

Pseudodementia and Competency

Michael I. Good, M.D.

An increase in the number of challenges to competency determinations in probate cases parallels an increasingly aging population. In the literature on competency determination, there is little if any discussion of the implications of pseudodementing conditions, which can quite readily be misdiagnosed as true dementias, especially in the elderly. This case report describes a patient thought to have had a stroke with dementia and paresis who turned out to have had a pseudodementia. She later made a dramatic and somewhat surprising recovery. It subsequently came to light that a nearly successful attempt had been made to defraud her of her estate during her presumed dementia, which was thought to have been irreversible. The case underscores issues in competency determination, including matters of diagnosis, prognosis, and undue influence.

The occurrence of pseudodementia (false dementing illness) may raise special issues in the determination of competency, especially among nonpsychiatric patients. In older populations, these issues commonly involve the question of capacity to make a will or otherwise dispose of property. It is relevant that pseudodementia may be overlooked or mistaken for a "true" dementia, especially among the elderly.

In a previous paper on the subject of pseudodementia misdiagnosed as irreversible organic dementia,¹ I described several cases, including an elderly patient thought to have had a cerebrovascular accident with confusion and paresis who turned out to have hysterical pseudodementia and depression. A second follow-up of this patient provided information not originally reported be-

cause it apparently was not recalled by her nor known to others who might have reported it. This new information revealed a twist of a forensic nature in the case. As it happened, several years after I had last had contact with the patient, I was called by her attorney because of a property transaction of a questionable nature made during her illness. The transaction had only recently come to light and raised the question of her competency at the time the transaction was made. The fact that she had had a pseudodementia is uniquely relevant to the matter of competency in this case because, if she had had a "true" or irreversible dementia, the competency issue might never have come to light, and a fraud might have been perpetuated.

Case Report

Ms. B was a 69-year-old divorced, childless woman and retired legal secretary when she was admitted to her com-

Address for reprints: Michael I. Good, M.D., 74 Craftsland Road, Chestnut Hill, MA 02167.

munity hospital because of the sudden onset of leg weakness, confusion, and disorientation. The presumptive diagnosis was cerebrovascular accident, and she was transferred two weeks later to a rehabilitation hospital for intensive physical therapy. It was during her rehabilitation hospitalization that I saw her for psychiatric consultation because of her "extreme confusion and disorientation."

She had been an active gardener. Before the hospitalization she had been in her garden with a number of neighborhood children when she began to feel suddenly weak and dizzy. She "dismissed" the children and went inside, where she was able to move about only on her hands and knees. After several hours, two visiting sisters attempted to soothe her and put her to bed. She and her sisters reportedly had not been getting along well, and one sister was crippled after an unsuccessful hip joint replacement. She retained considerable ambivalence toward her former husband, who was currently hospitalized for his second leg amputation. Ms. B had no psychiatric history nor prior intellectual impairment. She had an eight-year history of arthritis in her wrists and hands and had been receiving prednisone 5 mg b.i.d. for the preceding month. Eleven years earlier she had had a colonic resection for carcinoma.

In the hospital, although she received intensive physical therapy, a physical examination revealed positive findings limited to variable weakness of both lower extremities, with proximal weakness greater than distal. At times her

strength was good. Her reflexes and sensation were normal. She demonstrated markedly impaired recent memory, difficulty with calculations, and a poor fund of information, although other language functions, including ability to name objects, were intact. Neurological consultation resulted in the impression of a diffuse dementia, senile or arteriosclerotic, and possible cerebrovascular accident. However, the variable weakness and lack of reflex signs were thought to point to myopathy or myasthenia. An electromyogram, tensilon test, and CT scan were recommended. Meanwhile, psychiatric consultation was requested to assess her mental status.

She presented as an alert, very engaging slender woman in a wheelchair who showed me her newly manicured nails and wanted to know what time it was because she was waiting for her hairdresser. She spoke spontaneously and fluently yet vaguely about her situation, saying, "Let's not get too specific." She did acknowledge depressive feelings and volunteered her concerns about aging and her ambivalence about not having any children. In response to formal orientation questions, she said she was at the Wrentham State Hospital (for the retarded) and later changed this to the Wentworth Institute (a technical school). When told the correct answer, she refused to repeat it and asked instead what kind of a therapist I was anyway. Although she had previously indicated her knowledge of the weekday, when asked the date she smilingly gave her birth date instead. Interestingly, she gave her birth date consistently, and it would

Pseudodementia and Competency

have made her not 69 but rather 75 years old. She often performed calculations correctly but at times gave preposterously wrong answers. Her responses to almost all questions were quick and effortless, although she often changed the subject to her appearance. In later sessions with me, she was more open about expressing feelings of disappointment and anger but remained vague about details except for missing her employment. She did indeed seem uneasy about the passing of the years and what could happen to her.

To the differential diagnosis were added conversion reaction manifested as lower limb paralysis and pseudodementia. Routine blood studies, EEG, lumbar puncture, and ⁹⁹Tc brain scan were normal. X-ray studies revealed some carotid artery calcifications and signs of rheumatoid arthritis in her wrists and hands but no evidence of metastases.

Ms. B was seen for further psychiatric interviews. Antidepressant therapy was considered but not pursued because by the third hospital week she began to show striking improvement both physically and mentally. After two months there was no evidence of limb weakness or dementia. Her discharge was arranged. She explained that she had "a lot" on her mind but felt she had made a remarkable recovery. At three-year follow-up, she remained well, still lived alone, and was still active in her garden. She could recall the names of her doctors in the hospital, spoke of her plants in detail, and kept up with current events. Although there was evidence of very slight memory impairment, it was con-

sistent with her age and entirely unlike her "confused" state in the hospital.

Four years after my original contact with Ms. B, her attorney called me. It happened that during her time in the hospital, when she was thought to have had a stroke, she allegedly had been induced by her nephew and his attorney to sign over to her nephew her savings accounts and a number of bonds, which totaled a considerable sum, as well as the deed to her home. Ms. B apparently had not remembered that she had signed any documents making these transactions. About six months after her discharge, when she was better and realized the money was missing from her accounts, she brought an action against her nephew. He reportedly contended that she had given over the property because she was thought to be near death, and he refused to return it because he contended that it was a gift and that she had been competent.

The case was subsequently heard in court. The previously documented findings of her confusion, disorientation, and conversion with pseudodementia were considered in retrospect to have made her incompetent to handle her personal affairs. She was found not to have been aware of the nature, quality, and effect of the acts of affixing her signature to the documents that had been presented to her. Furthermore, the defendant, her nephew, was found to have defrauded the patient by unduly influencing her and taking wrongful and improper advantage of her confusion and weakened condition. The transactions were thus voided, and her nephew

was ordered to return the sums of money, bonds, and title to the real estate.

Discussion

The issues of diagnosis and prognosis in pseudodementia

This case illustrates two issues pertinent to the matter of competency evaluations. First is the issue of diagnosis. In cases with impaired mentation and dementia-like signs, it is essential in contemporaneous evaluations to consider the possibility that the patient has a pseudodementia. The rate at which patients with primary functional psychiatric disorder are mistakenly diagnosed as demented may reach as high as 20 percent.² The distinction between dementia and pseudodementia is not always straightforward and may be overlooked by nonpsychiatrists, especially in nonpsychiatric settings. The diagnosis of a treatable pseudodementing condition may in particular be missed when depression or other psychiatric symptoms are not evident and when physical signs and symptoms dominate the clinical picture.¹ Pseudodementia may take a number of forms associated with such factors as psychiatric diagnosis, age, severity of depression, nature of defenses, self percept, motivation, and intelligence, and may include physiological or neurobiochemical changes.³ These forms of pseudodementia include cognitive impairment in elderly subgroups, information processing disorder, hysterical (conversion) pseudodementia and the Ganser state, depressive thought disorder, and delusional cognitive impairment. In certain cases these categories may overlap.

Conversion pseudodementia, as in the

case of Ms. B, has previously been described.⁴ McEvoy and Wells noted that the patient's pseudodementia could be diagnosed on clinical grounds alone, without waiting for resolution of the cognitive impairment to make the diagnosis. As is true with reconstructions in general, the assessment of possible pseudodementia is more difficult in retrospective psychiatric evaluations of competency when the diagnosis has not previously been made. Post⁵ and Wells⁶ have suggested criteria to differentiate dementia and pseudodementia. Although their criteria are often helpful, they could unfortunately lead to a false-negative diagnosis of pseudodementia in certain cases. For instance, a patient with the Ganser response who gives approximate answers could be misdiagnosed as truly demented because "near miss" answers to questions are said to be more typical of patients with primarily organic deficits, whereas "don't know" answers are considered more typical of the unwilling or depressed (pseudodemented) patient.¹ In addition to a focus on the presence of cognitive impairment alone, an assessment needs to include attention to behavioral and affective features.²

The second issue is prognosis and its bearing on subsequent competency. Redmond⁷ has noted a number of the chronic and progressive medical problems and primary psychiatric disorders that may impair competency. These medical and psychiatric conditions are likely to be properly diagnosed and appropriately treated. To my knowledge, however, pseudodementia and its implications in competency determinations

Pseudodementia and Competency

have not previously been considered in the literature on testamentary capacity. If the patient has a pseudodementia and is incompetent on that basis, the condition may be treated with a beneficial outcome that subsequently alters the state of incompetency, in contrast to many dementing medical conditions. But what distinguishes occult pseudodementia from other treatable medical or psychiatric disorders is not only difference in prognosis alone but also the greater chance that the pseudodementia will be misdiagnosed and remain untreated, so that a more positive prognosis may not be achieved.

The burden of proving testamentary capacity can be difficult, particularly in the face of a will challenge. Redmond⁷ observed that wills are more prone to challenge on the issue of testamentary capacity because, as people live longer, they are more likely to have the kind of conditions that interfere with capacity and because the courts are more apt to hear evidence and allow findings of lack of testamentary capacity. This situation points to the increasing need for accurate assessments by psychiatrists involved in determining testamentary capacity. Not only are retrospective assessments involving reconstruction of a prior pseudodementia likely to be especially challenging, but also a court contest involving review of a previous contemporaneous evaluation in which a patient's "dementia" had now disappeared could call into question the reliability of the psychiatric evaluation.

Undue influence and pseudodementia In part because of Ms. B's misdiagnosis, as well as her own consequent

concern about her prognosis, she was subject to undue influence. The issues of undue influence, testamentary capacity, and the role of mental illness have recently been reviewed by Spar and Garb⁸ from the perspectives of both contemporaneous and retrospective psychiatric evaluation. In general, they suggest that any debilitating mental or physical illness resulting in dependence on caretakers will increase susceptibility to influence. The association of pseudodementia with intense dependency needs has been proposed as a "dementia syndrome of dependency" by Howells and Beats,⁹ who favor that phrase over the term "pseudodementia." Nevertheless, there is evidence from a longitudinal study¹⁰ validating the clinical utility of the concept of pseudodementia.

Given Ms. B's manifest condition, it is noteworthy that her nephew's attorney did not arrange to have a contemporaneous competency evaluation performed. It would appear as if her recovery were not anticipated by anyone. A neurologist had diagnosed her as having senile or arteriosclerotic dementia with a possible cerebral infarction involving the right middle cerebral artery; her internist had concurred with that impression; and her nephew and his attorney may well have presumed that she would not recover and gambled on the unlikelihood of a challenge from her sisters, who were also elderly. Had the original diagnoses been correct, the likelihood that her condition would improve significantly would have been slim, and she then might never have become cognizant of the change in possession of her property.

Even if she had had her own legal representation at the time of the transactions or had actually been considered incompetent, it is conceivable that her nephew might have acquired power of attorney and that the turn of events described in this follow-up might never have occurred. Thus, even if a contemporaneous competency evaluation had been done, determination of incompetency would not have been sufficient to prevent the transfer of her property. Indeed, it might have legitimized the transfer and made its return to the patient more difficult. Considering the diagnostic possibility of pseudodementia in a competency evaluation is thus critical in anticipating the possibility of the mental status subsequently reverting to normal, with resulting competency to manage an estate.

References

1. Good MI: Pseudodementia and physical findings masking significant psychopathology. *Am J Psychiatry* 138:811-4, 1981
2. Wells CE: Pseudodementia and the recognition of organicity, in *Psychiatric Aspects of Neurologic Disease, Volume II*. Edited by Benson DF, Blumer D. New York, Grune & Stratton, 1982, pp 167-77
3. Good MI: Pseudodementia, depression, and cognitive impairment: a critical review and proposed typology, in *CME Syllabus and Scientific Proceedings in Summary Form* (pp. 206-207). 134th Annual Meeting of the American Psychiatric Association. Washington, DC, APA, 1981
4. McEvoy JP, Wells CE: Case studies in neuropsychiatry II: conversion pseudodementia. *J Clin Psychiatry* 40:447-9, 1979
5. Post F: Dementia, depression, and pseudodementia, in *Psychiatric Aspects of Neurologic Disease*. Edited by Benson DF, Blumer D. New York, Grune & Stratton, 1975, pp 99-120
6. Wells CE: Pseudodementia. *Am J Psychiatry* 136:895-900, 1979
7. Redmond FC: Testamentary capacity. *Bull Am Acad Psychiatry Law* 15:247-56, 1987
8. Spar JE, Garb AS: Assessing competency to make a will. *Am J Psychiatry* 149:169-74, 1992
9. Howells R, Beats B: A dementia syndrome of dependency? *Br J Psychiatry* 154:872-6, 1989
10. Perminder SS, Smith JS, Angus-Lepan, Rodriguez P: Pseudodementia twelve years on. *J Neurol Neurosurg Psychiatry* 53:254-9, 1990