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MEDICAL REASONS FOR RETROSPECTIVE CHALLENGES OF TESTAMENTARY CAPACITY

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SUMMARY

Objectives: *The aim of this study was to establish the morbidity structure among testators whose wills were challenged as well as to reveal if there is a specific relationship between certain diagnostic categories in the testators' health status and forensic psychiatry expert opinion on testamentary incapacity.*

Subjects and methods: *The authors analyzed 156 consecutive forensic psychiatry reports on retrospective, determination of testamentary capacity made in the Forensic Psychiatry Centre, Institute of Psychiatry, Belgrade in the period 1965 - 2005. The wills covered by this study were mostly made by male, 65 years old or older testators, with primary education, who executed a holograph will and survived it for less than a year.*

Results: *Testamentary incapacity for medical reasons was established in 47% of the testators, while a strong, statistically significant relationship between a diagnostic category and testamentary incapacity was established among the testators suffering from an organic mental disorder (Chi-square = 133.256, p = 0.000) or a substance induced mental disorder (Chi-square = 6.971, p = 0.008).*

Conclusion: *Testamentary capacity is a specific focus of medical assessment given that the evidence for overturning a will is generally dependent upon medical assessment. In that respect, much litigation and expenses could be avoided if medical experts were given a chance to correctly assess the testamentary capacity of a person at the time of making a will. The fact remains that our findings may not be a representative cross-section of the general population, and this important issue certainly deserves to be addressed by future research based on a larger sample.*

Key words: *testamentary capacity - medical condition - mental disorder*

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INTRODUCTION

Demographic forecasters predict a significant growth of the population of older people and epidemiological data strongly suggest that medical comorbidities aggregate with aging, so that now most persons over age 65 suffer from one or more conditions that significantly impair physical, mental and overall life functioning (Ahmed 1998, Kunik et al. 1998, Borson et al. 2001, Dunkin & Amano 2005). With respect to these profound changes in the demographics of chronic diseases, challenges to wills because of a lack of testamentary capacity along with requests for the expert assessment of testamentary capacity of individuals whose wills are being challenged are likely to increase in the next decades (Shulman et al. 2005).

In most jurisdictions, there is a basic presumption of competence when adults enter into contractual arrangements or make decisions such as making a will. Nonetheless, a last will always requires a judicial approval and the evidence for challenges to wills, based on a lack of testamentary capacity (i.e. capacity to contract and make wills and testaments) can be substantially dependent upon expert medical assessment (Sprehe & Kerr 1996). In general, jurisdictions require that a person is of "sound mind" when

executing or altering a will, that is, a person must appreciate the legal binding nature of the will and understand its personal, legal, social and financial implications (Kermani 1989). These principles represent an attempt to preserve the estate of the incompetent so that those who have rightful claims against the estate, as well as those who could be expected to be supported by the estate, would be protected from having the estate dissipated by the incompetent (Rajacic 1967).

When wills are contested, the mental capacity of a testator is questioned and usual forensic determination is a retrospective, post mortem expertise in interpreting relevant data from different sources such as direct testimony from witnesses who had first-hand experience with the testator, medical records, documentation at the time of the execution of the will and the will itself (Redmond 1987, Peisah 2005). At an international level, testamentary capacity is one of the few capacities that are almost entirely dependent on case law without much statutory direction (Posener & Jacoby 2002). The case that still dominates the question of testamentary capacity in the United States and United Kingdom (Banks vs. Goodfellow 1870, Jacoby & Steer 2007) is the 1870 English decision known as "Lord Cockburn's rule" based on Banks vs. Goodfellow. This case laid down criteria for medical experts in assessing capacity to make out a will, which include: 1) understanding of the nature of a will; 2) knowledge of the nature and extent of one's assets; 3) knowledge of persons who have a reasonable claim to be beneficiaries; 4) an understanding of the impact of the distribution of the assets of the estate; 5) a provision that the testator is free of any delusions that influence the disposition of one's assets; 6) wishes can be expressed clearly and consistently. In Europe, the issues relating to testamentary capacity are regulated in various civil codes. Similarly to the Banks vs. Goodfellow approach, the standards formulated by most courts emphasize almost exclusively cognitive capacity. For example, according to the German Civil Code (Paragraph 2221, Section 4) anyone who is unable as a result of mental illness or mental incapacity or deprivation of his or her senses of perceiving the importance of a declaration of will that he or she has issued and acting in this knowledge is not able to make a will (Godderis 1981). On the other hand, according to the Serbian (statutory) inheritance law (Paragraphs 79-82) a will may be signed by a person who is at least fifteen years of age, a testator must be capable of reasoning, his will must be serious, real and free, and his intent must be clear and unconditional.

There are several legal grounds upon which the validity of a will may be challenged. Those with the clearest relation to medical condition and mental incapacity are the claims that the testator lacked testamentary capacity at the time the disputed will was signed and, usually simultaneous, claims that specific contents of the will resulted from undue influence exerted upon the testator by one or more persons. In Serbian forensic practice most practitioners in assessing capacity to make out a will traditionally rely upon criteria referred to as "Davidson's criteria" (Davidson 1965, Kapamadzija 1989, Black et al. 1991). According to these criteria, testators must have the ability to know and understand: that they are making a will; the general nature and extent to their property; and the objects of their bounty and claims upon them. In other words, the testator's cognition must provide ability to decide freely and logically not as a result of mental illness or undue influence.

Apart from the role of personally meaningful life events and psychophysiological responses to them in the etiology, course, and outcome of a wide range of illnesses, there are several pathophysiological mechanisms mediating between mental status and body functions so that several medical conditions can present with psychiatric symptoms and impaired mental capacity (Lipowski 1975, Marjanovic 1980, Spar 1992, Peisah et al. 1994, Jovovic et al. 2002, Lishman 2003, Koludrovic 2007). Medical reasons for contestation of wills are typically on the basis of occasions where a testator: 1) becomes mentally incapacitated or shows evidence of severe physical incapacity before a will is made; 2) becomes more susceptible to the influence of others by virtue of a physical or mental disability and consequent dependence on the influencing caregiver; 3) refuses a medical intervention or procedure that may be necessary to prolong her life, which brings up a question of competency; 4) suffers from major depression, substance use disorder or

any psychiatric/medical disorder affecting the central nervous system function, and commits suicide after executing a will (Perr 1981, Sprehe 1998, Turcin & Milic 1991, Shulman et al. 2003).

As previously mentioned, typical of a will contestation is the presumption of testamentary capacity, except under certain circumstances, and the burden of proof that the will should not be admitted to probate - that is, found valid - rests with the party alleging deficiency. In most jurisdictions "clear and convincing" arguments must be made before the will is invalidated. A previous adjudication of incompetence, for example, guardianship, does not prevent establishing a valid will; however, the burden of proof is then on the proponent that the will was made during a "lucid interval". The important issue of lucid intervals deals with the reality that individuals who have psychiatric illnesses may have periods of time when they are quite ill and are not competent to make a will, but at other times they may have the minimal abilities required by law to fulfill the criteria for testamentary capacity. Lucid intervals are also found in individuals with psychoactive substance disorders, unless the substance abuse has led to some chronic, significant mental deterioration. Though at times the lucid interval doctrine has been extended to the individuals who are lucid for a few minutes, those few minutes are usually insufficient for the individual to assess and comprehend the factors involved in the distribution of assets, and the individual may be especially susceptible to undue influence during these few minutes of lucidity (Clements & Ciccone 1984).

Undue influence is defined as manipulation or deception in engaging the affections of the testator, significantly impairing his testamentary capacity . By its nature, undue influence is often the result of concealed actions and therefore it is difficult to determine. The courts look for evidence of "coercion, compulsion, or restraint", which led to a will that does not reflect the desires of the testator. Some grounds for undue influence include harassment to the point that the testator agrees in order to get relief, threats to never return, and lies that result in negative feelings toward a potential heir (Perr 1981). Individuals may be vulnerable to undue influence because of a chronic progressive disorder such as cancer, cardiovascular disease including strokes and heart failure, a variety of dementias, chronic organ failure, massive trauma, or metabolic disorders. These same impairments may be so severe that the individual may lack testamentary capacity. A less severe physical impairment may result in the individual's being more vulnerable to undue influence while retaining testamentary capacity (Crumbley 1999).

Slovenko found that of all wills probated, not more than 3% are contested, and of these contests, not more than 15% are successful (Slovenko 1973). Recently, Marcinkowski and Klimberg also have found the proportion of successful challenges of testamentary capacity to be much higher (40% of contests), and mostly associated with the frequent drawing up of testaments by chronically ill individuals immediately before death (Marcinkowski & Klimberg 2007). Various cerebral and somatic conditions as well as mental disorders can interfere with the "sound mind" required to make a will, and the aim of this study was to establish morbidity structure among testators whose wills were challenged as well as to reveal if there is a specific relationship between certain diagnostic categories in the testators' health status and forensic psychiatry expert opinion on testamentary incapacity.

SUBJECTS AND METHODS

The authors analyzed 156 consecutive forensic psychiatry reports on retrospective, post mortem determination of testamentary capacity made in the Forensic Psychiatry Centre, Institute of Psychiatry, Clinical Centre of Serbia, Belgrade in the period 1965 - 2005. According to court orders, the decedent's medical records were disclosed in all the cases, and the physician/patient privilege (where it existed) and confidentiality requirements were waived given that the decedent's medical condition was put into issue (by the executor, surviving spouse, heir at law, next of kin, or other parties in interest). In all the cases covered by this study, a judicial approval confirmed experts' opinion.

Expert opinion on testamentary capacity, testators' medical diagnoses and other relevant variables were established on the basis of available data from the forensic psychiatry reports involving citations of relevant medical records and judicial documentation such as testimony from witnesses (surviving, spouse, friends, relatives, neighbors, business associates, service and care providers) who had first-hand experience with the testator as well as (provided for the purpose of legal procedure) business records, personal documents (personal correspondence, notebooks or diaries), and the will itself. The testators' medical diagnoses, for the purpose of this study, were established based on available medical records (quoted in the forensic reports) and classified into corresponding diagnostic classification groups in accordance with the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health Organization 1992).

The design of this study was retrospective, and the Model Selection Loglinear Analysis procedure based on backward elimination which simultanously analyzes association of several categorical variables (Norusis 1994) indicated that a model with main effects and 2-way interactions (i.e., without 3-way and higher order effects) was adequate to present the data.

RESULTS

The wills covered by this study were mostly made by male, 65 years old or older testators, with primary education, who executed a holograph will and survived it for less than a year. Committing suicide after executing a will was found in 3 (2%) testators, while an advance refusal of treatment was found in 2 (1%) testators. None of previously mentioned variables, i.e. gender, age, level of education, holograph will (yes/no), committing suicide after executing a will (yes/no), an advance refusal of treatment (yes/no), and length of survival period after executing a will, was significantly related to testamentary incapacity which was established in 73 (47%) of the 156 testators (Table 1). In all the cases, retrospective determination of testamentary capacity was made by a team of two or three experts, specialists in neuropsychiatry and forensic psychiatry, and there were no significant differences between 8 expert teams (whose reports were involved in this study) regarding the proportion of testators pronounced incapable.

Table 1. Basic data on 156 testators

Variable	**N**	**%**
Men	113	72%
65 years old or older	125	80%
primary education	93	60%
a holograph will	138	88%
survived a will for less than a year	118	76%
committed suicide after a will	3	2%
an advance refusal of treatment	2	1%
Lack of testamentary capacity	73	47%

Note. N – count; % - proportion

All the wills involved in this study were challenged for medical reasons, and morbidity structure in the 156 testators whose wills were contested is shown in Figure 1. Here, medical diagnoses of the testators are classified into corresponding diagnostic classification groups with alphanumeric codes (e.g., D50-D89) assigned according to the ICD-10 criteria. General medical conditions with clinical signs and symptoms where an accurate medical diagnosis could not be assigned (R00-R99) were present in 7%. Mental and behavioral disorders (F00-F99) were established in 88 (56%) of the testators. The mental and behavioral disorders were additionally classified into three subgroups: organic, including symptomatic, mental

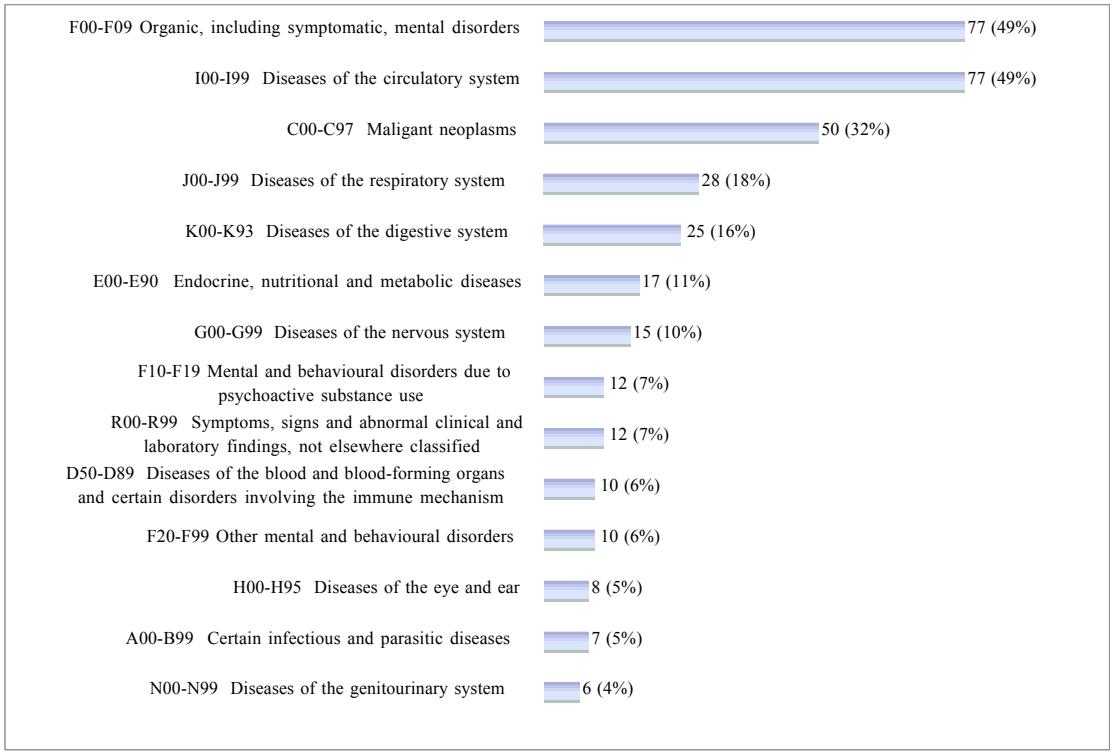

Figure 1. Morbidity structure in 156 testators

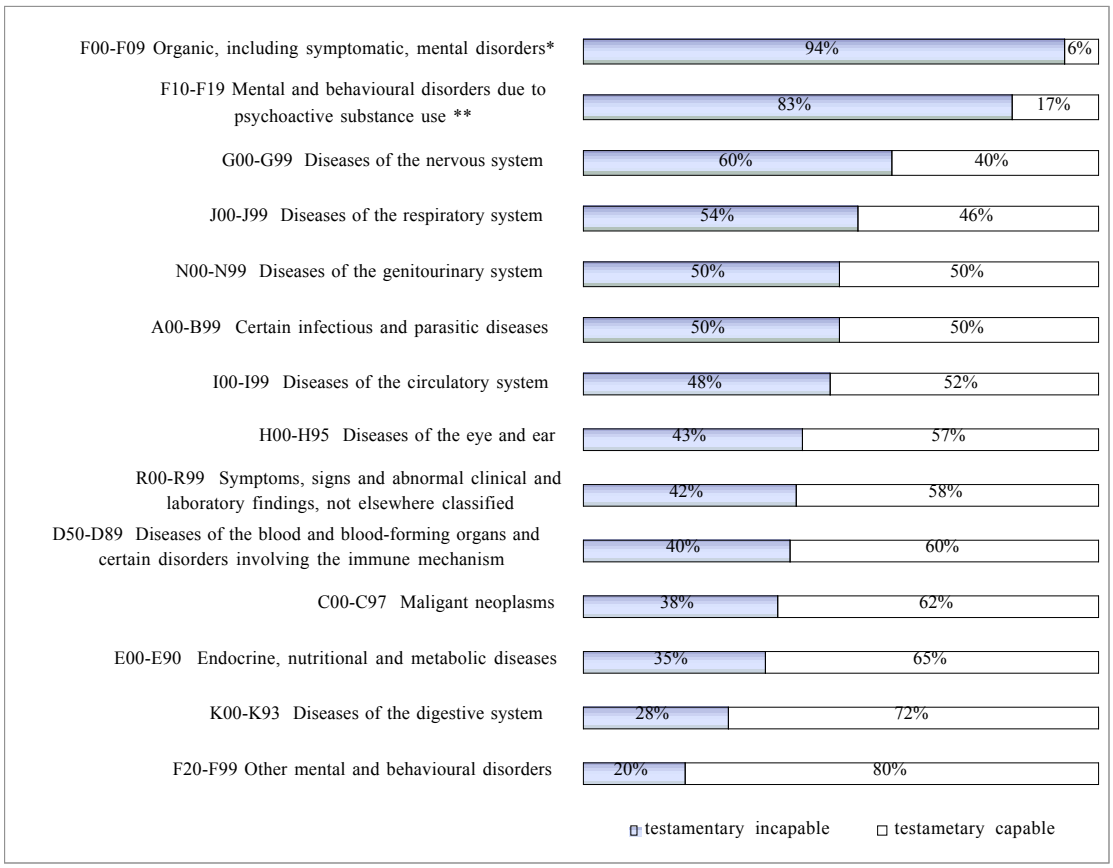

Figure 2. Proportion of testamentary incapacity across diagnostic groups in 156 testators

* Mostly vascular or senile dementia; significant association between the presence of a disorder from this diagnostic group and testamentary incapacity was established (Pearson Chi-square = 133.256, asymp. sig. 2-sided = 0.000)

** Mostly alcohol dependence with amnesic syndrome or alcohol psychosis; significant association between the presence of a disorder from this diagnostic group and testamentary incapacity was established (Pearson Chi-square = 6.971, asymp. sig. 2-sided = 0.008)

disorders, i.e. mental disorders due to a general medical condition (49%), mental and behavioral disorders due to psychoactive substance use (7%), and other mental and behavioral or disorders (6%). The organic, including symptomatic, mental disorders were mostly (52%) due to diseases of circulatory system.

Proportion of testamentary incapacity across diagnostic groups in the testators is presented in Figure 2. Statistically significant association between the presence of a medical disorder and testamentary incapacity was found only among the testators suffering from organic mental disorder (Pearson Chi-square = 133.256, asymp. sig. 2-sided = 0.000) or substance induced mental disorder (Pearson Chi-square = 6.971, asymp. sig. 2-sided = 0.008). In other words, the testators suffering from an organic mental disorder or substance induced mental disorder were significantly more likely to be incapable than testators without those disorders.

DISCUSSION

With respect to basic demographic characteristics of the subjects in this study (Table 1), a relatively high prevalence of men among the testators is typical of the traditionally patriarchal value system in Serbian society where a wast majority of rightfull owners are men, and were participation in public affairs and legal actions such as executing a will are generally considered a „man's job", while women still tend to passively leave the distribution of the assets to a spouse and children who are according to the Sebian inheritance law defined as legal beneficiaries of a will (i.e. inheritors in the first line who are rightful claimants to a share of the assets of the estate).

The subjects of our study mostly made their wills after reaching old age, less than a year before death and no one was examined for testamentary capacity *tempore acti*. As Jacoby and Steer wrote, " this would scarcely be a problem if people were to make wills before reaching old age, but this often does not happen, and a growing number of wills are challenged after the testator's death" (Jacoby & Steer 2007). On the other hand, much litigation could be also avoided, if doctors had an opportunity to asses testamentary capacity *tempore acti,* particualry in cases were testators are old people or people suffering from a serious medical condition (Regan & Gordon 1997). Nevertheless, this was not the case with any of our subjects.

As for the possibility of undue influence, given the old age, low education and poor health status of the subjects with consequently low levels of adaptational functioning, they were certainly raised as an issue at court. In that respect, while analysing the contents of court decisions to obtain an expert opinion on testamentary capacity we could not find explicite requests concerning undue influence. The reasons for such a finding must be concieved in the light of Serbian court practice where the issue of undue influence (as a legal ground for criminal charges) is considered strictly a court matter. In other words, experts at court are not allowed to explicitelly address this issue, that is, to arrive at an opinion as to whether or not there was undue influence. But forensic experts may nonetheless assist the court in understanding if the individual's character features and personal relationships, alone or in combination with physical or mental condition, made a testator susceptible to the influence of others. A number of factors may lead to a weakened ability to resist efforts at undue influence. Forensic experts must consider intellectual functioning, overall health and physical condition as well as whether the signs and symptoms of mental disorders do (or do not) reach the level of destroying testamentary capacity. According to recent research findings by

Schulman et al., typical of retrospective challenges to testamentary capacity where undue influence was alleged comprised the cases of radical change in the context of a complex or conflictual family environment among testators with no biological children, who executed their wills less than a year prior to death whose co-morbid conditions were predominantly dementia, alcoholism and other disabling neurological or psychiatric conditions (Shulman et al. 2005).

The data presented in Figure 1 and Figure 2 provide information about the frequency structure of established diagnostic categories which were reasons for challenging a will and the probability of an expert opinion of incompetence to make a will within each diagnostic category. A strong and statistically significant relationship between a diagnostic category and testamentary incapacity in this study was found only in cases of severe organic including symptomatic, mental disorders and chronic substance use disorders. With respect to the still questionable nosological status of „organic mental disorders", it is worth clarifying that the term organic mental disorders in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is no longer used because it is assumed to incorectly imply that „nonorganic mental disorders" do not have a biological basis (American Psychiatric Association 1994). In the DSM-IV, disorders formerly (in previous edition of the DSM classification system) called organic mental disorders have been grouped into a chapter called Delirium, Dementia, and Amnestic and Other Cognitive disorders where for each disorder the etiology is either a general medical condition or a substance or a combination of these factors. Contrary to the DSM-IV criteria, in the ICD-10 disorders induced by alcohol and other psychoactive substances (i.e „Mental and behavioral disorders due to psychoactive substance use, coded F10-F19) are classified separately from organic mental disorders.

Theoretically various medical (i.e., both cerebral and somatic) conditions, such as cardiovascular, neoplastic, and autoimmune diseases as well as primary mental disorders can interfere with the "sound mind" required to make a will. However, evidence of the existence of one of these conditions in reality does not necessarily lead one to the conclusion that the person was incompetent (Gutheil & Bursztein 1986). A forensic expert must demonstrate that signs and symptoms of the illness from which a testator was suffering caused significant deficit in cognitive functioning and directly affected his capacity to make a valid will. The individual with a mild dementia may have difficulty recalling new information but may nonetheless know her children, the approximate size of her estate, and that she wishes to reward the child with whom she is living with a larger share of inheritance (Clements & Ciccone 1984). Nearly one third of our sample comprised the challenges of testamentary capacity in testators suffering from malignant neoplasms. However, according to our research findings the testators with malignant neoplasms were not more likely to be incapable than other testators. Likewise, the fact that a testator committed suicide (3 of 156 cases in this study) calls for an inquiry into its effect on the testator's decision-making, but it does not invariably lead to an opinion of incompetence to make a will; it must be demonstrated that the testator suffered from specific signs and symptoms that impaired his ability to draw up a valid will (Francis 2001).

As for the issue of an advance refusal of treatment, which was found in 2 of 156 cases in this study, there is a widespread consensus in law and medical ethics that living wills have to be obeyed by the physician if the patient was competent when the medical directive was signed and if, after the patient becomes incompetent, additional conditions occur which were considered by him. This opinion may be questionable for it does not take into account the

empirical fact that the formerly competent person's critical interests do not necessarily correspond with his experiential interests after incompetence is established irreversibly (Bernat 1999). In similar cases one may also argue that forensic expert testimony at contestation of wills is "little more than a psychiatric excuse to invalidate wills that do not conform to conventional social norms", and that "the will contestation itself robs a person of the right to exercise last will" (Szasz 1963, Jovanovic 2004). Finally, the use of judical outcome in validating forensic evaluation of testamentary capacity may not be satisfactory since legal judgements in such cases are confounded by many variables beyond the mental state of a testator tempore acti. In the cases of retrospective challenges of testamentary capacity each judical outcome is also affected by a forensic evaluation and therefore is not an independent criterion measure (Poythress & Petrella 1983).

CONCLUSION

Though testamentary capacity is a legal concept and challenges are made on legal grounds, it is also a specific focus of medical assessment given that the evidence for overturning a will is generally dependent upon expert medical assessment. The results of our study, based on the analysis of 156 consecutive psychiatry reports on retrospective determination of testamentary capacity, showed that retrospective challenges of the testamentary capacity for medical reasons may be successful in nearly half the cases, while a strong, statistically significant relationship with testamentary incapacity was established among the testators suffering from an organic mental disorder or a substance induced mental disorder. As for the limitations of this study, the fact remains that our findings may not be a representative cross-section of the general population, and this important issue certainly deserves to be addressed by future research based on a larger sample, which should overcome two substantial obstacles, i.e. the traditional inaccessability of Serbian court archives to medical research and the lack of an integral, national database with relevant variables.

REFERENCES

1. *Ahmed MB: Psychological and legal aspects of mental incompetence. Tex Med, 1998; 94:64-7.*
2. *American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 123-4. Washington DC: American Psychiatric Association, 1994.*
3. *Banks* vs. *Goodfellow. 5 LR QB 549, 1870.*
4. *Bernat E: The living will: does an advance refusal of treatment made with capacity always survive any supervening incapacity? Med Law Int 1999; 4:1-21.*
5. *Black HC, Nolan JR & Conolly MJ: Law Dictionary, 6th edition. St. Paul, MN: West Publishing Co., 1991.*
6. *Borson S, Bartels SJ, Colenda CC. Gotlieb GL & Meyers B. Geriatric mental health services research: Strategic plan for an aging population: Report of the Health Srvices Work Group of the American Association for Geriatric Psychaitry. Am J Geriatr Psychiatry 2001, 9:191-204.*
7. *Kermani EJ: The Mentally Disabled and the Law. Handbook of Psychiatry and Law. 109-15. Chicago: Year Book Medical Publishers, Inc, 1989.*
8. *Clements CD & Ciccone JR: Ethics and expert witnesses: The troubled role of psychiatrists at court. Bull Am Acad Psychiatry Law 1984; 12:127-36.*
9. *Crumbley M: Undue influence and lack of testamentary capacity. American Journal of Psychiatry 1999; 271-4.*
10. *Davidson HA: Forensic Psychiatry. 273-92. New York: The Ronald Press, 1965.*

11. *Dunkin JJ & Amano SS. Psychological changes with normal aging. Sadock BJ, Sadock VA, editors. Kaplan & Sadock's Comprehensive Textbook of Psychiatry, Eighth Edition. 3624-31. Philadelphia: Lippincott Williams & Wilkins; 2005.*
12. *Francis LP: Decisionmaking at the end of life: patients with Alzheimer's or other dementias. Georgia Law Rev 2001; 35:539-92.*
13. *Godderis J: Psychiatric considerations concerning the competency for making a will. Gerontologie 1981;12:81-90.*
14. *Gutheil TG & Bursztein HJ: Clinicians guidelines for assessing and presenting subtle forms of patient incompetence in legal settings. Am J Psychiatry 1986; 143:1020-3.*
15. *Jacoby R & Steer P: How to assess capacity to make a will. BMJ 2007; 335:155-7.*
16. *Jovanovic AA: Legal status of the persons with mental illness in Serbia. Srp Arh Celok Lek. 2004; 132:448-52.*
17. *Jovovic S, Maric J & Jovanovic AA: Analysis of influence of malignant disease on testamentary capacity. Engrami 2002; 24:29-42.*
18. *Kapamadzija B: Forensic Psychiatry. Novi Sad: Dnevnik, 1989; 185-91.*
19. *Koludrovic M: Psychiatric issues in expert opinion on inheritance-legal contracts in persons with malignant diseases. In: Zarkovic Palijan T, Kovacevic D, (eds). (From Forensic Psychiatry). Zagreb: Ceres d.o.o., 2007; 316-31.*
20. *Kunik ME, Benton CL, Snow-Turek AL, Molinari V, Orengo CA & Workman R: The contribution of cognitive impairment, medical burden, and psychopathology to the functional status of geriatric psyciatric inpatients. Gen Hosp Psychatry 1998; 20: 183-8.*
21. *Lipowski ZJ: Psychiatry of somatic diseases: epidemiology, pathogenesis, classification. Compr Psychiatry 1975; 16:105-24.*
22. *Lishman WA: Organic Psychiatry: The Psychological Consequences of Cerebral Disorders, 3th Edition. 32-58. Oxford: Blackwell Publishing, 2003.*
23. *Marcinkowski JT & Klimberg A: Medico-legal opinions in cases for annulment of testament. Part II. Final conclusions of opinions. Quality of medical documentation. Evaluation of witnesses' testimonies. Arch Med Sadowej Kryminol 2007; 57:42-8.*
24. *Marjanovic S: Severe somatic disorders and testamentary capacity. Engrami 1980; 2:132-36.*
25. *Norusis MJ: SPSS Advanced Statistics 6.1. Michigan: SPSS Inc., 1994; 145-69.*
26. *Peisah C: Reflections on changes in defining testamentary capacity. Int Psychogeriatr 2005; 17:709-12.*
27. *Peisah C & Brodaty H: Dementia and will-making process. The role of medical practitioner. Medical Journal of Australia 1994; 161: 381-4.*
28. *Perr IN: Wills, testamentary capacity and undue influence. Bull Am A cad Psychiatry Law 1981; 9:15-22.*
29. *Posener HD & Jacoby R: Testamentary capacity. In Jacoby R, Oppenheimer C, editors. Psychiatry in the Elderly. 932-46. 3rd edition. Oxford: Oxford University Press, 2002.*
30. *Poythress NG & Petrella R: The quality of forensic examinations: An interdisciplinary study. J Clin Consult Psychology 1983; 51:76-85.*
31. *Rajacic C: Capability of reasoning in inheritance law. In: Rajacic C, (ed) Civil and legal status and the issues of protection of mental patients. 221-38. Zagreb 1967; (Croatian).*
32. *Redmond FC: Testamentary capacity. Bull Am Acad Psychiatry Law 1987; 15:246-256.*
33. *Regan WM: Gordon SM. Assessing testamentary capacity in elderly people. South Med J 1997; 90:13-5.*
34. *Shulman KI, Cohen CA & Hull I: Psychiatric issues in retrospective challenges of testamentary capacity. Int J Geriatr Psychiatry 2005; 20:63-9.*
35. *Shulman KI, Hull I & Cohen CA: Testamentary capacity and suicide: An overview of legal and psychiatric issues. International Journal of Law and Psychiatry 2003; 26:403–415.*
36. *Slovenko R: Pschiatry and Law. Boston: Little Brown & Co, 1973; 336-45.*
37. *Spar JE & Garb AS: Assessing Competency to Make a Will. The Am J Psychiatry 1992; 149:169-74.*
38. *Sprehe DJ: Geriatric psychiatry and the law. In Rosner R, (ed). Principles and Practice of Forensic Psychiatry. 501-7. New York: Oxford University Press, Inc, 1998.*

39. *Sprehe DJ & Kerr AL: The use of law conditions in contesting wills. Bull Am Acad Psychiatry Law 1996; 24: 255-65.*
40. *Szasz T: Law, Libery and Psychiatry. 134-5. New York: Macmillan, 1963.*
41. *Turcin M & Milic S: Forensic Psychiatry. 33-49. Osijek 1991.*
42. *World Health Organization: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. Geneva: World Health Organization, 1992.*