Examining the Role of Race and Ethnicity in Competency to Stand Trial Evaluations

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Examining the Role of Race and Ethnicity in Competency to Stand Trial Evaluations

Abstract
Forensic evaluators, a specially trained subset of mental health professionals, conduct competency to stand trial evaluations and serve an important function in the criminal justice system. Through the reports they write, they provide the court with information about the mental state of the defendant on trial, which is then used to ensure that the defendant understands the charges and is able to participate in the defense process. This assurance of competence helps to uphold the standards of our justice system. Because fairness is an important aspect of these standards, and ethnic minority individuals have in the past been victims of unfair evaluation procedures at the hands of mental health professionals, it is important to assess whether race and ethnicity play a role in these evaluations and, if so, what role they play. In this study, seven hypotheses were tested relating to the outcome of these evaluations, race and ethnicity, and a third related variable, diagnosis. Although there was no statistically significant evidence of a direct relationship between ethnicity and the outcome of the competency evaluations, many hypotheses related to this relationship were in the expected direction. For example, African American defendants were less likely than Caucasian defendants to be found competent and more likely to be diagnosed with psychotic disorders. In addition, this is the first study to include Latino defendants as a comparison group of ethnic minority defendants, as previous studies have looked primarily at African American defendants. It was found that Latino defendants received different diagnoses than Caucasian defendants, such that Latino defendants were less likely to be diagnosed with any Axis I disorder and were more likely to receive no diagnosis on Axis I. No differences were found between these two groups with regard to the diagnosis of Axis II disorders. Combining the results of this study with the body of literature already compiled on this issue, it is likely that relationships between defendants' ethnicity, diagnoses, and competency status exist, but in a small and indirect manner such that it is difficult to detect in small-scale studies. Future research would best be directed toward large-scale projects to look for small, yet potentially systematic differences in the competency evaluations of ethnic minority and ethnic majority defendants.

Degree Type
Dissertation

Degree Name
Doctor of Psychology (PsyD)

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Subject Categories
Psychiatry and Psychology

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EXAMINING THE ROLE OF RACE AND ETHNICITY IN COMPETENCY TO STAND TRIAL EVALUATIONS

A DISSERTATION SUBMITTED TO THE FACULTY OF SCHOOL OF PROFESSIONAL PSYCHOLOGY PACIFIC UNIVERSITY HILLSBORO, OREGON BY ALECIA SUNDSMO IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY DECEMBER 7, 2007

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ABSTRACT

Forensic evaluators, a specially trained subset of mental health professionals, conduct competency to stand trial evaluations and serve an important function in the criminal justice system. Through the reports they write, they provide the court with information about the mental state of the defendant on trial, which is then used to ensure that the defendant understands the charges and is able to participate in the defense process. This assurance of competence helps to uphold the standards of our justice system. Because fairness is an important aspect of these standards, and ethnic minority individuals have in the past been victims of unfair evaluation procedures at the hands of mental health professionals, it is important to assess whether race and ethnicity play a role in these evaluations and, if so, what role they play. In this study, seven hypotheses were tested relating to the outcome of these evaluations, race and ethnicity, and a third related variable, diagnosis. Although there was no statistically significant evidence for a direct relationship between ethnicity and the outcome of the competency evaluations, many hypotheses related to this relationship were in the expected direction. For example, African American defendants were less likely than Caucasian defendants to be found competent and more likely to be diagnosed with psychotic disorders. In addition, this is the first study to include Latino defendants as a comparison group of ethnic minority defendants, as previous studies have looked primarily at African American defendants. It was found that Latino defendants received different diagnoses than Caucasian
defendants, such that Latino defendants were less likely to be diagnosed with any Axis I disorder and were more likely to receive no diagnosis on Axis I. No differences were found between these two groups with regard to the diagnosis of Axis II disorders. Combining the results of this study with the body of literature already compiled on this issue, it is likely that relationships between defendants' ethnicity, diagnoses, and competency status exist, but in a small and indirect manner such that it is difficult to detect in small-scale studies. Future research would best be directed toward large-scale projects to look for small, yet potentially systematic differences in the competency evaluations of ethnic minority and ethnic majority defendants.
ACKNOWLEDGEMENTS

I could not have completed this research project without the help, support, and encouragement of many different individuals. I would like to formally recognize these individuals for their role in the completion of this dissertation. I would like to thank my committee, Dr. Susan Tinsley Li and Dr. Genevieve Arnaut, for their guidance and mentorship throughout this professional endeavor. I would like to thank the staff at the Oregon State Hospital for allowing me to conduct my research using their evaluations. I would like to thank Dr. Krista Brockwood for her statistical support. I would like to thank my fellow graduate students whose parallel process helped this project continue to move forward: Julianna Machel, Sarah Fairchild, and Marsha Green. I would like to thank all of my early reviewers: Randy Chang, Aaron Sundsmo, Dr. James Heisler, and Jacqueline Heisler. Finally, I would like to thank my partner, Daniel Heisler, and my family for their continued love and support throughout my graduate school career.
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INTRODUCTION

In this paper, I examine the role of race and ethnicity in competency to stand trial evaluations. Evaluations of competency to stand trial are aimed at assessing a defendant’s mental capacity before going to trial so as to ensure the fairness and finality of the trial process (Bonnie, 1992). These evaluations are conducted by psychiatrists, psychologists, and/or social workers (Melton, Petrila, Poythress, & Slobogin, 1997) who evaluate competency to stand trial based on an interview, a mental status examination, and/or formal testing (Heibrun & Collins, 1995). The results of these evaluations are used by the court to help determine whether or not a defendant is competent to stand trial and whether the court can proceed with the trial process. This paper will focus on how the race or ethnicity of the defendant may play a role in the outcome of these evaluations by examining the relationships between these two variables (race/ethnicity and outcome), as well as a related third variable – diagnosis.

In particular, I make comparisons related to the outcomes of competency to stand trial evaluations and the diagnoses made therein among three racial and ethnic groups of defendants: African American, Caucasian, and Latino. The terminology used to describe these groups of individual varies throughout the review of the literature section, in order to reflect the original terms used in the studies referenced. For the purposes of the variables under study here, it is assumed that the terms African American and Black refer to groups of people of similar racial or ethnic origin. Also, it is assumed that the terms
Latino and Hispanic refer to groups of people of similar racial or ethnic origin. At times, more specific terms related to country of origin or nationality are used to differentiate groups of people (e.g., Puerto Rican or African Caribbean) that may have had substantially different experiences as a racial or ethnic group. Again, the terminology used throughout the literature review section will reflect the terminology used in the original source.

In order to thoroughly look at differences in the diagnoses and outcomes of competency to stand trial evaluations among African American, Caucasian, and Latino defendants, I will first review relevant literature in order to assess what is already known about the role of race and ethnicity in competency to stand trial evaluations. This review will include a brief summary of the literature related to social cognition as it addresses the human judgment aspect of competency evaluations. In this review I will also address the literature related to racial and ethnic disparities in diagnosis, as part of competency evaluations includes an assessment of whether or not a defendant has a mental disease or defect. Finally, I will review the literature related specifically to competency to stand trial evaluations. Following this review of the relevant literature, I will address the purpose of the current study and the hypotheses under examination. I will then describe my methodology and the results of the analyses. I will end the paper with a discussion of the implications of the results, along with a discussion of how the results of this study compare with other similar studies. Finally, I address the limitations of this study and make recommendations for future research.
LITERATURE REVIEW

Forensic evaluators essentially perform a gate-keeping function for the courts in competency to stand trial evaluations. Although the trier-of-fact (usually the judge in competency hearings) makes the ultimate decision, judges tend to agree with the forensic evaluator’s opinion in more than 90% of the competency to stand trial hearings (Melton et al., 1997). Consequently, the forensic evaluator holds great influence in helping the court decide whether to allow a defendant to proceed in the legal system or potentially restrict the defendant’s basic rights by confining the individual to a psychiatric hospital. In addition, Hicks (2004) identified that an evaluator’s own ethnicity, that of the defendant, “and the interaction between dominant and nondominant ethnic groups in the justice system may all affect an examiner’s neutrality in complicated ways” (p. 29). Given this possible influence of ethnicity on the legal process and the high import of the evaluator’s recommendation to the court, it is imperative that researchers examine the role that race and ethnicity may play in competency to stand trial evaluations.

Relevant literature that bears on this topic comes from a variety of areas in psychology. First, I will review the literature on general principles of social cognition that may affect forensic evaluations. Second, I will review the literature on racial and ethnic disparities in diagnosis because part of a competency evaluation includes an assessment of whether or not the defendant has a mental illness. Third, I will review the literature specifically addressing competency to stand trial evaluations with a particular focus on
those factors that have been found to correlate with evaluator’s recommendations to the
court about whether the defendant should be found competent or not. Finally, I will
address the limitations in the literature reviewed.

Social Cognition

A primary concept in the field of social cognition is the conservation of cognitive
resources in that human beings are “cognitive misers.” According to Fiske (1995), this
term refers to the fact that, in our complicated world, we cannot consider all possible
explanations for all stimuli with which we come into contact. Instead, we use shortcuts to
process information faster and with less effort. For example, we all have schemas (i.e.,
preconceptions) about people and events that are activated immediately when confronted
with a given stimulus, and “having these preconceptions helps one to understand things
with relative efficiency and accuracy” (Fiske, 1995, p. 163). At first glance, it would
seem that cognitive efficiency is a positive adaptation; however, this positive adaptation
of efficiency comes at the cost of specificity. In social situations where people form
impressions of others, this loss of specificity often means that people “engage in
effortless category-based impression processes” (Goodwin, Gubin, Fiske, & Yzerbyt,
2000, p. 228); in other words, people apply group stereotypes to individuals with little
attention to how the individual does not match the group stereotype. A stereotype, then, is
conceptualized as a kind of role schema or “people’s expectations about people who fall
into particular social categories” (Fiske, 1995, p. 162).

The idea that cognitive efficiency is related to human prejudice is not new. Billig
(2002) recently reviewed a classic paper by Tajfel dating back to 1969 on the “Cognitive
Aspects of Prejudice”: 
In prejudiced thinking, judgments are made about the members of other groups regardless of their individual characteristics: members of the out-group are judged negatively . . . simply because they belong to the out-group. Tajfel related this type of stereotyping to ordinary sense-making. In order to understand the world — both the physical and the social world — humans need to make cognitive short cuts. (p. 175)

Given the potential for cognitive errors in all human thinking, it is likely that clinical judgment would be affected by these errors. In their article on the role of healthcare providers in racial and ethnic disparities, van Ryn and Fu (2003) summarized the impact of social cognition research for providers (and by extension evaluators):

It is both difficult and painful for many of us to accept the massive evidence that social categories automatically and unconsciously influence the way we perceive people and, in turn, influence the way in which we interpret their behavior and behave toward them. However, given that this type of strategy is common to all humans in all cultures and is more likely to be used in situations that tax cognitive resources (e.g., time pressure), the expectation that providers will be immune is unrealistic. (p. 250)

Consequently, extra care must be taken to improve the accuracy of how mental health professionals think about themselves and the defendants they evaluate. Clinicians must consider which stereotypes they are using in categorization (e.g., a stereotype of what psychosis looks like, a stereotype of what a “normal” African American looks like, etc.) and whether possible alternative explanations exist for the observed behavior.

Borum, Otto, and Golding (1993) also discussed the role of cognitive errors in clinical decision making, specifically within the context of forensic assessments. One of the problems they identified is the influence of confirmatory bias, which they described as the “tendency to look for evidence that supports one’s hypothesis (what one is expecting or hoping to find) and to ignore, or fail to seek, information that is not consistent with that hypothesis” (p. 47). Borum et al. additionally noted that, in the interpretation phase of forensic assessment, this bias appears in the tendency to interpret
ambiguous data as supportive of the evaluator's preconceived ideas or hypotheses. It is therefore important for the forensic evaluator to be aware of which schemas (or stereotypes) are likely to be activated in a given evaluation and develop personalized strategies to counteract the biasing effects of those schemas. As Borum et al. (1993) suggested, "knowledge or awareness of these limitations alone is insufficient. Clinicians must know the research on these limitations, how they are manifested in clinical practice, and how to avoid, or at least minimize, their impact" (p. 64). Through awareness and forethought, clinicians can limit the extent to which bias plays a role in diagnosis, assessment, and recommendations for services; thus, clinicians can begin to reduce the disparities in the evaluation and treatment of ethnic minority clients.

Germaine to the discussion of stereotypes is a brief review of stereotypes of ethnic minority groups. As mentioned before, a stereotype here is considered similar to a role schema, as conceptualized by Fiske (1995). The current investigation focuses on African Americans and Hispanics in forensic evaluations and thus only stereotypes of these two groups are presented. In two studies of Caucasian individuals' perceptions of ethnic minorities, researchers have found similar stereotypes of African Americans and Hispanics, with the only difference being that views of the dominant culture toward African Americans were more negative than those toward Hispanics. Wilson (1996) found in a national sample of over 800 White individuals that the respondents reported believing that Blacks and Hispanics were less intelligent, more violent, lazier, more often dependent on welfare, and less patriotic than Whites in general. Almost a decade later, Dixon and Rosenbaum (2004) similarly found in a national sample of over 800 White individuals that Whites reported believing that Blacks and Hispanics were less intelligent,
lazier, and were less committed to their families than were Whites. Given that these stereotypes are held by White Americans across the nation, the onus is on White clinicians to be extremely careful not to allow these common negative stereotypes to influence clinical judgment. When ethnic or racial disparities do exist, it is up to the clinician to understand the factors that contribute to those disparities and to understand when group statistics are being misinterpreted. In addition to becoming more aware of these general stereotypes, clinicians must also be aware of how stereotypes might emerge in clinical work and influence their judgment.

Abreu (1999) presented one example of how these negative stereotypes of ethnic minority individuals can influence clinical judgment. In an experimental study, Abreu primed clinicians with stereotypes of African Americans, unrelated to psychopathology, prior to giving clinicians a vignette. Abreu found an interaction between years of clinician experience and the race of the individual in the vignette; such that more experienced clinicians gave more pathological interpretations of the vignette when the individual in the vignette was revealed to be African American (as opposed to the other condition in which the race of the individual in the vignette was not disclosed). Abreu hypothesized that the potentially racially based “clinical schemas [of the experienced clinicians] may be the source of biases in clinical judgment” (p. 392).

Racial and Ethnic Disparities in Diagnosis

In order for a defendant to be found incompetent to stand trial, the court must be convinced that the defendant has a mental disease or defect and that it is because of this mental illness that the person is unable to meet the functional standards of competency (these standards will be reviewed in a later section). In addition to the requirement that a
mental illness exists, diagnostic information is important in competency evaluations because specific symptoms of a diagnosis are functionally related to competence. This relationship has been demonstrated by previous researchers who have found that clinical variables related to diagnosis (e.g., whether a defendant has a psychotic disorder or not) are significantly correlated with whether a defendant is deemed competent to stand trial (Caldwell, Mandracchia, Ross, & Silver, 2003; Cooper & Zapf, 2003; Hart & Hare, 1992; Nicholson & Kugler, 1991). Previous researchers have claimed that, because forensic evaluators' opinions are dependent on clinical variables, the opinions of the evaluators must be free from racial or ethnic bias (Cooper & Zapf, 2003). However, numerous studies have shown that there are racial disparities in diagnostic prevalence rates and that these may be due to systemic bias in pathologizing non-dominant culture individuals. In this section, I address both the disparities between prevalence rates of diagnoses of African Americans and Latinos as compared to Caucasians and the numerous factors that may play a role in those disparate prevalence rates (e.g., clinician bias, discrimination, cultural variation in symptom expression, etc.).

African Americans/Blacks

A primary example of racial and ethnic differences in diagnosis is found in literature on the prevalence rates of psychotic diagnoses among the African American population in the United States (Kales, Blow, Bingham, Copeland, & Mellow, 2000; Mathews, Glidden, & Hargreaves, 2002; Minsky, Vega, Miskimen, Gara, & Escobar, 2003), as well as African-Caribbean and African populations in the United Kingdom (Coid, Kahtan, Gault, & Jarman, 2000). In these studies, Black patients were consistently diagnosed with psychotic disorders more frequently than were White patients. On
average, African American psychiatric patients appear to receive a psychotic disorder diagnosis approximately 1.5 times more frequently than Caucasian psychiatric patients (Kales et al., 2000; Mathews et al., 2002; Minsky et al., 2003).

Despite such a consistent trend, researchers have not presented consistent reasons for this trend. One explanation that has been offered is that clinician bias in diagnostic assessments results in the over-diagnosis of psychotic disorders in Black patients (e.g., Whaley, 1998). However, others hypothesize that the deleterious effects of discrimination have resulted in an increase in psychotic symptoms in Black patients (e.g., Karlsen & Nazroo, 2002). A few of these arguments are presented briefly below followed by a review of empirical research investigating these arguments.

Sharpley, Hutchinson, McKenzie, and Murray (2001) considered the evidence for biological, social, and psychological explanations for the higher rate of psychosis in African-Caribbean people living in England (as compared to Whites and African-Caribbean people still residing in their home country). After considering numerous hypotheses, they concluded that this population was more likely to adopt a paranoid attributional style “because their experience of social disadvantage and racial discrimination in the UK results in: (a) a need to question self-perception and identity; and (b) more threat in their everyday social life” (p. 65). According to this line of thinking, the paranoid attributional style then makes this population more likely to receive diagnoses of psychotic disorders than Whites because the dominant culture views paranoia as pathological. Sharpley et al. also found that the psychotic symptoms exhibited in this population had more of an affective quality as compared to Whites with
psychotic symptoms. The authors hypothesized that this may indicate that the paranoia is a defense strategy used to combat negative views of the self.

Researchers in the United States have come to similar conclusions regarding the relationship of paranoia to social disadvantage and attributional style, as well as the tendency to view paranoia as pathological and part of a psychotic spectrum disorder. Whaley (1998) found that paranoia and mistrust were associated not only with African Americans but with many different groups who have experienced powerlessness, such as women, people of low socioeconomic status, and people with less education. He, like Shipley et al., purported that this paranoia and mistrust were related to an acquired attributional style:

If people live in an environment in which they experience powerlessness in the face of victimization, then paranoia serves a self-protective function. People can protect their self-esteem and prevent depression associated with experiences of failure, when they can attribute that failure to the power of external others.

(p. 328)

Whaley further stated that psychotic disorders are over-diagnosed among African Americans and others when a diagnosis of depression (or no diagnosis) may be more accurate. In other words, paranoia among African Americans may be less often part of a psychotic, pathological spectrum and more often part of the normal experience of an oppressed individual. If there is pathology present, Whaley argued, it may be best accounted for by depression rather than psychosis.

Research directly assessing discrimination and its effects on mental health presents a mixed picture, which is in part due to the difficulty of operationally defining discrimination. One British study found that participants who endorsed experiences of verbal abuse related to race had a 150% increased estimated risk for symptoms of
psychosis and depression over those who did not endorse experiencing racism (Karlsen & Nazroo, 2002). Additionally, Janssen et al. (2003) researched the relationship between perceived discrimination (of all types, not limited to race) and psychotic symptoms in the Netherlands. These authors found that as the amount of perceived discrimination experienced increased so did the likelihood of delusional ideation. Conversely, Kessler, Mickelson, and Williams (1999) failed to find expected racial differences in the relationship between daily discriminatory experiences and mental illness in the United States. They reported that the reason they did not find the expected racial differences was possibly related to the fact that “a substantial proportion of people who are not thought to have disadvantaged social statuses think of themselves as experiencing major discrimination at some time in their life” (p. 225).

Boydell et al. (2001) researched the incidence of a diagnosis of schizophrenia in relation to the percentage of ethnic minorities in a given geographical area of London. They found a dose-response effect for the incidence of schizophrenia such that the fewer ethnic minorities living in the community, the higher the incidence of diagnosis of schizophrenia among those ethnic minorities. Although this is an interesting finding, the vast number of hypotheses that could account for it (e.g., less social support from one’s cultural network, more discrimination experienced, less power within the community, etc.) are too numerous to make the finding very meaningful.

*Latinos*

Research on bias in diagnosis of Latino populations is scarcer than that of African American and African Caribbean populations. Minsky et al. (2003) compared diagnostic prevalence rates among Latino, African American, and European American populations
in New Jersey. As previously mentioned, they found more psychotic diagnoses within the African American population than within the other two ethnic groups. Although Latinos were similar to European Americans in the prevalence rates of psychotic disorders, Minsky et al. found differences with regard to prevalence rates of depression. In fact, they found significantly higher prevalence rates of major depression diagnoses as compared to both European Americans and African Americans, such that Latinos were 74% more likely to be diagnosed with this disorder than European Americans. Minsky et al. attributed this diagnostic trend to “cultural variances in characteristic symptom clusters typically used by clinicians as a template for assigning a diagnosis in a treatment setting” (p. 643) for Latinos. Although Minsky et al. did not find differences between Latinos and European Americans with regard to prevalence rates of psychotic disorders, other researchers have found differences between these two groups when looking at particular symptoms often related to psychotic disorders.

Whaley (1998) found a trend among the Latino sample in his study for higher levels of mistrust and paranoia in comparison to Caucasian participants. The sample of Latinos in Whaley’s study were primarily of Puerto Rican heritage and because of the unique relationship between Puerto Rico and the United States these results may not generalize to the diverse populations that are subsumed under the label of Latino. Besides paranoia, another symptom that can often be mistaken for psychosis is hallucinations. This can be particularly problematic when diagnosing individuals with ethnic origins in Puerto Rico or the Dominican Republic (and possibly other Latin cultures). Geltman and Chang (2004) interviewed Caribbean Latinos (85% of whom were from Puerto Rico or the Dominican Republic) receiving outpatient mental health treatment and found that
46% reported some experience of hallucinations. Furthermore, they found that “hallucinations were not associated with clinical variables including neurological illness, history of head trauma, mood disorders, and current or prior substance abuse” (Geltman & Chang, 2004, p. 154). Instead, hallucinations appeared to be a common experience in these cultures and did not necessarily represent pathology.

In Appendix I of the American Psychiatric Association’s *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)* (2000), the authors identified one area of potential cultural difference to be explored in diagnosis as “the predominant idioms of distress through which symptoms...are communicated” (p. 897). Gonzales et al. (1997) stated that this “idiom of distress” factor played an important and under-recognized role in the diagnosis of Mexican Americans. Gonzales further observed that clinicians tended to restrict their diagnoses of Mexican Americans to a fraction of the disorders represented in the *DSM-IV-TR* (i.e., generalized anxiety disorder, schizoaffective disorder, borderline intellectual functioning, dependent personality disorder, and antisocial personality disorder). This restriction may be based on clinicians’ interpretation of the idiom of distress or it may be based on clinicians’ stereotypes of Mexican American patients.

Coelho, Strauss, and Jenkins (1998) interviewed Puerto Ricans and Caucasians to examine the potential differences in symptom expression between dominant and Latino cultures. They found that differences between the two groups tended to be related to intensity rather than number of symptoms, with Puerto Ricans expressing symptoms at a higher intensity than Caucasians. The authors found some differences in domains of symptom expression, such as Puerto Ricans expressing more anxiety and depression than
Caucasians; however, they cautioned about over-interpretation of this finding because of two important issues. First, Coelho et al. posited that the anxiety section of the Brief Symptom Inventory (the tool used to measure symptom presence and intensity) was tapping into the cultural construct of *nervios*, “a folk term for emotional distress and/or psychiatric illness” (Koss-Chioino, 2004, p. 182) and not the anxiety construct it was meant to measure. Second, the authors stated that the larger number of depressive symptoms endorsed on the Brief Symptom Inventory were almost all from female participants. With gender as a confounding variable, interpretation and understanding of the role of ethnicity alone was virtually impossible.

Another issue that may play a role in the diagnosis of Latino populations is language. Malgady and Constantino (1998) conducted an experimental study in which they varied the ethnicity of the diagnostic interviewer and the language spoken during the interview. They found that severity of diagnosis (as measured by the Brief Psychiatric Rating Scale) was highest in the bilingual condition, followed by the Spanish-speaking condition, and then the English-speaking condition, all with Hispanic clinicians. In addition, Malgady and Constantino found that the English-speaking Anglo clinician gave the least severe diagnoses. There were similar findings when the measure of severity was the Global Assessment of Functioning (GAF) rating, except that only the two extremes (the bilingual condition as the most severe with the lowest GAF and the English condition with the Anglo clinician giving the highest GAF) were significantly different. Without a Spanish-speaking Anglo clinician condition, no interpretations based on clinician ethnicity could be made; however, there was still an important effect of language on diagnosis. According to the results of this study, clinicians tended to rate
Latino clients speaking Spanish or those speaking both Spanish and English as having more severe diagnoses and as functioning less well than Latino clients speaking English only. Malgady and Constantino aptly noted that "what remains to be determined is whether or not this is bias in the form of overly pathologizing on the clinicians’ part or whether they are more sensitive to patients’ presenting symptoms" (p. 125).

Mathews et al. (2002) also found a relationship between language spoken and diagnosis. Among the Spanish-speaking Latinos, Mathews et al. found a higher prevalence of depression and a lower prevalence of bipolar and schizoaffective diagnoses. They did not, however, consider differences in severity of diagnoses. According to these studies, language appears to be a clear factor affecting diagnosis, although further research is needed to explicate the exact nature of the relationship between the two variables.

In summary, there is very little consensus about the relationship between ethnicity and diagnosis among Latinos. Some evidence suggests that the picture may look similar to that of African Americans in a bias toward psychotic spectrum diagnoses, but other evidence points toward differences in the mood disorder spectrum. Factors such as symptom expression and language may more frequently be issues among Latino populations than African American populations, although there is evidence to suggest that these may be common concerns among all ethnic minority populations. Despite the complexity of the research regarding the relationship between ethnicity and diagnosis, it is important for forensic evaluators to be aware of potential differences in diagnoses of Axis I disorders across ethnic groups.
Competency to Stand Trial Evaluations

In order to understand competency to stand trial evaluations and the factors that may impact their outcomes, it is first important to have a general understanding of the legal process. Factors that will be discussed here include potential biases in referrals for competency to stand trial evaluations, the assessment of functional capacities within competency to stand trial evaluations, and correlations between ethnicity and outcomes of competency to stand trial evaluations.

Overview of the Legal Process of Competency to Stand Trial

According to Melton et al. (1997), the primary ruling that currently governs federal and most state cases of competency was established in the federal court case *Dusky v. United States* (1960). In this case, the Supreme Court ruled that the “the test must be whether he [the defendant] has sufficient present ability to consult with his attorney with a reasonable degree of rational understanding as well as factual understanding of proceedings against him” (*Dusky v. United States*, 1960, as cited in Melton et al., 1997, p. 121). This ruling was important because it ensured that both parties could take full advantage of the adversarial process, that the defendant could provide counsel with information to maintain the accuracy of the process, and that the defendant, if found guilty, would be able to understand the reasoning behind the sentence (Blashfield, Robbins, & Barnard, 1994).

Competency to stand trial evaluations may occur at a variety of time points in the trial process and under a variety of circumstances. Bonnie (1992) described the range of situations to which the title “competency to stand trial evaluations” has referred as follows:
most typically, these evaluations occur before a defendant goes to trial and the process of questioning the defendant's competence is initiated by the defense attorney (Melton et al., 1997). Although it is then up to the trial court to decide whether or not enough doubt about a defendant's competency to stand trial exists, “in practice, a court will rarely refuse a request for a competency examination” (Melton et al., 1997, p. 127). Following the court's decision to proceed with a competency examination, the defendant is then evaluated by a clinician, most typically a psychiatrist, psychologist, or social worker, who offers the court an opinion with regard to the defendant's competency to stand trial (Melton et al., 1997). The court then makes the final decision regarding the defendant's competence and the trial process will either resume if the defendant is deemed competent, or be suspended, if the defendant is deemed incompetent (Melton et al., 1997). If the trial is suspended, then “the defendant is often committed to the public mental health system for treatment” (Melton et al., 1997, p. 130) until competence is regained and the process can be resumed.

Referrals for Evaluations

There are several points in the legal process at which race and ethnicity factors may come into play. The first is at the time of referral for an evaluation of competency. Minsky et al. (2003) raised the issue of referral bias as one area for future researchers to examine with regard to ethnic differences in diagnosis. Individuals with certain characteristics may be more likely than others to be referred for evaluations. Pinals, Packer, Fisher, and Roy-Bujnowski (2004) studied this referral process within the context
of the Massachusetts forensic mental health system. When competency issues are raised in this system, according to Pinals et al., defendants are sent for a competency screening by court clinicians. These screenings are used to assess whether further evaluation of the defendant is necessary, and, if so, in what type of setting the evaluation should occur. Options for setting include outpatient, inpatient, and strict-security facilities. Pinals et al. researched the outcomes of these court screenings for male pretrial defendants, controlling for diagnosis and criminal charges. They found that Black defendants were more likely than Whites (odds ratio of 1.25) and Hispanic defendants were less likely than Whites (odds ratio of .82), to be referred by forensic psychologists and psychiatrists for further evaluations to be conducted in an inpatient setting. When the referrals were made to a strict-security facility, then the rates were even more extreme: Black defendants were almost two times more likely than Whites to be referred (odds ratio of 1.87), and Hispanic defendants were also more likely than Whites to be referred (odds ratio of 1.37). The authors concluded that “findings showed statistically significant racial and ethnic effects in the referral patterns of defendants after a court clinic screening” (p. 877), establishing that Blacks and Hispanics were likely to be overrepresented within the forensic mental health system, at least in terms of evaluations for competency in Massachusetts.

One aspect of the findings from the Pinals et al. (2004) study was contradictory and not well explained by the authors. As noted above, Hispanics were less likely to be referred in general inpatient settings but more likely to be referred in the high security condition. This finding appeared to suggest a more complex process than just an overrepresentation of Hispanics. Three possibilities that could explain this finding are as
follows: (1) only severe cases of psychopathology were recognized in this population and thus those require a higher level of security, (2) psychopathology in this population is rated as more severe than in the Caucasian population and thus was more likely to be referred to a higher level of security, or (3) Hispanic individuals were perceived as being more violent and thus were only referred to higher level security facilities. Regardless of which of these is true, this trend creates a context of relating to Hispanic defendants under the assumption of increased severity of symptoms or potential for violence. The implication of this, then, is that relating to Hispanic defendants in high security settings may activate stereotypical thinking about these defendants, which in turn may bias the clinicians’ opinions.

**Evaluation of Functional Capacities**

Although the diagnostic assessment is an important part of competency to stand trial evaluations, it is not the diagnosis per se that influences the evaluator’s opinion with regard to competency to stand trial. Instead, “the legal test...is concerned with the level of the defendant’s cognitive functioning and its impact on his or her ability...to understand and participate meaningfully in the criminal process” (Melton et al., 1997, p. 125). Consequently, the evaluation is focused on the extent to which the symptoms of the mental disease or defect interfere with the defendant’s competency to stand trial. (Though these principles are typical in competency evaluations, it is important to remember that the specifics in each state’s statutes may vary.) In order to evaluate the potential for bias in the evaluator’s assessment of how much the symptoms impact a defendant’s functional capacity to stand trial, it is important to understand the tools forensic evaluators use to form their opinions.
According to Melton et al. (1997), there are numerous ways in which forensic evaluators examine an individual's functional capacity to stand trial. Heibrun and Collins (1995) surveyed hospital- and community-based forensic examiners about what decision-making tools they used in competency to stand trial evaluations. In their sample, 13% of hospital-based and 47% of community-based evaluators used traditional psychological tests (e.g., Wechsler Adult Intelligence Scale and Minnesota Multiphasic Personality Inventory), and 60% of community-based and 63% of hospital-based evaluators used mental status examinations in competency to stand trial evaluations. Almost all of the evaluators in both settings used clinical interviews as a part of the evaluation. Of those who addressed the specific state statute (which in this case was Florida's statute that included six separate components), hospital-based evaluators did so 95-99% of the time, whereas community-based evaluators did so 61-81% of the time. It is notable that the authors of this study did not mention the use of standardized instruments specifically designed to measure competency; however, at the time when this study was conducted there were far fewer options of quality tools than there are today.

No researchers have directly evaluated bias in the determination of functional capacities in terms of tools used, measures given, or questions asked. Thus, there is a gap in the literature with regard to whether or not ethnic minority defendants with similar test scores and interview responses as ethnic majority defendants receive different recommendations to the court regarding competency status as compared to ethnic minority defendants. Some authors, however, have examined the correlation between competency status and ethnicity and have provided hypotheses regarding whether or not bias affects evaluations of minority defendants.
Competency Status and Ethnicity

Research analyzing the role of race and ethnicity in competency to stand trial evaluations has been by no means exhaustive. Several researchers have found that ethnicity and other demographic variables appear to be related in some way to whether or not the defendant is recommended to the court as competent. Nicholson and Kugler (1991) reviewed 30 studies over a 25-year period in which researchers had investigated variables that correlate with or predict competency to stand trial. They found that ethnicity and marital status had significant relationships with competency status, such that minorities and unmarried individuals were more likely to be deemed incompetent. In contrast, employment status, type of offense (violent or nonviolent), and a diagnosis of mental retardation were unrelated to competency status.

In Canada, Hart and Hare (1992) similarly looked at correlates of competency status. These authors used a sample of 80 defendants and failed to find relationships between demographic variables (such as ethnicity) and competency status, in contrast to the review by Nicholson and Kugler. Instead, these authors found a strong relationship between a diagnosis of a psychotic disorder and being found incompetent to stand trial: “Over half of the patients with one of these diagnoses was found unfit [i.e., not competent], and almost nobody without one of the [psychotic] diagnoses was found unfit” (Hart & Hare, 1992, p. 61). Furthermore, the authors looked at the predictive efficiency of all the different types of variables they studied and concluded that “demographic, criminal, and other clinical variables could not improve over the diagnostic variables either alone or in combination” (p. 61). An important limitation of this study is that the sample was 90% Caucasian and was small ($N = 80$). Thus, it was
statistically unlikely that a significant difference across ethnic groups in such a limited sample could be detected unless the effect was moderate to large.

A third study in which researchers examined the relationship of ethnicity to competency status was conducted by Ho (1999). In a sample of mentally retarded defendants, Ho failed to find a significant relationship between ethnicity and competency status. He found a relationship only with gender, such that male defendants were more likely to be found incompetent than female defendants. A problem with this study was that most of the defendants were found to be incompetent due to insufficient cognitive capacities, which left little room for discrepancies based on ethnicity. In sum, the past literature has been relatively inconsistent as two studies since the 1991 meta-analysis have failed to replicate the relationship between ethnicity and competency status; however, both studies had substantial methodological limitations.

More recently, two studies were conducted by separate research groups and published in 2003. Caldwell et al. (2003) looked at the relationship between competency status and ethnicity indirectly. They examined the relationship between ethnicity and diagnosis and the relationship between diagnosis and competency status, but they did not look at the relationship between ethnicity and competency status. Their findings matched what has been shown previously in that African Americans (the only minority group that was included in their sample) were more likely than Caucasians to be diagnosed with psychotic disorders and that a psychotic disorder diagnosis was most highly related to a finding of incompetency over other Axis I disorders.

In the other study completed in 2003, the authors also looked at the differences between African American and Caucasian defendants. Cooper and Zapf (2003) found
significant associations between competency recommendation and 13 other variables. When they looked further at how well each of these variables predicted competency, they realized that only four of them were substantial predictors: presence of a psychotic disorder, presence of a non-psychotic major disorder (e.g., major depressive disorder or posttraumatic stress disorder), presence of a non-psychotic minor disorder (e.g., adjustment disorder or personality disorder), and employment status. The other variables showed multicollinearity with these four primary variables.

Based on these results, Cooper and Zapf (2003) hypothesized that the ethnicity variable was not a substantial predictor of competency because of its interaction with diagnosis, such that African American defendants were more likely to be diagnosed with a psychotic disorder than were Caucasian defendants. They therefore concluded that because “the predictive ability of sociodemographic variables can be explained through multicollinearity with clinical variables, then the high predictive accuracy cannot be said to reflect bias” (p. 433). Furthermore, the authors concluded that “it appears as though clinicians are basing their competency decisions on variables that one can reasonably assume affect a defendant’s functional ability to stand trial” (p. 433). This conclusion fails to take into account the possibility that bias may occur at the level of the diagnosis rather than being a direct effect of ethnicity, as well as the possibility that the diagnosis of a psychotic disorder does not necessarily indicate that the defendant does not possess the functional capacity to stand trial.

In summary, based on the above studies, it appears that there is a growing consensus around two basic correlates of competency status: (a) defendants diagnosed with psychotic disorders have been more likely than defendants diagnosed with other
Axis I disorders to be found incompetent, and (b) African American defendants tend to be more likely than Caucasian defendants to be diagnosed with psychotic disorders and therefore are also more often found incompetent.

Limitations of the Literature

Missing from these analyses of factors contributing to competency status is the potential for bias in diagnosis for African American defendants. In not one of these studies did the researchers separate out those diagnosed with psychotic disorders and examine whether competency recommendations varied by ethnic group. It is also problematic that these researchers have failed to analyze the relationship between competency status and ethnicity for the Latino population, which has now equaled the size of the African American population in the United States and is ever growing (U.S. Department of Health and Human Services, 2001).

Evidence of bias toward and stereotyping of ethnic minority populations has been discussed since the early social cognitive research of Tajfel (Billig, 2002). Although general cognitive biases have been delineated (Borum et al., 1993), information about the specific ways in which these biases and stereotypes may influence forensic evaluations of competency to stand trial with ethnic minority defendants have not been directly addressed in the literature. This information is especially needed because forensic evaluation is an area in which clinical opinion holds great weight in legal proceedings and hence defendants' futures. In competency to stand trial evaluations, "studies in a number of jurisdictions show judge-clinician agreement to be greater than 90%" (Melton et al., 1997, p. 129). Because judges rely heavily on clinical opinion, forensic examiners...
must provide evidence that they are in fact basing these opinions on the legally relevant
criteria of competency and not on stereotypes of ethnic minority defendants.

Purpose of the Current Study

The purpose of this study is to examine the role that race and ethnicity play in
competency to stand trial evaluations, with particular attention to the potential for bias in
the evaluations of minority defendants. Researchers thus far have primarily focused on
relationships among African American ethnicity, psychotic diagnoses, and incompetence;
however, no researchers have related competency status to Latino or Hispanic ethnicities
(or any ethnic group besides African Americans for that matter). There are a few studies
in which researchers have examined the relationship between Latino ethnic status and
diagnosis, but they provide little consistent information with respect to diagnostic
differences between Latino and Caucasian individuals. In this study, I sought to replicate
previous findings of a relationship between ethnicity and competency status within the
African American population and to provide preliminary information about competency
to stand trial evaluations of Latino defendants through exploratory analyses. Based on the
literature reviewed above, my hypotheses were as follows:

1. African American defendants would be more likely than Caucasian defendants
to be diagnosed with psychotic disorders.
2. African American defendants would be more likely than Caucasian defendants
to be recommended to the court as incompetent to stand trial.
3. African American defendants with psychotic disorders would be found to be
incompetent at a higher ratio than would Caucasian defendants with psychotic
disorders.
4. Latino defendants would be more likely than Caucasian defendants to be recommended to the court as incompetent.

5. Latino defendants would have significantly different proportions of diagnoses than Caucasian defendants.

6. Latino defendants who are evaluated in English with interpreters present would be more likely than Latino defendants who are evaluated in English without interpreters to be found incompetent.

7. Latino defendants who are evaluated in English with interpreters present would be diagnosed with significantly different diagnoses than Latino defendants evaluated in English without interpreters.
METHOD

Data Collection Procedures

Data was collected at a state psychiatric hospital in Oregon following Institutional Review Board approval from both Pacific University and the hospital. This hospital is predominantly an inpatient facility and most of the patients housed there were admitted through forensic routes, meaning that most patients are admitted under legal statutes related to criminal charges (e.g., competency to stand trial statutes and not guilty by reason of insanity statutes). This hospital is also the only one of its kind in the state and thus patients come from all counties across the state.

The data for this study was collected from archived records of reports written to the court regarding defendants’ competency to stand trial. The reports used for data collection were the first ones written to the court following admission to the hospital after the court deemed the defendants incompetent to stand trial. Consequently, the reports used in this study were not the first related to competency, but instead the first ones after being admitted to the hospital. These reports are typically written within 90 days following the defendant’s admission to the hospital, as required by state law.

In order to select relevant reports, I used a list generated by hospital personnel of all admissions for defendants deemed incompetent to stand trial from 1/1/2003 through 4/10/2006. During this time period, there were 898 admissions of defendants deemed by the courts to be incompetent to stand trial. Of these 898 admissions, 8.9% were for
African American defendants, 7.1% were for Latino defendants (of primarily Mexican ancestry), 3.2% were for other ethnic minority defendants, 2.0% were for defendants of unknown ethnic background, and the remaining 78.8% were for Caucasian defendants. (It is important to note that multiple admissions for some individuals were included in these statistics.) In comparison to the general population in Oregon in 2005, African Americans were over represented among these hospital admissions, as African Americans comprised only 1.8% of the total population in Oregon (U.S. Census Bureau, 2007). In addition, Latinos and Caucasians were slightly under represented among these hospital admissions, as Latinos comprised 9.9% and Caucasians comprised 81.6% of the total population in Oregon (U.S. Census Bureau, 2007).

Of the 898 admissions during the study time period, I was able to access 75.3% (696) of the first reports written regarding competency to stand trial following admission to the hospital. Despite having IRB approval to gather data, I was unable to access all of the reports because my access was primarily restricted to paper files, with limited access to copies kept in electronic records. The paper files were kept by the hospital’s records office for the current and prior year; however, reports written prior to that time were only kept electronically. Consequently, I had to gather data from these prior years via the forensic evaluators’ personal records, of which I could only access the records of those forensic evaluators employed as staff members of the hospital at the time of data collection. I then coded these reports according to the variables of interest in this study using a coding sheet I developed specifically for this study (see Appendix A). From these 696 coded reports, there were 57 reports of African American defendants and 60 reports of Latino defendants in which the ethnic background of the defendant was clear (i.e.,
ethnic background was listed in the report and there was no discrepancy between the ethnicity listed in the report and the ethnicity listed on the aforementioned admission list generated by the hospital. Of the pool of reports written about African American defendants, only 53 of the 57 were for different individuals. Of the pool of reports written about Latino defendants, only 56 of the 60 were for different individuals. Consequently, three of the reports on Latino defendants were randomly deselected to match the number of reports on African American defendants. Of the remaining reports, there were 433 in which the ethnic background of the defendant was clearly Caucasian. Of this pool, only 380 were for different individuals. These reports were separated by year and then 53 reports were randomly selected, stratifying according to year in order to eliminate any systematic bias that might occur over time (e.g., different evaluators conducting evaluations in different years).

Characteristics of Defendants

The final sample of 159 reports consisted of equal numbers of reports for defendants from African American, Latino, and Caucasian ethnic groups (53 reports per group). The sample was predominantly male (83%), which is consistent with most forensic populations, and the mean age for the sample was 35.3 years (SD = 10.9). I conducted a Chi-square analysis to see if there was any significant variance in gender across ethnic groups. The analysis was significant ($\chi^2 = 7.5, p = .02$), such that there were significantly fewer females represented among the Latino defendants (5.7%) than the African American defendants (20.8%) or the Caucasian defendants (24.5%). I conducted an ANOVA to see if there was any significant variance in age between ethnic groups and found that age did significantly vary across ethnic groups, $F(2, 157) = 5.44, p = .005$. In
order to determine which groups were significantly different, I conducted a Bonferroni post-hoc analysis and found that Latino defendants were significantly younger on average ($M = 31.49, SD = 10.24$) than either the Caucasian defendants ($M = 37.90, SD = 9.69, p = .01$) or the African American defendants ($M = 36.68, SD = 11.75, p = .04$); however, the difference in age between the Caucasian and African American defendants was not significant.

Characteristics of Evaluators

I sent a questionnaire to evaluators who wrote reports to the court regarding competency status during the study period to gather demographic and training information. Of the 25 evaluators writing reports during this time period, I was able to find contact information for all but 2 of them. Of the 23 questionnaires sent to evaluators, I received 13 completed questionnaires. Evaluators who were placed at the hospital as part of their graduate school training were overrepresented in the sample of respondents. All of the evaluators' self-reported ethnic background was Caucasian, with the exception of one evaluator who did not respond to this question. Males and females were equally represented among the 12 respondents who provided a response for gender. Evaluators' degrees possessed at the time each was conducting evaluations was as follows: two M.D.s, two Ph.D.s, four Psy.D.s, three M.S.s, and two M.A.s. A small majority of respondents ($n = 7$) possessed a practice license prior to becoming employed as a forensic evaluator at the agency, whereas others either did not possess a license because they were evaluators as part of their practicum training ($n = 5$) or obtained their license while working as a forensic evaluator at the agency ($n = 1$). Most of the respondents ($n = 9$) had performed evaluations at the agency for 2 years or less, with the remaining respondents...
performing evaluations for 4 years \((n = 2)\), 11 years \((n = 1)\), and 19 years \((n = 1)\). Although approximately one quarter of the respondents reported no training in conducting competency to stand trial evaluations prior to becoming an evaluator at the agency, all of the respondents reported on-site training of various forms including observation of evaluations conducted by senior staff, in vivo supervision, self-study, workshops, and consultation.

Analyses

Analyses were conducted to test each of the seven hypotheses using the Statistical Package for Social Sciences (SPSS), version 14.0. An a priori power analysis was run in order to determine whether the sample size would provide enough power for a logistic regression to detect differences among the three groups using G*Power (Faul, Erdfelder, Lange, & Buchner, 2007). According to this analysis, the sample size of 159 would be large enough to detect a .25 effect size with three groups and a projected power of .80.
RESULTS

In this study, I evaluated seven different hypotheses informed by and expanding upon previous literature relating diagnostic and demographic variables to competency recommendations. Frequency information for the different variables explored in these hypotheses is presented in Table 1. As previously mentioned, age and gender did vary significantly among the ethnic groups. Additional differences found are that African American defendants were the least likely to be given a substance use diagnosis and that Latinos were the most likely not to receive any Axis I diagnosis.

Correlations amongst these variables are presented in Table 2. The correlation matrix shows a similar pattern of results in that there are significant relationships between

Table 1. Frequency Information for Study Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Full Sample</th>
<th>Caucasian</th>
<th>African American</th>
<th>Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age**</td>
<td>35.3 (10.9)</td>
<td>37.9 (9.7)</td>
<td>36.7 (11.7)</td>
<td>31.5 (10.9)</td>
</tr>
<tr>
<td>Male*</td>
<td>83.0% (132)</td>
<td>75.5% (40)</td>
<td>79.2% (42)</td>
<td>94.3% (50)</td>
</tr>
<tr>
<td>Married</td>
<td>8.2% (13)</td>
<td>9.4% (5)</td>
<td>5.7% (3)</td>
<td>9.4% (5)</td>
</tr>
<tr>
<td>Competent</td>
<td>62.9% (100)</td>
<td>69.8% (37)</td>
<td>52.8% (28)</td>
<td>66.0% (35)</td>
</tr>
<tr>
<td>Substance Use**</td>
<td>62.3% (99)</td>
<td>79.2% (42)</td>
<td>43.4% (23)</td>
<td>64.2% (34)</td>
</tr>
<tr>
<td>Psychotic Disorder</td>
<td>66.7% (106)</td>
<td>67.9% (36)</td>
<td>75.5% (40)</td>
<td>56.6% (30)</td>
</tr>
<tr>
<td>No Axis I Diagnosis**</td>
<td>11.9% (19)</td>
<td>3.8% (2)</td>
<td>7.5% (4)</td>
<td>24.5% (13)</td>
</tr>
<tr>
<td>Mood/Anxiety Disorder</td>
<td>10.1% (16)</td>
<td>17.0% (9)</td>
<td>3.8% (2)</td>
<td>9.4% (5)</td>
</tr>
<tr>
<td>Other Axis I Disorder</td>
<td>11.3% (18)</td>
<td>11.3% (6)</td>
<td>13.2% (7)</td>
<td>9.4% (5)</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>15.7% (25)</td>
<td>20.8% (11)</td>
<td>17.0% (9)</td>
<td>9.4% (5)</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>7.5% (12)</td>
<td>7.5% (4)</td>
<td>9.4% (5)</td>
<td>5.7% (3)</td>
</tr>
</tbody>
</table>

* Age listed as mean (standard deviation); all other variables listed as percent (n).
* Difference amongst ethnic groups significant at $p < .05$; ** significant at $p < .01$.  
Table 2. Correlations Amongst Study Variables

<table>
<thead>
<tr>
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<th>1</th>
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<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
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<tbody>
<tr>
<td>1. Age&lt;sup&gt;a&lt;/sup&gt;</td>
<td>-</td>
<td>.26</td>
<td>.04</td>
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<td>.12</td>
<td>.15</td>
<td>.06</td>
<td>.08</td>
<td>.09</td>
<td>.08</td>
<td>.06</td>
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<td>2. Ethnicity&lt;sup&gt;b&lt;/sup&gt;</td>
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<td>.21*</td>
<td>.07</td>
<td>.15</td>
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<td>.16</td>
<td>.28**</td>
<td>.18</td>
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<td>3. Male</td>
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<td>.01</td>
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<td>.00</td>
<td>.18</td>
<td>.10</td>
<td>.21**</td>
<td>.03</td>
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<td>5. Incompetent</td>
<td>-</td>
<td>.21**</td>
<td>.30**</td>
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<td>6. Substance Use</td>
<td>-</td>
<td>.08</td>
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<td>7. Psychotic Disorder</td>
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<td>.52**</td>
<td>.47**</td>
<td>.50**</td>
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<td>8. No Axis I Diagnosis</td>
<td>-</td>
<td>.12</td>
<td>.13</td>
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<td>9. Mood/Anxiety Disorder</td>
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<td>10. Other Axis I Disorder</td>
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<td>.12</td>
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<td>12. Developmental Disability</td>
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</table>

<sup>a</sup>Age listed as Eta;  
<sup>b</sup>Ethnicity listed as Cramer’s V; all other variables listed as Phi. All correlations given in absolute value. See text for explanation of direction of relationship.

* Value significant at $p \leq .05$; ** value significant at $p \leq .01$. 
ethnicity and substance use, as well as ethnicity and no Axis I diagnosis. Additional findings include a significant relationship between marital status and the presence of a mood or anxiety disorder, such that those who were not married were likely not to be diagnosed with a mood or anxiety disorder. This relationship, though, is not particularly meaningful as the vast majority of defendants fell into this category ($n = 134$, or 84.3% of the sample). Furthermore, only 16 defendants received the diagnosis of a mood or anxiety disorder, and the majority of these ($n = 12$) were also not married. Other significant relationships were found among Axis I diagnostic variables. These too are not meaningful as the presence of one often meant the exclusion of the other by definition of the variable (e.g., one could not have both no Axis I disorder and a psychotic disorder).

Substantive findings from Table 2 included the relationship between competency status and the Axis I diagnostic variables, as well as the relationship between competency status and substance use. First, the correlation between competency status and the Axis I diagnostic variables showed that incompetency was significantly correlated with the presence of a psychotic disorder ($\phi = .30, p < .01$). Looking at the frequency data, 84.7% of the defendants recommended as incompetent were diagnosed with a psychotic disorder as opposed to only 56% of the defendants recommended as competent. Additionally, defendants recommended as incompetent were significantly less likely to receive no Axis I diagnosis or a diagnosis of a mood or anxiety disorder than defendants recommended as competent. The other important finding was a significant correlation between competency and substance use ($\phi = .21, p < .01$), such that defendants recommended to the court as incompetent were diagnosed with a substance use disorder
significantly more often (96.7% of the cases) than were those defendants recommended to the court as competent (70.0% of the cases).

The first hypothesis under investigation in this study was that African American defendants would be more likely than Caucasian defendants to be diagnosed with psychotic disorders. In order to evaluate this hypothesis, I conducted six Chi-square analyses comparing the observed and expected numbers of defendants diagnosed with (a) all psychotic disorders, (b) schizophrenia only, (c) schizoaffective disorder only, (d) substance-induced psychotic disorder only, (e) mood disorders with psychotic features only, and (f) all of the above diagnoses. The results of the above analyses are presented in Table 3. Although the differences between African American and Caucasian defendants were in the expected directions for four of the six variables, none of the differences reached statistical significance.

Table 3. Comparing Ethnicity and Frequency of Psychotic Disorder Diagnoses

<table>
<thead>
<tr>
<th>Category</th>
<th>African American</th>
<th>Caucasian</th>
<th>$\chi^2$</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Psychotic Disorders</td>
<td>75.5%</td>
<td>67.9%</td>
<td>.74</td>
<td>.26</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>34.0%</td>
<td>24.5%</td>
<td>1.14</td>
<td>.20</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>17.0%</td>
<td>13.2%</td>
<td>.29</td>
<td>.39</td>
</tr>
<tr>
<td>Substance-Induced Psychotic Disorder</td>
<td>5.7%</td>
<td>1.9%</td>
<td>1.04</td>
<td>.31</td>
</tr>
<tr>
<td>Mood Disorders With Psychotic Features</td>
<td>0.0%</td>
<td>7.5%</td>
<td>4.16</td>
<td>.06</td>
</tr>
<tr>
<td>All Disorders With Psychotic Features</td>
<td>75.5%</td>
<td>75.5%</td>
<td>.00</td>
<td>.59</td>
</tr>
</tbody>
</table>

a Given in percent of African American sample with the given diagnosis.
b Given in percent of Caucasian sample with the given diagnosis.
c Category includes all psychotic disorder diagnoses as well as all mood and substance use disorders with psychotic features.

Other hypotheses under investigation were that both African American and Latino defendants would be more likely than Caucasian defendants to be recommended to the
court as incompetent (Hypotheses 2 and 4). I ran a Chi-square analysis to test the relationship between ethnicity and competency status and found that 30.2% of the Caucasian defendants, 34.0% of the Latino defendants, and 47.2% of the African American defendants were recommended to the court as incompetent; thus, the results were in the expected direction though not significant. These differences between ethnic groups with regard to competency status were not found to be statistically significant ($\chi^2 = 3.61, p = .16$).

Taking a subpopulation of the sample, I further hypothesized that African American defendants with psychotic disorders would be more likely than Caucasian defendants with psychotic disorders to be recommended to the court as incompetent (Hypothesis 3). Because the aforementioned Chi-square analyses found no significant diagnostic differences amongst the different classifications of psychotic disorders, the following analysis was conducted with the population of Caucasian and African American defendants with any disorder involving psychotic features. Although more African American defendants were recommended to the court as incompetent as compared to Caucasian defendants (55.0% vs. 37.5%), this difference was not statistically significant ($\chi^2 = 2.46, p = .09$).

Another hypothesis investigated in this study was that Latino defendants would have significantly different diagnoses than Caucasian defendants (Hypothesis 5). The diagnostic breakdown according to ethnic group was presented previously in Table 1. The difference between Axis I diagnoses given to Latino and Caucasian defendants was significantly different ($\chi^2 = 9.85, p = .02$), such that Latino defendants were less likely than Caucasian defendants to have an Axis I diagnosis in any of the categories and were
more likely to receive no Axis I diagnosis. I conducted additional Chi-square analyses to test differences in diagnoses on Axis II. Neither diagnoses of personality disorders nor developmental disabilities differed significantly between the two groups of defendants ($\chi^2 = 2.65, p = .10$ and $\chi^2 = .15, p = .70$, respectively).

I further hypothesized that Latino defendants evaluated with the use of interpreters would be more likely to be recommended to the court as incompetent than Latino defendants evaluated without the use of interpreters (Hypothesis 6). In this sample, however, there were no significant differences in competency recommendation between those who were evaluated with the use of an interpreter and those who were not ($\chi^2 = .09, p = .50$).

Along similar lines, I hypothesized that those Latino defendants evaluated with the use of interpreters would be given significantly different diagnoses than those Latino defendants evaluated without the use of interpreters (Hypothesis 7). Because the sub-sample used to test this hypothesis consisted of only 52 individuals, the previous diagnostic breakdown for Axis I could not be used due to low cell counts. Instead, the analysis was simplified to compare the following three categories: absence of an Axis I disorder, presence of a psychotic disorder, and presence of an Axis I disorder other than a psychotic disorder. Overall, the Axis I diagnoses given to the defendants did not differ significantly between those who were evaluated using an interpreter and those who were not ($\chi^2 = 3.98, p = .14$). In addition, there were no differences among these two groups with regard to personality disorder diagnoses ($\chi^2 = .22, p = .64$) or developmental disability diagnoses ($\chi^2 = .35, p = .55$).
A logistic regression was considered to determine the effect of ethnicity on competency status while other variables previously shown to be related to competency were controlled. Because the Chi-square analysis involving ethnicity and competency status showed that there was no relationship between these variables in this sample, the logistic regression was not run.

Additionally, the role of evaluator experience in competency status was also explored. Because not all evaluators returned questionnaires, data were available on evaluator experience for only 58 of the 159 reports used in the study. Evaluator experience was defined as high or low depending on the years of experience as a forensic evaluator, such that four or more years of experience was categorized as high and less than four years of experience was categorized as low. Looking at all 58 cases in which data were available for evaluator experience, no significant relationship was found between evaluator experience level and competency status ($\chi^2 = 1.12, p = .37$). Analyses of the influence of evaluator experience on competency status for the different ethnic groups represented were not run due to low cell counts.
DISCUSSION

The purpose of this study was to examine the role that race and ethnicity play in competency to stand trial evaluations. Previous researchers have consistently shown some differences in the prevalence rates of diagnoses between African Americans and Caucasians, particularly with regard to psychotic disorder diagnoses. Additionally, researchers have consistently found relationships between diagnostic variables and competency status, such that those defendants diagnosed with psychotic disorders are more likely than those diagnosed with other disorders to be found not competent to stand trial. Few researchers have looked at these two lines of research in combination, and those who have looked at both have come to inconsistent conclusions. In this study, the combination of these lines of research were looked at in depth and expanded to include Latino defendants, whereas previous researchers had only focused on African American and Caucasian defendants. This research is especially important because ethnic minority individuals are more often than not over-represented in the defendant role, and ethnic majority individuals are more often than not over-represented in the evaluator role. A situation with this type of power differential lends itself to possible influences of racial and ethnic biases in the evaluation process and therefore the onus is on the evaluators to show that these evaluations are conducted as accurately as possible, regardless of the race or ethnicity of the defendant.
Of the seven original hypotheses proposed, the only one that was confirmed by the results of this study was that there were diagnostic differences among the Latino and Caucasian defendants. The exploration of this hypothesis and its relationship to other literature on diagnostic differences amongst Latino populations will be discussed below. All other hypotheses relating to differences between ethnic minority defendants and Caucasians on variables of competency status, diagnosis, and the role of interpreters were not significant in this sample. These results appear to be incongruous with previous research, specifically with regard to differences in diagnosis and competency status between African Americans and Caucasians. Possible explanations for these differences include sample variation and methodological differences. Following my exploration of these differences, I discuss the limitations of this study and make recommendations for future research.

Diagnostic Differences Between Latino and Caucasian Defendants

I hypothesized that there would be significant differences in the diagnoses of Latino and Caucasian defendants and found that this indeed was the case. The primary difference when comparing these two ethnic groups was that the Latino defendants were less likely to receive any diagnosis than Caucasian defendants. On each of the diagnostic categories I compared (psychotic disorders, mood/anxiety disorders, and other Axis I disorders), Caucasian defendants received the diagnoses more frequently than did Latino defendants. Due to limited prevalence rates of diagnoses other than psychotic disorders, I was unable to make a more detailed comparison than the broad categories previously mentioned. This result could reflect a true difference between the two ethnic groups (i.e., Latinos may have less psychopathology or are hospitalized for other reasons); however,
there are a number of alternative interpretations that could also explain this result and therefore should be explored.

One alternative explanation for the lack of Axis I diagnoses among the Latino defendants as compared to Caucasian defendants could represent a trend toward under-diagnosis of mental illness in this ethnic group. The fact that my study involved English-speaking Anglo clinicians fits with Malgady and Constantino’s (1998) research in which they found that this group of clinicians gave the least severe diagnoses, in comparison to English- or Spanish-speaking Hispanic clinicians. However, this explanation does not appear to fit with some of the other studies that have looked at diagnosis in Latino populations. Some researchers have found higher rates of symptoms and diagnoses rather than lower rates. Differences that have been documented include Latinos having higher rates of depression (Mathews et al., 2002; Minsky et al., 2003), higher rates of psychotic symptoms (Whaley, 1998), and more intense expressions of anxiety (Coelho et al., 1998) than Caucasians. Even though these studies do not present consistent symptom or diagnostic differences, they all present a consistent finding of more pathology among Latinos than Caucasians. Information was not provided about the ethnic background of the clinicians rating symptoms in these referenced studies.

Another alternative explanation could be that there are differences among the ethnic groups in terms of who is referred to the state hospital for competency evaluations. Pinals et al. (2004) researched ethnic differences in referral rates and found that Hispanic defendants were more likely than White defendants to be referred for pretrial evaluations at a strict-security facility, even with diagnosis and criminal charges statistically controlled. In the current study, defendants were committed to the most secure facility the
state has to offer for restoration of competency. The one problem with this logic is that the data for this study came from reports written after the court already deemed the defendant incompetent and committed the defendant to the state hospital for restorative purposes. Consequently, the difference would have to be in both the referral process and the first evaluation that was used by the court to deem the defendant incompetent, and it is to this latter issue that I now turn.

The final alternative explanation could be that there are differences between evaluations completed to raise competency as an issue and evaluations completed after the defendant has already been committed to the state hospital. There is currently no research that could help identify what these differences might be, but there are numerous differences that one could speculate about simply by taking a critical look at the process. For example, the first evaluation would likely occur while the person was still incarcerated, while later evaluations would be most likely to occur in the state hospital. The two different evaluations, then, may be influenced by how the defendant reacts to being in these two very different settings. The defendant could potentially appear more pathological in a jail or prison setting because of environmental or cultural issues than the same defendant would appear in a hospital setting, as well as because they have received mental health treatment longer by the time they are evaluated in the hospital as compared to the evaluation in the jail or prison. Finally, there could be differences in the types of evaluators conducting evaluations to raise the issue of competency to the court and the evaluators at the state hospital. These differences could include the fact that the state hospital evaluators are paid by the state in salary or contract, regardless of whether they are asked to conduct evaluations by the prosecution or the defense. The pressure they
face is often less from the side that retained them and more from the pressure to reduce the population in the hospital. Private practice evaluators, on the other hand, get paid directly by whom they were retained on a per evaluation basis; therefore, they tend to be more conscious of whether they are working for the defense or the prosecution than are state hospital evaluators. Other speculated differences could include the types of defendants the evaluators typically see with state hospital evaluators typically seeing defendants with psychotic symptoms and private practice evaluators typically seeing a wider range of pathology. Of course all of these, and potentially other differences, are purely speculation as researchers have yet to look into these differences; however, there is a sufficient number of potential differences to consider that the evaluations conducted to raise competency as an issue in typically a jail setting may be different from those conducted in the state hospital setting once the defendant has already been deemed incompetent and committed to the state hospital for restoration.

Sample Variation

In order to examine potential reasons why my study did not replicate the findings of other studies examining ethnicity, diagnosis, and competency among pretrial defendants (specifically that African Americans were more likely to be diagnosed with psychotic disorders and more likely to be recommended to the court as incompetent), I first compared my study sample to those used in other studies. I looked for potential differences in the representation of minority defendants, gender of defendants, age of the defendants, overall percent recommended to the court as incompetent, and evaluator differences.
In my study, I focused on comparing equal numbers of the three ethnic groups and thus my sample was 66.7% ethnic minority defendants, with equal proportions of African American and Latino defendants. For analyses comparing only two ethnic groups, the percent of minority defendants would therefore be 50%. This latter comparison is similar to the two most recent studies published in 2003 by Caldwell et al. and Cooper and Zapf. Both sets of researchers compared only two ethnic groups, African Americans and Caucasians, and the percentage of African Americans in their samples was 45.5% and 58%, respectively. Earlier studies used much less balanced samples. Ho’s (1999) sample consisted of 68% African American, 2% Hispanic (which was removed for analyses due to the low percentage), and 29% White. Hart and Hare’s (1992) sample consisted of 10% ethnic minority individuals of primarily indigenous North American heritage. No African Americans were included in this study. Finally, in Nicholson and Kugler’s (1991) meta-analysis, the average percentage of ethnic minority individuals across 19 studies was 36.6%. No information was given as to which ethnicities made up this minority category. Based on this variety of sample percentages of ethnic minority defendants, with no clear pattern of one ratio leading to a particular outcome, this variable does not appear to account for the differences found in my study.

With regard to gender, the current study sample was 83% male, which is consistent with the two most current studies whose samples ranged from 82% to 84% male (Caldwell et al., 2003; Cooper & Zapf, 2003). Older studies appeared to have slightly higher percentages of males in their samples, with Nicholson and Kugler (1991) reporting the average across 28 studies conducted over a 25-year period as 89.5%. This may reflect the changing gender breakdown in the criminal justice system in recent years,
as the Bureau of Justice Statistics (2006) reported increases in the percent of women in both state prisons and local jails. Because my sample is similar to the two modern studies looking at the relationship between competency status and ethnicity, it does not appear that gender is contributing to the difference in results.

With regard to age, my study sample was somewhat older on average (35.3 years) than were the samples used in other studies. In Nicholson and Kugler’s (1991) study, the average age across 22 studies was 30.2 years. In Ho’s (1999) study, the majority of individuals in the sample were younger than 30 years old. In Hart and Hare’s (1992) study, the average age in the sample was 32.6 years. Caldwell et al. (2003) presented separate average ages for males and females as 33 years and 37 years, respectively. In my study, the averages separated in similar fashion were 36 for males and 34 for females. Cooper and Zapf (2003) also presented separate averages, but instead of using gender they used competency status and reported an average age of 31.1 years for defendants recommended to the court as competent and 34.5 years for defendants recommended as incompetent. In my study, the averages separated in similar fashion were 34 for defendants recommended as competent and 37 for defendants recommended as incompetent. Because age has been shown in previous studies to be related to higher rates of incompetency (Cooper & Zapf, 2003, Nicholson & Kugler, 1991), having a slightly older sample in this study may have led to higher base rates of incompetency and thus less possibility of finding differences across ethnic groups.

Indeed, when comparing the percentage recommended to the court as incompetent in my sample to those of previous studies, I found a slightly higher rate (37.1%) than the majority of other studies. Nicholson and Kugler (1991) found an average across 29
studies of 30.6% recommended to the court as incompetent. Hart and Hare (1992) found a similar rate at 31.3% recommended as incompetent. The two most current studies conducted by Caldwell et al. (2003) and Cooper and Zapf (2003) found much lower rates at 17.9% and 18.9%, respectively. The only study with a higher percentage was Ho’s (1999) study, in which the rate of incompetency recommendation was 74%. This was largely due to the fact that each defendant in the sample was significantly cognitively impaired. Ho (1999) also did not find a relationship between African American ethnicity and competency status, which may be due to the high rate of incompetency recommendation in the overall sample that there was little room for differences based on ethnicity. Besides having a slightly older sample, this higher rate of incompetency may also be related to the fact that most other studies collected data from reports written about the first evaluation of competency, when the issue was first raised, rather than the reports written after the defendants were already committed to the hospital. This higher base rate of incompetency in this study as compared to previous studies makes it less likely to find significant differences across ethnic groups.

One final hypothesis for differences among the samples used in my study versus other studies is differences in the evaluators who write the reports and make the competency recommendations. Unfortunately, other studies did not report information on the evaluators and thus I was not able to compare the evaluators from my sample to those of others’. This is therefore a variable that may be explored in future studies, especially given the differences found by Malgady and Constantino (1998) in diagnosis by evaluators of different ethnic groups.
In summary, I looked for potential differences in the representation of minority defendants, gender of defendants, age of the defendants, overall percent recommended to the court as incompetent, and evaluator differences in order to evaluate whether sample variation between my study and previous studies could account for the difference in findings. There did not appear to be consistent differences that would account for the different findings related to the representation of minority defendants or the gender of defendants. Other studies did not provide much information about the evaluators and thus, this variable could not be assessed. The primary differences that were found related to sample variation were the age of defendants and base rates of incompetency. My study sample was older overall and had higher rates of incompetency. In addition, these variables may be related as previous researchers have shown that age is positively associated with incompetency (Cooper & Zapf, 2003; Nicholson & Kugler, 1991). Higher base rates of incompetency overall, whether due to an older sample of defendants or some other variable, would likely decrease the potential for finding differences across ethnic groups because it reduces the ability to improve upon predictions using base rates alone. Consequently, the high base rate of incompetency may have contributed to the lack of significant findings related to ethnic differences in this study.

Methodological Differences

Another area I examined for potential reasons as to why my study did not replicate the findings of other studies was methodological differences across studies. More specifically, I looked for differences in method of data collection, sample size, setting in which the data was collected, and time at which the data was collected.
In my study, the overall method of data collection was coding archival reports of competency to stand trial evaluations. This method appears to be the most common method utilized by studies examining competency and I was unable to find any other studies with a different method of data analysis. In addition, all studies I found utilized the recommendations made to the court given in the reports rather than using judges’ opinions to determine competency. The high percent of agreement between the two sources of information makes it appropriate to use the reports as the source of competency information, which are much easier to access than judges’ opinions. Consequently, general methodological strategies did not likely influence the differences in results between my study and others’.

With regard to sample size, my study sample included reports on 159 defendants evaluated for competency to stand trial. There was only one study on the relationship between ethnicity and competency status that had a sample size smaller than this. Hart and Hare (1992) used a sample size of 80 and did not find a relationship between ethnic minority status and competency recommendation. The sample sizes of the other studies ranged from 272.3, the average sample size across 30 studies reviewed by Nicholson and Kugler (1991), to 468 in Cooper and Zapf’s (2003) study. Consequently, one major factor that could have contributed to the lack of significant differences is that the relationship between ethnicity and competency status may be too small to be found in a sample size of 159.

Characteristics of the setting I considered for potential differences included the area of the country and the type of facility in which the data were collected. One reason that the area of the country the research was conducted in may matter is that state statues
defining competency may differ. Another reason location of data collection may matter is that the culture of the area may influence perceptions of ethnic minority individuals. The three American studies (Hart & Hare, 1991, was a Canadian study and the ethnic minorities were primarily of indigenous heritage) that looked at African Americans as the only ethnic minority group in their research took samples from Florida (Ho, 1999), Missouri (Caldwell et al., 2003), and Alabama (Cooper & Zapf, 2003). All of these states have higher percentages of African Americans in their state according to the U.S. Census Bureau (2007), with Missouri’s population at 11.5% African American, Florida’s population at 15.7% African American, and Alabama’s population at 26.4% African American, than does Oregon, with a population of 1.8% African American, where my research was conducted. With this smaller percentage of African Americans in the general state population, it could be hypothesized that evaluators’ everyday experiences outside of the hospital with African Americans are likely to be few and thus their cognitive associations with the population might be more highly linked to stereotypes than evaluators in other states where they are more likely to have other interactions with African American individuals. This hypothesis, though, is not supported by the data as there were no significant difference in diagnosis or competency status between African Americans and Caucasians. Consequently, it is unclear how this lower percentage of African Americans in the state population would lessen the effect of diagnostic or competency status differences.

In terms of the type of setting in which the data were collected, this could influence the results because defendants seen in outpatient versus inpatient settings, as well as defendants seen in public versus private settings, may be considerably different.
based on severity of symptoms and amount of resources. In my study, I collected data from an inpatient public hospital. Information on each of these variables was not consistently available in each of the other studies. Nicholson and Kugler (1991) reported that the majority of studies in their meta-analysis used samples from inpatient settings; however, they did not identify whether these were publicly or privately run facilities. Ho (1999) reported that their data were collected from a unit within a state hospital and thus was a public inpatient setting. Cooper and Zapf (2003) stated that they collected data from a "state secure facility," which is a public and most likely an inpatient setting. Finally, Caldwell et al. (2003) reported that they collected data within a community mental health outpatient clinic. Because these settings were largely similar in that they are mostly public and inpatient settings, with the only exception being Caldwell et al. (2003), it is unlikely that these factors differentially influenced the results.

In recent years, the field of psychology has emphasized multiculturalism and diversity awareness. Additionally, over time there can be cultural changes with regard to race issues. Because of the possibility that the practice of mental health professionals is influenced by these two factors, I examined the time of data collection as a potential variable contributing to differences between the results of my study and others. I collected data from reports written between 2003 and 2006 and thus my data are the only data to be collected following the release of the American Psychological Association's Multicultural Guidelines in 2002. Caldwell et al. (2003) had the most recent data prior to my study, from 1998-2001. The dates of other studies as follows: Cooper and Zapf (2003) collected data from 1994-1997; Ho (1999) collected data from 1977-1997; Hart and Hare (1992) collected data from 1986; and Nicholson and Kugler (1991) collected
data from studies conducted over a 25-year period beginning in the 1960s, with the majority of studies conducted in the 1980s. This is not to say that the publication of the Multicultural Guidelines themselves would be the reason for a difference, but instead that there was increasing attention in training programs and continuing education programs related to diversity issues around the time of the publication of these guidelines. Based on this comparison, it is possible that my lack of findings of a connection between competency status and ethnicity is related to the increased awareness of evaluators with regard to diversity issues and/or changes in the culture over time.

In summary, I looked for differences in method of data collection, sample size, setting in which the data was collected, and time at which the data was collected in order to evaluate whether methodological differences between my study and previous studies could account for the difference in findings. No differences were found in terms of data collection method or type of facility in which it was collected that would account for the lack of significant results in my study. However, there were differences found with regard to sample size, percent of African Americans in the state population, and the time period of data collection. It is unclear at this time how the lower percentage of African Americans in the state would influence the results, but the smaller sample size and the more recent data may have contributed to the lack of significant findings in this study.

Study Limitations

The utility and generalizability of the results of this study are limited by a number of factors. First, I was unable to access all reports written during the study time period as a result of the limited clearance I was given by the agency. As a result, not all reports of Caucasian defendants were included in the pool from which I took a random sample.
Consequently, there may be unforeseen systematic biases introduced into the data taken from reports written on Caucasian defendants. I attempted to limit potential biases by stratifying my sample of Caucasian defendants by year, in the hope of controlling for variation in reports over time (e.g., different evaluators in different years, different directors of the department having different expectations for reports, etc.); however, there still may be other systematic biases introduced as a result of this limited clearance.

Another limitation of this study is that, although the reports that were coded were the first evaluations at the state hospital after having been committed due to incompetency to stand trial, they were not the first evaluations of competency for the defendants. As described by Melton et al. (1997), typically when an attorney first raises questions regarding a defendant’s competency to stand trial, the trial court will order an evaluation at that time, and then the court will use this evaluation to help decide whether or not to find the person incompetent to stand trial. It would only be after this finding that the person would have been committed to the state hospital for rehabilitation. The fact that there would have been a report submitted to the court prior to the one used in this study indicates that an opinion about the presence of a mental illness and an opinion about the defendant’s capacity to stand trial would already be on record and could potentially influence the evaluator writing future reports. It could also mean the defendants are more likely truly incompetent by the time they are evaluated at the hospital, with less variation than initial evaluations. Past studies have most frequently used the true first report submitted to the court (e.g., Cooper & Zapf, 2003) and thus this study is limited in its ability to be compared to past research.
A final limitation of this study is the small pool of reports on ethnic minority defendants from which I could sample. As previously mentioned, only 19.2% of the admissions during the study time period were for ethnic minority defendants and this included some ethnic minority defendants admitted on more than one occasion. Because reports on defendants of ethnic groups other than African American or Latino only made up 3.2% of the reports, I was unable to include reports on defendants of other ethnic groups (e.g., Asian American, Native American, etc.) or of mixed ethnic backgrounds.

Future Research

The findings, as well as the limitations, of this study reveal a number of variables that future researchers in this field should address. Gender appears to be one such variable that could warrant further attention. In this study, there were differences in the gender ratio between the three ethnic groups and thus there appear to be some differences either in which groups of women are more often referred for evaluations (i.e., seen as more pathological) or in prevalence rates across groups of mental illnesses that interfere with the capacity to stand trial. Another variable worthy of additional attention is potential differences in the multicultural competency or diversity awareness of evaluators and how that training then influences their evaluations and reports. In addition, little research into competency has utilized the first evaluation of the defendants for competency. It therefore may be beneficial to look at a wider variety of influences earlier on in the process that play a role in raising the issue of competency, which would usually occur prior to evaluations completed in a state hospital setting where the vast majority of research has been conducted thus far. Another final variable that may be useful to attend to in future research would be a comparison of reports taken from a variety of
geographical locations around the United States with different concentrations of ethnic minority individuals. This could reveal any potential differences that result from varying regional demographics and how “minority” the defendants of different ethnic groups might be in a particular locale. Finally when comparing the current study to previous studies several areas of difference were noted including higher base rates of incompetency, older participants’ age, smaller sample size, and more recent time period of data collection. These variables should be explored to determine if they do indeed have an impact or are unrelated to competency decisions.

Summary

Using a combination of two lines of research, looking at ethnicity and diagnosis as well as that looking at diagnosis and competency status, I examined the role that race and ethnicity play in competency to stand trial evaluations. Previous researchers who have looked at these two lines of research have found mixed results. In this study, I found no statistically significant evidence for a direct relationship between ethnicity and competency status. This study went beyond previous research in adding Latino defendants as compared to Caucasian defendants, rather than looking only at the comparison of African American defendants to Caucasian defendants. It was in this area that I found evidence supporting one of the original hypotheses, in that Latino defendants received different diagnoses than Caucasian defendants. Combining the results of this study with the body of literature already compiled on this issue, it is likely that a relationship between competency and ethnicity exists, but in a small and indirect manner such that it is difficult to detect in small-scale studies. Future research would best be directed toward large-scale projects to look for small, yet potentially systematic
difference in the competency evaluations of ethnic minority and ethnic majority defendants.
REFERENCES


August 4, 2005, from


# APPENDIX A

## DISSERTATION DATA CODING SHEET

### DEMOGRAPHIC INFORMATION

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### EVALUATION INFORMATION

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</tr>
<tr>
<td>Ability to understand the nature of the proceedings:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ability to assist and cooperate with counsel:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ability to participate in the defense of the defendant:</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### DIAGNOSTIC INFORMATION

<table>
<thead>
<tr>
<th>Axis I:</th>
<th>__________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis II:</td>
<td>__________</td>
</tr>
<tr>
<td>Axis III:</td>
<td>__________</td>
</tr>
<tr>
<td>Axis IV:</td>
<td>__________</td>
</tr>
</tbody>
</table>

- [ ] Pending legal charges
- [ ] OSH inpatient status
- [ ] Lack of social support

<table>
<thead>
<tr>
<th>Axis V:</th>
<th>________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mental Disease or Defect listed in competency opinion statement:</th>
</tr>
</thead>
</table>