Sociocultural Context and Application of Criteria for Capacity to Marry

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We write to comment on the contribution of Glezer and Devido, which we found to be a cogent synopsis of the extant scholarship on the capacity to marry. The article raises several important matters that merit further consideration. In this commentary, we expand the discussion, emphasizing cultural and regional contexts. We submit that this is an important policy area, given the lack of capacity criteria for marriage both domestically and internationally.

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The article by Glezer and Devido[1] is grounded in European legal and social history and its evolution in the Americas. Much of this history has been particularly shaped by British common law. In the Caribbean, this influence was of greater strength and duration because of a longer term colonial period. In fact, much national legislation in the Caribbean has roots in older British law and precedent exercised in the colonies for the better part of 300 years in many cases. For the colonial period, law evolved under the rubric of occupation. Postcolonial jurisprudence has developed more independently, but retains many elements of British law as a foundation.

Current State Laws and Regulation

Many countries in the English-speaking Caribbean (Barbados,[2] Guyana,[3] Jamaica,[4] and Trinidad/Tobago[5]) recognize common law marriage as long as both parties have lived together for at least five years. If Mr. V. had lived in the Caribbean, he would have the same rights as if clergy or a court officer had performed the marriage.

Although marriage is a basic human right, capacity to marry has important implications for the responsibilities conferred on each member of the married couple. The hierarchy of capacity discussed by Glezer and Davido does not adequately capture the real-world legal and social responsibilities inherent in marriage. In general, the current criteria for capacity to marry tend to require a low threshold, one that is below that necessary for medical decision-making, testamentary capacity, and the capacity needed to enter into contracts. In fact, the responsibilities of marriage involve decision-making at all levels presented: acquiring a loan or mortgage; establishing joint investment accounts; estate planning and execution of wills; and making medical proxy decisions for minor children.

Some authors have suggested that the capacity threshold should be relatively low because the decision to marry is strictly personal. We find that assertion problematic, as the act of entering into a long-term, legally sanctioned relationship concerns both self and others. The standard defined for actions that concern others also has some practical shortcomings. Marriage does not exist in a vacuum, as people other than the married couple are potentially affected by their decisions and their marital status, such as children from first marriages, family members, and employers. In addition, potential reallocation of estate assets after a marriage has implications for those who may or may not stand to benefit.

Table 1 summarizes legal criteria for consent to marriage in several member states of the Caribbean community. Legislation has tended to address age thresholds and the role of parental consent; however, detailed legislation regarding capacity to marry is lacking. Barbados explicitly addresses capacity in legislation. However, even the comparably progressive

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Table 1 Criteria for Marital Consent

Legislative Code	Age of consent (Marriages Under 16 years not Allowed)	Consent	Lack of Capacity
Government of Barbados[2]	18 years (widow, widower or divorcee can marry without consent)	Must have consent from either parent/ guardian if 16 to ≤18 years	Consent not real because: consent obtained by duress or fraud; mistaken identity of other person or nature of ceremony; mentally incapable of understanding nature/effect of ceremony
Government of Guyana[3]	18 years, (widower/widow can marry without consent)	If 16 to ≤18 years, consent of parent/ guardian/Judge; if under 16 years and pregnant-petition from court for permission to marry	
Government of Jamaica[4]	18 years, (widower/widow can marry without consent)	If 16 to ≤18 years, permission is needed from father, lawful guardian, unmarried mother in descending hierarchy or judge on the Supreme Court	
Government of Trinidad and Tobago[5]	18 years	If under age of 18 years, parents/legal guardian, judge on the High Court	

Barbadian legislation contains some ambiguity. As there is no definition of capacity, the clinical criteria would have to be established by a clinician retained to evaluate a person whose capacity is questioned.

Barbadian law allows for *marriage in extremis*[2]; that is, a marriage officer or magistrate can solemnize a marriage without a license or magistrate certificate. If the official observes (or concludes on the basis of a medical certificate) that one party is very ill and is likely to die, the individual must declare a belief of being at the point of death before the marriage is solemnized.

Trinidadian[5] law also acknowledges *marriage in extremis* but with slightly different legislative language; the Act stipulates that such a person must be explicitly legally competent to consent to marriage, be of full age, and be of the same religious communion or denomination as the marriage officer. The Trinidadian Act is likely to present difficulties in practice. First, although competence to marry is referenced, the criteria for competence are not stated. Second, verifying a person's communion or denomination may be difficult or impossible to verify in many situations, particularly when the marriage officer does not personally know the persons desiring to marry.

In Jamaica and Guyana,[3,4] a marriage officer may solemnize a marriage if one person is in *articulo mortis* (at the point of death). For the present discussion, the most relevant point is that the marriage Acts either do not reference capacity to marry or, in the case of Trinidad, do not define capacity. Despite the gravity of such scenarios, the Acts are largely exempt, or at least insulated, from medicolegal scrutiny.

More generally, the implication for clinicians stems from the lack of criteria for capacity in any articulated legislative language. Therefore, a clinician retained to assess capacity is challenged to develop a defensible and culturally appropriate standard by which capacity is measured. To the extent of the authors' knowledge, this remains a hypothetical scenario in Barbados, as we are unaware of any legal proceedings in which a capacity assessment was requested.

Given that most marriages are officiated by a member of clergy, some understanding of the relevant theological dimensions of marriage is useful. In Barbados, the doctrine regarding capacity to marry differs significantly between the Anglican and Roman Catholic churches. The differences between these two dominant faiths[6] are of interest, as they relate to civil law regarding marriage.

In addition to civil requirements, the Catholic Code of Canon Law[7] articulates specific expectations for members of the faith. The sacrament of marriage involves the exchange of vows to form an exclusive, indissolvable partnership and the raising of children in the theology of the church.[8] Failure to meet these expectations may be grounds for annulment within the judgment of the church. Annulment is "a declaration by a Church tribunal (a Catholic church court) that a marriage thought to be valid according

to Church law actually fell short of at least one of the essential elements required for a binding union."[9]

According to Church Canon the following persons are incapable of contracting for marriage: those who lack the sufficient use of reason; those who suffer from a grave defect of discretion of judgment concerning the essential matrimonial rights and duties mutually to be handed over and accepted; and those who are not able to assume the essential obligations of marriage for causes of a psychic nature.

The Anglican tradition in contrast does not endorse the concept of annulment. A mental health colleague, who is also a member of the Anglican clergy, described the rationale in a recent interview, "Annulment can adversely impact the psyche of the partner and the children because it can be perceived as an attack on their core identity and existence" (Lashley M, personal communication, June 2017).

Clinical Application of Criteria

We now turn from a more abstract discussion of legal and faith-based principles to practical application of criteria for capacity to marry.

If an assessment were requested, the clinician could rely on criteria articulated in the literature, with appropriate, culturally competent interpretation for the Caribbean. To develop a framework for culturally based assessment, a clinical example may be useful. Relevant case studies in the English-speaking Caribbean are scant. However, for this discussion, we derive an example compiled from our collective clinical experience in the Caribbean context.

A clinician was called to consult about a patient after a suicide attempt by ingestion of Gramoxone (an organophosphate used as herbicide). Gramoxone ingestion is one of the most common means of attempted and completed suicide in some Caribbean countries[10] and, unfortunately, it is extremely lethal.[11] The patient was in acute distress and vomiting profusely; there was objective evidence of autonomic instability. Her immediate survival was in question, and her prognosis indicated a small chance of survival beyond a matter of days. In this context, the fiancé asked, "Can we get married now?" Both medical staff and the family found the request to be both unexpected and inappropriate. The patient's relative was particularly taken aback by his question, given the seriousness of the patient's condition. The acuity of the patient's clinical presentation afforded the opportunity to indicate that this was not the appropriate time, nor did any member of staff pursue the request further.

In this context, one might ask whether the patient was willing and able to consent to marriage. A salient aspect of the patient's presentation would be the acuity of her clinical status. The level of physical and related emotional distress would be likely to contribute to diminished understanding, judgment, and decision-making. This critical difference speaks to immediate capacity in a clinically unstable patient. Suppose that the patient's condition had improved and stabilized. What then? Presumably, the patient would be more capable of understanding and responding to the marriage proposal. The two scenarios present challenging ethics dilemmas and do not support facile assessment and conclusion. The most challenging ethics-related question regards the extent to which an acutely disturbed mental state is likely to affect judgment negatively and impulse control specifically, as well as capacity more generally.

Anecdotally, Gramoxone poisoning does not usually affect the crystallized aspects of cognition, such as remote memory, judgment, and abstraction. The physical and psychological turmoil that are sequelae of Gramoxone ingestion are likely to diminish attention and concentration, and to impair short-term memory. At a minimum, a mental status examination provides important evidence of all aspects of basic cognitive functions. If warranted, further assessment using psychological testing is an option. If a court has mandated the assessment, the components of the assessment can be modified to meet specific expectations or standards.

Let us assume in our case that the patient had accepted a marriage proposal before her hospital admission. At the time of that original proposal, we know nothing about her capacity. Assuming that no party involved in her episode of hospitalization referred her for a capacity evaluation or had information about some previous relevant matter, the central concern would be her understanding at the time of her hospitalization.

A salient consideration is the quality of her judgment as evidenced by her recent suicide attempt. This action raises questions about her ability to care for self, as well as to exercise sufficient impulse control. Equally important is the accuracy of her understanding of her prognosis. There is no information about her understanding. However, an accurate understanding of the near-term lethality associated with

her diagnosis could have a significant impact on her decision-making.

The ability to manipulate relevant information rationally is a function of several factors in addition to mental illness. Nonetheless, assessing the presence or absence of mental illness provides vital insight into a person's ability to manipulate information. The presence of a psychiatric history, such as a longstanding mood disorder, would be significant. Cognitive distortion and slowing associated with a mood disorder would be likely to affect her ability to manipulate information.

Glezer and Devido discussed external factors influencing voluntariness; however, we wish to point out that internal states may also influence voluntariness. These include predisposition to acquiescent responses and dependent personality features, among other potential factors. In the case that we described, the young lady's impulsivity and motivation to self-harm would certainly merit more attention. Similarly, her understanding and psychological response to her diagnosis are important to understand.

Finally, the authors provide brief mention of the criterion of knowing whom the potential spouse intends to marry. Prospective marriage partners must provide accurate and truthful information about themselves. A tandem requirement is the ability to understand the information provided. This criterion seems straight-forward and self-evident.

Conclusion

We applaud Glezer and Devido's efforts to address a neglected topic. Our commentary provides further context from a different sociocultural perspective, as well as a distinct history of jurisprudence. We concur that taking into account broader factors, such as culture, religion, and history, is an essential component of accurate and useful assessment of capacity to marry, particularly because there is scant guidance in the legal or scientific literature regarding capacity to marry. Therefore, individual clinicians are required to make judgment calls. We hope that our discussion of this topic and the original article will provide a useful structure for clinicians working in this area and will additionally stimulate greater attention to future policy and clinical practice.

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