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Mental Disorders That Erode Capacity

With the rapid aging of the U.S. population, mental disorders such as dementia, delirium, depression, psychoses, and combinations of these conditions are becoming more and more prevalent. Not surprisingly, concerns about elder abuse, the need for conservatorships and adult guardianships to protect the elderly and infirm, and disputes over estates are also on the rise. (See similar article in the September/October 2006 issue of *ABA Trust & Investments.*) Today, it is more likely than ever that we will encounter clients who are vulnerable to abuse, subject to undue influence, or unable to manage their affairs. It is useful to understand the legal issues involved when dealing with a client with diminished capacity, the illnesses that affect capacity, and the methods employed in evaluating capacity.

Legal Principles

State laws establish criteria for several different types of decisional capacity, including the capacity to execute a will or trust (testamentary capacity),[1] to enter into a contract (contractual capacity),[2] and to give informed consent for a medical intervention.[3] These statutes all concern the individual's mental state at the precise moment that a particular decision is executed, typically via signature on a document.[4]A different form of capacity is spelled out in statutes defining individuals eligible to have appointed for them a conservator (or guardian) of the person or estate.[5] These statutes focus on the individual's ability to carry out goal-oriented actions (self-care and management of

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finances) over time. For example, an individual who "is unable to provide properly for his or her personal needs for physical health, food, clothing, or shelter" may have a conservator of person appointed.[6] A conservator of the estate may also be appointed for "a person who is substantially unable to manage his or her own financial resources or resist fraud or undue influence."[7]

Both decisional and functional capacity are "threshold" concepts—that is, an individual is either impaired enough to lack capacity or he or she is not, and there is no middle ground. This is in contrast to the broader concept of susceptibility to undue influence, which is a "dimensional" concept—there are degrees of susceptibility. It follows that a cognitively impaired individual may be more vulnerable to undue influence than he or she would be without the impairment, even if the impairment is not severe enough to reach the threshold of decisional incapacity.

Decisional Capacity

Statutes defining capacity enumerate specific information that the competent person must have the ability to know, recall, or understand, but none requires that the individual has *actual* knowledge, recollection, or understanding. This principle has been articulated as follows:

It is the generally recognized rule that testamentary capacity requires only that the testator have capacity to know and understand the nature and extent of his bounty, as distinguished from the requirement that he have actual knowledge thereof.[8]

California Probate Code Section 6100.5 follows this principle, as do all other California statutes defining decisional capacity. Section 6100.5 states, in relevant part,

> (a) An individual is not mentally competent to make a will if at the time of making the will either of the following is true: (1) The individual does not have sufficient mental capacity to *be able to* (A) understand the nature of the testamentary act, (B) understand and recollect the nature and situation of the individual's property, or (C) remember and understand the individual's relations to living descendants, spouse, and parents, and those whose interests are affected by the will.

The distinction between the *ability* to "understand and recollect" and *actually* understanding and recollecting is extremely important in retrospective evaluations of capacity, and in the occasional contemporaneous evaluations of capacity, as discussed below.

Contractual capacity is defined in California Civil Code Section 38, which states,

> A person entirely without understanding has no power to make a contract of any kind, but the person is liable for the reasonable value of things furnished to the person necessary for the support of the person or the person's family.

Section 39(a) states,

> A conveyance or other contract of a person of unsound mind, but not entirely without understanding, made before the incapacity of the person has been judicially determined, is subject to rescission, as provided in Chapter 2 (commencing with Section 1688) of Title 5 of Part 2 of Division 3.

Subsection (b) adds,

> A rebuttable presumption affecting the burden of proof that a person is of unsound mind shall exist for purposes of this section if the person is substantially unable to manage his or her own financial resources or resist fraud or undue influence. Substantial inability may not be proved solely by isolated incidents of negligence or improvidence.

The term "unsound mind" is vague. However, Probate Code Section 812, which is a general standard for capacity, offers clarification:

> Except where otherwise provided by law, including, but not limited to, Section 813 and the statutory and decisional law of testamentary capacity, a person lacks the

capacity to make a decision unless the person has *the ability to* communicate verbally, or by any other means, the decision, and to understand and appreciate, to the extent relevant, all of the following: (a) The rights, duties, and responsibilities created by, or affected by the decision. (b) The probable consequences for the decisionmaker and, where appropriate, the persons affected by the decision. (c) The significant risks, benefits, and reasonable alternatives involved in the decision.

The statutory terms "understand" and "appreciate" appear in California Probate Code Section 812, which is the "default" definition of decisional capacity that applies wherever a more specific statutory definition of capacity does not exist; it is generally assumed to supplement Civil Code Sections 38 and 39(a) and (b), which together define contractual capacity.

The ability to understand and appreciate information (appreciation refers to the ability to relate relevant information to one's own personal situation) generally depends upon the ability to comprehend language, to think abstractly, and to reason via a rational thought process. In some cases these "higher" cognitive abilities are relatively preserved late in the course of dementia, even after memory is severely impaired, while in other cases these abilities are relatively more impaired, especially if the underlying dementing disease is complicated by focal damage to the receptive language area of the brain (for example, by stroke, trauma, or tumor). Some demented individuals who may not be able to recall important material are able to comprehend and appreciate detailed aspects of a contract; these individuals retain contractual capacity as long as they are not required to rely upon their unaided memory alone.

Undue Influence

To be considered undue, influence must contain an element of "coercion destroying the free agency on the part of the testator,"[9] and "Mere appeals or arguments, or influence resulting from gratitude or affection, even if the acts creating these feelings were performed selfishly and were designed to affect the testamentary act, do not constitute undue influence".[10] Rather, the testator's mind must be subjugated to that of another, the testator's free agency destroyed, or the testator's volition overpowered by another.[11]

Courts will presume the existence of undue influence if certain facts are proved, requiring the accused party (the "influencer") to produce evidence to rebut the charges.[12] Those facts are as follows: (a) the accused party played an active role in procuring the will; (b) the party occupied a confidential relationship with the testator (such as that of a close relative or advisor); and (c) the accused profited unduly under the will.[13] If any of those three factors do not exist, the burden of proof remains with the contestant.

Courts have also identified several indicia of testamentary undue influence, the existence of which will help establish the contestant's case. Awareness of the following indicia is important for the psychiatric consultant:

- unnatural provisions in the will
- will provisions inconsistent with prior or subsequent expressions of the testator's intentions
- a relationship between the testator and the beneficiary that created an opportunity to control the testamentary act
- a mental or physical condition of the testator that facilitates the subversion of the testator's free will
- the beneficiary's active participation in procuring the will
- an undue profit to the beneficiary under the will
- a confidential relationship between the testator and the beneficiary[14]

These indicia are applicable in most states, even those that do not recognize presumptive evidence of undue influence. The mental illnesses discussed in this article are referred to in "d," while "c" captures the other major factor, besides mental illness, where undue influence was either alleged or feared, and that is dependency.

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Mental Disorders That Can Erode Competency and Increase Vulnerability to Undue Influence

Mood Disorders

Depression. A substantial proportion of elderly individuals with depression exhibit concurrent cognitive impairment, particularly in visuospatial ability, psychomotor speed, and executive functioning. Depression with functionally significant cognitive impairment, sometimes known as depressive pseudodementia or the dementia syndrome of depression (DSD), is distinguished from the milder, clinically silent cognitive impairment associated with depression that may be detected only by comprehensive neuropsychological testing. The cognitive impairment of DSD is rarely severe enough to result in loss of decisional capacity but may be accompanied by enough apathy and loss of motivation to result in greatly impaired day-to-day function, and consideration of conservatorship may be appropriate, at least until the depression remits.

Hypomania and mania. These terms refer to states of pathologically elevated mood that occur in various forms of bipolar mood disorder ("manic depression" is the severest form) and as a result of abuse of psychostimulant medications such as amphetamine and cocaine. These syndromes are typically not associated with cognitive impairment per se, and therefore pose a similar challenge to traditional legal notions of "lack of capacity" as do the depressive decisions discussed above. In hypomania and mania the issue is impairment of judgment and impulse control, not lack of the ability to know and understand key information. Pathological mood elevation leads to decisions that severely overestimate the odds of success and underestimate both the odds and the consequences of failure.

Psychotic Disorders—Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Psychotic Depression

The common psychotic features of these illnesses include hallucinations, delusions, severe thought disorder, and bizarre behavior, all of which can impair decision making, capacity for self-care, and capacity to manage finances and resist fraud and undue influence. DSM-IV-TR (the standard classification of mental illnesses used by mental health professionals) defines a delusion as follows:

A false belief based upon incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary, that is not ordinarily held by other members of the person's culture or subculture. When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility.

Dementia

Each of the dementing illnesses discussed below is progressive and causes increasingly impaired decision making and day-to-day functional capacity, and increasing vulnerability to undue influence.

Alzheimer's disease (AD). This is the most common cause of progressive dementia. Including both early-onset (age 65 or younger, accounting for about 1 percent of all AD cases) and late-onset (older than 65) subtypes, AD is the cause of about 50 percent of all cases of primary dementia. It may combine with other conditions, primarily vascular dementia, in another 10 percent to 20 percent.[15] Impairment in all cognitive functions occurs eventually in AD, but early manifestations may be limited to impairment in recent memory. In cases uncomplicated by vascular disease, it is reasonable to assume a gradual course of progression, with a decline of two to four points on the mini-mental status exam (MMSE) per year.

Frontotemporal dementia (FTD). This term describes a group of disorders that share a common pattern of relatively focal degeneration of the frontal and temporal lobes of the brain. Classic Pick's disease, primary progressive aphasia, and several other histopathologically distinct conditions are the main contributors to this category. Personality changes may precede obvious cognitive deficits by several years, so FTD must be considered when a pattern of behavior that is "out of character" for the individual is observed. Otherwise, capacity issues follow principles outlined for AD.

Parkinson's dementia. Some patients with Parkinson's disease develop noticeable cognitive deficits within a year or two of the onset of motor symptoms, others remain free of all but minor executive deficits for 5 to 10 years, and many never exhibit the level of cognitive deficit that would be detected on mental status exams. When cognitive deficits become severe enough, the resulting dementia is sometimes described as subcortical, because it comprises a cluster of clinical features that are relatively less common in dementing illnesses with primarily cortical (referring to the cerebral cortex, or "gray matter," of the brain) pathology such as AD. These subcortical features include relative preservation of language

function, visuoperceptual skills, and ability to do mathematical calculations, with comparatively severe deficits in frontal executive functions, including attention, verbal fluency, and ability to plan and execute multi-step actions.

Lewy body dementia. Dementia with Lewy bodies is a progressive, degenerative dementing condition with clinical and pathologic features that overlap with those of Alzheimer's disease and Parkinson's disease.[16] Unlike other dementias, fluctuations in cognitive function are common, and this may be the only dementing illness in which the concept of a "lucid period," i.e., a period of relatively normal cognitive functioning surrounded by periods of significant impairment, is applicable. Unfortunately, there is no definitive diagnostic test for this illness. Forensic considerations are generally as for AD.

Vascular dementia. This condition is caused by the accumulation of small strokes (a stroke is caused by blockage of blood flow to a part of the brain, resulting in the permanent loss of function of neurons and other cells in that part), each of which may damage a small enough bit of brain tissue as to be not noticed by the patient or those around him or her. When enough brain tissue is damaged in this way, the result is cognitive and functional deficits severe enough to warrant a diagnosis of dementia. The history of the present illness in vascular dementia is classically one of a more abrupt, stepwise course of cognitive impairment than the more gradual onset and decline typical of "pure" AD and the other degenerative dementias listed above.

Dementia due to other medical conditions. Although many other conditions can cause impairment in cognition and function severe enough to meet the criteria for dementia, DSM-IV-TR specifically recognizes HIV infection, head trauma, and Huntington's, Creutzfeldt-Jakob, and Pick's diseases as capable of causing dementia via direct damage to brain structures (by infection, trauma, or degeneration). Differentiation of each of these conditions from AD, FTD, dementia with Lewy bodies, vascular dementia, and other dementing conditions depends on identification of the characteristic physical and laboratory abnormalities associated with each disease, supported by appropriate historical information.

Conclusion

Medical advances and healthier living are translating into greater longevity. That longevity, however, is in many instances outpacing our mental stability. The opportunity for unscrupulous or uncaring individuals to exploit the vulnerability of the elderly and infirm is also more prevalent. We may all become experts by necessity on the effects of aging and illness on the competence of clients to make decisions or function in their daily lives, and the legal issues that arise when capacity diminishes and opportunists seek to take unfair and improper advantage of our vulnerable clients.

Endnotes

[1]Cal. Prob. Code § 6100.5.
[2]Cal. Civil Code § 38.
[3]Cal. Prob. Code § 813.
[4]See, e.g., *Estate of Mann* (1986) 184 Cal.app.3d 593, 604.
[5]Cal. Probate Code § 1800 et seq.
[6]Cal. Probate Code § 1801(a).
[7]Cal. Probate Code § 1801(b).
[8]*Estate of Jenks* (1971) 291 Minn. 138, 141, 189 N.W.2d 695, 697.
[9]*Estate of Mann, supra,* 184 Cal.App.3d at 606.
[10]Id.
[11]Id.; see also *Estate of Baker* (1982) 131 Cal.App.3d 471, 480; *Estate of Gecht* (1958) 165 Cal.App.2d 431, 445.
[12]*Estate of Sarabia* (1990) 221 Cal.App.3d 599, 605.
[13]Id.
[14]Id.
[15]Langa, K., Foster, N., Larson, E., "Mixed Dementia: Emerging Concepts and Therapeutic Implications," *JAMA* 292, 2901-08 (2004).
[16]McKeith, I., Galsko, D., Kosaka, K., et al., "Consensus Guidelines for the Clinical and Pathologic Diagnosis of Dementia with Lewy Bodies (DLB): Report of the Consortium on DLB International Workshop," *Neurology* 47, 1113-24 (1996).

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