

Competency to Stand Trial: A Conceptual Model for Its Proper Assessment

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The assessment of competency to stand trial is frequently fraught with conceptual confusion resulting from a failure to properly apply the data of the clinical examination to the relevant legal criteria. A basic question scheme that encompasses (1) the defendant's psychiatric status, (2) the effects of that status on his functioning, and (3) his apparent ability to participate in legal proceedings, is introduced to clarify the evaluation of fitness to stand trial. The way in which combinations of answers to three "basic questions" generate a scheme that clarifies the difficulties encountered in most competency evaluations is shown. Eight paradigm cases are generated. Five of these (competence, incompetence, mentally ill but competent, malingering, and impaired but competent) are frequently straightforward. However, the three possibilities in which a defendant meets criteria entailed by two of the three questions are inherently subject to controversy. These situations (circumscribed psychosis related to the charges, malingering in the context of mental illness, and functional deficits in the context of minor mental illness) are discussed in detail and illustrated with case material.

"Competency to stand trial" is described by Roesch and Golding¹ as an "open-textured" construct in Anglo-American jurisprudence. Such constructs retain an essential indefiniteness, i.e., the criteria for their use are never completely reducible to a given set of facts or observations. The courts have kept the concept of competency to stand trial broad and flexible. They have chosen to outline general principles but recognize that

greater definition of this concept requires ongoing experience.

This "experience" involves two distinct disciplines, psychiatry and law, and as such the development of the competency construct proceeds through two pathways. This paper will attempt to advance the concept of competency to stand trial within psychiatry, by providing a scheme through which psychiatrists can more effectively apply their clinical data to the legal criteria.

A review of the literature and our own experience on a forensic psychiatric service suggests generally high reliability across examiners for competency determinations.¹ Nevertheless, there exists a

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small but significant percentage of cases that are complicated by confusion and disagreement.²

A basic scheme for competency assessment that would enable evaluators to isolate their difficulties and focus more clearly on the legal and psychiatric issues is needed. Such a scheme is necessary in order to safeguard the evaluation against contamination from factors that lie outside the relevant scope of the competency determination or interfere with the application of psychiatric data to the legal criteria. For this reason it is important that we begin by examining the legal criteria for incompetency that have been set forth by the courts.

Federal and most state statutes that define incompetence and provide legal criteria for this concept derive from the constitutional standard set by the U.S. Supreme Court in the 1960 case, *Dusky V. United States*.³ In *Dusky* the Supreme Court held that in order to be found competent a defendant must have "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding . . . and . . . a rational as well as a factual understanding of the proceedings against him." Although the constitutional standard makes no reference to a defendant's psychiatric status, the federal and most state statutes that are based on *Dusky* generally base triableness on the defendant's mental condition.⁴ Although a number of authorities have criticized the statutes for introducing psychiatric language into fundamentally legal criteria,^{1,5} it is clear that psychiatric status continues to be an essential factor in competency determinations.⁶ It is true enough that a find-

ing of mental illness or deficiency is neither an absolutely necessary nor sufficient condition for a determination of incompetence to stand trial.⁴ Nevertheless, the overwhelming majority of incompetent defendants are found incompetent partly on the basis of a psychiatric illness or mental deficiency.⁶ For practical purposes it will therefore serve us well to base our model on the statutes that include psychiatric status as a factor in the determination of competency.

The competency statutes are generally understood in terms of a three-pronged test that examines (1) the defendant's psychiatric status, (2) his understanding of the proceedings, and (3) his capacity to assist in his own defense. Although this conceptualization closely follows the language, for example, of the federal statute (U.S.C., Chap. 18, § 4244) its usefulness is limited by two factors. The first is that it fails to include the requirement of a causal relationship between Prong 1 and Prongs 2 and 3. For a finding of incompetency to stand trial it is not sufficient that a defendant be both mentally ill (Prong 1) and functionally deficient (Prongs 2 and 3). The functional deficiency must be caused by the mental illness or defect and not, for example, result from his philosophical beliefs or refusal to cooperate. A second problem with the classic three-pronged formulation is that Prongs 2 and 3 are not *both* required for a finding of incompetency; either one, as the language of *Dusky* indicates, is sufficient. If we are to obtain clarity concerning the evaluation of competency to stand trial we must look at the criteria for incompetency in a manner that enables us to

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more clearly distinguish competent from incompetent defendants. We must generate a model that takes into account the issue of causality and the problem generated by the "either/or" implications of *Dusky*. Such a model is suggested by the "fourfold analysis" of forensic psychiatric questions discussed by Weinstein.⁷ This fourfold analysis involves (1) the determination of the particular legal issue, (2) the specific legal criteria that are required to resolve the legal issue, (3) the collection of data through the clinical examination of the defendant, and (4) the application of the clinical data to the legal criteria. Once the particular legal issue has been determined (which in the present context is competency to stand trial) the three remaining components of this analysis are (1) the clinical examination and (2) its "application" to (3) the legal criteria. In our model of the competency construct we utilize these three components by calling for an assessment of (1) the pa-

tient's psychiatric status (clinical examination), (2) the causal relationship between this psychiatric status and the patient's functional capacity to participate in a legal proceeding ("application"), and (3) that functional capacity defined as the ability to understand the proceedings and assist in one's defense (the legal criteria).

Through a consideration of these three factors it is possible to develop a scheme that encompasses all possible competency evaluations and the difficulties that can be encountered through them. Table 1 provides such a scheme by translating the three criteria into yes/no questions and then describing the types of competency cases derived from each of these combinations. It should be noted that, of eight possible combinations, five yield cases that are ordinarily straightforward. It is our contention that the greatest difficulties are in the three situations in which two out of three criteria for incompetency are met (Cases 6,

Table 1
Basic Question Scheme for Understanding the Assessment of Competency to Stand Trial

Question 1. Is the defendant suffering from a psychiatric disorder severe enough to generally justify a finding of incompetence? (Diagnosis). Question 2. Is the defendant's mental state causing an incapacity relevant to the proceedings he is expected to participate in? (Causation). Question 3. Does the defendant appear to manifest an incapacity of sufficient degree as to render him incompetent for a given proceeding? (Observed Incapacity).

Case	Diagnosis	Causation	Observed Incapacity	Paradigmatic Description
1	Yes	Yes	Yes	Incompetent defendant
2	Yes	No	No	Mentally ill but competent defendant
3	No	No	No	Competent defendant
4	No	No	Yes	Malingering
5	No	Yes	No	Impaired but competent defendant
6	Yes	Yes	No	Circumscribed psychosis related to the charges
7	Yes	No	Yes	Malingering in the context of mental illness
8	No	Yes	Yes	Functional deficits in the context of minor mental illness

7, 8). It is our belief that all major difficulties that arise in the determination of incompetency either fit into one of the last three categories outlined in Table 1 or arise because there is confusion regarding the proper answer to one or more of the three "basic questions." The former difficulties are of significant legal/theoretical interest. The latter difficulties are of significant clinical interest. Although both are important and will be considered in this paper, our focus will be on the legal/theoretical set of difficulties. It is hoped that our basic scheme will enable forensic specialists to make sounder, more reliable competency determinations in those situations in which the clinical findings are generally clear. In addition, it should help clinicians to focus on the issues that stand in the way of a straightforward determination.

Three Basic Questions

The basic questions in our scheme are derived from the legal criteria set forth in *Dusky* and the various federal and state statutes defining incompetency to stand trial and are worded in such a way as to permit maximal differentiation between cases that are sometimes confused in forensic psychiatric practice.

Question 1 (Diagnosis) seeks to differentiate individuals with a general psychiatric disorder from those with a disorder that is ordinarily considered severe enough to justify a finding of incompetency to stand trial. Although some authors have recently implied that medical diagnosis is largely irrelevant to a finding of incompetency⁸ and others have called for an expansion of the kinds of diagnoses that could justify a finding of in-

competence,⁷ empirical studies have shown that nearly all findings of incompetency to stand trial involve a diagnosis of some form of psychosis and/or mental retardation.⁶ Accordingly, all the clinical examples offered by McGarry in his manual for use in conjunction with his "Competency to Stand Trial Assessment Instrument" involve mental retardation, organicity, or psychosis.⁹ As we shall see, individuals with nonpsychotic diagnoses (such as depression or character disorder) who meet the other criteria for incompetency that we have outlined constitute a class of difficult cases. We should note that cases of incompetency in the absence of any mental illness or deficit whatsoever generally involve the presence of a physical illness or disability. Such cases would, when they arise, warrant an expansion of the conditions allowable under Question 1. However, because of their rarity in forensic psychiatric practice, they have not been included in the discussion.

Question 2 (Causation) is worded to differentiate individuals who have a general psychiatric incapacity from those whose incapacity touches upon their understanding of their charges or is in some other way apparently relevant to the legal proceedings in which a defendant is expected to participate. Included among those cases for which one would answer "yes" to this question are all individuals with psychiatric diagnoses (major or minor) whose incapacity caused by their illness raises a *question* of their competency. Excluded by this criterion would be malingerers and individuals with chronic residual psychiatric symptoms or with symptoms that are acute but

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circumscribed and do not raise a question of their competency.

Question 3 (Observed Incapacity) is designed to differentiate those defendants whose *manifest behavior* apparently crosses the threshold of incompetency for their given proceeding. This question does not seek to penetrate the observed behavior to find its motivations or causes (this is the purpose of Questions 1 and 2); clearly some individuals who meet the criteria set forth by this question will be declared competent because their observed incapacity is deemed, by virtue of answers to Questions 1 and 2, "motivated" as opposed to "caused."

It is important to note that the specific criteria entailed by Question 3 fluctuates with the differing requirements that are placed on defendants in different proceedings. As Robey and, more recently, Winnick have emphasized, the competency evaluator must consider the defendant's capacity in light of the nature of the charges, the complexity of the case, and the expectations of the court.^{10,11} For example, according to some authorities, the standard for entering a guilty plea should be higher and more exacting than that for triableness.⁴

The Straightforward Cases

The focus of our discussion will be difficult competency determinations. Nevertheless, it will be worthwhile to briefly review all eight of the possibilities listed in Table 1. These are, as has been pointed out, all the possibilities that can arise from combinations of answers to our three basic questions. It will be useful to initially review the first five cases, which we have regarded as relatively

straightforward, as debate occasionally arises in the context of at least some of these.

Case 1 (Incompetent Defendant)

This case is typified by the acutely psychotic or severely mentally retarded individual whose psychiatric disorder causes an impairment that is relevant to the court proceedings and is such as to render the defendant unable to properly understand the proceedings and/or assist in the defense. An overwhelming majority of defendants found incompetent fall into this category.

Case 2 (Mentally Ill But Competent)

This case is typified by the psychotic individual whose psychosis does not cause an impairment that is relevant to the court proceedings. Although there has been a historical tendency for judges and court-appointed psychiatrists to equate incompetency with psychosis, a more recent trend has been to find many defendants competent in spite of these circumscribed psychotic symptoms. Roesch *et al.*, in a study they conducted in Canada (where competency standards are similar to those in the United States), found that nearly one third of defendants evaluated for competency and declared *competent* exhibited psychotic symptoms.⁶ It has been our experience that nearly all such defendants fall into this category.

Case 3 (Competent Defendant) This case is typified by the defendant whose competency is not (or should never have been) seriously questioned. There is no mental illness and no observed incapacity. When such individuals are seen in a forensic psychiatric setting, it is often because they had manifested a psychi-

atric disturbance (e.g., brief or drug-induced psychosis) that has since improved or had feigned mental illness and are no longer motivated to do so. Also included in this category are individuals with minor psychiatric disorders (e.g., adjustment reaction, character pathology) that do not create an incapacity relevant to their proceedings.

Case 4 (The Malingerer) This case is exemplified by the individual who intentionally feigns mental illness and/or who volitionally refuses to answer questions about his charges and court procedures or to cooperate with his or her attorney. Such individuals often claim that they are unable to perform any better in an interview, attributing their incapacity to vague defects in memory or "voices" commanding them to be uncooperative. Unless such volitional conduct is superimposed upon or is an exaggeration of real psychopathology (see Case 7 below), the malingerer can often be detected through serious inconsistencies in his behavior (e.g., between interview behavior and psychological tests and/or observed behavior in the hospital ward).

Case 5 (The Impaired But Competent Defendant) This case is exemplified by an individual who suffers from a psychiatric disorder that is not severe enough to generally justify a finding of incompetency and whose incapacity resulting from that disorder is relevant to the proceedings but not severe enough to warrant a finding of incompetency. Part of the wisdom inherent in the (perhaps too rigid) practice of only finding incompetence where there is psychosis and/or organicity/retardation stems from the

generally valid observation that individuals with character disorders, nonpsychotic depressions, anxiety disorders, adjustment reactions, and the like are rarely, if ever, so functionally impaired as to meet the criteria for incompetency set forth in *Dusky*. In addition, if they are functionally impaired (and meet the criterion of Question 3) it is questionable whether this level of impairment could be *caused* by their relatively minor illness. In spite of their straightforward nature (from a technical point of view), cases in this category sometimes generate difficulty for the examiner because they raise issues of "fairness." It seems only fair that an individual whose cooperation with counsel is *less than optimal* because of a severe reactive depression or anxiety disorder should be given time to recover before standing trial. However, as Slovenko points out, "An alleged case of nerves does not make a defendant incapable of understanding the proceedings against him or of assisting in his own defense, even if his emotional state impairs his recollection of the crime."⁴, p. 197¹ Such an individual is impaired but nonetheless competent. The examining psychiatrist can and should make a note in his or her report about the patient's current level of functioning, but to call such individuals "incompetent" is to arrogate for the psychiatrist decisions about fairness that ought properly to be left to the court.

Three Paradigmatic Difficulties

Cases 6, 7, and 8 are the three possible situations in which there can be clarity and agreement about the clinical findings yet confusion and disagreement

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concerning the determination of competency. These situations constitute, according to Goldstein and Stone, about half the cases in which competency experts disagree.² They can best be illustrated and understood through the use of case examples.

Case 6 (*Circumscribed Psychoses Related to the Charges*) This difficulty is typified by an individual with circumscribed delusions, in whom the delusions clearly affect the defendant's perception of the events leading to the charges but in whom a functional incapacity relating to the legal proceedings is not evident.

A 33-year old man, accused of the very recent murder of his girlfriend of four years, states that the reason he killed her was that she had been stealing parts of his body one at a time and replacing them with the body of a dog. One day, he states, he saw his entire body on her person, and, realizing that he himself had been destroyed, lunged at her with a knife, killing her. In separate interviews with three psychiatrists and a psychologist, the patient was extremely well related, and gave a complete account of his arrest, the charges, and the possible penalties that he might face. In addition, he was completely conversant with court procedure. All agreed, however, that he was genuinely delusional and not malingering. Psychologic testing revealed rigid defensive denial but minimal impairment in thought processes and reality testing, and moderate depression. When questioned about his defense, the defendant stated that he wished that the district attorney would exhume the body to see that his old body was on the corpse of the deceased. The defendant recognized, however that his story 'sounds crazy' and expressed a complete willingness to plead insanity if this was his lawyer's strategy. The attorney for the defendant stated he would enter an insanity plea; the district attorney said it was likely not to be contested.

It can be readily observed that the individual described in Case 6 meets the

criteria set forth in the first two basic questions: he is psychotic and his psychosis creates an incapacity (in his reality testing) that is *relevant* to the proceedings he is expected to participate in. A (deceptively) strong argument could be made for declaring this defendant incompetent by stating, for example, that his entire view of the case is distorted by his illness. There certainly was a time when all individuals who were actively delusional were considered incompetent,⁷ and there is still the temptation in cases such as these to invoke a general principle such as, "a person this sick must not go to trial," or, more sophisticatedly, "a defendant with ego-syntonic delusions about the crime could not function adequately in the legal process." However, each of these principles fails in the face of a functional analysis of the case at hand in response to Question 3. Such analysis fails to reveal a single *skill* or *function* required of the defendant that he would be unable to perform in court. A finding of competence in this case might actually be quite difficult to defend given many courts' prejudice against finding grossly delusional defendants competent, but unless a function can be found that this defendant cannot perform he must be declared competent.

Case 7 (*Malingering in the Context of Mental Illness*) This case is typified by an individual who is psychotic and who apparently manifests signs of incompetence but in whom such signs are not caused by the psychosis but are a function of evasiveness or malingering. Such an individual meets the criteria set for Questions 1 and 3 for incompetence,

but not the criteria for Question 2, that establish a causal link between psychopathology and an observed incapacity.

A 39-year-old man accused of Menacing and Criminal Possession of a Weapon has a long history of polydrug and alcohol abuse with several psychiatric hospitalizations and a previous diagnosis of schizophrenia. He was admitted to the hospital from jail after becoming agitated, claimed to be hearing voices, and stated that there were spirits in his body. In the hospital he swallowed a toothbrush and a pen. A competency exam was ordered. During interviews with two psychiatrists he was generally uncooperative, talked about spirits and concentration camps, denied being under any criminal charges, and claimed not to know the functions of a judge, jury, or district attorney even immediately after these were explained to him. Psychologic testing confirmed the presence of an underlying thought disorder with some delusional thinking but revealed that the patient had reasonably intact memory and judgment and showed great facility in working with (even difficult) concepts as long as they were not 'legal' in nature. Staff observations of good interactions and sustained card-playing with peers added to the picture of a mildly psychotic patient who was exaggerating symptoms for the purpose of evading the legal process.

Again a major difficulty with a case such as this is that a finding of competence would be difficult to defend in court. After all, the patient shows some deficits and, by the psychiatrist's own admission, is psychotic. It is likely that a majority of successful "malingerers" are similar to the defendant described here, their real psychopathology gaining them *prima facie* credibility, and that the examiner is unable to harness time-intensive sources of ancillary information (e.g., longitudinal observation, psychologic testing) to confirm the hypothesis of malingering.

Although there is a strong temptation to find incompetency in all cases in

which performance deficits are coupled with psychopathology, there is sometimes an equally strong temptation toward a finding of competency in all cases in which there is evidence of malingering. Occasionally willfully uncooperative defendants are still so impaired by their illnesses that they are rendered incompetent, their malingering acting as a sort of "overkill" for Question 3. The difficulty with these cases lies in making fine distinctions between causation and volition.

Case 8 (Functional Deficits in the Context of Minor Mental Illness) This difficulty is exemplified by the individual who appears to lack capacity for understanding his proceedings or (more frequently) cooperating with defense counsel, and whose *functional* deficits are the result of a psychiatric disorder not generally thought to be severe enough to justify a finding of incompetency. The difficulties encountered here are analogous to those described under Case 5, except that the defendants considered here are more severely limited by their nonpsychotic depression, anxiety disorder, or adjustment reaction.

A 41-year-old man accused of several counts of rape and aggravated assault is admitted to the hospital after refusing to eat for over two weeks in jail. A competency exam is ordered. It is determined that the defendant is suffering from a nonpsychotic depressive disorder with suicidal ideation superimposed upon a severe personality disorder. The patient is able to speak coherently about his charges but most of the time he is preoccupied and distractable with a limited span of attention. Although it is determined that he understands his charges and the proceedings against him, his relatedness is so impaired by depression, low self-esteem, and suicidal impulses that it creates a significant incapacity in his ability to cooperate in his own

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defense. Psychologic testing reveals the defendant to be of above average intelligence and depressed with no evidence of psychosis.

The difficulty here is that the defendant appears to lack sufficient present ability to cooperate with his attorney, not because he lacks rational understanding (the language of *Dusky*) but because his current illness has grossly interfered with his motivation to do so. The defendant does not suffer from a mental illness that is generally thought to justify incompetency, and a finding of incompetency in such a case would be based on what one might call the "frontier" of the competency construct. The issue raised here is analogous to a very similar issue currently being debated with regard to the insanity defense: Should clearly nonpsychotic illnesses serve as a foundation for legal insanity? At first glance it may seem reasonable that severe depression can cause a defendant's observed incapacity to cooperate with his attorney. However, it is questionable whether depression *causes* this incapacity in the same way that retardation or a thought disorder *causes* one not to understand the proceedings. Perhaps depression, which is usually accompanied by "guilt," simply provides defendants with a "motive" not to defend themselves and does not actually render them incapable of doing so. Such defendants might, for example, feel that they deserve punishment and therefore sees no point in cooperating in the defense strategy preferred by their attorneys. Our experience indicates that, although certain severely depressed, highly suicidal individuals genuinely lack the capacity to participate in their proceed-

ings, caution should be used in cases in which depression is the only or major psychiatric symptom. Frequently the "observed incapacity" suddenly lifts, or is found to be context specific (e.g., the patient is "incapacitated" with the psychiatrist but perfectly cooperative and productive with his attorney). These cases are truly in the "gray zone" of the competency concept.

Clinical Issues

The difficulties that have been discussed here and that appear as a combinatorial function of answers to the "Basic Questions" outlined in Table 1 are difficulties that arise in spite of relative clarity in the clinical findings. They arise because the competency concept is sometimes misapplied (Case 6), extremely difficult to apply (Case 7), or in some ways unclear (Case 8). In addition, competency exams are frequently influenced by issues that lie outside of the province of the exam proper (e.g., countertransference, issues of "fairness"). Finally, problems can result when there is a lack of clarity with respect to the clinical findings,² particularly an inability to answer any or all of the three basic questions we have outlined.

It is our experience that clinical difficulties can at times be clarified through a comprehensive competency exam, using hospitalization to obtain longitudinal observations on the defendant. This, coupled with psychologic testing, a review of previous hospital records (if any), and contact with family, friends, and others (e.g., parole officers) can vastly enhance (and alter) the picture of

a defendant obtained in a competency interview.

Whereas we will reserve the clarification of clinical issues for a future paper, it will be useful to enumerate several pitfalls that can arise when clinical confusion exists: (1) In an attempt to avoid the problems discussed under Case 6, the defendant's diagnosis or observed psychopathology is permitted to color the examiner's view of the defendant's functional incapacity. (2) In an effort to head off the difficulties discussed under Case 7, signs of serious psychopathology are overlooked in a patient believed to be malingering. (3) In an effort to avoid the problems enumerated under Case 8 or out of countertransference needs to find a defendant competent or incompetent to stand trial, the patient's diagnosis is dictated by the sought-after conclusion rather than derived from the clinical findings.

Conclusion

It is our view that the validity and reliability of forensic psychiatric work would be greatly increased if psychiatrists and others performing evaluations for the courts focused clearly on (1) the defendant's psychiatric status, (2) the effect of this psychiatric status on the defendant's capacity to participate in the court proceedings, and (3) the extent of the observed incapacity to proceed. We have presented a scheme that focuses on these issues and that we believe will help

to clarify the clinical and forensic issues to be considered in an evaluation of competency to stand trial. It is hoped that our conceptual model will enable the examiner to focus on the specific factors leading to confusion in examinations of competency to stand trial.

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