

INTELLECTUAL DISABILITY

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1. I am a psychologist and retired professor with an expertise in Intellectual Disabilities (ID) and Fetal Alcohol Spectrum Disorder (FASD). I was the primary or sole author of four chapters, the most of any contributor, in the American Association on Intellectual Disability (“AAIDD”) book *The Death Penalty and Intellectual Disability*. My main focus has been on “Adaptive Behavior” (also termed “Adaptive Functioning”) which is one of the three definitional “prongs” of ID. The so-called tripartite model (which divides adaptive behavior into Conceptual, Social and Practical domains) that is used to define ID is attributed to my writings from the early 1980s. Within the field of developmental disorders, I am also well-known for my writings about gullibility and social unintelligence (my 2009 book *Annals of Gullibility* remains the only comprehensive book on the subject). I have participated in many proceedings on these topics in state and federal courts. On four occasions, I have participated in cases that led to United States Supreme Court opinions on intellectual disability as it pertains to the death penalty, including the seminal case of *Atkins v. Virginia* in which the Supreme Court held that people with Intellectual Disability are exempt from the death penalty.

General Comments About Intellectual Disability

2. Intellectual Disability is considered a “developmental disorder” or “developmental disability.” These largely equivalent terms refer to conditions that have their origins in childhood or adolescence, involve abnormalities in brain functioning and brain development, and are characterized by deficiencies in academic and social intelligence. In the Diagnostic and Statistical Manual of the American Psychiatric Association, 5th edition, text revision (DSM5-TR), these are both characterized as “Neurodevelopmental Disorders” to differentiate them from other brain-

based “Neurocognitive Disorders” that originate mainly in adulthood, such as Traumatic Brain Injury (TBI) or dementia.

3. As with virtually all mental health conditions, there has been an evolution in the understanding and definition of ID. The constitutive definition of ID—significant limitations (prong one) in adaptive behavior (prong two) that originates during the developmental period (prong three)—has remained constant for over fifty years, but the operational definition has changed periodically. For example:

- a. Assessment of adaptive behavior is now seen as equally, and sometimes more, important than assessment of intellectual functioning for an intellectual disability evaluation.
- b. There is now a broader approach to assessment of intellectual functioning. There is less emphasis and focus on full-scale IQ scores. Indeed, neuropsychological measures of “executive functioning” (planning, reasoning, flexible and consequential thinking, etc.) are often now seen as better indicators of low intellectual functioning than IQ scores.
- c. It is now widely recognized that when adaptive behavior is extremely impaired, it is possible to have a full-scale IQ above 75 while still being found to have ID.
- d. To control for threats to the validity of IQ scores stemming from the obsolescence of test norms (the so-called “Flynn effect”) scores should be lowered (by 0.3 points per year of obsolescence).
- e. Developmental onset has been periodically raised to reflect better understanding of brain development. Today, the DSM-5 does not have a specific age cut-off and the AAIDD marks the onset age as up to 22.

4. Significantly, there is now widespread agreement against there being an “IQ cutoff” when diagnosing ID. The case against IQ cutoffs can be understood in two ways: (a) IQ is an incomplete indicator of intelligence, and (b) the particular number used (75, formerly 70, and before that 85) is arbitrary and an inadequate indicator of actual disability (level of support needs). With regard to the first concern (nature of intelligence), it should be understood that the first intelligence test in France (after which US tests were largely modeled) was derived from the

educational curriculum, and thus mainly measures “academic intelligence,” meaning that other forms of intelligence (social and practical) more relevant to actual life functioning are not tapped. With respect to the second concern (arbitrariness of cut-off scores), it should be understood that these numbers were selected on the basis of purely statistical criteria. It is highly debatable to think that a number based solely on statistical criteria can provide a valid picture of someone’s possible limitations (such as how gullible they are) and their need for human service or legal supports and protections.

5. Mild ID constitutes by far the largest sub-category of ID, making up around 80% of the total ID population. Virtually all individuals facing possible exemption from the death penalty under the *Atkins v. Virginia* legal standard are likely to fall in the mild ID sub-category (for the most part, people with moderate or severe ID would not be considered competent enough to be criminally charged). An unfortunate consequence of the term “mild” is that it implies an insubstantial level of impairment, not that different from “normality.” In fact, mild ID is a very disabling status. A diagnosis of mild ID will generally make someone eligible for adult vocational and residential services as well as lifelong SSI payments.

6. ID is known as a “functional” diagnosis, meaning that it is diagnosed according to whether certain behavioral or competence criteria are met, and there is no requirement that a biological cause be known. However, research has shown that Fetal Alcohol Spectrum Disorder (“FASD”), alcohol ingestion by the mother during pregnancy, is the number one known cause of ID in the US and other first-world countries. Additional known causes discussed by the AAIDD include narcotic ingestion by the mother during pregnancy, and birth injury and/or traumatic brain injuries occurring in infancy or early childhood. There can be a genetic component as well such

that intellectual disability can be heritable. Additionally, the AAIDD discusses “social” risk factors for ID, including being subjected to child abuse, extreme social deprivation, and/or malnutrition.

Misconceptions About Intellectual Disability

7. There are, unfortunately, many misconceptions about ID. Most of these are based on stereotypes derived from experience with severely impaired individuals. Some of these misconceptions are addressed briefly in the following bullet points:

- **Misconception 1: ID is an obvious condition, and one can spot a person with ID based on a brief interaction.**

For people with mild ID (where most affected offenders are found), the condition is relatively hidden, and it may take quite a while before the extent of a person’s limitations become apparent. People with ID can be very attractive and have relatively normal language and superficial social skills, and this can give the impression that they are more “normal” than they actually are.

- **Misconception 2: People with ID are globally incompetent, and have few if any areas of average ability or functioning.**

People with mild ID may be impaired with regards to particular functioning, but not show impairment in other areas. This is unsurprising—brain damage tends to be modular, meaning that when damage occurs some areas of the brain are affected more than others. In these instances, some areas of functioning remain relatively normal, while other areas are very impaired. This is reflected in the statement in both diagnostic manuals that only one of the three adaptive behavior dimensions needs to be significantly impaired to justify a diagnosis of ID.

- **Misconception 3: Someone with ID cannot get a GED, marry, work, drive, etc.**

The US Department of Education did a longitudinal study in which they followed up on persons who were in special education (including those labelled ID) at periodic intervals throughout their adult years. The fact is that there are few if any adult roles that one will not find significant numbers of persons with ID playing. Most of them work, and many of them have romantic relationships and even have children, obtain a GED, drive (some with a license, many without), etc. They may do these roles incompletely (a “roofer” turned out just to carry materials and was not allowed up on the roof), sometimes the roles offer an easy entry route (GED requirements vary tremendously according to state and setting), sometimes they get help (such as a sympathetic or corrupt driving license examiner), and they may do better or worse depending on context (people with ID can be good caregivers of infants but tend to do worse when dealing with oppositional toddlers or preschoolers, or children with

behavioral difficulties). But the rule (stated in both AAIDD and DSM) is that “ID is ruled in by incompetence but is not ruled out by competence.” Similarly, ID is assessed through the existence of adaptive deficits, not by ruling out adaptive strengths. One of the central principles of ID diagnosis, as stated by the AAIDD, is the idea that “within an individual, limitations often coexist with strengths.”

- **Misconception 4: Having Mental Illness or a Behavior Disorder rules out ID.**

The term “diagnostic overshadowing” refers to the tendency to deny or overlook the possibility that someone could have an ID diagnosis because of the existence of some salient or diverting characteristic of the person. But ID is not an exclusionary diagnosis, meaning that someone with ID can have other diagnoses as well. There is no other disorder that rules out ID. Because brain abnormalities can cause mental illness, because one’s childrearing environment may have been far from optimal, and because a history of failure and social exclusion can cause distress, people with ID have a higher than average likelihood of having psychopathology.

- **Misconception 5: High self-ratings on adaptive behavior forms are relevant for diagnosing ID in Atkins cases.**

Contrary to the mistaken belief that petitioners claiming relief pursuant to *Atkins v. Virginia* are universally motivated to present themselves in a poor light, the truth is often exactly the opposite. People with, or at the cusp of, ID typically have a life history of failure, and this is often a source of considerable pain. A phenomenon called the “cloak of competence” is nearly universal, where people with ID when asked about their abilities will claim to be able to do many things which in fact they cannot do. The AAIDD diagnostic manual repeatedly warns against self-ratings for this reason.

- **Misconception 6: If there is a high IQ or other cognitive score, one can dismiss lower scores as reflections of poor effort, on the grounds that “one can fake low but can’t fake high.”**

Many Atkins petitioners have multiple IQ scores in their record (some comprehensive individually administered ones, as well as some group or screening tests) going back to childhood in many contexts (school, jail, prison, military, pre-trial, habeas, etc.). Some variability is inevitable. A single high outlier score does not invalidate lower scores, or prove malingering. There are many possible reasons other than malingering for low scores, and there are many non-effort explanations for high scores. As a rule, outlier scores should be discounted, whether they are unusually high or low.

- **Misconception 7: One can use the facts of a crime (for example apparent premeditation) to argue against ID.**

The clinical manuals, and AAIDD “User’s Guides,” make clear that it is not appropriate to use the alleged or proven facts of a crime to dispute a possible diagnosis of ID. Reasons are: specific precipitating facts are often unclear, role of others may have played a role, what appears to be an accomplishment might actually reflect failure (e.g., lack of skills in handling victim resistance), there are no norms for specific criminal acts such as shooting a gun, and again, committing crimes is in no way impossible for persons with ID. Most crimes, even low-level ones, involve some degree of planning and the Supreme Court in *Moore v. Texas* dismissed use of the so-called “Briseño factors” (in which planning was argued to be incompatible with ID) as based on invalid stereotypes more appropriate for people with severe ID.

- **Misconception 8: In order to qualify for ID as an adult, there must be clear evidence of ID during the pre-22 period, such as qualifying IQ scores or a school diagnosis of ID.**

The purpose of the early onset requirement for ID is to establish a “continuity of concern” from sometime during the developmental period to the present adult period. In other words, someone who had average or above average functioning during the developmental period and then suffered a serious brain injury (such as from a motorcycle accident) with loss of cognitive and adaptive ability during adulthood would have dementia (in DSM-5 renamed “neurocognitive disorder”) as distinguished from ID. To establish the continuity of concern that is the basis for the requirement of developmental onset, an early diagnosis of ID is not required; signs of incompetence, such as having been held back or referred for special education, or having been seen contemporaneously by peers or adults as “slow” are sufficient to satisfy the developmental criterion.

- **Misconception 9: In persons who are poor or from a minority background, signs of incompetence reflect family ethnicity rather than an individual’s ID.**

Cultural or racial “overshadowing” causes ID to be routinely missed in poor or minority individuals. That is because any sign of cognitive or adaptive impairment is assumed to reflect racial or socioeconomic factors. This is a form of double discrimination, as it denies already discriminated against people the right to have their impairments acknowledged and addressed.

- **Misconception 10: Every licensed forensic examiner is equally qualified to diagnose or rule out ID.**

Few forensic psychologists or psychiatrists receive meaningful (or any) training in ID or neurodevelopmental disorders. Even when they have had some prior experience, it often was in an institutional setting with more severely impaired residents. Thus, when it comes to people with mild ID who mainly reside in the community, these professionals can suffer from some of the same misconceptions as laypeople with all of the stereotypes about ID common among the general public.

Without meaningful training and experience in mild ID, professionals tend to hold incorrect stereotypic ideas (such that everyone with ID is globally incompetent).

Implications of Intellectual Disability on Culpability

8. The Supreme Court decision in *Atkins v. Virginia* barred the execution of anyone found to have ID. The Court based its decision mainly on the growing consensus that executing an ID individual was an immoral practice. The author of the decision, Justice John Paul Stevens, also discussed two universal competence deficits in ID offenders that he believed took the death penalty off the table: impulsivity and defective reasoning.

9. The *Atkins* Court elaborated further on the disabilities afflicting people with ID, noting that this class of defendants had diminished capacity to (a) understand and process information, (b) communicate, (c) abstract from mistakes and learn from experience, (d) engage in logical reasoning, (e) control impulses, and (f) understand the reactions of others. The Court further indicated there was abundant evidence that persons with ID often acted on impulse and tended to be followers in social groups rather than leaders.

10. Eligibility for the death penalty requires that the defendant must have a conscious awareness of the possible consequences of their actions, both for their victims (death or severe injury) and for themselves (severe punishment). Such reflection is not likely to characterize the behavior of people who are impulsive or who are lacking in rationality. People with ID are extremely likely to suffer from impairments regarding reasoning and impulse control. People who lack executive functioning, and thus reasoning and impulse control, have significant limitations on culpability and thus are not by definition the most culpable, regardless of the heinousness or depravity of their action.

11. People with ID are not immune from punishment; for example, the alternate sentence for almost all people found to have ID in an “Atkins” proceeding is life without parole. In effect, ID operates as a mitigator not to secure the absence of punishment but, rather, to reduce the punishment for criminal conduct commensurate with reduced culpability.

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