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Psychological Perspectives on Competency

John Becker
Community Hospital of Los Gratos

Psychological Perspectives On Competency

By John Becker

Like two outstretched arms, one reaching east and the other reaching west, the differences between law and psychology are obvious. These are different disciplines, with different traditions, different means of seeking truth and knowledge, and sometimes even different "languages"—different ways of communicating and expressing themselves. Yet, with thoughtful intelligence, these markedly different entities can work together, like the right arm and the left cooperatively coming together to lift an object. This article will consider how law and psychology can work together cooperatively toward understanding the competency of individuals to make plans for themselves, to take care of themselves personally and financially.

Suppose an attorney faces a client or potential client, and the attorney detects signs that the person may not be entirely competent to reasonably understand and direct an agent to perform certain tasks such as preparing a will or trust. The attorney may not be entirely confident of his or her ability to determine that the person is competent, or to defend such a decision should someone later accuse the attorney of malpractice in representing that client. One option for the attorney, directly or through a court, is to seek consultation from a healthcare professional who is skilled in identifying strengths or weaknesses in the client that would render the client competent or incompetent. The attorney need not carry this burden alone.

Healthcare professionals such as psychiatrists and psychologists can conduct assessments of decision-making capacity. They can provide information to attorneys and ultimately to the courts, which make the legal determinations of competence. Attorneys can be helpful to the healthcare professionals by specifying the information legally required to clarify competency issues.

California law specifies that assignment of a diagnostic label alone is not sufficient. A client's level of functioning must be detailed and described in a manner that meets the requirements of the local law. The healthcare professionals can, therefore, be useful to attorneys in providing objective information about a client's level of functioning. This blending of information from both disciplines can be useful to all parties involved: client, attorney, healthcare professional, and the court.

For the sake of ease of writing, I shall use the term "psychologist" to refer to the mental-health professional involved in the case. Obviously, other mental-health professionals could be used (such as psychiatrists). My experience as a psychologist allows me to see some of the advantages of using psychologists, including skill in using and applying standardized measures of cognitive functioning. Typically, psychiatrists are not as well trained in standardized testing. However psychiatrists have the advantage of the training involved in acquiring a medical degree, and may, therefore, be more skilled in diagnosing physical problems that lead to dementia. Referral to a physician for a medical evaluation is clearly indicated in such cases.

John Becker, Ph.D. is a clinical psychologist practicing in Los Gatos, California. He is director of Psychology Services at Community Hospital of Los Gatos, where he provides psychotherapy as well as neuropsychological assessments, including evaluations of competency.

A very useful interaction can begin as the attorney and psychologist discuss the case during the initial dialogue about engagement of the psychologist in the case. A lively two-way discussion can estimate realistically what might be learned from an evaluation. The pertinent strengths and weaknesses of the client can be identified, and the likely strengths and weaknesses of the assessment process specified. This discussion, then, can be key to shaping an effective, useful assessment.

From this discussion can come a letter of engagement, written by the attorney. This can help ensure that the salient issues of the case will be addressed. The letter can enumerate the questions to be addressed and answered.

The attorney-psychologist dialogue can continue as the case progresses. Sharing of information helps both professionals optimally serve the interests of the client. Collaboration becomes particularly important should the case involve litigation. For example, an attorney may learn information about the case during the course of discovery and through depositions. Sharing this information can help the psychologist carefully frame answers to avoid giving misleading testimony.

Competence Defined From a Psychological Perspective

Grisso and Applebaum recently wrote about means of recognizing competence to make medical decisions for oneself.[1] They enunciated a standard against which a client's behavior can be measured. Although their work focused on competence to make medical decisions, the standard has application to financial matters as well. They emphasized that "competence is the state in which a person's decision-making capabilities are sufficiently intact for his or her decisions to be honored."[2] Please note that decision-making capabilities need not be entirely intact for a person to be able to exercise some competence.

Similarly, the definition offered by Melton, Petrila, Poythress, and Slobogin emphasized specification of the required degree of rationality to perform particular functions.[3] They state, "competency is the capacity to perform a given function with a degree of rationality, the requisite degree depending on the function to be performed."[4]

Conversely, incompetence can be described as well: "Functional deficits (due to mental illness, mental retardation, or other mental conditions) judged to be sufficiently great that the person currently cannot meet the demands of a specific decision-making situation, weighed in light of its potential consequences."[5]

Note that one's mental state can vary. Accordingly, a person who is competent to perform certain tasks one day may not be competent to perform those same tasks in the future. For example, Alzheimer's disease follows a course of steady decline and will progressively rob a person of competence. On the other hand, successful treatment of a condition will restore competence. For example, a person rendered incompetent by the "dementia syndrome of depression" may become competent again to perform certain tasks, if the depression is successfully treated. Reassessment of cognitive functioning can be very important in these cases.

Specific tools, such as psychological and neuropsychological assessment instruments, can be used to specify whether a person's decision-making capabilities are sufficiently intact. Use of these tools allows the consistent application of standard processes that are subject to outside verification. These objective tools also allow specification of the degree of impairment and the related ability to competently exercise decisions. Accordingly, the consistent use of objective tools provides the diagnostician advantages not available to the person who forms an opinion about competency on the basis of interview and observation alone.

Incompetence Defined

Functional impairment is judged to be sufficiently great when the person *currently* cannot meet the demands of a specific decision-making situation, weighed in light of its potential consequences.

Dementia As Described in The Diagnostic and Statistical Manual of Mental Disorders (4th Ed.) (DSM-IV)

By itself, a diagnosis of cognitive impairment or mental illness is not a sufficient reason to conclude that someone is incompetent. Nonetheless, it is useful to know the standards commonly applied to determine whether or not someone should be considered to have dementia. DSM-IV is the current edition of the classification system commonly employed by mental-health professionals.[7] The DSM-IV allows for communication with a common

nomenclature. It also supplies a nontheoretical, detailed description of the many conditions described. Familiarity with this publication will afford the attorney a greater understanding of the conditions that any of us can encounter, either in our clients' lives or our own.

The characteristics of dementia, as described by DSM-IV, are:

A. Development of multiple cognitive deficits manifested by both:
   1. Memory impairment (new information or recall of previously learned information); and
   2. One or more of the following:
      a. aphasia (language disturbance);
      b. apraxia (impaired ability to perform motor activities despite intact motor function);
      c. agnosia (failure to recognize or identify objects); or
      d. disturbance in executive function (planning, organizing, abstracting).

B. The deficits cause a significant impairment in social/occupational functioning.

C. The deficits represent a decline from previous level of functioning.

Please note that the course of dementia can be progressive, static, or remitting, depending on the type of dementia.

Impairment of retrieval of information learned in the distant past is a characteristic of some forms of dementia. However, there are other dementias in which one can still apparently recall "old" information while being significantly impaired in the recall of newly learned information. In such cases, one could rely only on a person's recounting of the past, and fail to adequately test the ability to recall newly learned information. This could lead one to erroneously conclude that the person is still "sharp as a tack," to employ the oft-used expression. This can be a very serious source of error, and one that explains why a neuropsychological assessment will often put particular emphasis on the person's ability to recall newly learned information. It is indeed difficult to overemphasize the importance of the ability to retrieve new information, for this is the skill that allows one to perform many functions effectively, including adjusting to new conditions and reacting effectively to changes in one's circumstances.

It is also important to distinguish between "benign senescent forgetfulness," an apparent characteristic of normal aging, and a more troubling type of memory problem that may signal the onset of a more problematic state. The questions based on the material developed by Mark and Mark can serve as a useful guide to identify some of the everyday problems that do not necessarily signal the presence of a troubling condition.[8] (Please see Table 1.) The work

Table 1.
Checklist - Conditions Requiring Investigation[6]

Some or all of the following conditions require investigation. Please put a check in front of the items you think require investigation.

1. ☐ Forgetting names.
2. ☐ Misplacing keys, glasses, or other small items.
3. ☐ Not being able to find your car in a parking lot.
4. ☐ Not being able to remember items to shop for at the store.
5. ☐ Not being able to recognize someone in an unfamiliar setting.
6. ☐ Getting lost while driving a familiar route.
7. ☐ Completely forgetting important appointments.
8. ☐ Telling the same stories over and over to the same people during a short space of time.
9. ☐ Having periods of confusion over what time it is or where you are.
10. ☐ Being unable to manage a checkbook or take care of simple finances.
11. ☐ Experiencing a sudden or gradual change in personality.
12. ☐ Having difficulty with language (e.g. consistent problems with naming objects).
13. ☐ Experiencing a sudden change in artistic or musical ability.
14. ☐ Undergoing a loss of memory which is disabling to the point that work is impossible or your daily activity level is upset.

(6 - 14 most warrant investigation)

of Mark and Mark (1999) also details many treatable conditions which, when successfully treated, will result in an improvement in cognitive functioning. The fact that dementia can be reversed is an excellent argument for the use of careful investigation of physical functioning to ensure that some treatable condition is not being overlooked.[9]

Stages of dementia are described clearly by Reisberg, Ferris, Leon, and Cook.[10] A summary of typical stages are listed in the Table 2.

Maxims of Legal Competence

Although the recent work of Grisso and Applebaum focuses on competency for decisions about medical treatment, their "maxims of legal competence" can serve as an excellent guide in preparing assessments of competence for financial matters as well. The interested reader is encouraged to study their thoughtful and helpful book.[12]

Functional Abilities Define Competence

Mental disorders are explanations for deficits in abilities. They are not sufficient conditions alone to address competence. There are relationships between impaired mental states and incompetence. However, if one has an impaired mental state, it does not mean that one must be incompetent in every domain, or even necessarily incompetent in any domain. A detailed specification of a person's functional abilities will permit effective assessment of competence.

Situations Place Varied Demands on a Person's Functioning

A person who is incompetent to balance a checkbook may still be able to effectively designate someone to do that task or to perform other tasks with possibly far greater consequences, such as working out details of a complicated trust agreement.

Careful definition of the cognitive demands of a situation is vitally important. It is also critical that an assessment considers how consistently a person has expressed and is expressing his or her wishes. It is important to know whether current wishes reflect a pattern consistent with the other known facts of the person's history.

Consequences of Person's Decisions for Their Welfare Vary

Consider the degree of harm associated with the person's choice.

High Benefit, Low Risk: Low Threshold

For example, some medical treatments carry the possibility of high benefits with low risk. In such a case, a lower threshold of cognitive competence would be required. Similarly, a person may wish to designate disposition of a small part of the person's substantial estate. This designation may bring the person marked satisfaction, while not depriving the person of the means of continued self-support and comfort.

Low Benefit, High Risk: High Threshold

A higher threshold of cognitive skill should be required for a decision to engage in (or to avoid, in some instances) certain medical treatments. Similarly, one can reasonably demand a better ability to articulate the rationale for a course of action in which a person would radically restructure the disposition of the person's estate.

A Person's Capabilities May Change with Time and Treatment

For the reasons noted previously in this article, someone who displays competence today may be unable to demonstrate the same competence for the same task at some future date. With successful treatment, the reverse may also occur: incompetence at present, competence in the future.

Essential Features of Assessments

From following these maxims of legal competence, it is possible to describe, as Grisso and Applebaum have, the essential features of a good assessment of competence, including cognitive functioning.[13]

Assess Functional Abilities Related To Decision Making

It is critically important that the psychologist focus on actual functional abilities. For example, a commonly used instrument developed to measure IQ is the Wechsler Adult Intelligence Scale, now in its third edition and known as WAIS-III. One of the subtests of the WAIS-III is Comprehension, which is correlated with awareness of social conditions and expectations. It requires the ability to verbalize responses that reflect what society commonly expects a person to do or know in certain situations.

Although the WAIS-III has been well validated as an IQ test, it would be a mistake to conclude from a good score on Comprehension that a person will necessarily exhibit good judgment in all situations,

Table 2. Phases of Decline in Alzheimer's Disease[11]

Stage	Cognitive Deficits	Personality Changes
1. Normal	No evident deficits.	No evident changes.
2. Forgetfulness	Complaints of memory deficits, such as forgetting names that were formerly well known or misplacing familiar objects, but without deficits in work or social situations	Appropriate concern with mild forgetfulness
3. Early confusional	Increased cognitive decline and signs of confusion: gets lost going to a familiar place; family and coworkers notice forgetting of words/names; poor reading comprehension; inability to concentrate.	Denial of memory problems, but anxiety accompanies symptoms of forgetfulness and confusion.
4. Late confusional	Decreased knowledge of current events; forgetting of one's personal history; decreased ability to handle finances or to travel.	Very obvious use of denial about memory problems. Flattening of affect and withdrawal from more challenging situations.
5. Early dementia	Moderately severe decline and intensified confusion: Inability to recall one's life, such as address, phone number, or the names of close family members/children; inability to recall major personal facts, like name of one's high school; some time disorientation (e.g., for date); may need assistance with choosing proper clothing.	
6. Middle dementia	Severe cognitive decline and confusion: Occasionally forgets name of spouse; largely unaware of all recent events and experiences and many past life events; unaware of surroundings; does not know season of year; can't distinguish familiar from unfamiliar persons.	Totally dependent on others for survival. Severe personality and emotional changes, such as delusions, obsessions, and high anxiety. Fails to follow through on intentions due to forgetfulness
7. Late dementia	Very severe decline and confusion: Loss of all verbal abilities; incontinent, need for assistance in eating and toileting; loss of basic psychomotor skills (e.g., inability to walk).	Unresponsive to all but the simplest communications. Total loss of social skills and personality.

particularly in challenging situations. Nor does a good score on Comprehension tell the examiner whether other conditions (such as emotional responses) would limit one's ability to carry out what he or she would otherwise report to be the best course of action.

Assess Psychopathology

It may be important to know whether a person suffers from personality problems or dysfunctions, either short term or long term, in considering whether the person can perform certain tasks. Some mental conditions, including an acute or chronic mental-health problem, could render the person capable of reasoning well, although markedly limited in the actual exercise of good judgment. For example, a person with irrationally fixed beliefs could, in theory, understand what needs to be done in certain situations. Yet this person would be unable to act prudently if the person ardently held to an irrational belief that people were maliciously conspiring against him.

Determine Task Demands

It is important to know whether there is a match or mismatch between a person's abilities and the decision-making demands of the situation that the person faces. As noted before, competency in one domain does not necessarily imply competency in all domains.

Consider Consequences of the Person's Decisions

Some decisions produce relatively trivial consequences. Some decisions can have life-enhancing or life-threatening consequences. In weighing the data gathered, the clinician needs to consider the seriousness of the consequences of possible decisions that the person being evaluated proposes to make.

Employ Reassessment of Functioning

Since level of functioning can change, timely reassessment is most important. The prudent clinician and the prudent attorney are alert to changes in a client's circumstances or life challenges, and then use reassessment when necessary. The consistency or inconsistency of displayed cognitive and emotional states is useful in preparing to prove the competence or incompetence of a person who is faced with a particular decision at a particular time.

Assess Four Functional Abilities

Grisso and Applebaum have summarized the functional abilities that should be assessed, including the abilities to express a choice, understand information relevant to the decision, appreciate the significance of that information to one's own situation (especially the probable consequences of the decision), and reason with relevant information so as to engage in a logical process of weighing options.[14]

Express a Choice

This is the *sine qua non* of competence. Expression can be verbal or nonverbal. It must be clear and consistent. Marked and protracted ambivalence about a decision could render the useful expression of choice impossible. Similarly, rapid shifts in decisions signal the presence of possible impairment.

Understand Information Relevant to the Decision and Appreciate the Significance of that Information to One's Own Situation, Especially Regarding the Probable Consequences of the Decision

Adequate appreciation involves acknowledgement of the present circumstances and acknowledgement of the consequences of varied courses of action. Markedly irrational beliefs will impair this essential appreciation.

Denial of deficits can render impossible the adequate appreciation of one's own situation. Since it is the brain that detects and assesses problems in the rest of the body (or the rest of the world, for that matter), it is especially problematic when the brain itself becomes impaired. In other words, the "problem detection device" has developed a dysfunction and is no longer able to adequately detect problems within itself.

It is important to recall that appreciation of one's situation can vary. Cognitive distortion, including an overemphasis on the severity and pervasiveness of problems, is a characteristic of depression. As noted before, effective treatment of depression can help restore effective cognitive functioning.

Reason With Relevant Information so as to Engage in a Logical Process of Weighing Options

To reason effectively, one must be able to concentrate sufficiently to keep one's focus on the problems at hand. Consequences must be evaluated thoughtfully, and possible courses of action considered carefully. Deliberation is a hallmark of thoughtful decision-making. One should be able to consider and imagine the consequences of decisions as well as assess the likelihood of those consequences.

The Competence Balance Scale

With their usual clarity, Grisso and Applebaum have offered a conceptual model to consider the task of balancing the needs to attend to both protection and autonomy in preparing an evaluation. The authors propose considering a scale with two suspended cups: one cup is labeled "protection" and the other one is labeled "autonomy." The scale can be suspended from a bar, with the fulcrum in the middle: this would grant equal weight to any evidence placed in the "cup of protection" and "cup of autonomy." Alternatively, the fulcrum can be moved to the right or to the left, thus giving more weight to protection or to autonomy.[15]

As a society, we tend to favor autonomy over protection. In fact, in California law, it is explicitly stated that "there shall exist a rebuttable presumption . . . that all persons have the capacity to make decisions and to be responsible for their acts or decisions."[16] This presumption must be overcome before protection can be legally applied against a person's will. In this phase, "as the weight of both cups is increased with the deposit of information in them, more will be required to tip the scales in favor of incompetence—with its intrusion on the patient's right to an autonomous choice in the name of protection—than to keep autonomy (and therefore the conclusion of competence) in the winning position."[17]

Put another way, "[A] judicial determination should be based on evidence that one suffers from one or more mental deficits so substantial that, under the circumstances, the person should be deemed to lack the legal capacity to perform a specific act, and should be based on evidence of a deficit in one or more of a person's mental functions rather than on a diagnosis of a person's mental or physical disorder."[18] This requirement of evidence about mental functions that substantially interfere with legal capacity is the operationalization of the preference for autonomy over protection.

There are times, however, when the fulcrum needs to be moved to the other side of the scale, consciously and overtly granting additional weight to evidence favoring protection. Protection should be favored when negative consequences (potential harms or risks from a certain decision) outweigh positive consequences (benefits). Accordingly, an intelligent assessment will consider the likelihood and the magnitude of benefits and harms, and make explicit the criteria used in drawing these conclusions.

In summarizing the competence balance scale, there is a brief way to answer the question, "Does this person have sufficient ability to make a meaningful choice, given the circumstances with which he or she is faced?" The answer depends on the balance of (1) the patient's abilities in the face of the decisional demands, weighed against (2) the probable gain-risk status of the patient's treatment choice, and (3) when the fulcrum is set to favor autonomy."[19] What was written to discuss medical choices can be easily modified by substituting "person" for "patient" and "financial choice" for "treatment choice."

Assessment Tools

There are several tools available to help the clinician measure a person's level of functioning.

Mental Status Exam, Clock Drawing

A very widely used version of the "Mini-Mental Status Exam" (MMSE) is that devised by Folstein, Folsein, and McHugh.[20]

Teng and Chui created the Modified Mini-Mental Status Exam (3MS), a standardized form of the mini-mental status exam.[21] This form provides for more detailed testing, including recognition memory. Tombaugh, McDowell, Kristjansson, and Hubley developed norms that allow for comparisons that account for age and education. With norms adjusted for age and education, this format is much more useful in reporting a person's functioning in comparison to other similar individuals.[22] One can also estimate the MMSE from 3MS, if one needs to compare the results.

By itself, a mental status examination is like a brief snapshot of someone's cognitive functioning. It is not a portrait and does not allow for much depth of knowledge. However, it has been shown that cut-off MMSE scores correlate with mild and moderate degrees of Alzheimer's disease.[23]

Independent Living Scales

This is a standardized, direct, performance-based assessment of instrumental activities of daily living. Under development since 1977, it has been nationally normed and recently published. This battery of tests allows for direct observation of functioning. For example, a person is asked to record a beginning balance, write two checks against that balance, and then derive an ending balance. The person must also identify the amount due on each of two utility bills.

Possible ranges of functioning described by this test are "High," "Moderate," and "Low." "High" scores (T scores greater than 50) characterize individuals who can live alone at home, with family, or in a community, using resources only for convenience, not out of necessity. Scores in the "Moderate" range (T scores of 40 to 50) characterize individuals who are deemed Semi-Independent. Such individuals may require assistance for some activities of daily living such as meals, transportation, social activities, and daily reminders. "Low" scores (T scores of 20 to 40) are found in individuals who are rated as dependent, i.e. living in a nursing home, a rehabilitation hospital, or a home with full-time caregivers. In general, they require full-time supervision and assistance with most activities of daily living.

MicroCog

MicroCog is a series of computer-administered subtests, which assesses important neurocognitive functions in adults. The Standard Form has eighteen subtests. This allows a broadly based comparison of both the speed and accuracy with which a person performed tests, some of which have time limits. Subjects are told that, "both speed and accuracy are important, but accuracy is more important."

It is also possible to compare a person's scores with age- and education-adjusted norms. This allows consideration of the presence or absence of cognitive deficits relative to cognitive changes expected as part of normal aging.

MacArthur Competence Assessment Tool—Treatment

This structured interview has been designed to require a few minutes of preparation, approximately twenty minutes to conduct the interview, and two or three minutes to rate the responses. Issues scrutinized include appreciation of the disorder, understanding of treatment and risks/discomforts, appreciation of treatment, alternative treatments, reasoning, and expressing a choice.

General Neuropsychological Instruments

Halstead's Category Test

Halstead's Category Test (HCT), a measure of abstract thinking related to rule learning, assesses the deduction of classification rules. This test is used as a measure of executive function. Three subtests require reasoning involving spatial positioning and two subtests involve simple proportion (e.g. 1/2, 1/4). The task also requires staying on track. The possibility of changing circumstances is announced to the subject while taking the test and progressing from one subtest to the next.

Wisconsin Card Sorting Test

The Wisconsin Card Sorting Test is a measure of abstract thinking involving attribute identification, which entails discrimination of relevant two-dimensional features. The task also requires some concentration and ability to stay on track as well as the ability to adjust to unannounced changes. This test allows for the quantification of perseverative errors, which reflect a repeated failure to learn from one's own mistakes, and often indicate difficulty in adapting to changing circumstances. This test is also used to address executive functioning.

Weschsler Memory Scale - 3rd Ed. (WMS-III)

This is a series of memory tests that allow comparison of verbal and visual memory, both for immediate and delayed recall. It is difficult to overestimate the importance of adequate delayed recall in the ability to adequately perform many daily tasks as well as more complicated functions, such as engaging in financial planning and performing testamentary deeds.

Repeatable Battery for Assessment Of Neuropsychological Status

This is a brief battery of tests that measure immediate memory, delayed memory, language, attention, and visuospatial/constructional skills. This test has two similar forms so that serial testing is possible without the risk of the patient becoming familiar with the material used.

California Verbal Learning Test— 2nd Ed. (CVLT-II)

The CVLT-II allows one to conduct a detailed examination of the processes one uses in attempting to learn and recall new information. In addition to scrutinizing age-corrected scores of new learning and delayed recall, one can examine the strategies used (or not used) as retrieval strategies. Careful examination of recognition memory is one of the tools that helps distinguish among possible impairments of brain functioning.

Assessment of the Cases of Peter, Paula, and Mary

Peter

When Peter first came to my office, he was able to offer a clear description of how he wanted to change the disposition of his property. He knew who family members were, and could indicate how they would be impacted by the changes that he wanted to make. My initial impression was that Peter was quite competent to make the changes he proposed.

However, in the interest of being thorough, I decided to test Peter further by asking him to review the numbers and changes that he had proposed. He recognized these as correct. Then I warned Peter that I would write some more numbers, which might or might not be the same as he had selected. I purposely wrote incorrect numbers, and he said he thought that these were correct. The more I continued with this procedure, the more confused Peter became. Eventually, I concluded that Peter was not competent to make changes.

Some time later, I was informed that Peter was most distressed at my findings, had repeatedly told people on different occasions what he wanted to do, and was very consistent in the expression of his wishes. A psychologist who had treated Peter for many years told me that, based on multiple conversations with Peter, he believed that Peter knew what he wanted, although an excess of detailed numbers could confuse Peter.

To test this assertion, I saw Peter on two more occasions. On those occasions, he told me what he wanted, and I did not present him with alternate plans to choose among. He was able to clearly identify whether seventy-five was bigger than seventy, and whether twenty-five was bigger than twenty. These numbers were presented to him in individual pairs (seventy and seventy-five, then twenty-five and twenty). Note that the position of the larger number changed in the presentation on the page: once the right-most member of the pair was larger, and once the left-most member of the pair was larger. Peter was able to select the larger number from the individual pairs. He then selected the correct numbers when he was presented these numbers in a two-by-two format. Peter was clearly able to understand and work with numbers when presented in these formats.

In the course of the discussion one day, I repeatedly asked Peter what he wanted to do. Each time he gave me the same answer. Interspersed between these questions were discussions of other information. Peter remained consistent. Thus, I concluded that he was able to retain material despite distraction. Before asking Peter for the fifth time, I apologized for repeating the same questions. Peter displayed good social awareness as well as awareness of the demands of the situation in his response: He did not mind, for he knew that I was doing what I had to do in order to be certain of any position I might take.

After these two sessions, I concluded that Peter was competent to make the changes that he wanted. During the very first session, I had been able to overwhelm Peter with data. During the next two sessions, Peter demonstrated that he could understand the numbers that he was proposing to change. Further, he was quite consistent in his expression of his desires.

I observed Peter signing the documents on another occasion. Before the final signing, I once again asked Peter what he intended to do, and he was able to give a clear, consistent description of his desires.

This case illustrates the point made above: one's cognitive skills can be limited in some ways while the individual remains competent to perform certain tasks. For example, Peter could be overwhelmed by a series of numbers when those were presented in rapid succession. However, Peter could also clearly and consistently state his desires and indicate increases and decreases in the amounts he wished to give to different relatives.

Paula

Paula's life was characterized by substantial wealth, and by substantial bickering. After her first husband died, Paula had a history of frequently changing the disposition of her assets to match her list of adult children who were currently in her favor or out of favor. When she remarried, arguments ensued between the children and her new husband.

In my office, Paula's recitation of her personal history was most remarkable for the omission and denial of her first marriage. She also created a story that her children had been adopted, although there was abundant evidence to the contrary. Paula could not accurately read or understand documents she had signed in the past including a Durable Power of Attorney for Health Care, and a document transferring ownership of real property. Not surprisingly, on formal testing, her memory was rated as quite impaired.

It was demonstrated that she was very limited in her ability to learn and retrieve new information. On the Cognitive Competency Test, Paula's score was so low that over ninety-five percent of people in her age group could be expected to do better than she did.

Following interviewing and testing, it was very clear that Paula was not competent to manage her own financial affairs. She also appeared quite vulnerable to the exercise of undue influence.

Mary

Mary had been under conservatorship for years. At the time of the evaluation, Mary was seeking release from the conservatorship, and the conservator was petitioning the court for more power to help regulate Mary's life. Mary was living alone in the house that she and her former husband had once shared.

Mary had not been cooperative with her court-appointed attorney's requests that she contact me for an appointment. Finally, I went to the house with the conservator, who wanted the police present when the conservator used a house key to open the door. When the door was opened, Mary came forth from her very cluttered household. She was quite upset and tried to call the police, although two uniformed officers were plainly present. Instead of dialing 911, she called 411 (directory assistance). Eventually Mary became calmer. She told the conservator and the police to get out, slammed the door behind them, and implicitly allowed me to remain inside the house with her.

Mary spoke to me but would not tolerate any note-taking, let alone any formal testing. Mary's house was so cluttered that there were only a few, narrow, dust-strewn pathways among her stacks of boxes and other belongings that filled her home. It appeared that she lived in a reclining chair that seemed like a small nest in the midst of her chaos. The house was not heated, and Mary wore several layers of clothing. Mary did not have running water in her kitchen sink. She said she was "on strike" because she did not like the type of faucet installed by the conservator. Her breakfast dish was "cleaned" by sweeping away cereal and storing the dish in a plastic bag.

Mary's speech was very fluent but quite disorganized. She flitted from subject to subject, sometimes illustrating her point with some object that she found in the house. She could stay on a given topic for only a brief while, for she soon became distracted by some other object or topic. She was eager to persuade me that her ex-husband was regularly invading her home and causing mischief, including changing the dial on her washing machine. (Despite her claims, the dial seemed to be the standard type of equipment commonly used for washing machines.) Mary also showed me more evidence of her ex-husband's "sabotage." However, it seemed most likely that what she showed me simply reflected normal wear and tear rather than a systematic invasion of her belongings. (Interestingly enough, Mary also told me about her abiding interest in the Fourth Amendment. Although she never explained this interest, I had to wonder whether she felt the need to be protected from unreasonable search and seizure.)

One irony of the interview was that Mary talked for over two hours and seemed reluctant to allow me to leave, even though she had begun to repeat herself. Unfortunately, in the future she would not return phone calls, nor would she answer the door when I attempted to visit her again.

Although no testing was possible, it seemed very clear that Mary needed more protection, not less. She had fixed, irrational beliefs. Her poor judgment imperiled her safety, in that her house was any number of accidents waiting to happen. She would not avail herself of use of the central heater for warmth, or use the running water to clean her dishes. Unfortunately, it seemed abundantly clear that the state of Mary's mind was reflected in the clutter and chaos of her home.

Conclusions

With thoughtful collaborations and cooperation, attorneys and psychologists can work together. Their search for objective evidence of functional ability describing competencies consistent with legal requirements can benefit all concerned: clients, courts, attorneys, and psychologists.

Resources For Finding A Psychologist
The following resources are helpful in locating a psychologist:

- National Academy of Neuropsychology (www.nanonline.org)
- National Register of Health Service Providers in Psychology (www.nationalregister.org) (online searchable database)
- Local (state or county) psychological association
- Local Court (e.g. Court Investigators, etc.)
- Northern California Neuropsychology Forum (www.ncnf.org)

Endnotes

1. THOMAS GRISSO & PAUL S. APPLEBAUM, ASSESSING COMPETENCE TO CONSENT TO TREATMENT (1998).
2. *Id.* at 13.
3. GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS (2d ed. 1997).
4. *Id.*
5. GRISSO & APPLEBAUM, *supra* note 1, at 27.
6. Table 1 appears in VERNON H. MARK & JEFFREY P. MARK, REVERSING MEMORY LOSS (Rev. ed. 1999). Reprinted by permission of Houghton Mifflin Company.
7. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. 1994).
8. MARK & MARK, *supra* note 6, at 83-84.
9. *See* JOHN WALLIS ROWE & ROBERT LOUIS KAHN, SUCCESSFUL AGING (1998) for an excellent discussion of healthy aging.
10. Barry Reisberg et al., *The Global Deterioration Scale For the Assessment of Primary Degenerative Dementia*, 139 AM. J. PSYCHIATRY 1136 (1982).
11. *Id.*
12. GRISSO & APPLEBAUM, *supra* note 1.
13. *Id.* at 30.
14. *Id.* at 31.
15. *Id.* at 103.
16. CAL. PROB. CODE § 810(a) (West 2001).
17. GRISSO & APPLEBAUM, *supra* note 1, at 131.
18. CAL. PROB. CODE § 810(c) (West 2001).
19. GRISSO & APPLEBAUM, *supra* note 1, at 139.
20. Marshal F. Folstein et al., *"Mini-Mental State": A Practical Method For Grading the Cognitive State of Patients For the Clinician*, 12 J. PSYCHIATRIC RES., 189 (1975).
21. Evelyn L. Teng & Helena C. Chui, *The Modified Mini-Mental State (3MS) Examination*, 48 J. CLINICAL PSYCHIATRY 314 (1987).
22. Tom N. Tombaugh et al., *Mini-Mental State Examination (MMSE) and the Modified MMSE (3MS): A Psychometric Comparison and Normative Data*, 8 PSYCHOL. ASSESSMENT 48 (1996).
23. Daniel C. Marson et al., *Assessing the Competency of Patients with Alzheimer's Disease Under Different Legal Standards*, 52 ARCH. OF NEUROLOGY 949 (1995).