

No. 24-5221

IN THE
Supreme Court of the United States

ARTHUR LEE BURTON,

Petitioner,

v.

STATE OF TEXAS,

RESPONDENT.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE TEXAS COURT OF CRIMINAL APPEALS

PETITIONER'S SUPPLEMENTAL APPENDIX

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1
2 **AFFIDAVIT OF JONATHAN DeRIGHT, Ph.D., ABPP-CN**

3 1. I am Jonathan DeRight, a licensed clinical psychologist. I am over the age of 18
4 and competent to testify to the matters herein.

5 2. Attached to this Affidavit is a 28-page report I prepared at the request of Dorsey
6 & Whitney LLP, counsel for Arthur Burton, Jr. Everything contained therein is true and correct
7 to the best of my knowledge and belief.
8

9 I swear or declare under penalty of perjury that the foregoing is true and correct to the
10 best of my knowledge and belief.

11 DATED this ³⁰~~29~~th day of July 2024 in McLean, Virginia.



19 *Jonathan DeRight*
JONATHAN DERIGHT

20 VIRINIA:
21 City/County of Fairfax

22 The foregoing was acknowledged before me this 30 day of July, 2024, by

23 *JONATHAN DeRight*

24 Notary Signature: *Judith Logwood*

25 Registration # 7730769

My commission expires 10/31/2025.



FORENSIC NEUROPSYCHOLOGICAL EVALUATION

IDENTIFYING INFORMATION

Name: Arthur Lee Burton, Jr.
Date of Birth: March 29, 1970
Date of Examination: July 09, 2024
Date of Report: July 29, 2024

SUMMARY OF EVALUATION

Mr. Arthur Burton is a 54-year-old man whose history and neuropsychological test results indicate significant limitations in intellectual functioning and adaptive functioning since childhood. These characteristics, in my opinion, are sufficient to meet both the AAIDD and DSM-5 diagnostic criteria for intellectual disability. Neither of these two sets of criteria have a hard cutoff for an IQ score, and equal or more weight is placed on the individual's adaptive functioning when considering impairment. Especially in light of his history and poor performance on measures of suggestibility and social judgment—which span both intellectual and adaptive domains—Arthur's symptoms and history fit squarely within the definition of intellectual disability. Arthur's WAIS-IV IQ score of 77—with a 95% confidence interval of 73 to 82—indicates significant intellectual deficits and is consistent with a diagnosis of intellectual disability, and this score becomes even lower (66.5 to 76.5) when error variance through the Flynn Effect is considered. A newer version of the WAIS (the WAIS-5) is on the cusp of being released, but it will not yet be available until September 2024. It is well established that someone with an IQ in the 70s can indeed be diagnosed with intellectual disability so long as their adaptive functioning is impaired, and this pattern is present in Arthur's case. Even prior to incarceration, he had never lived on his own, and he had significant problems completing everyday tasks independently without outside supports. He was also reported to have been gullible and easily influenced, and this was consistent with cognitive test scores on the present exam. He also exhibited poor practical judgment, ability to write a check to pay a bill, following simple commands, learning new information consistently and efficiently, and ability to read a map. Based on multiple sources of information, Arthur's functioning has not improved dramatically over time and was present throughout childhood.



BASIS OF EVALUATION

- Review of Records:
 - o Crossett School district, school records of Arthur Burton dated 09/02/1986 to 05/25/1990
 - o Sworn Voluntary Statement of Arthur Burton Jr. dated 08/08/1997
 - o Statement of Arthur Burton Jr. (State's Exhibit D) dated 08/08/1997
 - o Testimony transcript of Arthur Burton Jr. dated 06/18/1998
 - o Affidavit of Arthur Burton dated 07/13/2000
 - o Affidavit of Arthur Burton, Sr. (Arthur Burton's father) dated 07/17/2000
 - o Affidavit of Jennifer Honea (law clerk) dated 07/18/2000
 - o Affidavit of Felisha Batts (Arthur Burton's wife) dated 07/18/2000
 - o Affidavit of Tommy Sturgeon (Chief of Police) dated 07/18/2000
 - o Affidavit of Edward P. Friedman, PhD (forensic psychologist) dated 07/19/2000
 - o Declaration of Fannie Burton (Arthur Burton's mother) dated 07/19/2000
 - o Declaration of Micheal Burton (Arthur Burton's brother) dated 07/19/2000
 - o Affidavit of Chris Huffman (former juror at Arthur Burton's capital murder trial) dated 07/20/2000
 - o Dee Dee Halpin, MS, summary of educational records dated 08/29/2002
 - o Testimony transcript of Dee Dee Halpin dated 09/04/2002
 - o Amended Consent Decree for Case No: 1:18-cv-1076 dated 02/03/2020
 - o Declaration of Scott Sasser (school counselor) dated 07/12/2024
 - o Declaration of Marcia Alexander (Arthur's former teacher) dated 07/13/2024
 - o Declaration of Fannie Burton (Arthur Burton's mother) dated 07/20/2024
 - o Declaration of Cheryl Douglas (Arthur Burton's former girlfriend) dated 07/21/2024
 - o Declaration of Micheal Burton (Arthur Burton's brother) dated 07/22/2024
 - o Declaration of Cassandra Green (Arthur's former classmate) dated 07/25/2024
- Clinical interview and mental status exam on 07/09/2024
- Administration of the following neuropsychological tests on 07/09/2024: b test; Wechsler Adult Intelligence Scale, 4th Edition (WAIS-IV); Reynolds Intellectual Screening Test, Second Edition (RIST-2); Wide Range Achievement Test, 5th Edition (WRAT-5) Word Reading subtest; D-KEFS Word Context Test; D-KEFS 20 Questions Test; Neuropsychological Assessment Battery (NAB) Language Module; Rey Word Recognition Test; TOMM; Rey Auditory Verbal Learning Test (RAVLT); WRAML-3 Story Memory; NAB Daily Living Module; Test of Practical Judgment (TOP-J); Gudjonsson Suggestibility Scales; & embedded measures of performance validity.
- Interview of Fannie Burton and administration of the Vineland Adaptive Behavior Scales Comprehensive Level Interview, Third Edition (Vineland-3) on 07/14/2024

At the beginning of my interview with Arthur, I explained the nature, purpose, and scope of the evaluation, including the relevant limits of confidentiality and privilege. I also explained the non-therapeutic nature of my role as a forensic evaluator. Arthur indicated that he understood these explanations and cooperated fully with the evaluation process.

My qualifications are discussed in Exhibit A. My CV is attached as Exhibit B.

RELEVANT STATUTES AND STANDARDS

Intellectual Disability (ID) can be diagnosed using two similar but distinct criteria: the American Association on Intellectual and Developmental Disabilities (AAIDD)¹ and The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).² Practice guidelines recommend that equal weight and joint consideration be given to intellectual functioning and adaptive behavior and that the 95% confidence interval (i.e., the obtained score plus or minus two times its standard error of measurement) be used.³

The AAIDD criteria are as follow:



Significant limitations in intellectual functioning, which means a Full Scale IQ standard score of approximately 2 (or more) standard deviations below the mean as measured with an appropriately-normed, standardized test of intelligence.



Significant limitations in adaptive behavior, which means a standard score of approximately 2 (or more) standard deviations below the mean measured with an appropriate and standardized test of adaptive behavior in one or more of the following domains: conceptual, social, or practical skills.



Onset of both of the above limitations during the developmental period, which means that significant limitations in both intellectual functioning and adaptive behavior in the individual have manifested before the age of 22.

The AAIDD manual further states that all test results must be interpreted within the context of their administration and any potential sources of testing error and that clinicians should consider all sources of evidence in making a clinical judgment of a person's overall functioning as part of a diagnosis of ID. The manual also stresses the importance of linguistic diversity and cultural differences in the way people communicate, move, and behave. A diagnosis of intellectual disability does not assume that a person is deficient in all areas assessed; as described in the AAIDD manual, assessments must assume that limitations often coexist with strengths, and that an individual's level of life functioning will improve if appropriate, personalized supports are provided over a sustained period.

As with the AAIDD, the DSM-5-TR criteria no longer specify a specific IQ score to be required for a diagnosis, and increased weight has been placed on adaptive functioning than in previous diagnostic criteria. While it would seem as

¹ Schalock, R. L., Luckasson, R., & Tassé, M. J. (2021). *Intellectual disability: Definition, diagnosis, classification, and systems of supports* (12th ed.). American Association on Intellectual and Developmental Disabilities.

<https://www.aidd.org/publications/bookstore-home/product-listing/intellectual-disability-definition-diagnosis-classification-and-systems-of-supports-12th-edition>

² American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Association Publishing.

³ Chafetz, M. (2015). *Intellectual Disability: Criminal and Civil Forensic Issues*. Oxford University Press.

though this change would make it easier to obtain a diagnosis of intellectual disability, research has found the opposite to be true: about 9% fewer children who met DSM-IV-TR criteria for intellectual disability met the DSM-5 criteria.⁴

The current DSM-5-TR criteria for intellectual disability as follow:



Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.



Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.



Onset of intellectual and adaptive deficits during the developmental period.

Examples of significant deficits in intellectual functioning include problems with thinking/learning (e.g., difficulties with problem solving, abstract thinking, comprehending complex ideas, learning quickly, and learning from experience), reasoning and planning (e.g., lessened interpersonal competence/decision making, deficits in social problem solving and flexible thinking), and learning from experience (e.g., difficulties generalizing from past experience, increased vulnerability/risk of victimization, tendency to deny or minimize their disability, desire to please authority figures, and gullibility/suggestibility).⁵

“Intellectual disability is a condition, not a number.”

The above sentence stems from Justice Kennedy’s *Hall v. Florida*⁶ decision, which emphasized that IQ scores, while helpful, are imprecise and are better understood as a range of scores rather than a single score. This is also found in the AAIDD manual, which states, “Because no test is without some measurement error or imprecision, using a confidence interval establishes a statistical range within which the assessed person’s true score falls within a certain (e.g., 95%) probability... Consistent with best practices, we recommend interpreting all obtained standard scores using a 95% interval (i.e., the obtained scores plus or minus two times its SEM).”

Intellectual disability is a clinical diagnosis much like Alzheimer’s disease, and it requires consideration of both intellectual and adaptive factors. There is no longer a cutoff score for intellectual disability; not 70 nor 75. Both the DSM-5-TR and the AAIDD criteria specify a score that is *approximately* (emphasis added) two standard deviations below the mean, and an IQ score does not even appear in the DSM-5-TR diagnostic criteria. One reason to consider a range of scores rather than a single score is to account for various sources of error variance. Small differences in

⁴ Papazoglou, A., Jacobson, L. A., McCabe, M., Kaufmann, W., & Zabel, T. A. (2014). To ID or not to ID? Changes in classification rates of intellectual disability using DSM-5. *Mental Retardation*, 52(3), 165-174.

⁵ Chafetz, M. (2015). *Intellectual Disability: Criminal and Civil Forensic Issues*. Oxford University Press.

⁶ Supreme Court of the United States. (2014). *Hall v. Florida*, 572 U.S. 701.

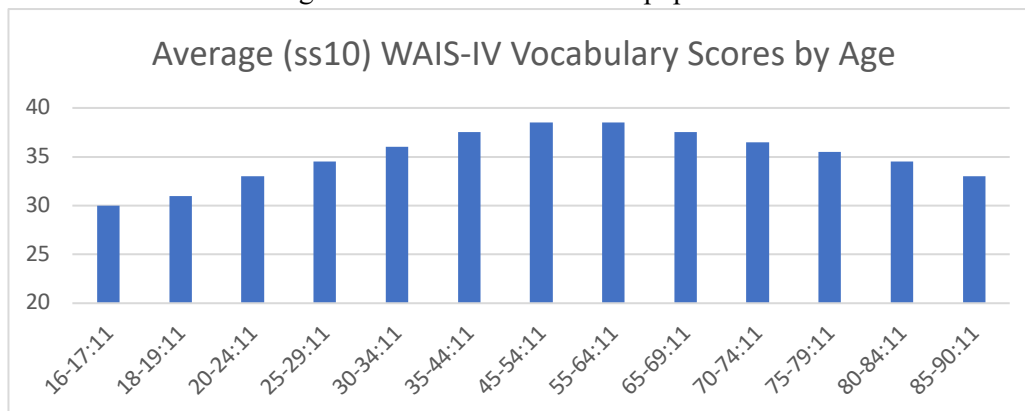
responses can lead to small, but important, changes in a test score, and when a high stakes decision is being made based on a test score, it would be unwise to base that decision on a score that does not account for possible sources of error. For example, a Full Scale IQ score of 77 on the WAIS-IV reduces to a score of 75 if the person less accurately defines one word, knows one fewer historical/scientific fact, and finds two fewer matching symbols in a span of two minutes. In clinical practice, this difference is essentially meaningless, but in a high stakes situation, error variance must be considered. While the WAIS-IV is a very reliable measure, its test-retest reliability of 0.95 means that one the same person taking the same test within a span of about three weeks, on average, is going to have a score that is 95% the same. While relatively insignificant in clinical practice, this inherent variability in scores could mean a difference of about 5 points. For this reason, among others, IQ is best understood as a range of scores.

When an individual has an IQ score above 70 but still within a range that may indicate deficits in intellectual functioning, the task then is to determine whether additional evidence of intellectual disability regarding adaptive deficits qualifies the individual for a diagnosis. Indeed, this notion is contained in the DSM-5-TR as well:

"Such [IQ] testing may identify areas of relative strengths and weaknesses, an assessment important for academic and vocational planning. IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with deficits in intellectual functioning whose IQ score is somewhat above 65–75 may nevertheless have such substantial adaptive behavior problems in social judgment or other areas of adaptive functioning that the person’s actual functioning is clinically comparable to that of individuals with a lower IQ score. Thus, clinical judgment is important in interpreting the results of IQ tests, and using them as the sole criteria for the diagnosis of an intellectual developmental disorder is insufficient.”

The DSM-5-TR also states, “Individual cognitive profiles based on neuropsychological testing as well as cross-battery intellectual assessment (using multiple IQ or other cognitive tests to create a profile) are more useful for understanding intellectual abilities than a single IQ score.”

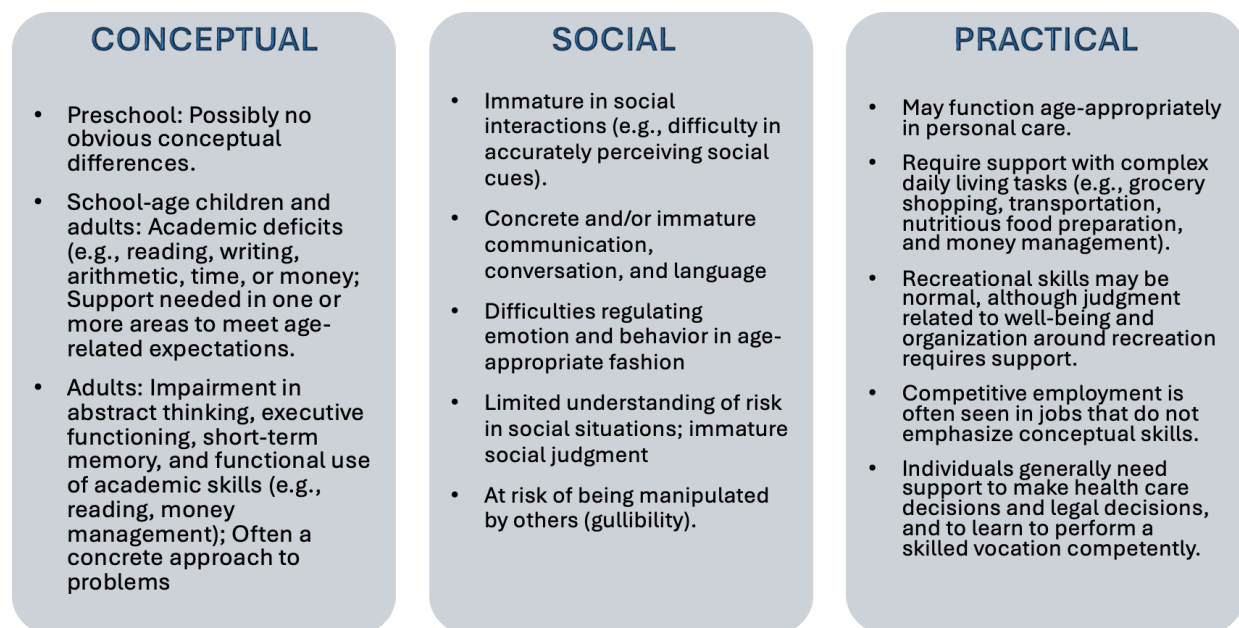
The Presence of Strengths Does Not Preclude a Diagnosis of Intellectual Disability. Individuals with intellectual disability are expected to have areas of strength. For example, Arthur’s verbal abilities are a clinically significant strength compared with his other scores. While this magnitude is rather large (e.g., 12 points higher than his nonverbal reasoning and 20 points higher than his working memory), it is not particularly uncommon, as a difference of 12 points between verbal and nonverbal reasoning occurs in about 20% of the population.



As shown in the graph above, a 54-year-old, on average, is expected to score about five raw points higher than a 20-year-old despite them both having an exactly average score; that is, one's ability to define a word will be better, on average, when he is in his 50s than when he is in his 20s. Similar improvements verbal abilities have been shown in groups of intellectually disabled individuals as well,^{7,8,9} meaning that it is possible to improve in reading skills while still having intellectual disability.

In the original Atkins case¹⁰, the prosecution's expert argued that Atkins had higher functioning because he used words such as "orchestra," "decimal," and "parable," but knowledge of such words is not dispositive of intellectual disability. IQ scores are not expected to correlate universally with neuropsychological test scores, as not all neuropsychological tests have the same type of score distribution that is found in an IQ test.¹¹ For example, a test of dementia severity intended for seriously disabled populations is going to have a very skewed distribution, meaning that it will be relatively rare to have a low score. This means that someone with, say, intellectual disability may score highly on this measure, but it does not discount the presence of other deficits.

The DSM-5-TR further defines common adaptive deficits and supports needed for mild¹² intellectual disability, as shown below.



⁷ Van den Bos, K. P., Nakken, H., Nicolay, P. G., & Van Houten, E. J. (2007). Adults with mild intellectual disabilities: Can their reading comprehension ability be improved?. *Journal of Intellectual Disability Research*, 51(11), 835-849.

⁸ Dessemontet, R. S., Martinet, C., de Chambrier, A. F., Martini-Willemin, B. M., & Audrin, C. (2019). A meta-analysis on the effectiveness of phonics instruction for teaching decoding skills to students with intellectual disability. *Educational Research Review*, 26, 52-70.

⁹ Hatch, P. (2009). *The effects of daily reading opportunities and teacher experience on adolescents with moderate to severe intellectual disability* (Doctoral dissertation, The University of North Carolina at Chapel Hill).

¹⁰ Atkins v. Virginia, 536 U.S. 304 (2002).

¹¹ Greiffenstein, M. F. (2009). Clinical myths of forensic neuropsychology. *The Clinical Neuropsychologist*, 23(2), 286-296.

¹² The term "mild" in something as serious as intellectual disability is somewhat of a misnomer. It would be akin to saying that one form of cancer is milder than another, yet both can still have devastating effects.

Making a Retrospective Diagnosis

In many cases, a diagnosis of intellectual disability is made during childhood, but this is not a defining factor of the diagnosis. The symptoms and behaviors leading to the diagnosis must have been present in the developmental period, but this can be assessed retrospectively using 1) a thorough social, medical, and educational history; 2) basing the diagnosis on multiple data points; 3) interpreting previously administered adaptive behavior assessments in terms of the quality of information and situations that were analyzed; and 4) interpreting previously administered intellectual functioning assessments in terms of the extent to which the assessment used a standardized and up-to-date test, considered the confidence interval, and corrected for the age of the norms that were employed (i.e., “the Flynn effect”).¹³

People tend to become smarter (and therefore perform better on IQ tests) over time.¹⁴ This means that a score compared against out-of-date test norms may appear artificially higher depending how much time has passed since a test was normed. A person’s IQ score should not change over time, but the normative group against which a score is measured must in order to provide accurate results. Flynn, in 2006, offered an example highlighted in another study¹⁵ in which there was an immediate rise in the number of children being classified as mentally retarded because some school psychologists had begun to use the new test (normed in 1989) rather than the older WISC–R (normed in 1972). Due to IQ gains over time, children in the mentally retarded range who took the new test were averaging 5.6 IQ points lower than those who were still taking the old test, and this was due to the 17 years between the time when the data was collected and the data of testing.¹⁶

IQ scores are relative measurements based on the performance of groups known as standardization samples, and collection of these samples is costly both in time and resources, so the tests are not updated frequently.¹⁷ Thus, the problem of comparing a current score to a standardization sample that may have been collected decades earlier arises. Consideration of a more extreme difference highlights the importance of accounting for these changes over time. For instance, if someone in 2024 took the original WAIS IQ test that was released in 1955, their score would be expected to be significantly higher than it would on a more recently normed test because the population as a whole is now smarter than it was almost 70 years ago.

The Flynn Effect has been applied to the WAIS-R, WAIS-III, and WAIS-IV.^{18,19,20} This has also been deemed as acceptable practice in the courts as well. For instance, a Maryland Federal court found the Flynn effect to be a

¹³ Chafetz, M. (2015). *Intellectual Disability: Criminal and Civil Forensic Issues*. Oxford University Press.

¹⁴ Flynn, J. R. (2009). The WAIS-III and WAIS-IV: Daubert motions favor the certainly false over the approximately true. *Applied Neuropsychology*, 16(2), 98-104.

¹⁵ Kanaya, T., Scullin, M. H., & Ceci, S. J. (2003). The Flynn effect and US policies: the impact of rising IQ scores on American society via mental retardation diagnoses. *American Psychologist*, 58(10), 778.

¹⁶ Flynn, J. R. (2006). Tethering the elephant: Capital cases, IQ, and the Flynn effect. *Psychology, Public Policy, and Law*, 12(2), 170.

¹⁷ Young, G. W. (2012). A More Intelligent and Just Atkins: Adjusting for the Flynn Effect in Capital Determinations of Mental Retardation or Intellectual Disability. *Vanderbilt Law Review*, 65, 615.

¹⁸ Zhou, X., Zhu, J., & Weiss, L. G. (2010). Peeking inside the “black box” of the Flynn effect: Evidence from three Wechsler instruments. *Journal of Psychoeducational Assessment*, 28(5), 399-411.

¹⁹ Grégoire, J., & Weiss, L. G. (2019). The Flynn effect and its clinical implications. *WISC-V assessment and interpretation: Scientist-practitioner perspectives*, 245-270.

²⁰ Trahan, L. H., Stuebing, K. K., Fletcher, J. M., & Hiscock, M. (2014). The Flynn effect: a meta-analysis. *Psychological bulletin*, 140(5), 1332.

persuasive argument with regard to a defendant's intellectual functioning ("In conclusion, the Court finds the defendant's Flynn effect evidence both relevant and persuasive, and will, as it should, consider the Flynn-adjusted scores in its evaluation of the defendant's intellectual functioning.")²¹

Practical Issues in Assessing Adaptive Functioning in Capital Cases

A retrospective assessment of adaptive behavior is often considered as the only viable option when the assessed individual is incarcerated, let alone on death row with even more restrictions. In these situations, it is necessary to interview a knowledgeable respondent (if available) to capture the individual's typical adaptive behavior in the community when they were not incarcerated. Adaptive functioning refers to behaviors *typically* displayed by an individual, not necessarily their adaptive *abilities*, which can take into account how someone would be able to function with ongoing support. Further, limitations in adaptive functioning are not synonymous with solely a lack of motivation; someone with adaptive deficits, as a function of their condition, would be expected to have limitations in their ability to carry out everyday tasks that is beyond what would be expected by lack of motivation alone. In the vast majority of cases, adaptive functioning is measured through a combination of interviews and neuropsychological testing, and relevant life experiences—such as romantic relationships, hobbies, social outings, and occupational performance—are considered. When the person being assessed is incarcerated, the freedom to engage in adaptive behaviors previously enjoyed is highly restricted. In this circumstance, it is common for an evaluator to obtain collateral reports and records to obtain converging lines of evidence when possible. The additional restrictions placed on someone on death row make the assessment even more challenging because certain characteristics that could otherwise be considered in the prison setting—such as job performance—are not allowed.²² In this situation, it is recommended that information from multiple sources and contexts be considered, and diagnostic interviews should be performed in the context of a clearly identified time period for which the respondent should consider (e.g., how the individual was functioning before they were incarcerated).^{23,24}

BACKGROUND

DEVELOPMENTAL HISTORY:

Arthur's mother, Fannie Burton, stated that he was born via a full-term pregnancy with no complications. She could not recall him being delayed in meeting developmental milestones.²⁵ Arthur has many developmental risk factors for

²¹ *US v. Davis*, 611 F. Supp. 2d 472 (D. Md. 2009).

²² Chafetz, M. (2015). *Intellectual Disability: Criminal and Civil Forensic Issues*. Oxford University Press.

²³ Schalock, R. L. (2007). *User's guide: mental retardation: definition, classification, and systems of supports: applications for clinicians, educators, disability program managers, and policy makers*. AAMR.

²⁴ Tassé, M. J. (2009). Adaptive behavior assessment and the diagnosis of mental retardation in capital cases. *Applied Neuropsychology*, 16(2), 114-123.

²⁵ While some conditions that lead to intellectual disability involve clear deficits from birth and/or delays in meeting developmental milestones, many individuals with ID do not display concerning signs of it until they are school-aged.

intellectual disability (e.g., malnutrition, exposure to environmental air pollution such as dioxin, low SES).^{26,27,28,29,30} Fannie married Arthur's father when she was 16 and he was 22, and they had their first child about a year later. She reported that Arthur's father was unfaithful and violent towards her, and she and the children later moved in with her mother (Arthur's grandmother) in Louisiana and Arkansas. Arthur reported that they lived with his grandmother in a one-bedroom house in Arkansas, and they were later able to move into a larger home. Arthur lived less than a mile away from a factory was eventually shut down due to excess environmental toxins (e.g., hydrogen sulfide and known carcinogens such as formaldehyde, dioxin, acetaldehyde and chloroform) exposure.^{31,32,33,34} This event was also recalled by Arthur's former classmate, Cassandra Green, who recalled that the Centers for Disease Control (CDC) came to her town to test the area and found that there were very high cancer rates in their county. Fannie, in her declaration, stated that money was tight when Arthur was a child, and they did not always have food or electricity. Arthur's brother, Micheal, stated that they occasionally did not have food at home for several days and that water and electricity were sometimes turned off. Arthur recalled frequently going to school hungry.

EDUCATIONAL HISTORY AND EVIDENCE OF CONCEPTUAL DEFICITS:

Arthur's academic history provides significant evidence of conceptual deficits. Fannie recalled that she realized Arthur needed extra help in school when he was in elementary school. She stated that math was always especially hard for him, and he was in special education classes throughout his schooling. Micheal also reported that Arthur was in special education classes along with him. Fannie recalled that Arthur enjoyed reading comic books from a young age, but for many years he seemed to look at the pictures more than read them. According to school records from Crossett School District, Arthur's grades in elementary and middle school were generally poor to average, depending on the class. He was in a remedial reading class, and he failed math, English, and social studies courses at times.

Records indicate that he repeated the 2nd and 8th grades, but Arthur had difficulty recalling which grades he repeated. In his second time in the 8th grade, he still earned almost entirely Ds (with the exception of remedial reading). In his senior year of high school, Arthur earned a D in an independent living skills class. Arthur's 10th grade basic math teacher, Marcia Alexander, recalled that Arthur failed her math class and had to retake it and that he would try to mask

²⁶ Bellinger, D. C. (2019). Environmental chemical exposures and intellectual disability in children. *Handbook of Intellectual Disabilities: Integrating Theory, Research, and Practice*, 347-363.

²⁷ Chattopadhyay, N., & Saumitra, M. (2016). Developmental outcome in children with malnutrition. *Journal of Nepal Paediatric Society*, 36(2), 170-177.

²⁸ Uzun Cicek, A., Sari, S. A., & Mercan Isik, C. (2020). Sociodemographic characteristics, risk factors, and prevalence of comorbidity among children and adolescents with intellectual disability: a cross-sectional study. *Journal of Mental Health Research in Intellectual Disabilities*, 13(2), 66-85.

²⁹ Waber, D. P., Bryce, C. P., Girard, J. M., Zichlin, M., Fitzmaurice, G. M., & Galler, J. R. (2014). Impaired IQ and academic skills in adults who experienced moderate to severe infantile malnutrition: a 40-year study. *Nutritional neuroscience*, 17(2), 58-64.

³⁰ Huang, J., Zhu, T., Qu, Y., & Mu, D. (2016). Prenatal, perinatal and neonatal risk factors for intellectual disability: a systemic review and meta-analysis. *PloS one*, 11(4), e0153655.

³¹ U.S. Environmental Protection Agency. (2018, December 14). *Georgia-Pacific settles EPA Clean Air Act claims at Crossett, Ark., facility, will correct alleged violations and pay civil penalties*. U.S. Environmental Protection Agency. <https://www.epa.gov/archive/epa/newsreleases/georgia-pacific-settles-epa-clean-air-act-claims-crossett-ark-facility-will-correct.html>

³² Crunden, E. A. (2016, April 12). *Small town in Arkansas battles Georgia-Pacific pollution*. Newsweek. <https://www.newsweek.com/crossett-arkansas-georgia-pacific-factory-pollution-446954>

³³ NWA Online. (2018, March 25). *Findings list smell from mill over limit*. NWA Online. <https://www.nwaonline.com/news/2018/mar/25/findings-list-smell-from-mill-over-limi/>

³⁴ Wiener, D. (2019, August 1). *Koch closes plant after huge EPA fine*. Exposed by CMD. <https://www.exposedbycmd.org/2019/08/01/koch-closes-plant-after-huge-epa-fine/>

his deficits so he would not appear impaired to other students. She stated that she still has the textbooks that were used in that course, and they included information about sales tax, how to read a bank statement, and how loan payments worked. She also provided an example of a basic high school biology class that she taught and how she used activities from her daughter's 4th grade science book to teach, which gives a sense of how academically challenged the students in a basic biology class were.

In a declaration, a school counselor who is knowledgeable about the standard practices of the school district stated that only a small minority of students were held back, and it was done due to insufficient progress rather than as a punishment. Arthur was 11 years old when he was in the 4th grade, and almost all of his scores on standardized tests were still below grade level at that time. He also indicated that Arthur's GPA of 2.18 included grades from his special education courses, meaning that it was not likely to be a true reflection of his abilities. Arthur graduated from high school, but he did so with a "basic" diploma, which is the "lowest path." Arthur's former teacher, Marcia Alexander, concurred, stating, "Basic diplomas were for the students who were mentally and academically challenged. Obtaining that sort of diploma meant that they had satisfied the absolute minimum requirements to graduate from school." Arthur's former classmate (who is now a public school administrator), Cassandra Green, stated, "The Basic diploma typically meant that a student was in special education," and she added that, at that time, special education courses were taught at a much lower level. Ms. Green's father was the principal of Arthur's high school, and she recalled that it was important to her father than all children have the ability to graduate, no matter their struggle.

Communication problems are highlighted as an area of conceptual adaptive functioning deficits in the DSM-5-TR. Arthur's problems in communication were recalled by several individuals. Arthur's mother recalled that he would often forget instructions that were told to him seconds earlier, and he struggled to find words to communicate. She stated that he would probably have been able to tell you how to get somewhere and that "there would be a couple wrong turns, but you'd get there eventually." One of Arthur's ex-girlfriend's, Cheryl Douglas, also remembered that Arthur had a hard time communicating, stating "Arthur needed extra support to speak up for himself. It was hard to know what was on Arthur's mind because he couldn't verbalize it." She observed that, at the time she was spending time with him, "he had a hard time putting his thoughts together to be able to say what he was thinking or feeling."

SOCIAL HISTORY AND EVIDENCE OF SOCIAL DEFICITS:

Arthur's social history reveals evidence of deficits in the social domain, including gullibility and being easily lead. Arthur's mother and brother reported that he was teased and bullied frequently as a child. The DSM-5-TR indicates that individuals with intellectual disability often display gullibility that involves "naiveté in social situations and a tendency for being easily led by others." Fannie recalled that Arthur was a "follower" who mainly went along with what others were doing. She stated that there were times when he thought people were his friends, but it was clear that they were getting him in trouble by telling him to do something. For example, she stated that his friends once convinced him to take something from a store by telling him that it was easy to do. She also recalled that Arthur had difficulty saying no to people when they asked him to do something, and he was easily influenced by others. One of Arthur's ex-girlfriends, Cheryl Douglas, concurred with this. In her declaration, she stated, "Arthur didn't really think for himself. People he cared about told him what to do, especially his mother. Arthur didn't rock the boat when someone else was telling him what to do. He would just go along with it." She also stated that he had difficulty making friends, and he often did not realize that people did not have his best interests in mind until it was too late. She recalled

that Arthur would often laugh to try to fit in, even when there was not anything funny happening. She and Arthur had a son together, and she reported that her son was diagnosed with intellectual disability as a child.

The DSM-5-TR also highlights low social participation and difficulty in accurately perceiving peers' social cues as characteristics of adaptive deficits. Arthur's former classmate, Cassandra Green, recalled that Arthur was quiet, withdrawn, and often did not have facial expressions that matched his actions. She provided an example of him cracking a joke but still having a sad expression on his face. She recalled that Arthur would try to make others laugh to distract from his schoolwork, but she did not recall him to get in trouble frequently. Like Ms. Douglas, Ms. Green recalled that Arthur would often "get mixed up in something his friends were doing."

DAILY LIVING ABILITIES AND PRACTICAL DEFICITS:

It is common for individuals with ID to be able to work in lower-skilled occupations.³⁵ After graduating from high school when he was about 20 years old, Arthur worked at the Georgia-Pacific—a chemical plant and plywood mill—that was later shut down due to excess environmental toxins as described above. Arthur has also worked in warehouse jobs, where he loaded and unloaded trucks. Arthur also worked for his father, who owned a construction business. He did not recall having seen his father for over 20 years until he decided to move to Texas and work for him along with his brother Micheal. In his declaration, Micheal said the job, which involved pouring concrete, was more physically challenging than mentally demanding, as the concrete was pre-mixed and delivered on a truck, and they did mostly the same things each day. Arthur Sr. was generally the person who did the planning of the day's activities. He worked with his father for about five years, even after Micheal stopped working there because his father was not treating them well. Micheal recalled that their father's treatment worsened over time and extended to physical abuse. He recalled that his father tried to break his arm with a baseball bat and pulled a gun on him. He felt that their father only wanted them there for the money, and he decided to leave this job, but Arthur stayed "for quite a while" thereafter. Arthur's choice to stay at this job despite receiving abusive treatment is further evidence of a practical deficit (i.e., failure to maintain a safe environment for himself).

According to the DSM-5-TR, practical aspects of adaptive functioning involve activities such as personal care, job responsibilities, money management, self-management of behavior, and nutritious food preparation, among others. Arthur's mother and brother stated that he could not cook meals, did not go grocery shopping, needed to be told to do anything around the house. Arthur stated the same in his interview. He stated that he never lived by himself. He was living with his common-law wife for about five years before he was incarcerated. He stated that she paid the bills, did the grocery shopping, planned and cooked meals, did the laundry, and did most of the cleaning. He stated that he knew how to make eggs and toast but otherwise rarely cooked. He denied having problems with personal self-care.

When Arthur was testifying in his case, he was unable to recall his previous address and how old he was when he lived in Louisiana and Arkansas. His mother recalled that he generally cashed his paycheck and did not utilize a bank account. Micheal also recalled that Arthur would carry cash with him. His mother was unaware of him being directly responsible for any bills. His brother Micheal, who also lived with him as an adult, stated that Arthur would do anything that someone in authority told him to do. He recalled that Arthur and Felisha's home was dirty and "looked like a hoarder's home."

³⁵ For example, the DSM-5-TR states, "In adulthood, competitive employment is often seen in jobs that do not emphasize conceptual skills."

Arthur's mother recalled an instance in which he almost drowned in a pool when he was 10 years old because he jumped in along with others but did not know how to swim. She also recalled a time in which he drove a car from Texas to Louisiana and did not know to check the oil or the radiator to ensure that it was working properly, which caused major problems with the car. Arthur's mother described his love for animals and questionable judgment related to caring for them. For instance, she described a time in which Arthur rescued a cat and put it in her bed while she was sleeping. Micheal also recalled a time in which Arthur tired sneaking in a cat by putting it under his shirt and hoping no one would notice. On another occasion, he rescued a dog, which he would try to bathe daily, and upon being frustrated that the dog would get dirty again, he felt the solution would be to nail boards over the doghouse so that it could not exit.

Arthur's mother recalled that he had significant difficulty putting furniture together with an instruction manual. He often did not think about how healthy one food was compared with another, and he often did not pick the correct clothing for the weather. She stated that he would come to someone when he was feeling sick and did not know to take his own temperature or take a medication such as Tylenol. She recalled that she could not trust that he washed his hands before touching food and that he would not think to rinse off produce before consuming it. She stated that he was eventually not allowed to put dishes away because he accidentally broke too many of them, and he was not allowed to use the stove or the oven for cooking because he forgot to turn it off at one point.

MEDICAL, PSYCHIATRIC, AND SUBSTANCE USE HISTORY:

Arthur denied having any major medical problems or taking any medications. He reported having a history of depression especially after being incarcerated, but he stated that this generally improved over time. He reported that he was consuming alcohol (mostly hard liquor) with coworkers after work on a regular basis prior to incarceration.

In July 2000, Arthur was evaluated by psychologist Edward Friedman, PhD. Dr. Friedman's evaluation of Arthur involved the use of a significantly outdated test that was given in non-standard conditions. He also did not review school records, perform any additional cognitive testing, or speak with any family members. According to an affidavit dated 07/19/2000, Dr. Friedman stated that Arthur did well in science and history courses, which was apparently based on Arthur's self-report. This is inconsistent with school records that show him making C and D grades in these courses at times. Dr. Friedman administered the Wechsler Adult Intelligence Scale, Revised (WAIS-R), which even then was an extremely old test, and it did not comport with practice guidelines for the assessment of intellectual functioning.³⁶

The WAIS-R was released in 1981 and utilized the same data from the original WAIS, which was published in 1955, with new norming. At the time of the evaluation in 2000, the WAIS-III had been out for about three years. I was unable to review data from the WAIS-R that was administered to Arthur, and I was thus unable to validate its scoring to ensure its accuracy; however, Dr. Friedman did mention that the test was administered in the presence of third party observers, which is also against protocol and may have affected his test score. According to Dr. Friedman, Arthur produced a Full Scale IQ of 84 on the WAIS-R. He did not administer any additional cognitive testing. Dr. Friedman also administered the Personality Assessment Inventory, which was an up-to-date test but was also incorrectly administered, as Dr. Friedman stated that he was not present while Arthur was taking it, which violates the typical

³⁶ According to the AAIDD, practice guidelines for assessing intellectual functioning include, among others, the use of "a current, reliable, valid, and individually administered, comprehensive, and standardized that is normed on the general population and yields a full-scale IQ score for the individual." They also state that the most recent norms of an instrument should be used and that the 95% confidence interval be used to consider an IQ score.

procedure for the test. Nevertheless, Dr. Friedman commented on Arthur being especially suggestible. He did not address adaptive functioning otherwise.

FINDINGS

MENTAL STATUS & BEHAVIORAL OBSERVATIONS:

Arthur was evaluated via a contact visit at TDCJ Polunsky. The evaluation was completed in a private attorney consultation room, and no one else was present in the room. I checked in several times to ensure that Arthur could hear, see, and otherwise complete testing without issue, and he stated that he was able to do so. He remained shackled during testing, but he was able to use his hands to manipulate blocks and use a pen without issue. As described below, one of the validity tests that he passed involved moving his hands quickly, and one of his better scores was also on a measure that required hand speed. Thus, the conditions of the evaluation were not deemed to have affected Arthur's ability to produce valid and reliable test scores on this exam.

Arthur was dressed in standard issued attire and wore eyeglasses. He appeared to have problems with articulation (e.g., a mild lisp), but his speech was otherwise normal in rate, rhythm, and volume. He appeared to have problems coming up with words in conversation. He tended to say little in conversation, but his thought process was generally linear and on-topic. At the conclusion of the evaluation, I asked him if he had any questions for me, and he stated that he did not. He reported thinking about his potential execution date "sometimes." He denied experiencing hallucinations and there were no signs of delusions. He denied having suicidal thoughts. He reported his mood to be "not so great," and his affect was congruent with his mood. When he was asked why his mood was low, he stated that there was "nothing to do but sit around" due to the power outage, and he did not bring up his potential execution date.

In addition to standardized testing, I showed Arthur a series of letters—some real and some fake—to determine if he was able to identify areas of risk in everyday situations. For example, on letter that was shown to him promised him to be a "secret shopper" as long as he fronted the money, and he indicated that he could call the number listed on the letter. He was later presented a fraudulent letter related to taxes being owed and the need for him to provide personal information, and he indicated that he would comply with the letter.

PERFORMANCE AND SYMPTOM VALIDITY:

Methods.

If results of questionnaires and cognitive tests are to be used to make important decisions and conclusions, it is important to ensure the accuracy of the test results, such that lack of engagement or purposeful incorrect or symptomatic responses (i.e., malingering) can be ruled out. This is primarily performed by administering assessments designed to measure performance and symptom validity, examining score profiles within tests designed to measure other abilities, and monitoring unusual test behaviors or performances that are drastically inconsistent with known neurological conditions. To assess performance validity, I selected stand-alone measures, embedded measures, and cut off scores *a priori* and used scores that were appropriate for the examinee's population³⁷. I chose widely accepted

³⁷ Boone, K. B. (Ed.). (2021). *Assessment of feigned cognitive impairment, 2nd Ed.* Guilford Publications.

measures with strong sensitivity and specificity rates and considered other conditions that could create inaccurate validity testing results.

Results.

Arthur passed all stand-alone and embedded measures of performance validity that were administered. Passing a performance validity test does not imply that a person is not impaired; it merely indicates that an examinee was putting forth adequate effort to produce valid and reliable cognitive test scores. Arthur also appeared to be engaged during the evaluation and did not appear to have any problems concentrating on the tests administered. Thus, the following test scores can be considered to be a valid and reliable indication of his current abilities.

NEUROPSYCHOLOGICAL TESTING:

Methods.

Arthur was administered numerous measures of cognitive functioning that were appropriate for the referral question and his background. It is not uncommon for neuropsychological test selection to vary depending on the needs of the individual completing the test and the referral source. While many of the same measures are often selected for evaluation of a particular disease, disorder, or condition, it is through clinical judgment that certain measures are and are not selected, and this methodology is a common and standard practice in the field of neuropsychology.

Because disorders such as intellectual disability may not be formally identified in childhood, a clinical interview often holds more weight than simply determining whether someone was diagnosed as a child. A combination of information from both contemporaneous and retrospective contexts is recommended.³⁸ As described above, it is challenging to assess adaptive functioning for an individual who has been on death row for many years, but there are clinically sound methods for doing so. To conduct this assessment, I followed guidelines³⁹ offered for this situation including the following:

- Use of standardized adaptive behavior scale that was normed on the general population
- Obtaining corroborating information to support the information obtained on the standardized assessment
- Identifying a clear time period for which the respondent should focus their report of the individual's adaptive behavior
- Building rapport with the respondent prior to the standardized assessment interview
- Periodically reminding the respondent that they are assessing the individual's adaptive behavior in that specific time period

*Cognitive Test Results*⁴⁰

³⁸ Cunningham, M. (2010). *Evaluation for capital sentencing*. Oxford University Press.

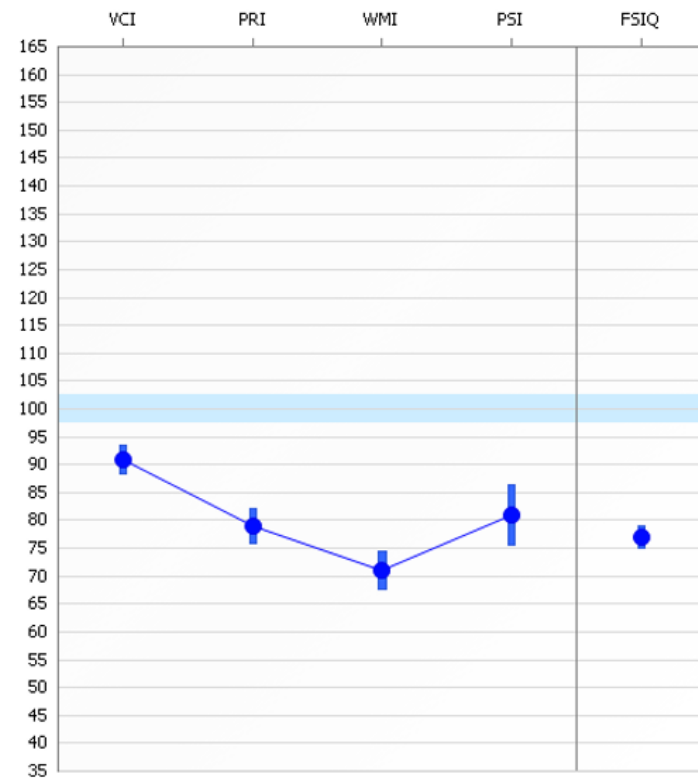
³⁹ Tassé, M. J. (2009). Adaptive behavior assessment and the diagnosis of mental retardation in capital cases. *Applied Neuropsychology*, 16(2), 114-123.

⁴⁰ A complete table of test results is provided at the end of this report. Results are summarized here.

Arthur's WAIS-IV Full Scale IQ was found to be 77, and there is a 95% chance that his "true" score is between 73 and 82⁴¹. He exhibited a relatively significant strength on measures of verbal abilities, and he performed especially poorly on measures of working memory, which was consistent with his prior evaluation. About 50% of people with mild intellectual disability have a profile like Arthur's in which tests involving speed are generally worse than tests that do not.⁴²



Composite Score Profile



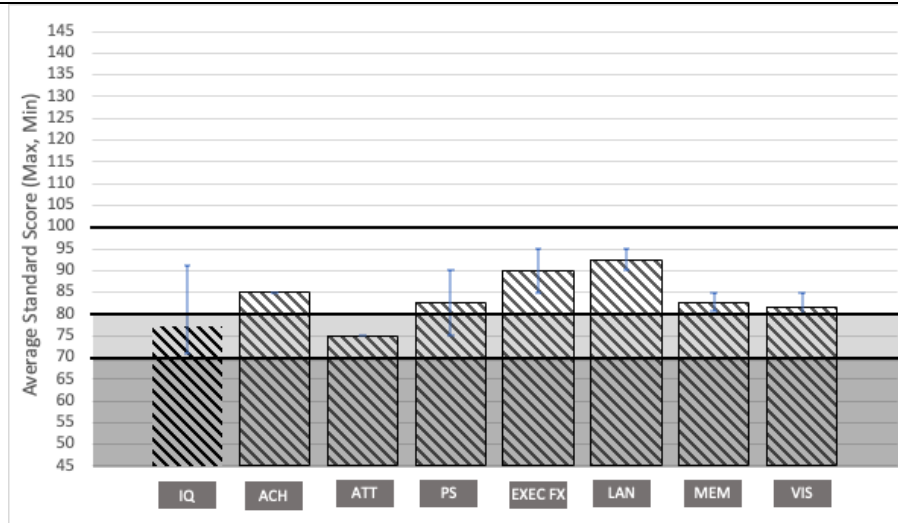
The vertical bars represent the standard error of measurement (SEM).

Arthur was also administered several other neuropsychological tests, and a visual depiction of Arthur's cognitive test results is shown below⁴³.

⁴¹ While the SEM on an IQ test is typically considered to be plus/minus 5 points, this is calculated mathematically when the test is considered, and it is provided in the test output. This can sometimes result in an asymmetrical confidence interval (e.g., minus four points, plus five points).

⁴² WAIS-IV Technical and Interpretive Manual, Table C.4

⁴³ Scores shown indicate a mean of 100 and a standard deviation of 15. The blue bars indicate the highest and lowest scores in each area. The light gray shading indicates Below Average scores, and the dark gray shading indicates Exceptionally Low scores.



As stated in the AAIDD manual (Tables 3.1 and 3.3), there is some overlap between measures of intellectual and adaptive functioning. For example, both domains might include problems with social problem solving/decision-making, problems with language comprehension, suggestibility, and a desire to please authority figures.

Arthur's current test results indicated **Exceptionally Low**⁴⁴ (worse than over 98% of his peers) scores on the following:

- attention to detail in a visual scene (NAB Daily Living Module: Driving Scenes)
- writing a check to pay a bill (NAB Daily Living Module: Bill Payment)
- following instructions by reading a map (NAB Daily Living Module: Map Reading)
- following simple two-step verbal instructions (NAB Language Module)
- writing a paragraph to describe a visual scene (NAB Language Module)
- judgment of various safety scenarios (Test of Practical Judgment)
- suggestibility following slightly negative feedback (Gudjonsson Suggestibility Scales)

Arthur's paragraph describing a visual scene, as shown below, included generally intact spelling but only consisted of two sentences, and he was missing a great deal of information from the picture shown to him. The scene shown to him involved a family having a cookout in a backyard, and there were numerous details including clothing, emotions, characters, and items that were present.

The family is having a barbaque they are not paying attention to the girl who is trying to get a hotdog from the grill. The boy is giving his food to the dog.

⁴⁴ Score categories are based on the descriptors provided in Guilmette, T. J., Sweet, J. J., Hebben, N., Koltai, D., Mahone, E. M., Spiegler, B. J., ... & Conference Participants. (2020). American Academy of Clinical Neuropsychology consensus conference statement on uniform labeling of performance test scores. *The Clinical Neuropsychologist*, 34(3), 437-453.

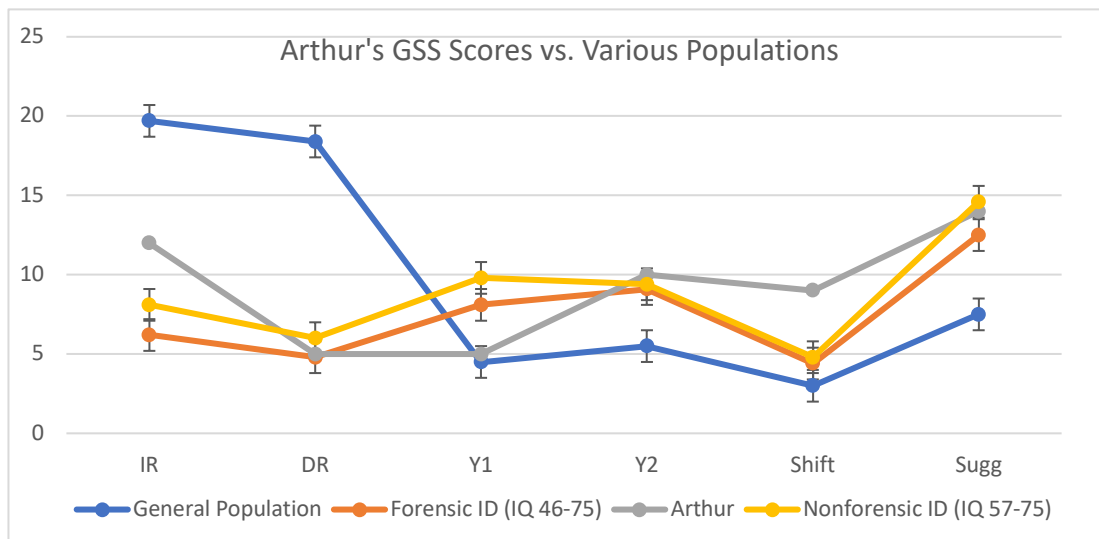
Arthur was presented with various safety and judgment scenarios on the Test of Practical Judgment, and his score was extremely low. The concepts measures on this test are shown below, with those in red indicating completely incorrect responses and those in orange indicating partially correct responses (1/3 points).

Table 2. Scenarios presented for Forms A and B by primary content area.

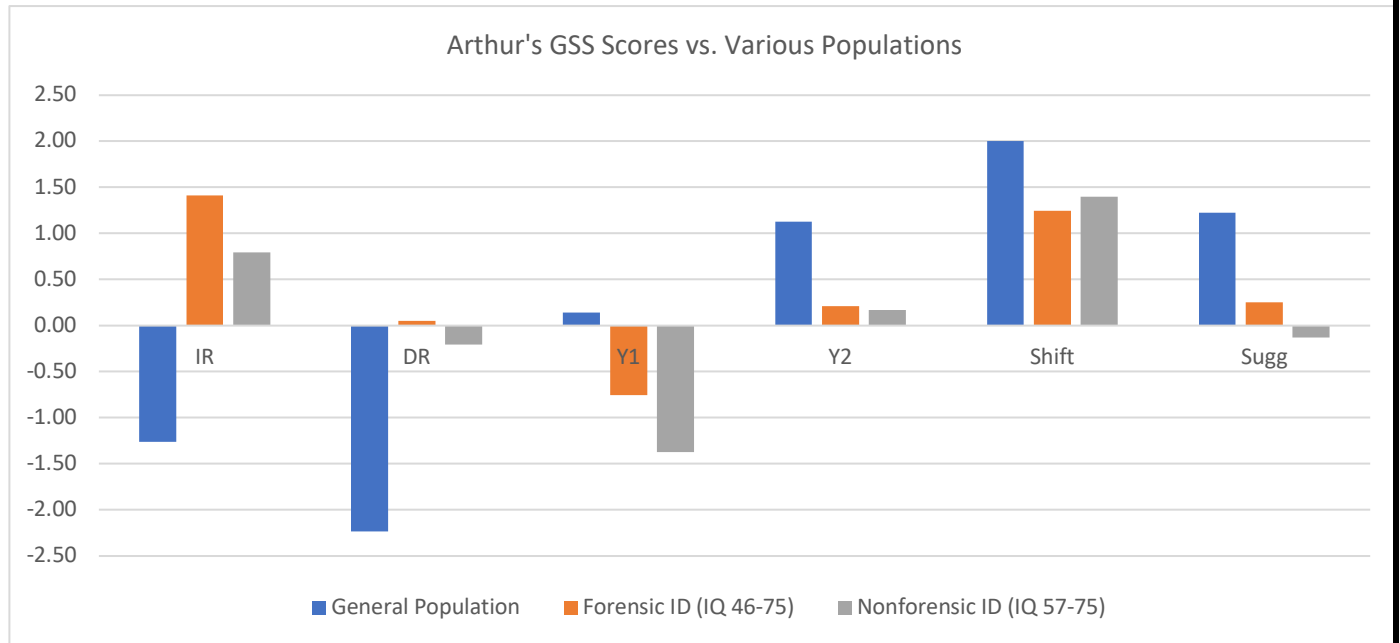
	Form B
Medical	Natural supplement advertised for memory* High risk for skin cancer and volunteering outdoors* Needs to make medical decision concerning surgery* Chest pain after exercising
Safety	Drowsiness from medication and scheduled appointment* Low fuel while driving and running late to wedding* Unannounced utility worker asks to come inside home Lost and without a cell phone
Financial	Two competing bills and delayed income* Additional costs for certain doctors' visits* Grandchild's graduation gift and competing bills
Social/ethical	Finds money and wallet while dining out* Schedules two engagements at the same time* Finds dog struggling in car Friend asks for ride home while very tired

Arthur performed very poorly on the Gudjonsson Suggestibility Scales (GSS). When presented with a forced choice answer in which neither was correct (e.g., “was the car black or blue?” when it was really red), he acquiesced to the forced choice response (e.g., chose one of the incorrect answers rather than saying that neither occurred) much more than the general population (Y1 and Y2). His Shift score was especially poor when examining the change in this behavior after being provided with negative feedback (e.g., “You have made a number of errors. It is therefore necessary to go through the questions once more, and this time try to be more accurate”), meaning that he either changed a response from one choice to another or from no to yes. His total suggestibility score (“Sugg”) was higher than 89% of others.

As described above, Arthur’s scores on the GSS indicated a very strong tendency to acquiesce to social pressure and change his responses. The graphs below show Arthur’s scores in comparison with other populations including the general population and those with intellectual disability.



The second graph shows how discrepant Arthur's GSS scores were compared with these populations. These are shown using z-scores, with a score of zero meaning that it is average compared with a particular group, while positive and negative scores show whether a score was better or worse than that group. As shown below, Arthur's scores on measures of suggestibility were often significantly higher (worse) than the general population and highly consistent with the intellectual disabled population.



Arthur produced **Below Average** (worse than 92 to 98% of his peers) performances on the following measures:

- nonverbal abstraction (Odd Item Out)
- confrontation naming (NAB Language Module)
- mental arithmetic from word problems read aloud (WAIS-IV Arithmetic)
- repetition and mental rearrangement of numbers read aloud (WAIS-IV Digit Span)
- speeded matching of numbers and symbols (WAIS-IV Coding)
- efficiency of learning and remembering words read aloud (RAVLT)
- recognition of words from a list (RAVLT)
- retention of everyday information (NAB Daily Living Module: Daily Living Memory)

Arthur produced **Low Average** scores (worse than 76 to 92% of his peers) on the following measures:

- single word reading (6th grade equivalent)
- problem solving efficiency (although his overall score on the D-KEFS 20 Questions test was normal, he exhibited a very poor and inconsistent strategy)
- learning of medication instructions and a name/address
- recall of medication instructions and a name/address
- recall of words from a list after a delay
- using blocks to re-create a visual design
- nonverbal pattern analysis

- mentally rotating pieces of an object to match a stimulus
- learning of everyday information
- recall of everyday information
- ability to express why basic everyday scenarios could be unsafe
- basic knowledge of societal rules and customs
- delayed recognition of everyday information

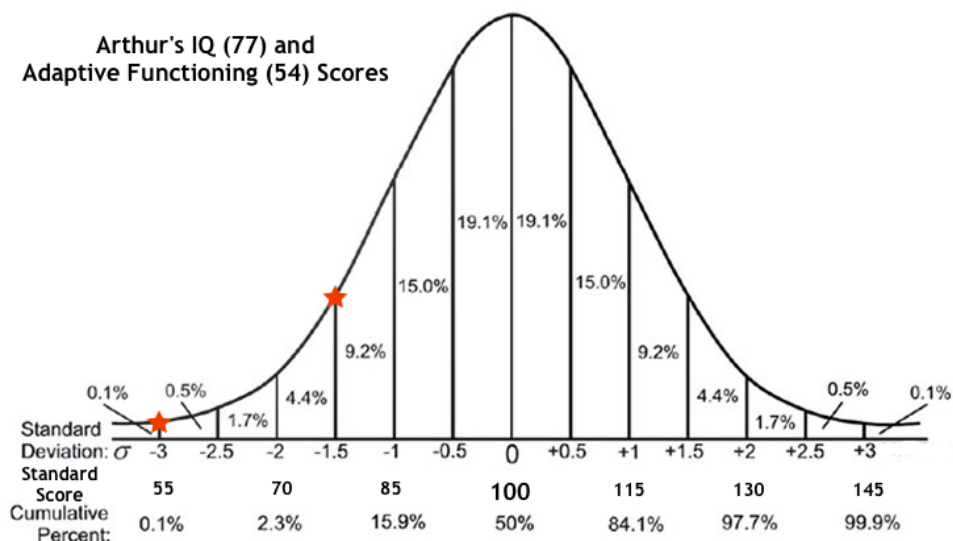
Arthur produced **Average** scores on the following measures:

- verbal reasoning
- speeded comparison of visual designs
- finding a shared similarity between two words
- expressive vocabulary
- knowledge of geographical, historical, and scientific facts
- learning of a list of words over several trials

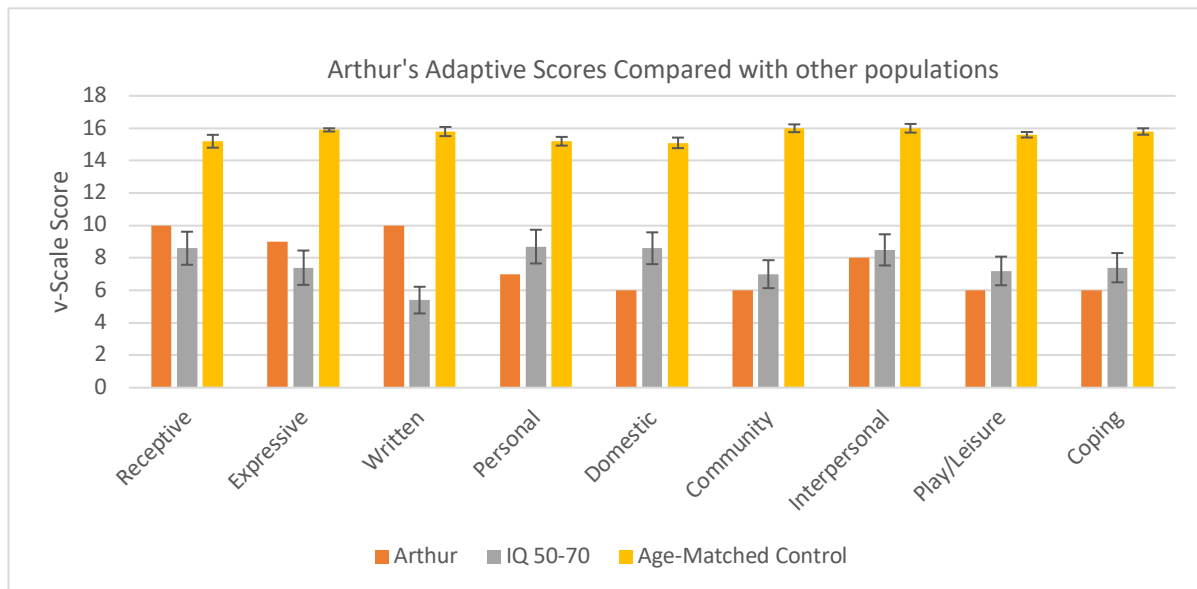
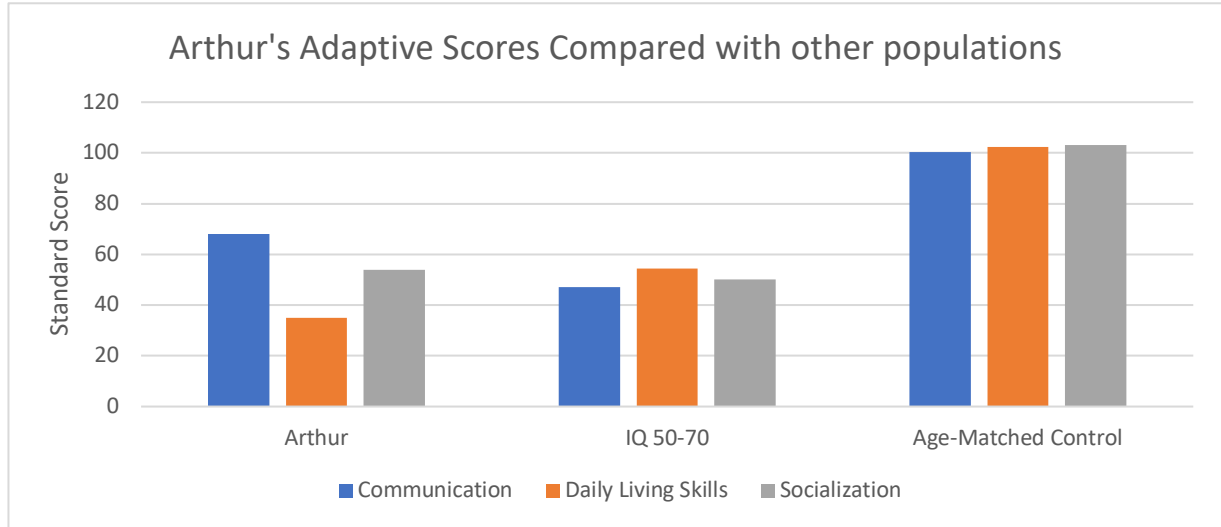
Adaptive Functioning

I administered the Vineland 3 Comprehensive Interview to Arthur's mother. I instructed her to provide responses that were consistent with her most recent direct memories of his functioning, which was before he moved to Texas when he was about 20 years old. I frequently reminded her and framed questions to indicate that this was the time period she should consider when answering a question. Instead of comparing these scores with Arthur's current age (which would have often led to lower scores due to increased expectations of functioning with age even in those with intellectual disability), I used the normative database for a 20-year-old, which is the age he was during that time period.

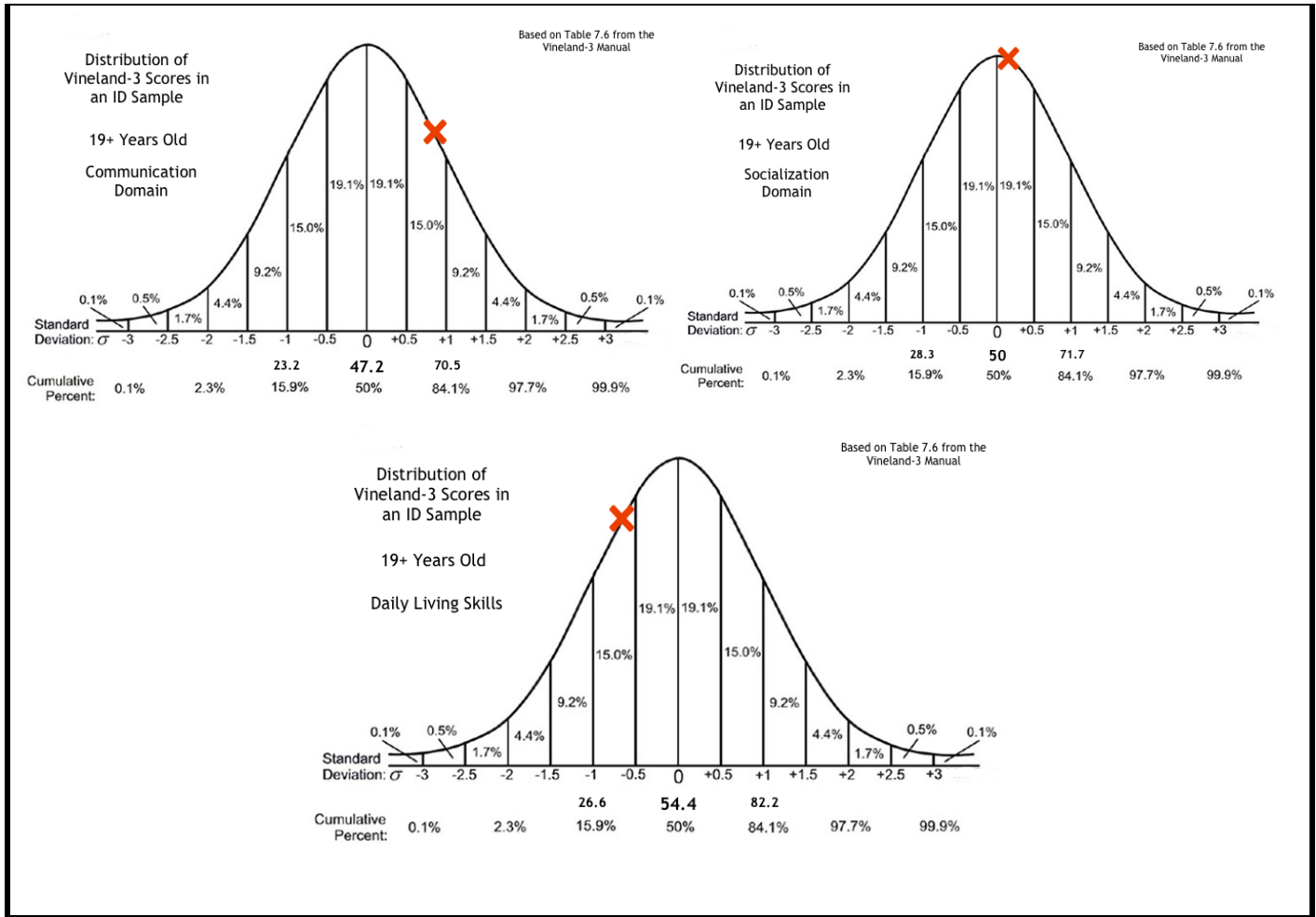
Vineland-3 scores are on the same scale as an IQ score, and both follow the bell curve. As shown in the graph below, Arthur's adaptive functioning composite score of 54 is worse than over 99% of his peers, while his IQ is between 1.5 and 2 standard deviations lower than his peers.



Arthur's Vineland-3 scores are outlined in the graphs below. As shown in the graphs below, Arthur's adaptive functioning scores are much more similar to those of an intellectually disabled sample than those of the general population. He produced especially low scores on measures of daily living and socialization, while communication was a relative strength, which is consistent with his IQ score profile.



Arthur's adaptive functioning scores are typical for an individual with intellectual disability. As shown in the graphs below, his scores on all three domains of the Vineland-3 are rather typical of someone with intellectual disability but are still far discrepant from the general population. The graphs below show mean scores of 47, 50, and 54, which were the average Vineland-3 scores in the intellectually disabled population, but all of these are lower than 99% of the general population.



FORMULATION

Mr. Arthur Burton is a 54-year-old man whose history and neuropsychological test results indicate significant limitations in intellectual functioning and adaptive functioning since childhood. These characteristics, in my opinion, are sufficient to meet both the AAIDD and DSM-5 diagnostic criteria for intellectual disability. Neither of these two sets of criteria have a hard cutoff for an IQ score, and equal or more weight is placed on the individual's adaptive functioning when considering impairment. Especially in light of his history and poor performance on measures of suggestibility and social judgment—which span both intellectual and adaptive domains—Arthur's symptoms and history fit squarely within the definition of intellectual disability.

LIMITATIONS IN INTELLECTUAL FUNCTIONING:

Arthur's Full Scale IQ range of 73 and 82—when accounting for inherent variance in test scores—is in the typical (albeit higher end) range of individuals with mild intellectual disability. As is typical for persons with intellectual disability, Arthur's cognitive abilities involve areas of both strengths and limitations, but his strengths do not take away from his deficits.

Arthur's neuropsychological test scores indicated that he had areas of strength, and this is expected in a comprehensive assessment of intellectual disability.⁴⁵ Specifically, he exhibited low scores on tests of learning, reasoning, comprehending complex ideas, problem solving, and suggestibility, all of which are examples of significant limitations in intellectual functioning in the AAIDD manual. In his book about intellectual disability,⁴⁶ Dr. Chafetz describes three hypothetical cases in which an individual has an IQ score of 67, but each patient has a vastly different cognitive profile. One such example includes someone with higher verbal abilities (VCI=83) and lower working memory scores (WMI = 66), which is very similar to Arthur's score profile.

Research findings have also highlighted strengths and weaknesses in functioning of individuals with ID who have higher IQs (i.e., above 70). As with Arthur, it is not uncommon for someone with ID to be employed, but the level of jobs that someone with ID procures is substantially lower than the general population. Individuals with ID who have relatively higher IQs have also been shown to be especially vulnerable to risky behaviors due to interpersonal incompetence/social judgment and a general assumption that they are functioning at a higher level than they really are. They are more apt to do what others tell them to do in an effort to fit in or be liked, and they are especially prone to acquiescing to authority.⁴⁷

While Arthur would meet criteria for intellectual disability even without consideration of the "Flynn Effect," it is important to account for other sources of error variance in an IQ score. Research has found⁴⁸ and replicated^{49,50} that an IQ score is expected to be overly inflated by 0.3 points per year, or 3 points per decade. In Arthur's case, this means that factoring the Flynn effect to his score of 77 would be equivalent to a score of 71.5 (0.3 x 17 years since the WAIS-IV was normed), with a SEM range of 66.5 to 76.5. The DSM-5-TR acknowledges the "Flynn Effect" as a factor that may affect test scores. While it is not standard practice to simply "adjust" an IQ score *per se*, it is recommended to report IQ scores as obtained and be prepared to address those factors that might affect their reliability.⁵¹ Especially in a case with a high stakes decision (such as a capital case or one related to eligibility for Social Security Disability or special education services), it is recommended for IQ scores to be considered in the context of the Flynn effect.⁵²

⁴⁵ Schalock, R. L., Luckasson, R., & Tassé, M. J. (2021). *Intellectual disability: Definition, diagnosis, classification, and systems of supports* (12th ed.). American Association on Intellectual and Developmental Disabilities.

<https://www.aaidd.org/publications/bookstore-home/product-listing/intellectual-disability-definition-diagnosis-classification-and-systems-of-supports-12th-edition>

⁴⁶ Chafetz, M. (2015). *Intellectual Disability: Criminal and Civil Forensic Issues*. Oxford University Press.

⁴⁷ Snell, M. E., Luckasson, R., Borthwick-Duffy, W. S., Bradley, V., Buntinx, W. H., Coulter, D. L., ... & Yeager, M. H. (2009). Characteristics and needs of people with intellectual disability who have higher IQs. *Intellectual and Developmental Disabilities, 47*(3), 220-233.

⁴⁸ Flynn, J. R. (1984). The mean IQ of Americans: massive gains 1932 to 1978. *Psychological bulletin, 95*(1), 29.

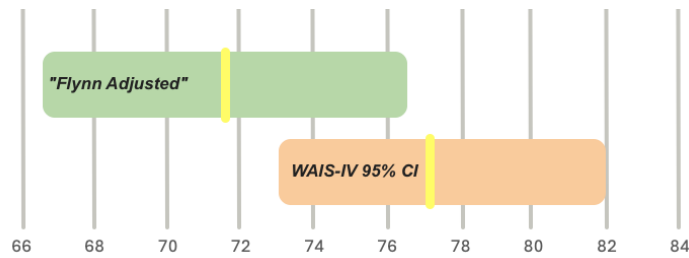
⁴⁹ Young, G. W. (2012). A More Intelligent and Just Atkins: Adjusting for the Flynn Effect in Capital Determinations of Mental Retardation or Intellectual Disability. *Vanderbilt Law Review, 65*, 615.

⁵⁰ Trahan, L. H., Stuebing, K. K., Fletcher, J. M., & Hiscock, M. (2014). The Flynn effect: a meta-analysis. *Psychological bulletin, 140*(5), 1332.

⁵¹ Hagan, L. D., Drogin, E. Y., & Guilmette, T. J. (2010). IQ scores should not be adjusted for the Flynn effect in capital punishment cases. *Journal of psychoeducational Assessment, 28*(5), 474-476.

⁵² Fletcher, J. M., Stuebing, K. K., & Hughes, L. C. (2010). IQ scores should be corrected for the Flynn effect in high-stakes decisions. *Journal of Psychoeducational Assessment, 28*(5), 469-473.

Optimally, intelligence test norms must be periodically recalibrated to maintain their accuracy in reflecting an individual's level of intelligence.⁵³ The WAIS-5—the newest version of the IQ test—is set to be released in September 2024.⁵⁴



Arthur's WAIS-IV IQ score of 77—with a 95% confidence interval of 73 to 82—indicates significant intellectual deficits and is consistent with a diagnosis of intellectual disability. Further, his “Flynn-adjusted” score equates to 71.5, and applying ± 5 points for standard error of measurement would make his score range from 66.5 and 76.5. Additional cognitive test scores highlight important areas of intellectual functioning, such as gullibility and problems with memory, that are present. Arthur's intellectual deficits are consistent with those described in the AAIDD and DSM-5-TR criteria. Further, as cited in the *Hall* decision,⁵⁵ an individual with an IQ score above 70 may properly be diagnosed with intellectual disability if significant limitations in adaptive functioning also exist. As is illustrated in the DSM-5, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score.⁵⁶

LIMITATIONS IN ADAPTIVE FUNCTIONING:

Upon review of information from multiple sources and contexts including a diagnostic interview with Arthur's mother and the administration of the Vineland 3 Comprehensive Interview, it is clear that Arthur's background and test scores indicate that he has had deficits in real-life situations and poor mastery of practical tasks since childhood. This determination is based on multiple data points including information from various individuals, school records, and standardized testing. The evidence from the Vineland-3 was consistent with evidence in Arthur's background, as described above.

Consistent with AAIDD and DSM-5-TR criteria, Arthur's history and test scores indicate impairment in abstract thinking, short-term memory, functional academic skills, social immaturity, communication problems, poor social judgment, gullibility, and needing support for most complex daily living tasks. Arthur exhibited poor social reasoning/practical judgment on a cognitive test in this area, and this was consistent with scores on the Vineland-3 and reports from several of his friends and family. Similarly, his friends and family described social naiveté and

⁵³ Gresham, F. M. (2009). Interpretation of intelligence test scores in Atkins cases: Conceptual and psychometric issues. *Applied Neuropsychology*, 16(2), 91-97.

⁵⁴ <https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Cognition-%26-Neuro/Wechsler-Adult-Intelligence-Scale-%7C-Fifth-Edition/p/P100071002.html>

⁵⁵ Supreme Court of the United States. (2014). *Hall v. Florida*, 572 U.S. 701.

⁵⁶ American Psychological Association: Brief of American Psychological Association, American Psychiatric Association, American Academy of Psychiatry and the Law, Florida Psychological Association, National Association of Social Workers, and National Association of Social Workers Florida Chapter as Amici Curiae in support of Petitioner, in *Hall v. Florida*, No. 12-10882 (U.S. March 3, 2014)

gullibility, and this was also highly significant on testing. Arthur's Vineland-3 scores were strongly consistent with a sample of intellectual disability, and all three of these scores were well below two standard deviations below the mean.

Arthur's adaptive functioning scores are extremely low, but they are not so low that they are implausible. As shown in the results above, it is not unusual for someone with ID to produce a standard score below 50 on the Vineland-3. Similar to his IQ score profile, he produced a relative strength in the Communication domain, but this was still worse than 98% of his peers. These scores are consistent with multiple other sources of information (e.g., former teachers, classmates, romantic partners, and family members) and reflect clinically significant adaptive deficits that are likely to interfere with his ability to learn and apply everyday knowledge to function at the level of a typical adult. Arthur's history and test results indicate limitations in conceptual (e.g., deficits in writing, arithmetic, memory, and reasoning), social (e.g., immature social interactions, communication problems, poor understanding of risk, being easily manipulated), and practical (e.g., limitations in complex daily living tasks such as grocery shopping or money management and maintaining only a minimal level of employment) domains of adaptive functioning.

ONSET DURING THE DEVELOPMENTAL PERIOD:

The totality of information available at the time of the present report includes information from several sources that indicate that Arthur's intellectual and adaptive deficits have been longstanding and present throughout his life. There is no identifiable condition that would be expected to have led to otherwise explained Arthur's history and test scores. Thus, based on presently available information, Arthur's intellectual and adaptive functioning deficits are known to have begun during the developmental period and persisted throughout his life.

CONCLUSIONS

In light of findings from multiple sources including records, interviews, and test scores, it is my opinion⁵⁷ that Arthur Burton meets criteria for mild intellectual disability (F70). It is also my opinion that, when accounting for the outdated norms on the WAIS-IV, the lower-end of the range of Arthur's score on the WAIS-IV falls below 70. There is ample evidence to conclude that he exhibits deficits in intellectual functions such as reasoning, judgment, and academic learning along with deficits in adaptive functioning that resulted in failure to meet developmental and sociocultural standards for personal independence and social responsibility.

⁵⁷ References to verbiage such as "reasonable scientific certainty" have been excluded in light of a growing push to remove these terms from forensic opinions. Nevertheless, should a certain statute require that an opinion is made to a reasonable degree of psychological certainty, medical probability, or a similar term, the above opinions can be considered to have been rendered within that guideline.

National Commission on Forensic Science (2016). Testimony Using the Term "Reasonable Scientific Certainty." <https://www.justice.gov/archives/ncfs/page/file/641276/download>;

Epstein, J. M. (2018). Reasonable Certainty: A Term It Is Certainly Reasonable to Repudiate. *Crim. Just.*, 33, 39.

The conclusions, opinions, and recommendations contained in this report are based on information that was available at the time of this report's preparation. Should additional information be forthcoming from any source, these conclusions, opinions, and recommendations are subject to review and revision.



Jonathan DeRight, PhD, ABPP
Board Certified Clinical Neuropsychologist
Licensed Clinical Psychologist

Attachment: Tabulated results

TABLE OF TEST RESULTS⁵⁸:

*** The numeric data presented below is intended only for use by qualified professionals and should not be interpreted without consideration of all the information that is contained in the rest of the neuropsychological report. ***

Adj	Test Name	Raw	Standard Score	Percentile	Val
--	b Test				
	E-Score	52	--	--	P
A	WAIS-IV				
	Verbal Comprehension	25	91	27	
	Perceptual Reasoning	19	79	8	
	Working Memory	10	71	3	
	Processing Speed	13	81	10	
	Full Scale IQ	67	77	6	
A	Vineland-3				
	Communication	29	68	2	
	Daily Living	21	35	<1	
	Socialization	20	54	<1	
	ABC	157	54	<1	
A	RIST-2				
	GWH	48	108	69	
	OIO	73	70	2	
A	WRAT-5				
	Word Reading	49	85	16	
A	Arithmetic (WAIS-IV)				
	Total Score	8	75	5	
A	Digit Span (WAIS-IV)				
	Total Score	18	75	5	
	RDS	7	--	--	P
A	Symbol Search (WAIS-IV)				
	Total Score	26	90	25	
A	Coding (WAIS-IV)				
	Total Score	40	75	5	
A	Similarities (WAIS-IV)				
	Total Score	22	90	25	
A	D-KEFS Word Context Test				
	Total Consecutively Correct	21	95	37	
	Consistently Correct Ratio	84	90	25	
	Correct-to-incorrect	2	--	13	

⁵⁸ "Val" refers to measures of performance validity, with P signifying a "pass" and F signifying a "fail." A single pass or fail does not constitute a decision on the validity of the overall assessment; please refer to the test validity section for more details. For adjusted scores, A = age, S = sex, and E = education. Validity measures and score adjustments were selected a priori.

A	D-KEFS 20 Questions					
	Initial Abstraction	1, 3, 5, 5	85	16		
A	Vocabulary (WAIS-IV)					
	Total Score	34	95	37		
A	Information (WAIS-IV)					
	Total Score	10	90	25		
A	NAB Language Module	152	61	<1		
	Oral Production	14	87	18		
	Auditory Comprehension	82	61	<1		
	Naming	27	75	4		
	Writing	8	64	<1		
	Bill Payment	12	55	<1		
--	Rey Word Recognition Test					
	Total Correct	11	--	--		P
--	TOMM					
	Trial 1	50	--	--		P
	Trial 2	50	--	--		P
	Retention	50	--	--		P
A	NAB Daily Living Memory					
	Immediate Recall	37	85	16		
	Delayed Recall	11	81	10		
	Retention	73	--	8		
	Recognition	8	--	16		
	RAVLT					P
A	Total 1-5	9, 8, 8, 10, 10	96	38		
A	DR	5	81	10		
A	RC	73	76	5		
ASE	Memory Efficiency Score	1.02	79	8		
A	WRAML-3					
	Story Memory Immediate	25	80	9		
	Story Memory Verbatim	16	85	16		
	Story Memory Gist	9	75	5		
	Story Memory Delayed	20	75	5		
	Story Memory Recognition	28	75	5		
A	Block Design (WAIS-IV)					
	Total Score	28	85	16		
A	Matrix Reasoning (WAIS-IV)					
	Total Score	9	80	9		
A	Visual Puzzles (WAIS-IV)					
	Total Score	7	80	9		
A	NAB Daily Living					

	Driving Scenes	29	66	1	
	Bill Payment	12	55	<1	
	Memory Immediate Recall	37	85	16	
	Memory Delayed Recall	11	81	10	
	Map Reading	2	66	1	
	Judgment	13	87	18	
A	Test of Practical Judgment				
	Total Score	13	44	<1	
A	Comprehension (WAIS-IV)				
	Total Score	18	85	16	
A	Gudjonsson Suggestibility Scales				
	Immediate Recall	12	81	10	
	Delayed Recall	5	67	1	
	Yield 1	5	102	56 ^{*59}	
	Yield 2	10	117	87*	
	Shift	9	130	98*	
	Total Suggestibility	14	118	89*	

⁵⁹ * indicates that a higher score is considered to be worse

EXHIBIT A



SUMMARY OF QUALIFICATIONS

I am a clinical psychologist licensed in Virginia, Maryland, and Washington, DC. I am also a diplomate in the specialty of clinical neuropsychology from the American Board of Professional Psychology. I have completed additional trainings in adult forensic assessment from the University of Virginia Institute of Law, Psychiatry, & Public Policy which qualifies me as an approved forensic examiner in the Commonwealth of Virginia. I am also a member of the Forensic Evaluation Oversight Panel for the Commonwealth. I work as a clinical and forensic neuropsychologist in independent practice. In my role, I routinely evaluate patients with a broad array of mental health diagnoses (both cognitive and psychiatric in nature) to determine their diagnosis, recommendations for treatment, and, when applicable, the context of their condition in various legal contexts. I have delivered trainings in clinical and forensic neuropsychology to judges, attorneys, mental health professionals, and the general public. Finally, I have been qualified as an expert in various state and federal courts in a retained and court-ordered capacity.

Jonathan DeRight, PhD, ABPP
Board Certified Clinical Neuropsychologist
Licensed Clinical Psychologist



EXHIBIT B

JONATHAN DERIGHT, PHD, ABPP-CN

CONTACT

Office	1464 Ingleside Ave / McLean, Virginia / 22101
Mailing	1390 Chain Bridge Rd # 85 / McLean, Virginia / 22101
Phone/Fax	703-957-7300 (P) 256-957-7300 (SMS) 844-238-6630 (F)
Email	deright@braindiagnosis.com

EDUCATION

2014 – 2016	Postdoctoral Fellowship in Clinical Neuropsychology The Johns Hopkins University School of Medicine Baltimore, Maryland
2008 – 2014	Doctor of Philosophy in Clinical Psychology Syracuse University (APA Accredited) Syracuse, New York
2008 – 2011	Master of Science in Clinical Psychology Syracuse University (APA Accredited) Syracuse, New York
2004 – 2008	Bachelor of Science in Neuroscience University of Rochester Rochester, New York

LICENSURE & CREDENTIALING

2019 – Present	Diplomate, American Board of Professional Psychology: Clinical Neuropsychology Certification Number: 8900
2016 – Present	Commonwealth of Virginia License Number: 0810005431
2016 – Present	District of Columbia License Number: PSY1001167
2016 – Present	State of Maryland License Number: 05722
2021 – Present	PSYPACT Authority to Practice Interjurisdictional Telepsychology (APIT)

Temporary Authorization to Practice (TAP)

Authorized to practice in Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, Wisconsin, & Wyoming

2016 – Present

National Register Health Service Psychologist

Registrant Number: 55393

CLINICAL EXPERIENCE

2020 - Present

President & Clinical and Forensic Neuropsychologist,

Precision Neuropsychology, PLLC
McLean, Virginia

2016 – Present

Clinical and Forensic Neuropsychologist,

Woodbridge Psychological Associates, PC
McLean, Virginia / Woodbridge, Virginia

2014 – 2016

Postdoctoral Fellow, Division of Medical Psychology

Department of Psychiatry, Division of Medical Psychology
The Johns Hopkins University School of Medicine, Baltimore, Maryland
Director: Jason Brandt, Ph.D., ABPP-CN

2013 – 2014

Predoctoral Intern, Psychology Internship Program – Adult Track

Department of Psychiatry and Behavioral Sciences
SUNY Upstate Medical University, Syracuse, New York
Director: Roger Greenberg, Ph.D.

2012 – 2013

Forensic Psychology Extern, Central New York Psychiatric Center

New York State Office of Mental Health, Marcy, New York
Director: Nichole Marioni, Ph.D., ABPP-FP

2010 – 2013

Psychology Extern, Psychological Services Center

Syracuse University Department of Psychology, Syracuse, New York
Director: Kevin Antshel, Ph.D.

2011 – 2012;

2009 – 2010

Neuropsychology Extern, Neuropsychology Assessment Program

SUNY Upstate Medical University, Syracuse, New York
Director: Dominic Carone, Ph.D., ABPP-CN

2004 – 2007

Medical Assistant, Emergency Department

Newark-Wayne Memorial Hospital, Newark, NY

ADDITIONAL TRAININGS

- 2023** **AAFP: Assessment of Competence to Stand Trial**
4-hour online course taught by Lori Hauser, PhD, ABPP-FP
- 2023** **Artificial Intelligence in Health Care**
6-week online course through the MIT Sloan School of Management
- 2021** **Conducting Financial Capacity Assessments for Older Adults**
10-week training course through Wayne State University
- 2021** **Evaluation of Defendant's Intent under Virginia Code §19.2-271.6**
1-day training through the Institute of Law, Psychiatry and Public Policy, University of Virginia
- 2017** **Mental Competency in Immigration Review**
Sterling Medical/U.S. Department of Justice Initiative, Baltimore, Maryland
1-day training: Preparation for mental competency assessments to assist the DOJ Executive Office of Immigration Review (EOIR)
- 2016** **Adult Basic Forensic Evaluation required according to Code of Virginia §19.2-169.1 regarding evaluation of trial competence and § 19.2-169.5 regarding evaluation of sanity at the time of the offense**
5-day training through the Institute of Law, Psychiatry and Public Policy, University of Virginia
- 2016** **Conducting Mental Health Evaluations for Capital Sentencing Proceedings**
2-day training through the Institute of Law, Psychiatry and Public Policy, University of Virginia

EXPERT QUALIFICATIONS

Dr. DeRight is an approved forensic evaluator for the Commonwealth of Virginia, which allows him to be a court appointed evaluator in competency to stand trial and mental sanity at the time of the offense evaluations. His credentials and testimony have been accepted in every court or proceeding in which he has been offered as an expert, including the following:

United States District Court (DC, EDVA, WDVA, MD)
Superior Court of the District of Columbia
Fairfax County Circuit Court
Loudoun County Circuit Court
Prince William County Circuit Court
Arlington County Circuit Court
Alexandria Circuit Court
Alexandria General District Court
Alexandria Juvenile and Domestic Relations Court
Mecklenburg County District Court
Bedford County Circuit Court

RESEARCH EXPERIENCE

- 2014 - 2016** **Research Fellow**, Division of Medical Psychology
Department of Psychiatry
The Johns Hopkins University School of Medicine, Baltimore, Maryland
Principal Investigators: Jason Brandt, PhD, David Schretlen, PhD & Vidya Kamath, PhD
- 2008 – 2013** **Research Associate**, Psychophysiology Lab
Department of Psychology
Syracuse University, Syracuse, New York
Principal Investigator: Randall Jorgensen, PhD
- 2010 – 2012** **Research Associate**, Translational Neuroscience Lab
Department of Psychology
Syracuse University, Syracuse, New York
Principal Investigator: Stephanie Cacioppo, Ph.D.
- 2006 – 2008** **Research Assistant**, Alzheimer’s Disease Lab
Department of Brain and Cognitive Sciences
University of Rochester, Rochester, New York
Principal Investigator: Robert Chapman, Ph.D.
- 2007** **Research Assistant**, Molecular Biology Lab
Burnett School of Biomedical Sciences
University of Central Florida, Orlando, Florida
Principal Investigator: Ella Bossy-Wetzel, Ph.D.
- 2004 – 2006** **Patient Enroller**, Emergency Department
Strong Memorial Hospital, Rochester, NY

PEER-REVIEWED PUBLICATIONS

- Buchholz, A. S., **DeRight, J.**, Gerner, G. J., & Schretlen, D. J. (2023). Do “effort tests” really test effort? *Neuropsychology*, 37(1), 104–112. <https://doi.org/10.1037/neu0000865>
- Kamath, V., Chaney, G-A., **DeRight, J.**, & Onyike, C.U. (2018). A meta-analysis of neuropsychological, social cognitive, and olfactory functioning in the behavioral and language variants of frontotemporal dementia. *Psychological Medicine*, Dec 6, 1-12.
- DeRight, J.**, Jorgensen, R.S., & Cabral, M. (2015). Composite cardiovascular risk scores and neuropsychological test performance: A meta-analytic review. *Annals of Behavioral Medicine*, 9(3), 344-357. doi:10.1007/s12160-014-9681-0
- DeRight, J.** & Jorgensen, R.S. (2015). “I just want my research credit”: Frequency of suboptimal effort in a non-clinical healthy undergraduate sample. *The Clinical Neuropsychologist*, 29(1), 101-117. doi:10.1080/13854046.2014.989267
- DeRight, J.** & Carone, D.A. (2015). Assessment of effort in children: A systematic review. *Child Neuropsychology*, 21(1), 1-24. doi:10.1080/09297049.2013.864383

BOOKS, CHAPTERS, AND OTHER PUBLICATIONS

DeRight, J. & Vartkessian, E. (2022). Working with the Expert. In E. Kelley (Ed.), *Representing People with Dementia: A Practical Guide for Criminal Defense Lawyers* (pp. 141-153). American Bar Association. ISBN: 1639051325

DeRight, J. (2022). *Essential Neuropsychology: A Concise Handbook for Adult Practitioners*. Springer Nature: Switzerland. ISBN 978-3030853716

DeRight, J. (2019). History of “Frontal” Syndromes and Executive Dysfunction. In J. Bogousslavsky, F. Boller, & M. Iwata (Eds), *A History of Neuropsychology: Frontiers in Neurology and Neuroscience, Vol 44* (pp 100–107). Karger. DOI: 10.1159/000494957

DeRight, J. (2014). Detection of Dementia Risk in Primary Care: Preliminary Investigation of a Compositive Dementia Risk Score in Veterans. *Dissertations*, 142.

DeRight, J. (2011). Feedback, Task Demand, and Cognitive Test Performance in College Students. *Master’s Thesis*.

POSTER PRESENTATIONS

Chaney, G.A., **DeRight, J.**, Aita, S., Onyike, C., & Kamath, V. (2017, February). *A meta-analysis of neuropsychological functioning, social cognition, and olfaction in the frontotemporal dementias*. Poster presented at the 45th International Neuropsychological Society Conference, New Orleans, Louisiana.

Bagger, J., **DeRight, J.**, & Brandt, J. (2017, February). *The Effect of Generation Gap on Informant Ratings using the IQCODE in a General Population Sample*. Poster presented at the 45th International Neuropsychological Society Conference, New Orleans, Louisiana.

DeRight, J. & Jorgensen, R.S. (2012, November). *Composite cardiovascular risk scores and neuropsychological test performance: A meta-analytic review*. Poster presented at the 32nd National Academy of Neuropsychology Conference, Nashville, Tennessee.

DeRight, J., Jorgensen, R.S., Lewandowski, L., & Ortigue, S. (2011, November). *The effects of feedback, state anxiety, and gender on neuropsychological test performance*. Poster presented at the 31st National Academy of Neuropsychology Conference, Marco Island, Florida.

INVITED TALKS & APPEARANCES

DeRight, J. (2024, June). *Responsibly Using Artificial Intelligence (AI) to Enhance the Practice of Clinical Neuropsychology*. CE Workshop at the 2024 American Academy of Clinical Neuropsychology Annual Meeting, Scottsdale, Arizona.

DeRight, J. (2023, November). *Plenary: Neuropsychological Testing in Capital Cases*. National Association of Criminal Defense Lawyers/Advancing Real Change Inc./Arizona Capital Representation Project BYOC Capital Defense Training. Orlando, Florida.

DeRight, J. & Shultz, E. (2023, June). *Selecting and Effectively Using Mental Health Experts*. 2023 Holistic Defense and Leadership Conference. Baltimore, Maryland.

DeRight, J. (2023, March). *Application of Clinical Neuropsychology to the Forensic Setting*. Johns Hopkins Medical Psychology Seminar at Johns Hopkins Hospital.

DeRight, J. (2023, July). *Signs of a Psychopath (Season 6)*. Consulting Expert for Red Marble Media, Inc.

DeRight, J. (2023, January). *Signs of a Psychopath (Season 5)*. Consulting Expert for Red Marble Media, Inc.

- DeRight, J.** (2022, October). *Signs of a Psychopath (Season 4)*. Consulting Expert for Red Marble Media, Inc.
- DeRight, J.,** Jackson, L., Cassis, A., Perme, D., & Gilbertsen, T. (2022, September). *Aging Attorneys: A Multi-Disciplinary Examination of the Clinical, Legal and Professional Challenges & Benefits*. 2022 National Conference for Lawyer Assistance Programs. Washington, DC.
- DeRight, J.** (2021, October). *Signs of a Psychopath (Season 3)*. Consulting Expert for Red Marble Media, Inc.
- DeRight, J.,** Jackson, L., Cassis, A., Perme, D., & Gilbertsen, T. (2021, September). *Our Aging Legal Profession: Working with The Benefits and The Challenges*. Panel presentation to District of Columbia Superior Court Judges.
- DeRight, J. &** Shultz, E. (2020, November). *Selecting and Effectively Using Mental Health Experts*. National Alliance of Sentencing Advocates & Mitigation Specialists (NASAMS) Certificate Program.
- DeRight, J.,** Jackson, L., Cassis, A., Perme, D., & Gilbertsen, T. (2020, September). *Our Aging Legal Profession: Working with The Benefits and The Challenges*. DC Bar CLE course.
- DeRight, J.** (2020, July). *The aging workforce: Distinguishing between normal and abnormal signs in the workplace*. PsyBar 2020 Webinar Series.
- DeRight, J.** (2020, May). *A Primer on Neuropsychology*. Advancing Real Change, Inc.
- DeRight, J.** (2018, April). *A primer on neuropsychological evaluations following stroke*. Sentara Northern Virginia Medical Center, Woodbridge, Virginia.
- DeRight, J.** (2017, February). *Beyond classification: Dimensional measurement of effort in neuropsychology*. James Madison University, graduate course in neuropsychological assessment.
- Schretlen, D.J. & **DeRight, J.** (2016, June). *Reconsidering the clinical implications and assessment of cognitive effort in neuropsychology*. CE Workshop at the 2016 American Academy of Clinical Neuropsychology Annual Meeting, Chicago, Illinois.
- DeRight, J. &** Puente, A.N. (2016, February) *Differential diagnosis of dementia*. Kennedy Krieger Institute Neuropsychology Continuing Education Lecture Series, Baltimore, Maryland.

TEACHING EXPERIENCE

2024 – Present	Clinical Professor in Clinical Psychology <i>The George Washington University</i>
2020 – 2021	Neuropsychology Extern Supervisor <i>Precision Neuropsychology, PLLC</i>
2017 – 2018	Neuropsychology Extern Supervisor <i>Woodbridge Psychological Associates, PC</i>
2015 – 2016	Neuropsychology Extern Supervisor <i>Johns Hopkins University School of Medicine</i>
2015	MCAT Instructor <i>Odyssey Program</i> Krieger School of Arts and Sciences, The Johns Hopkins University
2014;	Adjunct Professor

- 2013** *Assessment in Counseling* (graduate course)
Department of Counseling and Human Services, Syracuse University
- 2008 – 2014** **Elite Course Instructor**
GRE and GMAT Preparatory Courses
Kaplan Inc.
- 2008 – 2010** **Teaching Assistant**
Foundations of Human Behavior (undergraduate course)
Department of Psychology, Syracuse University

SERVICE

- 2022 – Present** **Legislative Action and Advocacy Committee**, National Academy of Neuropsychology
- 2019 – Present** **Forensic Evaluation Oversight Panel Member**, Commonwealth of Virginia
- 2016 – Present** **Ad Hoc Pro Bono Case Work**
- 2015 – Present** **Ad Hoc Peer Reviewer**
*Archives of Clinical Neuropsychology, The Clinical Neuropsychologist
Applied Neuropsychology, European Journal of Neurology, BMJ Open,
Journal of Experimental Social Psychology*
- 2009 – 2013** **Student Volunteer**, National Academy of Neuropsychology Conference
- 2013** **Admissions Recruitment Coordinator**, Department of Psychology,
Syracuse University
- 2012 – 2013** **Clinical Representative**, Psychology Action Committee, Syracuse University

PROFESSIONAL AFFILIATIONS

- 2009 – Present** National Academy of Neuropsychology (NAN)
- 2011 - Present** International Neuropsychological Society (INS)
- 2013 - Present** American Academy of Clinical Neuropsychology (AACN)
- 2018 - Present** American Psychological Association (APA)
- 2018 - Present** American Psychology-Law Society (APA Division 41)
- 2020 - Present** Society for Clinical Neuropsychology (APA Division 40)

HONORS AND RECOGNITION

- 2016** Early Career Psychologist Credentialing Scholarship
- 2012** National Academy of Neuropsychology Student Poster Award
- 2008** Shari & Joel Beckman Scholarship
- 2004** New York Lottery “Leaders of Tomorrow” Award
- 2004** Bausch & Lomb Honorary Science Award