How does one scientifically verify a psychometric instrument designed to assess the mental competence of medical patients who are asked to consent to medical treatment? Aside from satisfying technical requirements like statistical reliability, results yielded by such a test must conform to at least some accepted pretheoretical desiderata; for example, determinations of competence, as measured by the test, must capture a minimal core of accepted basic intuitions about what competence means and what a theory of competence is supposed to do. The concepts of “face validity” and “content validity” are both important here. Face validity “indicates that an instrument appears to test what it is supposed to and that it is a plausible method for doing so” (Portney and Watkins 2000, 82). Content validity “means that the test contains all the elements that reflect the variable being studied” (Portney and Watkins 2000, 83). An adequate instrument for measuring mental competence must at minimum satisfy both of these requirements.

What Tan and her colleagues (2006) have shown is that the MacArthur Competence Assessment Tool—Treatment (MacCAT-T) test for mental competence may not be an empirically valid measure of mental competence for some cases of anorexia. The data they report show that “competence,” as measured by the MacCAT-T, does not conform sufficiently well with what is wanted of a clinical medical theory of competence. More specifically, the MacCAT-T is deficient in both face and content validity. This result is extremely significant; previous challenges to the validity of the MacCAT-T have often been largely theoretical in nature. My own objection that the MacCAT is inadequate because it omits the influence of emotion is based on a combination of empirical theory (Charland 1998a) and philosophical argument (Charland 1998b). However, it is entirely theoretical in nature. So is my argument that in ignoring emotion the MacCAT misses a crucial contributing ingredient in competence, namely, value (Charland 2001, see especially 136 note 2). Tan’s study provides valuable empirical evidence for...
the second of these challenges, which deals more specifically with value. On the one hand, the study clearly demonstrates that patients sometimes do base their treatment decisions on reasons derived from values. And on the other hand, it also nicely illustrates the centrality of values—“utilities” or “preferences”—in the decision-making process generally; a basic assumption of standard decision theory for which, paradoxically, there appears to be no satisfactory counterpart in the MacCAT-T model of reasoning and decision making.

Thus, values figure among the reasons that patients actually use in reasoning when they weigh the risks and benefits of proposed treatment options. The MacCAT-T must be amended to incorporate this fact if it is to be a satisfactory clinical medical tool. Without such a correction, the concept of mental competence it measures is empirically invalid. At the root of the problem is a clash of intuitions. Tan’s data provide convincing evidence that some of the patients who are deemed to be mentally competent by MacCAT-T standards should not in fact be considered competent. Note that the language in which this clash is expressed—“should not in fact”—involves a combination of descriptive and prescriptive elements, reminding us that the concept of competence is dual in nature: it is both prescriptive and descriptive (Freedman 1981). These problems underscore the need for greater clarity about what pretheoretically we want a clinical theory and test of competence to capture. It is of course reasonable to say that such a test must be consistent with major tenets of the relevant case law (Appelbaum 1998). But a legally valid concept of competence of this sort is too thin and arbitrary a foundation on which to build a clinical medical theory of competence. An empirically valid theory and test of the latter sort must incorporate the role of values if it is be truly helpful in medical practice.

**Value and the MacCAT-T**

I agree with Tan and her colleagues that some notion of “pathological value” needs to be devised for the concept of value to function effectively in a clinical medical theory of competence. I also agree that the best way to proceed with this question is to focus on diagnoses of mental disorders that have clear behavioral, cognitive, and affective clinical consequences in the area of value. As Tan’s data show, in anorexia, thinness is usually pathologically overvalued. It is crucial that this pathology in valuation is not simply an idiosyncratic matter of personal choice and “lifestyle,” a mere social abnormality. In full-fledged chronic anorexia, the value of thinness acquires a different character. It also becomes a medical abnormality that is both caused and reinforced by the disease. Significantly, this medical abnormality in valuation varies with the incidence and severity of disease. When the disease is active, pathological overvaluation of thinness persists or increases. As the disease abates, the pathological overvaluation wanes and may even disappear. This variation between pathological overvaluation of thinness and the incidence and severity of anorexia strongly suggests that the overvaluation of thinness in anorexia is largely a medical abnormality, a causal consequence of disease. This can be contrasted with cases where overvaluing thinness is simply a matter of personal choice based on abnormal social preferences, which an individual can adopt or relinquish at will. Admittedly, some medical diseases may largely be caused by social factors, and anorexia is a case in point. But this does not annul the appropriateness of sometimes distinguishing between social and medical abnormalities in valuation, as Tan proposes.

In anorexia, the value of being thin becomes an addictive fixation that overrides all aspects of personal life. Negative consequences of illness behaviors are accompanied by denial and deception, and the natural course of disease tends to have the chronic relapsing character of chronic substance dependence. The parallel is worth exploring; in some respects, the emergence and persistence of pathological values in anorexia resembles what is known about traditional substance addictions. Severe substance dependence provides a clear and compelling example of a mental disorder that poses dramatic challenges for mental competence (Charland 2002). Chronic abuse of addictive substances can result in a descending spiral of dependence—“loss of control”—where the final overriding value around which all other
preferences gravitate is to seek and use addictive substances. The drug has been the dominant gravitational center of attraction in that person’s value system. As with anorexia, the pathology in valuation that results from addiction can be caused and reinforced by social factors and lifestyle choices. To that extent, it may be appropriate to refer to the unusual valuations involved in addictive behavior as a “social” abnormality. However, the overvaluation of addictive substances that occurs in addiction sometimes also develops into a medical pathology that is undeniably a result of the prolonged action of drugs on the brain (Leshner 1997). In that respect, addiction involves the emergence and persistence of “pathological” values in Tan’s medical sense.

There are evidently interesting parallels between how mental disorder can cause pathological valuations to occur in anorexia and addiction. These raise puzzling and fascinating questions for mental competence. One especially interesting aspect of those problems is the manner in which the emergence of pathological values in mental disorder can impact on personal identity and how that in turn impacts on competence. As Tan notes elsewhere, “insight and ability to make decisions, and even the authentic self, can be lost in certain stages of mental disorders” (Tan 2005, 92). Occurrences when competence is obviously impaired by pathological values that are caused by mental disorder may not be the only manner in which competence is compromised. There is also the question of whether over time a person suffering from a mental disorder that generates pathological values can be considered competent. Tan’s data contain examples of individuals who say that they have come to identify with their disorder and cannot imagine living without it. She questions whether a person who refuses treatment based on such reasons can really be considered to have made an “authentic” decision. Who is speaking in such a case? And whose values are in play? Tan’s study suggests that sometimes it is perhaps best to say that it is not the authentic self in control here, but rather “the anorexia talking” (Tan 2003; see also Charland 2004). A similar phenomenon can be argued to occur in addiction (Charland 2002) and depression (Rudnick 2002).

**Emotion and the MacCAT-T**

The philosophical and clinical case for the importance of values in understanding psychiatric disorder and diagnosis is now well established (Fulford 1989; Sadler 2004). One of the great merits of the work of Tan and her colleagues is the empirical demonstration that, for disorders like anorexia, this concern must be extended to mental competence. We have seen that are good reasons to include substance addictions among the class of disorders that raise difficult questions of value for mental competence. Further research in this domain requires both philosophical and empirical investigation into the concept of value. This requires more attention to emotion, which is both a source and expression of value. Other aspects of affectivity also have to be considered, such as emotional feelings and mood.

It is interesting that many of Tan’s study participants employ the language of “feeling.” They also allude to emotions when giving reasons for their putative decisions to accept or refuse treatment. This important phenomenon calls for further study and analysis. Probably it is related to the fact that affectivity is intimately intertwined with value. In their cognitive dimension, emotions often involve beliefs that serve as reasons for action. However, it is important not to forget that on their simpler affective dimensions, emotions also usually involve feelings that are interpreted and rationalized as beliefs that then serve as reasons. In addition, sometimes emotional feelings provide more direct input into action, without elaborate cognitive mediation.

The contribution of emotion to mental competence is therefore both a matter of emotional cognition and a matter of emotional feeling or perception, often both (Charland 1998a, 364, 373 note 3). The difference between these two dimensions of emotional functioning lies in the degree of conceptual sophistication of the mental states involved, as well as the nature of the underlying processes in which those states figure. Thus, affective states can differ in conceptual sophistication. And although some affective processes may be alterable in light of cognitive changes in belief and desire, others remain stubbornly “hardwired” despite attempts to change them. Evidently, the contribution of
emotion to mental competence raises difficult and complex issues. At the same time, it is clear that any clinical theory or test of mental competence that ignores emotion and other general elements of affectivity must be deemed empirically invalid from a clinical medical point of view.

It should be emphasized that there is no inconsistency in criticizing the MacCAT-T on the basis of the fact that, as a purely cognitive measure of competence, it omits the cognitive dimension of emotion; that is, emotional cognition. This criticism has been made by defenders of the cognitive exclusivity of the MacCAT-T (Appelbaum 1998). Two points can be made in response to the criticism. First, the objection overlooks the fact that cognition and emotional cognition are different, which is precisely the point of positing and developing so-called “cognitive theories of emotion” (see e.g., Lazarus 1991; Ortony, Clore, and Collins 1988). Second, affective states generally involve both emotional cognition and emotional feeling or perception (Damasio 1994). Whether these aspects of emotion are considered jointly or separately, both are equally relevant to competence, as defenders of the role of emotion in competence have argued (Charland 1998a, 364 note 3). Focusing on one for the purposes of discussion by no means negates the importance of the other; both are equally central to emotional functioning.

In conclusion, there are good reasons for including value and emotion in mental competence and Tan’s results suggest we must. However, there are also reasons to be cautious. Factoring value and emotion into mental competence may lead to a conception of competence that yields more determinations of incompetence than current conceptions that ignore those factors. Tan and her colleagues are understandably concerned about this, and I agree. However, many of these worries spring from the fact that our responses to findings of incompetence are often thought to be coercive and ineffective. Forced feeding in anorexia is a case in point. Compulsory treatment in addiction is another.

A first step in responding to these concerns is to clearly distinguish a determination of incompetence from what is done about it. That a person is deemed incompetent to make a particular treatment decision is one thing. However, what we do about it is another. A better theoretical understanding of the manner in which persons are incompetent to make decisions may provide clues that can help us to develop improved treatment options. To date, legal validity has been the guiding foundation in the development of instruments for the assessment of competence. Tan’s study shows that despite its compatibility with current legal standards and many other merits, the MacCAT-T is seriously lacking as a measure of what mental competence should capture and reflect in medical clinical treatment contexts. Although perhaps legally valid, it cannot reasonably be considered an empirically valid measure of what a clinical medical determination of mental competence should be. The challenge is to see how we can build on the achievements of the MacCAT-T to build a more satisfactory clinical medical theory of mental competence.

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