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THE EFFECT OF ATTITUDES TOWARDS THE DEATH PENALTY ON FORENSIC
CLINICAL JUDGMENTS OF COMPETENCY FOR EXECUTION

By

Eugenia García-Dubus

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2016

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This manuscript has been read and accepted for the
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ABSTRACT

Capital punishment has been a part of the American Justice System since colonial times. A brief historical overview reveals a general tendency towards the imposition of restrictions on who is eligible for the death penalty (DP). In a series of decisions, the Supreme Court has held that the execution of an incompetent inmate is unconstitutional, but the topic is controversial among mental health professionals. The likelihood of clinician attitudes towards the DP affecting judgments of competency for execution (CFE) is discussed in the context of existing literature. The vagueness of the current CFE standard is thought to contribute to this possibility; however, no study has tested the influence of attitudes towards capital punishment on clinical judgments of CFE. Thus, two studies were conducted in an attempt to understand this relation. Study One was a national survey of psychologists' attitudes towards the DP. Study Two used forensic clinicians drawn from Study One's sample to examine the relationship between attitudes and competency decisions. Participants were presented with vignettes depicting an inmate of varying degrees of psychopathology and fit with CFE criteria, and asked to provide their opinion on the inmate's CFE status. Results indicated that psychologists hold less favorable views on capital punishment than the general population. In addition, degree of fit with CFE criteria was the strongest predictor of forensic psychologists' CFE judgments, followed by psychopathology severity; attitude towards the DP was not a statistically significant predictor of clinician's judgments of CFE. Strengths, weaknesses, and implications for practice are discussed.

Keywords: capital punishment, attitudes, competency for execution, survey, clinician bias

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CHAPTER I: INTRODUCTION

Capital punishment is a unique legal situation in many respects. From the way the trial is conducted to the review process that ensues once a death sentence is pronounced, capital procedures are subject to a more meticulous review than any other in the American legal system. Currently, 31 states in the country allow the death penalty. At the time of writing 1,417 people had been executed in the United States since 1976, the year in which the *Gregg v. Georgia* decision reinstated the death penalty with the requirement that guilt and sentence be determined in separate trial phases.

As with any other prison population, inmate mental health is a significant concern on death row. A total of 3,002 inmates are currently awaiting execution (Death Penalty Information Center, 2015). An estimated five to ten percent of these inmates suffer from mental illness (Mental Health America, 2012). In addition to those who already carry a diagnosis when they are sentenced to death, it is not difficult to imagine how the living conditions on death row and looming threat of execution can precipitate mental illness in even the healthiest person, and how such problems may interfere with the state's ability to move forward with the relevant legal process. As in any other criminal legal proceeding, the defendant's competency is essential to ensure fairness and is required by law. In addition to being competent during trial, a death row inmate is required to be competent at the time of execution, which may be more difficult to ascertain than competency to stand trial in light of the unique characteristics of the inmate's legal position.

The requirement for competency at the time of execution places mental health experts in the delicate position of providing the courts with opinions that could be used to justify an irreversible sentence. Although some take issue with participation in these evaluations, the fact is

that mental health professionals routinely participate in such cases. These sensitive evaluations should be conducted with the utmost competence and objectivity; however, empirical data examining these issues is notably lacking.

Capital Punishment in the United States

The history of capital punishment in America goes back to colonial times (Bedau, 1997). In the seventeenth century, the laws of each of the colonies were merely variations on English law, which meant that all colonies allowed hanging for several crimes, ranging from murder to more minor offenses, such as stealing. The revolutionary war and the creation of the Bill of Rights were catalysts, in the late eighteenth century and the first half of the nineteenth century, for significant changes to the state of the death penalty in the country. Some of these changes included the creation of degrees of murder, the ending of public executions, giving the jury authority to decide on sentencing, and a large reduction in the number of crimes that were eligible for the death penalty. Parallel to these changes an abolitionist movement was developing, culminating in the prohibition of the death penalty in Michigan, Rhode Island and Wisconsin in the years preceding the Civil War, and followed by a relatively quiet period where little changed in this arena. Early in the twentieth century the abolitionist trend continued in some states, while an increase in the number of executions was taking place in those that retained death penalty statutes. Other notable changes in these years were the search for more humane methods of execution, such as the gas chamber and lethal injection, and the increase in the use of federal appellate courts by inmates petitioning for relief (Bedau, 1997).

The years between 1950 and present day have seen many challenges to the constitutional basis for the death penalty (*Atkins v. Virginia*, 2002; *Chavez v. United States* 1981; *Ford v. Wainwright*, 1986; *Furman v. Georgia*, 1972; *Gregg v. Georgia*, 1976; *Roper v. Simmons*, 2005).

At the pinnacle of such challenges lies the case of *Furman*, which led to a nation-wide moratorium on the death penalty on the basis of its arbitrariness at the time. Four years later, the Supreme Court of the United States reinstated capital punishment as a consequence of new statutes requiring a bifurcated trial and consideration of mitigating and aggravating circumstances in sentencing decisions (*Gregg v. Georgia*, 1976).

Other cases heard by the Supreme Court of the United States have placed limitations, albeit of varying degrees of clarity, on procedures for capital trials, the types of individuals states are permitted to execute, and for what crimes. Some examples include the prohibition of capital punishment for rape (*Coker v. Georgia*, 1977), the prohibition of the execution of juveniles (*Roper v. Simmons*, 2005), mentally retarded individuals (*Atkins v. Virginia*, 2002), and the insane (*Ford v. Wainwright*, 1986)¹. Rationales for these prohibitions were generally rooted in whether or not the purposes of capital punishment are fulfilled by execution of such individuals.

Purposes of Capital Punishment

Theories of sentencing have been widely discussed by philosophers, sociologists and criminologists. A thorough review of the literature on this topic is beyond the scope of this paper; however, a general overview of the rationales behind criminal punishment is warranted in order to give some context to the justifications for capital punishment and the limitation placed on its applicability.

Theories of sentencing or punishment can be classified into two general groups: consequentialist and deontological. Consequentialist theories, as the name suggests, are concerned merely with the effect of the sentence and are epitomized in Jeremy Bentham's writings on utilitarianism (Read, 2007). The main rationale here is that punishment should be

¹ The Supreme Court uses the term *insane* interchangeably with the term *incompetent* in the context of competency for execution.

chosen based upon a cost-benefit analysis of how much harm it causes versus how much good results. In other words, the aim should be to bring about the greatest good to the greatest amount of people. According to this theory, the benefit society derives from the sentence outweighs the inmate's suffering by such a sentence.

Sentencing purposes that fall under the consequentialist umbrella include general deterrence, individual deterrence, rehabilitation, and incapacitation (McFatter, 1982). The first two refer to the social benefit that comes from the punishment, making it less likely that others will engage in the criminal behavior and that the individual in question will engage in the criminal behavior, respectively. Rehabilitation is based on the idea that the individual can be changed, thus maximizing the "good" by benefiting both society and the individual. Lastly, incapacitation refers to the social benefit incurred when an individual is prevented, by incarceration, execution, and other methods, from engaging in criminal behavior in the future. With the exception of rehabilitation, each of these purposes has been cited by supporters of capital punishment as justification for the death penalty (Radelet & Borg, 2000). When we execute individuals, they purport, we deter others (and clearly the inmate in question) from committing capital crimes. In addition, capital punishment is the ultimate mode of incapacitation, as the inmate will be unable to commit further crimes after his or her execution.

Critics of utilitarian views on sentencing contend that such a stance would theoretically allow for the punishment of the innocent without regard to fairness, as long as it creates a greater benefit to society than the suffering of the punished (Carlsmith, Darley, & Robinson, 2002; von Hirsch, 1992). Conversely, deontological views on punishment, personified by Immanuel Kant, suggest that sentences should be decided based on what the criminal deserves for his behavior, as opposed to what would be most beneficial to most people (Fish, 2008). This is also known as the

just deserts theory, which is retrospective in nature and not concerned with the future consequences of the sentence. The purpose here is retributive, for the punished to pay back his or her debt to society in a way that is proportional to the harm he or she has inflicted, while factoring in circumstances that may ameliorate culpability (e.g. extreme necessity, mental incapacity, remorse; Carlsmith et al., 2002). Under this theory, capital punishment is justified only when the damage caused by the inmate is so great, and the mitigating factors are insufficient, as to warrant the greatest penalty (Saks, 2009). Hence, the death penalty is not justified when the crime is anything other than murder or when the inmate is intellectually disabled or too young to understand what he or she has done.

Critics of capital punishment have attacked its legitimacy by citing empirical evidence that suggests it has no deterrent effect on crime beyond that of life imprisonment. Comparisons of capital murder rates in states with and without death penalty statutes support this idea and experts in law enforcement appear to be in agreement about capital punishment's lack of utility as a general deterrent (Radelet & Ackers, 1996). Moreover, other studies discredit the incapacitation justification of the death penalty, finding that only about 1% of offenders on death row go on to commit other murders. But beyond the empirical evidence against these justifications, there are those who purport that with the limitation of the death penalty to murder and the advent of modern prisons these arguments lose their philosophical meaning altogether and the only justification that remains is that of retribution or *just deserts* (Bedau, 1997).

The purposes of criminal punishment are central to any criminal justice system. The Bill of Rights of the United States incorporates *just deserts* elements into the fifth, sixth, and eighth amendments, and legal procedures and policies in the American Justice System are also infused with its principles. Elements such as the right to confront your accuser and the right to legal

counsel are in place to preserve fairness in adjudication. Release from criminal responsibility for defendants who were insane at the time of the crime incorporate nearly all the justifications discussed so far. Moreover, the requirement that an individual be competent during trial is also heavily based in these principles.

Legal Competencies

The American legal system has traditionally afforded defendants the right to be competent during pre- and post-conviction procedures. These competencies date back to the nineteenth century and are rooted in common law (Grisso, 2003; Otto, 2006). They are meant to allow individuals to contribute to their defense in a meaningful way and in a manner that would maximize fairness in the proceedings. Modern standards of competency to stand trial in the United States require defendants to have “sufficient present ability to consult with [their] lawyer with a reasonable degree of rational understanding...[and have a] rational as well as factual understanding of the proceedings against [them]...” (*Dusky v. United States* 1960, p. 403). The language in the Dusky decision implies, by use of the terms *sufficient* and *reasonable degree*, that the defendant’s level of understanding does not need to be optimal; however, the standard also requires from the defendant a more sophisticated grasp of the situation than the mere knowledge of the facts of the case, as he or she should be able to contribute to his or her defense and make relevant legal decisions (Otto, 2006).

Although, of all legal competencies, competency to stand trial (CST) has been the focus of most of the research, defendants and inmates are required to be competent for other legal proceedings as well. Some of these include waiving the right to an attorney, proceeding *pro se*, pleading guilty, and being sentenced. The Supreme Court of the United States held that the same legal standard used for CST applies for other legal proceedings where constitutional rights might

be waived (*Chavez v. United States* 1981; *Godinez v. Moran*, 1993) and that a higher standard needs to be met for self-representation in light of the increased complexity of the task (*Indiana v. Edwards*, 2008).

The case is slightly different for situations in which the individual is not waiving his or her rights, such as sentencing proceedings and parole revocation hearings. Initially, the standard for competency to be sentenced was whether the person could “understand the nature of the proceedings and participate intelligently to the extent participation is called for” (*Chavez v. United States* 1981, p. 8); a lower requirement than the ability to consult with his lawyer with a reasonable degree of rational understanding. The courts have allowed the issue of competency to be sentenced to be raised at any point between conviction and the imposition of the sentence (*Saddler v. United States*, 1976); however, a more recent decision has raised the standard to match the one set forth in *Dusky*, effectively demanding that defendants be able to confer with their attorney in the sentencing process as well (*United States v. Sanchez*, 1999).

Generally speaking, capital trials are no different in terms of the standards for competence that apply. Defendants have to meet the same standard in order to be CST for shoplifting as they do for capital murder, although the meaning of the term *sufficient* is necessarily affected by the context. However, unlike other criminal proceedings, the moment at which a defendant receives a death sentence is usually very distant in time from the moment at which such sentence is actually carried out. In fact, the average time spent on death row has steadily risen since Furman and has hovered at around the 15-year mark as recently as 2012 (Death Penalty Information Center, 2015). And so, a special case of competency to be sentenced can be found in the cases of death row inmates who cannot be executed if their competency is in question.

Competency for execution. Prohibition of the execution of the insane is long-standing and rooted in English common law (Brodsky, Zapf, & Boccaccini, 2001; Ewing, 1987; Radelet & Barnard, 1986). Some of the reasons that have traditionally been offered against the execution of the insane include the assertion that such an execution would be an offense to “general notions of humanity” (Ebert, 2001, p. 32) as well as religious arguments such as the need to allow the inmate to “make peace with his maker” (Ewing, 1987, p. 178). However, failure to achieve deterrence and retribution is often cited in the literature as an argument against the execution of inmates while incompetent (Heilbrun, 1987). Although there are those who disagree (Bonnie, 1990a), the general contention is that if the prisoner cannot understand the reason for his execution, the retributive purpose of capital punishment is not satisfied. This rests on the assumption that the execution of an insane inmate is of lower moral value than the killing for which said inmate received the death sentence, and so no retribution is accomplished in such a case.

Legal background. Zapf (2009) suggested three main types of sources that should be consulted for descriptions of competency for execution (CFE) standards: relevant Supreme Court opinions, state statutes, and commentary from related professional organizations. These sources will be discussed in detail below following Zapf’s proposed classification, for better understanding.

Supreme Court cases. Despite such a long history on the topic, the first contemporary Supreme Court ruling that directly addressed issues related to the prohibition of the execution of the insane was that of *Ford v. Wainwright* (1986). Alvin Ford was convicted of murder in 1974 with no question as to his competence raised during the proceedings. However, eight years later, he started developing delusional ideas about the Ku Klux Klan and others conspiring to have him

commit suicide. This idea evolved into a more complex delusion that included the prison guards on death row torturing him and other people, his family being taken hostage, and him having the ability to help them from death row. His attorneys had him evaluated by two psychiatrists, one of who opined Ford was not competent for execution (Mello, 2007). This prompted Ford's counsel to request the evaluation prescribed by Florida law, in which a panel of three psychiatrists appointed by the governor would examine the inmate. After a joint interview that lasted no more than 30 minutes, these psychiatrists found Ford competent to be executed, despite disagreeing on his diagnosis, which ranged from paranoid schizophrenia to "severe adaptational disorder" (Miller & Radelet, 1993, p. 81). Soon after, the governor signed Ford's death warrant without allowing him to present evidence to his incompetence and without any further explanation. After numerous appeals and petitions, Ford's case reached the Supreme Court of the United States where he claimed his due process rights were violated, as he was not allowed to bring forth evidence to dispute the findings of the panel of experts appointed by the governor.

The Court's majority opinion touched on several points. First, citing English common law as well as a host of legal scholars, the Court held that executing an insane convict would constitute cruel and unusual punishment and was unconstitutional under the Eighth Amendment. In the majority opinion, Justice Marshall stated that such an execution would "simply offend humanity" (p. 10) and would serve no purpose.

In addressing the issue of whether Ford should have had an evidentiary hearing to determine his sanity, the Court questioned the fairness of Florida procedures due to its exclusive reliance on the executive branch for the examination and decision-making process. The Court held that these procedures were inadequate and that the prisoner had a right to be allowed to bring evidence to his sanity in order to effectively protect his due process rights. The precise

manner in which an inmate would be allowed to do this was not specified in the *Ford* opinion, but instead was left up to each state and currently ranges from more informal hearings to a trial-like proceeding.

Recognizing the Court's failure to provide a clear definition of competence to be executed in its majority opinion, Justice Powell outlined in his concurring opinion the closest thing to a standard on CFE that we have today. He concluded that the execution of inmates was forbidden only if they are "unaware of the punishment they are about to suffer and why they are to suffer it" (p.17). Only then, said Powell, can the convict prepare mentally, emotionally and spiritually for death, while the purposes of deterrence and retribution continue to be served. Following the *Ford* decision a number of publications in the mental health field emerged, focusing mainly on the ethical dilemmas faced by mental health professionals who participate in this kind of evaluation (Appelbaum, 1986; Bonnie, 1990a; Brodsky, 1990; Heilbrun, 1987; Radelet & Barnard, 1986). In addition, the standard proposed by Justice Powell was criticized by scholars as vague and as providing insufficient information for mental health professionals charged with assisting the courts in making these determinations (Brodsky, 1990; Radelet & Barnard, 1986; Small & Otto, 1991).

The standard proposed by Justice Powell in *Ford* is thus strictly a cognitive one and commonly referred to as the single-prong standard. It calls for mere *awareness* of the punishment and the reason for it, and seems to be a lower threshold than the one delineated for CST in *Dusky*, which requires factual and rational understanding of the proceedings as well as the ability to consult with counsel. However, Justice Marshall's allusion to the term *comprehension* in the majority opinion opens the door to different practical interpretations of the

requirements in the standard and leaves forensic experts with a nebulous description of abilities to be assessed in CFE evaluations.

On a final note, the issue of Ford's competency was remanded for determination by the District Court. This court eventually found Ford to be malingering and competent for execution in 1989. Ford's attorneys appealed this decision. While awaiting ruling on the appeal Ford became severely ill in prison and died of acute respiratory distress and pancreatitis a couple of days later in a Florida hospital (Miller & Radelet, 1993).

More recently, the Supreme Court had the opportunity to reexamine the CFE standard in *Panetti v. Quarterman* (2007). Unlike Ford, Panetti had a long history of mental illness that existed well before the crime in question took place. He had been diagnosed by some with schizophrenia and by others with schizoaffective disorder, had delusions about the devil possessing his home, and reportedly had an alter personality named "Sarge." Other overt signs of mental illness included a series of bizarre displays of behavior during the court proceedings, after Panetti's motion to represent himself, some of which included calling the Pope and President Kennedy as witnesses. Despite these signs and multiple CST examinations through multiple trials, Panetti was eventually convicted of the murder of his in-laws and sentenced to death by a Texas jury. Following his conviction, his mental health continued to deteriorate leading his attorneys to request a competency evaluation in the face of his execution (Bonnie, 2007).

The experts who examined Panetti agreed that he suffered from delusions regarding the reasons why the State wanted to execute him, believing that it wanted to stop him from preaching. However, he was able to tell examiners that he had committed the murders and that the State "claimed" this was the reason for his execution. Based on these findings, experts concluded that Panetti was competent to be executed. In other words, he had a factual

understanding of the reasons for his execution and, therefore, fulfilled the standard required by *Ford*.

Panetti appealed this decision on the grounds that, while he had a factual understanding of the reasons for the execution, his delusions prevented him from having a rational understanding of it, making him incompetent for execution. The American Bar Association (ABA) submitted an *amicus* brief in support of his position. The American Psychological Association, American Psychiatric Association, and the National Alliance on Mental Illness also submitted briefs to the Supreme Court supporting Panetti's position. These briefs will be discussed later on this paper.

The Supreme Court sided with Panetti stating that the District Court erred in its narrow interpretation of the *Ford* standards and that "gross delusions stemming from a severe mental disorder may put an awareness of a link between a crime and its punishment in a context so far removed from reality that the punishment can serve no proper purpose" (*Panetti v. Quarterman*, 2007, p. 687). This means that the mere ability to verbally state the reasons for the execution would not be sufficient evidence to justify competence and that a higher level of understanding (i.e. a *rational* one) is required for such a finding (Mello, 2007). However, once again, the Court remanded the decision back to the District Court and did not put forth a clear and well-defined standard for CFE. Panetti remains on death row; as of this writing no execution date has been set.

Although *Ford* and *Panetti* are the most often cited cases in any discussion about the execution of the incompetent, neither directly addressed whether the ability to consult with counsel was a necessary component of CFE, as has traditionally been required in other competency standards. In fact, the Supreme Court has avoided directly ruling on the issue by referring back to the *Ford* standard with little further explanation (Seeds, 2009). In the case of

Rector v. Bryant (1991) the court held that Rector’s ability to assist counsel—found to be severely limited by organic deficits—was irrelevant to his *Ford* claim and was denied.

Nevertheless, capacity to assist counsel remains an important and actively discussed issue in the legal scholarship and will be described in more detail in a later section.

State cases. While the *Ford* and *Panetti* decisions clearly affirmed prohibition of the execution of an incompetent inmate and proposed a minimum standard of competency, they also left each state free to write their own statutes within the boundaries elucidated by the Supreme Court’s decisions. This section is an attempt to highlight the most important state cases that have dealt with CFE-related issues and that differ from the national standards that have already been discussed.

There are currently 31 states with death penalty statutes (Death Penalty Information Center, 2015). Each of these states prohibits the execution of the insane, either explicitly or by virtue of *Ford*, and most have outlined CFE standards (Zapf, 2009). State statutes on CFE can broadly be classified into single-prong and two-prong statutes. The single prong statute was described earlier and was first established in *Ford* and later expanded in *Panetti*. It requires inmates to factually and rationally understand both the nature of the punishment they are about to receive and the reasons for it. Almost two thirds of death penalty states subscribe to the single-prong standard. The two-prong standard adds to this the requirement that the inmate have the ability to assist counsel. Since the single prong standard has already been described, the latter will be the main focus of this discussion.

South Carolina is one of the states to have adopted the two-prong standard (*Singleton v. South Carolina*, 1993). In addition to taking on the standard recommended by the ABA (to be discussed below) they also describe some procedural details. First, the burden of proof for a

showing of incompetency is that of preponderance of the evidence and falls on the defendant. This level of proof has also been adopted in other states as well (*van Tran v. Tennessee*, 1999). Once a finding of incompetency has taken place, the burden of proof shifts to the state. Second, that “justice can never be served by forcing medication on an incompetent inmate for the sole purpose of getting him well enough to be executed” (*Singleton v. South Carolina*, 1993, p. 4). And third, that the standard for CFE is the same as the standard for competency to waive appeals, so an inmate who has been found to be competent to waive his or her appeals is automatically competent for execution and does not need to be reevaluated unless questions about his competency arise after this evaluation and before the execution date (*State v. Motts*, 2011).

Inmates of different states have unsuccessfully challenged the use of the single prong standard by arguing that *Godinez v. Moran* (1993) mandates the inclusion of the assistance prong for CFE (*Barnard v. Collins*, 1994; *Coe v. Tennessee*, 2000). Others have suggested that the *Ford* decision prohibits the execution of all mentally ill inmates, and not just those who were found incompetent (*Swann v. Taylor*, 1999). And lastly, some have erroneously raised claims of incompetency before the execution date had been set (*Stewart v. Martinez Villareal*, 1998). By far, the most detailed description of legal procedures to follow from the moment at which a *Ford* claim is legally ripe to the steps to follow for evaluation and re-evaluation can be found in *Van Tran v. Tennessee* (1999) and may aide clinicians in search for more guidance in this type of case.

Professional associations' commentary. In 2006 the American Bar Association (ABA) issued recommendations on the administration of capital punishment. Most of these were in line with existing case law and suggested that capital punishment may not be imposed on juveniles

and defendants whose intellectual capacity and adaptive functioning were in question. Moreover, the ABA adopted the two-prong standard for CFE, citing cases of death row inmates who had been found factually innocent as support for the need to have an assistance prong on the standard up until the time of execution and requiring both *awareness* and *appreciation* of the reasons for the punishment. Later, in their *amicus* brief in support of Panetti (2007), the ABA elaborated on the reasons behind the need for a more sophisticated level of understanding as they relate to the generally accepted retributive purpose of capital punishment and agreed with the Supreme Court in that retribution is not accomplished by the execution of someone who does not understand why they are being punished.

The ABA also discussed the possible legal consequences of a finding of incompetency and suggested that such a finding should lead to an automatic commutation of the death sentence. This was partially supported by the judicial and ethical conflict contained in forcibly medicating a prisoner for the purpose of making him or her competent enough for execution. According to the ABA, once a defendant is found incompetent for execution, the sentence should be whichever would have been administered in that jurisdiction if the death penalty were not an option.

The American Psychological Association, American Psychiatric Association, and National Association for Mental Illness (NAMI) also submitted a joint *amicus* brief in favor of Panetti (2007). In line with the reasoning outlined by the ABA and Justice Powell, these organizations agreed that the retributive purpose of a sentence of death cannot be fulfilled if the inmate does not understand the reasons for his or her execution and concluded the following:

If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment or to appreciate the reason

for its imposition in the prisoner's own case, the sentence of death should be reduced to a lesser punishment. (p. 16)

Although the *amici* did not explicitly endorse the use of a two-prong standard, they did further elaborate on the manner in which delusions, such as Panetti's, might interfere with the understanding and appreciation of the sentence and explained how mental health professionals can aid the court in making determinations of CFE by assessing inmates and providing reliable opinions and diagnoses. This content was ultimately reflected in the *Panetti* opinion.

Despite the differences of opinion on the purpose of a death sentence and the appropriate standard for CFE, the current legal landscape in the United States explicitly prohibits the execution of the insane, making the assessment of the prisoner's mental state an essential part of the legal decision of proceeding with an execution when competency is called into question. This, of course, means that psychologists and psychiatrists will inevitably be called to provide their opinion on cases like these and, given the irreversibility of the penalty that the state seeks to impose, important questions arise regarding the manner in which mental health professionals go about completing this type of assessment.

Ethical issues. An examination of the literature on the topic reveals that following the *Ford* decision debate ensued on the ethical dilemmas faced by clinicians who are asked to participate in this type of evaluation. Some authors suggest that clinicians should not be concerned at all with the ultimate consequences of their decision in this type of evaluation (Miller, 1988). Other scholars propose there is no difference between mitigation evaluations and competency to be executed evaluations, as they both require the clinician to participate in a process where death is a possible outcome (Bonnie, 1990b). Moreover, the argument is made that other forensic evaluations analogous to CFE (e.g., competency for parole evaluations) are routinely performed with no ethical questions about the psychologist's participation in the

administration of justice, which is ethically allowed, versus the administration of punishment, which carries ethical conflicts (Bonnie, 1990a).

Lastly, there are those who assert that mere participation in CFE evaluations does not promote harm (Mossman, 1987) as some propose (Ewing, 1987; Radelet & Barnard, 1986). After all, the decision to proceed with an execution is not the psychologist's but the governor's. As a possible solution, Mossman (1987) suggests clinicians should stay away from using phrases like "fit for execution" in their reports in order to avoid the interpretation of the assessment and the psychologist's participation in the imposition of the death penalty. However, this seems to trivialize the ethical issue by implying that the practical matter at hand can be resolved semantically while ignoring the reality that, although the ultimate power lies on the legal agent, these legal decision makers almost always act in accordance with the recommendation of the evaluating clinician.

Bonnie (1990) suggests that the main reason mental health professionals are reluctant to participate in these assessments is because of the immediacy with which the punishment is administered once the evaluation is finalized and the adverse psychological effect it has on the clinician who conducts it. However, it is also possible that, while these factors surely play an important role, the main reason for questions being raised with respect to psychologist's ethical obligation to avoid harm is that of directness and not temporal immediacy. The ethical problem is not so much that the death penalty is immediately applied upon conclusion of the competency evaluation, the ethical problem is that the administration of the punishment is a *direct* result of a finding of competency, arguably making the psychologist responsible for the inmate's death.

Some authors also warn that a refusal to conduct these evaluations by mental health professionals may result in the inmate having his or her right not to be executed while insane

denied (Miller, 1988). Along the same line, others suggest that if all mental health professionals who oppose the death penalty refuse to participate in this type of evaluation the result might be that a select, possibly biased, group of professionals are the ones who end up conducting these assessments (Bonnie, 1990a; Radelet & Barnard, 1986). Bonnie (1990a) and others further support their argument for the participation in CFE evaluations by stating that an evaluation that may lead to such irreversible consequences is better conducted by highly scrupulous clinicians, as opposed to clinicians who may hold political interests in the outcome. However, empirical studies examining the possibility of clinician bias in CFE evaluations are notably absent.

Practical issues.

Notification of purpose. As in any other clinical situation, psychologists are faced with the necessity of notifying the convict of the nature and purpose of the evaluation before proceeding with the assessment (Brodsky, 1990; Heilbrun, 1987; Small & Otto, 1991). Notification of purpose in this case would include the components normally found in consent procedures including, but not limited to, an explanation the purpose of the evaluation, the limits of confidentiality, the possible consequences of not participating and a disclosure of who retained the evaluator (American Psychological Association, 2002; Heilbrun, 1987). Clinical issues, such as the possibility of malingering, are salient in this type of situation, especially in light of the information provided to the convict at the time of consent, and further highlights the need for specialized competence in forensic assessments (Brodsky et al., 2001; Heilbrun, 1987; Radelet & Barnard, 1986).

Also to be considered is the question of whether the inmate has the capacity to make a decision regarding his participation in the evaluation at that particular point in time. If the clinician finds that the convict is not competent to decide to participate an opinion of

incompetence to be executed may also be appropriate. Others suggest that the inmate's attorney or guardian be used as a decision maker in those cases (Small & Otto, 1991). However, some scholars claim that the state's interest in executing a sentence is so great that it could preclude the need for informed consent for CFE evaluations (Mossman, 1987). Ultimately, as delineated by Small and Otto (1991), it is unlikely that an inmate would refuse to participate in this type of evaluation as these claims will, more often than not, be brought forward by the defense, as opposed to the State.

Recommended practice. The nature of CFE evaluations places serious restraints on the idea of conducting empirical research in the area and most of the work that informs clinical practice regarding these evaluations is survey based (Miller, 1988). Zapf and colleagues (2003), as well as other authors (Ebert, 2001; Small & Otto, 1991), have attempted to create guidelines to help orient clinicians who participate in these evaluations on how to conduct the best evaluation possible. Ebert (2001) identified three mental disorder categories as possibly impacting CFE: diminished intellectual capacity, psychopathology, and dementia. This becomes central for CFE evaluations because presence of a mental disorder is a necessary threshold for incompetence thereby rendering diagnostic and malingering assessment a necessity in any CFE evaluation (Ebert, 2001).

Among the more general recommendations found in the literature are the practice of detailed documentation of the process and consideration of the physical environment and other evaluation-related situational factors when interpreting the findings (Ebert, 2001; Heilbrun, 1987; Zapf et al., 2003). In addition, efforts to create standard guidelines for clinicians traditionally recommend the inclusion of a forensic clinical interview (preferably over several meetings), a thorough review of records, and an attempt to obtain collateral information from

prison guards, family members and other relevant third parties (Brodsky et al., 2001; Ebert, 2001). Areas of inquiry typically include the inmate's history of psychiatric or medical treatment, violence, employment, substance use, social functioning and other standard components of a comprehensive psychosocial history. Plain language should be used during the interview in light of the lower level of education typically found in the death row population (Zapf et al., 2003). In addition, a mental status exam should be conducted at each encounter and all of the inmate's custodial records should be reviewed (Ebert, 2001). Some authors suggest that neuroimaging techniques might also aid in clarifying an inmate's level of competency (Perlin, 2010).

In terms of the use of standardized psychological tests for CFE evaluations, opinions are split. Some authors have advocated for routine use of such measures (Ebert, 2001; Heilbrun, 1987), while others have suggested there is little use for standardized testing in a CFE evaluation. Small and Otto (1991) have a more balanced view and suggested that, although standardized tests may be rendered invalid by the typical death row testing environment and the prisoner's level of education, there are some advantages to their use. First, they may be helpful in identifying the inmate's main pathology as well as in detecting exaggeration or feigning of symptoms. Second, formal assessment of cognitive abilities may also be helpful in situations in which it is suspected that cognitive deficits are affecting competence.

However, there are those who believe that standardized testing is less useful in CFE evaluations and that clinicians would be better informed by an assessment of the inmate's functional abilities (Brodsky et al., 2001; Small & Otto, 1991). These would include things like observations of inmate-attorney interactions in jurisdictions where inmates are required to be

able to communicate with counsel for a finding of competency to take place, as well as the assessment of other functional abilities.

Zapf et al. (2003) proposed the most structured interview checklist available to be used by professionals in CFE evaluations. They suggested four main areas of assessment that mirror the requirements in *Ford* and some state statutes. These areas are: understanding the reasons for punishment, understanding the punishment, appreciation and reasoning, and ability to assist counsel. The first area is made up of questions assessing factual knowledge of the crime and should include the time and place of the crime, an understanding of the criminal charges for which the inmate was convicted and how they relate to the crime, identifying information about the victim and a general appraisal of the inmate's beliefs about the fairness of the conviction and sentence. The second area—understanding of the punishment—should include questions about the inmate's understanding of what it means to be dead, what he or she thinks will happen after death, and how he or she would know if someone was dead. In addition, specific knowledge about the execution procedures to be used should be assessed.

Although at the time of the publication of their article *Panetti* had not reached the Supreme Court and “rational understanding” was not explicitly required, Zapf and colleagues (2003) included appreciation and reasoning as an area to be assessed in their checklist. Here they recommend that clinicians ask inmates about how their death would impact others, how they think death will change them physically and mentally, and whether they believe that they would be affected by death differently than other people being executed. Other questions to bear in mind are whether the inmate believes he or she is invulnerable to execution and whether there is any reason why he/she should or should not be executed. These questions are meant to help the clinician gain a better understanding of how deeply the inmate has thought about these issues and

would also help in eliciting any irrational or delusional thoughts about themselves, the execution or the reasons behind it.

Last on the proposed checklist is the ability to assist counsel. This area includes questions about the inmate's general knowledge about his or her attorney's name and contact information, as well as the attorney's trustworthiness. In addition, the authors suggest that the inmate's familiarity with important case details—such as appeal status and substance and execution date—be assessed, as these will directly impact the inmate's ability to communicate with counsel. Finally, any pathological reasons for not trusting counsel or not moving forward with appeals should also be directly inquired about as these may not otherwise lead to an accurate depiction of the inmate's perception.

The standard. One of the main problems cited in the literature as affecting psychologists' ability to conduct execution competency evaluations is the vagueness of the definition of the construct of CFE (Brodsky, 1990; Radelet & Barnard, 1986). Although the *Ford* court addressed an important legal issue and provided further safeguards against the execution of incompetent inmates, it failed to provide a clear standard for competency. Radelet and Barnard (1986) outline several practical problems related to the vague wording of the statute that may affect clinicians in conducting this type of evaluation. Among these is the lack of definition provided by the court regarding the term *understanding* as it relates to the death penalty. Brodsky (1990) adds to this point by highlighting the many different meanings death can have to an individual. While some see it as a brief sleep, others may view it as the beginning of their real punishment, without necessarily impacting their level of understanding. Radelet and Barnard (1986) further questioned what is meant in the statute by the level of understanding of the *nature* and the *effect* of the death penalty that the inmate must have to be found competent. In other

words, most statutes do not specify whether the inmate needs to understand what happens to his body during and after execution or whether he also needs to demonstrate that he understands the effect the punishment will have on others (e.g. the victim's family members, the inmate's family members).

Others propose that the standard for CFE should be modeled based on the justifications for the death penalty (Heilbrun, 1987; Saks, 2009). Namely, if the main purpose of capital punishment is retribution, we should require that the inmate understand *why* he is being put to death. On the other hand, if the main purpose is deterrence, an argument could be made that competency is not necessary. Either way, Heilbrun (1987) suggests that the lack of clarity in the *Ford* standard is directly related to society's lack of clarity on the reasons for capital punishment.

Other problems related to the standard include issues related to time. Since competency is a requirement *at the moment* of execution, there is always a chance that evaluations done days or even hours before such an event may not necessarily reflect the inmate's mental state at the moment preceding the imposition of punishment. Lastly, there are issues related to the statute not providing a clear level for the standard of proof. This is likely to be problematic because it creates a lack of uniformity on how the procedure is implemented (Radelet & Barnard, 1986) across professionals and across states. Brodsky (1990) further supports this point by noting that the more vague the standard the higher the likelihood that clinicians will consciously or unconsciously allow their values to guide the assessment. Others have expressed similar concerns about the lack of clarity in the *Ford* standard and the effect this may have on how experts conduct their evaluations and report their opinions to the court (Dietchman et al., 1991; Radelet & Barnard, 1986; Svec, 1991).

Clinician bias. Earlier in this paper, one of the arguments mentioned in favor of psychologists' participation in CFE evaluations was that the abstention of clinicians who are opposed to capital punishment or against participation in CFE evaluations could result in a biased pool of experts who may be predisposed towards finding inmates CFE (Deitchman, Kennedy, & Beckham, 1991). Other factors that may amplify the potential for bias include the ambiguity of the CFE standard, the unreliability of clinical diagnoses and clinician attitudes and attributions (Dietchman et al., 1991).

The idea that humans rely on heuristics and biases when making judgments has long been recognized and studied by cognitive psychologists (Tversky & Kahneman, 1974). It has consistently been shown that people's judgments and decisions are systematically affected by how easily other instances of the case come to mind (availability heuristic), how much a situation or person fits a certain stereotype (representativeness heuristic), and by arbitrary reference points (anchoring heuristic) (Kahneman, 2003; Tversky & Kahneman, 1974).

In the case of capital trials—where jurors who are so opposed to the death penalty that they would be unwilling to impose it are constitutionally excludable (*Witherspoon v. Illinois*, 1968)—there is ample evidence in the psychology and law literature that suggests that attitudes and heuristics affect jurors' deliberation processes, decisions on guilt, and decisions on sentencing (Cowan, 1984; Fitzgerald & Ellsworth, 1984; Haney, 1980). Death qualified jurors have been shown to be more conviction prone and more likely to endorse a sentence of death, effectively biasing the judicial process (Gross, 1984). Moreover, the effect of other biases on jury verdicts and sentences – such as those related to race – seems to be enhanced when jury instructions are poorly understood (Lynch & Haney, 2000).

While there is little evidence that some of these biases affect forensic clinical judgment (Cooper & Zapf, 2003; Hart & Hare, 1992), clinicians are not completely immune from the influence of heuristics and attitudes in decision-making. These may affect any aspect of clinical work, ranging from diagnostic assessment and treatment decisions to expert opinions provided to courts of law. The literature on how attitudes might affect forensic opinions has been sparse, but some evidence can be found in the criminal responsibility literature.

In a series of three studies, Homant and Kennedy (1987b) examined the relationship between attitudes and forensic clinical judgment using a random sample of psychologists and psychiatrists from Michigan. The authors found clinicians to be divided in terms of their opinions about the insanity defense and found a strong relationship between political ideology (conservative vs. liberal) and attitudes towards the insanity defense. Interestingly, this relationship was curvilinear, with people on both political extremes endorsing the least support for the insanity defense. These findings should be put in context by mentioning that, at the time, the John Hinckley case – which sparked a reform on laws on criminal responsibility – was somewhat recent, so it is likely that this pattern of results may have been affected by the ongoing debate on the subject.

In a second study, these authors had a subsample of clinicians who participated in the initial study make judgments about the degree of criminal responsibility of a fictional defendant. This case vignette had been created to ensure that it was not leaning more towards one extreme or the other in terms of criminal responsibility. The authors found that attitudes towards the insanity defense and judgments of insanity had a strong, positive correlation ($r=.68$; $p<0.001$). This relationship remained significant for both clinicians who reported they would be willing to

participate in such an evaluation and clinicians who reported they had testified as experts in insanity cases.

Following up on these results, the authors used a national sample of experts and varied how sympathetic the hypothetical defendant was perceived to be. In addition, they collected data on previous experience and attitudes towards mental illness. The authors found that 34 percent of the variance was explained by factors that were not related to the defendant, but instead were related to the clinician. Moreover, the strongest predictor of judgments of insanity was clinicians' attitude towards the insanity defense. This pattern of results was closely replicated when experts were asked to opine on the Hinckley case (Homant & Kennedy, 1987a).

A few weaknesses are worth noting. First, inherent to this type of study is the limitation of using one or two cases. The amount of information provided is not analogous to the amount of information gathered in a real world case and it is impossible to predict whether these findings would replicate with real cases. Second, this study was correlational, so causal inferences are not possible; however, as the authors note, it is impossible for the cases presented to the experts to have caused expert attitudes and political ideology. Lastly, these studies were conducted by the same authors and searches in databases such as PsycInfo yielded no other study examining the relationship between attitudes and expert opinions.

In addition to being discussed within the context of commentary (Brodsky et al., 2001), there is also mixed empirical evidence for this phenomenon as it relates specifically to clinical judgments of CFE (Ackerson, Brodsky, & Zapf, 2005; Deitchman et al., 1991; Pirelli & Zapf, 2008). Deitchman and colleagues (1991) examined clinicians' willingness to participate in CFE evaluations and the relationship to attitudinal variables regarding capital punishment and attribution of criminal responsibility. After sending out questionnaires to hundreds of forensic

mental health professionals in Florida, these authors found that examiners who were in favor of capital punishment were significantly more likely to be willing to participate in CFE evaluations, but did not differ from unwilling clinicians in terms of criminal responsibility attribution. However, while statistically significant, the difference between these means was relatively small and the samples overlapped slightly. Also of interest, authors found that psychologists and psychiatrists differed in terms of attitudes towards the death penalty, with psychiatrists favoring capital punishment more than psychologists. In addition, they found that more years of forensic experience were associated with more favorable views towards capital punishment. Nevertheless, whether these attitudes were related to more than willingness to participate (e. g., actual participation in CFE evaluations, or actual judgments of CFE) was not examined.

These results, while striking, are not without limitations. The sample used by the authors was drawn exclusively from the state of Florida, restricting the generalizability of these conclusions. It is also worth mentioning that this study was wrought by the weaknesses inherent in self-report methods and the use of surveys and so the results could be a consequence of response biases and self-selection of the participants and not necessarily due to a relationship between the variables examined.

Building on the work by Dietzman et al. (1991), Pirelli and Zapf (2008) conducted a national survey to examine forensic psychologists' attitudes towards participating in different aspects of a capital case, including CFE evaluations. These authors found that the majority of psychologists do not oppose participation in most capital proceedings, with the notable exception of CFE evaluations, which carried the highest levels of opposition at around 60 percent. In line with the results from Dietzman and colleagues, Pirelli and Zapf (2008) found that psychologists who were opposed to capital punishment were more likely to be generally opposed to

participation in capital evaluations. Together, these findings provide support for the idea that self-selection bias may be at play in the pool of experts who agree to participate in CFE evaluations, above and beyond the bias that might occur in other capital evaluations. This leads one to question whether this attitudinal bias stops at willingness to participate in CFE evaluations or whether it would translate to a bias in clinical judgment that could be affecting the actual CFE opinions.

The work of Ackerson, Brodsky and Zapf (2005) partially answered this question in the context of the development of an instrument for the assessment of CFE. Initially, they surveyed judges on the relative importance of different legal components as they relate to CFE. Based on the survey results and expert feedback the authors constructed the Competency for Execution Research Rating Scale (CERRS).

In a second study, psychologists were sent vignettes that varied the presence of the CERRS, the level of symptomatology, and level to which CFE legal criteria were met. Results showed a main effect for the presence of the CERRS only when the legal criteria were ambiguous, with clinicians in the CERRS group rating the inmate as more incompetent than participants without the CERRS. The authors' attempt to address the issue of attitudinal bias, however, was limited to asking participants to rate their approval of psychologists' participation in CFE evaluations. They found this did not have an effect on competency ratings in either group but they failed to assess general attitudes towards the death penalty. This allows for the possibility that some clinicians might hold negative attitudes towards capital punishment while approving of psychologists' participation in CFE evaluations, a position that has often been discussed in the literature and that, again, opens the door to the possibility of clinical bias (Brodsky et al., 2001). Moreover, the fact that the CERRS had an effect only on cases where the

legal criteria were ambiguous provides further support to the contention that bias is more likely to occur in situations that are not well-defined.

While difficult to ascertain, there is some real-world evidence of clinician bias in CFE evaluations. For example, as recently as 2011, a forensic psychologist with a long history of conducting CFE evaluations in Texas was reprimanded by the Texas State Board of Examiners of Psychologists for reporting IQ scores and adaptive functioning that were higher than they actually were in several cases, in order to make inmates seem to be competent for execution (Lichtenstein, 2013). The clear concern in the field about the clarity of the standard for CFE coupled with the ethical debate surrounding psychologists' participation in these evaluations and some empirical evidence suggesting attitudes towards capital punishment can influence people's opinions of individual cases are the basis for the current study.

Current Study

While there is a wealth of commentary on the ethical issues associated with the participation of mental health professionals in CFE evaluations and a good amount of published legal debate regarding the competency standard, empirical literature on the topic is limited. Available studies support the idea that CFE evaluations are highly controversial among mental health professionals and that a considerable number of clinicians would refuse to participate in such an assessment (Pirelli & Zapf, 2008). Other studies suggest that those who are willing to participate in CFE evaluations are more likely to favor capital punishment (Dietchman et al, 1991).

However, clinician attitudes and willingness to participate are irrelevant unless they actually have an effect on forensic opinions. And although the rate of findings of CFE has not been examined empirically, anecdotal evidence suggests that a finding of incompetence is rare.

Only four cases are listed on the Death Penalty Information Center's website as having had their death sentence commuted as a result of incompetency; a number that seems disproportionately small when compared to the more than one thousand inmates who have been executed. And yet no study to date has examined whether attitudes towards the death penalty are related to clinical judgments of CFE.

The importance of conducting objective assessments of CFE cannot be overstated. Despite numerous disagreements in the field, most experts do acknowledge that CFE evaluations be held to the highest standards of professionalism and objectivity (Brodsky et al., 2001; Heilbrun, 1987; Radelet & Barnard, 1986; Small & Otto, 1991). Moreover, no other forensic evaluation has the potential for such severe and irreversible consequences. An examination of factors that could affect professional objectivity, therefore, is not only important but also necessary. The current study is an attempt to fill this gap in the literature on CFE and to inform mental health professionals about some of the factors that may affect clinical judgment in this situation.

CHAPTER II: METHOD

This project was comprised of two separate but related studies, to be outlined in detail below. Study One was an online survey of clinical and forensic psychologists, recruited via electronic mailing addresses gathered from the American Psychological Association's (APA) directory, and surveyed clinicians' attitudes towards the death penalty and other demographic and professional variables. In Study Two, a subset of participants from Study One—those who reported dedicating some portion of their practice to forensic work—were presented with case vignettes that varied both degree of CFE and severity of psychopathology and asked to evaluate

the degree to which the inmate in the vignette met the criteria for CFE based on *Ford* and *Panetti*.

Study One

This study was a survey aimed at obtaining descriptive information regarding clinical and forensic psychologists' attitudes towards capital punishment, in addition to collecting professional experience and demographic information. These data served two other purposes. The first was to compare death penalty attitudes both within this sample (i.e., forensic vs. non forensic mental health professionals) as well as to a general sample. This comparison was based on data indicating that individuals with graduate education tend to have attitudes towards the death penalty that are significantly less favorable than individuals with a college degree or less (O'Neil, Patry, & Penrod, 2004). In addition, past findings indicating those with more forensic experience tended to favor capital punishment was a basis for the other comparison (Dietchman, et al., 1991). The second purpose was to collect data to be used in study two in examining the relationship between these attitudes and CFE judgments (see a detailed description below).

Hypotheses. Two hypotheses were examined:

H1. Psychologists will endorse less favorable attitudes towards capital punishment than the general population.

H2. Forensic practitioners will have more favorable views on the death penalty than non-forensic practitioners.

Participants. Participants were recruited from the APA's member directory. A database containing first names, last names, and electronic mail addresses, was created using the APA's directory of relevant divisions. Specifically, members the Society of Clinical Psychology (Division 12), the American Psychology-Law Society (Division 41), and Psychologists in

Independent Practice (Division 42) who were also members of APA were included in the database. These directories include active members who have chosen to publish their information. A total of 5,707 individual electronic mail addresses were collected, of which 5,035 were valid.

In order to be eligible for Study One, participants had to practice in the United States of America and had to hold a doctoral degree in psychology (in addition to having a working email address). Professionals were deemed eligible to participate in this phase regardless of their practice or professional activities (e.g., assessment, treatment, research, etc.).

A total of 927 participants responded to the survey, yielding a response rate of 18.3%. Of these, 60 respondents were excluded due to not meeting inclusion criteria. An additional 74 respondents were excluded due to incomplete Death Penalty Attitudes Questionnaire (DPAQ) responses, leaving a total of 793 participants in the sample.

Participants resided in every state, with the exception of Alaska. The final sample was 59.9 percent male and 39.3 percent female. In terms of race and ethnicity, participants were overwhelmingly white, with less than five percent of the sample identifying as non-white. This percentage is significantly different than the APA's latest estimates (APA, 2014), which report percentages of white members ranging from 69 to 92 in the surveyed Divisions. In addition, a very small percentage of the sample identified as Hispanic (2.3%). The majority of the sample (86%) reported being over 50 years old, reflecting a similar age distribution in membership reports from the relevant APA divisions. Full demographic information on the sample can be seen on Table 1.

Table 1
Study One Sample Demographic Variables

	<i>N</i>	Percent
<i>Gender</i>		
Male	475	59.9
Female	312	39.3
Missing	6	0.8
Total	793	100.0
<i>Age</i>		
26-30	6	0.8
31-35	13	1.6
36-40	20	2.5
41-45	36	4.5
46-50	41	5.2
51-55	69	8.7
56 & over	597	75.3
Missing	11	1.4
Total	793	100
<i>Race</i>		
White	750	94.6
Black	14	1.8
Asian/Pacific Islander	4	0.5
Native American	8	1
Other	10	1.3
Missing	7	0.9
Total	793	100
<i>Hispanic</i>		
Yes	17	1.9
No	758	95.9
Missing	18	2.2
Total	793	100

Materials. The materials used for this phase included the Death Penalty Attitudes Questionnaire (DPAQ; O'Neil et al., 2004); a Professional Experience Questionnaire; and a Demographic Information Form (see Appendix B). Each will be described below.

Death Penalty Attitudes Questionnaire (DPAQ). The DPAQ is a 15-item measure designed to gauge a person's support of capital punishment (O'Neil et al., 2004). In the original

instrument, participants were asked to say how much they agree with statements assessing different aspects of capital punishment on a scale from one to nine. Total DPAQ scores range from 15 to 135, with higher scores indicating more pro-death penalty attitudes. Items 2, 3 and 9 are reverse coded. The mean score in a large ($n= 2,849$) sample made up of undergraduate students, as well as jury-eligible non-student participants, was 72.39 points and internal consistency was high ($\alpha=0.79$) (O'Neil et al., 2004).

The DPAQ was originally developed in the context of jury research in response to mounting evidence that support for the death penalty was a multifaceted construct and could not be adequately measured by one item. O'Neil et al. (2004) found the DPAQ to have five factors: general support for the death penalty (general support), retribution and revenge (retribution), death penalty is a deterrent (deterrent), death penalty is cheaper (cheaper), and life without parole allows parole (LWOP).

The DPAQ has been shown to have good convergent validity, as its factors correlate highly with other death penalty attitude measures ($r=.86$ for the general support factor with the Thurstone Attitudes towards Capital Punishment Scale), as well as with constructs associated with increased support for capital punishment, such as authoritarianism ($r=.34$), punitiveness ($r=.42$), and beliefs about due process ($r=.40$). For a full review on the development and psychometric properties of the DPAQ see O'Neil et al. (2004). The complete instrument is available in Appendix B.

Professional experience questionnaire. This questionnaire was developed for the purposes of this study and was designed to get a rough idea of the participant's experience in psychology. Amount of forensic experience is a variable that could affect the dependent

variables and has been included for use as a covariate (Deitchman et al., 1991) (see Appendix B for full list of questions).

Demographic information form. This form was constructed for the purposes of this study. It contains standard questions about age, gender, race and ethnicity. A list of all questions can be found in Appendix B.

Procedure. The survey was created using the online survey site Qualtrics.com. Once the questions were in place, the researcher tested that the survey was functioning as intended and had several doctoral students at John Jay College confirm appropriate survey functionality.

Once functionality was established, two email invitations were sent to the participant pool before the start of the work day, as suggested by Trouteaud (2004) and Cook et al. (2000), to maximize response rate. These emails were sent on days one and seven. The original plan to send a second invitation on day two had to be foregone due to limits on the number of weekly emails allowed by Qualtrics, which caps this at 5,000 emails a week. Invitations were personalized with the recipient's name and contained a plea for participation (see Appendix A). The body of the email explained the purpose of the study and contained a link to the survey.

The first page of the survey contained the two screening questions (i.e. what's your highest degree? and where do you practice?). The appropriate waiver of consent for screening procedures was obtained by the IRB (protocol number 646799-1) in order to be able to screen participants before obtaining informed consent. If participants were found to meet inclusion criteria, they proceeded to the informed consent form, where the study procedure was described, potential risks and benefits outlined, and the limits on confidentiality and the participant's right to withdraw without penalty were explained. By clicking on the "next" button participants agreed to participate in the study

Participants were then presented with the survey materials including the DPAQ, a brief questionnaire about professional experience, and a demographic questionnaire. Demographic and professional experience questions were positioned at the end of the survey, since it has been found that doing so decreases the chances of participant drop out (Sills & Song, 2002; Trouteaud, 2004).

Analysis Plan. Data analyses were performed using IBM SPSS Statistics 22.0 and were planned in two steps. First, descriptive analyses were conducted and then a second set of analyses were conducted to test each hypothesis by comparing this sample's attitudes towards the death penalty to the existing normative data on the DPAQ (O'Neil et al., 2004), in addition to comparing attitudes towards the death penalty in forensic and non forensic practitioners. All descriptive statistics were computed using total DPAQ score as well as factor scores. Descriptive statistics were also computed for the remaining professional experience and demographic data.

Study Two

Study two was designed to examine the relationship between attitudes towards the death penalty and clinical judgments of CFE in a subsample of psychologists from Study One. This subsample was made up of mental health professionals who met the inclusion criteria for and completed Study One (i.e., practice in the United States and hold a doctoral degree) and who dedicated at least some of their time to forensic clinical work. This study used a 3 x 3 factorial design similar to the one used by Ackerson et al. (2005) with a total of 9 vignettes representing orthogonal variations on psychopathology severity and degree of fit with CFE criteria.

Descriptive participant data was collected in Study One, including attitudes towards the death penalty (as measured by the DPAQ) and professional forensic experience (as measured in

years). These data were linked to the current study's using the Panels feature in Qualtrics, where each participant is assigned a unique identification number embedded in the URL associated with their invitation. This identification number remains constant across studies and allows the data from both studies to be linked.

The dependent variables were clinical judgment of CFE and clinician confidence in said judgment, both measured continuously on a scale of 1 to 9, with higher ratings indicating higher levels of competence and confidence, respectively. Additional items requested that clinicians make a dichotomous decision regarding CFE and assess the inmate's ability to consult with their attorney. Vignettes were pilot tested on advanced forensic psychology students to ensure manipulations were working as intended under the current CFE standards. Additional manipulation checks were instituted in order to assess participants' comprehension of the CFE standard.

Hypotheses. A total of 6 hypotheses were tested:

- H3. Attitudes towards the death penalty (DPAQ scores) will predict judgments of CFE, in that more favorable attitudes towards capital punishment will be associated with a tendency to find inmates competent, and less favorable attitudes towards the death penalty will be associated with a tendency to find inmates incompetent across all levels of psychopathology and degree of fit. DPAQ scores will be the strongest predictor of judgments of CFE.
- H4. CFE Level will be positively correlated with CFE judgments. The higher the CFE Level, the more likely it will be the inmate will be judged competent.
- H5. Severity of psychopathology will be inversely correlated with judgments of CFE. The more severe the psychopathology, the less likely the inmate will be found competent.

This correlation will be weaker than the correlation between CFE Level and CFE judgment.

H6. There will be an interaction between attitudes towards the death penalty and CFE Level, such that attitudes towards the death penalty will have greater predictive power in vignettes in which competency status was ambiguous.

H7. There will be an interaction between CFE Level and Psychopathology Severity, such that defendants in the high psychopathology conditions will be more likely to be found incompetent regardless of degree of fit with CFE criteria.

H8. Attitudes towards the death penalty will be directly and positively correlated with willingness to participate in CFE evaluations.

Participants. The initial pool of participants for this study was generated from participants from Study One. Specifically, only participants who indicated that they dedicate some portion of their practice to forensic work were included in Study Two. This procedure produced a pool of 455 potential participants. Participants who met inclusion criteria were contacted via electronic mail address through Qualtrics. A total of 164 people responded to the invitation to participate (36% response rate) and, of those, 141 completed the study. Of the 141 participants, five were excluded due to not meeting the requirement of dedicating part of their time to forensic practice.

Similar to Study One's sample, the majority of participants in Study Two were white (98.5%), male (66.9%), and 56 years of age or older (72.9%). Participants represented 39 states, suggesting considerable, although not comprehensive, geographical coverage.

Table 2
Study Two Sample Demographic Variables

	<i>N</i>	Percent
<i>Gender</i>		
Male	89	66.9
Female	44	33.1
Total	133	100
<i>Age</i>		
26-30	2	1.5
31-35	3	2.3
36-40	2	1.5
41-45	9	6.8
46-50	4	3
51-55	16	12
56 & over	97	72.9
Total	133	100
<i>Race</i>		
White	131	98.5
Black	1	0.8
Other	1	0.8
Total	133	100
<i>Hispanic</i>		
Yes	3	2.3
No	129	97
Missing	1	0.7
Total	133	100

Power Analysis. A power analysis using G*Power 3.1 revealed that a minimum sample of 92 participants would be needed in order for multiple regression to be sensitive enough to detect a medium effect size ($f^2=0.15$) and achieve a statistical power of 0.8, which is generally considered acceptable. For statistical power to increase to 0.95, a sample of 138 would be needed. With a final sample consisting of 393 observations and 133 participants, statistical power was not a concern.

Materials. This study used case vignettes and a clinical judgment questionnaire, described in detail below.

Case vignettes. This study used case vignettes constructed and used by Ackerson (1994) and published by Ackerson et al. (2005), with some modifications. In the original vignettes, Ackerson and colleagues (2005) manipulated severity of psychopathology (mild, moderate and severe) and degree of fit with the CFE standard (criteria met, uncertain, criteria not met), which varied orthogonally, yielding a total of nine vignettes. The CFE standard at the time these vignettes were developed was the *Ford* standard. Since then, the case of *Panetti v. Quarterman* (2007) added the requirement that inmates have a rational, as well as factual, understanding of the reasons they are being put to death. In order to account for this change, the vignettes were pilot tested on advanced forensic psychology students to ensure manipulations were working as intended under the new standard. Below, the development of the original vignettes is outlined, followed by the most recent testing and subsequent modification.

Development of the original vignettes. The nine original vignettes depicted inmates with the following combinations: mild psychopathology and competent (vignette 8), mild psychopathology and uncertain competency (vignette 2), mild psychopathology and incompetent (vignette 4), moderate psychopathology and competent (vignette 7), moderate psychopathology and uncertain competency (vignette 1), moderate psychopathology and incompetent (vignette 3), severe psychopathology and competent (vignette 5), severe psychopathology and uncertain competency (vignette 6) and severe psychopathology and incompetent (vignette 9).

The clinical presentation of the inmates depicted in the vignettes was based on existing research on the mental health of death row inmates. Symptoms were classified into two general categories: those causing a high level of dysfunction (those requiring immediate intervention; e.g., self injury) and those causing a low level of dysfunction (those not requiring immediate intervention). The levels of severity were defined as follows:

1. "Severe" diagnostic symptomatology: six symptoms, at least three of which were from the category of high level of dysfunction.
2. "Moderate" diagnostic symptomatology: four to five symptoms, with two of these symptoms from the category of high level of dysfunction.
3. "Mild" diagnostic symptomatology: four or less symptoms; no more than one symptom from the high level of dysfunction.

The level to which CFE criteria were met (competent, uncertain, incompetent) was based on the requirements outlined in *Ford*, plus the ability to assist counsel. These criteria were defined as: (1) understanding of the meaning of punishment, (2) understanding the nature of punishment (i.e., death penalty), (3) awareness of the reason for being punished, (4) understanding the connection between crime and punishment, (5) ability to appropriately assist the attorney, and (6) understanding of death and ability to prepare for one's own. The level to which legal criteria were met was operationalized as follows:

1. "CFE Criteria Met": all six criteria satisfied or at least five were satisfied and one was questionable
2. "CFE criteria uncertain": three out of the six criteria satisfied
3. "CFE criteria not met": satisfied less than two of the criteria

In addition, manipulation checks were conducted with advanced doctoral students at the University of Alabama and results indicated that the manipulations were working as originally intended by the authors. The full set of original vignettes has been provided in Appendix C and a more detailed description of the development process can be found in Ackerson (1994).

Testing the current vignettes. The nine original vignettes were slightly modified to include some information on the clinical history of the fictional inmates. Then, they were tested

on advanced clinical forensic psychology Ph.D. students from John Jay College of Criminal Justice and Sam Houston State University, who were instructed on both the *Ford* and *Panetti* standards (see Appendices D and E for invitation email and instructions). In order to test the vignettes on a group that was analogous to the sample to be used in the study, only students who were on their third year of training or beyond, and who completed the Forensic Assessment course were considered. By the third year of training, clinical psychology doctoral students have had at least one year of clinical practicum experience and have taken coursework on abnormal psychology, making them qualified to assess general psychopathology. In addition, because these students had training in forensic assessment, they had general knowledge of how to conduct these types of evaluations.

A total of 20 students participated in the first manipulation check. An initial test revealed all vignettes were working as intended, with the exception of vignettes 3 and 5. Vignette 3 was modified by removing details related to self-harm, effectively reducing the severity of psychopathology. Vignette 5 was modified by adding details related to the inmate's ability to recount the facts of the crime to his lawyer, in order to increase the level of competency. After these modifications, these vignettes were retested on a total of 19 students. On the second test, vignette 5 remained problematic. This vignette was modified again, by adding details related to the inmate's ability to prepare for his death, and was found to be working properly on the third test. Results from each round of testing are provided in Appendix I, and both the original and modified vignettes are presented in Appendices C and H, respectively.

Procedure. The initial recruitment procedure was identical to that used in Study One and began seven months after data collection for that study had concluded. This lapse of time was hoped to be long enough to minimize any priming effect that may result from having taken the

DPAQ. Electronic mail invitations were personalized with the recipient's name and contained a plea for participation (Trouteaud, 2004). Participants were informed in the invitation email that they had been specifically selected to participate in this study due to the nature of their training (see Appendix F for invitation email). This was intended to increase the salience of the invitation, as it has been found that doing so contributes to an increase in response rate (Cook et al., 2000). In addition, participants were offered an opportunity to enter a raffle for a US\$100 Amazon gift card as an incentive.

Study materials were put together using Qualtrics and a link directing potential participants to the materials was included in the email. The first page of the survey contained the informed consent form explaining participants' right to withdraw without penalty and that expected risks were minimal. The second page of the survey included the study instructions, as well as the *Ford* and *Panetti* criteria (also displayed with each vignette).

Each participant was presented three case vignettes, and asked about his or her judgment of the inmates' CFE, and confidence in said judgments. In addition, clinicians were asked to rate the inmate's ability to consult with his or her attorney, and were asked about their willingness to participate in each vignette's CFE evaluation. The Qualtrics server was set up to select the case vignettes presented to the participant randomly, with the constraint of keeping an equal number of people per vignette. A full list of the questions included in this study can be found in Appendix G.

Analysis plan. Multiple regression analyses were conducted using DPAQ score, Psychopathology Severity, CFE Level, the interaction term between Psychopathology Severity and CFE Level, and the interaction term between DPAQ score and CFE Level as predictors. Judgment of CFE was used as the outcome variable. All predictors were treated as continuous

measures. A logistic regression was also conducted with the same predictors and the dichotomous measure of Judgment of CFE as the outcome variable. In both cases, years of forensic experience was entered on the first step, as a means of controlling for this variable. Lastly, Spearman correlation terms were calculated to test whether willingness to participate in the case was correlated with attitudes towards the death penalty.

CHAPTER III: RESULTS

Study One

Descriptive statistics. Of the 926 people who responded to the survey, a total 796 participants produced complete DPAQ scores and were included in the following analyses. In terms of professional experience, more than half (55%) of the sample reported their practice included assessment and 66% reported engaging in the delivery of treatment. A minority of participants reported engaging in consulting (32.9%), research (19%), and administrative work (17.5%). Ten percent indicated they engaged in some other activity as part of their practice. In addition, 63% reported dedicating more than half of their time to clinical work, while 32% reported dedicating more than half of their time to forensic work.

On average, participants had 16 years of forensic experience ($SD=14.85$). About 45% of the sample indicated they had formal forensic training, while 6.4% indicated they were board certified in forensic psychology. Roughly 20% of the sample reported having participated in a death penalty case.

Table 3
Study One Sample Professional Variables

	<i>N</i>	Percentage
<i>Degree</i>		
Ph.D.	696	87.8
Psy. D.	97	12.2
Missing	0	0
Total	793	100.0
<i>Type of work</i>		
Assessment	438	55
Treatment	523	66.4
Research	153	19.3
Consulting	261	32.9
Administrative	139	17.5
<i>Percentage clinical</i>		
0%	52	6.6
less than 20%	134	16.9
20-50%	101	12.7
50-70%	144	18.2
I do clinical work almost exclusively	355	44.8
Missing	7	0.8
Total	793	100.0
<i>Percentage forensic</i>		
0%	337	42.5
less than 20%	190	24.0
20-50%	66	8.3
50-70%	57	7.2
I do forensic work almost exclusively	131	16.5
Missing	12	1.5
Total	793	100.0
<i>Forensic training</i>		
Yes	354	44.6
No	430	54.2
Missing	9	1.2
Total	793	100.0
<i>ABPP Certified</i>		
Yes	51	6.4
No	721	90.9
Missing	21	2.7
Total	793	100.0

<i>Capital case participation</i>		
Yes	160	20.2
No	621	78.3
Missing	12	1.5
Total	793	100.0

Due to a formatting error, the DPAQ was displayed with a scale from 0 to 9, instead of the original scale from 1 to 9. In order to compare this study's DPAQ mean scores to the sample used by O'Neil and colleagues (2004) the two highest points in the scale were collapsed into one point, to make a 9-point scale. This approach was deemed the most appropriate because it did not affect minimum or maximum scores, it least affected the distribution of scores, and affected the mean minimally when compared to the 10-point scale (see Table 4). Moving forward, whenever the DPAQ score is mentioned it will be in reference to the converted scale using the aforementioned method.

Table 4

DPAQ Descriptive Statistics

	<i>N</i>	Minimum	Maximum	Mean	Std. Deviation
DPAQ10-pt scale	793	15	140	53.85	23.41
DPAQ 9-pt scale	793	15	127	53.00	22.68

The mean total DPAQ score for this sample was 53 (SD=22.677), significantly lower than the mean of 72.39 reported by O'Neil et al. (2004). Descriptive statistics on the total and factor scores are reported in Table 5. In every case, factor mean scores were lower than the normative sample.

Table 5

DPAQ Factors: Descriptive Statistics

	Minimum	Maximum	Mean	S.D.
DPAQ Total	15	127	53.00	22.68
General Support	4	36	15.93	9.36
Retribution	4	36	11.94	7.12
Deterrent	3	27	10.24	6.50
Cheaper	2	18	8.35	6.09
LWOP	2	18	6.54	4.10

An exploratory factor analysis was conducted on the DPAQ scores to examine the factor structure of the instrument for this particular sample. Consistent with how the instrument was developed, a Varimax rotation was used but a more stringent criterion for item loading values was imposed, including only items loading greater than 0.4, as per Stevens' (2002) recommendation. The factor analysis revealed a structure in line with the five-factor model presented by O'Neil et al (2004). Factor loadings of each item can be seen in Table 6.

Table 6

DPAQ Items Rotated Component Matrix

	Component				
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
Item 1	0.61				
Item 2	0.88				
Item 3	0.88				
Item 4	0.51				
Item 5		0.82			
Item 6		0.80			
Item 7		0.58			
Item 8		0.64			
Item 9			0.57		
Item 10			0.87		
Item 11			0.87		
Item 12				0.93	
Item 13				0.94	
Item 14					0.86
Item 15					0.89

Note:

Extraction Method: Principal Component Analysis.

Rotation converged in 5 iterations.

Rotation Method: Varimax with Kaiser Normalization.

Comparison of mean scores. A one-sample *t* test was conducted comparing the DPAQ mean score for this sample to O’Neil and colleagues’ (2004) sample. This test revealed the difference between means was statistically significant, $t(792)=-24.08$, $p<.001$, Cohen’s $d=-0.9668$, 95% C.I. [0.8851,1.0486], with psychologists showing less favorable views of the death penalty than a community sample. A series of subsequent one-sample *t* tests was conducted to compare each of the mean factor scores in this sample to those from O’Neil and colleagues’ (2004) sample. The differences in scores for each factor were statistically significant, each in the same direction as the total scores, with psychologists showing less favorable views on each factor. Effect sizes were strongest for the general support and LWOP factors. Relevant statistics, including Cohen’s d , are reported in Table 7.

Table 7
DPAQ Factors One-Sample t tests

	Test Value	<i>t</i>	Df	Sig. (2-tailed)	Mean Diff.	95% C.I. of the Difference		<i>d</i>	95% C.I. of <i>d</i>	
						Lower	Upper		Lower	Upper
General										
Support	22.03	-18.36	792	0.000	-6.10	-6.75	-5.45	-0.74	-0.82	-0.66
Retribution	15.84	-15.43	792	0.000	-3.90	-4.40	-3.40	0.62	-0.70	-0.54
Deterrent	13.95	-16.11	792	0.000	-3.72	-4.17	-3.26	-0.65	-0.73	-0.57
Cheaper	10.69	-10.81	792	0.000	-2.34	-2.76	-1.91	-0.43	-0.51	-0.36
LWOP	9.88	-22.91	792	0.000	-3.34	-3.62	-3.05	-0.92	-1.00	-0.84

An independent sample T-test was conducted to test whether the death penalty attitudes of those who reported dedicating some of their practice to forensic work were statistically significantly different than the attitudes of those who reported not doing any forensic work. This test showed differences were not statistically different, $t(792)=-.74$, $p=.184$, Cohen’s $d=-0.10$, 95% C.I [-0.45, 0.24].

Study Two

Descriptive statistics. A total of 160 people responded to the invitation (35% response rate), yielding 480 observations; of these, complete data were obtained for 393 observations, corresponding to 133 individual participants. Those who participated in Study Two had nearly identical DPAQ scores and demographic characteristics to those who were eligible to participate, but did not respond to the invitation.

The majority of participants (61.7%) reported dedicating more than half of their time to clinical psychology, and almost half of the sample (48.9%) reported that they dedicate more than 50% of their time to forensic psychology. In addition, 74.4% of participants reported having formal forensic training, 12% reported being board certified in forensic psychology by the ABPP, and 41.4% reported having participated in a capital case. On average, participants reported having 20 years of forensic experience ($SD=11.7$).

Most participants reported that their practice consisted of conducting assessments (84.2%), roughly half said they conduct treatment (51.1%), and a minority of participants reported engaging in research (20.3%), consulting (39.8%) or administrative work (21.1%). Detailed frequency counts are provided on Table 8. The mean DPAQ score for this sample was 53.46 ($SD=23.883$), almost identical to the mean in Study One.

Table 8
Study Two Descriptive Statistics on Professional Variables

	<i>N</i>	Percentage
<i>Degree</i>		
Ph.D.	117	88.0
Psy. D.	16	12.0
Total	133	100.0
<i>Type of work</i>		
Assessment	112	84.2
Treatment	68	51.1
Research	27	20.3

Consulting	53	39.8
Administrative	28	21.1
Other	19	14.3
<i>Percentage clinical</i>		
less than 20%	28	21.0
20-50%	23	17.3
50-70%	28	21.1
I do clinical work almost exclusively	54	40.6
Total	133	100.0
<i>Percentage forensic</i>		
less than 20%	48	36.1
20-50%	20	15.0
50-70%	23	17.3
I do forensic work almost exclusively	42	31.6
Total	133	100.0
<i>Forensic training</i>		
Yes	99	74.4
No	33	24.8
Missing	1	0.8
Total	133	100.0
<i>ABPP Certified</i>		
Yes	17	12.8
No	113	85.0
Missing	3	2.2
Total	133	100.0
<i>Capital case participation</i>		
Yes	55	41.4
No	78	58.6
Total	133	100.0

Multiple linear regression model.

Assumptions. In order to test the predictive value of DPAQ scores on continuous judgments of CFE, a multiple linear regression analysis was conducted. A logistic regression was

used to test the predictive value of DPAQ scores on the dichotomous judgment of CFE, and will be reported later.

Before beginning logistic regression analysis, statistical assumptions were tested. The sample size for this study was determined to be adequate ($n=393$) for the number of predictors used. Outliers and significant skewness were identified in one predictor variable (*DPAQ*, Skewness=.89, SE=.12). In order to address the presence of outliers and positive skewness in DPAQ scores, a square root transformation was applied. Descriptive statistics showed the transformed data continued to be significantly skewed, so a log10 transformation was applied, successfully eliminating univariate outliers (Skewness=-0.20, SE=0.12, see Figure 1).

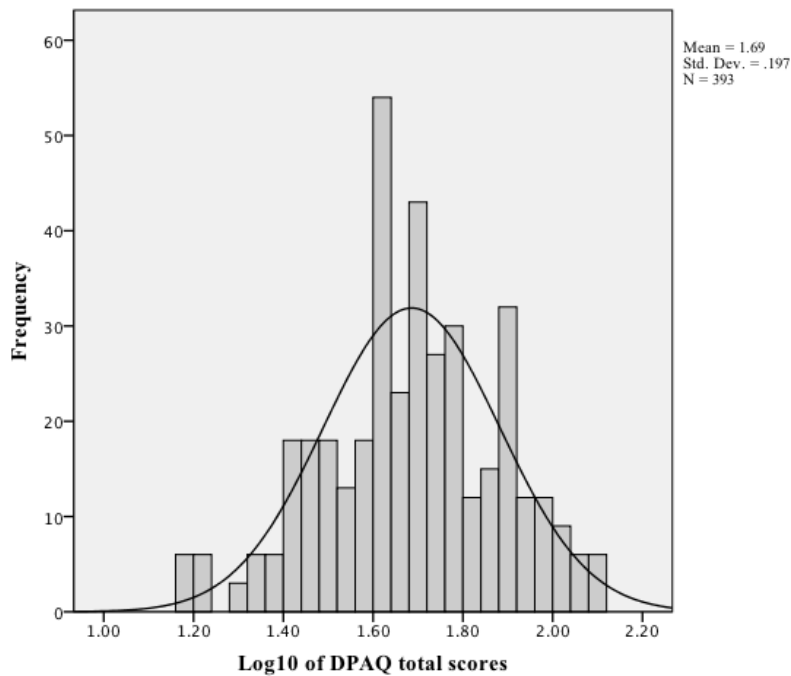


Figure 1

DPAQ Scores Histogram Transformed with Log10

The same procedure was applied to each factor score. All five factors were found to be positively skewed, therefore, appropriate transformation were applied. General Support was

transformed using square root, achieving normality. All remaining factors were transformed using log10. After being transformed, Retribution, Deterrent and Cheaper had normal distributions, but LWOP remained positively skewed. A final transformation of inverse was used for LWOP, but was unsuccessful in eliminating the skewness. As a result, this factor scale was excluded from factor level analyses. Descriptive statistics for each of the successfully transformed variables are presented below.

Next, data were tested for the presence of multivariate outliers. This was done by calculating the Mahalanobis distance for the three main predictors and examining extreme values. Extreme values for Mahalanobis distance were all under the critical value ($\chi^2=16.27$, $df=3$, $p=.001$), so the presence of multivariate outliers was ruled out, and the assumption was deemed met. In order to test for independence of errors, the Durbin-Watson statistic was examined first for DPAQ, CFE and Psychopathology. A Durbin-Watson value of 2.02 indicated this assumption was met.

The assumptions of normality, linearity and homoscedasticity were examined by looking at residuals. When residuals were plotted for the dependent variable it was observed that they were randomly distributed around zero and thus met all the above-mentioned assumptions (see Figure 2). This was true for both the general DPAQ score and factor scores.

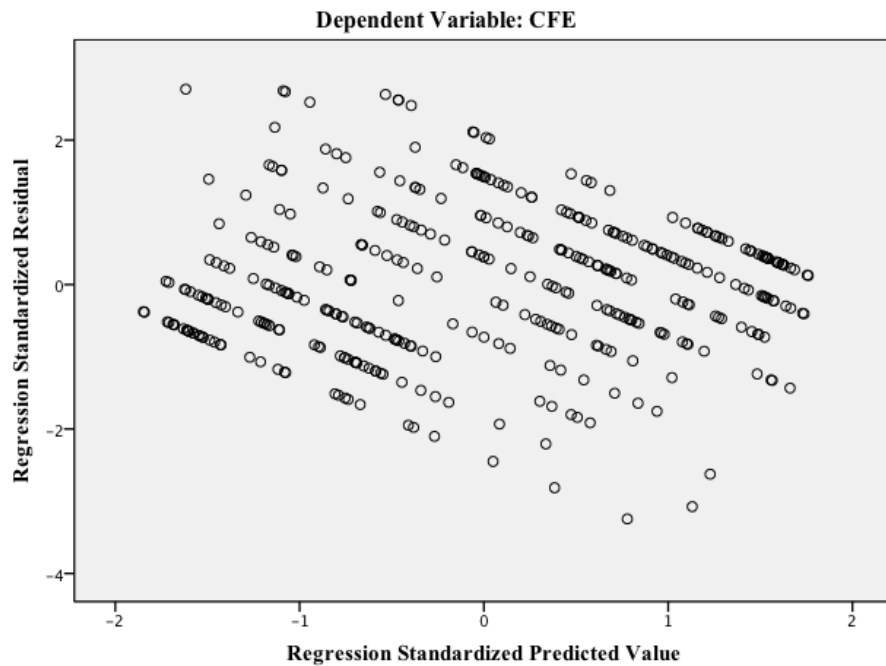


Figure 2

CFE Residuals Scatterplot

Multiple linear regression results. A stepwise multiple regression analysis was conducted, entering years of forensic experience as a covariate in step one, followed by DPAQ total scores in step two, and CFE Level, Psychopathology group and the interaction between DPAQ and CFE Level, as well as CFE Level and Psychopathology Group interaction in step three. Although the first two models were not statistically significant, the final model was, $F(6, 379) = 78.31, p < .001; R = .74; R^2 = .55, adjR^2 = .55; 95\% \text{ C.I.} = 0.49-0.61$, with a standard error of the estimate of 1.81. This model accounted for 55 percent of the variance in CFE judgments, and statistically significant predictors included CFE Level and Psychopathology Severity. The interaction terms and DPAQ scores were not statistically significant predictors. Details of the model, and regression coefficients are reported in tables 9 through 11.

Table 9

Multiple Linear Regression Model Summary

Model	R	R ²	Adj. R ²	Std. Error of the Estimate	R ² Change	Change Statistics			Sig. <i>F</i> Change
						<i>F</i> Change	df1	df2	
1	.00 ^a	.00	-.00	2.69	.00	.01	1	384	.944
2	.09 ^b	.01	.00	2.68	.01	3.21	1	383	.074
3	.74 ^c	.55	.55	1.81	.55	115.70	4	379	.000

Note: Dependent Variable: CFE

a. Predictors: (Constant), Years of Forensic Experience

b. Predictors: (Constant), Years of Forensic Experience, DPAQ log10

c. Predictors: (Constant), Years of Forensic Experience, DPAQ log10, CFE Group, Psychopathology Group, Psychopathology by CFE Interaction, CFE by DPAQ Interaction

Table 10

ANOVA

Model		Sum of Squares	Df	Mean Square	<i>F</i>	Sig.
1	Regression	0.04	1	0.04	0.01	.944 ^a
	Residual	2772.84	384	7.22		
	Total	2772.87	385			
2	Regression	23.10	2	11.55	1.61	.202 ^b
	Residual	2749.77	383	7.18		
	Total	2772.87	385			
3	Regression	1534.87	6	255.81	78.31	.000 ^c
	Residual	1238.00	379	3.27		
	Total	2772.87	385			

Note: Dependent Variable: CFE

a. Predictors: (Constant), Years of Forensic Experience

b. Predictors: (Constant), Years of Forensic Experience, DPAQ log10

c. Predictors: (Constant), Years of Forensic Experience, DPAQ log10, CFE Group, Psychopathology Group, Psychopathology by CFE Interaction, CFE by DPAQ Interaction

Table 11

Multiple Linear Regression Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	β	<i>t</i>	Sig.
1	(Constant)	5.31	.27		19.50	.000
	Forensic Experience	0.00	.01	.00	0.07	.944
2	(Constant)	3.16	1.23		2.56	.011

	Forensic Experience	0.00	.01	.01	0.25	.804
	DPAQ	1.25	.69	.09	1.79	.074
3	(Constant)	-1.06	2.26		-0.47	.640
	Forensic Experience	-0.01	.00	-.02	-0.65	.516
	DPAQ	1.92	1.25	.14	1.53	.127
	Psychopathology group	-0.67	.30	-.21	-2.22	.027
	CFE group	3.08	1.03	.94	2.98	.003
	Psychopathology x CFE Interaction	-0.06	0.14	-.05	-0.41	.682
	CFE group x DPAQ Interaction	-.41	0.58	-.22	-0.71	.478

Note: Dependent Variable: CFE

Logistic Regression Model. A logistic regression model was run using the same predictors regressed onto the dichotomous version of CFE judgment, where participants were asked to make an ultimate judgment of whether or not the inmate was competent to be executed. The assumptions of logistic regression were met, as multicollinearity had previously been ruled out, and the dependent variable was categorical. With respect to sample size, Pedzhazur's (1997) recommended minimum of 30 cases per parameter being estimated was surpassed with a total of 393 cases and 6 predictors being entered in the model.

Variables were entered into a logistic regression model in a step-wise fashion, starting with forensic experience on step one, followed by DPAQ scores on step two, and CFE Group, Psychopathology Group and the two interaction terms described in the previous section on step three. The final model significantly predicted group membership, $\chi^2 = 197.053$, $df=6$, $p < .001$, and accounted for 55% of the variance, Nagelkerke R Square=.545, 95% C.I. [.049033, 0.59967]. Using the proposed predictors, the model correctly classified 82.6% of cases as competent or incompetent. However, the only predictor that reached statistical significance was CFE group. For each increase in level of CFE, the odds of being found competent increased 53.4 times. Details on the model are provided in tables 12 through 15.

Table 12

Final Model Omnibus Tests of Model Coefficients

		χ^2	Df	Sig.
Step 1	Step	195.82	4	.000
	Block	195.82	4	.000
	Model	197.05	6	.000

Table 13

Final Logistic Regression Model Summary

Step	-2 Log likelihood	Cox & Snell R ²	Nagelkerke R ²
1	318.22 ^a	0.41	0.55

a. Estimation terminated at iteration number 6 because parameter estimates changed by less than .001.

Table 14

Classification Table

		Observed	Predicted		Percentage Correct
			CFE		
			Incompetent	Competent	
Step 1	CFE	Incompetent	129	28	82.2
		Competent	38	185	83
	Overall Percentage				82.6

Note: The cut value is .500

Table 15

Variables in the Logistic Regression Equation

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1	Forensic experience	0.00	0.01	0.01	1	0.912	1.00
	DPAQ	0.02	0.01	1.40	1	0.237	1.02
	Psychopathology group	-0.46	0.50	0.83	1	0.362	0.63
	CFE group	3.98	1.61	6.08	1	0.014	53.38
	Psychopathology x CFE Interaction	-0.24	0.27	0.83	1	0.362	0.78
	CFE x DPAQ Interaction	-0.70	0.88	0.64	1	0.426	0.50
	Constant	-3.90	1.33	8.62	1	0.003	0.02

Bivariate correlations. In order to test the last hypothesis, two correlation terms were calculated. First, reported willingness to participate in the capital case was correlated with DPAQ score. This correlation was not statistically significant, $r=.076$, $p=.135$. 95% C.I [0.02, 0.18]. A second correlation was calculated between reported participation in a capital case and DPAQ scores. This correlation was statistically significant and moderate in magnitude, $r=.279$, $p<.001$; Fisher's $Z=.29$, 95% C.I.[0.19,0.39], indicating that those who reported having participated in a capital case had more favorable views of the death penalty.

Lastly, Pearson correlation terms were calculated for confidence ratings and DPAQ scores, as well as for competency ratings and ratings of ability to consult with attorney. In both cases, correlations were statistically significant. Specifically, confidence ratings were positively correlated with DPAQ scores, $r=.152$, $p=.05$, Fisher's $Z=0.15$, 95% C.I. [0.54, 0.25], indicating more favorable views of the death penalty were associated with higher confidence levels. In addition, competency ratings and capacity to consult with attorney were also positively correlated in a statistically significant manner, $r=.840$, $p<.001$, Fisher's $Z=1.22$, 95% C.I. [1.12,1.32], with higher ratings of capacity to consult with attorney associated with similarly higher ratings of competency.

CHAPTER IV: DISCUSSION

Study One

Study One sought to explore clinical and forensic psychologists' attitudes towards the death penalty and compare them to a more general sample. Having reached a large number of practicing psychologists, representing almost all 50 states, and having a demographic makeup that was very similar to the population from which it was drawn indicates that this sample appears to be appropriately representative of current APA members belonging to Divisions 12,

41, and 42. Psychologists in this sample reported less favorable attitudes towards the death penalty (as measured by the DPAQ) than a large sample of undergraduates and jury-eligible community members (O'Neil et al, 2004). An examination of the DPAQ's specific factors revealed all factor scores were also significantly different from the normative sample in the same direction. These findings support this study's first hypothesis and, in line with previous research, suggest that clinical and forensic psychologists hold less favorable views towards capital punishment than the general population. An exploration of differences in attitudes towards the death penalty between clinical and forensic psychologists revealed no significant differences. This might imply that attitudes towards capital punishment are not be affected by working within the legal context, and are likely determined by other factors.

It is important to note that selection bias may have been at play, as participants' beliefs about capital punishment may have impacted their decision to participate in a death penalty study. However, given the range and variability of scores on the DPAQ, this issue seems less likely. In addition, attitudes towards the death penalty were measured using a self-report instrument, which is vulnerable to all the limitations inherent to this kind of measure. One such limitation is social desirability bias, which may have been an issue in this research, as psychologists might feel pressure to express views more liberal than they really hold, as these may be more in line with the general views of the profession. However, it is worth mentioning that the factor structure of the DPAQ proposed by O'Neil et al (2004) also held for this sample, lending further support to the validity of this instrument as a measure of attitudes towards capital punishment.

Study Two

It was hypothesized in Study Two that attitudes towards the death penalty would be the strongest predictor of judgments of CFE in a sample of practicing forensic clinical psychologists. Degree of fit with CFE criteria (CFE level) and symptomatology severity (psychopathology group) were also hypothesized as being predictive of CFE judgments, although they were expected to be weaker than attitudes towards capital punishment. Lastly, interaction terms of degree of fit and psychopathology, as well as degree of fit and attitudes towards the death penalty were entered as predictors in the model. Years of forensic experience was entered as a covariate.

Results from Study Two suggest that, of the variables included in the model, only degree of fit with the legal criteria and, to a lesser extent, severity of symptomatology were predictive of forensic psychologists' judgments of CFE, when measured continuously. These findings disprove did not support the main hypotheses of Study Two (H3), but lend support to two others (H4 and H5). These data suggest that, all things being equal, experts might be more inclined to find someone with a less severe clinical presentation as competent, when the determining factor should be whether the inmate meets the legal criteria, as opposed to how sick they are. Upon further analysis, the predictive value of severity of symptomatology ceased to be statistically significant when forensic clinicians were asked to make the judgment of CFE in a dichotomous manner. Still, due to evidence of some psychopathology bias, when engaging in CFE evaluations, experts should make efforts to minimize the influence this variable has on their judgment of CFE and how they deliver the information to the court, to the extent that it may be legally irrelevant. In conducting these assessments it is important for clinicians to remember that, while a mental illness is a necessary component of incompetency for execution, its severity may

not be legally relevant in this determination. Use of a rating scale, such as the CERRS, might aid clinicians in avoiding this problem, by providing a structure on to which clinicians can plot the data.

Contrary to what was hypothesized, attitudes towards the death penalty did not predict judgments of CFE in either in the continuous measure of CFE or the dichotomous one. This suggests that participants in this sample seemed to be able to put aside their opinions about the death penalty when conducting this type of evaluations, and did not allow them to contaminate their assessment. This is in direct contradiction to a previous finding in the literature, where attitudes towards the death penalty were correlated with judgments of CFE (Svec, 1991). However, Svec (1991) used a different, but highly correlated, measure of attitudes towards capital punishment than that used in the current study, which may explain some of the differences. In addition, not only was Svec's study conducted more than two decades ago, but it was also conducted a mere five years after the *Ford* decision. The amount of time that has elapsed since then, and the debates and studies that have emerged in the literature on the topic may have had some effect on how experts handle CFE evaluations in particular. Lastly, as support for the death penalty has been steadily declining in the United States, it may be that these differences are explained by this general trend, as opposed to by methodological variables.

Attitudes towards capital punishment were not correlated with self-reported willingness to participate in a CFE evaluation, unlike previous findings reported by Dietchman et al (1991). Dietchman and colleagues (1991) were able to correctly classify clinicians as willing or unwilling based on their attitudes towards the death penalty and the belief that participation in CFE evaluations is against the ethical principles of the profession. They used these findings as a basis to suggest that there may be self-selection bias among examiners who conduct CFE

evaluations. Differences between those results and the current study's may be due to the use of different instruments to measure death penalty attitudes, and the way the questions were formulated, in addition to having a sample that was geographically limited (participants were from Florida). Specifically, in this study participants were asked how willing they would be to participate in the CFE evaluation for each case they were presented with, as opposed to general willingness to conduct CFE evaluations asked by Dietzman et al (1991).

Despite this null finding, death penalty attitudes were positively correlated with past participation in a capital case. This gap between reported willingness to participate and actual participation may be interpreted in more than one way. One possibility is that it may be due to response bias on the part of participants, and that only a percentage of those who say they are willing to participate in a CFE evaluation actually are. Another possibility is that this difference is due to the low base rate of capital cases, and even lower base rate of CFE evaluations. So these experts may be willing to participate in a CFE evaluation, but only a subset get the opportunity to actually do so. A third possibility is that this gap is the result of a combination of both of these phenomena. There is some support for the latter in the literature, as Pirelli and Zapf (2008) found CFE evaluations to be the one in which psychologists were least frequently involved of all capital evaluations, and the one that generated the most opposition.

Confidence in one's judgment of CFE was positively correlated with death penalty attitudes, in that more favorable views towards capital punishment were associated with more confidence in one's CFE opinion. So, while death penalty attitudes may not be directly affecting experts' opinions on CFE, they appear to be related to how confident experts are of their opinions and may affect how they deliver the information to the court, as well as how it is received by the court. Judges might place more weight on a report that is written in more

definitive and self-assured language, than a report that conveys some degree of doubt, even if such doubt is scientifically warranted. When conducting CFE evaluations and communicating findings to the court, experts should consider their confidence and assess whether it is a result of case-specific variables, rather than clinician variables.

In addition, higher levels of judged competency were also associated with higher confidence levels, suggesting that as an expert has formed the opinion of competence, confidence levels in this opinion increase. This may be a result of an attempt on the part of the expert to avoid negative affect due to cognitive dissonance generated by doubts about one's assessment of CFE. In other words, having reported opinions of an inmate being competent to be executed, the clinician may experience considerable anxiety if they have some doubts about their judgment, especially in light of the immediacy of the imposition of the sentence in relation to their judgment. Conversely, if the clinician held the opinion that the inmate was incompetent to be executed, the level of anxiety may be significantly lower, as this opinion would not necessarily be immediately followed by an execution.

Finally, confidence levels were negatively correlated with years of forensic experience. This correlation is counterintuitive, as one normally expects more experienced professionals to be more confident in their work. However, in this case, it may be that more experienced forensic psychologists are more aware of the ambiguities in the standard and the rarity of a clear cut case when it comes to CFE, and may be less likely to report absolute confidence in these cases. It is also worth restating that years of forensic experience had no effect on the actual judgments of CFE, suggesting that there is no difference in the way more experienced examiners are assessing the cases as compared to less experienced ones, despite differences in how confident they are in their findings.

This study also found that when participants judged an inmate as competent, they were highly likely to also judge them as being capable to consult with their attorney. This finding, coupled with the fact that most participants in the sample reported they believed capacity to consult with one's attorney was subsumed under the construct of CFE, provides strong support for the idea that, despite not being formally included in *Ford or Panetti*, psychologists routinely include this functional indicator as an element of CFE. These findings should bolster the ABA's call for a two-prong CFE standard to be instituted nation-wide.

General Discussion

This study was the first to systematically examine the effect of practicing forensic clinicians' attitudes towards capital punishment on judgments of competency for execution. Psychologists and psychiatrists' participation in CFE evaluations has generated a great deal of debate, but very little empirical research. Generally speaking, legal standards for CFE are considered to be vague and provide little guidance to experts called upon to aid the court in making an irreversible decision. Moreover, it has been suggested that clinicians who are against the death penalty may decline to participate in this kind of evaluation in greater numbers, on the grounds that they may be unable to be objective due to their opinions on capital punishment, potentially leading to a biased pool of experts for CFE evaluations (Brodsky, 1990; Dietchman et al 1991; Radelet & Bernard, 1986). In addition, favorable attitudes towards the death penalty have already been found to negatively affect other decision makers (i.e. jurors) in the capital legal process.

In this study, some evidence was found that psychologists with more favorable attitudes towards the death penalty were more likely to have participated in a capital case, lending some support to the idea of a biased pool of experts. However, death penalty attitudes were found to

have no effect on clinicians' judgments of CFE in this sample. More importantly, actual degree of fit with the legal criteria was the strongest predictor in the model, followed by severity of symptomatology when competency judgments were measured continuously, suggesting that even if those conducting CFE evaluation are pro-death penalty, those attitudes do not seem to be affecting how they evaluate the case in front of them. Moreover, these results indicate that clinicians are basing their judgments, in large part, on elements of the case that are relevant to the task at hand.

On another note, despite the fact that *Ford* and *Panetti* do not include ability to consult with one's attorney as an element of CFE, it appears to be the case that clinical forensic psychologists overwhelmingly include this as a necessary component of this particular competency. Forensic psychologists and attorneys alike have hotly debated this issue in the literature. Including this ability in the construct of CFE is in line with the positions of some experts in the field, the ABA, as well as some individual states that have included it in their statutes.

In sum, the results of this study may be taken as an indication that forensic psychologists appear to be basing their opinions on CFE mainly on legally relevant factors, and that their personal beliefs about capital punishment are not likely to be influencing how they form their opinions. These results have to be considered with the caveat that a good portion of the variance was not explained by this model and that there are a host of other variables that may, in fact, bias how psychologists form CFE opinions that were not measured in this study. Further limitations are discussed below. Also, some deviation from the expected frequency distribution was found only in the vignettes where fit with CFE criteria was uncertain, with clinicians rating the cases as competent two thirds of the time, when one would expect that outcome to happen only about half

of the time. This suggests that there was a tendency on the part of experts to err on the side of competence when it was not clear whether the inmate met the legal standard of CFE. The same tendency towards competency was found in Ackerson and colleagues' (2005) sample when experts were left to rate vignettes without the aid of a CFE instrument. This did not occur when clinicians used the CERRS, instead they produced the expected 50/50 split in terms of competence. This tendency may be due to the CFE standard setting a very low bar for competency, as compared to other legal competencies, leading clinicians to assess inmates as competent when the clinical presentation is not clear. It may also be the case that this is due to other sources of bias that were not measured in this study. This tendency, however, should lend further support to the recommendation of using a rating scale as a tool in CFE evaluations, in an attempt to minimize any bias.

Limitations

There are some important limitations that must be discussed. First, as is the case for all survey studies, sampling was a concern. In this case, although efforts were made to reach all members of relevant APA divisions, some may have chosen not to publish their email address, and did not have the same chance of being reached and participating in the study. In addition, although it is possible that some members of these divisions may have been excluded from the initial pool due to not having an email address, it is safe to assume that the vast majority of working doctoral level professionals in the field has some electronic contact information. It is worth noting that 337 (5.57%) of the people whose information was included in the database chose not to publish an electronic mail address, suggesting that a small percentage of potential participants were not reached for this reason. However, because the APA does not publish full membership counts, it is impossible to accurately assess coverage in this case.

Moreover, as mentioned earlier, because this sample was made up of volunteers, self-selection bias was also a concern, as participants who chose to complete the present study may have done so because they held particular views on the death penalty and psychologists' participations in CFE evaluations. In addition, due to the self-report nature of surveys, there was no way of assessing the accuracy of the responses given by participants with respect to their attitudes towards the death penalty, professional experience, and demographic variables. And, because the study was done online, the researcher had no control over the context under which participants completed the study, or even whether the participant him or herself completed it. Having said that, precautions were taken to minimize duplicate entries, by keeping track of the IP addresses and blocking duplicate ones.

It is also important to note that a significant amount of time elapsed between when attitudes towards the death penalty were measured and when participants evaluated the vignettes. Attitudes are malleable, and due to the design of this study, it is impossible to ascertain whether participants' attitudes towards the death penalty changed in the period of time between Study One and Study Two. This may be a distinct possibility especially in light of intense media coverage of recent controversies surrounding how humane execution procedures are in several states. On the other hand, it is also possible, albeit less likely, that some participants may have associated the initial request for participation in study one, with the request for participation in study two, leading to a priming effect. However, due to the fact that several months passed between studies, this is a lesser concern.

Perhaps most importantly, the fact that this study used short case vignettes presents a serious threat to the generalizability of these findings. Capital cases tend to be long processes, with extensive documentation and information to review for all involved. When it comes to CFE

evaluations, experts would normally have access to numerous sources of information, including medical and psychiatric documentation of the inmate's history, prison disciplinary records, extensive interviews with both the inmate and people related to him or her, testing reports, and past competency findings, to name a few. By contrast, the vignettes presented in this study were less than a page long. This, of course, was done in order to minimize the amount of time and effort required for participation, and maximize response rates. In addition, the vignettes were constructed using data regarding the most common mental health symptoms in death row inmates, in an effort to make them as realistic as possible. However, no matter how carefully constructed the vignettes were, they can never approximate the volume of information involved in a real case, therefore presenting a threat to the external validity of this study.

Last, as mentioned earlier, a host of other variables that might affect how clinicians make CFE judgments were not measured or manipulated in this study. Other attitudinal variables, like attribution of criminal responsibility, have been found to affect willingness to participate in CFE evaluations, and may have some effect on clinical judgment of CFE (Deitchman et al., 1991). In addition, other demographic variables that may affect psychopathology assessment (e.g., race) were not manipulated, and might also affect the likelihood of an inmate being judged as competent or incompetent. With the current research design, it would be impossible to estimate the effect of these variables on the outcome.

Future directions

There are many questions left unanswered by these two studies. Future research should make an effort to use more comprehensive case descriptions, in order to provide a closer approximation of the kind of information an expert would have access to in a real capital case. In addition, to the extent possible, other relevant attitudinal variables should be measured, in order

to get a better picture of what may be associated with clinician bias, if there is any. An exploration of how the inmate's demographic variables affect CFE judgments may also yield useful data.

In examining clinician bias in CFE evaluations in particular, future studies might benefit from relying on cases in which the degree of fit with the legal criteria was not clear, as clinicians seem to be judging clearly defined cases appropriately, and little variability occurred there. This may allow researchers the flexibility of manipulating other relevant variables without creating an overly complex design or limiting the statistical power of their study.

Despite the limitations outlined above, this study provides evidence that forensic clinicians are relying mainly on the legal criteria for CFE when assessing inmates' competency to be executed, and clinicians' attitudes towards capital punishment are not influencing the way they form their opinions on CFE. This study improved upon previous research by using multiple case vignettes of varying CFE and symptomatology, randomly presented to participants, and recruiting participants from nearly all states in the union. However, clinicians should remain vigilant to the possibility of other sources of bias, as these were not measured in this study, and their influence on forensic clinical judgment is unknown.

Appendix A

Study One Email Invitation

Dear _____:

The following is a survey examining clinicians' attitudes towards the death penalty. This project is part of my dissertation as a last step to complete my Ph.D. in psychology at John Jay College of Criminal Justice. Mental health professionals play an important role in assisting the criminal justice system in the adjudication, sentencing and, sometimes, execution processes in capital cases.

There is an urgent need to better understand clinician's attitudes towards different aspects of the death penalty. This information can potentially help individual practitioners and professional associations make ethical judgments, as well inform future policy on these issues. As a mental health professional, your participation in this study is vital.

If you agree to participate, you will be asked some questions regarding your opinions of the death penalty and your professional experience. In addition, you'll be asked for basic demographic information. Your participation will take no more than 10 minutes. Please consider participating by clicking on the following link <insert link here>.

Sincerely,

Eugenia Garcia-Dubus

Appendix B

Study One Questionnaire

(PAGE 1)

Please answer these two questions to determine your eligibility for participation.

1. Highest degree held
 - a. Bachelor's
 - b. Master's
 - c. Ph.D.
 - d. Psy.D.
 - e. M.D.
 - f. Other (specify) _____

2. Where do you practice? (check all that apply)
 - a. United States of America
 - b. Canada
 - c. Other _____

<IF answer to question 1 is a, b, e, or f, OR answer to question 2 is b or c, participant will be excluded and taken to a page thanking them for their participation.>

(PAGE 2)

<Insert informed consent form>

(PAGE 3)

Instructions: For each of the statements below, please indicate to what extent you agree or disagree. If you strongly disagree with the statement please circle “1.” If you strongly agree with the statement please circle “9.” Of course, you may neither agree nor disagree with the following statements. If so, please use the numbers in the middle of the scale that describes the best fit.

3. I think the death penalty is necessary.

Strongly										Strongly
Disagree										Agree
1	2	3	4	5	6	7	8	9		

4. It is immoral for society to take a life regardless of the crime the individual has committed.

Strongly										Strongly
Disagree										Agree
1	2	3	4	5	6	7	8	9		

5. No matter what crime a person has committed executing them is a cruel punishment.

Strongly										Strongly
Disagree										Agree
1	2	3	4	5	6	7	8	9		

6. The death penalty should be used more often than it is.

Strongly										Strongly
Disagree										Agree
1	2	3	4	5	6	7	8	9		

7. The desire for revenge is a legitimate reason for favoring the death penalty.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

8. Society has a right to get revenge when murder has been committed.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

9. There are some murderers whose death would give me a sense of personal satisfaction.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

10. The death penalty is the just way to compensate the victim's family for some murders.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

11. The death penalty does not deter other murderers.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

12. The death penalty makes criminals think twice before committing murder.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

13. Executing a person for premeditated murder discourages others from committing that crime in the future.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

14. It is more cost efficient to sentence a murderer to death rather than to life imprisonment.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

15. Executing a murderer is less expensive than keeping him in jail for the rest of his life.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

16. Even when a murderer gets a sentence of life without parole, he usually gets out on parole.

Strongly									Strongly
Disagree									Agree
1	2	3	4	5	6	7	8	9	

17. There is no such thing as a sentence that truly means “life without parole.”

Strongly										Strongly
Disagree										Agree
1	2	3	4	5	6	7	8	9		

(PAGE 4)

We will first ask you a few questions regarding your professional experience

18. Year of degree

19. What best describes the nature of your work in psychology or psychiatry? (check all that apply)

- a. Assessment
- b. Treatment
- c. Research
- d. Consulting
- e. Administrative
- f. Post doctoral student
- g. Other _____

20. (IF CHECKED a or b on last question) What percentage of the time would you say you dedicate to clinical work (i.e. assessments or treatment)? a) 0% b) less than 20% c) 20-50% d) 50-70% e) I do clinical work almost exclusively

21. Do you have special training in forensic psychology/psychiatry? Y N

22. (IF YES) Years of forensic experience _____

23. What percentage of the time would you say you devote to forensic work? a) 0% b) less than 20% c) 20-50% d) 50-70% e) I do forensic work almost exclusively
24. Have you ever participated as an expert in a death penalty case?
25. Are you board certified in forensic psychology or psychiatry?
26. Please indicate approximately what percentage of your forensic clinical work has been for the defense _____ and the prosecution _____.

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Almost done! We just need some basic demographic information.

1. Age
2. Gender
 - a. Male
 - b. Female
3. Race
 - a. White
 - b. Black
 - c. Asian/Pacific islander
 - d. Native American
 - e. Other (specify)
4. State of residence _____
5. State(s) of practice or license?

Appendix C

Case Vignettes (Ackerson et al., 2005)

Vignette #1

This 23-year-old male has been sentenced to death. The correctional officers report that he had been a model inmate until approximately 6 months ago. They state that at that time, the inmate became almost totally mute and currently only provides brief and vague answers to questions. He has been sleeping 10-14 hours a night, has little appetite, and has lost about 20 pounds so that he is very slim. He no longer converses with a fellow inmate with whom he had previously associated. The staff psychologist reports that the inmate acknowledges auditory hallucinations: two distinct voices that talk to him about death, sin, and guilt. When asked if he would consider committing suicide, the inmate sighs and replies, "Only if it is God's will."

When asked about being sentenced to death, the inmate answers, "I am going to die for all the suffering my victim's family is experiencing." He also indicates that the judge sentenced him for the crime he was arrested and found guilty for. The inmate acts pleasant toward his lawyer but will rarely answer questions and offers minimal spontaneous information. During the lawyer's most recent visit, the inmate indicated that he would no longer require legal services and was not interested in meeting again.

Vignette #2

This 50-year-old male has been sentenced to death. He has few, if any, conversations with other inmates and prefers to be by himself. He reports feeling awkward when other inmates attempt to engage him in conversation. He spends his time reading newspapers and magazines. He also reads the Bible avidly and can often be heard mumbling passages to himself. Although

the other inmates tease him that he is a "cold fish," he does not appear to notice. According to correctional officers, when the inmate is not reading he can be found in his cell, lying on the bed and staring at the ceiling. The staff psychologist describes the inmate as being cold and lacking in affective expression.

The inmate will meet with his lawyer but refuses to discuss his case except to say that he is innocent and that the victim "deserved it." According to the lawyer, the inmate received the sentencing by the court without emotion and reported feeling no remorse. The inmate also stated that he feels confident that his lawyer will successfully appeal his case. He reports that he is on death row only, "until the appellate court sets things straight." Prior to his trial, the inmate's competency to stand trial was questioned and an assessment was performed.

Vignette #3

This 30-year-old male was sentenced to death. He reports that he is afraid that he might hurt himself and that he feels on the verge of going crazy. One minute he appears angry at the whole world and yells and curses at the guards and other inmates. However, within a few minutes of the episode, he feels guilty, worthless, and cries uncontrollably. According to the staff psychologist, the inmate is experiencing difficulty remembering the names of fellow inmates and his overall level of cognitive functioning has declined. The correctional officers report that the inmate is angry and irritable and often screams that the other inmates are out to hurt him. Moreover, the officers report that when the episodes subside, the inmate becomes quiet and calm. The inmate has recently been put on suicide precautions after screaming that he would "rather die than live in this hell."

The inmate had difficulty recognizing his lawyer when she paid a recent visit. According to the lawyer, the inmate continually asked during her visit why he was in prison. When she asked the inmate if he had committed a crime, the inmate responded, "I think I did something terrible but I cannot remember what it was." He could remember only a few details about his trial. After about a half hour, the inmate became verbally abusive toward his lawyer and threatened to harm her.

Vignette #4

This 36-year-old male was sentenced to death. This previously healthy and physically fit inmate has had a recent history of diarrhea, fatigue, and a weight loss of approximately 8 pounds. He reports a loss in appetite but continues to eat adequately. He also reports feeling "down in the dumps" and appears somewhat preoccupied with his loss of physical strength. He has recently started to spend up to three hours a day exercising vigorously. The inmate has complained to the staff psychologist of some difficulty with memory and concentration. The inmate remains polite to the correctional officers but is mainly non-talkative.

The inmate is pleasant toward his lawyer but refuses to work with counsel on appealing his case. According to the staff psychologist and lawyer, the inmate cannot remember the details of the crime he was arrested, subsequently tried, and found guilty for. The inmate vehemently denies that he is residing on death row. Moreover, the inmate states that he is presently serving a sentence for a minor crime he committed 10 years ago and that he will be up for parole in the near future. When the psychologist asked the patient what death means, the inmate answered, "it means it's all done" and refused to elaborate.

Vignette #5

This 44-year-old male has been sentenced to death. Correctional officers have reported a significant behavioral change in the inmate and have become concerned about his and their safety. Inmate is claiming that he has seen "visions of the spirits" and has been keeping a vigil in his cell for the last week. He makes frequent demands for a priest stating that "an exorcism must be performed." He accuses all officers of being "idol worshippers" and states that he will kill them all soon. Various homemade weapons have been found in the inmate's cell. The inmate has recently begun to throw urine on many of the officers which he claims is necessary to "cleanse their soul."

According to the staff psychologist, the inmate can maintain some behavioral control especially when visiting with family members or his lawyer, whom he trusts. He is also visited frequently by the prison chaplain. During visits with the chaplain, the inmate speaks in a rather fearful manner about visions, death, and the hereafter. The inmate has worked with his lawyer previously to obtain a stay of execution. The lawyer reports the inmate as having stated, "I must eventually pay for the crime that I have committed and will make my peace with God at that time."

Vignette #6

This 20-year-old male has been sentenced to death. The inmate was referred for psychological services after a suicide attempt in which he deeply gashed his wrist with a razor blade. He described to the psychologist how he sat on the cell floor and watched the "blood with demonic spirits" drip for some time before he screamed to the correctional officers for help. The inmate reported experiencing frequent bouts of depression and states that these are the result of

the "demonic spirits." When describing the suicide attempt the inmate was observed to smile and laugh out loud. The inmate has refused all prescribed psychiatric medications. Correctional officers report that the inmate typically sits on the floor of his cell and rocks back and forth while mumbling nonsense words.

During initial visits with his lawyer the inmate admitted to killing his mother with "a passion I could barely control." He claimed that while he was growing up his mother abused him physically. He also stated that she used to call him names and tell him that he was the devil who would "rot in hell." The psychologist has noted that the inmate seems preoccupied with his rage at his mother. When asked by his lawyer if he understood he was going to be executed, the inmate started laughing out loud saying "I'm coming mother." Recently, the inmate has refused all contact with either his lawyer or the staff psychologist.

Vignette #7

This 48-year-old male has been sentenced to death. The inmate is a model prisoner and follows orders well. The inmate recently disclosed to the staff psychologist that he feels remorse about the crime he committed and stated that he "only followed the orders that the voices gave." Although the inmate denies having heard voices since committing the crime, officers have observed him staring and talking to the walls in his cell. He sleeps only an average of three hours a day and spends much of the late evening hours writing letters to his family. He has told them both in writing and verbally that he is ready to die because it will "end my misery and suffering." According to family members, the inmate also reports that he would like to receive forgiveness from each of them and the victim's family before he receives his punishment.

The inmate is cooperative with his lawyer but has reported that he would prefer not to work on obtaining an appeal or a stay of execution because, "I have been sentenced to death, not to life in prison." The inmate became tearful as he described the crime that he committed. He was also observed to become highly anxious when asked about his experiences with auditory hallucinations.

Vignette #8

This 37-year-old male has been sentenced to death. According to the staff psychologist, the inmate has been spreading malicious and false rumors about certain correctional officers he does not like. The rumors implied that these officers were having homosexual affairs with inmates. As a result of these rumors, some officers have been assaulted by angry inmates who believed the rumor. The inmate does not deny that he spread the false rumors, but showed no remorse or apprehension about possible repercussions for himself.

The inmate is always well groomed and his hygiene is impeccable. He presents as charming and enjoys talking to many guards about a variety of intellectual subjects or current affairs. However, he assumes a condescending, cynical attitude toward the inmates. He agrees that most inmates view him as cold or insensitive but dismisses this as unimportant. The inmate believes that he is envied by other inmates and states "they long to associate themselves with me." The inmate spends a great deal of time playing chess with selective inmates. He is also very proficient at card games and often wins. According to the officers, the inmate sleeps only an average of four hours a night and during the day, he is observed to be very restless and, at times, anxious.

The inmate has confided in one of the officers and has bragged about his crime in great detail. He also stated that he feels his punishment to be too severe and that a sentence of life would have been more appropriate. The inmate is very charming with his lawyer, who happens to be female. According to the lawyer, the inmate is "very nervous" about his upcoming execution date and has been eager to work on an appeals case.

Vignette #9

This 45-year-old male has been sentenced to death. According to the staff psychologist, the inmate is currently experiencing both hallucinations and delusions. Previous mental health records indicate that the inmate first began evidencing psychotic symptoms after suffering a closed head injury from a motor vehicle accident. Neurological tests taken after the accident revealed "significant and irreversible structural damage." The prison psychologist reports that the inmate is also experiencing depressive symptoms. He has been reported to have memory deficits and his thinking is noted to be "concrete". Correctional officers deny any behavior problems on the part of the inmate. They do note, however, that the inmate's mannerisms and behaviors are very childlike and other inmates often harass him.

Counsel has reported that it is difficult to work with the inmate. The lawyer reports that the inmate does not believe that he can be killed, or that he will die if he is electrocuted. The psychologist reports that the inmate has a delusional belief system revolving around "clones" that protect him from death. The inmate has stated, "I have an extra that will protect me from all harm and death." He also has stated that electrocution "will not hurt," and he believes that he will return the next day to his cell.

Appendix D

Pilot Testing Email Invitation

Dear fellow students,

I know you're all very busy, but I really need your help for my dissertation!

I am in the process of testing the vignettes I will be using later on. I need 20 advanced (3rd year and above) clinical students who have also taken the course Forensic Assessment, to look at these cases and answer a few questions.

If you decide to participate, you will be shown several case vignettes depicting death row inmates who have been sent for a competency for execution evaluation. You will be asked two questions for each of the vignettes. Participation should take about 20 minutes.

Please click on this link for the study.

Sincerely,

Eugenia Garcia-Dubus

Appendix E

Pilot Testing Instructions

(PAGE 1)

Thank you for clicking on our link!

First, you'll be asked two questions to ensure you meet eligibility criteria.

(PAGE 2)

1. What year of training are you in?

1. First
2. Second
3. Third
4. Fourth or above

2. During your training, have you taken the course Forensic Assessment?

1. Yes
2. No

(PAGE 3)

In the next few pages you will find short case vignettes of death row inmates. Your job is to rate each of them on a three-point scale, according to severity of symptomatology and degree of fit with the competency for execution (CFE) standard. Below you'll find more details on how to make the assessments.

Severity of Symptomatology

For severity of symptomatology you should use your clinical training to assess whether the inmate falls under a category of mild, moderate, or severe symptoms. When appropriate, you

should take into account whether the inmate's mental health symptoms require immediate intervention, and whether they present a danger to himself or others.

Degree of Fit with CFE Standard

There are two Supreme Court cases directly relevant to CFE. The first is *Ford v. Wainwright* (1986). In *Ford*, the Supreme Court stated the Constitution forbade "...the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it". More specifically, (1) the inmate must have an understanding of the meaning of punishment, (2) the inmate must understand the nature of his or her punishment (i.e., death penalty), (3) the inmate must be aware of why he or she is being punished (i.e., for the crime he or she was judged guilty for), (4) the inmate must understand the connection between crime and punishment, (5) the inmate must be able, and choose to, appropriately assist his or her lawyer, and (6) the inmate must have an understanding of death and be able to prepare for one's own (Ackerson, 2005).

In a subsequent ruling (*Panetti v. Quarterman*, 2007), the Supreme Court added the requirement that the inmate's understanding of death had to be both factual and rational. In other words, it is not enough to understand that the State is putting them to death, but the explanation the inmates provide for the punishment must also be rational. In the case of *Panetti*, although he was able to state that he was convicted of a crime and sentenced to death, he held delusional beliefs that the State wanted to execute him to prevent him from preaching. This meant he had a factual understanding, but lacked a rational understanding of the reasons for his punishment.

You may refer back to this page at any point in your participation by clicking the "back" button below. You may return to the vignette you were working on by clicking on the "next"

button until you reach the vignette you were working on. The vignettes will be presented to you in random order. Participation should take between 15-20 minutes.

(PAGE 4)

(Insert Vignettes 1 through 9, each followed by the following questions.)

1. How would you rate this inmate's symptomatology severity?

Severe (3)

Moderate (2)

Mild (1)

2. How would you rate this inmate's overall degree of fit with the competency for execution standards?

1. Clearly fits the standards (i.e. inmate is clearly incompetent)

2. Uncertain

3. Clearly does not fit the standards (i.e. inmate is clearly competent)

(PAGE 5)

Thank you for your participation!

Appendix F

Study Two Email Invitation

Dear _____:

I am a doctoral student at John Jay College of Criminal Justice working on my dissertation under Dr. Patricia Zapf's supervision. This project has been approved by John Jay's Institutional Review Board (IRB no. 646799-1).

You have been specifically selected on the basis of your training and experience to participate in my study, which explores clinical decision-making in competency for execution evaluations. Mental health professionals play an important role in assisting the criminal justice system in determining whether a convict is competent to be executed. Your participation is needed in order to gain a better understanding on how clinicians make these significant decisions.

Your participation would entail an evaluation of brief fictional case vignettes using the legal standard for competency for execution set forth in *Ford v. United States* (1986) and *Panetti v. Quarterman* (2007). You will be asked a few short questions about the cases immediately after. Completion should take around 15-20 minutes.

Participants will have the opportunity to enter a raffle to win a US\$100 Amazon gift card. If you have any questions about this study or would like to contact the researchers, you may do so at egarciadubus@me.com.

I appreciate your participation!

Sincerely,

Eugenia Garcia-Dubus

Appendix G

Study Two Questions

(PAGE 1)

Although this is not a realistic situation, and ordinarily you would have a lot more information, please do your best to imagine these are real cases of death row inmates. You have been asked to evaluate the inmates for their competency to be executed. In the course of your evaluation, you have been able to reasonably rule out the possibility of malingering.

Below are the legal standards currently used for this type of evaluation. The standards will be available for review in each case.

Competency for Execution Standards

"The Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it." (*Ford v. Wainwright*, 1986)

In order to be competent for execution, inmates must have both factual and rational understanding of the reasons for their execution. (*Panetti v. Quarterman*, 2007)

(PAGE 2)

[INSERT VIGNETTE]

1. How competent do you think this inmate is based on the *Ford* criteria?

1 2 3 4 5 6 7 8 9

Not competent at all

Perfectly competent

2. What would be your expert opinion in regards to this inmate's competency for execution?

Competent

Incompetent

2. How confident are you in this assessment?

1 2 3 4 5 6 7 8 9

Not confident at all

Perfectly confident

3. How would you rate this inmate's capacity to consult with his or her attorney?

1 2 3 4 5 6 7 8 9

Not capable at all

Perfectly capable

4. How confident are you in this assessment?

1 2 3 4 5 6 7 8 9

Not confident at all

Perfectly confident

5. How would you rate your willingness to participate in a CFE evaluation of this inmate?

1 2 3 4 5 6 7 8 9

Not willing at all

Perfectly willing

4. In general, do you agree with psychologists and psychiatrists' participation in CFE evaluations?

1 2 3 4 5 6 7 8 9

Do not agree

Absolutely agree

(PAGE 3)

[INSERT SECOND VIGNETTE, REPEAT PAGE 2]

(PAGE 4)

[INSERT THIRD VIGNETTE, REPEAT PAGE 2]

(PAGE 5)

From your perspective as a clinician, which of these competency-related criteria are subsumed under the standard for competency for execution (check all that apply).

1. Factual understanding of the crime for which the inmate has been sentenced to death
2. Rational understanding of the crime for which the inmate has been sentenced to death
3. Factual understanding of death
4. Rational understanding of death
5. Awareness of the meaning of death
6. Awareness of the crime for which the inmate has been sentenced to death
7. Understanding of the procedure for execution to be used
8. Ability to consult with lawyer
9. Presence of a mental health diagnosis

PAGE 6

Thank you for participating! Please enter your email below if you'd like to be entered in a raffle for a US\$100 Amazon.com gift card.

Appendix H

Modified Vignettes

Vignette #3, version 2: Moderate psychopathology/ not competent for execution

This 30-year-old male was sentenced to death. He reports that he is afraid that he might be on the verge of going crazy. One minute he appears angry at the whole world and yells and curses at the guards and other inmates. However, within a few minutes of the episode, he feels guilty, worthless, and cries uncontrollably. According to the staff psychologist, the inmate is experiencing difficulty remembering the names of fellow inmates and his overall level of cognitive functioning has declined. There is no reported psychiatric history prior to his arrest.

The correctional officers report that the inmate is angry and irritable and often screams that the other inmates are out to hurt him. Moreover, the officers report that when the episodes subside, the inmate becomes quiet and calm.

The inmate had difficulty recognizing his lawyer when she paid a recent visit. According to the lawyer, the inmate continually asked during her visit why he was in prison. When she asked the inmate if he had committed a crime, the inmate responded, "I think I did something terrible but I cannot remember what it was." He could remember only a few details about his trial. After about a half hour, the inmate became verbally abusive toward his lawyer and threatened to harm her.

Vignette #5, version 2: Severe psychopathology/ competent for execution

This 44-year-old male has been sentenced to death. Correctional officers have reported a significant behavioral change in the inmate and have become concerned about his and their safety. Inmate is claiming that he has seen "visions of the spirits" and has been keeping a vigil in

his cell for the last week. He makes frequent demands for a priest stating that "an exorcism must be performed." He accuses all officers of being "idol worshippers" and states that he will kill them all soon. Various homemade weapons have been found in the inmate's cell. The inmate has recently begun to throw urine on many of the officers, which he claims is necessary to "cleanse their soul."

According to the staff psychologist, the inmate can maintain some behavioral control especially when visiting with family members or his lawyer, whom he trusts. Records show this inmate has a history of psychiatric hospitalization since adolescence. He is also visited frequently by the prison chaplain. During visits with the chaplain, the inmate speaks in a rather fearful manner about visions, death, and the hereafter.

The inmate has worked with his lawyer previously to obtain a stay of execution, and currently his lawyer reports he is able to discuss the details of his trial in a lucid manner. The lawyer reports the inmate as having stated, "I must eventually pay for the crime that I have committed and will make my peace with God at that time."

Vignette #5, version 3. Severe psychopathology/ competent for execution:

This 44-year-old male has been sentenced to death. Correctional officers have reported a significant behavioral change in the inmate and have become concerned about his and their safety. Inmate is claiming that he has seen "visions of the spirits" and has been keeping a vigil in his cell for the last week. He makes frequent demands for a priest stating that "an exorcism must be performed." He accuses all officers of being "idol worshippers" and states that he will kill them all soon. Various homemade weapons have been found in the inmate's cell. The inmate has recently begun to throw urine on many of the officers, which he claims is necessary to "cleanse their soul."

According to the staff psychologist, the inmate can maintain some behavioral control especially when visiting with family members or his lawyer, whom he trusts. Records show this inmate has a history of psychiatric hospitalization since adolescence. He is also visited frequently by the prison chaplain. During visits with the chaplain, the inmate speaks in a rather fearful manner about visions, death, and the hereafter; however, the chaplain reports the inmate has begun to spiritually prepare for his death and appears to have accepted his sentence.

The inmate has worked with his lawyer previously to obtain a stay of execution, and currently his lawyer reports he is able to discuss the details of his trial in a lucid manner. The lawyer reports the inmate as having stated, "I must eventually pay for the crime that I have committed and will make my peace with God at that time."

Appendix I
Pilot Tests Results

Testing Round	Vignette	Expected	Rated Psychopathology			Rated CFE			
			<u>Psychopathology</u>	<u>CFE</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>	<u>Incompetent</u>	<u>Uncertain</u>
1	1	Moderate	Uncertain	2	10	7	1	13	5
1	2	Mild	Uncertain	15	2	1	1	11	7
1	3	Moderate	Uncertain	0	8	11	11	8	0
1	4	Moderate	Incompetent	9	8	3	11	7	2
1	5	Severe	Competent	0	3	16	1	11	7
1	6	Severe	Uncertain	0	2	17	7	12	0
1	7	Moderate	Competent	3	13	3	1	5	13
1	8	Mild	Competent	15	4	0	1	1	17
1	9	Severe	Incompetent	1	3	16	17	2	1
2	3	Moderate	Uncertain	2	10	7	8	11	0
2	5	Severe	Competent	0	4	15	3	9	7
3	5	Severe	Competent	1	4	5	2	3	5

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