

Testamentary Capacity of the Schizophrenic Patient

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ABSTRACT: Testamentary capacity refers to an individual's capability to write his or her own will. Psychiatrists are required occasionally to give expert opinions regarding the testamentary capacity of individuals with a medical history or suspected diagnosis of a mental illness. This may stem from the patient/lawyer/family initiative to explore the current capacity to testate in anticipation of a possible challenge, or may be sought when testamentary capacity of a deceased has been challenged. In this article we examine the medico-legal construct of testamentary capacity of the schizophrenic patient, and discuss the various clinical situations specific to schizophrenic patients, highlighting their impact on the medical opinion regarding testamentary capacity through examining the rulings of Israel's Supreme Court in a specific case where the testamentary capacity of a mentally ill individual who was challenged postmortem, and provide a workable framework for the physician to evaluate the capacity of a schizophrenic patient to write a will.

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The concept of will-writing among schizophrenic patients seems to harbor inherent contradictions. Schizophrenia, the 'prototype' of mental illness, usually affects young adults and writing a will is often associated with older age. Schizophrenic patients generally have difficulties maintaining relationships and are less likely to form families – the potential beneficiaries of estates [1]. Also, the employment potential of schizophrenic patients is reduced, limiting their ability to accrue property. When attempting to establish testamentary incapacity of a patient, assets and social environment are central issues. Furthermore, the question of capacity may arise in various contexts during the patient's life cycle, e.g., compulsory hospitalization and need for guardianship [2]. In contrast stands the healthy elderly testator, whose capacity to perform legal actions such as writing a will is rarely questioned – until the writing or execution of a will. As stated in Israel's Legal Capacity and Guardianship Law: "every man proclaims the capacity for rights

and debts," and "every man is capable of any legal action unless this was denied by virtue of legal action" [3]. Nevertheless, though to a lesser extent, mentally ill patients do write wills. Shulman et al. [4] defined 25 retrospective challenges to testamentary capacity, and dementia emerged as the most common (40%), followed by alcohol-related issues (28%), and neurological or psychiatric disorders (28%) [4].

In practice, psychiatrists are occasionally asked to give expert testimony regarding the testamentary capacity of individuals with a medical history or suspected diagnosis of schizophrenia. For example, if an individual with a suspected diagnosis of schizophrenia wishes to write a will, contemporaneous assessment of his/her testamentary capacity when signing the will might be requested [5]. In this case a lawyer, family member or the testator seeks expert testimony regarding the testator's current mental disorder and capacity to testate in anticipation of a possible challenge to the will by potential beneficiaries. Second, after the demise of the testator, his/her testamentary capacity at the time the will was written might be challenged. The psychiatrist might then be asked to provide an expert retrospective or 'postmortem' evaluation based on extrapolations from indirect evidence and interpretations of assessments by other clinicians. Though this situation is more common, it is less revealing than direct examination of a living patient. In these cases, the expert opinion is generally sought by the court or by potential beneficiaries [4]. Psychiatrists find themselves in the juridical arena and are asked to use their clinical expertise and professional experience to evaluate a schizophrenic patient, and their clinical evaluation is often the basis for a legal ruling.

In this article we discuss the impact of various clinical situations specific to schizophrenic patients on the medical opinion with regard to testamentary capacity. We also offer insights into a specific case in which the testamentary capacity of a mentally ill individual was challenged postmortem in the Israeli Supreme Court and provide a workable framework for the physician to evaluate the capacity of a schizophrenic patient to write a will.

PATIENT WITH AN ACTIVE DISEASE AND PATIENT IN COMPLETE REMISSION

Most patients move along the clinical spectrum of schizophrenia from complete remission and absence of positive symptoms

(delusions, hallucinations) through partial remission to active stages of the illness including psychoses. In the psychotic state there may be various relationships between the active psychotic content and issues concerning the will. Psychotic content related to delusions does not necessarily influence the patient's judgment or capacity to make decisions in other facets of life such as bequeathing possessions, i.e., testamentary capacity. The situation differs when the patient suffers from hallucinations and delusions concerning his capacity and his assets. For example, if the patient has delusions of grandeur she might be convinced that she has assets beyond her actual possessions, has nothing at all, or that all her property was stolen. In this case it is clear that she does not have the capacity to judge the extent of her assets and therefore does not have testamentary capacity.

If psychotic content distorts the patient's conception of reality with regard to his relatives, it may influence his decisions regarding the heirs. For example, paranoid delusions towards a spouse could lead to disinheriting her. We emphasize that a psychotic state alone does not revoke testamentary capacity. In addition, 'bizarre' decisions in the eyes of the observer do not necessarily indicate decisions resulting from illness whatsoever. Psychiatrists must restrict themselves to decisions directly related to psychotic content.

IMPACT OF COGNITIVE DISABILITY AND NEGATIVE SYMPTOMS

A psychiatric patient with unidentifiable active positive symptoms might exhibit illness-related components that could influence testamentary capacity. Negative symptoms (e.g., affective flattening, avolition) and cognitive decline are also part of the schizophrenia process. Certain cognitive and intellectual impairments, especially in language, semantic memory and executive function, are observed in schizophrenic patients in the early stages of the illness [6]. Chronic schizophrenic patients with prominent negative symptoms demonstrated poor cognitive functioning on tests sensitive to frontal and parietal lobe functions [7], and studies of young schizophrenic patients revealed stability in scoring on neurocognitive batteries up to 10 years following the first psychotic episode [8,9]. In older schizophrenic patients with suspected cognitive/intellectual impairments, a dementia process might be emerging.

Cognitive screening instruments such as the Mini Mental State Examination and the clock-drawing test used by clinicians demonstrated deficits in elderly patients with severe mental illness, but the cutoff point was determined mainly for elderly dementia patients [10-12]. The presence of such deficits does not necessarily indicate an impairment of testamentary capacity.

LEGAL GUARDIANSHIP AND INCOMPETENCE

When a guardian has been appointed we must differentiate between a patient who was declared legally incompetent, in which case under Israeli law he lacks testamentary capacity [3], and a patient for whom a guardian was appointed though

he/she was not declared legally incompetent. For the latter, the patient's legal rights are not revoked and testamentary capacity must be evaluated.

Appointment of a guardian is a warning light, as the court assumed that the patient lacked the capacity to manage his affairs – personal/physical affairs, medical care and/or affairs related to his property (purchase of basic needs, financial management). However, this does not imply absence of testamentary capacity. For example, a patient might lack the capacity to manage his daily affairs but can still have a general desire to leave all his assets (even if he does not know exactly what they are) to his children. What happens if the beneficiary of part or all of the estate is the guardian? The guardian is often a family member who cares for the patient, and it might be assumed that the patient would want to bequeath part or all of his/her estate to the guardian/relative. Because the guardian is supposed to devote his time and energy to the patient's needs and not for his own benefit, a guardian/relative might be considered a conflict of interest [13]; thus the court should be informed if the guardian is a potential heir.

UNDUE INFLUENCE AND SIGNIFICANT OTHERS

The Israeli Inheritance Law states that: "a will that was formed under rape, threats, *undue influence*, etc., conning or scamming holds no validity" [14]. The question of undue influence is complex, even when the testator does not have schizophrenia. Israel's Supreme Court ruled on a problematic case involving undue influence when an elderly man with no living relatives and no mental illness chose to leave all his assets to a woman who nursed him prior to his death and who he had met only 4 months before he wrote his will. The Attorney General appealed the will and argued that the elderly man wrote his will while subjected to undue influence of his caregiver, creating a flaw in the will that should therefore not be executed. The appeal was denied by the District Court and subsequently by the Supreme Court, and the deceased's will was honored:

Each and every one of us is subject to the influence of those who surround us ... Our acts are the consequence of our personality as well as these and other constraints that life puts before us. ... All these influences are components of the 'true' desires of man and do not harm intent. ... An elderly man, sick, weak and forgotten – should we deny his true and independent will to leave all his possessions to the woman who cared for him in the last months of his life? (even if only for that reason?), why should we assume that it is obvious that the woman used undue influence on the deceased and declare the will invalid?.. There is no doubt that his disturbed mental and physical conditions contributed to his decision to leave all his assets to the woman, but why should we characterize this as undue influence in order to disqualify the will? [15]

When the testator suffers from schizophrenia it is more difficult to distinguish “fair” from “undue” influence owing to the complex network of relationships created within the patient-family-disease triad. The term “high expressed emotion” expresses the influence of communication patterns in some families on the illness process of the patient and is an example of this complexity [16]. Patients might depend on their families for long periods due to extensive functional impairment stemming from the chronic illness. It is then difficult to define whether the family’s influence on the patient is “fair” or “undue influence.” Clearly, mental illness, and its medical, social and economical consequences make the patient vulnerable to those who seek to take advantage of him/her within and outside the family.

MENTAL ILLNESS AND THE CONSTRUCT ‘TESTAMENTARY CAPACITY’ – THE CASE OF BANKS VS. GOODFELLOW

A mentally ill individual, tried in an English Court, led to the examination of the legal term “testamentary capacity” and formalization of a legal test (Cockburn’s laws) for the evaluation and validation of wills according to the Anglo-Saxon legal tradition [17]. The case *Banks vs. Goodfellow* was brought to court in 1870 [18]. Mr. Banks changed his will in 1863 and left all his property to a niece through marriage who was a remote blood relative. Mr. Banks was hospitalized for several months in 1840 and was declared insane. Following discharge he continued to suffer from paranoid delusions. Under the influence of these delusions, he believed that a deceased person’s spirit was trying to hurt him. It was determined that the very existence of this delusion did not affect his decision to bequeath his property to his niece. From the legal test in the trial, clinical criteria for the evaluation of testamentary capacity were derived. Understanding, knowledge and lack of influence are the three main factors to be examined by the expert. Does the ‘creator of the will’ (the testator) understand what a will is; is he aware of the nature of his assets and their quantity? Does he know who might claim to inherit from him, and does he understand the consequences of the division of the assets in a specific manner? Is he under the influence of a delusion that directly affects the division of his assets? Does he have the capacity to express his desires in a clear, explicit and orderly manner? [19]. It was decided that Mr. Banks was fit to write a will and his will was fully respected.

INSIGHTS ON TESTAMENTARY CAPACITY: THE SUPREME COURT IN ISRAEL

Israel’s Supreme Court ruled on a case concerning testamentary capacity of an individual with mental illness (case of 1212/91) [20]. The testator, Mr. M, had a diagnosis of schizophrenia, paranoid type, was childless and had a history of psychiatric hospitalizations. He died and left three wills. In all three wills he

left his apartment to his employer of many years. In the first will he left the rest of his possessions to his sister and her children, but in the second will he chose to leave the rest of the property to a foundation that supports enlisted soldiers. The third will, which did not differ from the content of the second will, was submitted to the court due to a technical error. Owing to the deceased’s psychiatric history, following his lawyer’s advice he had been examined by a psychiatrist the day before he wrote the second will. The psychiatrist confirmed that Mr. M was fit and capable to write a will. Twelve days later he was admitted to a psychiatric hospital, where he remained hospitalized for 2 years. The third will was written a month after the second will, while he was hospitalized in the daycare facility of the hospital. After Mr. M’s death his sister contested the will. She argued that her brother had been mentally ill and thus “was incapable of discerning the nature of the will.” The district court examined the case according to the Israeli Inheritance Law [3].

The law refers (in article 26) to the capacity to make a will and states that “a will made by a minor or by a person declared ‘legally incompetent’ or that was written when the testator could not discern the nature of a will is invalid.” There is no specific reference in the law to mental illness. Two expert opinions were submitted to the court. The opinion on behalf of the plaintiff claimed that the testator was delusional and believed that his sister was trying to poison him and this belief influenced his will. This expert opinion was prepared post-mortem by a psychiatrist who had never examined the patient but had reviewed the patient’s medical records. The opposing opinion was prepared by a psychiatrist who examined the patient the day before he wrote his second will. The case was further complicated when it became apparent that after writing the first will the deceased had deposited some jewelry and money with his sister and her son, and only the jewelry had been returned to him after the intervention of his lawyer. The money was never returned and the nephew admitted that he had spent it. The District Court favored the plaintiff’s claim but differentiated between the nephew and the patient’s sister, claiming that he was disinherited for “normative motives,” while regarding the sister and the rest of her children eligible for the deceased’s property. The District Court determined that in that context there was a “misconception” resulting from mental illness that had to be corrected by the court to the situation that the court had perceived would have happened in the absence of a mental illness. The district court explained that a will made under the influence of a delusion is a will based on a misconception [21] and should therefore be rectified before it is executed. However, the District Court maintained that the deceased “knew to discern the nature of a will.”

An appeal was made to the Supreme Court. The Supreme Court did not accept the opinion of the District Court and maintained that the will of the deceased was valid and should be implemented verbatim. The Court relied on the interpreta-

tion of section 26 of the Inheritance Law that excludes three persons who cannot testate: a minor, a person declared legally incompetent, or a testator who composed a will when he/she could not discern the nature of a will [12]. The question whether the case of a mentally ill person whose concerns for heritage were dictated by “mental tricks” is addressed. The Supreme Court interpreted that the ability to discern the nature of a will is not only general knowledge of what a will is, nor private knowledge of the implications of one’s will for himself and those around him. In addition, the wishes of the testator must represent his “free” and “true” will, i.e., a will free of “morbid mental pressures.”

The Court maintained that there is testamentary capacity only when all of these components are present. In cases of an appeal, the court must be convinced it was not the “free will” of the testator that dictated his last words, that “his understanding was forcefully thrown by delusions,” that there is a clear causal relationship between these delusions, and that distorted realities influenced his/her will. In any other case, appeals on a will are an impingement on the basic dignity and basic right of the person to divide his property according to his will in life as well as in death:

In the end of all ends, the deceased did not harm anyone – he did not bequeath anything but his assets – apparently there is no reason not to respect his wishes concerning the distribution of his assets after his death. If the deceased had divided his property while alive, we would have encountered great difficulty, perhaps even an undue difficulty to undo his dispositions. And after his death, can we permit ourselves not to acknowledge the will? Ignoring the will of the deceased bears a great deal of paternalism and is perhaps even an insult to human dignity.

Every man has a fundamental right to his own truth and his own reality even if it is not perceived as” normative “or as the opinion of a “reasonable person.”

According to the Supreme Court, distorted perception of reality by a testator who does not suffer from delusions caused by a mentally ill mind does not impair testamentary capacity. There is no place to change one’s distorted desires to the desires of a reasonable person under the same circumstances. Otherwise, we coerce into a frame of “normality,” as we perceive it, those who live their lives deviating from this frame. The unusual person has his own desires and his own truths in accord with his reality. He lives his life in his own bubble that is burst after his death, under the pretensions of the desire to follow his “true” inner world. This is not more than an attempt to reconstruct what never occurred in his world. If there was a justification for bursting the ‘bubble’, then it was already present prior to his death.

The Supreme Court sided with the opinion of the defendant’s expert mainly (but not exclusively) because of that psychiatrist’s acquaintance with the deceased and the fact that he personally examined the deceased close to the time of the writing of the will.

DISCUSSION

We presented the various aspects of the assessment of testamentary capacity in schizophrenic patients and distinguished between the clinical definition of fitness (capacity) and its legal definition (competency). While the court seeks competency, it relies on the clinical psychiatrist to formulate a decision for a legal question. In evaluations of capacity, the psychiatrist is asked a fundamental question regarding the autonomy of the patient. It seems there is a legal as well as a clinical premise that mental illness can indeed impede this autonomy; the degree of impediment varies and relies on different characteristics that require evaluation on a case-by-case basis. In the case of testamentary capacity, the patient’s autonomy is examined in a goal-oriented context – the ability to create a will. However, despite this limited context, a broader evaluation is necessary when examining schizophrenic patients.

The evaluation of testamentary capacity presents the psychiatrist with challenges that are far beyond her usual clinical experience. Jacoby and Steer [22] offer some general guidelines. Prior to performing the clinical evaluation, the psychiatrist must receive from the patient’s attorney confirmed information concerning the assets of the patient and must verify that the patient indeed agreed and legally authorized (via his attorney) that he is aware that the psychiatric evaluation is required for legal matters and will be revealed to non-medical authorities. Reasonable time for assessment must be allowed, and cognitive testing of the patient should be included in order to assess the existence or absence of a demented state. Afterwards, the degree of the patient’s understanding must be evaluated based on the points proposed by the Banks vs. Goodfellow ruling. It is important to verify whether earlier wills were written and to understand any changes in the current will. This examination may reveal deficits in judgment, memory and the existence of delusions. The examination may be embarrassing and felt by the patient to be intrusive, so it is important to explain to the patient the reasons for the detailed questioning. It is necessary to record the findings of the examination in detail and to quote the patient verbatim because the psychiatrist might be required to testify in the event that the will is contested. It is necessary to be thorough in the examination of the testator and to understand his/her decision concerning his/her heirs, in order to expose the motives and to be convinced that they do not result from illness.

Hence, when there is a psychotic condition or impairment, in addition to evaluating the mental and medical state of the

patient, for which they are trained, clinicians must also evaluate the familial, social and economic situation of the patient and emphasize how these are affected by the patient's illness and how they subsequently affect his testamentary capacity; issues that doctors generally do not deal with. We are expected not only to rely on the diagnosis but to try to precisely evaluate the extent of the illness symptoms and their influence on the specific patient's testamentary capacity. Thus the clinician must seek all available information concerning the expression of the patient's illness, including a review of the content of his past delusions and the degree to which they were executed by the patient. Evaluations by various professional authorities over the years should also be included. Thus we can respect the desires of individuals with mental illness in their quest to integrate into society, even after their deaths.

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Capsule

Daily stressors, stress vulnerability, immune and HPA axis

Both stressors and stress vulnerability factors together with immune and hypothalamus-pituitary-adrenal (HPA) axis activity components have been suggested to contribute to disease fluctuations of chronic inflammatory diseases, such as rheumatoid arthritis (RA). Evers et al. investigate whether daily stressors and worrying as stress vulnerability factor as well as immune and HPA axis activity markers predict short-term disease activity and symptom fluctuations in patients with RA. In a prospective design, daily stressors, worrying, HPA axis (cortisol) and immune system markers (interleukin-1 β , IL-6, IL-8, interferon-gamma, tumor necrosis factor-alpha), clinical and self-reported disease activity (disease activity score in 28 joints, RA disease activity index), and physical

symptoms of pain and fatigue were monitored monthly during 6 months in 80 RA patients. Multilevel modeling indicated that daily stressors predicted increased fatigue in the next month and that worrying predicted increased self-reported disease activity, swollen joint count and pain in the next month. In addition, specific cytokines of IL-1 β and IFN γ predicted increased fatigue 1 month later. Overall, relationships remained relatively unchanged after controlling for medication use, disease duration and demographic variables. No evidence was found for immune and HPA axis activity markers as mediators of the stress-disease relationship.

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“A free society is a place where it's safe to be unpopular”

Adlai Stevenson (1900-1965), U.S. governor and ambassador