Assessment of Competency for Execution? A Guide for Mental Health Professionals

Kirk S. Heilbrun, PhD; and Harry A. McClaren, PhD

Assessment of competency for execution presents two compelling ethical questions for mental health professionals: *whether* clinicians can ethically provide such assessment and, if so, *how* it should be done in order to maximize quality and minimize ethical conflict. In this article we address the issue of whether to participate and, if so, how. The question of whether to participate is discussed by summarizing the arguments for and against participation and offering guidelines for making a decision. The question of how to proceed is discussed in two contexts: preadjudication (before a formal decision about competency) and postadjudication (following a determination of "incompetent" and transfer of the offender to another facility for treatment and further assessment). Finally, recommendations are made regarding research that would improve the quality of execution competency assessments.

There is no magical resolution to the difficult ethical dilemma faced by mental health professionals attempting to decide whether to perform an assessment of competency for execution and, if so, how to proceed. Some aspects of this dilemma are not, under present circumstances, resolvable. Other aspects create enormous difficulties. However, it is possible to discuss these questions in a comprehensive fashion and expand upon arguments offered by others (e.g. Appelbaum[1]; Radelet and Barnard[2]) regarding the ethics of participating in assessment of competency for execution.

Two separate questions must be addressed. The first is *whether* mental health professionals should participate at all in assessing this kind of competency. The second, which arises only when the first is answered affirmatively, is *how* such assessment should be done. For the sake of clarity, these questions will be discussed separately.

Dr. Heilbrun is affiliated with the Forensic Service, Florida State Hospital. Dr. McClaren is affiliated with the Corrections Mental Health Institution. Address correspondence and requests for reprints to Dr. Heilbrun, Forensic Service, Florida State Hospital, Chattahoochee, FL 32324.

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Whether to Participate

The question of whether to participate in assessment of an individual's competency for execution is one that most mental health professionals will never face. For those who do face it, we cannot be too emphatic: the question should be considered *very* seriously. The option to refrain from participation should be treated as a viable one. Organizational and professional pressures to participate should not be sufficient inducement. It will be hard enough for those who participate voluntarily, after having carefully considered the arguments and weighed the potential consequences.

The arguments for and against participation must first be considered. The strongest arguments supporting participation might be described as *reality* and *contextual fairness.* Capital punishment is currently a political and social reality in the United States. Competency for execution is a firmly-established legal competency, integral to the capital punishment process.[3-5] Given the rapidly increasing population under death sentence, it is very likely that the competency issue will be raised, and assessments done, with increasing frequency in coming years. This reality will not be changed by the abstention of some mental health professionals. Indeed, one consequence of "selective refusal" may be that less competent or less scrupulous individuals perform competency assessments.[1-2,6] One could thus argue that there is an "affirmative duty" for those who are well trained, experienced in forensic assessment, aware of the limits of our knowledge, and determined to proceed within the boundaries imposed by ethical standards to *actively seek* an opportunity to participate.[7]

Contextual fairness recognizes the interests of both the inmate and the state in this matter. Anglo-American law proscribes execution of the incompetent; inmates have the right not to be executed when their mental condition prevents them from meeting the standard of competency for execution. However, the state has an interest in carrying out a lawfully imposed sentence. It is thus unfair to use competency as another avenue for post-conviction appeal when it does not apply. When competency for execution is assessed accurately, the interests of both the state and the inmate can be served.[8]

Convincing arguments may also be made to dissuade mental health professionals from taking part in execution competency assessments. For several reasons the imposition of the death penalty often appears arbitrary. The vast majority of those executed since the resumption of capital punishment in 1977 have killed white victims.[9] "Death-qualified" juries are more conviction prone and more likely to impose the death penalty.[10-13] Mitigating clinical/medical factors may be ignored or given little weight at sentencing.[14] In addition, it is very difficult to do an accurate assessment under the circumstances surrounding competency for execution. The reliability and validity of mental health diagnoses are imperfect even when made under more favorable conditions. Clinician characteristics may add to "error variance." Other aspects

of the examination not necessarily under the control of the examiner, such as place, time, and the presence of others, may also adversely affect accuracy. Finally, some bias may be introduced by the process of appointing clinicians to perform assessments. All of these influences are discussed at length elsewhere.[9]

The other argument against participation that must be considered is the altered public perception of mental health professionals that may result. Dramatically close to the administration of capital punishment, psychiatrists and psychologists who provide assessment of competency for execution risk harm to public and client perceptions of these professions as "professionally autonomous, treatment-oriented service providers."[1,15] This risk applies particularly to mental health professionals working with clients in criminal justice settings.[15]

A decision cannot be made simply by weighing the arguments, however. It is virtually impossible to separate thoughts from feelings, beginning with one's own feelings about the death penalty. There can be no "emotional neutrality" in the highly charged arena of the capital punishment process; prospective evaluators should expect to be caught up in an emotional storm that at times approaches gale force. The idea that one consequence of a professional activity might be the death of another human being can evoke confusion, frustration, and guilt. Emotion seems to enter into the question even when the clinician appropriately recognizes that he or she is a consultant (not a decision maker), playing a limited part in the broader capital punishment process. It is hard for the clinician to avoid the sense of being the "last hope" for keeping a condemned inmate from dying. This difficulty is exacerbated by contact with the inmate's attorneys and family, who are trying desperately to prevent the execution. Contact with the inmate himself can also increase this difficulty immensely. It is one thing to regard the death penalty in the abstract. It is quite another to talk and interact with an individual who may die in the near future if evaluation results in a recommendation of competence for execution. On the other hand, it is also difficult to avoid the anger that can result from learning of the gruesome details of an offense and imagining the effects of the offense on the victims and their families and friends. Anger toward the offender can be intensified by interactions with prosecuting attorneys and correctional staff, who may focus on the inmate's "manipulative" avoidance of consequences.

Furthermore, this evaluation is a highly public process. Those who participate should expect their efforts to be subjected to intense public and professional scrutiny. Media attention, much of it in the "How could a helping professional even consider . . ." vein, should be expected. Interviews with colleagues who would not have participated in such a process will be published/aired, often with the most pithy quotations selected. The clinician's observations and clinical-legal reasoning may be cited in excruciating detail by subsequent appellate courts. A strong stomach, a thick skin, and a firm commitment to doing a thor-

ough job will prove useful, even necessary, for participating clinicians.

First, however, comes the decision about participating. It should be treated as an essential first step and must be addressed adequately, or it will return to haunt those who have rushed in where angels fear to tread. A review of the arguments on participation, careful personal reflection, and consultation with colleagues who have done these assessments are recommended. Those whose decision to participate has included these steps will be much better prepared, professionally and personally, to go forward. This kind of preparation should also prove useful during the assessment process. Having carefully considered the arguments and his or her own feelings at the outset, the clinician can more easily monitor ongoing feelings and reactions and keep them from overly influencing the assessment.

How to Proceed

Preadjudication Assessment This section applies to evaluations performed after the issue of competency for execution has been raised, but before formal judgment regarding competency has been made by the decision maker. If the clinician decides to provide an assessment, then the ethical obligation is to do so in a thorough and excellent fashion. While excellence in evaluation has been emphasized with a criminal justice population generally,[16-17] it is particularly applicable to assessment of competency for execution because of the decision to be based (at least in part) on the results of evaluation.[7] Thus the clinician must have a clear idea of the minimum requirements for performing an excellent evaluation and make his or her participation contingent upon those requirements being met.

The first requirement is to inform the individual being assessed as to the purpose of the evaluation, the procedures to be used, and the possible consequences. Legal questions, such as whether the inmate has a right to remain silent or to have counsel present during questioning (*Miranda v. Arizona*[18]; *Estelle v. Smith*[19]) should be answered *before* the clinician is allowed to anticipate their effect upon the evaluation. The issue of informed consent is not precisely the question here. The inmate can refuse to participate, in part or entirely, and the examiner cannot ethically compel participation. However, refusal by itself should not necessarily keep the evaluation from proceeding. After being informed that the examination may continue anyway, although the accuracy of the results will be affected, the inmate should be questioned about his or her reasons for refusal. During this discussion a distinction should be made between rational and "crazy" reasons. Finally, the inmate should be given an opportunity to confer with counsel on whether and to what extent to participate in the evaluation.[20] If the inmate does refuse to participate, it then becomes the examiner's obligation to decide whether available information will be sufficient. Finally, the clinician must make every effort to determine how notification of purpose was understood. At

the least this should involve having it repeated back. When understanding of the notification is limited, the reasons should become more clear with formal intellectual and mental status assessment.

The preferred setting for such an assessment would be a private, distraction-free area in which interviewing and testing could be performed. This ideal may not be achieved when the individual is evaluated on death row. Again, it is useful for the participating clinician to have a clear idea of the *minimally adequate* conditions. The circumstances of some past evaluations almost certainly did not meet this requirement. For example, Alvin Ford was interviewed in a "courtroom" in Florida State Prison by a panel of three psychiatrists while being observed by attorneys, paralegals, and correctional staff.[21] When conditions do not meet the minimally adequate standards for performing an assessment, the clinician must then recommend that needed changes be made and be prepared to withdraw his or her participation if these recommendations are not implemented.

The need for independent (third-party) information is urgent whenever the individual being assessed may have some motivation to exaggerate or minimize psychopathology. The potential gain for exaggerating or faking psychopathology is obvious in the assessment of competency for execution. Reasons for minimizing or denying psychopathology in this situation are less obvious but clearly important as well. Some inmates subscribe to the ethos against appearing "crazy"; this attitude can contribute to what have been described as "overdetermined requests to be executed."[6]

Information should be gathered independently in the areas of history and current functioning. Relevant historical information can often be obtained from the attorneys for the defense and/or the state; a simultaneous request to both will help enhance comprehensiveness. Social and medical history are both important. Criminal and psychiatric history, when considered together, can help to establish the existence of longstanding patterns. Behavior observed during the current assessment can then be considered within a broad historical and developmental context.

Current functioning should be considered over a period encompassing the past year. Accounts offered by family, friends, correctional officers, prison medical and mental health staff, and attorneys are necessary supplements to information contained in prison records. Many of the persons interviewed will not have had any specialized training in mental health, nor will they be objective observers. For these reasons, their conclusions (e.g., "he was faking," or "he was crazy") are far less useful than their observations ("he said X," or "he did Y"). Such sources should be interviewed individually. Previous evaluations by mental health professionals should always be reviewed as well, if only as another source of observations (presumably collected more systematically and made more accurately than those of nonprofessionals). Some inconsistent information is always obtained during an

assessment of this magnitude. The examiner should first consider all such information, identify the consistent trends, and then describe the generally unsupported data as inconsistent. This provides some explanation for the discrepant information.

The next stage in assessment involves direct contact with the person being assessed. There are several general considerations here. First, the evaluator must be aware of the particular legal criteria that constitute the standard for competency in his or her state. For those states in which the criteria are not specified, it is advisable for the clinician to consider the standard in its broadest form and allow the court to determine whether all or only part is applicable (for a discussion of variations in standards between states, see Heilbrun[4]; Ward[5]). The second consideration, as discussed earlier, involves the need to inform the inmate of the purpose, procedures, and possible consequences of the evaluation. Thirdly, the clinician should plan these contacts to include a minimum of two and preferably three or more meetings with the inmate, all on different days. The fluctuations in mental state that can occur when an individual is genuinely psychotic make a single observation inadequate for generalization.[22] Finally, the clinician should consider that motivation, intellectual functioning, and personality style as well as psychopathology are all potentially relevant to determination of competency for execution.

The accuracy of the self-report obtained from the inmate is crucial. The instrument that has received the most empirical support in detecting exaggeration and minimization of psychopathology is the Minnesota Multiphasic Personality Inventory.[22–25] Other, more comprehensive approaches have been advanced in recent years.[26–28] Whatever the approach employed, however, the motivation of the inmate should be *explicitly* assessed as part of the evaluation.

Formal assessment of intellectual functioning is also recommended, using an instrument with empirically established levels of reliability and validity such as the Wechsler Adult Intelligence Scale–Revised Edition. Measures of cognitive organization, verbal skills, capacity for attention, understanding of societal mores and laws, and capacity for abstraction are all (arguably) related to the minimal legal criterion—understanding of death and the reasons for its imposition. Although intellectual functioning is routinely estimated from mental status examination, in these cases it would appear preferable, for reasons of comprehensiveness and empirical grounding, to measure it formally. Formal intellectual assessment, in conjunction with medical history and interview data, permits screening for the various manifestations of brain dysfunction. When organic impairment is indicated, further neurological and neuropsychological testing should be performed to clarify the nature and extent of the deficits.

Personality variables are potentially more problematic. Application of psychodynamically based inferences, such as those relating to unconscious conflicts and defenses, to clinical-legal questions

has been both advocated[29] and heavily criticized.[30] Those inclined to this approach should be aware of the substance of the debate. Patterns of behavior discerned from the history and current functioning investigation, however, are more directly applicable to the relevant legal task(s) at hand; they can be compared with the current behavior to help assess the causal connection between mental condition and legal competency for execution.

Assessment of psychopathology has been the primary focus of evaluations of competency for execution, judging from published accounts.[3,21,31] Although an emphasis on psychopathology would appear appropriate, we would argue that psychopathology must be judged in the context of the other influences just discussed. It should also be assessed in a sufficiently systematic fashion to allow formulation of a DSM-III-R diagnosis.[32] Toward this end, use of a structured interview such as the Schedule for Affective Disorders and Schizophrenia (SADS) or the Structured Clinical Interview for DSM-III (SCID) may provide useful information to supplement other assessment procedures.

The next step is assessment in terms of the relevant legal criteria. There have been a number of instruments developed to assist in assessing other types of legal competency.[33] The lack of such an instrument applicable to competency for execution is a problem that must be addressed in coming years.[6] Meanwhile, however, clinicians are left to determine "competency for execution" without empirical guidance. The problem is compounded by the absence of a consistent legal standard for competency for execution (comparable to the "understand and assist" criteria for trial competency set forth in *Dusky v. United States*[34]). To fill this void, the standard should be considered broadly rather than narrowly. For example, in a state in which the criterion for competency for execution is given only as "insane," the examiner might use the most broadly described standard: understand the impending death and the reasons for it, be able to assist counsel in ongoing appeals, and be able to psychologically and spiritually prepare for death (proposed in Brief for Petitioner, *Ford v. Wainwright*[3]). If the court determines that some aspects of that standard are irrelevant, then they can be disregarded in making the legal determination. Should the reverse occur, however—an examiner assessing only *understanding* and the court requiring information on *assist* and/or *prepare*—then that examiner must either say, "I don't know," or formulate a post hoc opinion on an issue not specifically assessed. Neither alternative is desirable. The same "broad versus narrow" reasoning may be applied to operational words like *understand* the *nature* and *effect* of the death penalty. Such wording should be considered broadly during the assessment; the narrowing, if necessary, should be the task of the court. In order to consider the standard broadly, clinical assessment of mental condition must likewise be considered broadly. Our recommendations for history gathering, interviewing third parties, psychological testing, medical

and neuropsychological testing when indicated, and multiple interviews with the inmate are made on this basis.

It is very important that this comprehensive assessment be fully documented in a report. The first reason is legal—the report is part of the record that will be considered in further appellate review and in challenges to the constitutionality of the proceedings.[21] The second reason is to document what was done, what mental condition (broadly considered) was observed, and what causal connection between mental condition and legal competency for execution was made, as well as the evaluator's reasoning and "degree of certainty" in making this causal connection. This is the essence of the clinical-legal evaluation, described by the United States Supreme Court in *Ake v. Oklahoma*[35]:

> [by] organizing mental history, examination results and behavior, and other information, interpreting it in light of their expertise, and laying out their investigative and analytic process to the [decision maker], the psychiatrists for each party enable the [decision maker] to make its most accurate determination of the truth of the issue before them. (p. 1096)

The question of whether the evaluator should conclude this report with an opinion about the ultimate legal issue—the inmate's competency for execution—is part of a larger controversy centering around whether such opinions should be expressed in *any* kind of clinical-legal evaluation. Many have argued against expressing an opinion, noting that opinions of law are not within the province of mental health expertise and that expressing ultimate opinions invades the province of the court.[17,28,36–37] However, failure to express an opinion can, in some jurisdictions, result in exclusion of the entire testimony. Even when testimony is not excluded, a variety of other problems can result from such abstention.[38–39] If the examiner does offer an "ultimate opinion" on competency for execution, then it should be done with recognition that the most important part of the evaluation is description of mental condition, legal criteria for competency, and reasoning about the causal connection between them. This connection might well vary depending on whether the competency standard is interpreted broadly or narrowly. When this variance is made explicit in the report, then the court is (appropriately) forced to select the breadth of the standard. For example, an examiner might discuss how the inmate's mental condition permits a superficial awareness of impending death, but has impaired broader awareness of its impact on others such as his or her family. The relation between mental condition and other potentially relevant legal criteria (e.g. assisting counsel in further appeals and psychologically preparing for death) could be discussed as well. If the court chooses the most narrow standard (i.e. understand the impending death and the reasons for it) and interprets to mean only that a superficial awareness of impending death is required, then it would decide that the inmate is competent. If the standard were interpreted more broadly, then the decision might be different. The point is that interpretation of the standard is appropriately made by the court, not by

the clinician. To underscore this distinction, the clinician might consider concluding the report with a statement recognizing the legal decision as the responsibility of the court, not of the mental health professional.

Postadjudication Assessment If the court determines that the inmate is incompetent for execution, he or she will presumably be transferred from death row to a correctional or forensic hospital to be treated until competency for execution seems to have been restored. Whether explicit or not, this process has two components: treatment and assessment. Treatment of these individuals presents even more formidable ethical problems than does the assessment. Issues such as the inmate's competency to consent to treatment and the question of using treatment procedures to effect a change that will result in his or her death have been addressed at length elsewhere.[1-2,6,40] For present purposes, suffice it to say that treatment under these circumstances presents immensely difficult and probably unresolvable problems. It has been suggested that the capital sentence of a person found incompetent for execution should automatically be converted to mandatory life imprisonment. This solution would resolve the treatment dilemma and place a premium on the accuracy of preadjudication evaluations, and may thus merit serious consideration.

Under present circumstances, however, the inmate is transferred to a facility with an expectation that both treatment and ongoing assessment will occur. The expectation that both can be provided by the same individuals, or even by the same treatment team, is not realistic. Tremendous confusion is experienced by staff between the roles of empathic helper and objective assessor. One can only imagine how such roles are perceived by the inmate/patient, whose cognitive organization and reality-testing are hardly intact to begin with. Assessment and treatment must be strictly separated. Treatment staff can then proceed without the added burden of knowing that information obtained during the course of treatment might also be used in competency assessment. If it is not otherwise guaranteed, we would recommend that at least one therapist be assigned to the inmate with absolute confidentiality assured (excepting, of course, information relevant to the immediate safety and security of that individual and/or other patients, but *not* excepting the assessment of his competency for execution).

Other mental health professionals, consulting from outside the immediate treatment section, could perform the ongoing assessment. For a variety of reasons, it may not be feasible in some settings to have hospital staff perform this assessment. Using consultants from outside the hospital to perform the assessment in such cases may be a more viable alternative. The question of the assessment team's access to chart notes, staff observations, medical tests, and other documentation routinely contained in hospital records should be clarified from the beginning. The issue of "off-the-record" observations shared among the assessment team but not doc-

umented in the record should be considered as part of this question. The other assessment procedures and considerations discussed in the previous section remain applicable.

Research Needs

Scientific papers typically conclude with a discussion of what is not known and what additional research is needed. The reader occasionally gets the feeling that these remarks will be made whatever the current state of knowledge or the utility of additional research. These issues are neither scientific indulgences nor polite disclaimers in the case of competency for execution, however. They are acute needs, made even more urgent by the consequences of the decision involved and the imminent likelihood of more such decisions being made in the near future.

The need for at least four areas of research is immediately apparent. The first involves the relation between clinician characteristics, inmate characteristics, and evaluation outcome. Is it reasonable to assume that evaluative accuracy is possible under the circumstances surrounding competency for execution? How reliable are various aspects of the evaluation? For example, do clinicians agree more often on diagnosis and symptomatology than on legal conclusions?

The second area of research would address the process of "death qualifying" clinicians. What procedures are currently used to select clinicians to participate in the assessment of competency for execution? Is the bias introduced by death qualification for juries also applicable to clinicians? How do clinicians who are qualified but would not, on principle, participate in such a process compare with those who would? Does the selection process itself exert any influence on the manner in which clinicians perform these evaluations?

A third area of needed research concerns the measurement of competency for execution. A number of structured approaches to assessing legal competencies have been developed (see Grisso[33] for a review). Development of comparable instruments, with measurable reliability and validity, would be extremely useful in assessment of competency for execution. First, however, it would be helpful to have a reasoned proposal for a "model standard" for execution competency, based upon relevant abilities, contextual demands, and societal justifications for capital punishment. Such a proposal might include a narrow, intermediate, and broad standard, differing as a function of the influences just mentioned. Research could then proceed on the development of approaches to measuring these varying standards.

Finally, it would be useful to know more about the population under death sentence. What is the incidence of severe mental disturbance among these inmates? How do death row conditions contribute to such disturbance? What is the psychological impact of living under death sentence for an extended period of time? Some such information is available[14,41–44]; more is needed.

The irony of this discussion of research needs is that the same ethical

questions facing clinicians regarding assessment of competency for execution will also confront researchers. Will they acknowledge the reality of capital punishment and devote their efforts to improving an imperfect process? Will they regard the process as too flawed to resurrect, avoid the risk of grafting respectability onto it, and instead devote their limited time and energy to other endeavors? It is our hope that this article will help researchers as well as clinicians to make that decision in a thoughtful way.

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8. This context would be broader under the argument justifying exclusion of the incompetent from execution called "tacit clemency."[5] This argument holds that the number of executions should be decreased in various ways to mitigate the overall impact of the death penalty. One of the ideas underlying tacit clemency is that society accepts the death penalty, but with implicit reservations about its justice or humanity. The broader context would thus be the death penalty itself and all those under death sentence, rather than the relatively few whose mental condition would prevent them from meeting the explicit standard for competency for execution.
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