

DECLARATION OF STEPHEN GREENSPAN, PhD

I, Stephen Greenspan, declare as follows:

BACKGROUND

1. I was asked by Attorneys Richard Burr and Naomi Terr, on behalf of their client Yokaman Hearn, to review various psychological and other records and render an opinion as to whether one could make a reasonable case for diagnosing him as having mental retardation (MR). Specifically, I was asked to consider the following question: “Can neuropsychological deficits such as those revealed by neuropsychological testing of Mr. Hearn satisfy the first criterion of the definition of mental retardation – significant limitations in intellectual functioning (AAIDD) or significantly sub-average general intellectual functioning (APA) – despite full-scale IQ scores ranging from 87-93?”

2. In preparing this declaration, I have examined the following documents:

- May 19, 2007 report by Dr. Dale G. Watson
- May 19, 2005 report by Dr. James R. Patton
- July 10, 2006 Supplemental report by Dr. James R. Patton
- May 10, 2005 Report by Dr. Mary Alice Conroy
- May 20, 2005 Report by Dr. Pablo Stewart
- July 26, 2005 Petition for a Writ of Habeas Corpus
- May 20, 2007 Petitioner’s Report to the Court Concerning the Continued Viability of [Yokaman Hearn’s] Atkins Claim
- September 27, 2007 Court’s Memorandum Opinion and Order

3. I have not met or interviewed Mr. Hearn and the opinions expressed by me in this Declaration are based entirely on the materials that I have reviewed, and on my extensive knowledge and expertise in the field of mental retardation.

MY QUALIFICATIONS AS AN AUTHORITY ON THE CURRENT AND EVOLVING NATURE OF MENTAL RETARDATION

4. I am a Clinical Professor of Psychiatry at the University of Colorado Health Sciences Center, and Emeritus Professor of Educational Psychology at the University of Connecticut. I received a Ph.D. in Developmental Psychology from the University of Rochester, and was a Postdoctoral Fellow in Mental Retardation and Developmental Disabilities at UCLA's Neuropsychiatric Institute. In addition, I have held academic positions at Vanderbilt University and the University of Nebraska.

I have been elected "Fellow" (a designation given only to the most qualified members) by the Mental Retardation division of the American Psychological Association and by the American Association on Mental Retardation. I was also elected to a term as President of the Academy on Mental Retardation (the most prestigious research organization in the field) and received a license to practice psychology in the states of Tennessee and Nebraska. I have allowed my license status in Tennessee to become inactive but am still licensed in the state of Nebraska.

5. In the past few years, I have testified and consulted as an expert on Mental Retardation (MR) and related cognitive disorders in several California and Arizona "Atkins" (death penalty exemption) hearings, and have been authorized for future testimony in cases in Texas, Georgia and other states. I have published extensively on MR, with particular emphasis on the relationship between "adaptive behavior" and "general intellectual functioning." I am considered a leading scholar in the MR field, as seen in the most recent diagnostic manual of the American Association on Mental Retardation (AAMR), AM. ASS'N ON MENTAL RETARDATION, MENTAL RETARDATION: DEFINITION, CLASSIFICATION AND SYSTEMS OF SUPPORTS (10th Edition, 2002) (hereinafter "the 2002 AAMR-10 Manual"), which cited at least twelve publications by me, considerably more than that of any other authority. My book WHAT IS MENTAL RETARDATION, co-edited with H. Switzky (AAMR; 2003; rev. ed. 2006) has quickly become one of the standard reference works in the field of mental retardation and was cited by famed Yale psychologist

Edward Zigler as “likely the most important book ever published on the classification of mental retardation”.

I have also published extensively on related cognitive and neurologically-based disorders, such as autism, hydrocephalus, and Nonverbal Learning Disabilities, where one’s IQ may not be quite low enough to qualify one for a diagnosis of MR, but where there are still very specific cognitive processing deficits in the area of “social intelligence” (see Stephen Greenspan, 2006, Gullibility in Persons with High-Functioning Autism. Autism Spectrum Quarterly, 8, 14-16; Stephen Greenspan & Peter F. Love, (1997). Social intelligence and developmental disorder: Mental retardation, learning disabilities and autism. In W.F. MacLean, Jr. (Ed.) Ellis' handbook of mental deficiency, 3rd ed. Mahwah, NJ: Erlbaum).

BRIEF OVERVIEW OF THE CONSTRUCT OF MENTAL RETARDATION/ INTELLECTUAL DISABILITIES

6. Mental Retardation (MR), in the process of being widely renamed Intellectual Disabilities (ID), has been around for a long time (see Shakespeare’s speech for Macbeth: “life is a tale told by an idiot...”). In the early 19th century, British physicians Ireland and Morison wrote textbooks in which they discussed the disorder, under no-longer-used terms such as mental sub-normality, imbecility, etc. Thus, current conceptions of MR did not emerge in a historical vacuum, but were influenced by earlier writings on the topic. In the period before the invention of intelligence tests (which in the United States came into currency in the second decade of the 20th century), MR was diagnosed informally, based entirely on a person’s overt behavior. With the invention, and increasing popularity, of IQ testing, this IQ index came to be substituted for judgments about one’s behavior. This was obviously a problem, in that too many people who functioned in a non-impaired way in the world were viewed as having MR (often with consequences such as involuntary institutionalization and even sterilization) based solely on a single IQ score. The result of a growing concern about the injustice of this state of affairs led over 40 years ago to the invention of a second diagnostic criterion: “adaptive behavior”. However, this construct was never really adequately defined or measured, which has the effect of trying to clarify a muddled construct of MR by embedding within it an even

muddier construct of adaptive behavior. Recently, the adaptive behavior construct has become clarified, in part because of adoption of a “tripartite” model that I first proposed in 1979 (see final section on the evolving category of mental retardation). But more work remains to be done in that regard.

7. The biggest problem in defining and diagnosing MR is at the upper boundary, namely in the sub-category of “mild MR”, at the cusp of “MR” and “normality”. This is also the sub-category from which virtually all successful Atkins pleaders are likely to be found. The reason why mild MR is so difficult to diagnose is because the disorder is somewhat hidden, in the sense that people with mild MR are more likely to look normal, to talk in complete and syntactically correct sentences, and to have a number of strengths mixed in with their weaknesses. It is because people with mild MR can function normally in many areas, that current definitions of MR do not require global adaptive functioning impairments. Instead, it is necessary only to show impairments in some areas, and these can differ from individual to individual.

Legal definitions of MR in virtually all jurisdictions are derived from either or both the diagnostic manual of the American Association on Mental Retardation (AAMR; recently changed to American Association on Intellectual and Developmental Disabilities, AAIDD) or the Diagnostic and Statistical Manual on Mental Disorders (DSM) of the American Psychiatric Association. Starting with the third DSM edition (DSM-3) in 1980, the DSM has deferred to AAMR, and based their definition of MR largely on the most current AAMR edition. The most recent DSM is DSM 4-TR (Text Revision) which was published in 2000, and is thus based on the definition contained in the 9th edition (AAMR-9), published in 1992. The most recent AAMR manual (AAMR-10) was published in 2002, and it is very likely that the in-process DSM-5 will base its MR section on either AAMR-10 or on the in-process AAMR-11, depending on whether or not AAMR-11 comes out first.

8. In discussing the definitions of MR in DSM 4-TR or AAMR-10, one must make a distinction between an initial “constitutive” (abstract) and a following “operational” (concrete) definition of MR. The constitutive definitions of MR in DSM 4-TR and AAMR-10 are virtually identical and in fact have hardly changed since they were first articulated in 1961 in AAMR-5 (see S. Greenspan and H.N. Switzky, 2006. Forty-four years of AAMR manuals. In H.N. Switzky and S. Greenspan, eds., WHAT IS MENTAL RETARDATION?. Washington: AAMR). The elements of this constitutive definition are: (1) significant intellectual deficits (“significant limitations in intellectual functioning” [2002 AAMR-10], “significantly subaverage intellectual functioning” [2000 DSM 4-TR]) ; (2) significant adaptive [real world] deficits (“significant limitations in adaptive behavior” [2002 AAMR-10], “significant limitations in adaptive functioning” [2000 DSM 4-TR]); and (3) a “Developmental Criterion”, i.e., “onset of which occur prior to age of 18” (both AAMR-10 and DSM 4-TR). Except for minor wording changes, this three-prong definition has remained constant since it was first articulated in 1961 in AAMR-5, except that initially the developmental criterion was set as an onset prior to age 16.

9. This three-prong constitutive definition is widely accepted and has remained relatively non-controversial (except for some hold-out psychologists who never accepted the insertion of the adaptive functioning second prong, and who continue to believe that intelligence alone should be sufficient for diagnosing MR). It is in the operational definition of these constitutive elements that things become problematic and controversial. The problem with defining and diagnosing MR, especially in its milder forms, is that it is a bureaucratic category masquerading as a natural or medical category. Natural categories are easy to define, because they are based on underlying structural qualities, rather than solely on eternal symptoms. Disability categories are bureaucratic inventions, based entirely on external functional qualities, and the criteria used are often arbitrary. As example, patients with cancer and tuberculosis may share certain external qualities (such as fever, exhaustion, confusion) but one can differentiate them precisely based on underlying causative agents (a bacteria in the case of TB, a tumor in the case of cancer). In the case of MR, the criteria (an IQ score below a certain level, adaptive deficits in one or more areas) are arbitrary and may not always serve to

accurately discriminate between those with a real disability and those without one. The use of IQ scores are an attempt to create an illusion of scientific certainty in identifying a disorder whose causes and manifestations are often hidden and subtle.

This is not to say that mild MR is not a real disability, or for that matter that it lacks a biological basis. Although the causes of mild MR are not typically known (unlike moderate or severe MR where a biological cause is typically known), there are many biological causes of mild MR and these biological causes are being uncovered with astonishing rapidity. The problem is that there is a tendency to “reify” IQ scores, that is to put them on a pedestal and consider them to be the phenomenon of interest rather than merely an external manifestation of an underlying biological mechanism and a predictor of limitations in real-world functioning. In fact, it is often the case that the seriousness of a known serious biological syndrome, accompanied by observed adaptive deficits, is dismissed because of a full-scale IQ score that falls above some number selected by a committee as of diagnostic significance. The problem is that when the artificial number fails to fit with the disability as it is experienced and documented by others, which criterion should one use? Typically, clinicians and government entities find it easier to go “by the book”, but there are times when that results in a wrong and, possibly, unjust decision.

The basic question I am being asked to address in this Declaration is if and when it is appropriate to change the operational criteria one uses to diagnose MR, in order to meet the spirit of the constitutive definition. My answer is that under certain circumstances, such as when an individual has a mixed pattern of intellectual deficits owing to a diagnosed developmental brain syndrome such as Fetal Alcohol Spectrum Disorder, it is appropriate and necessary to change the operational criteria. My reasons will, hopefully, become clear in the balance of this Declaration.

SUMMARY OF THE DISABILITY PROFILE AND FINDINGS PERTAINING TO YOKAMAN HEARN

The findings of experts are already known to the court, so I shall summarize them briefly. I shall organize the findings under the three definitional prongs. Because the main diagnostic dispute in this case appears to center around the first (“intellectual”) prong, I shall address the intellectual findings last.

DEVELOPMENTAL FINDINGS:

10. The developmental history shows Mr. Hearn to have been intellectually challenged very early in life, with a first grade teacher recommending he be tested for Special Education placement (mother refused), and with him repeating first grade as well as ninth grade. He failed to meet minimum state standards for reading and math in fifth grade, and for reading, math and writing in seventh grade. He received failing grades in virtually all subjects (in ninth grade, he failed seven out of eleven classes). In ninth grade, he ranked 257 out of 274 students, while in 10th grade, he ranked 174 out of 200. He dropped out of school in the middle of the 10th grade. Such a record of academic failure is quite extreme, and it is obvious that he should have been in a special education placement, possibly with a label such as “Educable Mental Retardation”.

Because Mr. Hearn never received a Special Education placement, standardized test scores are apparently not available for the Developmental period. However, in addition to abysmal school performance, Mr. Hearn was described by family members as someone who “learned at a slower pace”. An ROTC teacher noted that he could not “think on his feet”. A cousin stated that he could not be asked to perform a task without having it broken down, and other family members stated that he required close supervision when given any chore to perform.

Although a known organic cause is not required for a diagnosis of MR, knowledge of a likely cause helps to establish the diagnosis and, especially, to determine if an individual meets the developmental criterion. In the case of Mr. Hearn, there is strong reason to suspect that his intellectual difficulties are attributable to alcohol exposure *in*

utero. It is now known that even a small amount of alcohol consumption during pregnancy can cause significant learning and adaptive difficulties, and it is reported that Mr. Hearn's mother drank very heavily during the whole time that she was carrying him. At one time, a diagnosis of Fetal Alcohol Syndrome (FAS) was made only when physical or cognitive effects were extreme and severe, but now less obvious, but still serious, forms of the disorder are captured under the rubric of "Fetal Alcohol Effects" (FAE) and the broad spectrum of alcohol-caused developmental disability is captured under the rubric of "Fetal Alcohol Spectrum Disorder" (FASD). Such a medical diagnosis should be made only by an MD with advanced training in psychiatry or neurology. Dr. Pablo Stewart possesses such credentials, and his report concluding that Mr. Hearn has FAS, in combination with the early and variable pattern of impairments and abilities (see next two sub-sections) typical of such a disease, provides convincing evidence that Mr. Hearn acquired his intellectual and adaptive limitations within the developmental period.

ADAPTIVE FINDINGS:

11. To my knowledge, the only formal assessment by any expert of Mr. Hearn's level of adaptive functioning was by Dr. James R. Patton. He is a highly respected authority on mental retardation, co-author of a best-selling textbook on the disability, and extremely knowledgeable and experienced in the area of adaptive behavior assessment. In his report dated May 19, 2005, Dr. Patton evaluated Mr. Hearn's adaptive behavior and rendered an opinion as to whether he met the three diagnostic criteria for a diagnosis of MR based on his own findings and also on findings of other experts, such as the IQ data obtained by Dr. Conroy. It is my understanding that the state contended that Dr. Patton was not qualified to diagnose MR because he is not a licensed psychologist, but that the United States District Court did not accept that argument.

In his 2005 report, Dr. Patton used a variety of methods and data to evaluate Mr. Hearn's level of adaptive functioning. These included interviews with relatives and a former teacher, analyses of school, work and other data, and a quantitative instrument, the Adaptive Behavior Assessment System—Second Edition (ABAS-II), using a cousin, Ms. Zamin Bell, as the principal informant. On the

ABAS-II, Mr. Hearn received standard scores of 66 on overall adaptive behavior (“General Composite”, comparable to “full scale”); 69 on Conceptual Adaptive Skills; 65 on Practical Adaptive Skills; and 70 on Social Adaptive Skills. This more than exceeded the AAMR-10 adaptive behavior operational criterion of 70-75 or below on either overall adaptive behavior or only one out of the three adaptive behavior domains.

This quantitative index of adaptive behavior impairment was also buttressed by the qualitative information gathered by Dr. Patton. Some of this information, especially relating to school failure, was summarized by me in the earlier section on the Developmental criterion. Dr. Patton found numerous bits of evidence pertaining to the area of gullibility and social vulnerability (which I have argued is a universal sign of adaptive deficit in people with mild MR). There was considerable information indicating that Mr. Hearn is a follower, easily fooled and manipulated by others, and that in fact he does fit the social adaptive profile of someone with MR. With respect to Practical Adaptive skills, Dr. Patton found other bits of evidence suggesting that a diagnosis of MR is appropriate. Among this evidence is the fact that Mr. Hearn has struggled to master basic household tasks, needs supervision to accomplish tasks of daily living, and has never been able to hold a job for very long.

12. In sum, it appears from the 2005 report by Dr. Patton that Mr. Hearn met the second diagnostic prong, of significant deficits in adaptive functioning. In his supplemental report dated July 19, 2006, Dr. Patton explained why the so-called “Briseno Factors” do not undermine his earlier conclusion that Mr. Hearn displayed a pattern of adaptive deficits consistent with a diagnosis of mild MR.

INTELLECTUAL FINDINGS:

13. The main issue in contention in this case appears to be whether or not Mr. Hearn meets the first—Intellectual Functioning—prong of a diagnosis of MR. Initially, 2005 intelligence testing by psychologist Dr. Mary Alice Conroy found that Mr. Hearn met the operational criterion of full-scale IQ below 70-75. However, later intelligence testing in 2006 by Dr. Randall Price and Dr. Thomas G. Allen found that he fell above that ceiling. As corrected in 2007 by

Dr. Dale G. Watson (who found scoring errors in the reports by all three experts), the full-scale IQ scores are as follows: 73 (WAIS-III) by Dr. Conroy, 87 by Dr. Price (WAIS-III) and 93 (Stanford-Binet-V) by Dr. Allen. In addition to correcting the earlier tests, Dr. Watson in 2007 administered the Woodcock-Johnson Tests of Cognitive Abilities, third edition (WJ-III). On the WJ-III, Mr. Hearn obtained a General Intellectual Abilities (full-scale equivalent) score of 87. Corrections for the “Flynn Effect” (subtracting 0.3 points per year of test obsolescence) were apparently not done by any of the four experts, but such correction would not have changed the conclusion that Mr. Hearn’s full-scale IQ scores do not fall below the operational ceiling of 70-75.

In an attempt to better understand the causes of Mr. Hearn’s history of significant adaptive functioning deficits, including marked academic failure, Dr. Watson administered an extensive battery of neuropsychological tests, built around an expanded Halstead-Reitan Battery. On the General Neuropsychological Deficit scale, Dr. Watson found Mr. Hearn to fall more than two standard deviations below the population mean (mild neuropsychological deficit) range. In addition, Dr. Watson found lateralized brain dysfunction, with greatest impairment in left-brain functions that affect verbally-mediated abilities, such as reading. Dr. Watson presents a great deal of test data that convinced him (and me) that Mr. Hearn has very significant impairments in intellectual abilities, and that these impairments explain his history of dramatic school failure as well as documented deficits in various aspects of adaptive functioning. The question, to be addressed by me in the next section, is whether such a pattern of severe neuropsychological impairments can be used to satisfy the first prong of the MR definition, in the face of IQ scores above the ceiling score currently specified as the standard for differentiating “non-MR” from “MR”.

UNDER EXISTING DEFINITIONS OF MR, COULD A CASE BE MADE FOR DIAGNOSING SOMEONE AS MEETING THE INTELLECTUAL CRITERION, EVEN WITH IQ ABOVE THE 70-75 CEILING?

14. The main question I have been asked to address is whether one is obligated to interpret the first definitional prong of MR in a narrow operational sense as Full Scale IQ below 70-75 (taking into account possible confounds such as the Flynn Effect and Practice Effect) or whether one is justified in interpreting the first definitional prong of MR more broadly and flexibly in its constitutive sense as involving “significant limitations in intellectual functioning” (1992 DSM 4-TR) or as “significantly subaverage intellectual functioning” (2002 AAMR-10). In particular, the question being asked of me is whether one can exercise clinical judgment, as Dr. Watson attempted to do, in substituting neuropsychological measures for full-scale IQ in cases of apparent brain damage, where full-scale IQ may not provide a valid indicator of the full extent of an individual’s intellectual functioning impairments.

In my view, such a broader and more flexible operational approach is justified when there is a medical diagnosis of a brain syndrome or lesion, such as Fetal Alcohol Spectrum Disorder. That is because it is well known that such conditions cause a mixed pattern of intellectual impairments that, while just as serious and handicapping as those found in people with a diagnosis of MR, are not adequately summarized by full-scale IQ or by an arbitrary ceiling score such as 70 or 75.

If one views MR as a disability status assigned by various official entities, then there are ample precedents in which an adult individual was granted MR status—that is, was deemed to meet all three definitional prongs—even in the face of a full-scale IQ score well above 70-75. These precedents can be found in the realms of both criminal law and adult habilitation services. The first Atkins petition brought to a decision on facts in the state of California in fact fits this description. The case involved Jorge Junior Vidal, a man condemned to death in Tulare County, California. Similar to Mr. Hearn, Mr. Vidal had a profile of intellectual deficits that were particularly evident in the area of verbal functioning. On the WISC-R

(the childhood equivalent of the WAIS), he received a full-scale IQ in 1980 of 81. In 1987, he received a full-scale IQ on the WAIS-R of 92. In 2003, he received a WAIS-R full-scale IQ of 78. In spite of these three full-scale scores above the 70-75 AAMR ceiling, the judge ruled that Mr. Vidal met the three prongs for a diagnosis of MR, and this ruling was eventually allowed to stand by the California Supreme Court.

15. The decision was based on testimony by two defense experts—a forensic psychologist, Dr. Eugene Couture, and a Professor of Psychology, Dr. Keith Widamin. Dr. Couture argued that the extreme (30-point) discrepancy between Mr. Vidal’s verbal and Performance IQ scores was indicative of neurological damage, and that in such a case, the summary score of full-scale IQ was not a reliable indicator of the true extent of Mr. Vidal’s intellectual limitations. Dr. Widamin agreed with this conclusion that full-scale IQ is not an adequate indicator of significant intellectual impairment in someone with brain damage. He further argued that the extremely deficient verbal IQ would be a better index in this case. In making this argument, Dr. Widamin cited my writings on gullibility (an apparent area of adaptive deficit for Mr. Vidal, as for Mr. Hearn). Specifically, Dr. Widamin argued that the very low Verbal deficits could be linked to Vidal’s adaptive behavior impairments, in explaining his extreme gullibility and social vulnerability.

The practice of adopting a more flexible operational interpretation of the intellectual functioning prong in the face of a known neurological or developmental syndrome has many precedents in the area of adult service eligibility. The basis for such flexibility stems from the fact that such syndromes (for example, Fetal Alcohol Spectrum Disorder) produce adaptive deficits (including academic learning problems as well as social vulnerability) that are universally present, in spite of the fact that some individuals do not fall below the full-scale IQ ceiling score of approximately two standard deviations below the population mean. The inherent unfairness of granting residential or vocational service eligibility to one person while denying it to another person with identical needs and impairments--because of where they fall on an arbitrarily determined full-scale IQ ceiling--has caused several states to interpret the first prong of the AAMR-10 and DSM 4-TR standards more flexibly. Thus, the state of

Connecticut now automatically provides services to all individuals with a medical diagnosis of “Prader-Willi syndrome” (a chromosomal disorder marked by a very mixed pattern of intellectual deficits, and very severe Adaptive Behavior deficits) regardless of full-scale IQ score. Other states have begun to provide similar flexibility in interpreting the intellectual functioning prong for individuals with Fetal Alcohol Spectrum Disorder (which evidence, including a declaration from Dr. Stewart, suggests applies to Mr. Hearn). The state of Washington is an example of a state where adults with medically-diagnosed Fetal Alcohol Spectrum Disorder and documented adaptive behavior impairments will qualify someone for a diagnosis of MR in spite of full-scale IQ above 70-75.

16. In its 2002 diagnostic manual (AAMR-10), as well as in the later USER’S GUIDE to that manual, the AAMR (now AAIDD) wrestled with the issue of what operational criterion to use. They acknowledged that full-scale IQ is an imperfect measure that may be replaced in the future. They noted that “the assessment of intellectual functioning through the primary reliance on intelligence tests is fraught with the potential for misuse...” (AAMR-10, p. 57). They state further that “neither of these organizations [i.e., AAMR and DSM] intend for a fixed [IQ] cutoff point for making the diagnosis of mental retardation.” (AAMR-10, p. 58). Mention is made in several places to the existence of special situations that “may, at times, require information from multiple sources” (AAMR-10, p. 66), including specialized test batteries or functional analysis. There is a great deal of emphasis in AAMR-10 as well as in its supplemental USER’S GUIDE (R. Schalock et al, 2006, AAMR) on the importance of exercising “clinical judgment” in determining how to interpret and apply the three definitional prongs to diagnosing MR in each individual case. The meaning of clinical judgment [see also R. Schalock & R. Luckasson (2005) CLINICAL JUDGMENT (AAMR)] in diagnosing MR basically requires that a clinician be more than just a reporter of test scores. It requires a psychologist or other diagnostician to use their knowledge of the test literature as well as of the various forms of mental retardation to determine what is the best kind of information to use in any particular case. Certainly, where one is dealing with an individual with a neurological deficit (such as Fetal Alcohol Spectrum Disorder) known to produce a highly mixed pattern, one would be highly justified, in my opinion, in concluding

that highly deviant results from a neuropsychological test battery, such as the Halstead-Reitan battery used by Dr. Watson, would provide a more meaningful basis for diagnosing MR than would full-scale IQ score.

17. In sum, I believe that a reasonable case can be made under existing diagnostic standards for saying that someone can meet the intellectual prong for a diagnosis of MR, even with a full-scale IQ in the 80's or even 90's. This is because for individuals with a diagnosed brain syndrome, full-scale IQ can be, and usually is, highly misleading. In a syndrome such as Fetal Alcohol Spectrum Disorder, one typically finds a mixed pattern, with areas of relative strength combined with areas of severe impairment. Such a mixed pattern provides an overall full-scale IQ score that can be very misleading, in that it masks the true extent of the individual's limitations in learning and in other areas of adaptive functioning, including social vulnerability. The admonition to clinicians to exercise "clinical judgment," spelled out in both AAMR-10 and its companion USER'S GUIDE, requires a clinician to not just be a reporter of test scores but to evaluate the extent to which such test scores can be relied on validly in any particular case. Such an exercise of clinical judgment allows a qualified psychologist such as Dr. Watson, to conclude that an individual with a documented brain disorder meets the AAMR-10 and DSM 4-TR criteria for diagnosing MR, even in the face of IQ above 70-75.

UNDER EVOLVING DEFINITIONS OF MR, COULD A CASE BE MADE FOR DIAGNOSING SOMEONE AS MEETING THE INTELLECTUAL CRITERION, EVEN WITH IQ ABOVE THE 70-75 CEILING?

18. As is true of most other human service disability categories, MR/ ID is an evolving construct, which is not set in stone but which has changed and continues to change. The 1961 AAMR-5 diagnostic manual contains the first modern definition (in which the term "mental retardation" was substituted for mental deficiency, idiocy, etc.), and it established the "developmental" criterion as onset before age 16; that was later changed to onset before age 18. In 1961, there were five sub-categories, with the highest level of mental retardation set as IQ below one standard deviation, or a ceiling of 85; in 1973,

that ceiling was lowered to two standard deviations, or IQ of 70, while in 1992 it was raised to 75 and in 2002 to 70-75. In 1961, Adaptive Behavior was approached as a global impairment (although a quantifiable score was not specified), while in AAMR-9 (1992) it was framed as requiring deficits in two out of ten adaptive skills (2 out of 11 in DSM 4-TR). In AAMR-10 (2002), that was reframed as requiring deficits in one out of three broad adaptive behavior domains, and for the first time psychologists were encouraged to use standardized adaptive behavior scores. In 1992 and before, there was no mention of gullibility/ social vulnerability as an important indicator of deficits in the social adaptive skills domain, but in 2002 (citing my writings extensively), there was such mention. Furthermore, AAMR is developing its own diagnostic adaptive behavior rating instrument in which gullibility items (many contributed by me) will be prominently featured. Another difference is that in 1992, levels of severity sub-category (mild, moderate, etc.) were dropped to be replaced by profiles of support needs, while in 2002, the possible use of distinct qualitative sub-categories was brought back somewhat. In short, it is important to view official documents defining the nature of MR not just in terms of where they are currently but in terms of where they are headed and why they are being tinkered with.

19. As spelled out in my historical overview of AAMR definitions [S. Greenspan & H.N. Switzky (2006). Forty-four years of AAMR manuals. In H. N. Switzky & S. Greenspan (Eds.) WHAT IS MENTAL RETARDATION? AAMR)], the most important explanation for the changes in definition manuals over the past few decades has been dissatisfaction with the excessive reliance on specific IQ score ceilings to diagnose a disorder which before the invention of IQ testing had been diagnosed based on behavior, and which often manifests itself differently across individuals in a manner that could not be adequately or fully captured by a single summary test index. The Adaptive Behavior prong was invented and added in 1961 to address the main concern at that time, which was the over-identification of individuals who functioned adequately in the world in spite of low IQ. That same concern with eliminating “false positives” underlay the dropping of the ceiling from 85 to 70 in 1973 (AAMR-6). In recent years, the concern has shifted from wanting to eliminate false positives to a concern that the class has been redefined too narrowly: *“the problems faced by people who have mental*

retardation but do not receive the diagnosis can be severe. These individuals are vulnerable to the denial of essential supports and exclusion for eligibility for important protections” (AAMR-10, p. 57, their emphasis).

In line with this recent emphasis on avoiding “false negatives” (an issue with obvious relevance to this case), AAMR-9 added the 5-point reliability factor, thus raising the ceiling from 70 to 75 (and AAMR-10 to 70-75). This had the effect of more than doubling the potential size of the class (from the 2nd to the 5th percentile). Concern over the possibility that the class had been redefined too narrowly also underlies the imposition of a relatively easy-to-meet adaptive behavior criterion (2 out of 10 in AAMR-9, 1 out of 3 in AAMR-10), in contrast to the more global adaptive behavior criterion that had preceded it. In sum, the motive that drove the adoption of AAMR-9 (which also underlies DSM 4-TR and AAMR-10), was a concern that too rigid a reliance on a specific IQ ceiling score creates a strong possibility of denying the supports or protections flowing from the MR label to those who deserve such a label.

20. One important reason for the recent rise in concern by AAMR over the problem of false negatives stemming from overly-rigid reliance on specific IQ ceilings has been the tremendous recent advances in identification and understanding of various brain-based syndromes and disabilities. Thirty years ago, there were perhaps 200 known biological causes of MR, while today the number is probably closer to 700. Thirty years ago, there was virtually no understanding of the deleterious effects on the developing fetus of alcohol consumed during pregnancy, and the emphasis when it first became known was on very severe cases where physical and cognitive consequences were extreme and dramatic. Today, there is an explosion of research in this area, with much better ability to diagnose the disorder reliably and much better understanding of its many manifestations, including cases where effects are more subtle but still likely to bring about major disruptions in adaptive functioning. Partly because of early educational intervention, partly because of the general population rise in intelligence, but also because of the varied nature of the brain lesions associated with such syndromes, the mean IQ for many syndromes has risen significantly. This increases the possibility of false negatives, which is why in cases of brain damage or

neurologically-based syndromes, rigid reliance on an IQ score is problematic. That is why in many states, adult Developmental Disability service agencies are actively exploring the development of eligibility criteria that are not rigidly tied to an IQ ceiling, especially for individuals with Fetal Alcohol Spectrum Disorder.

21. I have been in close touch with members of the committees that wrote AAMR-9 and AAMR-10, and have been assured that the AAMR-9 and AAMR-10 were transitional documents. Whether it is reflected in AAMR-11 or in a subsequent manual, I believe that there is a definite trend toward reducing the importance of a specific IQ score as the main basis for ruling in or out a diagnosis of MR. The reason why I have been given this assurance is because both AAMR-9 and AAMR-10 cited my writings on personal competence and multiple intelligence as providing the main theoretical framework for the definition of MR, but have yet to fully implement the ideas expressed in those writings. The eventual intent, I have been told, is to finally more fully incorporate my ideas into the official definition of MR.

Without going on at excessive length, the basic idea I have expressed since 1979 in my writings (for which there is ample research support over a long period) is that there are three forms of intelligence: “Conceptual” (or Academic) Intelligence, “Practical” Intelligence and “Social” Intelligence. Intelligence tests producing IQ scores are basically measures of only one form of intelligence, namely Conceptual Intelligence. (In fact, they were assembled by sampling items from the educational curriculum). That is why IQ scores are highly correlated with educational achievement scores and are best at predicting future educational achievement. The problem is that IQ is not always a good predictor of Practical Intelligence (one’s understanding of the mechanical world) or Social Intelligence (one’s understanding of the interpersonal world). MR is a disorder properly thought to reflect low “intelligence”, but it is important to understand that it can manifest in one or more of three areas of intelligence, and not just in the area of Conceptual Intelligence (i.e., IQ). Thus, I have advocated for dropping the too fuzzy Adaptive Behavior criterion, and for adopting a definition of MR as “a disorder, first manifesting in childhood, characterized by significant deficits in one or more of Social, Practical and Academic aspects of intellectual functioning.”

22. The AAMR latched onto my theory because it provided a more coherent and justifiable framework for defining adaptive behavior (which previously had ignored the cognitive aspects of everyday functioning and had too much content relevant mainly to diagnosing mental illness). But they were reluctant to go the whole way because of fear of opposition from the psychological community to the notion that IQ is not fully synonymous with all of intelligence. So they adopted the tripartite model, but changed it from a tripartite model of intelligence to a tripartite model of adaptive skills. This had the effect of keeping the construct of intelligence as something separate from Adaptive Behavior, and of maintaining the view (some would say fiction) that IQ tells you all you need to know about someone's intelligence. Consequently, the need to keep playing around with IQ ceiling scores, instead of addressing the core problem more directly, namely to adopt a view of MR/ ID as reflecting a variety of forms of intellectual deficit rather than continuing to base it first and foremost on a specific score in only one form of intelligence.

The issue of brain syndromes also comes into play here in two ways. First, syndromes such as Fetal Alcohol Spectrum Disorder always manifest in Social Intelligence impairments that are greater than the impairments in Cognitive Intelligence, and show adaptive limitations sufficient for diagnosing MR even when IQ is above 70-75. This fact, and the concern over the serious social and practical vulnerabilities flowing from the disorder, is what is fueling the drive for more inclusive eligibility criteria and what is fueling the drive to more fully adopt my theoretical model. The second way these organic syndromes come into play is in the substitution of the term "Intellectual Disability" for the older term "Mental Retardation". This change in terminology, reflected in the name change of AAMR to AIDD will be fully discussed in AAMR-11, and the terminology almost certainly will be used eventually in state statutes and court decisions. The question is whether this is just a semantic substitution, or whether it indicates an eventual desire to broaden the class significantly. I think the latter is the most likely explanation, and the change in terminology, while driven in part by a desire to characterize people more respectfully, was even more motivated by a desire to move the field in a direction that is more inclusive. Such a more inclusive meaning of the disability category is intended to bring under

the disability umbrella people, such as Yokaman Hearn, to whom the label applies but from which they may be excluded under an overly rigid reliance on full-scale IQ. In sum, in a very few short years, I predict that the question of whether it is appropriate to apply the ID label to someone with an IQ in the 80s will be seen as hopelessly outdated.

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I declare under penalty of perjury under the laws of the State of Colorado and the United States of America that the foregoing is true and correct.

Executed this 10th day of October, 2007.



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