Commentary: Competency Restoration Research—Complicating an Already Complex Process

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Predicting restorability in individuals found not competent to stand trial is an enduring focus of interest among forensic clinicians and academicians. In our commentary, we suggest that to understand this area even more comprehensively, we must look further. We must build on existing research on fitness to stand trial, move beyond diagnosis and a binary competence variable, and include the complex interplay between symptoms and fitness-related capacities that may be associated with lack of adjudicative competence and challenges to restorability.

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Predicting restorability in individuals found not competent to stand trial is an enduring focus of interest among forensic clinicians and academicians. While the impetus for such exploration may arise from a statutory requirement for an opinion about the likelihood of restoration at the time of the initial competency examination, this requirement is not universal. Seven states require no such prediction.[1] However, the ethics and legal principles articulated in *Jackson v. Indiana*, that the length of an individual's involuntary confinement be reasonably related to the purpose of the confinement, demands that we apply the best scientific and forensic thinking to the question of who requires and would benefit from competency-focused institutionalization.[2] To this end, Colwell and Gianesini[3] have done the field a service in looking beyond restoration-related factors available to forensic clinicians at the initial examination, to include possible factors discovered during the period of restoration-focused hospitalization. We suggest that to understand restoration of competency even more comprehensively, we must look further. We should build on existing research on fitness to stand trial, move beyond diagnosis and a binary competence variable, and include the complex interplay between symptoms and fitness-related capacities that may be associated with lack of adjudicative competence and challenges to restorability.

Colwell and Gianesini[3] report that, as they had hypothesized, clinical variables (including psychosis diagnoses and low cognitive functioning, more medications, and lower assessment of functioning (GAF) scores) were more associated with lack of restorability than were criminal justice variables (offense type and exposure to incarceration) or demographic variables. Lack of restorability was also associated with longer lengths of stay, suggesting that the continuing lack of competence and need for institutionalization were both related to clinical challenges in treating refractory psychiatric illness, rather than to more narrow legally driven criteria.[3] These findings echo those in our review of New York State insanity acquittees whose longer length of stay was related to clinical variables—in particular, refractory psychotic symptoms.[4] This finding would appear to make good clinical and legal sense, except when we consider that, as opposed to legal insanity, mental illness is not necessarily a statutory requirement for incompetence to stand trial (and indeed is not in the Connecticut statute that is in force where this study was performed). The specific areas of dysfunction associated with diagnoses, therefore, bear greater explication.

The authors' statement that "the most common reason that defendants are deemed incompetent is

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their inability to form a collaborative relationship with an attorney to assist in their own defense" (Ref. 3, p 304), also demands further scrutiny. Although they do not cite the source of this assertion, there is common-sense logic to it: whether directly driven by lack of trust or related to a lack of understanding that then impairs the collaboration, ultimately the ability to assist suffers. However, in reducing the incompetence to a singular relational disability, multiple adjudicative capacities are not afforded adequate attention. Combine these capacities with the variety of symptoms that may be associated with impairment, and the possible scenarios for incompetence to stand trial increase significantly, as do the areas for study of restoration and lack of restorability.

Finally, whether the symptoms of the disorder and/or the areas of impaired capacity represent an inability to understand the proceedings or an inability to assist the attorney is yet another area that merits further discussion with respect to the findings presented. The authors, for example, found that the diagnosis of personality disorder was associated with the restored cohort, despite the fact that, by definition, personality disorders are persistent and are often resistant to intervention. As will be discussed, it is unclear whether these individuals had actually changed clinically since the initial examination or were found restored because the diagnosis of personality disorder itself meant that they were deemed able to understand and assist, despite a seeming lack of capacity. If it was the latter, was the seeming lack of capacity determined to be a genuine reflection of their persistent world view or interpersonal challenges, or was it a deliberately malingered presentation of deficits? How one understands the diagnosis of personality disorder and a finding of malingering adds another layer to the exploration of what it means to be restored to competence to stand trial.

Diagnosis Versus Symptoms

Colwell and Gianesini used diagnoses determined, presumably, at some point during the competency-focused hospitalization as a critical independent variable in their study of restorability. However, diagnosis alone is never determinative; specific deficits ultimately kill the capacity. A patient with schizophrenia retains the right not to be medicated against his will unless, among other considerations, he loses the capacity to understand his need for treatment. So, too, does he remain competent to stand trial until such time as he no longer is able to understand his legal circumstance and assist in his defense. Even in states in which mental disease is an explicit component of a lack of fitness, there is always further specific dysfunction required. This reflects both the legal reality that individuals are presumed competent and that lack of capacity is situation- or decision-specific, as well as the clinical reality that individuals with the very same diagnosis can present with very different sets of symptoms. One patient with schizophrenia may be impaired by thought disorganization and agitation, whereas another may be quite organized but grossly delusional, and treatment response varies accordingly. Delusions, in the absence of thought disorder or behavioral disorganization, for example, are often more refractory to psychopharmacologic intervention and therefore the patient is potentially less likely to be restored.

Skeem *et al.*[5] suggested the use of nine domains to describe the spectrum of psychiatric deficits found in competence evaluations: impaired attention, delusions, hallucinations, thought disorder, impaired reasoning, memory impairment, cognitive impairment, mood impairment, and impaired impulse control. Thus, while diagnosis-based inquiries shed some light, a more complete understanding would require consideration, for instance, of whether a defendant's lack of fitness was due to hallucinations or delusions. On the other hand, the prognosis associated with similar individual deficits may differ based on the underlying diagnosis. The lack of motivation in a mentally ill defendant with negative symptoms of schizophrenia has very different clinical implications in a defendant with depression.[6,7] Specific considerations of such deficits, in the context of their underlying disorders, therefore, would help to incorporate a fuller clinical understanding of the natural course and treatability into restorability research.

Incompetence to Stand Trial Versus Adjudicative Capacities

So, too, the two-pronged *Dusky* standard—ability to understand and ability to assist—is really the final common legal pathway for a long list of adjudicative capacities. The MacSAC-CD (MacArthur Structured Assessment of the Competencies of Criminal Defendants), for example, divides fitness to stand trial into competence to assist and decisional competence.[7] Each of these competencies is then subdi-

vided into five distinguishable capacities: understanding of various legal concepts, reasoning around legal situations, appreciation of one's own legal case, understanding the consequences involved in offering a guilty plea or waiving one's right to a jury trial, and having the ability to approach and appreciate the legal decision in a rational manner. In the aforementioned study by Skeem *et al.*,[5] 11 domains were used to describe an incompetent finding: appreciation of charges, capacity to disclose information, appreciation of penalties, knowledge of legal options, capacity for reasoned choice, understanding of adversarial nature of proceedings, ability to appreciate appropriate courtroom behavior, capacity to testify, capacity to participate in proceedings, relationship with counsel, and medication effects on competence.

As each adjudicative capacity could be handicapped by any one of multiple diagnosis-specific deficits, the result is a large number of possible reasons for an opinion of not competent to stand trial and a correspondingly large and varied number of scenarios for predicting competency restoration. While intimidating in scope, we should challenge ourselves to incorporate into our research as much of the complexity as is practicably feasible.

Inability Versus Unwillingness: Personality Disorders and Malingering

The finding that a diagnosis of a personality disorder was associated with successful restoration is clinically counterintuitive, particularly in light of the authors' assertion that the inability to form a collaborative relationship is the most common reason for a finding of incompetence. Characteristics of personality disorder are, by definition, persistent[8] and are often resistant to treatment. If a finding of incompetence were rooted in a personality disorder, such as paranoid personality disorder, the associated pervasive, suspicious world view would not necessarily be a restorable condition.

On the other hand, in this study the finding may reflect two related phenomena: the timing of the diagnosis and the philosophical understanding of personality disorders. As opposed to some studies of restorability, this was a study of the relationship between hospital-based variables rather than variables emerging from the initial examination. Thus, the diagnosis of personality disorder in the present study reflects a later, hospital-based diagnosis. It is possible that under the initial stress of arrest and incarceration, interfering personality characteristics were more in evidence. Later, when less stressed, the defendant returned to a more competent baseline. Alternatively, the association with restorability may not be related to characterologic improvement, but rather to the ultimate determination that the defendant only had a personality disorder, rather than a more severe cognitive disorder diagnosed at the time of the initial opinion of incompetence. In other words, a personality disorder was, by definition, not a qualifying illness for continued incompetence. However, as noted earlier, mental illnesses are not a statutory requirement for incompetence to stand trial in many jurisdictions. Where mental illness is a criterion, personality disorders are not ruled out statutorily, although the case law is variable.[1] Therefore, the determination that a personality disorder does not qualify for incompetence may reflect clinical bias rather than legal criterion.

The clinical perspective is not necessarily helpful here. Whether personality disorders are mental illnesses with attendant symptoms and impairments is a subject of enduring clinical controversy[9,10] that is of particular importance within the context of competence-to-stand-trial evaluations, in which forensic clinicians are called on to opine whether a defendant is unable to assist his attorney, or merely unwilling.[11] Within the disease paradigm a finding of illness suggests inability. However, even if we accept the stated illness paradigm and assume some degree of impairment, the competency question remains. For example, is an individual with antisocial personality disorder unable to overcome his opposition to following court rules, or is he able to do so? That is to say, is he diagnosed as antisocial because he chooses not to follow the rules? His volitional resistance may be both a symptom of an underlying disorder but also, paradoxically, evidence of capacity. In actuality, the defendant is unwilling, not unable. The volitional prong may have been expunged from most insanity defense statutes, but it is alive and well in many fitness evaluations. Symptom-approached studies of incompetence could be a useful focus in this area as well and help avoid the thorny philosophical questions for which there are no ready clinical or legal answers.

One other piece of data that would have been helpful in interpreting the personality disorder finding is whether these defendants were found to have feigned their initial impairments. Given the concern

about malingering in all forensic contexts and the estimates of malingering base rates in forensic populations, it would have been helpful to know whether the defendants' final restorations were based on determinations that they were actually competent to begin with.[12]

Finally, with reference to nonpsychotic interference with competence abilities, a confound that may be confused with symptoms of personality disorder (and/or psychosis) is the influence of cultural background. As noted in the AAPL Practice Guidelines,[1] mistrust of the American legal system may be related to a misunderstanding of the system by a defendant from another country, and further compounded by having come from a legal system in which there is known widespread abuse and unfairness. One other cultural influence is worth noting: the influence of the culture of incarceration, with its attendant reinforcement of, among other values and behaviors, lack of trust, reliance on self, and lack of openness. There is a demonstrated negative correlation between adaptation to incarceration and the subsequent development of a working alliance.[13] While this research was performed in a clinical setting and focused on the relationship between clinician and patient, it is logical that the relationship impairment could extend to the fiduciary relationship between attorney and client. Just as in our work on working alliance, in the present study, more exposure to incarceration predicted poorer outcomes. Restoration efforts may be enhanced by attention to this phenomenon as well.

Conclusion

As Colwell and Gianesini correctly note, "competency restoration is a complex process, with many unique variables. . .not all of which were measured [here]" (Ref. 3, p 304). Indeed, they are probably beyond the scope of any individual study. However, enumerating these variables and the even more complex interplay between those that are general clinical factors and those that are more specifically legally relevant, as we have attempted to do herein, is, we believe, necessary in appreciating fully why defendants are found not competent to stand trial, what interventions may help to restore competence, and which defendants may not be able to attain competency.

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