Evaluation of the Capacity to Marry

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Clinical and forensic evaluators are often faced with the task of answering unique questions about capacity and competency. One seldom-discussed question is that of an individual's capacity to marry. This article uses a case example as a framework for discussing the challenges of evaluating an individual's capacity to marry. We will set the background with legal history and then provide guidance for making this type of assessment.

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In June of 2015, the Supreme Court of the United States voted on marriage equality, granting the right to marry to same-sex couples. In the majority opinion,[1] Justice Kennedy stated, "No union is more profound than marriage, for it embodies the highest ideals of love, fidelity, devotion, sacrifice, and family. . . . In forming a marital union, two people become something greater than they once were." Although this is an opinion taken from the land's highest federal court, legal concerns regarding marriage fall under the statutes that govern contracts, which are regulated by the state. For this reason, there are differences among states regarding marriage. States have various guidelines regarding who can and cannot enter into a marriage contract; for instance, many have age restrictions. However, there are no explicitly stated guidelines that describe an individual's decisional capacity to choose to get married.[2] Nor is there a structured framework through which one's decisional capacity to enter into marriage can be assessed.

From a legal perspective, the capacity to marry can be compared to the capacity to enter into other legally binding contracts, in that the various ramifications of the contractual agreement that should be understood and appreciated by all involved parties. The goal is to prevent manipulation of a potentially impaired or otherwise vulnerable person through exploitative contractual arrangements and to balance respect for autonomy against beneficence and nonmaleficence. By analogy, in the clinical setting, we often either explicitly or implicitly assess an individual's capacity to make medical decisions, such as whether a patient can provide informed consent for a procedure, or whether someone can decline lifesaving interventions, also based on the goal of balancing the ethics-based principles of respect for autonomy against beneficence and nonmaleficence.

Perhaps this analogous relationship between determination of one's capacity to enter into contractual agreements and assessment of capacity for medical decision-making will allow us to put forth the guidelines one can follow when assessing an individual's ability to enter into a marriage contract. These guidelines will be valuable to forensic evaluators who may be involved in cases where an individual's capacity to enter into such a contract is called into question. They will be valuable also to clinicians, particularly those who work with geriatric populations (as this population is most likely to have the capacity to marry called into question) and those who provide consultations, such as consultation-liaison psychiatrists or forensic experts.

The following is a composite case created to illustrate certain points relevant to a discussion of the capacity to marry. Mr. V., an elderly man, was admitted to the hospital with terminal cancer. His physicians informed him that he had a short time to live. At his bedside was his partner. Mr. V and his partner had cohabited for 20 years, and she was the primary breadwinner in the partnership. At the time of admission his mental status was normal.

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Mr. V. expressed a strong desire to marry his partner before his passing, citing his religious faith as a primary reason. His specific spiritual concerns were not explored, but he maintained that his motivations were spiritual rather than legal. A close relative expressed concern about this union to his physicians, wanting to ensure that the patient had the capacity to make this choice and was not being taken advantage of, and hence a consultation was called to evaluate Mr. V.'s capacity to marry.

History of Marital Laws

In pre-13th century Europe, marriage was fluid and informal. For European Catholics, marriage became increasingly formalized during the Middle Ages after the fall of the Roman Empire. This process of formalization culminated in the completion of the Council of Trent (1563), during which marriage became a Catholic sacrament with formal ritualistic, spiritual, and civic and public dimensions. In biblical times, Judaic marriages consisted of two parts: the betrothal wherein the woman was legally married and the wedding wherein the woman officially joined her groom's family. These two parts reflected the somewhat civic, business-centered nature of this transaction: first, a price is paid and the sale conditions are finalized, then the purchaser takes possession of what has been purchased. These practices have faded in time in favor of a more spiritual understanding of marriage, rather than one driven primarily by economics. Conceptually, marriage in Judaism can be considered a kind of spiritual starting over, whereby the bride and groom are forgiven past mistakes and transgressions as they merge into a more complete soul. Similarly, in Islam, marriage has both a binding legal contract dimension and a spiritual one wherein the unified couple moves to a higher spiritual level through their marriage.

Generally speaking, marriage began to assume a more civil domain in Europe after the Protestant Reformation,[3] and civil legal frameworks have evolved that are unique to various countries and cultures since that time. The British Common Law interpretation of marriage came to the American colonies and is the basis for today's U.S. marriage laws. In 1970, the Uniform Marriage and Divorce Act suggested several federal provisions, including setting the presumptive age of consent, but there is variability in these provisions across states. Despite the evolution of these various civil dimensions of marriage, it continues to retain the spiritual implications unique to the many religious communities and traditions that formally unite couples through marriage.

Current State Laws and Regulation

Legal marriage contracts are regulated at the state level, and there are differences. Only a small minority of the states recognize common law marriage (i.e., that persons who cohabitate for a set amount of time are considered, by law, to be wed even in the absence of formal civic proceedings). All except Mississippi set the age of consent at 18 without parental permission, but for marriage with parental consent, some states allow for marriage at ages as low as 13. Some states also require medical examinations or a waiting period for a license. Checking their state's requirements is a necessity for the couple planning marriage.

Some states regard a marriage contract as similar to other contracts, such as a commercial venture, whereas other states define the capacity to enter into marriage as requiring less capacity than, for example, testamentary capacity or entering into a contract. In a California appellate case, the court opined that "[M]ental capacity can be measured on a sliding scale, with marital capacity requiring the least amount of capacity, followed by testamentary capacity, and on the high end of the scale is the mental capacity required to enter contracts."[4] In this case, the primary question was the capacity to dissolve a marriage (the husband sought to separate from his wife of 48 years, who in turn asserted that he was mentally incompetent to do so). It was determined that the capacity to end a marriage was similar to the capacity to enter into marriage.

We can turn to the probate code guidelines for comparisons to other capacities. In California, the probate code defines testamentary capacity as "[having] the ability to understand the nature of the testamentary act, understand and recollect the nature of his or her assets, or remember and understand his or her relationship to family, friends, and those whose interests are affected by the will."[5] More generally, the California probate code declares several principles that guide the necessary legal capacity for entering into contracts,[6] including the existence of a (rebuttable) presumption that individuals have capacity and are responsible for their decisions; that those with mental disorders may still be capable of contracting, marrying, and making medical decisions, among other capabilities; and that a lack of legal

capacity is related to evidence of deficit in mental function rather than a particular diagnosis.

Lack of Capacity to Marry

As mentioned above, the agency of bride and groom in the marriage contract has expanded significantly over the centuries. Whereas it was customary for early marriages to be executed without input or opinion from either the bride or groom (as these were transactions of a more practical economic nature), in time the couple's preferences became more important. Generally speaking, modern Catholic, Jewish, and Islamic teachings espouse a more egalitarian view of marriage in which the decision to marry is made by the couple themselves and both parties have equal say and importance in the transaction. Centuries ago, therefore, the concept of decisional capacity to wed would have been moot. However, as the major religions began to focus more on the couple's decisional role in marrying, so did civic legal systems. Hence, the concept of one's state of mind, regarding his capacity to marry, has become an increasingly valid consideration.

According to U.S. law, several factors can eliminate an individual's capacity to marry, such as youth. Most states set the age of 18 as the minimum for marriage without parental consent. Many states set 16 as the minimum even with parental consent, though some states, like California, do not have an age minimum. Exceptions are made in some states in case of pregnancy or a child in the partnership.[7] In the case of youth, it has been decided that an individual under the age of majority does not have the reasoning abilities to make the decision to enter into a marriage contract, but the laws differ from country to country. In most, the legal age to marry is similarly 16 to 18, but there are no minimums with parental consent. The Convention on Consent to Marriage, Minimum Age for Marriage, and Registration of Marriages was a treaty agreed upon in the United Nations on the standards of marriage, which included stipulations regarding the voluntariness of marriage, being of "full" age, and decrying any limitations to marriage based on race, nationality, or religion.[8] It was initially signed by 16 countries in 1964. The primary goal of this type of legislation is to decrease child trafficking, particularly of young girls.

One population of particular interest to psychiatrists is patients with mental illness, with questions arising regarding an individual's capacity to marry if he or she has active mental illness or has been involuntarily committed or conserved. It is important to note that having a diagnosis of mental illness does not automatically mean the absence of the capacity to marry or, for that matter, to enter into other legal contracts or make other decisions. In a New Jersey case, a plaintiff husband sued for the annulment of his marriage, stating that his wife hid her mental illness from him fraudulently. The court dismissed the case, noting that evidence demonstrates that the defendant "had a proper conception of the marriage ceremony and understood the responsibility attached to the marriage relationship."[9] Similarly, in a case in the state of Washington where the sister of a man challenged his marriage posthumously on the grounds that her brother did not have the mental capacity to enter into marriage because of his diagnosis of *dementia praecox* (now termed schizophrenia), the court concluded that "at the time the common-law marriage was entered into Lawrence Gallagher was neither insane nor an idiot. The marriage was not void."[10]

In California, an individual with mental illness may be placed under conservatorship if there is a concern that, because of mental illness, the individual is gravely disabled and therefore is unable to provide for food, shelter, or clothing. As part of this conservatorship, the judge may also determine the individual's ability to enter into legal or financial contracts, drive an automobile, or make medical decisions. If an individual cannot enter into legal or financial contracts, then he or she also likely cannot enter into a marriage contract. A similar process of conservatorship or guardianship is delineated in other states.

When a court deems that a marriage is invalid, an annulment, meaning determination that the marriage never existed, may be obtained. Such a judgement may be handed down because of fraud, forced consent, or mental incapacity, including intoxication.

Importance of the Assessment of Capacity to Marry

There are several grounds under which a marriage can be challenged. Some grounds make a marriage void (meaning it never existed in the first place), such as polygamous marriages, whereas others allow a marriage to be voidable, such as when concerns about fraud, duress, undue influence, lack of consent, or mental incapacity are substantiated.

There are several implications, usually financial, that can place an individual, particularly an elderly person, at risk of abuse and manipulation. Legal cases have described situations wherein an older individual with financial means is manipulated into the contract of marriage, allowing the spouse to receive significant financial benefits upon the individual's death, prompting difficult legal battles among family members and other potential beneficiaries.[11] These situations call into question the individual's capacity to enter into the marriage contract in the first place. One such noteworthy case took place in 2001, when a former California judge Ralph Dills married his stepdaughter, 34 years his junior. Reports indicated that she impersonated his wife of 30 years and sought financial support from Dills after filing for bankruptcy.[12] In another case, Ms. Lillie Rahm-Riddell was in her 90s when she married Mr. Riddell, in his 60s. She had a diagnosis of dementia, but the court found that "persons suffering from dementia have fluctuating periods of more contact with reality and ability to cope." The court reviewed the evidence and found credible testimony indicating that the woman was competent and understood the consequences of her actions at the time that she married Riddell.[13]

Because of the rising age of the U.S. population, some have suggested that there may be a growing number of elders at risk and that a test of capacity to enter into marriage for those over 65 is necessary.

The state of California requires both parties to have the capacity to marry, as defined above under contractual law. They must meet the minimum age requirements and must not undertake marriage under duress or as part of a polygamous relationship or a fraud, and they must obtain a marriage license and certificate. The couple must marry within 90 days of receiving the license, and the license becomes a marriage certificate when the individual presiding over the marriage (justice of the peace, minister, rabbi, and others) registers the license with the county clerk. In California, there is an option to have a confidential marriage, meaning only the couple and the county clerk's office have access to the marriage license, in addition to the usual public marriage common to all other states.

Further Discussion of Mr. V

Several problems arose out of this case, and we will discuss them here to illustrate key points. First, we want to emphasize the importance of evaluating mental status to determine capacity. Mr. V.'s hospital course could have been prolonged due to complications of delirium, hypernatremia, hypoxia, sepsis, renal insufficiency, and gastrointestinal bleeding. Delirium is a condition of waxing and waning mental status, and therefore it would be essential to evaluate Mr. V.'s mental state over time to ensure that he was consistent in his choice. This case would have been more challenging if Mr. V., given his failing health, had ongoing, rather than resolved symptoms of delirium.

Next, this case allows us to think about the problem of financial abuse in the elderly. The assessment of capacity to marry would have been significantly more challenging if it were Mr. V. who had the financial resources or if the relationship was new. In this case, his partner was the one providing for the couple financially and the relationship itself had been stable for 20 years. As we noted previously, though, there are instances where financial abuse can take place over many years, and therefore the longevity of the relationship cannot be the only marker of validity.

Finally, Mr. V. spoke about the importance of faith in his decision to marry, an important point to begin a discussion about the complex secular and religious complexities inherent in the decision to marry.

Defining Capacity to Marry

It is first valuable to think more generally about evaluating capacity. A capacity assessment can be done by any qualified clinician, not only by psychiatrists, though psychiatrists are often called in cases where the assessment is more challenging or nuanced. There are four basic elements to assessing capacity,[14] and it is important to keep in mind that capacity is decision specific and can be fluid. The first criterion is that a patient must be able to express a clear and consistent choice. This means that if our Mr. V. perhaps had an episode of delirium and agreed to the marriage contract on one day and on the next day, changed his mind, he likely would not meet this criterion. However, he consistently maintained his decision when asked by various providers at different times. In addition, at the time of the consultation, he was stabilized with respect to some of the medical factors that predispose to delirium.

Second, the patient must be able to understand the risks and benefits of the decision, as well as the alternatives. In the case of Mr. V. or someone engaging in

a marital contract, the risks and benefits may relate to finances and living arrangements. It may also have implications for end-of-life decision-making, as the spouse is the one to whom providers turn first to make these decisions in the setting of patient incapacity if a formal health-care proxy is not designated. In Mr. V.'s case, information about his housing and financial situation was obtained independently from his partner and his daughter and directly from Mr. V., and all corroborated each other.

The third prong of a capacity assessment is to be able to apply those risks, benefits, and information regarding the decision to the evaluee. In Mr. V.'s case, this means that he would understand beyond the general implications of the risks, benefits, and alternatives to marriage and instead be able to understand how those elements apply in his particular case. Mr. V. himself was able to acknowledge that others had concerns about his decision to marry at this time in his life, and he indicated that the risks to him of not marrying (loss of peace of mind and the negative spiritual/religious implications of dying unwed) far outweighed the risks to him of getting married (minimal, if any, financial implications to his estate).

Finally, the patient must be able to manipulate the relevant information rationally, meaning that there is not, for example, a mental illness such as dementia, psychosis, or severe depression that is hindering rational thought. In other words, there is not a cognitive or information-processing barrier preventing the patient from grasping the gravity of the decision at hand. In Mr. V.'s case, he had no psychiatric history, expressed no paranoia or delusional content, did not appear to be responding to any internal stimuli, and had no history or evidence of dementia. As mentioned above, Mr. V. was intermittently delirious; however, at the time of the evaluation, there was no evidence of active delirium that would have influenced our assessment.

An individual must meet all four criteria to be deemed to have the capacity to make the decision.

It is valuable to keep in mind that the capacity threshold changes depending on the implications of the decision. In medical situations, this is exemplified by the lower threshold to meet capacity criteria when the intervention is low risk, such as a nonurgent laboratory draw versus a proportionally higher threshold to be deemed to have capacity when the decision has potentially life sustaining, limb preserving, or significant quality of life ramifications. In any of these situations, the four prongs of capacity assessment remain the same. However, the threshold is different. The patient facing a higher risk decision must have a more defined understanding of risks and benefits, a clearer alternative plan, and be able to discuss the issue in more depth with continued rational thought than the patient facing a lower risk decision. With the capacity to marry, this capacity threshold also applies, and the higher risk situations are those with more financial or family implications. In Mr. V.'s case, we can consider the capacity threshold low, based on his relationship history and the current lifestyle and financial circumstances.

We can see several guidelines emerge as we apply these principles to the capacity to marry. First, an individual entering into marriage must do so voluntarily. There cannot be undue influence or coercion. Second, the individual must have the capacity to do so, as defined above by the four criteria. Finally, the individual must know with whom he is entering this contract; that is, he must know whom he is marrying. In essence, these principles are an amalgam of the principles we use in medical venues (medical decision-making capacity) and legal venues (such as testamentary and contract capacity).

Potential Challenges

What happens if an individual has been deemed to lack the capacity to marry? When an individual in the hospital lacks the capacity to make a particular medical decision, a surrogate decision-maker is sought. Often, this is a spouse or child whose job is to follow two principles: substituted judgment and reasonable person principle. This means that surrogates should take into account their knowledge of the incapacitated person's beliefs and wishes and ask what a reasonable person would do in a similar situation.

However, the capacity to marry is not a medical decision, *per se*, even though in the case of Mr. V., the question arose in the context of medical illness. It does not have implications for life-prolonging or life-saving measures, although one could argue that the psychological and emotional impact influence the quality of life. In the legal world, when an individual lacks capacity to make certain decisions, such as financial or contract decisions, a judge may appoint a conservator or guardian to assist with those matters. As entering into marriage is a form of entering into a contract, it could be argued that the capacity to marry should be treated similarly, with a conservator

appointed to make those decisions. Yet, entering into marriage is not the same as, for example, entering into a land lease contract, as there are relational and potentially spiritual and religious implications or stakes. Therefore, a guardian may not be able to act appropriately in that instance, and an individual deemed to lack capacity to marry may not, therefore, be able to do so in the eyes of the law.

An assessment of decisional capacity is a clinical one, and as such, it is predicated on the idea that psychiatrists, as clinicians, share a certain degree of knowledge and expertise in those medical or psychological dimensions of a patient that could bear upon ability to consent to marry. The landscape is much less shared when exploring spiritual and religious dimensions of a particular patient or situation. For example, in the medical decision-making construct outlined above, the patient pays close attention to the medical risks and benefits of a proposed procedure. However, when it comes to spiritual and religious risks and benefits, most people are unable to consider themselves expert. Therefore, it would behoove the medical/psychiatric team to seek expert consultation from spiritual and religious community leaders to gain the best understanding and to advise appropriate next steps from a spiritual or religious point of view.

Conclusions

The ability to enter into a marriage can be viewed through many different lenses: spiritual and religious, legal (from a contractual and a statutory perspective), and medical and clinical. More often than not, the ability of either party to enter into a marriage is not questioned. However, in those situations where the validity of the process is called into question, it is important to think through these various domains (spiritual and religious, legal, and medical and clinical) and their relative contributions to how we understand marriage. The assessment of a couple's ability to enter into marriage, therefore, may require a multidisciplinary approach involving experts in spiritual and religious matters and legal processes and statutes and clinicians skilled in assessing mental status. For the latter, there has been heretofore no documented application of the Appelbaum clinical capacity evaluation process[14] to the assessment of capacity to marry, and as a result, there is little guidance on how to apply the four criteria effectively in this context. The capacity to enter into a marriage contract may be evaluated as though evaluating capacity to enter into other legal and financial contracts and medical decision-making capacity. The legal and financial capacities differ state by state and it is therefore important to understand relevant state regulations.

The general principles that apply are voluntariness, the four criteria that determine capacity, and understanding the person with whom the marriage contract is being made: An individual must express a consistent choice, understand the implications of the decision, and be able to reason rationally about the decision. It is not a high threshold to meet, but it is particularly important to evaluate in cases where there is a possibility of manipulation or abuse. There are certain important differences, however, as noted above, such as the fact that there is likely no alternative decision-maker in these situations (i.e., no option for a guardian), to enter into a marriage contract when a person is deemed to lack capacity for that decision.

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