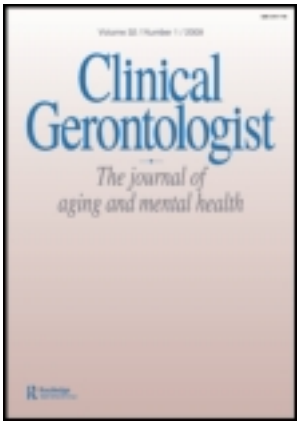

Clinical Gerontologist
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wcli20

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Peter A. Lichtenberg PhDABPP [a]
[a] Wayne State University, Detroit, Michigan, USA

Available online: 07 Dec 2011

To cite this article: Peter A. Lichtenberg PhDABPP (2012): Misdiagnosis of Alzheimer's Disease: Case Studies in Capacity Assessment, Clinical Gerontologist, 35:1, 42-56

To link to this article: http://dx.doi.org/10.1080/07317115.2011.626516

Clinical Gerontologist, 35:42–56, 2012

ISSN: 0731-7115 print/1545-2301 online
DOI: 10.1080/07317115.2011.626516

Routledge
Taylor & Francis Group

Misdiagnosis of Alzheimer's Disease: Case Studies in Capacity Assessment

PETER A. LICHTENBERG, PhD, ABPP
Wayne State University, Detroit, Michigan, USA

The intense focus on Alzheimer's disease has led even experienced practitioners to misdiagnose older adults' cognitive impairment as Alzheimer's. The impact of misdiagnosis may be greatest in cases of capacity, especially conservatorship and testamentary capacity. Two case examples are presented, with an emphasis on diagnostic issues and the importance of accurate diagnosis in light of increasing cases of cognitive dysfunction in older adults. In the first case, issues of delirium and frailty were misdiagnosed as Alzheimer's disease, while in the second case, overreliance on family report and a lack of cultural competency caused a woman with mild cognitive impairment (executive functioning type) to be diagnosed with moderate Alzheimer's disease. As the older adult population grows, clinical gerontologists will continue to be called on to assess capacity, and accurate diagnosis is essential for accurate assessment.

KEYWORDS Alzheimer's disease, capacity, misdiagnosis

The misdiagnosis of Alzheimer's disease can be devastating. The emotional toll is obvious, but other damage to a patient's life can be just as severe; one of the most serious results can be loss of financial independence. Alzheimer's disease affects more than five million older Americans and is the most common form of age-related dementia. Furthermore, it is frequently viewed as the cause of all cognitive impairment, even by physicians and psychologists who are not familiar with the various etiologies of cognitive dysfunction in older adults. One widespread belief about Alzheimer's disease

Address correspondence to Peter A. Lichtenberg, PhD, ABPP, Director and Professor of Psychology, Institute of Gerontology, Wayne State University, 87 E. Ferry Street, Detroit, MI 48202, USA. E-mail: p.lichtenberg@wayne.edu

is that it completely strips personhood and all competencies along with it (Lichtenberg, 2009). Because many lawyers and judges share this assumption, proper assessment by a qualified clinician and a more comprehensive understanding of cognitive impairment is critical for the fair adjudication of competency suits and contested testamentary capacity.

Over the past year, the National Institute on Aging has made a concerted effort to publicize reported breakthroughs in the identification of Alzheimer's disease: For the first time since 1984, when the first criteria for Alzheimer's disease diagnosis were created, new diagnostic criteria have been adopted (McKhann et al., 2011). The chief difference is the use of biomarkers as adjunctive tests. Of particular note, De Meyer et al. (2010) have studied the clinical testing of cerebral spinal fluid (CSF) in the diagnosis of Alzheimer's disease. The authors measured levels of amyloid and tau proteins in the CSF of 114 normal subjects and 302 subjects with mild cognitive impairment and Alzheimer's disease. A cut score was developed, and using Receiver-Operating Curve (ROC) analyses, the authors found a specificity of only 64%, for a false-positive rate of 36%. In their rush to describe these new results as potentially groundbreaking, several Alzheimer's experts were quoted in lay publications stating that the new CSF test provided definitive diagnoses. This was not the case, and analysis of the clinical utility data reveals a level of validity that no clinician would consider acceptable. Thus, caution and care continue to be necessary in diagnosing Alzheimer's disease, and clinical gerontologists must continue to enhance their diagnostic skills.

The coverage of Alzheimer's disease in the popular press has given rise to two misconceptions: Alzheimer's disease is clearly understood and can be easily diagnosed, and Alzheimer's disease strips the individual of personhood and renders him or her incompetent to make important decisions. These messages can influence how even seasoned clinicians view older adults, and may lead them to assume that Alzheimer's disease is present whenever an older adult displays cognitive impairment.

Over the past 15 years, I have participated in approximately 75 probate capacity cases (e.g., capacity to live alone, conservatorship, guardianship, testamentary capacity, capacity for sexual consent). During that time, I have found that professionals, even experienced ones, misdiagnose older adults, and that these misdiagnoses have a significant impact on questions of capacity. The purpose of this paper is to examine two such cases and discuss the mistakes made by the clinician involved in each. The cases are presented to underscore the importance of careful diagnosis, particularly when individual liberties are at stake.

Even scholarly materials can fall short in emphasizing the diagnostic process. For instance, a recent publication, *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists* (American Bar Association [ABA], 2008) examines general and specific approaches to a

number of capacity issues in depth—yet the critical importance of accurate diagnosis is not stressed. The authors state, "Documentation of the medical diagnoses is a key element in capacity determination as they may be causative factors explaining any functional disability" (p. 25) and "The clinical interview should include questions to help determine if there is a medical, psychiatric or neurological condition impacting cognition" (p. 32). Though both statements are sound, they do not caution clinicians to carefully check the diagnostic accuracy of previously "diagnosed" conditions, nor do they discuss the major syndromes besides Alzheimer's that can affect cognition, particularly syndromes of delirium, frailty, and vascular cognitive impairment. For instance, cognitive dysfunction in delirium and frailty is often more transient than in persons with Alzheimer's disease, and in Vascular Cognitive Impairment, the cognitive deficits more typically affect executive functioning than memory. In the latter case, capacity can be enhanced by methods such as using a calendar to organize schedules and creating structured routines to reduce distractibility.

CASE 1: TESTAMENTARY CAPACITY

Mr. A, who was nearing his 80s with increasing disability due to post-polio syndrome, was cared for primarily by one of his sons. Fifteen months before Mr. A's death, he made some minor changes to a previous will, leaving more money to his caregiving son than his other children. After he died, the three siblings sued in probate court, claiming that the final will was invalid due to their father's lack of testamentary capacity. I was asked by the caregiving son's attorney to review the medical records. The issue was Mr. A's testamentary capacity on February 21, 2005, the date he changed his will.

Testamentary capacity in Michigan (In re Sprenger, 1953) requires that an individual making a will (1) understands the purpose of the document, (2) knows the nature and extent of the property, (3) knows the natural object of his bounty, and (4) knows the manner in which he desires to dispose of this property.

This case was a retrospective evaluation of testamentary capacity (see ABA, 2008, pp. 85–87), which requires a thorough review of not only medical records, but also business records and other financial documents, as well as any letters, diaries, or family videos. In Mr. A's case, there were several medical records that were contemporaneous with the changes made in the will. A comprehensive review of these records allowed me to analyze several years' worth of cognitive and physical functioning, disabilities, and other medical disorders to determine Mr. A's level of functioning as close as possible to February 21, 2005.

Review of Medical Records

Mr. A, twice married and a widowed, retired senior supervisor, was born in 1925. By 2000, when he was 75, he had suffered from several medical problems during his lifetime, including childhood polio, congestive heart failure, diabetes mellitus, hypertension, high cholesterol, arrhythmia, gastric disorders, and post-polio syndrome; he also used a pacemaker. There were no cognitive difficulties noted in any of the medical records in 2000 and 2001.

Mr. A's medical highlights across the years were:

2002

- Hospitalized in March, April, May, July, and August.
- Consistently demonstrated intact cognition in hospital bedside assessments.
- March, May, August: Presented to Dr. X, his longtime family physician, with symptoms of lethargy and weakness, with multiple falls. The March, May August:underlying cause was determined to be anemia; symptoms cleared when the anemia was treated.

2003

- February: Presented to Dr. X with multiple complaints, including pain and gastric distress.
- Dr. X noted on 2-10-03 that "according to his daughter he is also having some short term memory problems."
- Diagnosed with gastroparesis and started on medication.
- May: Fell and suffered a right-lower-extremity fracture, for which he was hospitalized.
- Underwent a medical rehabilitation examination and was found by Dr. Y, a physiatrist, to be "alert and oriented times three" (i.e., oriented to person, time, and place).
- Underwent a 2-week medical rehabilitation stay and was noted to be "alert and oriented times three" and "able to follow commands without difficulty."
- A social-work note during this rehabilitation stay indicated that he was "dressing and bathing independently, doing some of his meal prep."
- November-December: Seeing Dr. X for ongoing cellulitis (skin infection caused by bacteria).

2004

- January: Presented with worsening symptoms of fatigue and lethargy, which was attributed to increasing renal insufficiency and cellulitis.

- February: Hospitalized due to lack of response to treatment. Dr. Z's (a hospitalist) note of 2-18-04 stated that "patient is alert and oriented to time, place and person."
- March: Presented to Dr. X for shortness of breath and coughing; returned later in the month for continuing cellulitis in his left lower extremity.
- April-May 2004: Saw Dr. X for increased weakness and decreased mobility; a CT scan revealed mild cortical atrophy, but no evidence of acute stroke.
- June-late August: Continued to be seen for lower-extremity edema and cellulitis.
- August-December: Leg ulcerations, shortness of breath, multiple falls.
- December: Hospitalized for severe cellulitis; examined by Dr. Z and found to be "alert, awake, and oriented to time, place and person."

2005

- January: Continuing severe swelling and shortness of breath due to congestive heart failure.
- February 1: Brought to Dr. X's office by caregiving son, who reported that his father was exhibiting significant confusion and losing track of time. After conducting a cognitive screening exam, the Mini Mental Status Exam (MMSE), Dr. X wrote, "There is evidence for some diminished function, showing perhaps some degree of mild impairment, with a total score of 23 out of 30."
- February 3: A CT scan revealed chronic ischemic changes, but no acute stroke or other signs of acute change.
- February 5: Diagnosed by Dr. X with Alzheimer's disease and started on Namenda, a drug approved for use with persons in the moderate stages of dementia (MMSE 3–14).
- February 10: Seen by Dr. X, who noted improvement in breathing and cellulitis.
- February 16: Confusion had also cleared with treatment, as evidenced by Mr. A's phone call to Dr. X's office, in which he told the nurse that "[Dr. X] told me I need the IV antibiotics for one more month." Dr. X noted in his record that Mr. A was correct, and an additional month of IV antibiotics was ordered.
- March: Dr. X noted improvement in cognitive functioning and ascribed this to Namenda.
- April: Leg ulcerations due to cellulitis continued to worsen.
- May: Saw Dr. X, who noted that the leg infection appeared to be improving significantly. Dr. X also reassessed Mr. A's mental status and concluded, "At the present time, I believe the patient is of clear mind to make assessments and judgments and there does not appear to be any concern or issues at this point in time with dementia or Alzheimer's."

2006

- January 10: Presented to Dr. X with a syncopal episode, lethargy that had lasted 2–3 days, and increased confusion. A CT scan showed no acute brain changes, such as a stroke.
- January 10: Caregiving son called to say that Mr. A was experiencing hallucinations and would not come out of the house, as a result of which he was admitted to the hospital.
- January 12: Evaluated further by Dr. X and noted to be agitated, restless, unable to follow directions, hallucinating, experiencing severe memory impairment, and "not capable of focusing and completing any goal directed task."
- January 16: Too lethargic to complete any part of the MMSE; diagnosed with pneumonia.
- January 23: Transferred to a nursing center, where some cognitive symptoms, severe attentional and memory disorders, eventually resolved.
- April 5: Died in nursing center.

Summary of My Conclusions

Dr. X diagnosed Mr. A with Alzheimer's disease in 2005—but did not correctly apply the diagnostic criteria for dementia, and omitted a diagnostic examination for delirium. The first notation that Mr. A was exhibiting mental-health symptoms was made in February 2003, when Dr. X noted that Mr. A's daughter was concerned about her father's memory problems. These cognitive symptoms were clinically correlated with acute pain and gastroparesis, and appeared to improve when the conditions had been treated. Cognitive dysfunction was not mentioned again for two years, when, in February 2005, Mr. A suffered an abrupt onset of confusion and decline in self-care. These symptoms were clinically correlated with severe cellulitis and breathing difficulties. At that point, Dr. X concluded that Mr. A had Alzheimer's dementia and began to treat him with Namenda. Dr. X also noted that Mr. A exhibited symptoms of mild cognitive impairment (MMSE = 23/30).

The DSM-IV (American Psychological Association, 2000) criteria for diagnosing dementia include:

A. Memory impairment and one other area of cognitive decline.
B. Significant impairment in functioning.
C. Course is characterized by gradual onset and continuing cognitive decline.
D. Deficits do not occur exclusively during the course of a delirium.

Evidence of Delirium

The evidence from Mr. A's record does not support either criteria C or D. The cognitive confusion was abrupt, and was later resolved (i.e., did not demonstrate a continued decline), and the deficits occurred exclusively during the course of a delirium. In contrast, the DSM-IV criteria for diagnosing delirium due to medical infection include:

A. Disturbance of consciousness (reduced attentional abilities).
B. Change in cognition.
C. Disturbance develops over a short period of time (hours to days).
D. Evidence of underlying medical condition.

Lethargy and new-onset cognitive dysfunction are common to delirium. When the source of the delirium is treated in a timely manner, symptoms can quickly remit. Mr. A's medical record was consistent with a diagnosis of delirium throughout 2002–2005, and that delirium—not dementia—was the cause of Mr. A's cognitive confusion. The record stated that once treatment had begun for the celluitis, Mr. A's cognition improved: On February 16, 2005—2 weeks after seeing Dr. X for confusion—Mr. A called the office to remind Dr. X to order another month of IV antibiotics. In early March 2005, Dr. X noted an improvement in Mr. A's cognitive functioning, and in May 2005, Dr. X documented a total absence of cognitive dysfunction.

Evidence of Dementia, Delirium, or Both?

Mr. A's medical records provide no evidence that he suffered from a progressive dementia. Most importantly for the suit brought by his children, Mr. A did not suffer from a progressive dementia during 2003–2005, the time during which he made a new will. Further, there was no evidence that Mr. A had had an episode of acute delirium during any of these transactions.

Misdiagnosis by Second Psychologist

Another geropsychologist reviewed the medical records, interviewed the three children who were contesting the will, and presented his conclusions. This expert determined that Mr. A had Alzheimer's disease because (a) one daughter had complained of Mr. A's memory problems in 2003, and, when interviewed by the psychologist, stated that there had been a continuing decline over the three-year period; (b) one CT scan had shown mild cortical atrophy and white-matter changes; and (c) Dr. X, the family physician, had diagnosed Mr. A with Alzheimer's disease on February 5, 2005.

Legal Outcome

The case went to a jury trial, and without being able to document any cognitive confusion apart from episodes of delirium, Mr. A's capacity was upheld.

Commentary

There are at least three possible reasons the physician and second psychologist in this case misdiagnosed Mr. A's delirium as progressive dementia.

First, Alzheimer's disease has come to be equated with cognitive dysfunction in older adults—yet medical conditions such as urinary-tract infections and cellulitis can cause transient cognitive problems in an older adult. In this case, it appears that there was no serious consideration of the multiple instances in which Mr. A's cognition had cleared and returned to baseline. Stereotypes about Alzheimer's disease are so pervasive that the other psychologist dismissed medical records that documented the clearing of cognition—including Dr. X's note that there were no longer any symptoms of dementia, a reversal that is not consistent with Alzheimer's disease.

Second, both Dr. X and the second psychologist failed to consider frailty syndrome. Repeated episodes of delirium can occur in cases of frailty, which is a common geriatric syndrome that occurs when multiple systems are failing and is related to both disability and comorbidity (Fried et al., 2001). Frailty has its own set of symptoms, which include exhaustion, loss of weight, weakness, and difficulties with gait and balance. Mr. A suffered from significant multisystem difficulties, including weakness due to post-polio syndrome, exhaustion and lethargy during acute infections, gait problems, and multiple falls. These symptoms are consistent with frailty syndrome. As the syndrome progresses, cognitive impairment becomes more prominent and, at the end—due to subacute delirium—more permanent. Mr. A's medical records did not indicate a late stage of frailty, when cognition is often significantly and consistently impaired, during the time frame in contention. The underlying cause for cognitive difficulties in later-stage frailty is not clear, but its course is not typical of Alzheimer's disease, in which memory disorders, once they become prominent, worsen over time, as do executive, attentional, and language deficits.

Third, there appears to have been an over-reliance on family report. In geriatric memory assessment, collateral reports are highly valued and relied upon. Capacity work differs crucially from clinical work, however, in that the individuals involved may have powerful motivations that can color their perceptions and even lead to falsehoods. In Mr. A's case, the second psychologist relied heavily on reports from the group of three siblings that Mr. A's memory had declined over time, despite the fact that none of them had seen their father more than once a year during this period.

Furthermore, the psychologist ignored the statements in Mr. A's medical records that he was functioning independently, managing his medications and medical affairs independently, and tracking his condition.

CASE 2: FINANCIAL AND TESTAMENTARY CAPACITY

Ms. B was an 87-year-old single woman who was born and raised in Africa. She had been a schoolteacher in India until she immigrated to the United States, where two of her brothers lived, in her late thirties. A sister immigrated with her, and they lived together until the sister's death in 2003. In the United States, Ms. B. worked for a utility company. Following her sister's death, she moved in with her oldest brother, and they were joined by a second brother. The three siblings moved into a three-bedroom apartment in 2008, and in 2009, the oldest brother died.

In 2009, a niece took Ms. B to a neurologist because she had noted that Ms. B was having some memory problems. When she moved into her oldest brother's apartment, Ms. B had given power of attorney to her oldest brother's son so that he could pay her bills. In the spring of 2010, at the urging of a friend, Ms. B. contacted an attorney because she wanted more control over her money. The attorney helped her open a second bank account—one that the nephew could not access—and transferred funds into that account. The nephew immediately filed for conservatorship and got a note from a neurologist who had diagnosed and treated Ms. B for mild dementia. At that point, Ms. B's attorney contacted me and asked me to do an independent medical evaluation. The attorney also provided financial records that showed that no financial improprieties had occurred.

A neurologist, Dr. N, and I conducted a prospective assessment of Ms. B's capacity. Dr. N had seen Ms. B seven times over a 1-year period, during which he had diagnosed and treated her for Alzheimer's disease.

Neurologist's Records

I reviewed Dr. N's notes, which can be summarized as follows:

- August 14, 2009: Niece stated that there had been memory loss over the past year; Ms. B. considered herself asymptomatic.
- August 14, 2009: MMSE score 20/30; recalled 1 of 3 items after 5 minutes. There was some cognitive impairment worse than orientation with naming of places; Dr. N speculated that this may have been due to "nondominant parietal dysfunction."
- August 21, 2009: CT scan showed some loss of brain volume and chronic white-matter ischemia.
- August 27, 2009: EEG revealed mild widespread cerebral dysfunction.

- September 11, 2009: Recalled 1 of 3 items as part of an unstructured mental status exam and was diagnosed with mild Alzheimer's disease and placed on Aricept.
- October 23, 2009: Alert; recalled 2 of 3 items. Switched to an Exelon patch due to an Aricept side effect (nausea).
- November 13, 2009: Recalled 3 of 3 items.
- March 12, 2010: Alert; recalled 0 of 3 items and inquired twice about the reason for the visit. Severity was sufficient to warrant addition of Namenda.
- May 21, 2010: Recalled 2 of 3 items and demonstrated better ability to draw small inferences about the type of information requested.
- July 26, 2010: Ms. B was not in attendance. Her nephew and niece reported that an outsider wanted to assume power of attorney (Ms. B's attorney). They also reported that Ms. B had refused to shower or change out of soiled clothes. Dr. N. concluded, "Unfortunately patient's dementia has advanced to a point where her judgment about important matters including who should have power of attorney is no longer satisfactory."
- July 28, 2010: Dr. N wrote that "nephew with power of attorney for her should manage all of her financial assets and health care. It would seem appropriate for him to become conservator and guardian." As was the case with his July 26 note, this judgment was rendered without having seen Ms. B.
- August 20, 2010: Alert, recalled 1 of 3 items; could not name months.

To summarize, Dr. N initially diagnosed Ms. B with mild-stage Alzheimer's disease. Over the course of the year, he noted that the dementia had progressed and diagnosed her Alzheimer's disease as moderate-stage, in which she lacked capacity even for self-care, let alone for management of financial, testamentary, or other legal matters.

Prospective Capacity Assessment from Neuropsychological Perspective

I evaluated Ms. B, who had been consulting with her attorney for 6 months, across five aspects: mental-health diagnosis and severity, decisional abilities, potential for compensatory strategies, integration of findings with specific legal standards, and issues of undue influence and possible financial abuse. For the purpose of this article, I will focus only on the first two categories, mental-health diagnosis and severity and decisional abilities.

Mental Health Diagnosis and Severity

I interviewed Ms. B and performed a neuropsychological evaluation of her cognitive abilities on two occasions, separated by16 days, for a total of 4.5 hours. Ms. B was well groomed for each of the sessions, which took

place in her apartment, and was aware that I was coming to interview and evaluate her. She gave me a tour of her kitchen, bedroom, and bathroom and showed me her medications and food supplies. The apartment was in good order. I also observed her at the congregate meal, where she fed herself independently and was clean and neat.

Ms. B appeared highly anxious, with pressured speech, and initially I had trouble understanding her. This was greatly reduced, however, by my structure for the conversation, and her pace relaxed. English was not Ms. B's first language, and although she was fluent in English, it is well known that with any cognitive dysfunction, difficulties with word-finding will be more pronounced in a non-native language. This was exacerbated by living with her family of origin, as they often spoke in African dialects in the home.

Summary of Neuropsychological Evaluation

I administered tests of memory, language, attention, visual-spatial skills, and executive functioning: Temporal Orientation Test, Animal Naming (Benton, Hamsher, Varney, & Spreen, 1983), Boston Naming Test (Kaplan, Goodglass, & Weintraub, 1983), Stroop (Golden, 1978), Dementia Rating Scale (Mattis, 1978). I also assessed Ms. B's money-management and math skills. Her reading abilities in the English language were in the average range, and were perhaps a slight underestimate of her premorbid functioning. On both testing occasions she was fully oriented to time (date, month, day of week, time of day) and to place. Her MMSE score was 24/30, with 3 of 3 items recalled after 5 minutes. This was a 4-point increase from the MMSE Dr. N had administered 1 year earlier (August 9, 2005). On a test of basic cognitive functioning (Mattis Dementia Rating Scale), her overall score was in the mildly impaired range, with significant deficits in initiation and verbal fluency, and mild deficits in memory. Attentional skills and reasoning were in the average range. On a test of language comprehension, Ms. B scored in the intact range. On a test of naming, she had significant difficulty with word-finding. This can likely be attributed in part to the fact that English was not her first language, and thus the naming process was not as automatic.

To reduce the effects of language (i.e., of her being a non-native English speaker), I administered the Fuld Object-Memory Evaluation (Fuld, 1981), which is a memory test for object learning and memory that has been validated cross-culturally, and thus is less reliant on English as a first language. Ms. B scored in the intact range for storage and retrieval, demonstrating good abilities for learning and remembering new information that does not rely solely on language encoding.

On a test of mental flexibility, Ms. B. scored in the moderately impaired range on a task measuring interference and disinhibition: Her attention and concentration were easily interrupted. This observed disinhibition with complex tasks was the most prominent cognitive weakness noted.

On a direct test of money management (e.g., check-writing and balancing a checkbook) using the Direct Assessment of Functional Skills (Loewenstein & Mogosky, 1999), Ms. B scored in the intact range, with no errors on checkbook-balancing or writing a check. In addition, Ms. B showed me her checkbook register, in which she had recorded checks in the correct order and correct amounts. There was no evidence of money having been mishandled in the account.

Ms. B displayed no endorsement of symptoms of anxiety, but significant endorsement of symptoms of depression, including feeling unhappy, helpless, hopeless, and worthless. She missed her late brother a great deal, and believed that she had failed by not taking care of him until his death.

Given the results of my neuropsychological evaluation—which included slight improvement in her MMSE compared to her performance a year earlier in Dr. N's office—and the variable results of her performance in Dr. N's office over the previous year, Ms. B met the criteria for Mild Cognitive Impairment, Executive Dysfunction Type with Depression. On the Clinical Dementia Rating (CDR), which is the gold standard for rating dementia, her stage would be 0.5. In contrast, Dr. N's notes indicate that Ms. B would have a CDR of 2.0, Moderate Alzheimer's Disease, which would suggest severe problems with time relationships and a need for assistance with basic self-care skills.

Decisional-Ability Assessment

The following six areas are standard in the assessment of an individual's decisional abilities:

A. Evidence of choice relative to the capacity in question.
B. Ability to communicate rationale for choice.
C. Reasonableness of the stated choice.
D. Appreciation of the consequences of choice (including risks/benefits, awareness of past problems, and plans to compensate for these problems).
E. Variability of the choice.
F. Consistency of the choice with the individual's values.

I conducted decisional-ability assessments on each of my two visits to determine the consistency of her choices and rationales. Ms. B told me on both occasions that she wanted to be in charge of her money; her rationale was that she had earned her money and had always been in charge of it. She wanted her nephew to continue paying her bills, but it was important to her to retain control of her money. These responses, across two assessment sessions 16 days apart, also demonstrated consistency of response and were in line with her lifestyle and long-held values.

I asked Ms. B if she wanted to make or change her will, and she stated that she did want to make a will. She could not tell me the amount of her financial holdings, but said that they were in the Bank of America. She stated that she wanted to leave $6,000 to a friend and other money to a temple in memory of her late sister. Dr. N had assessed neither Ms. B's decisional abilities nor any skills relative to financial and testamentary capacity.

I concluded that Ms. B suffered from executive dysfunction and depression. These cognitive and mental-health deficits are mild, unlike the severe deficits described by Dr. N and Ms. B's nephew and niece. Indeed, Ms. B's functioning did not meet the criteria either for dementia or Alzheimer's disease. Her judgment was not impaired, her decisional abilities were intact, and there was no evidence that she had wasted or drastically reduced the amount of money she had. Neither of the two criteria for conservatorship was supported; instead, Ms. B met the criteria for financial capacity.

As to testamentary capacity, Ms. B knew what a will is and its purpose. Although she did not know the exact value of her property, she knew its nature and location (i.e., bank accounts). She knew how she wanted to dispose of her property, that her brothers were the natural object of her bounty, and that her nephew and niece would succeed her brothers as objects of her bounty. Ms. B met the criteria for testamentary capacity given her lack of dementia, her consistent and appropriate decisional abilities, and her grasp of information in all areas required by the criteria.

Legal Outcome

The case went before a probate judge, who ruled that Ms. B did have both financial and testamentary capacity.

Commentary

In this case, two elements appeared to contribute significantly to Dr. N's misdiagnosis. First, he failed to modify his assessment in light of multicultural issues and Ms. B's status as a non-native English speaker; she was initially a bit difficult to understand, and communicating with her took time. Accurate assessment of her cognitive skills, therefore, simply required the use of an instrument that was less dependent on verbal testing. This was not done.

Second, Dr. N relied too heavily on reports from the niece and nephew; one lived out of state, and the other rarely saw Ms. B.

SUMMARY

These two cases illustrate several aspects of the misdiagnosis of Alzheimer's disease. In the first case, delirium—not Alzheimer's disease—was

responsible for the abrupt onset of cognitive symptoms, which were transient. In the second case, lack of knowledge about the accurate assessment of older adults for whom English is a second language—and, seemingly, blanket acceptance of reports by relatives—led to an incorrect diagnosis of Alzheimer's disease.

Tremendous emotional, legal, and financial tolls are exacted when older adults' rights to handle their own affairs are subjectively revoked. In the second case, for instance, it took months for Ms. B to reclaim control of her money. Once a motion for conservatorship had been made, a guardian ad litem was assigned, and this person kept a close watch on Ms. B's behavior. While protection for vulnerable elders is important, having a guardian ad litem can be a major source of stress for older adults, particularly those who value their independence. Clearly, a careful and objective diagnostic process is essential for assessment of capacity.

Both of these cases illustrate some of the distinctions between clinical and legal assessments. Perhaps most striking are the different roles family members played in the two types of assessments. Clinical assessments almost always include a thorough interview of at least one family member for an independent history of symptoms and events. In legal assessments, however, family members may have a vested interest in the outcome, whether they are seeking to gain conservatorship for an older person or challenging a will after the person's death. In both cases, family reports were not confirmed by objective assessment data.

Also, clinicians in legal cases may not be able to obtain all relevant medical records before they conduct the assessment and make a provisional diagnosis. It is essential, therefore, that complete medical records be available for review. For both clinical and legal cases, the clinical gerontologist must have a thorough understanding of dementia, related geriatric syndromes, and the correct assessment of older adults.

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