Beyond Cognition: The Role of Disordered Affective States in Impairing Competence to Consent to Treatment

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Most of the criteria for competence in current use emphasize cognitive rather than affective dimensions. Our clinical experience indicates that affective disorders may impair competence in a detectable and identifiable way. In particular, patients with major affective disorders can retain the cognitive capacity to *understand* the risks and benefits of a medication, yet fail to *appreciate* its benefits. A case study of a pathologic grief reaction is introduced to illustrate how cognitive and affective impairments may coexist and require separate remedial strategies for restoration. Further empirical work on the role of affective disorder in impairing competence is warranted and planned.

While the legal finding of competency is a determination made only by a judge, psychiatric formulations and input play a central role in contributing to this determination. What has traditionally made the assessment of competency a complex and difficult undertaking is the fact that—with few exceptions such as competence to stand trial and testamentary capacity—precise standards have never been articulated for just what constitutes competency in relation to particular acts, tasks, and choices. More specifically, while the criteria for competency to stand trial are relatively explicit,[1] the precise aspects of competency involved in consenting to various forms of medical treatment are undefined, ambiguous, or inconsistent among authorities and practitioners. Furthermore, in the clinical practice of an individual practitioner, these precise aspects may well vary from case to case depending on such context variables as degree of risk of options and amount of time available to assess competency.[2] More importantly, the extent models have tended to emphasize cognitive processes as the sole elements of

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competence. The role of affect and of affective disorders in impairing competence has been scanted.

This relative neglect of affect, affective state, and the presence of affective capacity or disorder as factors influencing the competence of a decision maker to consent to treatment can perhaps be best understood as a remnant of an antiquated mechanistic model (or paradigm) of rationality and the image of the rational decision maker.[3] Such a paradigm considers the ideal decision maker to be one who decides in the absence of affect and affective factors. The presence of affect is treated as a force that hopelessly contaminates competence for rational decision making.

The view we here illustrate is that decision makers under conditions of uncertainty are inevitably bound to engage in an affect-laden decision-making process.[4] In fact, free-ranging access to one's own affective states is a necessary prelude to a decision-making process that involves the evaluation of risks and benefits of treatment outcomes. This probabilistic paradigm takes, as *its* measure of the rational decision maker, the latter's ability to access, reflect upon, integrate, and communicate the variety of affective states aroused in assessing the relative value of particular treatment outcomes under conditions of uncertainty. An implication of the foregoing is that—while the presence of affective disorder may, under certain circumstances, impair the decision maker's competence to consent to treatment—the mere presence of an affective dimension is expectable and, perhaps, desirable.

It is thus our thesis that affective states may influence (and affective disorders may impair) competence in a detectable and identifiable way, primarily influencing the meaning and weight given to treatment risks and benefits, such that the patient may be unable to appreciate the "benefits" side of the equation, or may become unduly concerned about risks.

Some Models of Competence Assessment

A number of authorities[3,5] are in relative agreement that the presence of particular capacities constitutes reasonable competence to consent to treatment. These include several abilities: to assimilate information; to weigh risks and benefits of the proposed treatment plan; to consider the risks and benefits of alternative treatments; and, finally, to weigh the risks and benefits of no treatment at all. What is noteworthy in these determinations is that they involve dynamic processes of weighing, assimilating, and considering, as well as substantive contents (that is, the actual risks and benefits).

Extending these themes somewhat further, Roth and colleagues[6] have discussed the dilemma of denial in relation to competence and treatment refusal. They describe the case of a paranoid woman who insisted that she was not ill and therefore required no treatment. As is common in paranoid conditions, her cognitive functioning remained intact in

many areas (compare ref. 7)). The authors note:

> . . .to evaluate [this patient] as having the capacity to make treatment decisions can be said to give undue weight to a single area of mental functioning, that of cognitive understanding. Her intellectual understanding of the risks, benefits, and alternatives to the proposed treatment, however thorough, cannot have meant the same thing to her as it would have to a person who believed that this information was directly relevant to him or her. Cognitive understanding appears to be an insufficient measure of the individual's capacity for interpreting his or her situation (pp. 912–3).

Extending the discussion somewhat, Appelbaum and Roth[8] have outlined the ways in which a number of diverse psychological factors can bear upon a person's competency: (1) psychodynamic elements of the patient's personality, (2) the accuracy of the historical information conveyed by the patient, (3) the accuracy and completeness of information given to the patient, (4) the stability of the patient's mental status over time, and (5) the effect of the setting.[7] While affective issues may be implicit in criteria nos. 1, 4, and 5, the authors make no direct mention of the possible role of the patient's affect in impairing competence.

An Illustrative Case

The patient, a 72-year-old, retired college professor, hospitalized while symptomatic with an aortic aneurysm and in severe congestive heart failure, was seen by a psychiatrist consulting to the attending surgeon regarding the patient's competence to refuse resection. While denying depression, the patient's affect was clearly constricted and he admitted to a three week history of weight loss, fatigue, anhedonia, early morning awakening, and indecisiveness. The patient was able, in a dead-pan way, to recite (by referring to his notes) the list of risks and benefits regarding the proposed operation that had been clearly communicated to him by his attending physician. Although suffering from a clear short-term memory impairment and impaired concentration, he was able to compensate by taking notes when the physician gave him information. He even went so far as to reproduce a drawing of the resection that had been shown to him by the surgeon. However, he was adamant that, for him, the operation would be tantamount to a death sentence. Even if the resection were successful, he stated that life had no joy for him and that he did not expect this to change, even with reversal of his congestive failure.

Further exploration revealed that the patient's wife had died, unexpectedly, 15 years ago, following what was considered a relatively risk-free minor operative procedure. Unresolved grief over her loss colored the patient's appreciation of risks and benefits aside from any cognitive evaluation. When the psychiatrist asked to hear more about the wife, he was told she was an architect who in her personal and professional life exercised a quick, dead-pan style of wit. The psychiatrist responded by saying, "You sounded a lot like the way you describe her now when we were talking before about this operation." This brought a flood of tears from the previously reserved patient, followed by an acknowledgement of the deep sense of loss contained in his unacknowledged iden-

tification with her. At a follow-up visit, the patient reported that he had had "my first full night's sleep in weeks", and was "feeling more alive, more here." The patient expressed a range of affects including anger over his illness, fear of surgery, and humor about the existential situation of being aware of risks and benefits under conditions of uncertainty in which one is asked to contemplate the value of one's life and the different varieties of good lives and death. He proceeded to reverse his refusal and to choose to go ahead with the operative resection.

Discussion

In the case we have just discussed, the patient himself had found an effective strategy for resolving impaired cognitive competence: note taking. However, it required the psychiatric intervention, grief work, to assess and restore that dimension of competence impaired by affective disorder. This case also extends Freedman's description[9] of the ways in which a person may fail to produce "recognizable reasons" for a particular decision. Freedman cites two predominant aspects of incompetent reasoning: false premises and non sequitur conclusions. The latter (non sequiturs) are seen most frequently in cognitive disturbances. The former (false premises) encompass two forms of incompetence found in patients with severe affective disorders.

The first is the false premise of fixity more typical of the depressed state, based on the feeling of hopelessness (i.e., the erroneous prediction that one's mood will never change). The second aspect of incompetence is one commonly found in manic patients in our experience: an emotionally involving, self-convincing preoccupation with the risks of treatment coupled with denial of the benefits. Thus, affective disturbances in both mania and depression as well as in other affectively altered states such as unresolved grief may influence competence.

The model of the reasonably competent patient we propose places an even greater emphasis on the availability of a full range of affects to the patient. As noted elsewhere,[4] the assignment of values to outcomes (i.e., assessing their clinical utility) is context dependent. The assessment of the clinical utility of an outcome is far more likely to be a process of reasoning by analogy and association than by propositional logic. Given this fact, a constriction of affect, or its skewing in the direction of despair, can lead to an impairment via undervaluing positive outcomes and a "tunnel-vision" focus on negative outcomes.

Competence assessment is subject to two types of standard errors: competence misassessed as incompetence and the reverse. Both types of errors can lead to the same tragic outcome: diminution of the patient's autonomy. Whether such autonomy is diminished by inappropriate and inaccurate assessment as competent or incompetent, the opportunity for treatment designed either to support existing competence or to restore absent competence is significantly diminished.

Clearly, a number of factors can impinge on a patient's capacity to weigh

risks and benefits. Soskis[10] discovered that paranoid schizophrenic patients selectively retained in memory the negative effects (risks, side effects) of antipsychotic medication, but retained far fewer of the benefits. While this finding would suggest, as did Roth *et al.*'s[6] article noted earlier, that paranoid conditions, perhaps schizophrenia in particular, might be likely to constitute the largest population of treatment refusers, a multicenter study[11] from Massachusetts suggests that it is patients with affective disorders that appear to dominate the treatment-refusing sector.

To digress briefly, note that these data do not yet permit concluding that denial is the critical mediating psychological mechanism in those patients. We have elsewhere[7] suggested that manic denial is one of several states posing particular difficulty for assessment of the patient's competence and presentation of the clinical basis for a court opinion as to incompetence and the need for guardianship.

It has been demonstrated that laypersons have a lower threshold than medical professionals for demanding the explicit specification (in terms of both frequency and severity) of side effects of medications;[12] they are risk-sensitive. We hypothesize that individuals with affective disorders ranging from unresolved grief reactions to organic affective syndromes may exceed normal laypersons[12] (and may resemble paranoid patients) in their preoccupations with the negative side effects of medications, even while they are less disposed to credit the therapeutic benefits of the same medications because of their affective state. This imbalance may lead to decision-making that is itself unbalanced, i.e., incompetent. While cognitive impairments in affective disorders have been well described,[13] our case illustrates affective impairment and a consequent state of affective incompetence independent of the more easily compensable cognitive impairments. Our recommendations regarding competency assessment can be best understood in keeping with our earlier work regarding the movement of informed consent from a *pro forma* to a *process* model.[14] Once competency assessment is understood as a dynamic process rather than a mere test, the role of affect and range of affect in the determination of competency becomes central. Moreover, the assessment becomes linked to an overall process designed to enhance the patient's autonomy.[15]

We hope that empirical work will shed light on the important question of the role of affective disorder in impairing competence. Such information is crucial for the clinical treatment of affectively disordered patients. Moreover, where such treatment fails to restore affective competence, it is essential for clinicians to become familiar with these affective issues, so that they can be clearly presented to courts involved in competence assessment. Only thus can patients be spared the negative consequences of being found falsely competent, their true incompetence unrecognized and untreated.

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References

1. Dusky v. U.S., 362 US 402 (1960) (per curiam)
2. Roth LH, Meisel A, Lidz CW: Tests of competency to consent to treatment. Am J Psychiatry 134:279–84, 1977
3. Bursztajn HJ, Feinbloom RI, Hamm RM, Brodsky A: Medical Choices, Medical Chances: How Patients, Families and Physicians Can Cope with Uncertainty. New York, Routledge, 1990
4. Bursztajn HJ, Hamm RM: The clinical uses of utility assessment. Med Decision Making 2:162–5, 1982
5. Appelbaum PS, Gutheil TG: Clinical Handbook of Psychiatry and the Law (ed 2). Baltimore, Williams and Wilkins, 1991
6. Roth LH, Appelbaum PS, Sally R, *et al.*: The dilemma of denial in the assessment of competency to refuse treatment. Am J Psychiatry 139:910–3, 1982
7. Gutheil TG, Bursztajn H: Clinicians' guidelines for assessing and presenting subtle forms of patient incompetence in legal settings. Am J Psychiatry 143:1020–3, 1987
8. Appelbaum PS, Roth LH: Clinical issues in the assessment of competency. Am J Psychiatry 138:1462–7, 1981
9. Freedman B: Competence, marginal and otherwise: concepts and ethics. Int'l J Law Psychiatry 4:53–72, 1981
10. Soskis DA: Schizophrenic and medical patients as informed drug consumers. Arch Gen Psychiatry 35:645–7, 1987
11. Hoge SK, Appelbaum PS, Lawlor T, *et al*: A prospective multicenter study of patients' refusal of anti-psychotic medication. Arch Gen Psychiatry 47:949–56, 1990
12. Keown C, Slovic P, Lichtenstein S: Attitudes of physicians, pharmacists, and laypersons toward seriousness and need for disclosure of prescription drug side effects. Eugene, OR, Decision Research Report 81-6
13. Beck AT: Depression: Causes and Treatment. Philadelphia, University of Pennsylvania Press, 1970
14. Bursztajn HJ, Gutheil TG, Cummings B: Legal Issues in Inpatient Psychiatry: Diagnosis and Treatment (ed 3). Edited by Sederer L. Baltimore, Williams and Wilkins, 1991
15. Deaton RJS, Colenda C, Bursztajn HJ: Medico-legal issues in consultation-liaison psychiatry, in Principles of Medical Psychiatry. Edited by Fogel BS, Stoudmire A. New York, Grune Stratton, in press, 1992