Moving the Focus Away From the IQ Score Towards the Subjective Assessment of Adaptive Functioning: The Effect of the DSM-5 on the Post-Atkins Categorical Exemption of Offenders with Intellectual Disability From the Death Penalty

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I. INTRODUCTION

In 2002, in the landmark case of Atkins v. Virginia, the Supreme Court of the United States held, in a 6-3 majority, that the execution of a defendant with mental retardation was considered to be a violation of the Eighth Amendment. The Eighth Amendment prohibits cruel and unusual punishment, which led to the Court’s ruling that the execution of a defendant with an intellectual disability was unconstitutional. In order to make this decision, the Court had to determine how to differentiate between a defendant with normal intellectual functioning and one with a significant intellectual disability. The Court utilized a few psychological resources, including the Diagnostic and Statistical Manual of Mental Disorders (“DSM” or “Manual”) IV-TR, to determine what criterion was necessary to qualify a person as having mental retardation. By citing the definition of mental retardation from the DSM in their decision, the Court acknowledged that the Manual has an important legal use; this would later influence many states to use it in the creation of their own legislation.

In May of 2013, a fifth edition of the DSM was released. In this new edition, several revisions were made to mental retardation that are different from the information provided in the DSM-IV-TR, which was the current edition during the Atkins decision. The changes made include a name change from mental retardation to intellectual disability, as well as a change in the criterion used to make a clinical diagnosis. The diagnostic

4. See Atkins, 536 U.S. at 308–09.
6. See Atkins, 536 U.S. at 308 n.3.
10. AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 33.
criteria in the new edition moves away from the prior focus on the Intelligence Quotient (“IQ”) score—an objective standard—to a concentration on a measure of the person’s adaptive functioning, which is a more subjective measure. These changes, which create a greater overall subjective standard for a diagnosis of intellectual disability, differ from those in place when the *Atkins* decision was made.

With the newly released DSM-5 starting to be used by mental health professionals, the definition in operation for intellectual disability will now be different from that in place when the *Atkins* case was decided; this change will inevitably have an impact in the legal field for criminal cases with defendants that have intellectual disabilities. This article will first discuss the facts of the *Atkins* case, as well as background information about mental retardation and the death penalty, the DSM, and the specific diagnostic standards for mental retardation that were current at the time of the *Atkins* decision. This section will provide the history and details of the *Atkins* case, as well as an explanation of the final holding of the Court. The third section will note the relevant revisions made in the DSM-5 with the shift from mental retardation to intellectual disability. The final section will analyze the differences between the DSM-IV-TR and the DSM-5. This discussion will be an attempt to predict the inevitable impact that the changes in the new edition of DSM will have on the legal system when courts are presented with mentally retarded defendants that face capital punishment; the diagnostic criteria used by professionals to assess the patient and determine a diagnosis will no longer match up with the law in most states. Additionally, the final section will hypothesize solutions to the problems that may be created by the revisions.

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12. *See Atkins*, 536 U.S. at 308–09; *AM. PSYCHIATRIC ASS’N*, DSM-5, supra note 8, at 33.
13. *See infra* Part III.
14. *See infra* Part IV.
15. *See infra* Part II.
16. *See infra* Part II.
17. *See infra* Part III.
18. *See infra* Part IV.
19. *See infra* Part IV.
20. *See infra* Part IV.A.
II. MENTAL RETARDATION AND THE DEATH PENALTY

The history of mental retardation and the death penalty is a relatively simple and straightforward one. Evidence of the relationship between the two can be seen dating back as early as the late 1700s when a person that was deemed by the court to be an idiot “was not subject to criminal liability.” By today’s standards, an idiot would be a person with severe or profound mental retardation. More recently, the Supreme Court of the United States heard the case of Godfrey v. Georgia in 1980. In this case, the Court “discussed the necessity of finding that a defendant has [a] higher moral culpability than an average criminal in order for the death penalty to be imposed.” The holding of this case will prove to be particularly important for future defendants with mental impairments when capital punishment is under consideration; their level of culpability is a factor that will be assessed by the courts as a determination of whether this punishment is appropriate.

Nine years later, the Supreme Court of the United States granted certiorari and heard the case of Penry v. Lynaugh in 1989; this was the first time the Court would address the issue of execution of a mentally retarded defendant. In this case, Johnny Paul Penry was sentenced to death after he confessed to the rape and murder of Pamela Carpenter. In state court, a clinical psychologist testified that Penry had mild to moderate mental retardation and an IQ score between fifty and sixty-three. Despite this, the jury found Penry competent to stand trial. The result of the trial was that “[t]he jury rejected Penry’s insanity defense and found him guilty of capital murder.”

23. Id. at 308.
25. Id. at 420.
27. See Godfrey, 446 U.S. at 432–33; Hagstrom, supra note 26, at 248.
29. Ellis, supra note 21, at 174.
31. Id. at 307–08.
32. Id. at 308.
33. Id. at 310.
In granting certiorari, the Supreme Court of the United States specifically addressed the question of whether “it [is] cruel and unusual punishment under the Eighth Amendment to execute a mentally retarded person.”\textsuperscript{34} The result of this case was that the Court failed to find an Eighth Amendment violation and stated that mental retardation should be viewed only as a mitigating factor when considering sentencing.\textsuperscript{35} The Court also stated that “[w]hile a national consensus against [the] execution of the mentally retarded may someday emerge . . . there is insufficient evidence of such a consensus today.”\textsuperscript{36} Despite the holding, after the \textit{Penry} decision, eighteen states enacted legislation granting categorical exemption to any mentally retarded defendant from the death penalty.\textsuperscript{37}

A. \textit{A Brief History of the Death Penalty}

Prior to \textit{Penry}, in 1972, the Supreme Court of the United States heard the case of \textit{Furman v. Georgia}\textsuperscript{38} and held that in its current use, the death penalty—also referred to as capital punishment—violated the Eighth Amendment.\textsuperscript{39} In this case, three black men had each been accused of the rape or murder of a woman and for this, they faced the death penalty.\textsuperscript{40} The Eighth Amendment “bans the use of cruel and unusual punishment.”\textsuperscript{41} Specifically, the Eighth Amendment reads, “[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.”\textsuperscript{42} In writing this amendment, the Framers of the Constitution were aiming to prevent methods of punishment that would be equivalent to torture.\textsuperscript{43} In their decision, the Supreme Court Justices had different opinions and reasoning behind their choice of whether or not the death penalty was unconstitutional per se, but did agree on the final holding that the death penalty in its current form was cruel and unusual punishment.\textsuperscript{44}

However, in 1976, the Supreme Court of the United States heard the case that established the death penalty could be reinstated and was not

\begin{itemize}
\item \textsuperscript{34} \textit{Id.} at 313.
\item \textsuperscript{35} U.S. \textit{Const.} amend. VIII; \textit{Penry}, 492 U.S. at 340.
\item \textsuperscript{36} \textit{Penry}, 492 U.S. at 340 (emphasis added).
\item \textsuperscript{37} Bonnie & Gustafson, supra note 2, at 812.
\item \textsuperscript{38} 408 U.S. 238 (1972) (per curiam).
\item \textsuperscript{39} \textit{Id.} at 239–40; Amanda M. Raines, \textit{Note, Prohibiting the Execution of the Mentally Retarded}, 53 CASE W. RES. L. REV. 171, 177–78 (2002).
\item \textsuperscript{40} \textit{Furman}, 408 U.S. at 239, 252–53 (Douglas, J., concurring).
\item \textsuperscript{41} Raines, supra note 39, at 177.
\item \textsuperscript{42} U.S. \textit{Const.} amend. VIII.
\item \textsuperscript{43} Raines, supra note 39, at 177.
\item \textsuperscript{44} \textit{Furman}, 408 U.S. at 239–40; Raines, supra note 39, at 178.
\end{itemize}
entirely unconstitutional.\textsuperscript{45} Gregg v. Georgia\textsuperscript{46} presented a case in which the defendant committed armed robbery and murder; he sought to challenge the constitutionality of his death sentence.\textsuperscript{47} The Court held that, as a penalty for murder, the death penalty does not violate the Eighth Amendment.\textsuperscript{48} “[T]he goals of retribution and deterrence of capital crimes may be permissible” as factors to be considered when making the determination of “whether the death penalty should [or should not] be imposed.”\textsuperscript{49} Simply put, to satisfy the goal of retribution, the Court must determine if the crime committed is serious enough to deserve the punishment.\textsuperscript{50} To make this determination, it is important to note, “the punishment of death is sufficiently related to an individual’s personal culpability.”\textsuperscript{51} Essentially, the levels of culpability of the offender and severity of the punishment must match.\textsuperscript{52} The theory of deterrence is based upon the idea that punishment would inhibit a criminal from engaging in that particular behavior; capital punishment can only be considered a deterrent if the murder is premeditated and deliberate.\textsuperscript{53} The reason behind that is the cause and effect relationship between the crime and the punishment.\textsuperscript{54} In making its decision, the Court noted that the punishment of death could not be said to be disproportionate to the crime of murder, in which another life is intentionally taken.\textsuperscript{55} Despite this holding, opponents to the death penalty still believe that it should be abolished completely for all offenders.\textsuperscript{56}

\textsuperscript{46} 428 U.S. 153 (1976).
\textsuperscript{47} Id. at 158, 162.
\textsuperscript{48} Id. at 207; Elmore, supra note 45, at 1295.
\textsuperscript{49} Holly T. Sharp, Determining Mental Retardation in Capital Defendants: Using a Strict IQ Cut-Off Number Will Allow the Execution of Many That Atkins Intended to Spare, 12 JONES L. Rev. 227, 229–30 (2008); see also Gregg, 428 U.S. at 183.
\textsuperscript{50} J. Amy Dillard, And Death Shall Have No Dominion: How to Achieve the Categorical Exemption of Mentally Retarded Defendants from Execution, 45 U. Rich. L. Rev. 961, 970 (2011).
\textsuperscript{51} Hall, supra note 2, at 376.
\textsuperscript{52} Hagstrom, supra note 26, at 247.
\textsuperscript{53} Hall, supra note 2, at 377.
\textsuperscript{54} Hagstrom, supra note 26, at 247.
\textsuperscript{56} Sharp, supra note 49, at 232.
B. The Atkins Case

In 2002, the Supreme Court of the United States granted certiorari in the case of *Atkins v. Virginia*, a criminal case of murder from 1996. In this case, the defendant, Daryl Renard Atkins, was convicted of abducting Eric Nesbitt, robbing him of the money that he had with him, as well as forcing him to make a cash withdrawal from an automated teller machine. That evening, William Jones was also present and participated in the abduction and robbery. Later on, Atkins and Jones, who had both been armed with semiautomatic handguns the entire time, took Nesbitt to a remote location to shoot him eight times, which resulted in his death.

“Initially, both Jones and Atkins were indicted [under a] capital murder” charge for what happened to Nesbitt. However, Jones made a deal to plead guilty to first-degree murder in return for a full testimony against Atkins; this gave him the sentence of life imprisonment and made it no longer possible for him to receive the death penalty. During Atkins’ trial, his and Jones’ stories matched up substantially with the exception as to who actually took the shots resulting in Nesbitt’s death. As Jones did not have any sort of mental deficiency, his testimony was clearer and seemingly more credible to the jury than that of Atkins; Jones’ clear testimony provided the jury with sufficient evidence of Atkins’ guilt.

In the penalty phase of the trial, Dr. Evan Nelson, a forensic psychologist, testified for the defense about his pre-trial evaluation of Atkins. Taking into consideration “interviews with people who knew Atkins, a review of school and court records, and the administration of a standard intelligence test which indicated that Atkins had a full scale IQ of [fifty-nine],” Dr. Nelson stated that Atkins was mildly mentally retarded and had been consistently throughout his life. Despite this finding provided by Dr. Nelson, the jury sentenced Atkins to death. After a second sentencing hearing due to a misleading verdict form, the jury rendered the same verdict. With influence from the dramatic shift made in state legislation in

58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.* at 307 n.1.
63. *Id.* at 307.
64. See *id.*
65. *Id.* at 308.
66. *Id.* at 308–09.
68. *Id.*
favor of protecting mentally retarded defendants that had occurred since the Penry decision, as well as the severe opinion of the dissenters, the Supreme Court of the United States granted certiorari as that someday mentioned in the Penry decision had finally arrived, and it was time to review the relationship between mentally retarded criminal offenders and the death penalty.69

C. The Diagnostic and Statistical Manual of Mental Disorders

While reviewing the facts of the case in order to reach a decision, the Court used two similar psychological definitions to clearly understand Dr. Nelson’s diagnosis that Atkins was mildly mentally retarded.70 While multiple sources for a definition exist, the Court chose to use the DSM-IV-TR and the similar definition of the American Association of Mental Retardation (“AAMR”).71 These definitions may differ in language, but offer the same conceptual information as to how to reach a diagnosis.72 Specifically, the DSM is a diagnostic manual created by the American Psychiatric Association that classifies each type of mental disorder and provides diagnostic criteria to be used for a diagnosis.73 The DSM is particularly important, as it is the manual used by mental health professionals to make a diagnosis for a patient.74 Psychologists and psychiatrists—and their work—are important in the legal arena, as they serve as expert witnesses in cases where the defendant’s mental health is called into question.75

In the United States, the DSM is the primary tool used for mental health professionals to make their diagnoses.76 The DSM uses a multiaxial system, which assesses an individual on five different axes.77 These axes each refer to a different area of information about that person, which helps the clinician in creating a comprehensive evaluation of the person.78 This system also contributes to a convenient format that allows the universal

70. Atkins, 536 U.S. at 308 & n.3.
71. Id. at 308 n.3.
72. Bonnie & Gustafson, supra note 2, at 819.
73. John A. Zervopoulos, The Diagnostic and Statistical Manual of Mental Disorders (DSM): An Overview, in 2 EXPERT WITNESS MANUAL 1, 3 (1999); AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxiii.
74. Zervopoulos, supra note 73, at 3.
75. See id. at 2.
76. Id. at 3.
77. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 27.
78. Id.

https://nsuworks.nova.edu/nlr/vol38/iss2/6
understanding of the diagnosis. In addition to diagnosis, the DSM also serves as a tool to develop treatment plans and anticipate treatment outcomes. DSM is so widely accepted that it is also used by the insurance industry to determine appropriate reimbursements for psychological treatments.

As noted, psychologists and psychiatrists use the DSM in their clinical practices to make diagnoses and can serve as expert witnesses in death penalty cases involving potentially mentally retarded defendants. The expert must assess the defendant as they would if the defendant individually sought their help in a private practice. Diagnosis is particularly important for a mental health professional serving as an expert in a capital case as their diagnosis will be determinative of the defendant’s fate; it is a life or death determination. While it may not be a perfect forensic tool and was not specifically designed for legal use, due to its importance and overwhelming use in the mental health field, the Court chose to refer to the DSM for information about the psychiatric diagnosis of mental retardation. It has continued to be heavily relied upon for legal determinations that involve some sort of mental impairment or dysfunction.

DSM-IV-TR, the edition reviewed by the Supreme Court of the United States in Atkins, does include a section in the introduction that cautions about forensic usage of the Manual. It states “dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.” It could be argued that this warning is suggesting that mental health professionals should limit their conduct to their own field of expertise as the DSM is intended for

79. Id.
80. Zervopoulos, supra note 73, at 4.
81. Id.
83. See id.
84. Id.
85. See Hagstrom, supra note 26, at 265.
88. Atkins, 536 U.S. at 308 n.3; AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxxii–xxxiii.
89. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxxiii.
use of diagnosis in the mental health field and not for legal determinations. The addition of legal information into the DSM would prove to be more problematic than helpful, which is why forensic additions have not been included in new editions of the Manual. However, it is noted in the DSM that with proper awareness of the risks and limitations, the DSM should properly assist legal decision-makers in reaching their final conclusion.

Despite the brief textual warning in the introduction that the DSM should not be used for forensic purposes, as information may be misrepresented, it is frequently used when law and psychology or psychiatry intersect. “Courts, legislators, and government[al] agencies have relied on the DSM[] as a persuasive” tool when making decisions in cases that involve mental illness. For example, some state and federal statutes make use of DSM definitions of mental illness or diagnostic criteria. Some states make specific mention of the DSM while others just use the language found in it. The DSM is cited over 5500 times in court opinions, including other death penalty cases. Courts have also referred to the DSM with the use of highly respectful terms in several decisions. It is clear that the DSM has played an important role in the legal world—through the development of legislation and decisions made in the courtroom—and it will continue to do so.

1. Mental Retardation

As stated, the edition of the DSM that was current and in use during Atkins was the DSM-IV-TR, which is a textual revision of the fourth edition. According to the DSM-IV-TR, mental retardation “is characterized by significantly subaverage intellectual functioning—an IQ of approximately [seventy] or below—with onset before age [eighteen] years

92. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxxii.
93. Slovenko, supra note 91, at 6.
96. Id. at 97–98.
97. Slovenko, supra note 91, at 6, 8.
99. See Slovenko, supra note 91, at 11.
100. Atkins v. Virginia, 536 U.S. 304, 308 n.3 (2002); AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxix.
and concurrent deficits or impairments in adaptive functioning. At the time of publication, the prevalence rate of mental retardation was estimated to be one percent of the population. The estimated number of incarcerated offenders is two percent to twenty-five percent. Between four percent and twenty percent of the offenders currently on death row are estimated to be mentally retarded; of the three thousand five hundred, this comes out to about one hundred forty to seven hundred people. This is a significant number of people, which stresses why diagnosis is so important and will impact the implementation of the Atkins holding; it could result in pardons from the death penalty.

The DSM-IV-TR defines the diagnostic features of mental retardation as including three necessary criterions.

The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age [eighteen] years (Criterion C).

Each of the three diagnostic criterions is equally as important; all are necessary for a person to receive a diagnosis of mental retardation and one cannot be omitted. For example, even if an individual has an IQ score lower than seventy, a diagnosis cannot be made if there is no impairment in adaptive functioning. Per Criterion B, adaptive functioning is defined as “how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.” This serves as a protection to ensure that the person is not just a

102. Id. at 46.
104. Id. at 85–86.
105. Id. at 85–86.
106. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 41.
107. Id.
108. See id. at 41–42, 47.
109. Id. at 42.
110. Id.
bad test-taker. Adaptive functioning includes “self-direction, functioning academic skills, work, leisure, health, safety, personal hygiene, self-control, and aspects of unmanageable behavior” which are each taken into account when a determination for adaptive functioning is made. Any third-party contacts need to be carefully and thoroughly questioned about the individual in order for an accurate evaluation of adaptive functioning to be made. Assessments do exist, but this type of determination is not one that is easily assessed by a standardized test.

The third and final prong, that is equally as important for diagnosis, is that mental retardation exists and will present itself in childhood. Criterion C sets the specification that the person must show signs of cognitive impairment before the age of eighteen. What this means is that a person with seemingly normal cognitive function cannot unexpectedly become mentally retarded as an adult. This criterion is also in place to help clinicians with differential diagnosis; this allows them to distinguish between mental retardation and other intellectual deficits that can be acquired later in life due to a dramatic change such as brain trauma or disease. Additionally, while a mentally retarded person can be taught certain skills that can help them function in society in a more normal way, they can never be fully cured with therapy; this is a chronic condition. When Criterion C is evaluated along with the first two criterions, if a diagnosis of mental retardation is made, it can be sure that it is one that would reflect the person as a whole including their psychosocial and cognitive functioning.

A diagnosis of mental retardation is further divided into four varying degrees of severity: Mild, moderate, severe, and profound. The degree of severity that is most questioned in a legal setting, particularly in Atkins cases, is the lowest level—mild mental retardation—which is defined as having an

111. JAMES R. EISENBERG, LAW, PSYCHOLOGY, AND DEATH PENALTY LITIGATION 113 (2004).
112. Id. at 113–14.
113. Id. at 113.
114. See id.; Bonnie & Gustafson, supra note 2, at 846–47.
115. Raines, supra note 39, at 176.
116. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 41.
117. Raines, supra note 39, at 176.
118. Bonnie & Gustafson, supra note 2, at 854.
119. Raines, supra note 39, at 176.
120. EISENBERG, supra note 111, at 114; AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 41.
121. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 39.
“IQ level [fifty to fifty-five] to approximately [seventy].”\textsuperscript{122} Why is that? It is because this group is the closest or borderline to the level of normal cognitive functioning.\textsuperscript{123} This group, mild mental retardation, is the largest group consisting of approximately eighty-five percent of those who have mental retardation.\textsuperscript{124} They are described as having the “social and vocational skills adequate for minimum self-support.”\textsuperscript{125} Those with this low degree of severity should live successfully in a community setting either on their own or under supervision.\textsuperscript{126}

2. Intelligence Quotient

For Criterion A of a mental retardation diagnosis, general intellectual functioning is measured and classified by an IQ score.\textsuperscript{127} In order to assess subaverage intellectual functioning, it is necessary to implement an intelligence test.\textsuperscript{128} Several IQ tests exist and are used in psychometric testing, so a single individual may have multiple true IQ scores based upon their performance on each test they have taken.\textsuperscript{129} The standard and most frequently used tests are the Wechsler Adult Intelligence Test, 3rd edition (“WAIS-III”) and the Standford-Binet.\textsuperscript{130} These assessments are designed to measure a person’s general intelligence score by assessing a broad range of skills that produce a final numerical score that correlates to his or her level of mental functioning.\textsuperscript{131}

This score, as it is assessed through the psychometric measures, is an objective measure of a person’s cognitive performance.\textsuperscript{132} The person’s raw
score is compared to a norm that is predetermined to reach his or her result IQ score.  

133 Dowling, supra note 130, at 798–99; Fabian et al., supra note 82, at 414; see also Gresham, supra note 122, at 93.

134 Bonnie & Gustafson, supra note 2, at 825.

135 See Gresham, supra note 122, at 92.

136 Clark, supra note 7, at 137; Rumley, supra note 128, at 1317.

137 Sharp, supra note 49 at 231.

138 AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 41–42.

139 Rumley, supra note 128, at 1329.

140 Id. at 1333–34.

141 See Gresham, supra note 122, at 96.

142 Tobolowsky, supra note 103, at 95.

143 Gresham, supra note 122, at 93.
Flynn also believes that intelligence of a single individual does not change, but the norm changes over time; it could be said that the Flynn Effect has no impact on death penalty cases as it only concerns norms. However, the problem arises when the IQ assessment used produces scores that rely entirely on comparison to the norms for their meaning. It has also been found that individuals may score differently on an intelligence test depending on which point in the norming cycle the person took the assessment. For example, a person’s performance may result in a score in the mentally retarded range in the beginning of the cycle of a certain assessment and in a more borderline range at the end of the cycle of that same assessment.

The other important discrepancy with IQ assessment scores is practice effects, which is the theory that those with cognitive dysfunction are often administered multiple tests throughout their lifetime and that causes inflated IQ scores. Due to this, it is known that practice effects occur, and scores can increase due to the repeated administration of the measures; a useful rule of thumb is to only use each assessment once a year with an individual to reduce this effect. It is important to note that the smaller the time interval between administrations of the test, the larger the practice effect can be. The specific outcome of practice effects can also vary; factors that can alter the performance include “the person’s age, their learning ability and the time interval between testing.” This effect becomes problematic when a person shows an overall increase in their IQ score, but continues to display the same deficits in their adaptive functioning.

Additionally, race and socioeconomic background have also been found to alter an individual’s IQ score. Another possible influence on IQ score is that a defendant may be able to fake their mental retardation by purposely doing poorly on an IQ test; the faking of a mental illness is known as malingering. However, even if attempted, the faking of a low IQ score is difficult to do, and the IQ score is not the only consideration in a

144. Id.
145. Id. at 94.
146. Id.
147. Eisenberg, supra note 111, at 113.
148. Id.
149. Gresham, supra note 122, at 94–95.
150. Bonnie & Gustafson, supra note 2, at 839; Gresham, supra note 122, at 95.
151. Gresham, supra note 122, at 95.
152. Bonnie & Gustafson, supra note 2, at 839.
153. Id. at 840.
155. Id. at 245.
diagnosis.\textsuperscript{156} Despite the possibility that there may be some flaws in the IQ testing system, the IQ score has remained an important factor in determining the intellectual functioning of a person under the diagnostic criteria DSM-IV as it is a more objective measure used by the mental health professional to assess a person’s overall cognitive functioning; it has been continually used in courts as well.\textsuperscript{157} Between adaptive functioning and IQ level, the cognitive IQ tends to be the more stable of the two.\textsuperscript{158} However, some believe the IQ score should not be the sole measure used to determine mental retardation, and thus may not be suited for a legal use.\textsuperscript{159}

3. Adaptive Functioning

Criterion B describes a more subjective way of assessing the intellectual functioning of an individual by means of their adaptive functioning.\textsuperscript{160} This element, also referred to as adaptive behavior, includes the mental health professional’s assessment of how much service or support that a mentally retarded person needs.\textsuperscript{161} These limitations would affect the individual’s daily life as well as any stressors in his or her daily life or immediate environment.\textsuperscript{162} This measure is looking to “assess deficits in the performance of adaptive behavioral skills, even more than in the acquisition of such skills.”\textsuperscript{163} The reason that this measure is so subjective is that mental health professionals must rely upon interviews and other information collected from third parties to make their assessment.\textsuperscript{164} Other records, such as those from school, medical professionals, employment, etc., are also consulted, but those are also the result of a third party’s opinion or interpretation.\textsuperscript{165} In addition, over two hundred instruments are available to be used as a standardized assessment of adaptive behavior, but these assessments face the same level of scrutiny as IQ assessments; the large number of available tests shows the level of uncertainty as to what exactly is to be tested to make the determination.\textsuperscript{166} Overall, this assessment is

\textsuperscript{156} Id. at 246–47.
\textsuperscript{157} See Gresham, supra note 122, at 93.
\textsuperscript{158} AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 42.
\textsuperscript{159} See Rumley, supra note 128, at 1333; Sharp, supra note 49, at 243.
\textsuperscript{160} AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at 41–42; see also Bonnie & Gustafson, supra note 2, at 849; White, supra note 130, at 699.
\textsuperscript{161} White, supra note 130, at 699.
\textsuperscript{162} Id. at 700.
\textsuperscript{163} Tobolowsky, supra note 103, at 96–97.
\textsuperscript{164} White, supra note 130, at 700.
\textsuperscript{165} Id.
\textsuperscript{166} Bonnie & Gustafson, supra note 2, at 846; see White, supra note 130, at 700.
particularly important for individuals with mild mental retardation, as it may be the determining factor in diagnosis when the IQ score is close to borderline range.167

D. The Atkins Decision

The Court, by making use of a clinical definition of mental retardation, “put professional standards of measurement, assessment, and diagnosis in the center of Atkins adjudications.”168 The decision in Atkins creates law that is highly dependent on psychological determinations.169 With the use of the clinical definition of mental retardation and psychometric measure of IQ score, the Court concluded that the death penalty is not an appropriate punishment for a criminal defendant that is mentally retarded.170 The Court reasoned that the mentally retarded defendant was “categorically less culpable than the average criminal.”171 The public consensus from the consistency in direction of change shown by the states was also a contributing factor to the decision.172 The Court noted that it was “not so much the number of these states that is significant, but the consistency of the direction of change.”173 While looking at this, the Court found that mentally retarded defendants should be punished in some way, but the death sentence is not appropriate due to their lower level of personal culpability.174

The Court also held that execution of a mentally retarded person failed to meet either of the two goals of capital punishment, retribution or deterrence.175 These societal functions that the death penalty is supposed to accomplish are not obtained with mentally retarded defendants.176 The goal of retribution cannot be met with those that have mental impairments as they are held to have a lower level of culpability.177 Therefore, in order “to ensure that only the most deserving of execution are put to death, an exclusion for the mentally retarded is appropriate.”178 Deterrence is not met either due to

167. Bonnie & Gustafson, supra note 2, at 847.
168. Id. at 825.
169. Id. at 813.
172. Atkins, 536 U.S. at 315; Hall, supra note 2, at 370.
174. Hagstrom, supra note 26, at 250.
176. Clark, supra note 7, at 126.
177. Hall, supra note 2, at 376–77.
178. Atkins, 536 U.S. at 319.
the fact that the Court has held that a defendant with mental impairment cannot make the appropriate connection between his or her impulsive conduct—i.e. murder of another person—with the future punishment of death due to the imposition of the death penalty. The inability to further these two goals of the death penalty contributed to the Court’s decision to provide a categorical exemption.

A final consideration made by the Court was that mentally retarded defendants face a higher possibility of wrongful execution. By nature of their condition, mentally retarded defendants are at a disadvantage when it comes to their defense. Mentally retarded defendants serve as poor witnesses, do not serve as much help to their defense counsel, can get confused easily, can appear to feel no remorse, and suffer other seemingly negative results of their diminished capacity. In addition, mentally retarded defendants have a much larger risk of making a false confession than defendants with standard intellectual functioning. All of these factors were considered and contributed to the Court’s decision that mentally retarded defendants should belong to a categorical exemption and should not face the death penalty.

This decision is a unique one, as it expresses a constitutional rule that is entirely dependent on a definition and diagnostic criteria from clinical psychology. In this case, the Court established “a per se rule exempting all persons with mental retardation from the death penalty based on diagnosis alone.” The exemption includes all people with the diagnosis regardless of what level of severity they are found to have. This makes the important question to be answered in these types of cases to be whether or not the defendant is mentally retarded; this is something that the Court disagreed on how to determine and left this decision to the states. The class that will prove to be the most difficult to protect and have the most controversy is the mildly mentally retarded as they come closest to the normal border range.

179. Dillard, supra note 50, at 971.
181. Atkins, 536 U.S. at 321; Hagstrom, supra note 26, at 252.
182. Hagstrom, supra note 26, at 252.
183. Atkins, 536 U.S. at 320–21; Hagstrom, supra note 26, at 252.
184. Hagstrom, supra note 26, at 252.
185. Id.
186. Bonnie & Gustafson, supra note 2, at 813.
187. Id. at 814.
188. Id. at 823.
190. See Gresham, supra note 122, at 92; Tobolowsky, supra note 103, at 88.
However, even with this decision, which essentially overrules Penry, the death penalty remains an appropriate punishment “for a smaller, more culpable class of defendants.”

Justice Scalia makes an additional point about the purpose of the death penalty in his dissent. An additional purpose of the death penalty is to eliminate dangerous offenders; by doing this, the future crimes that they may commit are effectively prevented. It is quite clear that this goal is reached by the death penalty, as these offenders would no longer commit any crimes. This, however, is a purpose that would be properly served regardless of how high or low the offender’s IQ score is.

1. Determinations Left to the States

In making its decision, the Court neglected to implement a procedure or designate a specific definition to be applied to determine if a defendant is mentally retarded. By doing this, the Court left state lawmakers and officials, and in a way, forensic psychologists or psychiatrists, the task of determining how exactly to enact and properly implement their decision. The Court established some guidance by providing two similar definitions in the cases that implement the same three main criteria for a diagnosis. It could also be argued that the Court intended for the states to adopt one, or a hybrid form of the two definitions cited in the decision, due to their similarities. Its main determination was to justify the exemption of mentally retarded defendants from the death penalty; the exact way to enforce the exemption was not determined. Instead, the Court left this task up to the states, as it had done in Ford v. Wainwright for the determination of competency, and it became the task of the states to develop the

191. White, supra note 130, at 687; see also Shin, supra note 189, at 481.
192. Elmore, supra note 45, at 1330.
193. Id.
194. Id.
195. Id.
196. Dillard, supra note 50, at 969.
198. Bonnie & Gustafson, supra note 2, at 812–13, 819.
199. Id. at 818–19.
200. Dillard, supra note 50, at 979.
201. 477 U.S. 399 (1986). “[T]he Eighth Amendment prohibits states from carrying out the death penalty on defendants who are insane. . . . However, the Court left it to the individual states to determine the definition of competence for execution and the procedures they should use to assess whether a prisoner meets the standard [for] insanity.” Shin, supra note 189, at 474.
appropriate means of enforcement.\textsuperscript{202} Many states have chosen to use the DSM-IV-TR as their guidelines for making the determination of whether or not a defendant is mentally retarded.\textsuperscript{203} If a state were to fail to exclude the mentally retarded from facing the death penalty, that state would be in direct violation of the Eighth Amendment.\textsuperscript{204} Despite this, after the decision was made, state courts that did not agree with the decision could potentially use this freedom from the Court and lack of a uniform standard as a way to evade the Atkins decision.\textsuperscript{205}

The possibility of other complications arose for all states that complied; for example, the differences and discrepancies between the states allow for the possibility that one individual “could be found [to be] mentally retarded in one state, but not . . . another.”\textsuperscript{206} It depends on the exact language that was chosen by the state to be enacted in its legislation to determine what constitutes mental retardation.\textsuperscript{207} Even without giving a direct definition for mental retardation, some argue that the Court should have advised that the states not place as much weight on IQ test scores as they do.\textsuperscript{208} However, many states seem to agree that the IQ score cutoff is a particularly important factor to include in their legislation.\textsuperscript{209} There are significant differences amongst the states; some are strict on the IQ score requirement, while others are more vague by only demanding subaverage intellectual functioning.\textsuperscript{210}

In addition to a definition, the Court also left it up to the states to determine the specifics of the procedure, including determining who would be the fact finder, at which stage the mental functioning of the defendant should be assessed, and what the suitable burden of proof would be.\textsuperscript{211} For example, a majority of states with judicial procedures in place have chosen to make this determination prior to the start of trial.\textsuperscript{212} Some states give the task of determining mental retardation to a jury, while others give it to a trial judge.\textsuperscript{213} By neglecting to designate a specific definition and procedure to

\begin{flushleft}
\textsuperscript{202} Ford, 477 U.S. at 416–17; Dillard, supra note 50, at 978.
\textsuperscript{203} Clark, supra note 7, at 137.
\textsuperscript{204} White, supra note 130, at 688.
\textsuperscript{206} Hagstrom, supra note 26, at 260.
\textsuperscript{207} See id.
\textsuperscript{208} Id. at 262–63, 265.
\textsuperscript{209} Id. at 265.
\textsuperscript{210} Paul S. Appelbaum, Mental Retardation and the Death Penalty: After Atkins, 60 PSYCHIATRIC SERVICES 1295, 1296 (2009).
\textsuperscript{211} Blume et al., supra note 205, at 626–27.
\textsuperscript{212} Tobolowsky, supra note 103, at 114.
\textsuperscript{213} Dillard, supra note 50, at 966.
\end{flushleft}
follow, the Court allows for considerable differences to exist from state to state.\textsuperscript{214} These inconsistencies and differences in procedure and definition could cause contradictory rulings on whether or not a defendant has mental retardation.\textsuperscript{215}

2. Other Issues in Applying the Decision

Several other points of ambiguity and perplexity came to light with the \textit{Atkins} decision, such as the fact that the Court created a categorical exemption in the \textit{Atkins} case.\textsuperscript{216} The use of this general categorization of exemption for those with mental retardation eliminates the entire idea of individual sentencing in our legal system as far as this specific group of individuals is concerned; it separates those with mental retardation from everyone else.\textsuperscript{217} Beyond the separation between those with normal cognitive functioning and those with impairments, the categorization treats all those with mental retardation the same without any sort of distinction made for the varying degrees of mental retardation.\textsuperscript{218} This creates a level of equality amongst those with the disorder while diagnosis makes a differentiation.\textsuperscript{219}

In neglecting to provide a uniform standard for mental retardation, there is also an issue with IQ assessment.\textsuperscript{220} Multiple assessment tools exist to make an assessment, but each has their own set of norms.\textsuperscript{221} The lack of uniform testing requirements may be highly problematic.\textsuperscript{222} Without a set rule as to which test to use, psychologists must be ethical in their determination of which test to administer; they must administer a current edition of an assessment that they have the appropriate level of proficiency to administer.\textsuperscript{223} The presence of a uniform rule as to which test to use would eliminate some of the possible errors and ethical violations that can potentially occur.\textsuperscript{224} The uniform rule would have to be updated frequently as these tests are often revised and the courts would have to use a current test.\textsuperscript{225} However, on the other side, the benefits of uniformity could be

\begin{footnotes}
\item Hall, supra note 2, at 385.
\item Hagstrom, supra note 26, at 260.
\item Id. at 250; see also Atkins v. Virginia, 536 U.S. 304, 321 (2002).
\item Elmore, supra note 45, at 1337.
\item Id.
\item See id.
\item Dowling, supra note 130, at 807.
\item See id. at 799–800.
\item See id. at 807.
\item See id. at 808.
\item See id. at 810.
\item Bonnie & Gustafson, supra note 2, at 828.
\end{footnotes}
outweighed by other disadvantages such as individualized selection for the defendant and that the clinician should administer the test they feel most competent using.226

Another important point is potential ethical dilemmas that will be faced by the mental health professionals who will be assessing the specific defendant.227 One of the main issues that will be faced by any forensic psychologist is that they have the potential to do harm to their client; psychologists, under their ethics code, are not to do any harm to their clients.228 Additionally, these psychologists must be sure to go into their assessment of the defendant without any sort of preconceived thoughts about the crime on trial or what the outcome should be.229 Psychologists have to be mindful of any possible factor that may cause an unfair or incorrect result on the IQ assessment and properly account for these potential issues in their determination and assessment.230 The psychologists in these cases are faced with several potential ethical issues that they must avoid while trying to generate the most honest and truthful assessment that they can.231

3. Cases Since Atkins

In the time since the Atkins decision, many courts have encountered cases with mentally retarded defendants.232 However, the floodgates did not open for this type of litigation as was feared in the dissent by Justice Scalia; there has not been a complete overflow of claims by criminal offenders claiming to have mental retardation.233 Research shows that of the claims made that have lost, most failed to prove either subaverage intellectual functioning or significant limitations in adaptive functioning.234 Data also shows that the Atkins decision has not been applied to the states in a uniform way as could be expected from the differing legislation created by each state.235

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226. Id.
228. Id.
229. Id. at 125.
230. Id. at 128.
231. See id. at 121–23.
232. E.g., Jackson v. State, 963 So. 2d 150, 152 (Ala. Crim. App. 2006); see also Blume et al., supra note 205, at 625, 628, 630.
234. See Blume et al., supra note 205, at 629–30.
235. Id. at 629, 639; Elizabeth Dilts, Lawyers Worry New Measure of Mental Retardation Could Prompt More Executions, REUTERS LEGAL, May 13, 2013, available at http://archive.is/ToBPv.
In regard to intellectual functioning, or analysis of the IQ score, prior clinical research suggests that this should be only “a gateway to a rigorous assessment of adaptive functioning.”236 This is because it is believed that the employment of a strict cut-off of a score of seventy may wrongly exclude those who deserve protection under Atkins.237 In an analysis of multiple jurisdictions with various IQ cutoff points, it was found that over sixty percent of those who successfully prove intellectual impairment had no reported IQ scores over the score of seventy; it is also noted that fifteen percent of defendants that have been successful with their Atkins claim have had IQ scores that exceed seventy.238 A small number of successful Atkins claims involve defendants that have never scored below a seventy on any intellectual assessment.239 However, there have also been cases with less success that focus on IQ score; one example is a case in Texas, where a defendant met the requirement of having an IQ below seventy, but was not exempted from capital punishment.240

There have been almost one hundred cases since the ruling in Atkins in which defendants with death penalty sentences have been reduced when the courts found that they met the necessary requirements to prove they were mentally retarded.241 This is an impressive statistic considering that between 1976 and 2002, prior to Atkins, there were at least forty-one defendants executed who would have been found to be mentally retarded and could have been exempted.242 However, it seems less impressive when it is stated that only a quarter of the inmates that have claimed to be mentally retarded have received a stay of execution since the Atkins holding.243 Data shows that there have been varying levels of success for proving adaptive deficits; depending on which skill set was chosen as the definition for mental retardation, which includes several.244 There have also been very few cases that lose solely on the third prong, which requires onset before the age of

236. Blume et al., supra note 205, at 631.
237. Id. at 631–32.
238. Id. at 632.
239. Id.
240. Dilts, supra note 235.
243. Dilts, supra note 235.
244. Blume et al., supra note 205, at 634.
eighteen. Together, these results show the inconsistency of the implementation of Atkins.

III. THE DSM-5

The latest edition of the Manual was released in late May of 2013. This edition has been a work in progress for fourteen years as its development began immediately following the release of DSM-IV. DSM-5 was developed in hope of addressing concerns that had existed with the prior editions. It was also created in order to match up more closely with the World Health Organization (“WHO”) and their International Classification of Diseases (“ICD”) as well as other important leading health organizations; this will provide for more uniform diagnoses in the health system. The newest edition of the Manual features several differences compared to prior editions, such as a different organizational layout and a removal of the prior multi-axial system. In this edition, all mental disorders are considered to be on a single axis and are therefore, given equal weight; prior editions had five axes of unequal weight. It is also the first edition not to make use of traditional Roman Numerals because this edition is intended to be a living document. The believed explanation for this change to Arabic Numeration is that when new evidence surfaces or changes occur, the Manual can be changed online which will produce constant revisions, which will produce more editions labeled with a decimal. Each change and revision was made

245. Id. at 636.
246. Id. at 639.
249. Regier et al., supra note 248, at 646.
250. Regier et al., supra note 248, at 647; Luis Salvador-Carulla et al., Intellectual Developmental Disorders: Towards a New Name, Definition and Framework for “Mental Retardation/Intellectual Disability” in ICD-11, 10 WORLD PSYCHIATRY 175, 175 (2011); Intellectual Disability, supra note 9.
252. Wakefield, supra note 251, at 142; Intellectual Disability, supra note 9.
253. Wakefield, supra note 251, at 140.
254. Id.
255. Id.
carefully to improve the Manual and provide more effective treatment and services.\textsuperscript{256}

A. \textit{Intellectual Disability (Intellectual Developmental Disorder)}

The American Psychiatric Association states that “[t]he significant changes [to intellectual disability] address what the disorder is called, its impact on a person’s functioning, and criteria improvements to encourage more comprehensive patient assessment.”\textsuperscript{257} In DSM-5, the first and most noticeable difference to mental retardation is the name change; mental retardation is now referred to as intellectual disability (intellectual developmental disorder).\textsuperscript{258} “[T]he parenthetical name . . . is included in the text to reflect deficits in cognitive capacity beginning in the developmental period.”\textsuperscript{259} This change occurred for reasons including “policy, administrative, and legislative purposes.”\textsuperscript{260} The new terms were carefully selected to be widely used and understood\textsuperscript{261} as of when this name was determined.\textsuperscript{262} The phrase \textit{intellectual disability} is one that is commonly used in the medical, educational, and other professional fields.\textsuperscript{263} This name change will allow for a more universal understanding of what exactly the disability is.\textsuperscript{264}

In addition to the name change, the fifth edition emphasizes adaptive functioning of the individual as opposed to the more heavy reliance on the IQ score that is seen in DSM-IV-TR.\textsuperscript{265}

DSM-5 emphasizes the need to use both clinical assessment and standardized testing of intelligence when diagnosing intellectual disability, with the severity of impairment based on adaptive functioning rather than IQ test scores alone. By removing IQ test scores from the diagnostic criteria, but still including them in the text description of intellectual disability, DSM-5 ensures that they are not overemphasized as the defining factor of a person’s overall

\begin{thebibliography}{99}
\bibitem{256} \textit{Intellectual Disability}, supra note 9.
\bibitem{257} Id.
\bibitem{258} \textit{AM. PSYCHIATRIC ASS’N}, DSM-5, supra note 8, at 33; \textit{Intellectual Disability}, supra note 9.
\bibitem{259} \textit{Intellectual Disability}, supra note 9.
\bibitem{260} Salvador-Carulla et al., supra note 250, at 175.
\bibitem{261} Id. at 176–77.
\bibitem{262} Id. at 177.
\bibitem{263} \textit{AM. PSYCHIATRIC ASS’N}, DSM-5, supra note 8, at 33.
\bibitem{264} See id.
\bibitem{265} Wakefield, supra note 251, at 143.
\end{thebibliography}
ability, without adequately considering functioning levels. This is especially important in forensic cases.266

Furthermore, the specification that the disability must be present prior to the age of eighteen is removed and replaced with a more generalized categorization of beginning in the developmental stage.267 This edition does have some consistency with the prior edition as it states that the prevalence rate of intellectual disability remains at one percent of the population268 and still makes use of the four specifications for the degrees of intellectual disability: Mild, moderate, severe, and profound.269 However, these degrees of severity are now “defined on the basis of adaptive function[,] and not IQ scores“ as it is the level of adaptive functioning that determines the level of support that will be required for each level of severity.270

1. Diagnostic Features

DSM-5 defines intellectual disability as “a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.”271 In order to receive this diagnosis, there are three criteria that must be met by the individual, which was also true in the prior edition.272 In this edition, the diagnostic features of intellectual disability are:

The essential features of intellectual disability (intellectual developmental disorder) are deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual’s age-, gender-, and socioculturally matched peers (Criterion B). Onset is during the developmental period (Criterion C). The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions.273

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266. *Intellectual Disability*, supra note 9.
270. *AM. PSYCHIATRIC ASS’N, DSM-5*, supra note 8, at 33.
271. *Id.*
272. *Id.*; *AM. PSYCHIATRIC ASS’N, DSM-IV-TR*, supra note 5, at 41.
In regard to Criterion A, this refers to intellectual functioning. To meet this, there must be “[d]eficits in intellectual functions . . . confirmed both by clinical assessment and individualized, standardized intelligence testing.” This includes things such as abstract thinking, practical understanding, planning, and problem solving. IQ scores are used to determine part of this and are only approximations of the individual’s intellectual functioning. Clinical judgment should always be used when interpreting the results of an IQ assessment to determine the level of intellectual function.

Criterion B assesses “[d]eficits in adaptive functioning that result in [the] failure to meet developmental and sociocultural standards for personal independence and social responsibility.” Adaptive functioning is assessed in two ways; it is done with both clinical evaluations as well as with the use of individualized psychometric measures. “Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life . . .” There are three domains that are assessed by this criterion: Conceptual, social, and practical.

The conceptual—academic—domain involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations, among others. The social domain involves awareness of others’ thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The practical domain involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others.

This criterion is met when at least one of the domains of adaptive functioning is sufficiently impaired. Sufficient impairment is when the person needs continual support in order to perform that function adequately in at least one
life setting. Additionally, these adaptive functioning deficits must be directly related to the intellectual deficit assessed for Criterion A.

The final necessity, Criterion C, is that “[o]nset of intellectual and adaptive deficits [is] during the developmental period.” Specifically, the phrase developmental period refers to either childhood or adolescence; there is no specific numerical age assigned to this period of time. The removal of the cut-off age of eighteen is a significant change as this new term allows for more subjective discretion. The DSM-5 states that the time of onset may vary from person to person as it is dependent upon the specific and individualized level of brain dysfunction. In order to make a proper diagnosis, Criterion C, as well as both Criterion A and B, must be met by the individual either within their specific history or past presentations or their current presentation; in other words, all three must be met in order for an individual to receive this diagnosis. The intended purpose of all of these revisions was to “help clinicians develop a fuller, more accurate picture of patients, a critical step in providing them with” treatment personally tailored to each specific individual which will make it as effective as possible.

B. Cautionary Statement for Forensic Use

In its first few pages, the DSM-5 offers a cautionary statement towards its use in forensic settings; this warning receives much more emphasis compared to prior editions as it receives its own full page and separate heading. It warns that it has been designed to assist mental health clinicians in their work such as with assessments, diagnosis of patients, and treatment plans. The warning stresses that the definition in this edition was not developed to meet the needs of legal professionals. However, the statement also states that if used appropriately, the DSM-5 can serve as a useful tool to assist those in the legal profession to make necessary decisions by providing the necessary information for a legal decision maker to

285. Id.
286. Id.
287. Id. at 33.
288. AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 38.
289. See id.
290. Id.
291. Id.
292. Intellectual Disability, supra note 9.
293. AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 25.
295. AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 25.
296. Id.
understand the specific characteristics of a certain mental disorder. An important point, particularly when assessing mental retardation, is that the DSM-5 provides “diagnostic information about the longitudinal course [which] may improve decision making when the legal issue concerns [the] individual’s mental functioning at a past or future point in time.”

However, as with prior editions, this edition does stress that the information within its pages poses a risk for misuse or misunderstanding. It is noted that there is an imperfect fit between the DSM-5 information for a clinical diagnosis and “the questions of ultimate concern to the law.” It also stresses the importance of only trained, mental health professionals using the Manual for the diagnosis of mental disorders. Finally, the warning concludes that while the DSM-5 could be a helpful tool in the legal field when used appropriately, it is important to note that the meeting of all criteria for a certain disorder does not demonstrate the person’s behavior in the particular moment in question.

IV. IMPLICATIONS OF THESE CHANGES

As the DSM-5 has just been released, the direct result of the changes remains to be seen, but it is inevitable that there will be ramifications regarding the nation’s categorical ban of defendants with intellectual disability from the death penalty. The now outdated DSM-IV-TR was used as a guideline for many states when they created their legislation regarding capital punishment for offenders with intellectual disability. As mental retardation was revised to intellectual disability and the diagnostic criteria has been revised, discrepancies and issues are likely to surface over time in regard to the exact definition of intellectual disability for diagnosis. It will be important to deal with any issues quickly as this determination could mean the difference between life and death for criminal defendants. The issues that will arise will be the direct result of the varying procedures and definitions implemented by the each state’s legislation at the result of the

297. Id.
298. Id.
299. See AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxxvii; AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 25.
300. AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 25.
301. Id.
302. Id.
303. See id. at 33; Dilts, supra note 235; Hass, supra note 87, at 684.
304. AM. PSYCHIATRIC ASS’N, DSM-IV-TR, supra note 5, at xxiii, 39; Clark, supra note 7, at 137.
305. Appelbaum, supra note 210, at 1296.
306. Id.
Atkins case and definition and diagnostic criteria for the psychological field in the DSM-5.\textsuperscript{307} The importance and use of the DSM in fields outside of psychology is often overlooked, as are the implications of revisions made to the Manual.\textsuperscript{308}

The IQ score is highly emphasized in many state definitions, but has been removed from the diagnostic criteria in the DSM-5.\textsuperscript{309} It can easily be understood why it is hypothesized that this will cause confusion; a defendant may meet the criterion for intellectual disability by an expert witness, but may not meet the legislative standards for that state.\textsuperscript{310} The removal of the focus on the objective assessment of an IQ score will inevitably cause trouble in the courtroom as it “has traditionally been at the core of diagnosing” intellectual disability.\textsuperscript{311} The focus for judges, attorneys, and psychologists tends to remain on the IQ score.\textsuperscript{312} Even with the possible negative effects, such as the Flynn Effect, the IQ score earned an important spot in many state definitions.\textsuperscript{313} Variation did exist in the exact cut-off IQ score used by states.\textsuperscript{314} For example, several states require an IQ below sixty-five while others chose the traditional cut-off of seventy; however, there are also states that chose not to identify a minimum IQ score in their legislation.\textsuperscript{315} While it has been established that there are discrepancies amongst the states as to how they define and implement their post-Atkins procedures, regardless of their current system, problems are likely to arise.\textsuperscript{316} Most states modeled their current laws off of the clinical definition in the DSM-IV-TR, that was current at the time of the Atkins decision, and made a focus on the IQ score.\textsuperscript{317} With the revisions made to DSM-5, it is inevitable that there are now differences between the state’s legal and new clinical definition of intellectual disability.\textsuperscript{318} This will become problematic when discrepancies exist between a diagnosis made by a testifying clinical forensic

\begin{itemize}
\item 307. \textit{See id.}
\item 308. \textit{See Hass, supra note 87, at 684.}
\item 309. \textit{AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 33; see Hagstrom, supra note 26, at 265.}
\item 310. \textit{See Appelbaum, supra note 210, at 1296.}
\item 311. \textit{See Bonnie & Gustafson, supra note 2, at 825.}
\item 312. \textit{Fabian et al., supra note 82, at 421.}
\item 313. \textit{See Gresham, supra note 122, at 93; Tobolowsky, supra note 103, at 90.}
\item 315. \textit{Dowling, supra note 130, at 789–91.}
\item 316. \textit{See Clark, supra note 7, at 136, 139; Tobolowsky, supra note 103, at 114.}
\item 317. \textit{Clark, supra note 7, at 137; see also Tobolowsky, supra note 103, at 89.}
\item 318. \textit{AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 33; Clark, supra note 7, at 137; Tobolowsky, supra note 103, at 89.}
\end{itemize}
The focus now, according to DSM-5, is more on adaptive functioning. According to DSM-5, this is a positive change as the IQ scores became less valid on the lower end of the range where mild intellectual disability is located. A focus on IQ has also been found to lead to problematic outcomes in forensic settings. "IQ scores are too unreliable and too sensitive to external factors for courts to rely on when a person’s life is at stake." Additionally, the new edition of the Manual states that IQ scores are only approximations of a person’s intellectual functioning and may not be sufficient enough to assess their functioning in real life situations. However, as mentioned, most states put emphasis on the IQ score in their legislation—which is no longer relevant for diagnosis—and less concentration on adaptive behavior.

Another problematic function of this shift is that adaptive functioning is almost entirely based on third party accounts; while assessments do exist, that is not the type of behavior that is easily assessed with standardized testing. When it comes to adaptive behavior, there is more difficulty in measurement and presentation of conclusive evidence to the fact finder in court. Therefore, even as the need for clinical judgment in the diagnosis has always been significant, the role of the psychologists will become even more important. Their clinical judgment will be relied upon even further for the subjective assessment of adaptive behavior.

Even though it may seem minor, the change of the onset from age eighteen to during the developmental period is also a cause for concern. This diagnostic factor was in place to help clinicians rule out other possible

319. Hagstrom, supra note 26, at 260.
320. AM. PSYCHIATRIC ASS`N, DSM-5, supra note 8, at 33; see also Intellectual Disability, supra note 9.
321. AM. PSYCHIATRIC ASS`N, DSM-5, supra note 8, at 33.
322. Wakefield, supra note 251, at 143.
324. AM. PSYCHIATRIC ASS`N, DSM-5, supra note 8, at 37.
325. Hagstrom, supra note 26, at 265.
326. Id. at 254, 260, 262, 265.
327. Id. at 262, 265.
328. See Bonnie & Gustafson, supra note 2, at 825, 849.
329. Id.
330. Id. at 854–55.
diagnoses—such as brain injury—that can occur later in life. 331 In the alternative, it could provide protection for younger defendants who never took an intellectual assessment when they were below the age of eighteen. 332 While before the age of eighteen and during the developmental period are intended to refer to the same time frame, the lack of a solid age cut-off may allow more room for malingering. 333 The age-of-onset criterion served as a safeguard to keep a defendant from being able to feign an intellectual disability, but with a less restrictive terminology now in place, this safeguard may not be as strong. 334

So, why is this important? Changes and complications are in store for the legislation that requires use of the DSM, particularly Atkins cases.335 The exact result will be dependent on the state in which the trial is occurring. 336 The reasons for that are the varying definitions and procedures in place in each state for dealing with capital punishment and intellectually disabled criminal offenders. 337 However, despite these differences, a strong fear has developed among defense attorneys, as their hypothesis is that this new edition will allow for more executions of those that Atkins sought to protect. 338

Death penalty lawyers fear that this revision will allow courts to execute offenders with IQ scores below seventy more easily.339 Arguably, this shift in focus can give states more room to subvert the decision made in Atkins and allow the execution of a mentally retarded defendant in the mild range.340 The determination of adaptive functioning is exceptionally more subjective than an IQ score, which will undoubtedly allow for each side to have an expert witness arguing the alternative opinions on the diagnosis. 341 By replacing a diagnosis that requires one objective part and one subjective part with a fully subjective assessment, it gives courts more room to avoid following the Atkins decision if they so choose.342 Research has found that jurors have stereotypes of how they believe intellectual disability should manifest. 343 If a jury is the fact finder, it is more likely for a person with

331. Id. at 854.
333. Bonnie & Gustafson, supra note 2, at 854.
334. Id. at 854–55.
335. See Hass, supra note 87, at 684.
336. Hagstrom, supra note 26, at 260.
337. Id.
338. See Dilts, supra note 235.
339. Id.
341. Cheung, supra note 314, at 339.
342. Dilts, supra note 235.
343. See Cheung, supra note 314, at 342.
mild mental retardation to be executed, as they are unlikely to meet the standards of the stereotype; the jury may not accept the subjective assessment by a psychological expert witness because they will realize there is room for interpretation in the diagnosis.\(^{344}\) If the decision is for a judge to make and the defendant falls into a gray area for diagnosis based on their level of adaptive behavior, the judge has room to interpret the facts and use his or her own discretion to make a decision;\(^{345}\) this is a cause for concern as judges are not trained in this field.\(^{346}\) Defendants with IQ scores lower than seventy have been executed in the past several years despite the Atkins decision, and the DSM revision is highly likely to make this worse with the change to more subjective diagnostic criterion.\(^{347}\)

With a focus on adaptive function, this could lead to more executions of those the Atkins holding was intended to protect.\(^{348}\) It is believed that the removal of adaptive behavior from the requirements could actually bar more executions than required by the Atkins decision.\(^{349}\) A focus on this requirement of adaptive functioning allows for more erroneous findings of intellectual disability.\(^{350}\) With adaptive function, the focus is always on the weaknesses and never the strengths.\(^{351}\) If the focus were to return to the IQ score, the reach of Atkins exemption could arguably be expanded.\(^{352}\)

The DSM work group defends their decision and states that they do not agree with the fear of the defense attorneys.\(^{353}\) The American Psychiatric Association is a large organization that represents thousands of psychiatric professionals; its goal is for them to all work together and create the best mental health care possible.\(^{354}\) Additionally, the prior focus on IQ scores is more likely to result in a mentally retarded defendant facing the death penalty due to its inherent limitations.\(^{355}\) A single IQ point could be the difference between life and death for an offender if additional clinical interpretation and analysis is not considered.\(^{356}\) For example, in a stricter

\(^{344}\) Id. at 339, 342–43.

\(^{345}\) Fabian et al., supra note 82, at 421.

\(^{346}\) See id. at 401.

\(^{347}\) AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 37–38; Dilts, supra note 235.

\(^{348}\) Bonnie & Gustafson, supra note 2, at 824.


\(^{350}\) Bonnie & Gustafson, supra note 2, at 824.

\(^{351}\) Fabian et al., supra note 82, at 421.

\(^{352}\) Bonnie & Gustafson, supra note 2, at 824.

\(^{353}\) See Dilts, supra note 235.

\(^{354}\) Cheung, supra note 314, at 321.

\(^{355}\) Hagstrom, supra note 26, at 264–65; Rumley, supra note 128, at 1338–39.

\(^{356}\) Dilts, supra note 235.
cut-off state, such as Kentucky, a defendant must have an IQ score of seventy or lower in order to be considered to have an intellectual disability.\textsuperscript{357} An IQ score does not allow a legal fact finder to see the whole picture of who the defendant is and why they did what they did, but it does give them a numerical value as a comparison to assess their intellectual function, which makes their execution more likely.\textsuperscript{358} The DSM work group believes that their revision should be helpful to the courts by shifting the attention to adaptive behavior; this way, the courts can analyze the defendant more thoroughly and make more accurate decisions about the defendant’s mental abilities.\textsuperscript{359}

If the DSM does have a negative impact and results in the death of more mentally retarded defendants, this is a violation of the protection ensured to mentally retarded offenders by the \textit{Atkins} decision.\textsuperscript{360} That holding was intended to protect them from cruel and unusual punishment.\textsuperscript{361} In the \textit{Atkins} holding, the Supreme Court of the United States intended to provide a categorical protection to those with intellectual disability by providing exemption from the death penalty that is now challenged by the changing diagnostic criteria of intellectual disability.\textsuperscript{362} With this new update to the diagnostic criteria of intellectual disability and the already existing discrepancies amongst the states, confusion is inevitable and the need for a uniform definition is even clearer.\textsuperscript{363}

A. \textit{Possible Solutions}

In cases where the court is unclear as to whether or not a defendant has an intellectual disability, the court should revisit the deciding factors in the \textit{Atkins} holding.\textsuperscript{364} The court should consider the goals of capital punishment—deterrence and retribution—and whether they will in fact be furthered by the death of the defendant.\textsuperscript{365} In the end, “the court[] must conclude both that the defendant was more morally culpable than the average criminal and that the rationale behind the death penalty applies” appropriately to justify the most severe punishment in the country.\textsuperscript{366} In

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\item \textsuperscript{357} Cheung, \textit{supra} note 314, at 327.
\item \textsuperscript{358} Hagstrom, \textit{supra} note 26, at 264–65.
\item \textsuperscript{359} \textit{See} Dilts, \textit{supra} note 235.
\item \textsuperscript{360} \textit{See} Atkins v. Virginia, 536 U.S. 304, 321 (2002).
\item \textsuperscript{361} \textit{Id}.
\item \textsuperscript{362} Cheung, \textit{supra} note 314, at 337; Dilts, \textit{supra} note 235; \textit{see} Atkins, 536 U.S. at 321.
\item \textsuperscript{363} \textit{See} Cheung, \textit{supra} note 314, at 337.
\item \textsuperscript{364} Hagstrom, \textit{supra} note 26, at 274; \textit{see also} Atkins, 536 U.S. at 320–21.
\item \textsuperscript{365} Hagstrom, \textit{supra} note 26, at 274–75; \textit{see also} Atkins, 536 U.S. at 319.
\item \textsuperscript{366} Hagstrom, \textit{supra} note 26, at 275.
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addition, the states may just want to consider revising their legislation to include the updated diagnostic criteria. Each state still has the ability to determine the definition used to make their legislation to categorically exempt intellectually disabled defendants. By making a revision, the court can be assured that they will properly determine if the death penalty is appropriate when faced with an Atkins case. Going back to the original decision may help courts make a more appropriate decision.

Another seemingly simple solution, however, would be to implement a uniform national standard. A countrywide standard would eliminate the state-to-state discrepancies. The new standard should be made in accordance with the current psychological definition and diagnostic criteria in the DSM-5 as well as the Atkins decision. In addition to eliminating the confusion created by having multiple definitions, the standard should also include procedural information such as when this determination should be made, as well as whether the judge, jury, or both should make it. This would prevent the possibility of different holdings for the same person depending on which state their trial was held in. By embracing the new edition of the DSM and finally creating a uniform way to enforce the Atkins holding, those that the Atkins decision intended to protect are more likely to be spared from execution.

V. CONCLUSION

In 2002, the Supreme Court of the United States made a groundbreaking decision in Atkins v. Virginia and their decision created a categorical exemption for mentally retarded offenders. However, their lack of a uniform standard or specific guidance for the states regarding a definition of mental retardation led the states to make their own decision regarding legislation. Many states relied upon the DSM-IV-TR definition

367. Cheung, supra note 314, at 344–45; see also Hall, supra note 2, at 385.
368. Dilts, supra note 235.
369. See Cheung, supra note 314, at 344.
370. Hagstrom, supra note 26, at 274–75; see also Atkins, 536 U.S. at 321.
371. Cheung, supra note 314, at 344.
372. See id.
373. Atkins, 536 U.S. at 321; AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 33.
374. Cheung, supra note 314, at 348–49.
375. See id. at 344, 348–49.
376. See Atkins, 536 U.S. at 321; AM. PSYCHIATRIC ASS’N, DSM-5, supra note 8, at 25.
378. Id. at 317; Cheung, supra note 314, at 326.