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Fear of imminent death – use of evidence in forensic-psychiatric expertise

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Summary

In accordance with the Polish civil law, there are at least several ways to dispose of property in the event of death. One of them is a special form of oral testament. The main issue to be determined by the court is to either confirm or deny the existence of fear of imminent death of the testator at the time of bequest. For this purpose, the court uses expert psychiatrists' opinions. The article presents a case of a man in the terminal phase of a malignant disease who used an oral form of bequest. Such cases are relatively rare and therefore the described case is intended to illustrate the complex nature of the expertise. It points to the need for the experts to take into account complex legal regulations, the observance of which stipulates the possibility of using this form of will. Factual assessment of the witnesses' testimony complicates elaboration of the material, as the testimony is generally contradictory. It was proposed that the witnesses' testimony should be sorted out in terms of substance (psychopathology), based on the analysis of the separated research areas. Medical records can be treated not only as a source of information about the dynamics of somatic diseases of the testator and secondary changes in his/her mental state. It can also be a valuable source of knowledge about the testator's attitude to health and disease issues, treatment processes, prognosis, threat to his/her life and death.

Key words: oral testament, forensic-psychiatric expertise

Introduction

Making a will is a legal action regulated by a number of regulations and requirements. Their preservation determines validity of this action. A rigorous approach in this respect is due to the importance of the material action and to the fact that the testator's will can only be executed after his death. In addition to regular wills (notarial, handwritten – holographic, allographic), there are special wills: made during a trip on a Polish ship or aircraft, military or oral will. The possibility to make an oral will is also used in other European countries [1].

In the past, in Poland, circumstances determining the use of an oral will were described in Chapter 2 of the Decree of 8 October 1946 – inheritance law (Journal of Laws (Dz. U.) of 20 November 1946, No. 60, item 328). Under Article 82 in addition to epidemic, interruption of communication and warfare, the testator's disease or his misfortune were mentioned as conditions which justified the fear of imminent death. According to the current legal provisions – Article 952, Paragraph 1 of the Polish Civil Code – one can use oral will only if one of the two conditions is met. The first is the existence of fear of imminent death. The second is a situation in which an ordinary form of a will is impossible or very difficult to maintain due to special circumstances [2].

In the jurisprudence there are three ways to interpret the term "fear of imminent death". The first one points to the need for objective premises justifying a fear for life, not just mental changes alone (this is to eliminate possible pathological disorders). Verifiable assumptions that arise from the state of illness which can lead to rapid death, become important here. The second interpretation method points that a subjective assessment of the testator with regard to the inevitable coming of death is important, even if it results from a mistake. The third view is that in order to confirm the fear of imminent death, a subjective condition is required, which, however, is based on an objective premise, which is due to the existence of circumstances justifying the real possibility of imminent death of the testator [3, 4]. In recent years, the third (mixed) approach to judicial decisions in the area of fear of imminent death has been dominating.

Skupień and Kowanetz [5] point out cases where the testator has been suffering from somatic conditions for many years with sudden and often unpredictable health conditions (e.g., gastrointestinal hemorrhage). In such cases it is not difficult to confirm both types of premises [5] as long as the fear occurs at the time of making the will [2]. Doubts are related to situations in which the testator has a chronic illness (e.g., cancer) whose natural outcome is fatal, but at the time of making the will, the health condition remains stable. It seems that the very existence of a condition with a serious prognosis, but without an immediate risk to life, cannot justify objective premise. The situation with the old age is similar.

In the state of health of the testator, significant changes suggesting the inevitability of death should occur [1, 5]. The following conditions are listed among emergency states of life threat: cardiovascular diseases (cardiac arrhythmias, myocardial infarction, cardiogenic shock, aortic dissection), metabolic and electrolyte abnormalities, respiratory diseases (acute respiratory failure, exacerbation of bronchial asthma, pneumothorax, pulmonary embolism), endocrine disorders (adrenal crisis, thyrotoxic crisis) and others [6]. These are states that are, in principle, unexpected for a person and generally cause a fear for life.

Another problem is issuing decisions in situations in which chronic disease, at an advanced stage, results in death, which does not preclude circumstances of fear of imminent death (but only in the event of a sudden collapse of the somatic state) [7].

The mere fact that death occurs shortly after the oral will is made, it is not enough to confirm its validity. There are also no grounds for assuming the existence of a fear

of imminent death (objective and subjective premise) during the several days before being affected by the disease [5], which the testator could not have foreseen.

There is a difference between fear for one's own life in chronically ill people and the fear of death which will inevitably occur in the near future [1]. When the ill are not able to cope with the poor prognosis (even if delayed), they discuss the meaning of life, balance it, express disappointment, pessimistic judgment and communicate it to their surroundings. This may seem like a fear for life, but it is often just a reflection on one's own biography and the inevitability of death. Anxiety about own destiny is part of a universal approach to passing [8, 9].

Assessment of the testator's decision, especially in the state of justified fear for life, is a multi-faceted task. The testator is subject to internal factors, resulting from his/her psychological structure, and external circumstances, in this case, the inevitable death [10]. Psychological mechanisms related to the experienced anxiety affect cognitive processes, especially in terms of thinking, assessment of one's own situation, necessity of making final decisions regarding property [11, 12]. Emotions are expressed cognitively and behaviorally in a verbal and mimic form, gesturing, and voice modulation [13].

The essential issue to be determined by the court is to confirm or exclude the existence of a fear of death in the testator, which is a prerequisite in order to be able to make this particular type of will (assuming that the testator was found capable of making free and conscious decisions and expressing his will during making the will) [3, 14]. Taking into consideration the necessity of analyzing the material in terms of the presence of both premises, it may be difficult to choose specialization of experts [15]. The objective criterion can only be judged competently by a specialist in the field of somatic diseases, from which the testator suffered and which could have induced changes in his/her mental state. The psychiatrist's task is to assess the mental state in the context of the subjectively perceived fear of imminent death.

Issuing opinions on wills, an expert must take into account imperfection of evidence. It only contains descriptions of the testator coming from witnesses and medical records which differ with regard to the number of details they include, completeness and accuracy of diagnoses [16]. Półtawska [17] recommends establishing a certain hierarchy of evidence in testamentary cases, because not all have equal significance in expertise. First of all, they must provide information about the testator's health at the time of making the will. In her opinion, an expert should not avoid judging evidence, of course only from a psychopathological point of view. They should also seek their confirmation in the rest of the material. Scrupulous analysis of medical documents (especially in the context of a sudden deterioration of the testator's health that creates a risk of death) makes it possible to increase the accuracy of the opinion and its clarity as well as enables substantive assessment [18].

Usually, after the first analysis of testimonies, it can be seen that they are somewhat contradictory and even exclusive. They refer to opposite procedural positions. Their deeper elaboration (in conjunction with information from medical records) often suppresses these differences and even makes seemingly different descriptions of the

behavior of the testator from a psychiatric standpoint favor a coherent assessment of his/her mental state at the time of making the will (as long as the expert renounces from their factual assessment). The content of the testimonies can provide knowledge about the testator's attitude to his/her chronic diseases and somatic disorders, burden caused by treatment, possible deterioration of health (if such had ever occurred before). One can learn his/her views on passing and death. Evaluation of testimonies should focus on the period of making the oral will (behavioral manifestations of fear for own life).

While an oral will may be witnessed, from a legal point of view, by people who have not been specially summoned or even accidentally found themselves in the presence of the testator, and those to whom the testator did not explicitly direct the will [1], for judicial-psychiatric evaluations, it is of crucial importance. Summoning other people (so-called testamentary witnesses) may not be the result of an intention to make a will in an oral form, but it is rather a reflection of emotional needs of the testator or a way of coping with a psychologically difficult situation of the imminent death.

Subject of the case

The testator, 77 years old, died on 17.06.2008. One day after his death, the witnesses wrote a statement: "In relation to the death on 17.06.2008 and the fact that the above-mentioned deceased has not left a written will in which he would dispose of his property, we, the undersigned [names, surnames, addresses provided here] declare that on 16.06.2008 in our presence the deceased (…) informed that his last will was that after his death the dwelling he owned becomes the property of his son [name provided here] who has recently resided there and who pays for its buy-out and refurbishment". The court was requested by one of the sons of the testator to declare that the children: two sons and a daughter, inherit the deceased person' legacy on the basis of the law. At the hearing, the applicant's brother stated that the testator had left a will.

Medical records

Starting from 1980, the testator has been treated in a local clinic for various somatic disorders, e.g., upper respiratory tract infections, spinal pain, abdominal pain, gastrointestinal bleeding, hypertension, coronary heart disease, insomnia, shingles, bronchial asthma, prostatic hypertrophy, and lung cancer.

In September 2004, during cardiovascular hospitalization he was diagnosed with ischemic cardiomyopathy, cardiac failure, chronic obstructive pulmonary disease. In May 2005, the testator was admitted to the same unit due to left-sided pneumonia, dilated cardiomyopathy with chronic atrial fibrillation, chronic pulmonary heart disease, chronic renal failure, and prostatic hypertrophy. In July 2007, an ambulance service team was called to a local health centre because the testator had dyspnea and chest pain. During his stay at the cardiology centre, he gave a comprehensive medical history, listed his illnesses, described his lifestyle, gave family and professional interviews. He

was discharged home in a stable state and was informed that, in the event of a fainting, he would need an urgent medical consultation. He was then diagnosed with unstable angina pectoris, which was treated by stent implantation to the right coronary artery, chronic atrial fibrillation, heart failure, hypertension, and chronic renal failure. On 14.08.2007, due to hemoptysis, he was admitted to a pulmonary department, where he completed the necessary paperwork for hospitalization. During the admission to the hospital he gave a comprehensive medical history (he was in logical contact). For a few days he was weak, and later (the whole hospitalization lasted 22 days) he was in a moderately severe condition, quite good and good condition. He was diagnosed with left lung tumor – left for further diagnosis, hemoptysis, as well as previously diagnosed diseases. Again, he was admitted at the same ward in December 2007, where he was diagnosed with left lung tumor. In February 2008, the testator was twice admitted to the thoracic surgery department where he was diagnosed with non-small cell left lung carcinoma, hemoptysis, chronic coronary artery disease, atrial fibrillation. Two cycles of brachytherapy were performed. During both stays the testator was in a good mental and somatic condition. During the next month he had four outpatient consultations in a regional oncology centre.

Since 25.04.2008, the testator was under home hospice treatment. On that day he gave a written consent for treatment and hospice care, he authorized his daughter to obtain medical records and information on his condition. It was reported that the patient and his family were aware of the current disease. On that day, the testator was in a normal state, normal contact, presented a sad expression on his face, revealed no signs of damage within the central nervous system. He complained of weight loss, dyspnea, cough, weakness, and hemoptysis. During the next visits (on 02.05.2008 and 14.05.2008), fatigue, weariness, lack of energy, and weakness were reported. The quality of life was rated as average. During the next two visits (on 29.05.2008 and 11.06.2008), no such ailments were described. During the whole treatment in the hospice there was no confirmation (data from a special questionnaire) of the testator's concentration difficulties, irritability, worry, depressed mood, nervousness, hopelessness, internal tension, anxiety, disturbances of consciousness, or symptoms of dementia.

On 17.06.2008, a medical rescue team was summoned to the testator who had lost consciousness for about two minutes in his car. When an ambulance arrived, he was found to be weakened, but a good verbal and logical contact could be established with him. He was taken to a nearby hospital where he suffered a brief loss of consciousness with convulsions and cyanosis. After recovering consciousness, he was in logical contact, signed the hospital documents (authorizations, consent, information). At 17.15. the resuscitation attempts were undertaken and after 20 minutes death occurred. A direct cause of death was cardiac arrest in the asystole mechanism. In addition, non-operative left lung cancer, respiratory arrest, shock, chronic atrial fibrillation and COPD were identified.

Witnesses

The partner of the heir mentioned in the statement stated that on 16.06.2008 she came to the testator on her own initiative, without a specific purpose. On the spot she met a family friend – an electrician. On that day, the testator said he was feeling bad, which she associated with cancer about which she had known before. During the meeting everyone was talking about general topics. After half an hour, the testator instructed her to call for a neighbor. Upon her arrival, the testator in the presence of all said that he would like the apartment to be given to the son (mentioned in the statement), because "he bought this apartment and restored it". The witness did not know why the testator had not made the last will in writing. The next day (the date of the death of the testator) when she accidentally met him, he said he felt "weak" but still he was going to go to the post office with his son to collect pension. She claimed that the testator knew about cancer, heart disease and hypertension, having been ill for seven years. On the one hand, the testator "knew he was sick and would die soon", but "he did not think he could die, he wanted to live". "He told me he was going to leave soon, but not that he was going to die". He had previously told her that the apartment would be given to the son (mentioned in the statement) because he had sold his own apartment and bought his parents' apartment.

The electrician claimed that the day before his death the testator (on the date of making the will) "was rearranging furniture and was about to hang the TV on another wall" and had planned it before. He went to him to mount brackets and that was the purpose of his visit. He did not notice anything extraordinary in the testator's behavior or health. He worked his way up – he mounted the TV wall mount bracket on the wall and adjusted the decoder and TV. When he asked why the testator "was rearranging furniture in the apartment", "he replied that his son was rearranging furniture because the testator was going to give it to him". It was only from this statement that the witness concluded that this apartment was supposed to belong to a son, but at the same time he did not perceive it as a statement of the last will. "I found myself there accidentally and I did not think it would end in such a way". According to him, the testator did not feel good, but the witness did not see him worry about his life – "I did not think he could die. (…) That day, I did not hear him saying he was afraid of dying". The next day (the date of death) the testator called for the witness so that he would set up Cyfrowy Polsat.

The neighbor reported that the heir's parents had always said that because he had sold his apartment and bought his parents' one, he would get this aartment. On the eve of the testator's death she was summoned to his apartment. The testator told her to sign a letter that had already been signed by the son's partner, the electrician, and he himself. Without reading she signed the letter at the command of her neighbor, who pointed her signature place. She knew that the neighbor was ill, but she did not see anything special that would raise her anxiety about his health that day. "If I had known he was going to die, I would not sign it. (…) I signed it because the testator wanted it. (…) He looked that day as usual and did not make any statement".

The testator's daughter-in-law stated that the father-in-law knew of the disease and was not afraid of death. When he could not leave the house, he was looking for practical help from others. He regularly called her, but did not mention that he feared for his life. The hospice doctor also did not tell the family about any danger to the testator's life, he said his condition was satisfactory.

The son who was mentioned in the statement as heir claimed that his father's condition worsened about eight months before his death. Over time, the disease progressed. But he was able to walk, eat his meals, get dressed, wash himself, and walk the stairs unassisted. He went outside with other people (treatment, collecting his pension). "My father knew his condition and took medication by himself". On 16.06.2008, "he did not tell me he would die soon". A week before his death, he told the witness and his partner to clean up the apartment and rearrange the furniture, in which he also participated.

According to his daughter, the testator "was in a good mental condition", "he did not worry that he might die".

Experts

The court appointed two experts. The internist had to comment on the subject of presence of fear of death in the testator's behavior on 16.06.2008 in terms of objective and subjective condition. The psychiatrist was to assess the existence of a subjective condition during making the will.

The expert in internal medicine confirmed the presence of somatic disorders diagnosed before. In his assessment, the testator could have realized the severity of the disease and the possibility of an imminent death by increase in dyspnea requiring the use of an oxygen concentrator, hemoptysis after cough, and significant weight loss in a short time. "On 16.06.2008, he was in full logical and verbal contact, but the following day, in the afternoon, his condition deteriorated rapidly". The expert concluded that on 16.06.2008, the testator "could have an objective fear of imminent death, and at least a subjective conviction of an imminent death".

The psychiatrist, however, stated that since the 1980s, the testator has suffered from various somatic disorders: cardiovascular diseases, pulmonary diseases, renal failure, and left lung cancer, but without psychiatric disorders. The expert found no grounds to claim that on 16.06.2008, the testator presented a subjectively perceived fear of death.

Discussion

The analyzed case of making oral will is an example of the complexity and difficulties that may arise in a judicial process. The court took advantage of a two-tier assessment of existence of fear of death in the testator. He called for expert internist, however, to confirm both conditions, which led to complications in the judicial process. It seems that in such situations it is worth considering the use of a so-called comprehensive opinion in which experts could make common arrangements.

In the case of an oral will, for psychiatric assessments it is essential to take into account several aspects: the time of making the will, the place of making the will, the way the will was prepared, the form of the will, the behavior of the witnesses of the will, reasons for questioning the will, the general health of the testator, a serious deterioration of health predicting imminent death [17].

Medical records, apart from providing information about the testator's health status of and any risks to his life, also present his personality profile. In the present case, the testator in the last years of life underwent systematic and extensive treatment (especially after tumor diagnosis). He was described as involved in the therapy process. The documentation contained no descriptions of any psychiatric disorders, including especially depressive symptoms, anxiety or emotional insomnia. There were no reactive disorders (they may have occurred in response to chronic and debilitating somatic disorders and serious medical prognosis). In the history of the illness from the home hospice it was noted that he and his family were aware of the testator's health condition.

In the case of an oral will, it is worth considering how much the behavior of the testator was due to reactive factors (which speaks in favor of a fear of death) and to what extent it was a result of his well-thought-out aspirations towards the goal (which speaks against a fear of death) [10]. Reactive factors are particularly important in determining the possibility of making a will because the situation itself (the sense of threat of loss of life) has been identified by the legislator as a necessary condition to make an oral will. The behavior of the testator suggested the intentionality of the procedure, which was only slightly affected by biological factors. The decisions were based on a conscious attitude, which included his intellectual potential, life experience, individual preferences, and some socio-cultural standards [12].

Organizing of the testimony of witnesses – determining a few areas whose common point is the moment of making a will – facilitates the elaboration of the material. The first one is the circumstance of gathering witnesses during making an oral will. It should have occurred because of a sudden collapse of the testator's health. In this case the heir's partner and the electrician were in the testator's apartment for completely different reasons than to make a will. The testator's neighbor – upon his own request – signed a letter, so it is difficult to assume that he was in a state of fear for his life, since he controlled the witness's behavior and was able to supervise it.

The second area is an assessment of the testator's well-being by the witnesses. These testimonies should describe the approaching death, or at least a threat to the testator's life. The testator's son's partner testified directly that the testator did not expect to die soon. In the son's opinion, the testator's condition deteriorated, but it was eight months before his death. It is known that the testator knew of the severe diseases, looked sick, but did not mention the possibility of imminent death. During their meeting no one saw any signs of fear for his life in the testator's behavior, manner of speaking, or other behavioral manifestations.

The third area is to determine whether in particular circumstances a somatic condition has deteriorated or whether an extremely unfavorable outcome has occurred.

The descriptions given by witnesses and correlating information from the hospice documentation indicated that there was a stable health condition in which there were no additional factors predicting the testator's death, which – as highlighted in the literature – justifies an oral will [1]. It should be emphasized that the cause of death was related to cardiovascular problems, whose exacerbation the testator could not have predicted with one day in advance. The very existence of a disease, even a real life-threatening one, does not always determine the presence of a subjective feeling of fear of death [5].

As in the case of assessing the ability to make a will in any other case, in the case of oral will, it is important to identify the motivational background of the testator when disposing of his property. In the present case, the witnesses claimed that the testator had indented to give the apartment to his son, as he was involved in the purchase and renovation of the apartment. The testamentary decision was therefore not motivated by a drastic deterioration of health. None of the witnesses did not relate the testator's decision to his somatic health condition, and yet the fear of a sudden death is to be the factor that entitles one to make a will in a particular form [19]. Prior family arrangements, testator's promises, financial contribution of the heir, his merit for the family, special attachment to the testator, etc. are not relevant to the case.

Another issue is at a sole discretion of the court, but for a deeper assessment of the testator's motivation, it is worth paying attention to it. Witnesses were somewhat surprised that the testator did not use the services of a notary or that he did not write his last will, in which his somatic and mental state did not interfere.

The next area to be analyzed is behavior and feelings, however, not those of the testator, but those of eyewitness of a will. Their attitudes should result from assisting a person who feels a strong fear for his/her life [20]. In the presented case, the behavior of witnesses was not a reflection of such situation. Everyone was quiet, doing their job, they were absorbed in their affairs. They were not moved by a the testator's fear of imminent death.

In short, the witnesses of the events of 16.06.2008 expressed a similar, coincidental and mutually complementary opinion about the mental condition and somatic condition of the testator and his estate decisions, indicating there is no basis to state that at that time he had symptoms of anxiety or a sense of fear for his own life.

There is a need to separate the two aspects concerning an expression of will by the testator. In the first aspect, the expert focuses on the assessment of the occurrence of the genuine, subjective desire of an individual to produce a specific legal effect that manifests itself in his/her behavior. The second approach focuses on the analysis of the external manifestations of testator's behavior that are to justify his/her specific estate decision. This option exposes more objective criteria of assessments that are easier to grasp for the expert, but which also bring greater uncertainty in assessing the actual intentions of the testator [10]. An optimal solution would be to complement these two approaches, unfortunately this is not always possible due to the specificity of the material of the particular case.

The unique complexity of an oral will requires the expert to take into account the relationship between the motivational sphere, cognitive dispositions and emotional factors. The influence of a significant deterioration of health (if any) on deciding whether to transfer the property to other people, is of key importance [12]. However, these judgments cannot be separated from legal considerations which constitute the criteria that enable the use of this kind of will.

References

1. Borysiak W. *Funkcjonowanie w praktyce testamentu sporządzonego w formie ustnej (art. 952 k.c.)*. Warsaw: Institute of Justice; 2014.
2. Marcinkowski J, Klimberg A. *Opiniowanie sądowo-lekarskie w sprawach o unieważnienie testamentu. Cz. I. Charakterystyka materiału badawczego. Charakterystyka testatorów*. Archiwum Medycyny Sądowej i Kryminologii. 2007; 57(1): 34–41.
3. Hajdukiewicz D. *Opiniowanie sądowo-psychiatryczne w sprawach testamentowych*. Postępy Psychiatrii i Neurologii. 2003; 12(4): 469–477.
4. Krawczyk M. *Testament ustny w świetle regulacji kodeksowej, poglądów doktryny i orzecznictwa Sądu Najwyższego*. Zeszyty Naukowe Akademii Podlaskiej w Siedlcach. 2009; 81: 143–153.
5. Skupień E, Kowanetz M. *Obawa rychłej śmierci jako zagadnienie szczególne w opiniowaniu*. Z zagadnień Nauk Sądowych. 2011; 87: 264–277.
6. Hryniewiecki T. *Stany nagłe*. Warsaw: Medical Tribune Polska; 2009.
7. Niemczyk S, Łazarska A. *Prawno-medyczna wykładnia „obawy rychłej śmierci" jako przesłanka ważności testamentu ustnego*. Prawo i Medycyna. 2007; 9(2): 86–100.
8. Jastrzębski J. *Emocjonalne i religijne uwarunkowania lęku przed śmiercią u młodzieży akademickiej*. Studia Psychologica. 2001; 2: 83–102.
9. Żemojtel-Piotrowska M, Piotrowski J. *Skala lęku i fascynacji śmiercią*. Polskie Forum Psychologiczne. 2009; 14(1): 90–109.
10. Stanik JM. *Teoretyczne i metodologiczne problemy opiniodawstwa psychologicznego w sprawach o ważność oświadczenia woli i w sprawach testamentowych*. Przegląd Psychologiczny. 2009; 52(3): 243–261.
11. Jodzio K, Nyka WM. *Neuropsychologia medyczna. Wybrane zagadnienia*. Sopot: Arche; 2008.
12. Kocur J, Trendak W. *Psychiatryczno-sądowe kryteria oceny zdolności do świadomego albo swobodnego powzięcia decyzji i wyrażenia woli*. Archiwum Medycyny Sądowej i Kryminologii. 2009; 59(2): 136–140.
13. Cierpiałkowska L. *Psychopatologia*. Warsaw: Scholar Publishing House; 2009.
14. Skupień E. *Opiniowanie w sprawach o unieważnienie testamentu lub umowy darowizny*. Prawo i Medycyna. 2005; 2: 111–121.
15. Domański M, Rzecki Z, Domański M. *Testament szczególny, pojęcie rychłej śmierci, przedstawienie przypadków*. Badania nad Schizofrenią. 2006; 7: 50–56.
16. Marcinkowski J, Klimberg A. *Opiniowanie sądowo-lekarskie w sprawach o unieważnienie testamentu. Cz. II. Wnioski końcowe opinii. Jakość dokumentacji lekarskiej. Ocena zeznań świadków*. Archiwum Medycyny Sądowej i Kryminologii. 2007; 57(1): 42–48.

17. Półtawska W. *Ekspertyza sądowo-psychiatryczna w postępowaniu spadkowym testamentowym*. Warsaw: PZWL; 1974.
18. Hajdukiewicz D. *Struktura opinii sądowo-psychiatrycznych w sprawach karnych i cywilnych*. Postępy Psychiatrii i Neurologii. 2005; 14(3): 243–250.
19. Hajukiewicz D. *Opiniowanie sądowo-psychiatryczne w sprawach cywilnych*. Warsaw: Institute of Psychiatry and Neurology Publishing House; 2008.
20. Wróbel M. *O transferze emocji i nastrojów między ludźmi – mechanizm i psychologiczne wyznaczniki zarażenia afektywnego*. Psychologia Społeczna. 2008; 3(8): 210–230.

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