

Four Practical and Conceptual Assessment Issues That Evaluators Should Address in Capital Case Mental Retardation Evaluations

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What unique assessment issues do evaluators face when conducting mental retardation evaluations in capital cases? This article describes 4 assessment issues and reports how 20 evaluators in 1 state have approached them: (a) What methods are appropriate for evaluating adaptive functioning in this context? (b) Should information about criminal behavior be used as evidence of adaptive functioning? (c) Should correctional officers serve as informants regarding adaptive behavior? and (d) How should the Flynn effect influence the interpretation of intelligence test scores? Implications for practice are that practitioners should expect to be asked about the relation between criminal behavior and adaptive functioning, must think carefully about the validity of tests of adaptive functioning for inmates, and must be knowledgeable about the current state of Flynn effect research.

Keywords: mental retardation, adaptive functioning, forensic, capital case, Flynn effect

In 2002, the U.S. Supreme Court ruled in *Atkins v. Virginia* that the execution of persons with mental retardation constituted cruel and unusual punishment and was prohibited by the eighth amendment. Although many mental health practitioners are trained to conduct diagnostic evaluations of mental retardation, the circumstances surrounding capital cases and the characteristics of many capital case defendants require evaluators to address a series of practical and conceptual assessment issues in capital cases that go beyond those encountered in other cases. For example, should behavior during the commission of a crime be used to determine a defendant's level of adaptive functioning? Should past criminal behavior be used to make diagnostic decisions regarding mental retardation? What is the best way to evaluate the adaptive functioning of someone living in a restricted prison environment, such as death row?

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This article describes four practical and conceptual assessment issues that evaluators should address in capital case mental retardation evaluations: (a) What methods are appropriate for evaluating adaptive functioning in this context? (b) Should information about criminal behavior be used as evidence of adaptive functioning? (c) Should correctional officers serve as informants regarding adaptive behavior? and (d) How should the Flynn effect influence the presentation and interpretation of intelligence test scores?

These four assessment issues represent only a small subset of potentially controversial assessment issues in capital case mental retardation evaluations. For example, the Ad Hoc Committee on Mental Retardation and the Death Penalty formed by Division 33 of the American Psychological Association recently identified more than 50 controversial issues for psychologists in *Atkins* hearings (Olley, Greenspan, & Switzky, 2006, p. 12). Many of these issues relate to the selection and use of intelligence tests. Although intelligence testing is a major component of most mental retardation evaluations and many cases require detailed testimony about IQ scores, this article addresses what we perceive to be the most contentious issues in these cases (see Fabian, 2006; Flynn, 2006; Greenspan, 2006; Olley, 2006).

The goal of this article is to provide practical information about these four issues for professionals asked to conduct evaluations of mental retardation in capital cases. To achieve this goal, in this article we provide an overview of the issues and report how 20 experienced evaluators in one state think about and address them in their evaluations. We address each issue individually, providing implications for practice regarding that issue before discussing the next issue. The implications for practice are based on a combination of professional standards, scholarly opinion, and the experiences of the 20 evaluators.

Experienced Evaluator Survey

The research sought information about the four assessment issues from psychologists ($n = 13$) and psychiatrists ($n = 7$) in the state of Texas who had conducted at least one evaluation of mental

retardation in a capital case. The reasons for focusing on evaluators in Texas included the high prevalence of death penalty cases in Texas and the fact that Texas cases have played a prominent role in the development of case law in this area (*Ex parte Briseno*, 2004; *Penry v. Lynaugh*, 1989; *Tennard v. Dretke*, 2004).

The research team identified 92 potential participants for the study by contacting practitioners the research team knew had conducted capital case mental retardation evaluations and practitioners in Texas who were listed in the directories of the American Academy of Psychiatry and the Law and the American Academy of Forensic Psychology. Practitioners were allowed to participate if they had conducted an evaluation for mental retardation in any capital case. We did not ask specifically about evaluations conducted after the *Atkins* decision. Many of these practitioners ($n = 49$, 53.3%) stated that they had never conducted a capital case mental retardation evaluation, and 20 (21.7%) practitioners did not respond to telephone messages from the research team. Of the 23 practitioners who reported having conducted an evaluation, 20 (87.0%) participated in the study.

The experience of the 20 evaluators in conducting capital case mental retardation evaluations varied noticeably ($M = 21.4$ evaluations, $SD = 35.3$, $Mdn = 10.0$), with 2 evaluators having been involved in only one case and 3 having been involved in at least 20 cases. The psychologists reported somewhat more experience conducting capital case mental retardation evaluations ($M = 25.75$, $SD = 41.30$) than did psychiatrists ($M = 12.83$, $SD = 18.53$), with 9 psychologists (69.2%) having conducted 10 or more evaluations, compared with only 2 psychiatrists (28.6%). Eleven psychologists and 6 psychiatrists provided information about who had retained them in their cases. Of the 11 psychologists, 5 (45.5%) had been retained by both the defense and the state, 5 (45.5%) had been retained only by the defense, and 1 (9.1%) had been retained only by the state. Of the 6 psychiatrists, 3 (50.0%) had been retained by both the defense and the state, 3 (50.0%) had been retained only by the defense, and none had been retained only by the state.

Telephone Interviews

The research team developed a 17-question semi-structured telephone interview (see the Appendix) to inquire about evaluators' experiences and opinions relating to the four capital case mental retardation evaluation issues that are the focus of this article. The interviewer asked follow-up questions when needed to help clarify evaluators' original responses. For psychiatrists, questions about psychological test use were modified to ask about the tests they had seen psychologists use in their cases. The 17 questions in the Appendix were part of a longer 68-question interview with 24 evaluators about a variety of capital case evaluation issues, including competence for execution and ethical conflicts. Four participants in the larger study had not conducted a capital case mental retardation evaluation. The 17 questions in the Appendix were the only questions inquiring about mental retardation issues. This article reports on evaluator responses to these 17 questions. Time to complete the entire interview ranged from 30 to 90 min.

Coding Procedure

Each interview transcript was independently coded by the same two members of the research team. The coding process required

each coder to record a total of 187 pieces of information. For example, an evaluator's response to the question "In your opinion, what assessment methods are essential for a complete MR [mental retardation] evaluation?" required coding (mentioned vs. not mentioned) for the four pieces of information listed at the top of Table 1. Response categories for each study question were created by the research team after an initial reading of the interview transcripts. This initial reading was used to identify the most commonly occurring response variants for each question. Across the 20 interview transcripts, the overall percentage of agreement between the two coders was 100% for 65 pieces of information, 99%–80% for 109 pieces of information, and less than 79% for 13 pieces of information. Discrepancies in the ratings for each item with less than 100% agreement were reviewed by the research team until an agreed-upon response was identified.

Four Assessment Issues

1. What Methods Are Appropriate for Evaluating Adaptive Functioning in Capital Cases?

Although diagnoses of mental retardation require consideration of both intellectual and adaptive functioning, many of the controversial evaluation issues in these cases surround the assessment of adaptive functioning. Indeed, questions about the definition and

Table 1
What Procedures and Collateral Information Are Essential for a Complete Capital Case Mental Retardation Evaluation?

Question and essential element	<i>n</i>	%
What assessment procedures or methods are essential for a complete evaluation?		
Use of cognitive or intelligence testing	19	95.0
Reading of reports or records, or obtaining collateral information	16	80.0
Interview with defendant or inmate	13	65.0
Interview with others	7	35.0
What records do you feel are essential to review?		
School or educational records	18	90.0
Mental health records	13	65.0
Employment records	7	35.0
All that are available	6	30.0
Medical records	6	30.0
Prison or jail disciplinary records	5	25.0
Criminal history records	5	25.0
Progress notes or disciplinary or behavior records	2	10.0
What third-party information do you obtain?		
Who do you interview?		
Family members	14	70.0
Former teachers	6	30.0
Neighbors or friends	5	25.0
All who are available and willing	3	15.0
Former employers	3	15.0
Correctional officers	2	10.0
None	1	5.0

Note. Participants could endorse more than one response. Information in this table is based on participant responses to the following two questions: (a) In your opinion, what assessment procedures or methods are essential for a complete MR [mental retardation] evaluation? (b) What records and third-party information do you feel are essential to obtain and review?

assessment of adaptive behavior in death penalty cases have been the focus of a series of recent appellate court decisions (*Clemons v. Alabama*, 2005; *Ex parte Briseno*, 2004; *Pruitt v. Indiana*, 2005) and scholarly publications (Brodsky & Galloway, 2003; Everington & Keyes, 1999; Fabian, 2006; Olley, 2006; Olvera, Dever, & Earnest, 2000; Stevens & Price, 2006).

Defining adaptive functioning. In the *Atkins v. Virginia* (2002) decision, the Supreme Court described adaptive functioning by referring to the diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) and the then-current definition provided by the American Association on Mental Retardation (AAMR; Luckasson et al., 1992). The *DSM-IV-TR* and 1992 AAMR definitions state that impairment in adaptive functioning exists when a person demonstrates significant limitations in two of the following areas: communication, self-care, home living, social or interpersonal skills, use of community resources, self-direction, health and safety, functional academics, leisure, and work. The AAMR released a revised definition of mental retardation in 2002 stating that impairment in adaptive functioning should be identified through *standardized testing* and that impairment was indicated by significant limitations in conceptual, social, or practical skills or an overall score on a standardized measure that assesses these three skill areas (AAMR, 2002).

Community versus correctional environment. There are several reasons why typical methods used to assess adaptive functioning may be inappropriate or unavailable in capital case mental retardation evaluations. For example, many death row inmates and capital case defendants may have spent significant portions of their lives in restricted and regimented settings and may have had little opportunity to display social, conceptual, or practical skills on a routine basis in nonrestricted settings. The AAMR (2002) definition of mental retardation states "limitations in present functioning must be considered within the context of community environments typical of the individual's peers and culture" (p. 23). These are environments in which "people of similar age ordinarily live, play, work, and interact" (p. 8). Most persons being evaluated for mental retardation in capital cases will not be living in a typical community environment.

The *Atkins* decision's prohibition against executing persons with mental retardation applies to defendants in new capital cases and to inmates who were sentenced to death before the decision. Functioning in community environments may be especially difficult to assess for individuals who have had limited opportunities to learn adaptive skills, such as those who have spent many years in hospitals, group homes, juvenile detention facilities, or prisons. Deficits in adaptive behavior for these individuals may be related to mental retardation or to the lack of opportunity to develop the skills (AAMR, 2002). Assessment of adaptive functioning in typical community environments may be especially challenging for an inmate who has lived in a restricted death row environment for many years as opposed to a defendant who has spent most of his or her life living in the community (Brodsky & Galloway, 2003; Everington & Keyes, 1999).

Appropriate use of adaptive functioning measures. The current AAMR (2002) operational definition of mental retardation states that "significant limitations in adaptive behavior should be established through the use of standardized measures" (p. 23). Some adaptive functioning measures are completed by a practitioner after interviewing someone who knows the evaluatee well (e.g., Vineland Adaptive Behavior Scales—Second Edition [Vineland-II]; Sparrow, Cicchetti,

& Balla, 2005), whereas other measures use rating forms completed by the evaluatee, family member, or other person who knows the evaluatee well (e.g., Adaptive Behavior Assessment System II; Harrison & Oakland, 2003). Practitioner surveys have consistently found that the Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984) are the most commonly used measures of adaptive functioning for children (Hutton & Dubes, 1992; Stinnett, Havey, & Oehler-Stinnett, 1994) and adults (Harrison, Kaufman, Hickman, & Kaufman, 1988). However, the 1984 version of the Vineland scales was not developed to apply to people over the age of 18. The revised version of the instrument (Vineland II), which includes normative data for adults through age 90, has only recently become available (Sparrow et al., 2005).

Evaluators who use standardized measures of adaptive functioning in their general clinical practices must be aware that there are legitimate reasons to believe that these measures may be inappropriate for use in incarcerated populations (see Everington & Keyes, 1999; Fabian, 2006). Although AAMR guidelines state that "significant limitations in adaptive behavior can be established only through the use of standardized measures" (p. 23), they also state that limitations in adaptive behavior are those that exist in typical community environments. Experts in the area of mental retardation assessment have argued that standardized measures of adaptive functioning should not be used "in situations of prolonged incarceration . . . as the individual has had no opportunity to perform in most of the skill domains" considered by these measures (Everington & Keyes, 1999, p. 33). Thus, the utility of adaptive functioning measures may be especially limited for persons who have been incarcerated for long periods of time because they may not have had the same opportunities for displaying the behaviors scored on these instruments compared with people who provided their normative data (Fabian, 2006).

A second potential limitation of using existing adaptive functioning measures in capital cases is that behaviors that are considered to be adaptive in the general population may not be adaptive in prison environments or within certain peer groups. For example, the Vineland-II (Sparrow et al., 2005) and Adaptive Behavior Assessment System II (Harrison & Oakland, 2003) ask about behaviors that may be less common among those with a history of antisocial behavior, such as saying "please" and "thank you," belonging to organized clubs, following rules, asking for advice, and refraining from lying and saying rude things. Currently, no data exist either supporting or arguing against the validity of adaptive functioning measures in prison contexts or in persons with significant histories of antisocial behavior. Thus, the amount of bias, if any, that results from using existing measures in these populations is unknown.

Assessment practices of experienced evaluators. Table 1 summarizes participants' responses to questions about the essential components of a complete capital case mental retardation evaluation, including questions about reviewing records and interviewing third-party sources. The overall pattern of findings in Table 1 reveals that the most common assessment practices reported by evaluators are similar to those used by professionals to evaluate mental retardation in noncriminal cases, including intelligence testing (95.0%), reviewing educational (90.0%) and mental health (65.0%) records, interviewing family members (70.0%), and interviewing the defendant or inmate (65.0%). Only 1 participant, a psychologist, did not mention testing as essential in evaluating mental retardation in capital cases.

Evaluators were asked to provide separate descriptions for how they would evaluate the adaptive functioning of an inmate who has lived on death row for a number of years and a criminal defendant awaiting trial. As can be seen in Table 2, evaluators described similar approaches for evaluating the adaptive functioning of death row inmates and pretrial defendants. Most evaluators emphasized the importance of reviewing records and interviewing the defendant or inmate and others who might be able to provide descriptions of the defendant or inmate's behavior. When evaluators were asked directly whether their evaluation approach would differ in these two types of cases, only 4 (20.0%) said that it would. Three of these evaluators were psychologists and 1 was a psychiatrist. All 4 of these evaluators explained that it was much more difficult to assess the adaptive functioning of someone living on death row, because of the "constraints" and "not normal living environment" that are characteristic of death row. One evaluator explained that these evaluations were more difficult because the evaluator needed to determine how the person would function outside of the secure prison environment:

I think it isn't whether the person is well-adapted to an institutional setting but rather to what extent could they function in society at large . . . institutional adaptation and adaptive capability don't necessarily translate into adaptability in the community.

One noticeable difference between the evaluators' descriptions of their pretrial and death row evaluation practices was that they were somewhat more likely to report using standardized measures of adaptive functioning in pretrial as opposed to death row cases (53.8% vs. 30.7%, psychologists only). Five psychologists reported using either the first or second edition of the Vineland scales (Sparrow et al., 1984, 2005), whereas 1 reported using the Adaptive Behavior Assessment System II (Harrison & Oakland, 2003), and 1 reported using the AAMR Adaptive Behavior Scales

Table 2
How Do You Assess Adaptive Functioning for Someone Who Is on Death Row Versus Awaiting Trial?

Types of information	Death row		Awaiting trial	
	<i>n</i>	%	<i>n</i>	%
Interview inmate	11	55.0	12	60.0
Obtain information about:				
Communication skills	9	45.0	7	35.0
Day-to-day activities	8	40.0	5	25.0
Personal hygiene	4	20.0	4	20.0
Social activities	4	20.0	3	15.0
At least one of the four areas above	15	75.0	11	55.0
Obtain collateral reports and records	14	70.0	14	70.0
Criminal history or behavior	1	5.0	1	5.0
Interview others	16	80.0	14	70.0
Correctional officers	8	40.0	2	10.0
Conduct standardized testing (psychologists only, <i>n</i> = 13)	4	30.7	7	53.8

Note. *N* = 20. Participants could endorse more than one response. Information in this table is based on participant responses to the following three questions: (a) How would you assess adaptive functioning for someone who has been on death row for a number of years? (b) How would you assess adaptive functioning for someone who is awaiting trial? (c) Would these two evaluations differ in any way? If yes, how?

(Nihira, Leland, & Lambert, 1993). Only 1 of the 7 psychiatrists (14.3%) reported working on a case in which a psychologist had administered an adaptive functioning measure to an inmate on death row. None of the psychiatrists recalled having worked on a pretrial case in which a psychologist used a standardized measure of adaptive functioning.

Implications for practice. The main implication for practice from evaluators' descriptions of their general assessment practices is that the use of standardized measures of adaptive functioning may not be standard practice in capital case mental retardation cases. Although the current AAMR (2002) operational definition of mental retardation states that limitations in adaptive functioning should be supported through the use of standardized measures, only about half the psychologists participating in this study reported using standardized measures of adaptive functioning for pretrial evaluations and only about one third reported using them for evaluations of death row inmates.

The low rate of adaptive functioning instrument use may have been a product of concerns about the validity of the measures, difficulty finding a family member or friend who knew the defendant well enough to provide assessment data, or the lack of a clearly identifiable gold standard measure for use in these cases (Brodsky & Galloway, 2003; Stevens & Price, 2006). Given that the evaluators may have been describing evaluations conducted several years prior to the interview, these findings may also reflect the generally limited availability of instruments that were designed to be used with adults.

Ultimately, evaluators who do choose to use measures to assess the current level of adaptive functioning for adult inmates must be aware that there are legitimate reasons to believe that these measures may be inappropriate for use in incarcerated populations (see Everington & Keyes, 1999; Fabian, 2006). Given the potential bias that can result from the overemphasis on, or lack of understanding about, a specific test score, evaluators should avoid using an adaptive functioning measure that may produce a biased score. The American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (APA, 2002) clearly supports this position: "Psychologists use assessment instruments whose validity and reliability have been established for use with members of the population tested" (Standard 9.02b, p. 1071). Ultimately, determinations about potential bias must be made by the evaluator, who should carefully consider the extent to which the normative sample used to create scores for the test includes individuals who are similar to the defendant being evaluated (see American Educational Research Association et al., 1999).

2. Should Information About Criminal Behavior Be Used as Evidence of Adaptive Functioning?

Although courts have not openly disagreed with the AAMR or DSM-IV-TR diagnostic criteria for mental retardation,¹ several have been asked to address the questions of whether and how

¹ In *Ex parte Briseno* (2004), the Texas Court of Criminal Appeals argued that the criteria for determining mental retardation in capital cases should be based on the consensus of Texas residents, which may or may not be consistent with the diagnostic criteria used by mental health professionals.

criminal behavior should be considered as evidence of adaptive functioning (see *Clemons v. Alabama*, 2005; *Ex parte Briseno*, 2004; Fabian, 2006). In *Tennard v. Dretke* (2004), the Supreme Court ruled that evidence of mental retardation was “inherently mitigating” and that the defendant’s behavior during the crime did not need to be clearly associated with his impairment to qualify for a lesser sentence (p. 2563). Nevertheless, the Court did not state that it was inappropriate to consider the defendant’s behavior during the crime as evidence for or against a diagnosis of mental retardation. Courts in two states have argued that criminal behavior should be considered as part of the diagnostic process (*Clemons v. Alabama*, 2005; *Ex parte Briseno*, 2004). In Texas, the Court of Criminal Appeals ruled in *Ex parte Briseno* (2004) that fact finders should consider both behavior during the alleged crime (planning, forethought, complex execution of purpose) as well as behavior after the crime (hiding facts, ability to lie effectively) when making determinations of mental retardation. In Alabama, the Court of Criminal Appeals ruled in *Clemons v. Alabama* (2005) that it was appropriate for fact finders to consider factors relating to “post-crime craftiness” (p. 6), such as attempts by the defendant to minimize perceptions of his culpability, in their determinations of mental retardation.

The primary argument for collecting information about criminal behavior as part of an adaptive functioning assessment is that criminal behavior can show elements of adaptive or nonadaptive functioning, just like any other type of behavior. Thus, criminal behavior can provide important information about a person’s conceptual, social, and practical skills. A second argument for using information about criminal behavior is that it is likely to be one of the most well-documented sources of information available to the examiner, with reports from witnesses and law enforcement officers. However, one of the main arguments against using criminal behavior as part of an adaptive functioning evaluation is that the information may be unreliable or inaccurate because persons with mental retardation are suggestible, are likely to acquiesce to law enforcement officers, and lack the communication skills needed to correct misperceptions about their behavior (Everington & Keyes, 1999; Greenspan & Switzky, 2003). A second argument against using criminal behavior is that standardized and validated methods for assessing adaptive functioning do not provide guidance for how to use this information to make inferences about specific areas of adaptive functioning, such as conceptual, social, and practical skills. The absence of an accepted framework for relating aspects of criminal behavior to areas of adaptive functioning may be one reason why the same level of criminal behavior can be seen as adaptive by one expert and nonadaptive by another (see, e.g., *Ex parte Briseno*, 2004).

The fact that existing measures of adaptive behavior do not provide a framework for evaluating criminal behavior could be used to argue that criminal behavior should not be considered during evaluations of adaptive functioning or that existing measures of adaptive functioning are inappropriate for evaluations involving criminal defendants. The validity of existing measures of adaptive functioning for evaluating criminal defendants or prison inmates has never been examined (Fabian, 2006; Stevens & Price, 2006). When a defendant’s behavior, whether criminal or other, is associated with certain characteristics (such as impulsivity, recklessness, or low frustration tolerance), it can be difficult to determine whether the behavior is attributable to mental retardation,

antisocial personality disorder, some combination of both, or another diagnostic issue entirely (e.g., substance use, neurological impairment, other mental illness).

Assessment practices of experienced evaluators. Only 5 evaluators (25.0%) talked about reviewing the defendant’s criminal records or history when asked to identify the essential components of a complete capital case mental retardation evaluation (see Table 1), and only 1 reported using information about criminal behavior when asked to describe how they evaluated adaptive functioning in death row and pretrial cases (see Table 2). However, when evaluators were asked directly about whether the defendant’s past criminal behavior should be considered in the assessment of adaptive functioning, nearly all of the evaluators felt that it was appropriate to consider this information. Specifically, 16 evaluators (80.0%) responded “yes” to this question, 3 (15.0%) stated that “it depends,” and only 1 (5.0%) said “no.” An identical response pattern was obtained when evaluators were asked if the defendant’s behavior during the crime for which he or she was being evaluated should be considered in the assessment of adaptive behavior.

Each evaluator was asked to explain why criminal behavior should or should not be used to assess adaptive functioning. Fourteen evaluators (70.0%) reported that it was appropriate to consider criminal behavior because it can show planning and organizational abilities. Several evaluators noted that a diagnosis of mental retardation would be unlikely for defendants involved in planning an armed robbery, a white-collar crime, or “elaborate cons.” For example, one evaluator noted that he would consider the

level of planning, sophistication of the crime, the execution of the crime, efforts to avoid detection, the level of self-protection during questioning, interrogation, investigation. All those to me are ways to get information about how a person’s abilities to plan and carry out a plan can be assessed.

Five evaluators (25.0%) explained that criminal behavior was appropriate to consider because it is part of the defendant’s lifetime pattern of behavior. For example, one evaluator stated, “Well, I think it would be included in looking at everything in one’s past history. I can’t overlook things just because they might have a negative connotation.” Another stated that criminal behavior was “part of the pattern of life, and what we’re evaluating includes how that person functioned over a long period of time. You can’t isolate them from their lifestyle and experiences.”

There was a great deal of variability in how evaluators talked about the strength of the connection between criminal and adaptive behavior. Some evaluators seemed to believe that adopting an antisocial lifestyle was a sign of adaptive functioning in and of itself, with one evaluator stating, “Well it [criminal behavior] is the way that they have coped. That’s the mechanism they’ve used for dealing with life. That’s adaptive.” Other evaluators explained that they did consider criminal behavior during their evaluations but reported being more cautious about interpreting criminal behavior as adaptive functioning. For example, one evaluator stated, “I only think that’s relevant if the past criminal behavior reflects an unusual degree of intellectual capability . . . the vast majority of criminal offenses are well within the capability of someone who is mildly MR.”

Another evaluator noted that he or she tried to consider whether the criminal behavior was most likely attributable to mental retardation or antisocial personality traits:

The criminal behavior, the criminal history is only relevant if it's actually a better explanation for their behavior than MR. If someone has difficulty complying with certain rules or regulations, and they're alleging it's because they're retarded, then I have to rule out whether it's really related to retardation, or is it because they're antisocial personalities or psychopaths. So, you measure the adaptive behavior as directly as you can, using whatever devices, interviews, et cetera, but you have to take the criminal history into account if it's a better alternative explanation.

The one evaluator who was clearly opposed to considering criminal behavior as part of the adaptive functioning evaluation process described the problems that could arise if a defendant's criminal behavior was maladaptive but her or his adaptive functioning in many other areas was adequate. Specifically, this evaluator explained that if criminal behavior can indicate adequate adaptive functioning, it can also indicate an impairment in adaptive functioning, thus raising the possibility of a defendant being seen as having an impairment in adaptive functioning primarily because he is an impulsive, disorganized, and an overall unsuccessful criminal.

Implications for practice. Evaluators who conduct evaluations of mental retardation in capital cases should expect to be asked about what the defendant's criminal history and behavior during the alleged capital crime suggest about his or her level of adaptive functioning. Although few evaluators in the current study described information about criminal behavior as an essential component of their evaluations, all but 1 reported considering this information in their determinations of adaptive functioning. The evaluators' use of information about criminal behavior is consistent with the expectation of courts in Texas (*Ex parte Briseno*, 2004) and Alabama (*Clemons v. Alabama*, 2005), which have ruled that it is appropriate to consider criminal behavior and "post-crime craftiness" (p. 6) as evidence of adaptive functioning.

Findings from the experienced evaluators suggest that the standard of practice, at least in Texas, is to use information about criminal behavior in the evaluation of adaptive functioning. However, the findings also suggest that there is not a clear consensus about the importance of criminal behavior in making diagnostic determinations. Several evaluators clearly felt that criminal behavior was always relevant and no different from any other type of behavior in that it could reflect practical, conceptual, and social skills. Others seemed to feel that information about criminal behavior should be collected but was rarely diagnostic because most crimes were "well within the capability of someone who is mildly MR." Nevertheless, both of these positions require that the evaluator attempt to evaluate the criminal behavior in terms of adaptive functioning, regardless of whether the conclusion that the evaluator reaches is that the behavior could or could not have been performed by someone who was a person with mental retardation.

Although some professionals may feel that it is unethical to consider criminal behavior as adaptive functioning because of its potential prejudicial impact on laypersons' determinations of mental retardation, this view was not expressed by evaluators in the current study. Findings from the current study suggest that practitioners who have professional or ethical concerns about consid-

ering criminal behavior as diagnostic information should expect other experts in their cases to use this information as part of their evaluations and be ready to explain why they have not used this behavior to inform their own diagnostic impressions.

Practitioners who do consider criminal behavior in their evaluations must acknowledge that there is no agreed-upon standard for identifying the level of adaptive functioning indicated by specific antisocial behaviors. Indeed, recent court decisions indicate that the same criminal behavior can be seen as adaptive by some mental health professionals and impaired by others (see *Ex parte Briseno*, 2004; Fabian, 2006). Although criminal behavior could be used to suggest both impaired or unimpaired adaptive functioning, most evaluators we interviewed discussed criminal behavior in terms of suggesting generally unimpaired behavior, such as whether the crime involved a sophisticated level of planning or whether the defendant made attempts to cover up the crime. Practitioners who decide to consider criminal behavior as part of their evaluation of adaptive functioning should be open to considering it as suggesting either some degree of impairment or a lack of impairment.

Regardless of how practitioners choose to use information about criminal behavior in their evaluations, they must recognize the potential limitations of their approach and be willing to acknowledge them in their written reports and in the courtroom. For example, evaluators who use criminal behavior as diagnostic information must consider the ability of impaired defendants to correct potentially inaccurate information about their criminal behavior, both with respect to the current offense and prior offenses. Practitioners must also acknowledge that nobody has attempted to examine the extent to which mental health professionals agree about the level of functioning needed to engage in certain types of criminal behavior.

3. Should Correctional Officers Serve as Informants Regarding Adaptive Behavior?

Many death row inmates and capital case defendants may have spent significant portions of their lives in restricted settings. In these instances, collateral information regarding adaptive functioning may be available from those who have daily contact with the offender in the regimented environment, such as correctional officers. Although prison employees can be valuable sources of information about functioning in the prison environment (Everington & Keyes, 1999), they will not have observed the offender outside of the secure setting, may have little knowledge about the adaptive behavior of persons with mild to moderate mental retardation, and may feel pressured by peers to report a high level of functioning (Stevens & Price, 2006). Given the potential bias associated with correctional officer reports, is it appropriate to use them as sources of information about adaptive behavior?

Assessment practices of experienced evaluators. Only 2 evaluators (10.0%) talked about interviewing correctional officers when asked to identify the essential components of a complete capital case mental retardation evaluation (see Table 1). Eight evaluators (40%) talked about interviewing correctional officers when asked about how they assess adaptive functioning for inmates on death row, and 2 (10%) reported interviewing correctional officers in pretrial evaluations (see Table 2). However, when evaluators were asked directly about whether they interview cor-

rectional officers to gain insight into the prisoner's adaptive functioning, 18 evaluators (90.0%) said that they did.

Evaluators who reported that they interviewed correctional officers reported considerable variation in the weight they place on this information. Three evaluators specifically described information from correctional officers as less central to their evaluations than information from other collateral sources, with 2 specifically stating that they interviewed officers only for "completeness." Four evaluators stated that they were concerned about the accuracy of information from correctional officers, with 1 psychologist reporting that she or he does not interview officers because they are "maximally biased." This evaluator also stated, "there are very few [correctional officers] who understand MR, and their interpretation of behavior is always simplistic and uneducated and biased." One evaluator who was willing to interview officers acknowledged that most correctional officers do not know much about mental retardation but pointed out that

the cases where the officer says the person [inmate] is not functioning well, they're not functioning well. In other words, those persons [inmates] who were reported to be not functioning well are really dysfunctional, but those who were reported to be functional may or may not be functional.

Other evaluators did not express any reservations about interviewing correctional officers, making statements such as "I can't think of any reason not to do it," "you get a lot out of correctional officers," and they are "good sources of information." These evaluators explained that information from correctional officers was invaluable for evaluating the inmate's behavior. For example, one evaluator stated that the information from correctional officers

will show whether an inmate, for example, can keep himself clean, make sense when he talks, can make logical requests, can process information provided by the officer, can look after his health by putting in requests to see the medical personnel, can take care of himself in there, may be able to work, able to write letters home.

Implications for practice. Nearly all of the evaluators who participated in this study believed that it was appropriate to interview correctional officers as part of the evaluation process, although few reported that interviewing officers was an essential component of their evaluations. Several evaluators stated that they used information from officers with a great deal of caution, explaining that the officers tended to be biased and uninformed about mental retardation. The extent to which reports from correctional officers tend to be biased or inaccurate is an empirical question for which no data exist. Of course, this potential for biased reporting also exists for friends and family members of the defendant, who may be motivated to make a defendant appear impaired (Olley, 2006).

We did not ask evaluators whether they used correctional officers as informants for completing standardized measures of adaptive functioning, but information from correctional officers could conceivably be used for this purpose. The potential for biased reporting and absence of empirical support for this practice argue against using correctional officer reports for completing adaptive behavior rating scales. Nevertheless, there does not seem to be a clear reason why correctional officers cannot be interviewed, given that it is up to the evaluator to decide how much weight to place on this information.

4. How Should the Flynn Effect Influence the Presentation and Interpretation of Intelligence Test Scores?

The Flynn effect refers to the finding that the normal population's performance on intelligence tests has improved over the past 70 years (Flynn, 1985). Specifically, younger cohorts of individuals obtain higher scores on standardized measures of intelligence than older cohorts. Because of this trend, new revisions of existing intelligence tests are more difficult than older versions, meaning that a higher level of ability is needed to obtain a specific score on a newer test compared with an older test. Therefore, individuals who may have scored slightly above 70 on intelligence tests with older norms would be expected to score lower when tested using more recently normed versions of the same test or any other recently revised test.

The pattern of test scores predicted by the Flynn effect suggests that mental health professionals conducting evaluations in capital cases may evaluate persons with intelligence test scores that were somewhat above 70 when the defendants were children (older test) but below 70 at the time of the capital case evaluations (newer test; see Kanaya, Scullin, & Ceci, 2003). The Flynn effect was the focus of a recent decision from the Federal Court of Appeals (Fourth Circuit), which ruled that a trial court in Virginia erred by not considering the defendant's Flynn effect evidence (*Walker v. True*, 2005). The current study asked evaluators about their familiarity with the Flynn effect, whether it had been an issue in any of their cases, and how they used information about the Flynn effect in their evaluations.

Assessment practices of experienced evaluators. The interview questions about the Flynn effect differed from the other interview questions in that the interviewer provided a brief description of the Flynn effect before asking the Flynn effect questions (question 15). The interviewer provided this description to avoid challenging evaluators about their knowledge of a potentially important issue relating to their evaluations and to avoid gathering data based on the assumption that the evaluator knew what the Flynn effect was but really did not.

Most psychologists reported being aware of the Flynn effect after being given a description of the effect. Specifically, 9 psychologists (69.2%) stated that they knew of the effect by its name, 1 additional psychologist (7.7%) reported being aware of the effect but not the name, and 3 psychologists (23.1%) reported that they were aware of neither the effect nor the name. None of the 7 psychiatrists were aware of the Flynn effect by name, although 2 (28.6%) reported being familiar with the pattern of intelligence test scores described by the effect. Five psychiatrists (71.4%) reported being unaware of patterns of intelligence test scores described by the Flynn effect. Several evaluators who had not heard of the effect made comments such as "what you described doesn't make very much sense to me" (psychiatrist) and "I've seen the opposite occur; they tend to rise a little bit" (psychologist).

Five psychologists and 2 psychiatrists reported that the Flynn effect had been an issue in at least one of their capital case mental retardation evaluations. When asked to explain how the Flynn effect had been an issue in their cases, most of these evaluators explained that the defendants they had evaluated had multiple intelligence test scores and that the Flynn effect was only one of several arguments brought up to explain the varying test scores.

These evaluators noted that issues relating to the standard error of measurement and a pattern of rising IQ scores because of an “educational effect” had also been a focus of testimony in these cases.

Participants’ general descriptions of varying IQ scores in their cases made it difficult to determine whether they really understood the Flynn effect. However, several evaluators made insightful comments about how the Flynn effect had been used in their cases. One evaluator noted that an understanding of the Flynn effect was especially important when defendants were originally tested with the Wechsler Intelligence Scale for Children (WISC; Wechsler, 1949): “There was a significant time gap between the release of the WISC and WISC-R [Wechsler Intelligence Scale for Children—Revised; Wechsler, 1974],” and diagnostic determinations based on administrations of the WISC “may well have reflected IQ scores inflated by the distance between the standardization date of the test and when it was actually administered.” Another evaluator noted that he or she had seen other mental health professionals adjust IQ scores for the Flynn effect even when the scores were based on current versions of IQ tests (e.g., Wechsler Adult Intelligence Scale—Third Edition [WAIS-III]; Wechsler, 1997).

Implications for practice. Given the potential importance that the Flynn effect may have on how evaluators interpret test results from previously administered IQ tests, we were surprised that only 69% of psychologists were familiar with the Flynn effect by its name. The finding that no psychiatrists knew of the effect by its name is also problematic, especially because psychiatrists do review test results and do give IQ estimates in court (Watt & MacLean, 2003). Mental health professionals who conduct capital case mental retardation evaluations should be aware of the Flynn effect and be prepared to discuss their diagnostic conclusions in light of the effect, even if the Flynn effect had no influence on their conclusions.

Evaluators must also be aware that there is no agreed-upon method for how diagnostic conclusions should be influenced by the Flynn effect. One evaluator in the current study described working on a case in which another evaluator reported IQ scores from a current version of the Wechsler Adult Intelligence Scale (WAIS-III; Wechsler, 1997) that were “adjusted” to account for the inflated IQ score predicted by the Flynn effect. Although the *Standards for Educational and Psychological Testing* acknowledge that “test revision often brings a need for some linkage between scores obtained using newer and older editions” (p. 53), they also caution that score conversions are “subject to misinterpretation” (p. 58; American Educational Research Association et al., 1999). Although score conversions may be justifiable in light of the Flynn effect, established professional resources guiding determinations of mental retardation do not address the issue of adjusting test scores (AAMR, 2002; Reschly, Myers, & Hartel, 2002), and test manuals do not provide any procedures for making adjustments (see, e.g., Wechsler, 1997, 2003). In 2000, Flynn argued against adjusting current test norms to “avoid obsolescence” because “IQ gains are not caused by something analogous to a physical law but are a phenomena [sic] whose causes are unknown . . . Sometimes gains suddenly stop . . . sometimes they accelerate for prolonged periods” (p. 196).

Flynn’s original research suggested that there was a consistent increase in IQ test scores of about .30 points per year (Flynn, 1984, 1987), and this metric for interpreting outdated test scores has been

described in appellate court cases (*Walker v. True*, 2005). However, as Flynn’s (2000) statement above suggests, the application of this .30 points per year metric to all test scores may be problematic because more recent research suggests that there is considerable variation in the size of the effect. For example, although the size of the Flynn effect across versions of the WISC (WISC, WISC-R, and WISC-III [Wechsler Intelligence Scale for Children—Third Edition; Wechsler, 1991]) is generally about .30, the size of the effect from the WAIS-R (Wechsler Adult Intelligence Scale—Revised; Wechsler, 1981) to the WAIS-III is only about .17 points per year (see Flynn, 1998). Moreover, recent research with the WISC, WISC-R, and WISC-III suggests that the decline in scores that is observed when a child takes a newer version of the test is larger for younger children and smaller for older children (Kanaya, Ceci, & Scullin, 2005). Thus, the size of the effect may not be consistent across different age groups, at least for children. These researchers also found that children who completed the same version of the WISC on two occasions showed virtually no differences in their scores from the first to second test administrations (Kanaya et al., 2005). Although these findings were based on testing with children, they raise concerns about the accuracy of test scores based on current norms (e.g., WAIS-III) that have been adjusted downward to account for the Flynn effect. Adjusting test scores in this manner is equivalent to estimating what the person’s IQ score would be on a future version of the test. Finally, researchers in Europe have found that the size of the Flynn effect has decreased over time and have suggested that the Flynn effect may be ending in developed countries (Teasdale & Owen, 2005). Flynn (1998) entertains this argument as a possible, although unlikely, explanation for the smaller size of the effect for the WAIS-III compared with the WISC-III.

In 2006, Flynn used an article about capital case evaluations to provide a formula for converting IQ scores to account for the Flynn effect, and this method of calculating adjusted test scores has been supported by at least one other intelligence testing expert (Greenspan, 2006). The extent to which Flynn’s 2006 recommendation for adjusting test scores will be accepted by other psychometricians, intelligence testing experts, and practitioners is unclear. In our view, the Flynn effect is best used as a framework for explaining the variation in test scores across administrations of different versions of the same test, but explaining the effect does not require reporting adjusted scores. However, Greenspan (2006) argues that IQ scores need to be adjusted because of the “magical hold” (p. 6) that the exact values of these scores have on decision makers. Regardless of whether evaluators choose to use or not to use Flynn’s (2006) conversion formula, evaluators who use the Flynn effect to inform their diagnostic impressions must be familiar with the current Flynn effect research literature and be able to discuss findings that relate to the specific tests, and versions of the tests, they are discussing.

Limitations and Conclusion

The survey findings reported in this article represent the opinions and practices of a small group of practitioners in Texas who have conducted evaluations in capital cases involving questions of mental retardation. The extent to which these characteristics of the sample influenced the study’s findings is unknown but suggests that the findings should be interpreted cautiously. Indeed, evalu-

ator practices in Texas may not be the same as evaluator practices in other states and jurisdictions. Evaluators should always be aware of the laws and procedures guiding evaluation practices in their state or jurisdiction. For example, evaluations in Texas must be consistent with both U.S. Supreme Court (e.g., *Atkins v. Virginia*, 2002, *Tennard v. Dretke*, 2004) and state-level court decisions (*Ex parte Briseno*, 2004). In some states, procedures for evaluations have been outlined through the state legislature. Duvall and Morris (2006) recently provided a helpful review of these statutory definitions of mental retardation for death penalty cases, but practitioners must understand that these definitions can change and should always consult with the attorneys who have sought their services about the current laws and procedures regarding mental retardation evaluations.

Another limitation is that we asked evaluators to describe their evaluations of mental retardation in capital cases, without being limited to a specific type of evaluation (e.g., *Atkins*-type case). Thus, some evaluators may have conducted their evaluations before the *Atkins* decision, which could have influenced how they responded to questions in the current study. The extent to which variations in referral question and pre- versus post-*Atkins* evaluations influenced the survey findings is not known. Finally, we asked evaluators to share their opinions about four potentially controversial issues in capital case mental retardation evaluations, and we do not want our selective emphasis to lead evaluators to overlook other important assessment issues (see Olley, 2006; Olley et al., 2006; Stevens & Price, 2006).

Despite the limitations of the practitioner survey, the findings represent a first step in attempting to gauge professional consensus about controversial issues in capital case mental retardation evaluations. Stevens and Price (2006) have argued that this type of information is needed as a step toward the "development of best-practice guidelines" in these types of cases (p. 19). The Ad Hoc Committee on Mental Retardation and the Death Penalty formed by Division 33 of the American Psychological Association has also identified a need for professional opinions about these issues: "The tasks of psychologists in *Atkins* hearings would be made clearer, and we presume that justice would be served more effectively, if this committee could identify those areas in which there is consensus on standards for psychologists" (Olley et al., 2006, p. 12).

Perhaps the most noteworthy finding in this study is the variability in the evaluators' explanations for why they engage in certain practices, even when describing the same practice. This variation highlights the need for informed professional discussion, and ultimately some consensus, about these practices. This variation also highlights the need for basic research relating to many of these questions, such as measurement bias in adaptive behavior scales, the relation between antisocial behavior and adaptive behavior, and professional agreement about adjusting IQ scores to account for the Flynn effect.

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Appendix

Semi-Structured Telephone Interview Questions

1. How many capital case mental retardation (MR) evaluations have you conducted?
2. How many of these evaluations were performed for the defense? State? Court?
3. In what states have you conducted MR evaluations in capital cases?
4. What are the requirements for MR in Texas?
5. How would you assess adaptive functioning for someone who has been on death row for a number of years?
6. How would you assess adaptive functioning for someone who is awaiting trial?
7. Would these two evaluations [questions 5 and 6] differ in any way? If yes, how?
8. Should past criminal behavior be considered in the assessment of adaptive functioning?
9. Should the defendant/inmate's behavior during the crime for which he/she is being evaluated be considered in the assessment of adaptive behavior?
10. In your opinion, what assessment procedures or methods are essential for a complete MR evaluation? In other words, what things must the evaluator always do?
11. What records and third-party information do you feel are essential to obtain and review?
12. Would you interview correctional officers to gain insight into the prisoner's adaptive functioning? Why/why not? Who would you talk to?
13. What tests have you used in capital MR cases? How often and reasons for using?
14. What is your opinion about using psychological tests when they have not been normed specifically on an incarcerated population?
15. The Flynn effect refers to the trend for intelligence quotients (IQ scores) to continually increase over the years. Because of this trend, newer intelligence tests are designed to be more difficult than older versions. Therefore, individuals who may have scored slightly above 70 on an intelligence test years ago may not score as high when tested using newer instruments. Have you heard of the Flynn effect?
16. Has the Flynn effect been an issue in any of the cases in which you have participated? If yes, explain.
17. Have any of your cases had varying patterns of IQ test scores that could be explained by the Flynn effect? Explain.

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