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Lessons from the Atkins Decision for the Next AAMR Manual

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INTRODUCTION

In the past, the main use of AAMR manuals was in determining whether a client would get access to agency-based services or benefits. In light of the U.S. Supreme Court's ruling in *Atkins* v. *Virginia* (2002), the manual is now being used to determine whether a criminal defendant should or should not be exempted from the death penalty on the grounds of having mental retardation (MR). Obviously, this makes the manual's adequacy or inadequacy a much more serious matter than it was before the *Atkins* ruling.

We have recently begun to serve as consultants in what are termed "Atkins hearings," which can occur either at the pretrial or habeus (postappeal) stage, and which are used to determine whether a death penalty can be considered or carried out. Thus far, our experience has been as defense consultants, but we have seen our share of reports by experts on both sides, and the same issues affect diagnostic evaluations conducted by both defense and prosecution experts. The responsibility of any expert witness is not to be an advocate, but to report the *truth*, regardless of whom it helps or hurts. It behooves an expert, therefore, to do some initial screening before getting too far into a case, so that he or she can feel free to tell the contacting attorney, "I don't think I can honestly take the position you want me to take." Unfortunately, this may not always be done, as the adversarial, not to mention lucrative, nature of the judicial process places pressures on experts to become what Hagen (1997) termed "whores of the court."

The likelihood that an *Atkins* hearing will be adversarial rather than a neutral search for the truth is increased by the stakes involved (a person's life) and also by the ambiguous nature of mild MR itself. Most *Atkins* applicants fall at the upper end of the MR severity continuum, and present a mixed competence profile. People on death row typically have a history of academic failure, marginal social and vocational competence, and even overt brain damage (Lewis & Balla, 1976). So what differentiates a worthy Atkins applicant from one who is unworthy? We hope to answer this question in the last part of this chapter. Does the 2002 AAMR diagnostic manual provide an adequate basis for resolving these disputes in a manner which one can consider just? If the answer to this last question is

"Not really," then that should shed some light on what needs to be done, and in a hurry, to improve the situation.

Although each state legislature has established its own criteria and procedures to be used by courts in deciding such litigation (in many cases, these predate the Supreme Court's ruling), the 2002 AAMR manual (Luckasson et al., 2002) has become the gold standard that is most typically reflected in the legislation and used by clinicians on both sides. Based on our experience with *Atkins* cases over the past couple of years, there are some problems that we think need to be addressed by the AAMR in its next round at producing a diagnostic manual.

As some of these cases are still moving through the litigation process, we are obliged to keep our comments very general and cannot discuss details of specific defendants. Because virtually all condemned prisoners in the United States are male (and we are unaware of any *Atkins* claims involving females), we have opted to refer to defendants as "he" rather than the more usual and cumbersome "he and she." The points made in the pages that follow have less to do with the definition of MR than with the procedures that are used in applying that definition in making a diagnosis. That is a critical feature of any diagnostic manual, and we hope that the next T&C Committee will give some thought to lessons that can be learned from the use of the 2002 manual in *Atkins* hearings. Because these lessons are very practical in nature, this chapter will be less abstract and more concrete than most of the other chapters in this volume. Hopefully, this will be seen to have some advantages in helping to ground future discussions of the manual in messy reality rather than, as in the past, mainly on less (but still) messy theory.

PROBLEMS WITH THE ADAPTIVE BEHAVIOR CRITERION

Given that a court is unlikely to even take on an *Atkins* case unless the defendant's IQ scores are at least fluctuating around the 70–75 ceiling, the crux of most *Atkins* decisions will often hinge on the individual's adaptive behavior. This is not to deny that considerable disputation often occurs over whether a defendant meets the IQ criterion. But in our experience, there is usually less ambiguity over the IQ criterion (and an admirable reluctance, typically, to base an execution decision on one or two IQ points) than whether the individual meets the requirement of significant deficits in adaptive behavior. Thus, ironically, the *Atkins* decision has solved two major problems for the MR field.

The first problem solved is that the 2002 manual is now actually being followed, as the 1992 manual was not, which had as much to do with the problems inherent in the 1992 manual as with the fact that the Atkins ruling had not yet occurred. The second is that the adaptive behavior criterion is now, finally, being taken seriously by users of the AAMR manual. We both have had many experiences, in the very recent past, where adult service or educational agencies gave or withheld the MR label without even looking at an individual's adaptive behavior. The negative side of the courts' taking the adaptive behavior criterion seriously is that the inadequacies of the definition and measurement of adaptive behavior are now being brought into much greater relief. Hopefully, the lessons to be learned from *Atkins* cases about adaptive behavior will enable the next T&C Committee to come up with an approach to adaptive behavior that makes more *sense,* not just in terms of formal theory but in terms of guiding courts or other agencies to make just decisions.

To make our points about problems in the conceptualization and assessment of adaptive behavior as concrete as possible, we shall be using examples from a specific adaptive behavior instrument: the "Adaptive Behavior Assessment System, Second Edition," known as the "ABAS-II" (Harrison & Oakland, 2003), not because it is better or worse than other adaptive behavior instruments but because we have had the most experience with it. The problems we identify in the ABAS-II are likely found in all other existing instruments.

Inappropriateness of Relying on Self-Ratings

Some adaptive behavior instruments (e.g., the ABAS-II) have self-report forms. Sometimes an expert will ask the defendant to rate himself on such a form. In one such case, "John Doe's" adaptive behavior self-rating placed him in the "below-average" (but not MR) range, while another informant rated the individual as having adaptive behavior in the MR range. The expert chose to reject the third-party informant (for reasons addressed in the next section) and chose to give great weight (in deciding he did not have MR) to Mr. Doe's own self-rating.

There are two reasons why we believe it is inappropriate to use an individual's self-rating as a basis for deciding whether or not he has MR: (a) the near-universality of the tendency of people with mild MR to deny the extent of their limitations, and (b) the fact that MR is a status attributed by others, and that being viewed by others as "retarded" or "not retarded" is, thus, far more relevant for diagnostic purposes than how a subject views himself.

Typically, when a forensic psychologist evaluates a person's claim for criminal mitigation or civil monetary award, concern is expressed over possible "malingering." This term refers to a conscious effort on the part of the subject to make himself look crazy, incompetent, or disabled. Given that many defendants in Atkins cases have not previously been diagnosed as having MR, it is understandable that lawyers and experts would be on the lookout for possible malingering, when a defendant produces low IQ or adaptive behavior scores. When the person receives a high score, particularly when it falls squarely in the normal range, the tendency on the other hand is to assume, often wrongly, that there was no conscious effort at fakery, especially given the likely negative consequences for the defendant's claim. In fact, it is our contention that defendants with mild MR are much more likely to fake higher rather than lower competence when given an opportunity to rate or describe their adaptive behaviors.

"Reverse malingering" (for lack of a better word) is not really a problem when a subject obtains a high IQ score, given that one wants the subject to make his best effort anyway, and it is not really possible to make oneself brighter on such a test than one actually is. In the field of adaptive behavior measurement, in which rating instruments are used, reverse malingering is a real problem, in that what is required of the subject is not to make his best effort but to honestly admit whether or not he can perform certain tasks. In our experience, people with mild MR, whether or not they have adopted a criminal lifestyle, typically will go to great lengths to look more competent and "normal" than they actually are.

This problem was first written about by anthropologist Robert Edgerton (1993/1971) in his classic book *The Cloak of Competence.* In that book, and in later longitudinal follow-ups, Edgerton and his colleagues studied a number of people with mild MR as they went about their lives in community settings. A striking feature of all of these people was the great lengths to which they went to hide from others the extent of their limitations. A key strategy

in "passing" (Edgerton's term) as normal was the use of nondisabled benefactors to help them do things (such as filling out forms) that they were unable to do on their own.

An example of how this strong need to look normal can contribute to reverse malingering can be found in the poignant documentary *The Collector of Bedford Street*, by the film maker Alice Elliot (2001). The film depicts the efforts on the part of residents in New York's Greenwich Village to set up a trust fund to provide case management, home visiting, and supplemental cash for a neighbor, 59-year-old Larry Selman, a man who has mild MR .The film gets its title from the fact that the impoverished Mr. Selman donates over $10,000 per year to charities from money he collects in the neighborhood on behalf of various causes. Before this fund can be set up, Larry (whose closest living relative, an elderly uncle, is no longer able to come around) is required to take an IQ test, in order that the agency that will be administering the fund is satisfied that Larry actually qualifies as having MR. Even though it is clearly in his interest to receive the diagnosis (and, therefore, to do poorly on the test), Larry agonizes that he will not do well and that his neighbors will no longer have a good opinion of him as a result. (Interestingly, from our standpoint, adaptive behavior does not seem to have been a focus of the evaluation process, and no mention was made of the main reason, aside from his extreme goodness, why the community banded together to help Larry: which was his extreme gullibility in the face of a repeated pattern of exploitation by street people.)

When Mr. Selman in fact received the needed diagnosis of MR, his first reaction was embarrassment, even though it was clearly in his interest to receive that label. This story, and the research of Edgerton and colleagues, illustrates that people with mild MR have a strong motivation to appear more competent than they are, and that this motivation can persist even in the face of very strong incentives to look incompetent. In fact, one can argue that the tendency to exaggerate one's competence, even in a situation as an *Atkins* evaluation where it is clearly in one's interest to be seen as incompetent, is itself a pretty good indication that an individual probably does have MR.

The other reason why it is inappropriate to give significant weight to self-ratings of adaptive behavior in diagnosing MR is that MR is a social status that is intricately tied in with how a person is perceived by peers, family members, and others in his community and social ecology. In a very real sense, the best definition of MR is "a label given to someone who behaves in his everyday life in a manner which causes others to refer to him as having MR." An individual's self-perception may be worth knowing for therapeutic purposes but has no relevance to diagnosing him as having or not having MR, except to the extent that an unrealistically positive self-image may support, rather than detract from, a diagnosis of MR. Experts in *Atkins* cases should always keep in mind that individuals with mild MR rarely are willing to see themselves as having MR, and many of the things they claim to be able to do are conscious or unconscious fictions of competent behavior. In that regard, we are reminded of one defendant who would fake reading the newspaper when in fact he was only looking at the pictures, another defendant who claimed to be making large sums per day for odd jobs when in fact he was paid a small fraction of that amount, and another defendant who claimed an ability to cook when in fact nothing he concocted was edible and letting him near a stove was considered a serious fire hazard.

Need to Use Multiple Raters

It is an interesting and little-known fact that publishers of clinical rating instruments often do not publish any data on inter-rater reliability. This is the case with two of the most widely used clinical rating instruments: the Child Behavior Checklist (Achenbach & Edelbrock, 1983) and the Conners Rating Scales (Conners, 1997). The closest authors of those two scales come to present data comparing different categories of raters (e.g., parents vs. teachers), and they justify the extremely low correlations (around .4) between raters by attributing the differences to situational factors (e.g., children behaving differently at home versus in school) rather than to inherent problems in the rating process.

To their credit, the authors of the ABAS-II do present data on inter-rater reliability—for example, by having a sample of individuals rated by two raters on the same rating form, and then looking at correlations across these rater pairs. The inter-rater reliability coefficients reported for the ABAS-II are, in fact, quite high: around .9 on the composite standard score, around .8 on individual scale scores. The authors of the ABAS-II (or any other rating instrument) do not address one important issue, however, which is that no matter how reliable an instrument may be, there is always the possibility that any particular use of the scale may result in invalid scores.

As indicated by Suen and Ary (1989), the purpose of establishing an instrument's reliability (usually under relatively optimal conditions) is to be able to assure a user that any test error from a future application of the instrument is within acceptable limits. Thus, we talk about the reliability of the instrument and do not apply that term to any particular administration of it. For an instrument such as an IQ test, this is a safe thing to do, as we can be relatively assured that any two qualified testers will attain fairly similar results. For a rating instrument, however, the fact that the instrument has been found to have good inter-rater reliability does not enable one to say with assurance that any two raters will provide congruent scores, as there is always the possibility that one set of ratings will be "off the wall," for any number of reasons ranging from ignorance or dislike of the ratee, to having very deviant perceptions in general about the ratee.

There are two solutions to this problem (Driscoll & Greenspan,1994), although neither has been discussed in manuals for adaptive behavior or other rating instruments. The first solution is to calculate the standard error of the difference between pairs of raters (which could be done easily from existing inter-rater reliability data) and then publish a table giving confidence intervals for difference scores between raters. The other solution, flowing from the existence of such a table, would be always to have an individual rated by at least two raters. Then if the scores fell within the confidence interval, one would be justified in averaging across the raters. If, on the other hand, the score differences between a pair of raters exceeded the confidence interval, one would know to seek one or more other raters, and then one would be in a position to know which rater's scores could be discarded as invalid. Thus, in the example given earlier, where John Doe's self-rating scores differed significantly from those of a third-party rater, the decision to disregard the self-rating (made for other stated reasons discussed in the previous section) could have been further justified had the two third-party ratings been found to agree within the confidence interval. Even in the present absence of such an inter-rater confidence-interval table, it seems much more

desirable to obtain multiple adaptive behavior ratings, in order to attain some degree of "consensual validation" support for the adaptive behavior picture that emerges.

PROBLEMS WITH ADAPTIVE BEHAVIOR NORMS AND METRICS

In the evaluation of John Doe discussed earlier, the main reason the expert gave for rejecting the third party's scores (on the ABAS-II) was that her resulting scale scores were so uniformly low as to suggest that she was biased. An examination of her ratings showed considerable variation, however, as seen in the fact that on some of the ten subscales, she gave a fair number of "3"s (the highest score), a great many "2"s, and only a few "1"s and "0"s. The problem appeared to stem less from any (automatic "0" or "1") negative response bias on the part of the rater than from the likely skewed nature of the ABAS norms. The ABAS-II (adult version) has items such as "dresses himself/ herself" (from the "Self-Care" domain), "listens to music for fun or relaxation" (from the "Leisure" domain), "finds and uses a pay phone" (from the "Community Use" domain), and "goes out alone in daytime" (from the "Self-Direction" domain). For the vast majority of (nondisabled) adults, the score received on the above items will be a "2" ("sometimes when needed") or, more likely, a "3" ("always when needed"). All it takes is a few "1"s or "0"s on any of the ABAS-II subscales to produce a scale score well below the first percentile.

Contributing to this problem on the ABAS-II is the confusing nature of the rating metric. For each of the rating items (an example from "Functional Academics" would be "writes own name, including zip code"), a rater is asked to circle one of the following numbers: a "3" indicating the subject can "always when needed" perform the activity, a "2 indicating the subject can "sometimes when needed" perform the activity, a "1" indicating the subject can "never when needed" perform the activity, and a "0" indicating the subject "is not able" to perform the activity. For the life of us, we cannot figure out the difference between a "1" and a "0" and we imagine that lay raters have a similar problem. In the case of John Doe mentioned in the previous section, the third-party rater gave the defendant adaptive behavior scores which placed him at the bottom end of moderate MR. Because the defendant was relatively high functioning, the expert who administered this assessment concluded that the rater was biased and that her scores should be thrown out. We determined that part of the problem may have been that she may have been confused about when to give a "1" versus a "0", as she gave quite a few of the latter scores. Just to test this hypothesis, we decided to rescore her protocol, changing all of her "0"s to "1"s. When we did this, the defendant now received a composite adaptive behavior standard score in the mild MR range, which is much closer to how he actually functions. Thus it may be that the third-party rater's very low (below .1 percentile) ratings reflected problems with the ABAS-II (the skewed nature of the norms and confusion over the rating metric) rather than response bias. As mentioned in the preceding section, the best basis for concluding whether or not the rater was off in her perceptions of Mr. Doe would have been to use one or more other third-party raters.

PROBLEMS WITH ADAPTIVE BEHAVIOR CONTENT

The biggest problem with measures of adaptive behavior is that they don't measure all of the things which, in our opinion, they should be measuring (e.g., construct validity; see Switzky & Heal, 1990). This is a reflection of both of the following:

1   Confusion over the constitutive definition of adaptive behavior.
2. Problems in the way in which adaptive behavior instruments have been constructed.

Problems in the content of adaptive behavior instruments are particularly evident in the domain of Social Skill, which numerous clinicians and theorists (Doll, 1941; Ireland, 1877; Greenspan & Love, 1997; Schalock, 1999; Tredgold, 1908) have indicated are universally problematic for people with MR.

Given that adaptive behavior is often the most critical criterion for diagnosing MR in Atkins hearings, it is vital that measures of adaptive behavior tap behavioral domains that are closely indicative of what might be termed the MR taxon , e.g., a true scientific taxonomy (See Switzky, Greenspan, & Granfield, 1996). After all, what good is the use of adaptive behavior standard scores in diagnosing MR, if the scores don't measure competencies that are central to the construct of MR? With the first (2000) edition of the ABAS, constructed in line with the 1992 AAMR operational definition of adaptive behavior (as comprising ten skills), there were ten subscales, but only one was described as measuring "social" functioning. When the 2002 AAMR manual shifted to a model of adaptive behavior comprised of the tripartite model of conceptual, practical, and social adaptive skills, the authors of the ABAS-II (Harrison & Oakland, 2003) were able to quickly respond to this change. They did this not by devising new subscales and items, but merely by combining the ten subscales of the earlier measure into the three major domains of the new AAMR manual. Thus, the "social" domain in the ABAS-II was constituted by combining two subscales—"Leisure" and "Social"—from the original ABAS instrument.

The Leisure subscale contains items such as "has a hobby or creative activity," "listens to music for fun or recreation," "looks at pictures or reads books," "plays alone with toys, games, or other fun activities," "selects television programs or videotapes," "tries a new activity to learn something new," "participates in an organized program for a sport or hobby." Our question is: What is there about these items that are particularly "social"? It is true that some of the other items on the Leisure subscale (for example, "organizes a game or other fun activity for a group of friends" or ""follows the rules in games and other fun activities") have an interpersonal component, but no more so than items in other subscales, such as "Helps other workers with their work" (from the "Work" subscale, which is part of the "Practical" adaptive skills domain).

On the one other subscale, termed "social" from the old ABAS, that is now folded into the new "social" adaptive-skills domain, all the items, obviously, have something to do with functioning in a social context. The problem is that they have more to do with the absence of maladaptive behavior than with the presence of what we (Switzky, Greenspan, & Granfield, 1996) and others have termed "social intelligence." This subscale is a mix of the following:

1. Conventional politeness behaviors (e.g., "says 'thank you' when given a gift;" "offers guests food or beverages," and "laughs in response to funny comments or jokes").
2. Niceness versus nastiness behaviors (e.g., "offers assistance to others," "tries to please others," "apologizes if he/she hurts the feelings of others," and "offers to lend belongings to others").

3. Emotional intelligence items (e.g., "listens to friends or family members who need to talk about problems," "says when he/ she feels happy, sad, scared or angry," and "places reasonable demands on friends, for example, does not become upset when a friend goes out with another friend").

4. What might be termed social-outcome indices (e.g., "keeps a stable group of friends," "has good relationships with family members," and "has one or more friends").

There are no items having to do with gullibility or its opposite (ability to see through and resist deceit or coercion), or other behaviors that speak to the social essence of the MR taxon, which is found more in things such as naãvetÇ, innocence, and falling for practical jokes than in how nice or polite one is.

Another problem with the content of most adaptive behavior instruments is that they are a mix of items reflecting ability/competence with items reflecting motivational or personality dimensions. For example, under the subscale of "self-direction" are items such as "puts work or school over leisure activities," "controls temper when disagreeing with friends," "works on one home activity for at least 15 minutes," and "cancels fun activity when something important comes up." Similar examples of temperament (emotional and attentional self-regulation) and character (conformity to social norms) can be found in items scattered throughout the ABAS-II. Some examples are "puts things in their proper place" (from the Home Living subscale), "bathes daily" (from the "Self-Care" subscale), and "takes out trash when can is full" (from the "Home Living" subscale). Competence is confounded with motivation throughout the ABAS scales, as in items such as "keeps hair neat" or "gets hair cut" (both from "Self-Care").

The problem is that many of these items have nothing to do with MR. It may be desirable if a person "has pleasant breath" (an item in "Self-Care"), but can anyone inform us how having pleasant or unpleasant breath is related to the MR taxon? The same is true of all behaviors that reflect temperament or character. If social intelligence is, as we believe, the aspect of social competence that is most relevant to a diagnosis of MR, then the ABAS-II, as well as the Vineland-II and all other existing adaptive behavior instruments, has very little construct validity in the critical area of Social Skill.

Fortunately, we understand that the AAMR is devising its own adaptive behavior instrument that will have much more in the way of gullibility and related social intelligence items in the Social Skill area. That is certainly a welcome trend in the direction of bringing adaptive behavior assessment more in line with current thinking about the nature of MR and adaptive behavior. In particular, it is vital that adaptive behavior instruments maintain a clear focus on ability/competence as opposed to style/ personality, and that the abilities tapped are those, such as vulnerability to exploitation, that are particularly central to the MR taxon.

Can One Infer Adaptive behavior Level From the Crime?

In an *Atkins* hearing, the two sides present their experts and supporting evidence for or against a diagnosis of MR, and the court then decides which side is right. Typically, these cases are decided solely by a judge, but we know of at least one state, and there likely are others, where the *Atkins* hearing is decided by the vote of a jury, even when the hearing

takes place years after the original guilt trial and sentencing. In a sense, when the judge or jury decides the outcome of an *Atkins* hearing, he/ she/they are functioning as their own expert, in that they are deciding whether to assign the defendant the diagnosis of "MR" or "Not-MR." To us, this is inherently problematic, in that judges, and even more so juries, are much more likely than a qualified expert to base their diagnostic judgment mainly on their own intuitive notions, and prejudices, concerning how people with MR are supposed to behave in the world.

If it were merely a matter of a judge or jury deciding which set of experts to believe, that would be bad enough. However, what typically happens is that the judge allows the presentation of evidence, for example, about the crime or crimes allegedly committed by the defendant, about which an expert is typically not allowed to comment. The reason is that judges believe such information can shed light on the defendant's level of adaptive functioning. This is problematic, not only because such information (e.g., about the heinousness of the crime) can be very prejudicial, but also because, even more than when choosing among experts, it is asking the judge or jury to make a diagnostic judgment based on whether they believe a person with MR is capable of carrying out certain behaviors.

Any type of defendant behavior could be subject to such a "hearing within a hearing." An example involved a defendant who allegedly carried out a string of armed robberies, one of which resulted in a death. In this case (which never came to trial, as the defendant died in jail just before the hearing was to start), the judge would have been asked by the prosecutor whether someone who could drive himself to and from the site, show some degree of planning (i.e., by doing some prior casing), and show some practical competence (i.e., operating a gun) and social competence (i.e., locking up witnesses) could be eligible for a diagnosis of MR. The correct answer to this should be "Who knows?" Unfortunately, some experts and judges/juries often act as if they do know, as they make inferences about whether the defendant could or could not have MR based on the criminal conduct that is depicted.

There are two reasons why one 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. The first reason has to do with the fact 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. Among the situational factors we do not typically know about is the extent to which the defendant may have been coached and trained by a less impaired "robbery coach," as opposed to figuring out these things for himself. The second reason is that we simply do not possess normative information, adaptive behavior scales notwithstanding, about whether someone with MR can fire a gun, drive a car, case out a crime scene, or assert his will on victims. One of the lessons of the "support revolution" is that people with MR can do many things, including aspects of work and independent living, that previously one would not have thought they could do. Without meaning to be flip, one can think of a crime as a form of work. Just as people with mild MR have been found able to do jobs that previously might have been viewed as beyond their capabilities, it is possible that people with mild MR have a greater potential for a successful criminal career than might previously have been believed possible.

Herman Spitz (1988) has argued that MR is a "thinking disorder" and not a "learning disorder." By this, he meant that a person with MR can, through skillful instruction, be helped to learn many routine work and other schemas. But a person with MR has great difficulty when these learned schemas run up against novel challenges. In fact, that is precisely what seems to have happened with the defendant under discussion, as it is reported that on the two occasions when he fired his weapon (once with tragic consequences), something happened in the situation (e.g., a victim saying or doing something unexpected) that departed from his routine script. One lesson from our experience with Atkins cases is that there should perhaps be an attempt by the next T&C Committee to more fully delineate, based on research done or needing to be done, the kinds of behaviors that people with MR can and cannot perform. Such a delineation would, hopefully, limit the ability of experts in *Atkins* cases to make overgeneralizations about the meaning of isolated criminal or other behaviors for a diagnosis of MR.

Can One Infer Adaptive Behavior From Verbal Behavior?

The forensic evaluation process typically involves a clinical interview, in which the subject is asked to talk about himself, his history, ailments, interests, the circumstances of his current existence, and other matters that might shed light on his affective and mental state. Typically, experts are told not to delve into aspects of the current case, although information about other past criminal acts committed by the defendant will sometimes be discussed. Although not intended to be a primary basis for diagnosing MR, information from clinical interviews is often used to argue for, or more commonly against, a diagnosis of MR.

Most typically, the reason given for basing a "non-MR" diagnosis on clinical interview transcripts is that the defendant demonstrates average or above-average oral language, including occasional use of big words, along with a fair degree of insight into his past conduct and the dire situation in which he finds himself. As part of the insight into his current situation, a defendant may show a fair amount of understanding regarding which side the expert is working for, and may even show some degree of wariness and resistance to the interview that may be more in line with the suspicious style one associates more with hardened criminals than with the guileless/innocent stereotype that one often associates with the MR taxon. A problem with inferring non-MR status from normal language is that it is contradicted by research showing that adults with mild MR have relatively normal syntax, grammar and vocabulary (Kernan & Sabsay, 1988, 1992).Their deficits are more in the area of socio-linguistics (adjusting communication to take into account informational needs of others) rather than psycho-linguistics.

The same argument that we made in the previous section, involving problems in inferring MR status from someone's criminal history, can be made with respect to using material (e.g., vocabulary, verbal fluency, or seeming degree of verbal insight) from a clinical interview. This is nonstandardized data which is purely qualitative in nature and does not really provide a basis for making a diagnostic judgment. People with MR typically have normal language syntax and can be very facile verbally. In fact, some syndromes associated with MR, such as Williams syndrome, are associated with above-average verbal fluency that does not prevent the majority of individuals with these syndromes from being given a diagnosis of MR (Bellugi, Mills, & Jernigan, 1999). Forensic experts who do not have

a great deal of experience with persons who have MR may apply their own stereotypic notions, applicable perhaps more to people with moderate or severe MR, about the limited verbal abilities of people with MR, and these stereotypes may be quite misleading when applied to people with mild MR.

One interesting fact that we have learned about life on death row is that condemned prisoners often spend a great deal of time watching "The History Channel," "The Discovery Channel," and other TV shows which contain relatively sophisticated information about the world. As a result, Atkins defendants may occasionally use words or make comments which one might assume are beyond the repertoire of people with MR. Such exposure might also be expected to elevate an individual's "General Information" and other "crystallized" subscale scores on IQ tests, although it would likely not affect the quality of one's "fluid" problem-solving or information-processing based scores. Because isolated bits of data taken from conversations or interviews can be misleading, the standard practice is to use formal IQ assessment, rather than clinical description, in determining the precise level of an individual's cognitive deficits.

With respect to the great deal of verbal insight that a defendant sometimes shows about the lessons to be learned from his criminal past, one can assume that some of that is a result of the group sessions used in the rehabilitation process in prison settings. Given the amount of time that a condemned prisoner has to think about his life, and to discuss his case with attorneys and others, it is not surprising that an *Atkins* applicant, even one who clearly has MR, might be able to show some surface sophistication in discussing what he would and should have done differently to have avoided his current predicament. People with MR often can be quite eloquent in talking about their lives, as can be seen in the stories told by "self-advocates" (Williams, Bratt, & Shoultz, 1995) and in the use by agencies of client spokespeople in fund-raising or public awareness campaigns. Such behavior may shed light on the need to revise stereotyped beliefs about the limitations of people with MR but provides a shaky basis for making diagnostic judgments.

The misuse of clinically obtained verbal and other kinds of information from forensic interviews has caused us to rethink our earlier call for an increased use of clinical judgment in the process used to diagnose MR. To be sardonic, our revised position is that "clinical judgment is all right when it is used correctly, by us, but is not all right when it is used incorrectly, by experts other than us." As we are not able to participate in every *Atkins* case in America, it would probably be better if constraints were placed on the use of clinical judgment. In particular, we feel that it is important to use clinical judgment to interpret test scores and be aware of the limitations of particular measures, but that it is not appropriate—given the tremendous variability in the qualifications of evaluators and the extent to which qualitative information can be misused—to base a diagnosis of "MR" or "Not-MR" solely or even largely on a clinician's judgment. To the extent that global perceptions are relevant in establishing a diagnosis of MR, they should be the perceptions of people who have known the individual well over a period of months or years and not those of a clinician who knows the individual superficially from one or two meetings, especially when that clinician has limited experience and training in the MR field.

Can One Assess Adaptive Behavior (and Diagnose MR) Retroactively?

One issue that has not been fully resolved in *Atkins* case law has to do with the time frame during which MR has to have been manifest. Is it all right, from a legal standpoint, to establish that a defendant is eligible for a diagnosis of MR today (when he may have already been on death row for a dozen or more years), even if one cannot establish that he would have been eligible during the period when the alleged crime was committed? The opposite case may be even more common—namely there might be evidence that the person had MR during his childhood years, or in the period, typically in his late teens or early 20s, when the crime was allegedly committed, but based on his current functioning he might no longer be eligible for the diagnosis. We are not qualified to comment on the legal questions (although we are told that competence at the time of the crime is probably the most relevant), but we can comment on how one might go about addressing this matter clinically.

The 1992 AAMR manual emphasized repeatedly, starting on the first page, that MR is a dynamic status that one can grow into, out of, and back into across the lifespan, depending on a number of factors, including developmental processes, situational challenges, and personal choice. The 2002 manual did not state this point as clearly, although we have been informed by David Coulter, President of AAMR (2004), a member of both the 1992 and 2002 committees, that no change in this emphasis was intended. The possibility that one can have MR at time one but not at time two might seem puzzling to those who think of it as an intrinsic aspect of a person. The 1992 manual (Luckasson et al., 1992) attempted to clarify this point, as follows: "Mental 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 . . . Nor is it a mental disorder. Mental retardation refers to a particular state of functioning" (p. 9). This statement indicates that MR is a current social status which inheres not in the person but in how the person deals with the world and is perceived by others in that world at a particular point in time. It implies that one's status as a person with MR can change over time.

Certainly, for persons with moderate or severe MR, it is likely that one's status as having MR is permanent, but for persons with mild MR, it is possible that one could fluctuate above and below the boundary between the state of mental retardation and "normality." Furthermore, for many Atkins applicants it is possible, indeed likely, that a diagnosis of MR was never made at an earlier time, even though evidence such as IQ test scores below 70 might have justified such a diagnosis. The fact that someone was not diagnosed as having MR at an earlier time does not mean that such a diagnosis could not have been made; nor does it rule out the possibility that a diagnosis of MR could legitimately be made today.

Just as mental health professionals are often asked in murder cases, when the "insanity" defense is raised, to make a retroactive judgment as to whether a defendant could distinguish right from wrong at the time he committed a crime, it is also possible, and sometimes necessary, to make retroactive judgments regarding whether a defendant had MR at some point in the past. In terms of the intelligence and developmental criteria, it is typically the case with *Atkins* applicants that they came to the attention of school and mental health authorities early on, and a voluminous amount of testing and other data is available, Assuming it was not thrown out, such information could establish that during the developmental period an individual had significant cognitive problems, including, often,

IQ scores below or around the ceiling for a diagnosis of mild MR. Intellectual assessment is also typically available for the period before or after the trial, even if the defendant has been in prison for a decade or more.

The challenge for establishing the diagnosis retroactively is, thus, to identify two or more adaptive behavior informants who knew the individual well during various time frames (e.g., high school years, at the time of time of the crime, currently) and ask them to fill out a rating instrument such as the ABAS-II, and to be interviewed by the evaluator. In filling out the adaptive behavior instrument, the informant is asked to keep in mind a certain time frame and rate the defendant as he is remembered during that time period. Rating a condemned defendant on his current adaptive functioning can be a more difficult challenge, however, both in terms of locating appropriate raters and also because death row is a restricted environment in which there few if any opportunities to do most of the activities—cooking, working, or using public transportation—that are covered by the items. However, with some ingenuity, it is typically possible to find informants, such as inmates in neighboring cells, prison counselors or guards, or outside psychiatrists, who could fill out a rating instrument knowledgeably and with some guesswork and extrapolation on some items, assuming that they are willing and able to cooperate in such an endeavor. It should be noted that the use of retroactive assessment in Atkins cases has been endorsed as a legitimate practice in the recently-published "A User's Guide for AAMR's 2002 Definition, Classification and Systems of Supports" (Schalock et al, 2006).

Other Lessons Learned from *Atkins* Cases

In the preceding pages, we have focused mainly on practical issues in establishing the presence or absence of adaptive deficits in defendants subject to *Atkins* hearings. In the remainder of this paper, we shall address a range of other issues, including ones that speak more to the overriding conceptual question: "How can we be certain that an adult truly has mental retardation?"

Clarifying the Developmental Criterion

There is some confusion in the legal community about the meaning of the "developmental criterion," regarding the need to be able to trace the onset of one's MR to the period before the age of 18. Courts, in *Atkins* hearings, have increasingly interpreted this requirement to mean that one must demonstrate that one actually had MR before the age of 18. A more reasonable interpretation is that one must demonstrate that problems in development were apparent during the childhood or adolescent period, and that a diagnosis of MR made during the adult period should not be attributable solely to causes such as a car accident that occurred after the age of 18. Even if, as is usually the case with mild MR, one cannot identify a specific cause, it is essential that an individual have manifested problems in academic and other areas of functioning during the developmental period, and that, whether or not a formal diagnosis of MR was ever made, serious concerns about the individual were expressed by family members, educators, or medical professionals at a relatively early age.

Ironically, the success of the various AAMR manuals in reducing unfair application of the MR label to minority individuals has contributed to a situation in which deserving minority individuals have sometimes been unfairly denied the protections of the MR

label. For example, we know of one Atkins case involving an African-American male, "James Smith," who was born over three months premature, had very low birth weight, and had other neurological insults, including severe head injuries, and symptoms in childhood. James was one of eight children in a profoundly disadvantaged family living in an impoverished rural area. In school, he was not given special education services until high school, and even then he was labeled as "Learning Disabled" rather than "Educable Mentally Retarded," in spite of the absence of the required (for LD) discrepancy between his below-70 IQ and his low educational achievement.

From indications in the school reports, it seems to have been assumed that Mr. Smith's intellectual deficits reflected his family's impoverished circumstances, and that it would be unfair, therefore, to give him a label of MR. In fact, except for a severely mentally retarded sister, Mr. Smith's other six siblings functioned in a normal manner, and he was seen by his adult relatives and by his brothers and sisters as very impaired and in need of special protections—for example, from exploitation by pranksters and con artists—from an early age. In line with the continuing emphasis in the AAMR manuals on the importance of sensitivity to cultural factors, the severity of Mr. Smith's cognitive limitations has been consistently discounted as due solely to growing up "Black and Poor."

This tendency to overlook the possibility that one can be a member of a minority group and also have biologically based problems might be termed "racial overshadowing." We have seen it reflected in other *Atkins* cases in which the most serious of organically caused developmental histories, even involving diagnosed genetic syndromes, is given little or no mention in the face of cultural and racial explanations. It seems important for the next AAMR manual to emphasize that culture and organicity are not mutually exclusive and that poor people have as much right as do middle class people to have the extent of their biologically based disabilities acknowledged and dealt with.

Need to Reverse the Weight Given to IQ and Adaptive Behavior

A special issue on the *Atkins* decision in the psychology journal *Ethics and Behavior*, edited by Gerald P. Koocher (2003), included six papers by various psychologists addressing a range of matters. In only one of these, the paper by the two of us (Greenspan & Switzky, 2003), was the term "adaptive behavior" even uttered. This demonstrates dramatically that for most psychologists, MR continues to equal "low IQ," in spite of the fact that the dual-criteria formula of low IQ plus significant deficits in adaptive behavior has been in existence for the past 44 years.

In a case discussed earlier, involving "John Smith," a referral to a developmental disabilities diagnostic center was made after his conviction and a decade or more before his Atkins petition was filed. As part of a sentencing mitigation effort, his appellate attorneys wanted to know if he qualified for a diagnosis of MR. The report that was submitted—this was before the recent AAMR effort to emphasize more strongly the need to take into account the standard error of IQ tests—concluded that James did not have MR because his most recent full-scale IQ score was a couple of points above 70. Interestingly, no effort whatsoever was made at that time to assess Mr. Smith's adaptive behavior. The reason, most likely, was that adaptive behavior has been viewed mainly as something that can rule a diagnosis of MR out if IQ is below 70, but not as something that can rule MR in if IQ is above

70. This tendency to view the IQ criterion as the "necessary but not sufficient" condition for diagnosing MR can be seen also in the declaration filed by a prosecution expert in preparation for Mr. Smith's Atkins hearing. Although one of us had interviewed and obtained ABAS-II data from a large number of informants indicating very significant adaptive behavior deficits at various stages in Mr. Smith's life, the prosecution psychologist's declaration focused entirely on raising questions about whether the IQ criterion for diagnosing MR had been met. In other words, he assumed that if he could raise sufficient doubts about the IQ test results, his diagnosis of "Not-MR" would clearly be justified without even needing to comment on the substantial adaptive behavior piece of the defendant's claim.

This tendency to see adaptive behavior as running a distant second in importance to intelligence, if it is even acknowledged at all, is at the heart of what is wrong with the current approach to diagnosing MR. Much as we commend the efforts of the last two T&C Committees to focus more attention on the importance of adaptive behavior, we feel that there continues to be a fundamental flaw in the basic definition of MR which, unless corrected, will likely contribute to a continued slighting of adaptive behavior, if it is even assessed at all. This flaw is that adaptive behavior is always the second part of the definition, as in the 2002 statement that MR "is a disability characterized by significant limitations both in intellectual functioning and . . ." (p. 1). This, in addition to the fact that adaptive behavior is described as something separate from intelligence, contributes in our opinion to the notion that intellectual deficit must first be established before adaptive behavior even comes into play.

The solution seems fairly simple, and that is to reverse the order of the wording. Doing so, the definition might read as follows: "MR is a form of disability, first suspected in childhood or adolescence, that is characterized by significant deficits in adaptive social, academic, and practical functioning that are attributable to significant limitations in the ability to think and process information adequately." This proposed definition does several things that could, if taken seriously, serve to finally put "King IQ" in its place and raise adaptive behavior to an equal if not greater level of importance. The first is that adaptive behavior—termed "adaptive functioning" to free ourselves from all of the baggage associated with that poorly defined term—is now put toward the beginning of the definition, such that the starting point for the diagnosis is now establishing limitations in adaptive functioning rather than first establishing limitations in intelligence. By describing the intellectual criterion with the nonjargon words "ability to think and process information," we are indicating that what is important is not a score on an IQ test but an exploration of an individual's intellectual processes. However, by inserting the words "that are attributable," we hope to indicate that adaptive behavior deficit is not separable from intellectual deficit, but rather flows from it. This would, hopefully, cause a refocusing of adaptive behavior measures away from personality or stylistic aspects of incompetence, such as not having pleasant breath, and toward aspects of incompetence, such as vulnerability to exploitation, that are more clearly an outgrowth of difficulty in cognitively processing social or other challenges.

Need to Revisit the Borderline Category, but With a New Twist

There has been significant discussion that a concern underlying both the 1992 and 2002 AAMR manuals was to shift attention away from addressing the problem of "false positives,"

which was a major concern of the authors of the 1961 and 1973 manuals, and toward addressing the problem of "false negatives." In the next-to-last page of the 2002 manual, for example, mention is made of what Tymchuk, Lakin, and Luckasson (2001) termed "the lost generation"—a term which refers mainly to individuals who do not quite qualify for the MR label, in part because there no longer is a "Borderline" subcategory, but who still have significant needs for supports and protections. In raising the IQ ceiling to take into account standard error, and in adopting an easy-to-satisfy (e.g., deficits in only one out of three domains) adaptive behavior criterion, the 2002 T&C Committee obviously wished to swing the pendulum back in order that more of this disenfranchised population could be accommodated under the MR rubric.

In spite of the fairly overt desire on the part of the authors of the 2002 AAMR manual to accommodate a broader sample of the universe of cognitively impaired people, it seems unlikely the manual will have much success in attaining this objective, unless a more direct assault on the problem of false negatives is undertaken. A solution that has occurred to us, and to others such as MacMillan, Siperstein, and Gresham (1996), is to bring back something like the Borderline subcategory. It would have to be done in a very different way, however, in order to avoid the problems (i.e., gross overidentification of poor minority children), that caused the Borderline subcategory to be abandoned in 1973.

Two mistakes sank the Borderline subcategory in the first place. The first was that it was defined solely on where one fell in an IQ range, given that adaptive behavior was not really used or acknowledged in the 1960s or 1970s. The second was that it was identified as a new and separate subcategory, rather than being grounded in the broader pre-existing subcategory, unfortunately known as "moronity." While the previous subcategory had been believed to cover a fairly large chunk, at least up to 3%, of the general population, the new subcategory of mild MR defined on the basis of the minus-two-standard-deviations statistic reduced that population to a maximum of 2%, which arbitrarily threw out about one-third of the deserving population of people considered to have MR. The way to recapture the spirit of the Borderline subcategory (i.e., to allow deserving members of the "forgotten generation" to receive needed protections flowing from the diagnosis of MR) is to do three things:

1. Raise the IQ ceiling, if one has to have one at all, dramatically (say, to 80 or 85).
2. Base the diagnosis of MR, once one has gotten into that very broad IQ range, solely on adaptive deficits and, of course, the developmental criterion.
3. Place qualifying individuals not in a separate "Borderline" subcategory but rather in a somewhat expanded subcategory of "mild MR."

Thus, mild MR would now be a subcategory defined primarily by deficits in adaptive functioning attributable to problems in cognitive ability, but not necessary defined by an IQ level that fell below an arbitrarily, and statistically, defined score.

This proposed solution would go far toward addressing another problem that concerns lawyers and others who have written about the Atkins decision, and that is the need to expand that decision to cover other deserving individuals who do not quite qualify under the existing narrowly defined rubric of MR. The arbitrary diving line of IQ = 70 does not, unfortunately, correspond with the natural division between people who are vulnerable

and deserve protection and people who are not vulnerable and are not deserving of protection. Especially, as the mean IQ of people with various brain-based disorders (e.g., Prader-Willi syndrome) has risen, thanks to various medical and educational interventions, there are now many vulnerable people who at one time, even after the abolition of the Borderline category, would have qualified by use of an IQ score as having MR but no longer do. The proposed solution of bringing the Borderline subcategory back but in a different guise would solve this problem and would put attention where it belongs, namely on how an individual functions in the world rather than on whether his IQ score falls above or below some less-than-meaningful dividing line.

Conclusion: Need to Clarify the MR Taxon

A basic problem with the various AAMR definitions of MR is that they rely on artificial rather than natural criteria, and use jargon terms needing further definition rather than everyday words which need no further definition. In virtually every category in DSM-IV, the definition uses everyday words which describe behaviors that everyone can understand. Some examples would be pica ("the persistent eating of nonnutritive substances for a period of at least 1 month"); autism ("the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertory of activity and interests"); and separation anxiety ("excessive anxiety concerning separation from the home or from those to whom the person is attached"). Here is the 2002 definition of MR: "a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills" (p. 1). The meanings of "disability," "adaptive behavior," and "adaptive skills" are not evident and need further definition. "Intellectual functioning" is probably somewhat more of a natural/everyday term, but the way it is later operationally defined as minus two standard deviations below the population mean on a measure of IQ is nothing if not artificial. The application of the same statistical criterion to the assessment of adaptive behavior is also a step in the direction of greater artificiality, even if one assumes that measures of adaptive behavior tap into the natural taxon of MR, which we have argued that they do not do sufficiently.

The artificiality and arbitrariness of the 2002, and previous, AAMR definitions of MR contribute to the bickering and nit-picking over interpretation of IQ scores that can be found in the typical Akins hearings and shakes one's confidence that a just and correct decision will always be reached. It would be useful if the definition of the category of MR could be grounded in something more natural, such that the dividing line between "MR" and "Not-MR" would correspond to what Paul Meehl (1973), in describing medical categories such as TB, called "nature carved at the joints." Such a naturally based definition (taxon) hopefully would increase the likelihood that diagnostic decisions in *Atkins* cases were *true* in a real and not just a bureaucratic sense.

Given that MR is really a bureaucratic/disability category, rather than a medical one, although many medical conditions contribute to MR, it may be difficult to come up with a more natural, taxonically-based, definition. However, until a more natural definition is devised, there will always be problems in making the diagnosis, especially at the upper boundary where virtually all Atkins defendants can be found. We have discussed repeatedly in this paper the need to devise a definition of adaptive behavior and, by extension,

of MR, that taps into the "natural taxon " of MR. Because MR is a condition grounded in the perception of others, this natural taxon has to be based on the factors that other people use in deciding that someone has MR and needs the protections associated with that status. Greenspan (1997, 2003) has contended that the behavioral phenotype for MR is most likely to be found in the notion of social vulnerability in general, and gullibility in particular. This notion, explored more fully in another chapter by Greenspan in this book, might be expressed in an elaboration on the definition expressed earlier. To repeat, that definition went as follows: "MR is a form of disability, first suspected in childhood or adolescence, that is characterized by significant deficits in adaptive social, academic, and practical functioning that are attributable to significant limitations in the ability to think and process information adequately." The elaboration, bringing it closer to the pre-20th-century taxon, might add the following: "People with MR are seen by others as extremely naãve, trusting, and vulnerable in their dealings with others, and need protections against exploitation by others who would take advantage of their gullibility."

In every *Atkins* case where we feel that a legitimate claim for execution exemption can be made, we have found that the individual is described by everyone who has known him with words such as: "_____ is one of the most gullible people on the planet." Interestingly, although Justice John Paul Stephens, in his majority opinion in *Atkins v. Virginia*, justified the opinion on the basis of emerging national consensus about the inhumanity of executing people with MR, he did devote some attention to discussing adaptive deficits that justify such an exemption. His explanation focused on the inability of people with MR to see through manipulation by a less-disabled confederate, inability of people with MR to see through manipulation by police officers seeking a confession, inability of people with MR to understand how to cut a deal that might save their life, and inability of people with MR to understand the court proceedings well enough to be of assistance to their counsel. In other words, the taxon of MR, as expressed by a member of the U.S. Supreme Court, was grounded in social vulnerability in general, and gullibility in particular. Maybe the *Atkins* decision itself, and not just the experience of expert witnesses in *Atkins* proceedings, has something important to tell the authors of the next AAMR diagnostic manual about how to devise a definition of MR that will finally be found adequate.

REFERENCES

Achenbach, T. M., & Edelbrock, C. S. (1983). *Manual for the child behavior checklist and revised child behavior profile*. Burlington: University of Vermont.

Atkins v. Virginia. U. S. Case No. 8452. (2002).

Bellugi, U., Mills, D., & Jernigan, T. (1999). Linking cognition, brain structure, and brain function in Williams Syndrome. In H. Tager-Flusberg (Ed.), *Neurodevelopmental disorders* (pp. 111–136). Cambridge: Massachusetts Institute of Technology Press.

Conners, C. K. (1997). *Conners Rating Scales (Rev. ed.)*. Minneapolis: Pearson Assessments.

Doll, E. A. (1941). The essentials of an inclusive concept of mental deficiency. *American Journal of Mental Deficiency, 46*, 214–219.

Driscoll, J. H., & Greenspan, S. (1994, April). *How do we know when a rating of child behavior is off the wall?* Paper presented at the annual conference of the New England Educational Research Organization, Camden, ME.

Edgerton, R. B. (1993). *The cloak of competence*: *Revised and updated*. Berkeley: University of California Press.

Elliot, A. (Director). (2001). *The collector of Bedford street [Motion picture]*. (Available from Welcome Change Productions, 107 Bedford Street, Upper One, New York, NY 10014)

Greenspan, S. (1997). A contextualist perspective on adaptive behavior. In R. L. Schalock (Ed.), *Adaptive behavior and its measurement: Implications for the field of mental retardation* (pp. 61–80). Washington, DC: American Association on Mental Retardation.

Greenspan, S. (2004). Why Pinocchio was victimized: Factors contributing to social failure in people with mental retardation. In H. N. Switzky (Ed.), *International review of research in mental retardation (Vol. 28*, pp. 122–147). San Diego, CA: Elsevier/Academic Press.

Greenspan, S., & Love, P. F. (1997). Social intelligence and developmental disorder: Mental retardation, learning disabilities and autism. In W. E. MacLean, Jr. (Ed.), *Ellis' handbook of mental deficiency, psychological theory, and research* (3rd ed., pp. 311–342). Mahwah, NJ: Erlbaum.

Greenspan, S., & Switzky, H. N. (2003). Execution exemption should be based on actual vulnerability, not disability label. *Ethics & Behavior, 13*, 19–26.

Hagen, M. A. (1997). *Whores of the court: The fraud of psychiatric testimony and the rape of American justice*. New York: HarperCollins.

Harrison, P. L., & Oakland, T. (2003). *Adaptive behavior assessment system (ABAS-II)* (2nd ed.). San Antonio: PsychCorp/ Harcourt Assessment.

Ireland, W. W. (1877). *On idiocy and imbecility*. London: Churchill.

Kernan, K. T., & Sabsay, S. (1988). Communication in social interaction: Aspects of an ethnography of mildly mentally handicapped adults. In M. Beveridge, G. Conti-Ramsden, & I. Leudar (Eds.), *Language and communication in mentally handicapped people* (pp. 239–353). London: Chapman and Hall.

Kernan, K. T. & Sabsay, S. (1992). Discourse and conversational skills of mentally retarded adults. In A. M. Bauer (Ed.), *Students who challenge the system* (pp. 145–185). Norwood, NJ: Ablex.

Lewis, D. O., & Balla, D. A. (1976). *Delinquency and psychopathology*. Philadelphia: Saunders.

Luckasson, R., Borthwick-Duffy, S., Buntinx, W. H. E., Coulter, D. L., Craig, E. M., Reeve, A., et al. (2002). *Mental retardation: Definition, classification, and systems of supports* (10th ed.). Washington, DC: American Association on Mental Retardation.

Luckasson, R., Coulter, D. L., Polloway, E. A., Reiss, S., Schalock, R. L., Snell, M. E., et al. (1992). *Mental retardation: Definition, classification and systems of supports* (9th ed.). Washington, DC: American Association on Mental Retardation.

MacMillan, D. L., Siperstein, G. N., & Gresham, F. M. (1996). A challenge to the viability of mild mental retardation as a diagnostic category. *Exceptional Children, 62*, 356–371.

Meehl, P. (1973). *Psychodiagnosis: Selected papers*. Minneapolis: University of Minnesota Press.

Schalock, R. L. (1999). The merging of adaptive behavior and intelligence: Implications for the field of mental retardation. In R. L. Schalock (Ed.), *Adaptive behavior and its measurement: Implications for the field of mental retardation* (pp. 43–60). Washington, DC: American Association on Mental Retardation

Schalock, R. L., Buntinx, W., Borthwick-Duffy, S., Luckasson, R., Snell, M., Tasse, M., et al. (2006). *A user's guide for AAMR's 2002 definition, classification and systems of supports: Applications for clinicians, educators, disability program managers, and policy makers*. Washington, DC: American Association on Mental Retardation.

Spitz, H. H. (1988). Mental retardation as a thinking disorder: The rationalist alternative to empiricism. In N. Bray (Ed.), *International review of research in mental retardation* (Vol. 15, pp. 1–31). New York: Academic Press.

Suen, H. K., & Ary, D. (1989). *Analyzing quantitative behavioral observation data*. Hillsdale, NJ: Erlbaum.

Switzky, H. N., Greenspan, S., & Granfield, J. (1996). Adaptive behavior, everyday intelligence and the constitutive definition of mental retardation. In A. F. Rotatori, J. O. Schwenn, & S. Burkhardt (Eds.), *Advances in special education* (Vol. 10, pp.1–24). Greenwich, CT: JAI Press.

Switzky, H. N., & Heal, L. (1990). Research issues and methods in special education. In R. Gaylord-Ross (Ed.), *Issues and research in special education* (pp. 1–81). New York: Teachers College Press.

Tredgold, A. F. (1908). *Mental deficiency*. London: Baillere, Tindall, & Fox.

Tymchuk, A. J., Lakin, K. C., & Luckasson, R. (Eds.). (2001). *The forgotten generation: The status and challenges of adults with mild cognitive limitations*. Baltimore: Paul H. Brookes.

Williams, P., Bratt, B., & Shoultz, B. (1995). *We can speak for ourselves: Self-advocacy by mentally handicapped people* (Rev. ed.). Bloomington: University of Indiana Press.