of the ten DSM-IV skill areas.¹⁵⁸ 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

¹⁵⁵ *Id.* (emphasis added) ("Notwithstanding expert testimony to the contrary, juries are eminently capable of resolving the subjective mental retardation issue when furnished with all relevant evidence of the defendant's life, background, and criminal and mental health histories.").

¹⁵⁶ See *Van Tran v. State*, No. W2005-01334-CCA-R3-PD, 2006 WL 3327828 (Tenn. Crim. App. Nov. 9, 2006). The post-conviction petitioner presented the results of two standardized adaptive behavior tests (Independent Living Scales and Vineland) on which the petitioner 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.* at *7, *10. A psychologist specializing in neuropsychology, who administered additional tests, found that the post-conviction petitioner 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 one of the three AAMR skill areas (conceptual). *Id.* at *11. The expert also described environmental risk factors that contributed to the petitioner's deficits. *Id.*

¹⁵⁷ See *id.* at *15-16.

¹⁵⁸ See *id.* at *23, 25.

involved in that conduct when determining whether a person is mentally retarded.¹⁵⁹

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 areas and recognizing that a defendant need only show significant limitations in one or two, the court also applied the *Briseno* factors.¹⁶⁰ 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 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.”¹⁶¹

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.”¹⁶² For example, “we do not typically know . . . the

¹⁵⁹ *Id.* at *24–25.

¹⁶⁰ *See id.* at *23–24.

¹⁶¹ *Id.* at *23 (quoting *Atkins*, 536 U.S. at 319–20).

¹⁶² Greenspan & Switzky, *supra* note 139, at 291; *see* Everington & Olley, *supra* note 71, at 11 (“[M]ost important, adaptive behavior is the individual’s *typical* performance in his/her

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."¹⁶³ 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."¹⁶⁴

Additionally, because the focus must be on the specific areas of adaptive functioning identified by the clinical definitions,¹⁶⁵ the relevance of crime facts to the diagnosis depends on a variety of factors. For example, 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 in which the defense has presented evidence of a deficit.¹⁶⁶ In *Lambert*, the prosecution emphasized the crime's circumstances, which showed that the defendant could drive, give and understand directions, and use a weapon.¹⁶⁷ But as the Court of Criminal Appeals of Oklahoma astutely recognized, "[n]one of the evidence of criminal activity went to any of Lambert's claims of adaptive function limitations."¹⁶⁸ Therefore, "none of it was relevant."¹⁶⁹

In *Holladay*, 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."¹⁷⁰ 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

community setting. The details of the crime cannot be considered to be a sample of typical behavior.").

¹⁶³ Greenspan & Switzky, *supra* note 139, at 291.

¹⁶⁴ Everington & Olley, *supra* note 71, at 11 ("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.").

¹⁶⁵ See Young et al., *supra* note 146, at 173; Everington & Olley, *supra* note 71, at 11.

¹⁶⁶ See *Lambert v. State*, 126 P.3d 646, 651 (Okla. Crim. App. 2005). Similarly, the causation of an individual's adaptive functioning deficits does not negate the diagnosis of mental retardation when deficits are present.

¹⁶⁷ *Id.* at 656.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ *Holladay v. Campbell*, 463 F.Supp.2d 1324, 1346 (N.D. Ala. 2006).

least social limitations.”¹⁷¹ The *Holladay* court noted that the *Atkins* court, rather than finding that the heinous facts of the crime refuted mental retardation, saw the defendant’s criminal and impulsive behavior as potentially indicative of adaptive behavior limitations and consequently reduced culpability.¹⁷² The *Atkins* majority also recognized that “[t]here is no evidence that [people with mental retardation] are more likely to engage in criminal conduct than others.”¹⁷³ Perhaps most important, as with prison evidence, courts should be cautious of crime evidence and measure its value according to the level of detail with 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. This requires careful consideration of whether the stressed strengths involved in the criminal activity actually correlate to the asserted deficits and the level of detail of adaptive limitations provided by the defendant’s evidence. Courts must also ensure that strengths are not wrongly given dispositive weight by careless 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 by positing a false dichotomy between mental retardation and mental disorders. State and federal courts approach mental disorders and mental retardation differently.¹⁷⁴ In Williams’s case, the courts distinguished evidence as explained by mental retardation or another disorder.

¹⁷¹ *Id.*; see also *Holladay v. Allen*, 555 F.3d 1346, 1363 (11th Cir. 2009) (recognizing that defense expert’s testimony “cogently explained Holladay’s strengths with regard to the events of the crime but also explained that some of what Alabama points to as strengths are activities that an individual with mild mental retardation is capable of performing”).

¹⁷² See *Holladay v. Campbell*, 463 F.Supp.2d 1324, 1346-47. This has long been recognized in the field: “[A]daptive behavior is a term of art, which is not synonymous with maladaptive behavior.” Ellis & Luckasson, *supra* note 84, at 421-23. 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. See *Atkins*, 536 U.S. at 321-37 (Rehnquist, C.J., dissenting); *id.* at 337-54 (Scalia, J., dissenting). *Atkins*, for example, had sixteen prior felony convictions and shot the victim in the case eight times. See *Atkins*, 536 U.S. at 307.; cf. *Rivera v. Dretke*, No. Civ. B-03-139, 2006 WL 870927, at *25 (S.D. Tex. Mar. 31, 2006) (finding mental retardation despite a finding by the court 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”).

¹⁷³ *Atkins v. Virginia*, 536 U.S. 304, 318 (2002). Learning disabilities and inclination to impulsive behavior, the Court recognized, also enhanced the risk that offenders with mental retardation will not receive a fair and individualized sentencing proceeding. See *id.* at 306-07.

¹⁷⁴ Compare *Lambert v. State*, 126 P.3d 646, 659 (Okla. Crim. App. 2005) with *Briseno v. Dretke*, No. L-05-08, 2007 WL 998743, at *14 (S.D. Tex. Mar. 29, 2007).

der—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.”¹⁷⁵ The *Briseno* court accepted the same dichotomy, and cited it as a motivating reason for the need to enunciate its novel additional evidentiary factors.¹⁷⁶ These approaches are contrary to accepted clinical practice.¹⁷⁷

It is well recognized by clinical professionals that mental retardation and mental disorders coexist,¹⁷⁸ and may even be interrelated.¹⁷⁹ 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 others¹⁸⁰—overlap with the criteria for some mental illnesses.¹⁸¹ Accordingly, “[w]hen a defendant’s behavior, whether criminal or other, is associated with cer-

¹⁷⁵ *Williams v. Quarterman*, 293 Fed.Appx. 298, 312 (5th Cir. 2008) (quoting district court holding) (emphasis added).

¹⁷⁶ See *Briseno*, 2007 WL 998743, at *14.

¹⁷⁷ See, e.g., *Green v. Johnson*, No. CIV A 2:05CV340, 2006 WL 3746138, at *59 (E.D. Va. Dec. 15, 2006); see also *Simpson v. Quarterman*, No. 1:04-CV-485, 2007 WL 1008193, at *15 (E.D. Tex. Mar. 29, 2007) (citing *Ex parte Simpson*, 136 S.W.3d 600, 664-65 (Tex. Crim. App. 2000)). For more recent examples, see *Neal v. State*, 256 S.W.3d 264 (Tex. Crim. App. 2008) (finding no adaptive behavior deficits where experts diagnosed the defendant with conduct disorder and antisocial personality rather than MR). *But cf.* *Brumfield v. Cain*, Civil Action No. 04-787-JJB-CN, 2008 WL 2600140 (M.D. La. June 30, 2008) (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 mental retardation, low birth weight, mother’s use of drugs during pregnancy, abuse).

¹⁷⁸ See AAIDD 10th ed., *supra* note 5, at 15 (“In general, mental health disorders are more prevalent among individuals with MR/ID than the general population.”); HANDBOOK OF MENTAL ILLNESS IN THE MENTALLY RETARDED (Frank J. Menolascino & Jack A. Stark eds., 1984).

¹⁷⁹ See *Bonnie & Gustafson*, *supra* note 27 at 304–08; see also *Holladay v. Campbell* 463 F.Supp.2d 1324, 1344, 1346 (N.D. Ala. 2006) (referring to Appendix B).

¹⁸⁰ See *Atkins v. United States*, 536 U.S. 304, 318 (2002).

¹⁸¹ See DSM-IV-TR, *supra* note 5, at 706. 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” See Irving Phillips & Nancy Williams, *Psychopathology and Mental Retardation: A Study of 100 Mentally Retarded Children*, 132 AM. J. PSYCHIATRY 1265 (1975) (finding in study of 100 children with mental retardation, that the largest categories of co-morbidity were behavioral disorders, followed closely by personality disorders).

tain 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).¹⁸² “[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.”¹⁸³

Using a clinical approach, 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.¹⁸⁴ The Oklahoma Court of Criminal Appeals dismissed this argument, finding that “[a]n alternative explanation for an agreed condition is not a negation of that condition.”¹⁸⁵ The court went farther, taking issue with the relevance of the State’s evidence concerning the diagnoses and the drug use.¹⁸⁶ Because in the court’s view neither the drug abuse evi-

¹⁸² Young et al., *supra* note 146, at 173. See also Fabian, *supra* note 47, at 27 (“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.”).

¹⁸³ WILLIAM R. LINDSAY ET AL., *MENTAL HEALTH ASPECTS OF MENTAL RETARDATION: PROGRESS IN ASSESSMENT AND TREATMENT* 314–17 (2007). See 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 (Robert J. Fletcher & Anton Dosen eds.) (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); see also Jessica Moreland et al., *The Validity of a Personality Disorder Diagnosis for People with an Intellectual Disability*, 21 J. OF APPLIED RES. IN INTELL. DISABILITIES 219, 220 (2008) (“It 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.”); Louise F. Eaton & Frank J. Menolascino, *Psychiatric Disorders in the Mentally Retarded: Types, Problems, and Challenges*, 139 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); 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) J. FORENSIC PSYCHOL. PRAC. 1, 14 (2006) (“[S]ome offenders may have both antisocial personality traits and mild mental retardation . . .”).

¹⁸⁴ See *Lambert v. State*, 126 F.3d 646, 652-53, 655, 659 (Okla. Crim. App. 2005).

¹⁸⁵ *Id.* at 653. Regarding drug abuse, the *Lambert* court specifically 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.

¹⁸⁶ *Id.* at 659.

dence nor the evidence concerning mental disorders offset the alleged limitations, it was irrelevant to the mental retardation determination and improperly admitted.¹⁸⁷ *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 which has impeded adaptation."¹⁸⁸ The *Holladay* court's finding that an adverse home environment (parental physical abuse, alcoholism of 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," or "under-recognition of intellectual impairments among individuals with depression, psychosis, or anxiety disorders."¹⁸⁹ A defendant seeking to prove adaptive functioning deficits, therefore, "is not required to show that mental retardation is the cause of his limitations in certain skill areas."¹⁹⁰ 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. As the DSM-IV-TR states, "the diagnosis shall be made whenever the diagnostic criteria are met, regardless of and in addition to the presence of another disorder."¹⁹¹ "The diagnostic criteria for Mental Retardation do not include an exclusion criterion."¹⁹²

¹⁸⁷ See *id.*; accord *Rivera v. Dretke*, 2006 WL 870927 (S.D. Tex. Mar. 31, 2006).

¹⁸⁸ *Holladay v. United States*, 463 F.Supp.2d 1324, 1343 (N.D. Ala. 2006); see *id.* at 1345 ("This court rejects the argument that willful and antisocial behavior excludes a mental retardation determination. To the contrary, it suggests that a person whose IQ tests strongly indicate mental retardation has not adapted.").

¹⁸⁹ AAIDD 10th ed., *supra* note 5, at 16; see also Steven Reiss & J. Szyszko, *Diagnostic Overshadowing and Professional Experience with Mentally Retarded Persons*, 87 AM. J. MENTAL DEFICIENCY 396 (1983).

¹⁹⁰ *Lambert v. State*, 126 P.3d 646, 651 (Okla. Crim. App. 2005); see also *Rivera*, 2006 WL 870927. Indeed, "[m]ental 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." DSM-IV-TR, *supra* note 5, at 41. The major predisposing factors include: "heredity[;] early alterations of embryonic development[;] environmental influences[;] mental disorders[;] pregnancy and perinatal problems[;] [and] general medical conditions acquired in infancy or childhood." *Id.* at 45-46.

¹⁹¹ DSM-IV-TR, *supra* note 5, at 47; see also *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."); *id.* 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."); *id.* at 44 (stating that an individual may have mental retardation with another mental disorder or with a general medical disorder (e.g., Down syndrome)).

¹⁹² *Id.* at 47.

It may seem wrong for self-induced causes, such that the defendant is in part or in whole responsible for the limitation, to support a diagnosis of mental retardation. 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’ mental retardation (existing before age of eighteen) from whatever damage Rivera may have done to himself from his continual use of inhalants, cocaine, and marijuana.”¹⁹³ 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.”¹⁹⁴ But the rationale of *Atkins* is not that mental retardation absolves a defendant of criminal responsibility; rather, it lessens his moral culpability to a level where the death penalty is no longer an appropriate 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.¹⁹⁵

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.¹⁹⁶ 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 antisocial personality disorder 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.

IV. 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.¹⁹⁷ Most often, individuals with mental retardation have not taken standardized assessments of intelligence or

¹⁹³ *Rivera*, 2006 WL 870927, at *24, *26.

¹⁹⁴ *Id.* at *23.

¹⁹⁵ *See id.* at *23 n.55.

¹⁹⁶ *See Holladay v. United States*, 463 F.Supp.2d 1324, 1345 (N.D. Ala. 2006) (“It is obvious that negative influences such as parental physical abuse, excessive drinking of alcohol, etc. can have a negative effect [on adaptive functioning].”).

¹⁹⁷ *See Bonnie & Gustafson, supra* note 27, at 855.

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 responsibility. This may be particularly true in schools or other institutions serving lower socioeconomic neighborhoods.¹⁹⁸ 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 [that] 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.¹⁹⁹

The AAIDD also states, specifically with respect to 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.”²⁰⁰

¹⁹⁸ See *id.* (“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.”).

¹⁹⁹ AAIDD 10th ed., *supra* note 5, at 18.

²⁰⁰ *Id.*

Michael Stallings was one such defendant. The Ohio courts accepted that Stallings presented IQ 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's own experts.²⁰¹ When asked about onset, one expert testified that as a child, Stallings was described by family members, teachers, and mental health professionals as having characteristics associated with mental retardation, namely, that he was concrete-thinking, impulsive, immature, a follower, did not understand personal relationships, and had difficulty adjusting to new situations.²⁰² The expert also noted that Stallings was in "special education classes and developmental handicapped classes."²⁰³ 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."²⁰⁴ A second expert concurred. Acknowledging "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."²⁰⁵ The court was unimpressed with this testimony because neither expert would "definitely conclude" that onset preceded Stallings's eighteenth birthday; in the court's view neither expert said that Stallings had mental retardation, "only that it is *possible*."²⁰⁶ 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.²⁰⁷

While the Ohio Supreme Court recently reversed an 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 does not necessarily have to be proven by standardized test,²⁰⁸

²⁰¹ See *Stallings v. Bagley*, 561 F.Supp.2d 821, 883–84 (N.D. Ohio 2008).

²⁰² *Id.* at 882.

²⁰³ *Id.*

²⁰⁴ *Id.* (quoting Trial Transcript).

²⁰⁵ *Id.* at 883.

²⁰⁶ *Id.* at 884.

²⁰⁷ See, e.g., *Rosales v. Quarterman*, 291 Fed.Appx. 558 (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*, 202 P.3d 642 (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).

²⁰⁸ See *State v. White*, 885 N.E.2d 905, 917 (Ohio 2008); see *id.* at 916 ("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

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 federal court agrees that no proof of standardized testing is necessary to establish onset, it may find that a state court was not "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-eighteen 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*.²⁰⁹

CONCLUSION

The title of this article refers to John Steinbeck's famous novella *OF MICE AND MEN*, which tells the story of two depression-era wandering farmhands, George and his mentally retarded sidekick Lenny.²¹⁰ Both dream of getting their own little farm and living "off the fat of the land." But the dream dies hard when Lenny kills the young, flirtatious wife of a ranch owner's son, and George, in turn, kills Lenny to prevent him from being lynched or tried for murder. Steinbeck leaves the reader with no doubt that Lenny—because of his mental retardation—is not fully responsible for what he has done, and that George—faced with impossible, unjust alternatives—does the best he can.

Atkins v. Virginia promises to end the injustice of executing the Lennys of the world. But after reading the post-*Atkins* cases, it is not clear that George would have any better choices today. Imagine if Lenny's lawyer claimed that his client was not eligible for execution because he was a person with mental retardation, and was faced with the state glosses on the definition of mental retardation we have described. It is surprisingly easy to write the state court's decision rejecting Lenny's claim:

Lenny Small claims he is mentally retarded and thus ineligible for execution under *Atkins v. Virginia*. We disagree. While Smalls *may* have satisfied the first prong (substantially subaverage intellectual functioning), his claim fails on both the second and third prongs. First, as for the adaptive functioning prong, the evidence revealed that Small, when he wanted to, was able to obtain employment at a number of different agricultural busi-

court properly looked to White's grades in school, his achievement test scores, and the deficiencies indicated there corroborated by interviews with family members.

²⁰⁹ See *Stallings v. Bagley*, 561 F.Supp.2d 821, 884–85 (N.D. Ohio 2008).

²¹⁰ See STEINBECK, *supra* note *.

nesses. Various employers described him as a hard worker who understood their instructions and was able to successfully perform a variety of tasks. Additionally, the crime is inconsistent with mental retardation. After committing the murder, Small went to great lengths to conceal his crime, including hiding the body. Finally, we credit the testimony of the State's expert that the deficits in adaptive functioning (Small's inconsistent work history, lack of close relationships, dropping out of school, etc.) relied upon by Small's experts are better explained by antisocial personality disorder than mental retardation. Small also cannot satisfy the third prong (onset before age 18), as he has not produced any evidence of IQ tests prior to the age of 18, or that he was ever placed in special education classes, or deemed by any school or agency to be a person with mental retardation.

The understanding of mental retardation reflected in this hypothetical opinion, like the understanding in many post-*Atkins* decisions, is at odds with the clinical definitions of mental retardation. It is also inconsistent with the "evolving standards of decency"²¹¹ that *Atkins* holds have brought our society beyond the compounded tragedies portrayed so many years ago in *OF MICE AND MEN*.

²¹¹ *Atkins v. Virginia*, 536 U.S. 304, 312 (2002).

