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INCAPACITY TO CONTRACT MARRIAGE DUE TO GENDER IDENTITY DISORDERS

Introduction

For many years attempts have been made to negate the existence of the objective truth in the sphere of morality and the traditional social order through relativising all aspects of reality around us, this being a core manifestation of the “culture of postmodernism”. With this culture becoming more imposing, and shrouded with atheism and liberalism, it is human corporeality that has been recently subjected to mounting pressures from representatives of such discernible trends.

The Resolution of the European Parliament of 16 March 2000, making *de facto* unions, including same-sex unions, equal to the family, constituted one of the first legislative measures dictated by those ideologies that are keen on challenging the traditional vision of human sexuality. In response to that Resolution, the Pontifical Council for the Family issued the declaration of 17 March 2000, acting as a powerful reminder that only a marriage commitment between a man and a woman based on love can provide grounds for the family, thus fostering social development. Four months later, on 26 July 2000, the same body released a document entitled *Family, marriage and de facto unions*¹. In the introduction to that document, Cardinal Alfonso Lopez Trujillo, President of the Council, wrote that the family – as the fundamental cell of society – is facing

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¹ Pontificio Consiglio per la Famiglia, *Famiglia, Matrimonio e unioni “di fatto”*, Libreria Editrice Vaticana 2000.

unprecedented attacks, based on “an erroneous anthropology and a juridical vision which is inconsistent with the truth about man and woman”².

In analysing the causes behind the growing social acceptance for the concepts of human sexuality inconsistent with the truth about man, at some point in the document the Pontifical Council for the Family referred to the gender ideology which is predominantly invoked by those “claiming a similar status for marriage and de facto unions (including homosexual unions)”³. According to this ideology, “being a man or a woman is not determined fundamentally by sex but by culture”. Its followers further advocate that “generic sexual identity («gender») is the product of an interaction between the community and the individual, but that this generic identity is independent from personal sexual identity: i.e., that masculine and feminine genders in society are the exclusive product of social factors, with no relation to any truth about the sexual dimension [resulting from the birth-assigned sex – J.S.] of the person. In this way, any sexual attitude can be justified, including homosexuality, and it is society that ought to change in order to include other genders, together with male and female, in its way of shaping social life”⁴.

It appears obvious that nowadays the gender ideology constitutes one of the most aggressive attempts at relativising, or even negating, the objective truth about man, which is deeply grounded in biological facts. Attention to that issue was drawn by Pope Francis at the meeting with Polish bishops during the World Youth Day in Kraków. “In Europe, America, Latin America, Africa, and in some countries of Asia, there are genuine forms of ideological colonization taking place. And one of these – I will call it clearly by its name – is [the ideology of] «gender». Today children – children! – are taught in school that everyone can choose his or her sex. Why are they teaching this? Because the books are provided by the persons and institutions that give you money. These forms of ideological colonization are also supported by influential countries. And this is terrible! In a conversation with Pope Benedict, who is in good health and very perceptive, he said to me: «Holiness, this is the age of sin against God the

² Ibid.

³ Ibid., no. 8.

⁴ Ibid.

Creator». He is very perceptive. God created man and woman; God created the world in a certain way... and we are doing the exact opposite”⁵.

Claiming that human sexuality is a subjective, and hence modifiable, phenomenon, the advocates of the gender ideology are inclined to believe that we all have the right to decide (freely and several times during our lives) which gender we want to represent. This might imply an opportunity to freely opt for some “new” types of gender, rather than sticking to the “traditional” choice between being a man or a woman. Some ideologists are even proposing that indecisive people should abstain from making that choice and perceive themselves as totally “freed” from any features and behaviour typical of a specific gender. According to the gender ideology, transsexualism, i.e. transitioning from one’s assigned sex to another, is entirely possible and should be considered normal.

In view of the recent spread of the so-called gender mainstream, the Catholic Church is facing a stronger-than-ever challenge of vigorously defending the natural order and the anthropological vision of human sexuality based on the Gospel. This duty becomes even more complex as the arguments presented by the supporters of the idea of redefining human sexuality do not usually refer to the recent advancements in human sciences, and sometimes even ignore them or interpret them selectively. These ideologists build up their strength by skilfully abusing the concepts of human rights, dignity and non-discrimination on grounds of sex or sexual preferences [Peeters 2009, 23]. Such ideologisation virtually renders any meaningful dialogue impossible and significantly hinders a thorough analysis of the phenomenon in question, while the absolutisation of subjective experiences and desires of a person, also visible in other fields, makes matters even worse. However, in view of the integral good of man, the Catholic Church is not easily discouraged by accusations relating to its confessional bias or lack of a scientific basis, or by prejudice towards its moral teaching related to its alleged association with religious doctrine and

⁵ Pope Francis, A meeting with the Polish bishops on the occasion of the XXXI World Youth Day in Kraków (27.07.2016), in: https://www.deon.pl/religia/serwis-papieski/dokumenty/przemowienia-papieskie/art,149,papiez-z-biskupami-o-dechrystianizacji-i-uchodzcach-dokumentacja.html?utm_source=deon&utm_medium=link_artykul [accessed: 13.05.2018].

thus being perceived as having no universal significance [Wróbel 2016, 115]. Therefore, gender identity disorders form the subject matter of in-depth analyses for the Catholic Church in the fields of anthropology, theology, morality and canon law.

This study is aimed at determining the impact of gender identity disorders on the person's capacity to contract marriage in the light of canon law. The starting point to the discussion is provided by the scientific concepts of human sexuality and gender identity disorders, viewed through the prism of the latest achievements in biological and psychological sciences, and confronted with Christian anthropology. The issue of the validity of marriage contracted by people afflicted with gender identity disorders are also analysed in the study.

1. A scientific view on transsexualism

1.1. Definition

The phenomenon under consideration reflects an attitude which is directly caused by gender identity disorders and by rejecting one's own sex. Generally speaking, transsexualism develops through disapproving of one's birth-assigned sex, which is combined with the desire to function and be perceived as a representative of the opposite sex. Women who wish to be seen as men, and men who desire to be perceived as women are the classic examples of transsexualism.

One of the earliest attempts at offering a scientific explanation for gender identity disorders was made by Magnus Hirschfeld, a German physician and sexologist. In his work dated 1910, he described this phenomenon as follows: "the desire to dress in the clothes typical of the gender which the given person does not represent judging by the appearance of his or her sex organs; this desire often requires a very strong expression"⁶. It is worth noting that Hirschfeld's definition excluded dressing up for fun or disguise. Other terms previously used to describe the phenomenon in question include "mental cross-sexualism," "cross dressing", "eonism" or "metatropism".

⁶ Cf. Dulko 1993, 235.

The current and commonly used term “transsexualism” (Latin: *transire* – to transit, *sexus* – sex) was first used in scientific literature in 1949 by David Olivier Cauldwell, an American sexologist. In describing a case of a girl who obsessively wanted to be a man, he coined the term “psychopathia transsexualis” [Cauldwell 1949, 274-80]. However, it was only after 1952 that transsexualism came to be approached with greater interest as a separate phenomenon. This was due to two Danish physicians performing the first-ever sex reassignment surgery, as a result of which George Jorgensen became Christine Jorgensen. This fact was widely publicised in the media [Fajkowska–Stanik 1999, 769].

The most common definition employed by Polish sexologists was proposed by K. Imieliński, renowned for extensive studies of this phenomenon. He claimed that transsexualism was “a discrepancy between the mental identification of a person’s sex and anatomical and biological structure and their sex registered at birth, with the last two being perceived as «foreign» and belonging to the opposite sex” [Imieliński 1982, 253]. For clinical purposes, transsexual people are divided into the following two types: female-to-male (FtM) – people with feminine body features, but identifying themselves as men, and male-to-female (MtF) – people with masculine body features, but identifying themselves as women.

Transsexualism was recognised as a diagnostic category in the third issue of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III)⁷, first released in 1980. In the more recent DSM-IV (last review of 2000), it was classified among gender identity disorders, its diagnosis being based on the following criteria:

- A. A strong persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex).
- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
- C. The disturbance is not concurrent with physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

⁷ *Diagnostic and Statistical Manual of Mental Disorders* – the classification of mental disorders published by the American Psychiatric Association (APA).

The typical symptoms of transsexualism, according to DSM-IV, include a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex⁸.

According to the International Classification of Diseases and Related Health Problems, ICD-10, which is applied in Poland, transsexualism belongs to the category of gender identity disorders, together with dual-role transvestism, gender identity disorder of childhood and other (unspecified) gender identity disorders [Robacha 2017, 288]. Based on the ICD-10 definition, transsexualism is “[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one’s anatomic sex, and a wish to have surgery and hormonal treatment to make one’s body as congruent as possible with one’s preferred sex”⁹. Its diagnostic criteria specified in ICD-10 are as follows: 1) the transsexual identity has been present persistently for at least two years; 2) the disorder is not a symptom of another mental disorder, such as schizophrenia, or any other disorder related to intersexual, genetic or chromosomal abnormality¹⁰.

Recently the attitude taken by a large part of the scientific world to transsexualism has undergone dramatic changes, and the aforementioned offensive launched by the advocates of the gender ideology has most likely contributed to that. In DSM-V published by the American Psychiatric Association on 18 May 2013, which contains the most recent classification of mental disorders, transsexualism is classified as gender dysphoria. Similar to the previous classifications, it refers to people experiencing distress due to their birth-assigned sex and gender not matching their gender identity. In order to be diagnosed with gender dysphoria, a person must perceive, for no less than six months, his or her gender as being clearly distinct from that assigned by other people. In addition, the latest American classification contains separate diagnostic criteria for children

⁸ Cf. The American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, 4th ed. (DSM-IV) Washington DC 1994, No. 302.85.

⁹ Cf. *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines*, Kraków–Warsaw 1997, No. F64.0.

¹⁰ Ibid.

and adults, which results from children having more limited abilities to express their own sensations and feelings. Undoubtedly, the most significant change, compared to the diagnostic criteria previously proposed by the American Psychiatric Association, refers to the obvious intent to depathologise and depsychiatrise transsexualism. The word “dysphoria”, which has replaced the notion of “disorder” that is still present in the commonly used term of “gender identity disorder”, suggests that not accepting one’s birth-assigned sex and gender does not imply suffering from a mental disorder. According to the authors of the new classification, such people should rather be perceived as “gender non-conformists” [Bielas 2014].

As regards the issue under discussion, the new ICD-11 classification published in 2018 by the World Health Organisation suggests, *inter alia*, striving away from the clear-cut bisexual perception and assessment of gender identity disorders, recognising the possibility of performing sex reassignment in patients afflicted with what is currently referred to as dual-role transvestism¹¹. Another proposal is to exclude identity disorders from the group of psychiatric conditions and classify them among other disorders not associated with any specific medical field [Robacha 2017, 288].

1.2. The etiology and clinical presentation of transsexualism

Transsexualism is the most severe of all gender identity disorders. Transsexual people experience genuine distress while seeking to lead their lives in conformity with self-identified gender. This phenomenon stems from a radical discrepancy between the body and the psyche. Undoubtedly, human sexual identity develops in consequence of numerous co-occurring factors which are interrelated and influence one another. In the vast majority of cases, the chromosomal sex, which is determined at the time of fertilisation and remains unchanged throughout the whole life, corresponds to other types of human sex conditioned by physiological factors (gonadal, gonadophoric, phenotypic, hormonal, metabolic, and brain sex¹²), and

¹¹ Dual-role transvestism (or cross-dressing) is described as wearing clothes of the opposite sex in order to enjoy the temporary experience of representing the opposite sex but without the permanent sex reassignment intent or sexual satisfaction [Cysarz 2017, 304].

¹² The notions of “sex” and “gender” were extensively defined by: Jancewicz 2014, 138-40.

gender related to personality and social traits, which are defined right after birth and determine the fulfilment of certain roles in society. However, if this balance is distorted, especially in the mental plain, the so-called mental gender, i.e. the sense of being a man or a woman, becomes inconsistent with other aspects of human sexuality. This, in turn, leads to disapproving of one's own biological (or birth-assigned) sex [Dzięga 1999, 138].

As regards the prevalence of transsexualism, it affects 1 in 30,000 biological males, and 1 in 100,000 biological females. This corresponds to a proportion of 3:1 with male preponderance. Interestingly, in Poland this proportion is reversed, i.e. of 1:3.4 with female preponderance [Robacha 2017, 288-89]. So far no clear arguments have been put forward to explain this marked prevalence of female-to-male transsexuals in our country. Some researchers suggest that this may be connected with the different concepts of female sexual roles in the societies of the Western and Eastern Europe [Urban 2009, 720].

It is a commonly held view in contemporary science that the etiology of transsexualism is multi-faceted, but the ultimate factor determining its occurrence is yet to be explored. Obviously, genetic and neurodevelopmental factors come at play, along with environmental factors in the prenatal period of human life. Some sexologists actually recognise the possibility for gender identity disorders to develop as a result of mothers taking steroid drugs or hormone-derivatives during pregnancy. With the sufficient genetic susceptibility of the child, the induced endocrine disruption effects are likely to evolve into transsexualism at the subsequent development stage [Bancroft 2009, 301-12]. With genetic and hormonal factors playing vital roles, this condition is referred to as primary transsexualism.

It stands in opposition to secondary transsexualism which develops due to inappropriate child-raising methods or social impacts. The secondary form of the disorder is conditioned by improperly shaping one's psyche in childhood and adolescence. J. Huber, in his article devoted to the impact of transsexualism on the capacity to contract marriage, pointed out that "secondary transsexuals are people who have been exposed to the traumatic experience of various forms of violence since their early childhood. An inference can, therefore, be drawn that a person is not born a transsexual

but can become one at some point in his or her life” [Huber 1998, 36]. This last statement may seem a bit overgeneralised in the light of more recent studies revealing, as already noted, that biological factors have a tremendous impact on developing the primary (or proper) form of transsexualism. In contrast, secondary transsexualism can be defined as transsexual behaviour or attitudes which seem to constitute a condition reversible through psychotherapy combined, if need arises, with pharmacotherapy [Dzięga 1999, 138-39]. This issue appears quite important in the context of the capacity to contract marriage by people afflicted with sexual identity disorders.

When it comes to primary transsexualism, which constitutes the subject matter of this study, its proper etiology is yet to be explored. Nonetheless, it seems sufficiently well-proven that tendencies and behaviours related to that condition are practically irreversible and independent of social impacts [Robacha 2017, 291].

The principal component of transsexualism is the afflicted person’s determination to change his or her own sex and gender, perceived as a whole, i.e. from the physical, social, and other perspectives, including sex registered at birth. This also applies to the willingness to start a family, and thus to contract marriage and have children. Based on the essence of transsexualism as described above, its clinical presentation is dominated by the sense that one’s bodily features do not match self-identified gender. According to sexologists, this sensation usually develops at puberty, when young people become aware of their own sexual identity and roles. A separate group of transsexuals is formed by those in whom the sexual identity problems manifest themselves at a much later age. In such cases, they are likely to generate slightly different clinical consequences and can result from the previously mentioned secondary transsexualism. However, the problem most frequently occurs in very young people who, once the sexual identity disorders become apparent, are forced to struggle with a serious internal conflict caused by physical changes in the body, and especially its sexual attributes, which remain beyond their influence. The physiological components of puberty in transsexual adolescents induce increasingly strong aversion to their own sex organs and, as regards social relations, to traditional gender-specific roles. In consequence, they very often avoid forming close social bonds, prefer to lead a solitary life, or limit

their social contacts to groups of people struggling with problems similar to their own [ibid.].

FtM transsexuals, prior to undergoing surgical sex reassignment, tend to hide their female bodily attributes under baggy clothes, while MtF transsexuals wear items of female clothing and other accoutrements commonly associated with women. This stage is referred to as “pseudo-transvestism”, and it involves wearing the items of clothing that match self-identity whereas the desire to belong to the opposite sex is permanent, contrary to transvestism, which constitutes a totally different condition¹³.

The so-called pseudo-homosexuality, i.e. the sexual orientation consistent with the self-identified gender rather than with the somatic sex, is a manifestation of transsexualism observed among the vast majority of transsexual patients [Robacha 2017, 292]. It is worth noting that sexual orientation is a separate issue which should not be viewed as tantamount to gender identity. Sexologists determine the sexual orientation of transsexual patients by referring to their mental gender. Obviously, this is non-compliant with the anthropology rooted in Christianity in which the mere “sense” of belonging to the opposite sex, not matching the somatic sex, is insufficient to the person being considered a representative of the opposite sex. Therefore, from the perspective of Christian anthropology, in the case of transsexual people who are sexually attracted to representatives of the same birth-assigned sex as their own, we are dealing with a specific form of homosexuality.

To get the full clinical presentation of gender identity disorders, one needs to consider the different clinical presentations of female (FtM) and male (MtF) transsexualism. Biologically speaking, women afflicted with such disorders usually experience them from early childhood, evolving from pseudo-transvestism, through aversion to their corporeality and efforts to forcibly adjust to their somatic sex, to determined attempts leading to surgical sex reassignment. In the case of male transsexualism, two types are

¹³ The most common fetishist transvestism belongs to a group of sexual preference disorders and differs from transsexualism, *inter alia*, in the fact of being sexually aroused when wearing the items of clothing attributable to the opposite sex. The genotype of fetishist transvestites corresponds to their phenotype. Apart from sexual situations, such people can perfectly function in the clothing matching their gender and age [Kucz 2012, 50].

distinguished, i.e. androphilic and autogynephilic transsexualism. The former develops in childhood, frequently leading to the afflicted individual being oppressed by his peers, and its characteristic features include pseudo-transvestism and efforts to establish homosexual relations (considering that people struggling with this disorder prefer relationships with heterosexual men). The latter type pertains to “male” boys with transvestite experience who establish relationships with heterosexual women (homosexuality with regard to gender identity) [ibid., 293].

1.3. Transsexualism vs. psychotic disorders

Delusions of sex change occurring in patients suffering from psychotic disorders, including schizophrenia, constitute a striking phenomenon observed in clinical practice [Borras, Huguelet and Eytan 2007, 175-79]. They appear particularly interesting in the context of transsexual people's capacity to contract marriage. This issue will be dealt with in the second part of this study. At this point, it seems advisable to pay attention to some serious difficulties faced by sexology and psychiatry specialists looking to formulate the accurate diagnosis. Scientists currently distinguish four types of pseudo-transsexual delusions, i.e. 1) delusions of not representing one's own sex (“I'm not a man/a woman”); 2) delusions of being gender-neutral (“I'm neither a man nor a woman”, “I'm gender-neutral or sexless”); 3) delusions of simultaneously representing both sexes (“I'm both a woman and a man”); and 4) delusions of representing the opposite sex [Urban 2009, 723].

As regards the incidence rates, these pseudo-transsexual delusions are fairly uncommon, although some research results and clinical observations seem to show otherwise. In her article, M. Urban referred to the research conducted by British psychiatrists in the 1960s, indicating the occurrence of pseudo-transsexual delusions in 25% of men and women afflicted with schizophrenia [ibid.]. Other researchers quoted in the article claimed that they had frequently encountered in their medical practice patients “in whom gender (pseudo)dysphoria and sex change demands proved to disguise psychosis”. In addition, it was demonstrated that 44% of schizophrenic women and 30% of schizophrenic men in the acute stages of psychosis experienced hallucinatory sensations regarding their genitals, together with delusions of representing the opposite sex. Such phenomena

might persist and continue also in less acute periods of mental illness [ibid.; Commander and Dean 1990, 894-96]. Some schizophrenic patients demand that radical changes be made to their physical appearance, and may even attempt self-castration¹⁴.

The potential co-occurrence of schizophrenia and transsexualism is not recognised by numerous researchers, and many of them have little knowledge in this field. The author of the article advocated that the possibility for transsexualism to occur jointly with other mental disorders, including psychosis, was recognised in DSM-IV, whereas according to ICD-10, which is applied in Poland, it could only be diagnosed after excluding other mental disorders [Urban 2009, 724].

At the outset of the 21st century, in consideration of the above inconsistencies, the need for diagnostics and treatment of people with gender identity disorders, as well as the possible co-occurrence of transsexualism and other mental disorders, a questionnaire survey was conducted among Dutch psychiatrists. Responses were provided by 186 physicians who examined 584 transsexual patients, revealing that gender identity disorders were the sole diagnosis only in 225 (39%) cases, while in the remaining group transsexualism occurred jointly with other mental disorders. These included personality disorders, mood disorders, dissociative disorders and psychotic disorders [ibid.].

Although many psychiatrists do not recognise the possibility for transsexualism to co-occur with psychoses, the presented survey results in

¹⁴ The author of the article discussed an interesting clinical case described in the aforementioned study by Borrás, Huguélet and Eytan: “they (the authors) presented a dramatic description of a patient who had suffered from paranoid schizophrenia for many years before he eventually underwent hormonal and surgical sex reassignment treatment. This brought a short-term improvement in the patient’s wellbeing. After a couple of months, he discontinued hormonal therapy and demanded that another surgery be performed to transform him again into a man. He claimed that he wanted to be a hermaphrodite, able to use either the male or female sex organs, depending on his current need. At the same time, he was extremely hostile to the surgeons who had performed his procedure. Partial improvement in the patient’s mental condition and alleviation of pseudo-transsexual desires was achieved through clozapine treatment. However, the disease symptoms tended to aggravate each time the patient was confronted with the irreversible nature of his surgical treatment, which also involved developing suicidal thoughts” [Urban 2009, 724].

fact imply a serious need to take this into consideration. Whereas the diagnostic aspect is extremely important, as the proper diagnosis frequently makes it possible to prevent the pseudo-transsexual from the irreversible consequences of surgical sex reassignment, attention should also be paid to the legal aspect of this problem. From a canonist's view, the potential co-occurrence of gender identity disorders and serious mental illnesses constitutes a major factor in assessing the capacity to contract marriage by transsexual people.

2. Transsexualism vs. the capacity to contract marriage in the canonical form

2.1. The Catholic view on gender identity disorders

In determining the impact of gender identity disorders on the canonical status of a person, the fundamental truths regarding human sexuality which have been invariably advocated by the Magisterium of the Church cannot be neglected. The dissonance between the tendencies described at the beginning of this study reflecting the consequence of disseminating the gender ideology, on the one hand, and the ethics based on Christian values, on the other, stems from totally different concepts of the human person [Brzeziński 2014, 91-92]. Although a tendency to present various aspects of human sexuality as contradictory to one another is being observed increasingly often, also in scientific circles, the Church has upheld its standing that “man is neither an exclusively corporeal nor an exclusively spiritual being, but a substantial unity of the body and soul, i.e. a psychosomatic unity” [Wróbel 2016, 116].

For the advocates of the gender ideology, the human body is merely a modellable biological material, controlled by the subjective sensations that develop in the psyche. This concept, given the supernatural value of the human body and the dignity of the human person, jointly and equally consisting of the body and soul, constitutes an unacceptable violation of the fundamental truths of the Christian faith. As noticed by Bishop Józef Wróbel, “the inner disharmony whereby the soul contradicts the body, or the body contradicts the soul, not only distorts self-perception and self-reference but also hinders the mutual giving between two people as an interpersonal gift, as the latter assumes both unambiguously perceiving

oneself and being unambiguously perceived by the other person” [ibid., 117].

The Church has frequently recalled that the unity of the human person, comprising both the body and soul, also covers sexuality, which must not be divided into autonomous, and often contrasting, aspects which in fact constitute a certain whole rooted in the psychosomatic unity. The Church envisages a possibility for distinguishing the mental, genetic, genital, social or hormonal sexuality aspects only when this is done for the purpose of their description rather than for presenting them as contradictory in order to enable random tampering with human sexuality. A human person is, therefore, seen as both a spiritual and corporeal being with birth-assigned sexuality reflected in the division of the human population into men and women. This diversity, but also complementarity, of human sexes and genders enables people to establish relationships based on complementarity and the mutual offering of themselves to others in the acts of love, as well as on an openness to the gift of new life, i.e. procreation. A person, whether a man or a woman, not displaying such mental and somatic integration cannot be seen as capable of entering into deep interpersonal communion. In the *Persona humana* declaration of 1975, members of the Congregation for the Doctrine of the Faith stressed that “[a]ccording to contemporary scientific research, the human person is so profoundly affected by sexuality that it must be considered as one of the factors which give to each individual’s life the principal traits that distinguish it. In fact it is from sex that the human person receives the characteristics which, on the biological, psychological and spiritual levels, make that person a man or a woman”¹⁵. Pope John Paul II, in the Apostolic Exhortation *Familiaris consortio*, referred to the meaning of human sexuality in the context of the overall perception of the human being, “sexuality, by means of which man and woman give themselves to one another through the acts which are proper

¹⁵ Sacra Congregatio pro Doctrina Fidei, Declaratio de quibusdam quaestionibus ad sexualem ethicam spectantibus *Persona humana* (29.12.1975), AAS 68 (1976), p. 77-96.

and exclusive to spouses, is by no means something purely biological, but concerns the innermost being of the human person as such”¹⁶.

Serious gender identity disorders make the afflicted people lose the unity of the matter and spirit, and hence the entire integrity of human sexuality. Their personality is dominated by the desire to arbitrarily, and consistently with their subjective perception, tamper with their birth-assigned sex which transsexual people consider “foreign”. In the long-term consequences of the disintegrated and limited perception of one’s own sexuality, its interpersonal meaning is negated, the procreative ability is lost, and some irreversible mutilating pharmacological, hormonal or even surgical interventions are made. In the Church’s view, which is coherent with the Christian anthropology, such a grave and destructive interference with human sexuality can at no rate be assessed in a positive way.

Of note is the fact that sex reassignment, which is so strongly desired by transsexual people, is superficial and does not change the essence of their sexuality [Stawniak 2000, 253]. The complex medical and legal procedures aimed at “adjusting” the somatic sex to the subjective gender identity are of a limited use for the person afflicted with the disorder, as even the most sophisticated treatments cannot change the chromosomal sex. This implies that such a “therapy” is capable of only partly mitigating the conflict between the genetics and psyche of a transsexual person [Wenz 2001, 168]. Given the limited efficiency of psychotherapy, an importunate desire to reassign one’s sex, first through surgical and then also through legal procedures, is likely to develop which, from the ethical point of view, cannot receive the Church’s approval. The human sex and gender cannot be reduced either to their subjective perception or to social and legal acceptance¹⁷. In consequence, no change to the canonical status of the person undergoing sex reassignment is possible [Navarrete 1997, 101-24].

¹⁶ Ioannes Paulus PP. II, Adhortatio apostolica de Familiae Christianae muneribus in mundo huius temporis *Familiaris consortio* (22.11.1981), AAS 74 (1982), p. 81-191, no. 11.

¹⁷ A distinct opinion, critical of the Catholic Church’s teaching, was presented by P. Podgórski. He claimed that the integral vision of a human person and sexuality based on Christian anthropology was not supported by facts. “Obviously, I would not like my words to be misunderstood again. It is known that also medicine cannot deny that such a procedure is incapable of changing the human chromosome system. Nonetheless, it stresses the huge importance of the mental sense of the individual’s belonging to

The problem of the ethical acceptability of such medical procedures was directly addressed by the Pontifical Council for Pastoral Assistance to Health Care Workers, in its document dated 1995, stating that “[t]he physical integrity of a person cannot be impaired to cure an illness of psychic or spiritual origin. Here it is not a question of diseased or malfunctioning organs. And so their medico-surgical manipulation is an arbitrary alteration of the physical integrity of the person. It is not lawful to sacrifice to the whole, by mutilating it, modifying it or removing it, a part which is not pathologically related to the whole. And this is why the principle of totality cannot be correctly taken as a criterion for legitimatizing anti-procreative sterilization therapeutic abortion and transsexual medicine and surgery”¹⁸.

Taking all of these factors into account, it should be stressed that, if the Christian vision of man was adopted as the starting point, transsexualism would be seen as constituting, in the first place, a serious personality disorder at the level of sexual self-identification. A renowned expert in the field, K. Imieliński, emphasised that transsexualism “is not a disorder primarily located in the sexual plain. Sexual problems are rather of a secondary nature, and their essence is much deeper, referring to sexual identity and roles. In transsexual people, sexual problems tend to play a minor role, as the entire attention and desires are focused on re-adjusting their body to self-perceived gender” [Imieliński 1982, 255].

In consequence, considering the impact of severe personality disorders on the consensual capacity, along with frequent attempts made by transsexual people to enter into marriage with people representing the opposite sex to their own “reassigned” sexual identity, the legal and canonical implications of gender identity disorders are expected to pose an

a specific gender, which may prove that the person – as presented in our example – is indeed a woman”, wrote the author referring to sex reassignment [Podgórski 2009, 104]. In emphasising the contrast between the scientific and canonical approach to transsexualism and the potential sex reassignment, Podgórski seemed clearly inclined – as could be better seen in the context of his overall study – to accept the transsexual people’s desires to change their sexual affiliation, along with certain canonical consequences of this pseudo-adjustment. It is quite apparent that his vision cannot, at any rate, be reconciled with the Catholic Church’s teaching.

¹⁸ The Pontifical Council for Pastoral Assistance to Health Care Workers, *The Charter for Health Care Workers*, Rome 1995, no. 66, note 148 [Wróbel 2016, 119-20].

increasing challenge for the Church. In the following sections of the study, two basic issues will be considered, i.e. allowing transsexual people to contract marriage, and the possible causes of invalidity of marriage so contracted.

2.2. Allowing transsexual people to contract marriage

2.2.1. Before the surgical procedure

Canonists' views on transsexual people willing to contract marriage in the canonical form before surgical sex reassignment are not uniform. Some authors advocate that, in such cases, the right to contract marriage grounded in natural law should be viewed as prevailing over the mental disorder. According to J. Huber, if a transsexual person has not undergone irreversible sex readjustment procedures, the parson admitting that person to contracting marriage has no right to demand that he or she undergo clinical examinations. During the pre-marriage course, he should only ask the prospective spouse about his or her gender. If transsexual tendencies are denied, the phenotypic sex should be the point of reference, and marriage should be allowed, unless there are other serious factors that might call its validity into question. In Huber's view, before the surgical procedure takes place, it is extremely difficult to determine whether a given person is capable of entering into marriage or not [Huber 1998, 38].

This view was shared by A. Dzięga who argued that in the case of people displaying transsexual tendencies, but retaining their birth-assigned sex, the possibility for their entering into a permanent marital relationship is hard to rule out entirely [Dzięga 1999, 145]. A priest can only draw the prospective spouses' attention to the risk of the dissolution of such marriage, especially when one (or both) of them manifest clear symptoms of gender identity disorders. The author also stressed the necessity to distinguish between the already described primary transsexualism and the so-called secondary transsexualism, with the latter being acquired after birth under the influence of diverse external factors. Considering that targeted psychotherapy can often correct the acquired disorder, allowing such a person to contract marriage should not be viewed as impossible. In the case of primary transsexualism, the situation is much more serious. However, even if diagnosed by endocrinology, neurology, psychology and

other specialists, it merely increases the likelihood that the planned marital relationship will eventually be dissolved, but does not entail any certainty in this respect [ibid., 146]. The author concluded his deliberations with a statement that the right to contract marriage by those transsexuals who have not undergone surgical sex reassignment should be interpreted in their favour.

A different standpoint was taken by A. Kokoszka, who claimed that a transsexual, even before the surgery, is incapable of expressing marital consent due to suffering from serious gender identity disorders, despite seemingly representing his or her birth-assigned sex. This makes the transsexual unable to express marital consent when it comes to sharing *ius in corpus* with his or her spouse, which forms an intrinsic element of the marriage contract. The willingness of such people to engage in a true sexual intercourse oriented at procreation poses yet another problem [Kokoszka 1997, 97-99]. As noted by the author, since a transsexual person who has not undergone the surgical procedure feels affiliated with the opposite sex, by allowing him or her to contract marriage, we would in fact sanction same-sex marriage¹⁹. Undoubtedly, the mental status of the person planning to contract marriage is non-negligible when it comes to his or her consensual capacity. The marital relationship established by a transsexual, even before the surgery, can be expected to eventually dissolve, with that person feeling as if he or she was in a homosexual relationship. Therefore, the opinion that hastily allowing transsexual people to contract marriage constitutes an extremely risky practice cannot be neglected. In the circumstances under discussion, it appears crucial for pastoral workers to thoroughly investigate the degree and nature of the gender identity disorder affecting the prospective spouse [Brzeziński 2014, 95]. In some cases, transsexualism can pose a direct threat to the health and life of the afflicted person, while in others it does not affect the person's biological structure

¹⁹ Commenting on A. Kokoszka's arguments, A. Dzięga was quite right to notice that the author failed to indicate the decisive factor (whether biological or mental) in determining the transsexual person's gender. At some other point, A. Kokoszka noted that marriage contracted by a transsexual who has undergone surgical sex reassignment also constitutes a same-sex relationship. One can hardly disagree with A. Dzięga that this apparent inconsistency proves how important both the mental and biological aspects of human sexuality are for the functioning of a human being [Dzięga 1999, 144-45].

and enables him or her to properly function in the social domain [Daniluk 2008, 98-99].

Exceptionally drastic situations can obviously result in the inability of the transsexual person, even before the surgery, to express a valid marital consent, mainly under can. 1095, 2° and 3° of the 1983 Code of Canon Law²⁰. Therefore, after extensive investigations, “a person who, upon entering into marriage, would display an importunate desire to fully readjust his or her body, should not be allowed to contract marriage, and once contracted, the marriage should be considered invalid due to excluding the ability to procreate connected with the person’s birth-assigned sex” [Brzeziński 2014, 95]. Nonetheless, it should be generally assumed that the mere occurrence of gender identity disorders is not a sufficient cause for denying the prospective spouse the right to enter into marriage [Dzierżon 2007, 163]. Considering the material difficulty in determining the degree of transsexualism before the surgery, there are no grounds, except for some evident cases, to ultimately prevent them from contracting marriage in the canonical form.

An informed opinion can be given to a morally sufficient extent by way of conducting pre-marriage medical and psychiatric investigations. The above standpoint finds support in the note of the Congregation for the Doctrine of the Faith dated 28 September 2002, reading as follows: “when no such investigation is conducted, with obvious external manifestations supported by testimony of reasonable people pointing to serious transsexual pathologies, the Ordinary, once becoming aware of these, should prohibit the sacrament of marriage until sufficient evidence is offered that the anomaly has ceased to exist”²¹.

²⁰ *Codex Iuris Canonici auctoritate Ioannis Pauli PP. II promulgatus* (25.01.1983), AAS 75 (1983), pars II, p. 1-317 [henceforth cited as: CIC/83].

²¹ Congregation for the Doctrine of the Faith, *A note on the canonical implications of transsexualism on marriage and priesthood* (28.09.2002), in: Archives of the Polish Bishops’ Conference [Wróbel 2016, 129]. A note attached to the letter by Cardinal Joseph Ratzinger, the prefect of the Vatican’s Congregation for the Doctrine of the Faith, to Cardinal Józef Glemp, the Primate of Poland and President of the Polish Bishops’ Conference. See also: Congregazione per la Dottrina della Fede, “*Notificazione*” circa alcuni risvolti canonici riguardanti i casi di transessualismo, “Notiziario CEP” 1 (2003), p. 35-36.

2.2.2. After the surgical procedure

In contrast to the circumstances discussed above, the possibility for allowing marriage to be contracted by transsexual people who have already undergone irreversible surgical sex reassignment opens much less space for ambiguity. Taking into consideration the Catholic teaching on human sexual identity, as outlined earlier in this study, canonists seem to agree that even the most advanced surgical procedures, coupled with cutting-edge hormonal therapies, cannot change the genetic or chromosomal sex of the transsexual patient [Wenz 2001, 173-74]. Surgical removal of the natural sex organs and the subsequent creation of artificial organs, even when they are delusively similar to the organs of the opposite sex, does not constitute a valid basis for granting the transsexual person the legal and canonical status of a representative of the opposite sex to his or her biological sex. As emphasised by J. Huber, by allowing a person who has undergone surgical sex reassignment to contract marriage, we would in fact be dealing with a same-sex relationship [Huber 1998, 37]. U. Navarrete also claimed that no surgical procedure could change the ontological sex [Navarrete 1997, 115]. A similar view was expressed by H. Stawniak, pointing out that during the surgical and hormonal “therapies” administered to transsexual people, only the phenotypic gender-specific features are modified, which has no impact on the genetic structure of human sexuality [Stawniak 2000, 264].

Along with the fundamental barrier, i.e. the same-sex relationship problem arising in the case of transsexual people intending to contract marriage, canonists put forward other arguments against allowing such marriage to be contracted by prospective spouses who have had their sex reassigned. The doctrine also lists other factors, including organic impotence and consensual incapacity resulting from mental factors, and the potential deception of the partner in the case when he or she is unaware of contracting marriage with a person after surgical sex reassignment. All of these potential causes behind the invalidity of transsexual person’s marriage will be discussed in the following paragraphs.

Given the fact that the extensive part of the doctrine considers it inadmissible to allow marriage to be contracted by a transsexual person who has undergone surgical sex reassignment, the conclusions offered by

P. Podgórski in his work which has already been cited appear rather ill-considered. In Podgórski's opinion, the situation of transsexual people who have had their sex reassigned, from the point of view of canon law, is not so obvious [Podgórski 2009, 106-107]. To provide the reason for this lack of clarity, Podgórski referred to the scientific and theological symposium held in Vatican in 1984 devoted to sex reassignment problems, which did not end in any binding declarations due to the insufficient clarification of the problem's etiology at that point. However, it could hardly be expected from a scientific symposium that gathered with a view to outlining the current status of knowledge on transsexualism only thirty or so years after the first surgical sex reassignment to end in any binding church law declarations. According to canonists, the response provided by the Congregation for the Doctrine of the Faith on 28 May 1991 to the following question asked by the German Bishops' Conference: "Is it possible to allow a person who has undergone clinical and surgical treatment involving genital-altering procedures, resulting in that person displaying features of the opposite sex, to contract canonical marriage?" was a true milestone. The Congregation for the Doctrine of the Faith responded that: "[u]pon thoroughly verifying the documents attached to that question, it seems to be the case which pertains the actual status of transsexualism in the proper interpretation of that word. This concerns a person who, from the biological point of view, represents one gender while being mentally affiliated with the other and, by undergoing the adequate medical procedure, displays only the phenotypic features of the latter. Therefore, this person cannot be allowed to contract sacramental marriage as he or she would indeed marry a person biologically affiliated with the same sex"²². The above response clearly shows that the Holy See, back in 1991, opted against allowing transsexual people after surgical procedures to contract marriage.

The above view was upheld in another document released by the Holy See, in which these arguments were reiterated. As regards the possibility of allowing marriage to be contracted by people who have undergone surgical sex reassignment, the Congregation for the Doctrine of the Faith, in the

²² Congregation for the Doctrine of the Faith, Letter of 28 May 1991, *De processibus matrimonialibus* 2 (1995), p. 315 [Huber 1998, 37].

aforementioned note dated 28 September 2002, wrote as follows: “The prohibition to contract marriage becomes absolute in the case of a transsexual person who has undergone the so-called surgical sex reassignment, which can invoke some sense of emotional alleviation; however, it can neither delve deeper into mental pathology nor really change the human sex, but merely its external appearance. In the case of the already contracted sacramental marriage, whereby one of the spouses displays the mental anomaly in question, the marriage invalidation process should be launched in observance of cann. 1674-1675 of the Code of Canon Law”²³.

As regards the issue of allowing transsexual people who have undergone surgical sex reassignment to contract marriage, Wiesław Wenz pointed out that these people – considering their determination to totally change their gender affiliation – are likely to undertake increasingly successful attempts to amend their certificate of baptism. This mainly concerns the first name, last name and gender which, under the secular legal order, can be amended upon the transsexual person obtaining a decision of a competent civil court [Wenz 2001, 174]. The unquestionable progress in the field of medical technologies pertinent to surgical and other sex reassignment procedures makes the situation even more challenging. In some pastoral cases misunderstandings may occur, possibly leading to an erroneous determination of the prospective spouse’s gender affiliation. Considering the above, as noted by Wenz, much attention should be paid to ensuring a uniform practice that would make it impossible to amend certificates of baptism in baptismal registers. The author further claimed that, upon becoming aware that the person appearing at the parish office has undergone sex reassignment, the request to introduce any changes should be denied even if urgent demands are made, supported by a judicial decision on changing gender affiliation issued by a secular court. In that event, the fact of sex reassignment, and the resulting inconsistency of the civil documentation with canonical records, should be indicated on the margin of the certificate of baptism [ibid].

On 2 October 2004, referring to the issue of introducing changes to the baptismal register, as noted by W. Wenz, the Apostolic Nunciature in

²³ Congregation for the Doctrine of the Faith, *A note on the canonical implications*, p. 3.

Poland sent to Cardinal Józef Glemp, who then performed the function of President of the Polish Bishops' Conference, a set of indications²⁴, according to which no such changes could be introduced even if the transsexual person had previously obtained the adequate amendment to the civil anagraphic records. In accordance with the canonical procedure, sex reassignment information should be included "on the margin" of the certificate of baptism, especially "when the surgical procedure has involved a change of legal consequences". Such information should contain the date and number of the competent civil court's decision or the document issued by the Registry Office. It is also recommended for "the parson to store the said documentation under the relevant page of the Baptismal Register". The above indications are undoubtedly based on the Note of the Congregation for the Doctrine of the Faith which put forward the following arguments: "the changed status of the believer related to the civil consequences of his or her anagraphic identity, cannot result in changing his or her canonical identity – male or female – entered upon birth in the Baptismal Register, in which the gender of the baptised person is determined; it is [hence] impossible to introduce any changes due to surgical gender readjustment"²⁵.

In the light of these documents, which clearly present the Holy See's standpoint on allowing transsexuals to contract marriage once they have undergone surgical sex reassignment, the legal status of such people – contrary to Podgórski's view – appears unambiguous.

2.3. Declaring the invalidity of marriage contracted by transsexual people

Given the relatively minor scale of the phenomenon under consideration as compared to other mental disorders potentially giving rise to consensual incapacity, the problem of declaring the invalidity of marriage contracted by transsexual people appears rather marginal in the ecclesiastical court jurisdiction. In addition, as shown in the first part of this study, transsexual people, and in particular those with the primary form of the disorder, rarely

²⁴ The Apostolic Nunciature in Poland, Communication of 4 October 2004, No. 11.170/04 [Jancewicz 2014, 154].

²⁵ Congregation for the Doctrine of the Faith, *A note on the canonical implications*, p. 3.

decide to contract marriage with a person of the opposite sex to their birth-assigned sex. Nevertheless, given the theoretical possibility for such a situation to occur, creating the future risk of marriage dissolution, several causes of the invalidity of marriage are analysed in the canonical doctrine in respect of gender identity disorders, i.e. 1) the lack of sexual differentiation, 2) organic impotence, 3) mental imbalance, and 4) fraudulent misrepresentation.

2.3.1. The lack of sexual differentiation

The issue regarding the lack of sexual differentiation has already been discussed in the previous paragraph, as part of analysing the possibility for allowing people who have undergone surgical sex reassignment to contract marriage. This matter seems unambiguous, especially in the context of the Code of Canon Law (CIC/83) which defines marriage as a relationship between a man and a woman (can. 1055 § 1; can. 1057 § 2). With regard to declaring the invalidity of marriage, it seems advisable to once again stress that despite the material advancement in the field of medical technologies, the genetic or chromosomal structure, in which our affiliation with the male or female gender is coded from the moment of conception, cannot be changed. In consequence, as claimed by G. Erlebach, “in the case of sex reassignment through a surgical procedure, preceded by hormonal therapy [...], we are seemingly moving towards the radical form of invalidity which can be referred to as *inexistentia matrimonii* due to marriage being contracted by two people representing the same biological sex” [Erlebach 1998, 130]. A similar opinion was formulated by R. Sobański. Concluding his utterance, he suggested that in adjudicating on the invalidity of marriage in which one of the spouses, when granting his or her marital consent, pretended to represent the gender opposite to his or her biological sex, the ecclesiastical court should conduct an abridged process ending in the decision that the marriage has not been concluded (as per *inexistentiae actus iuridici*), and not that it has been invalid [Sobański 2001, 654].

As regards the issue of sex differences, a theoretical situation can be assumed whereby both prospective spouses have undergone surgical sex reassignment before contracting marriage. From the biological point of view, this relationship would be between people of the opposite sexes. Could it then be considered valid? This problem was addressed by G.

Dzierżon and H. Stawniak who consistently claimed that such a relationship would still be invalid, *inter alia*, due to the possible impotence of either of the spouses [Stawniak 2000, 258-62; Dzierżon 2007, 155-56].

2.3.2. Organic impotence

A more complex problem is posed by the potential inability of a transsexual person to engage in sexual intercourse, under canon law referred to as marriage consummation. It principally involves the insertion “of the male sex organ into the female sex organ, combined with ejaculation” [Góralski 2006, 29]. With the aim of determining the extent to which transsexual people, having undergone surgical procedures, are affected by impotence, the cases of MtF and FtM transsexuals should be analysed separately.

The doctrine leaves no space for ambiguity as to FtM transsexuals. It stipulates that the people who have had their vagina removed and replaced by an artificial penis are incapable of engaging in sexual intercourse which implies, under can. 1061 §1 of CIC/83 (*copula perfecta*), that the spouses have in a human manner (*humano modo*) engaged together in a conjugal act in itself apt for the generation of offspring [Stawniak 2000, 260; Idem 2001, 133]. In the previously cited article, J. Huber claimed that an artificially made penis of a FtM transsexual does not enable engaging in a full marital sexual intercourse. Referring to the arguments regarding the real opportunity for such a person to experience sexual arousal after the surgery, he noted that a similar state “could be achieved through masturbation”²⁶ [Huber 1998, 39].

When it comes to MtF transsexuals, i.e. situations which involve removing the male sex organ and creating from its remnants an artificial

²⁶ It is worth stressing that this matter does not seem so obvious for all canonists. R. Sobański cited an interesting response provided by the Congregation for the Doctrine of the Faith of 6 October 1999, in which that body – when considering the case of a FtM transsexual – found that, in the light of canon law, that person remained a woman. Nonetheless, among the conditions for invalidating the marriage contracted by that person, the Congregation did not refer to can. 1084 of CIC/83. According to Sobański, this might imply that “according to the expert witnesses, that person is capable of engaging in sexual intercourse with a woman” [Sobański 2001, 663].

vagina, most canonists perceive such cases as resulting in impotence, as per can. 1084 § 1, and thus in incapacity to contract marriage. J. Huber called the artificially created vagina “an aperture” which gives the person no pleasure and generates difficulties with finding a partner [ibid.]. A different opinion was presented by G. Erlebach who noted that, in some cases of MtF transsexuals, the physical impotence does not have to occur and, therefore, it should not always constitute the reason for declaring the invalidity of marriage [Erlebach 1998, 130].

It is worth noting at this point that arguments against classifying both FtM and MtF transsexuals as people affected with organic impotence have been presented by some canonists, including C.J. Ritty [Ritty 1981, 454-55] and, to some extent, also by A. Dzięga. According to the latter, despite the unquestionable infertility of the transsexual people who have undergone surgical sex reassignment, the possibility of their engaging in sexual intercourses cannot be ruled out *a priori*. While perhaps imperfectly imitating nature, they may be capable of establishing and strengthening – based on the mutual prospective spouses’ consent to accept certain limitations arising in this respect – a partnership of their whole life as husband and wife [Dzięga 1992, 53]. Making an overarching reference to the issue of impotence affecting transsexual people after surgical sex reassignment, the question asked by H. Stawniak [Stawniak 2000, 261] is worth repeating, i.e. could the conjugal act performed by a transsexual be referred to as *copula perfecta* if the medical achievements enabled eliminating all of the currently encountered difficulties? It seems that the response should not be based only on reference to the genital sphere. In his article, M.F. Pompedda was right to observe that a conjugal act performed by means of surgically created sex organs would be a pseudo-act, having lost its natural character replaced by “artificiality” [Pompedda 1992, 124]. This “artificiality”, as opposed to “naturalness”, implies an essentially unnatural reality created by scientific and technical means, and transposed into marital life. It is this “artificiality” that makes it impossible to call the sexual act performed by a transsexual person a true marital intercourse. As concluded by the author, even if science was developed so as to reach the currently unattainable level making it possible for transsexual people to procreate, the lack of “naturalness” of the sexual intercourse between the spouses would render their marriage invalid. One might be, therefore, right

to conclude that this is the case of *humano modo*, as provided for in CIC/83, which yields to artificiality and interference with the true human nature by people undergoing surgical sex reassignment. A similar standpoint was taken by G. Erlebach, who stressed that human sexuality is not determined merely by the genital sphere but also by the specific nature of being a man or a woman. That nature is not limited to phenotypic aspects but it is characterised with the very “existence” as a man or a woman [Erlebach 1998, 110-11]. While taking a thorough approach to the intimate marital relation between a man and a woman, it should be emphasised that even the potential artificially obtained physical ability to engage in a sexual intercourse cannot eliminate all the objections as to its true nature. Treating the sexual act performed by a transsexual person after the surgery as a real conjugal act would imply limiting the sense of the marital intercourse to the purely genital sphere. An inference can thus be drawn that surgically created artificial sex organs do not determine a person’s affiliation with any gender or that person’s ability to perform the conjugal act within the meaning of can. 1061 § 1 of CIC/83.

2.3.3. Mental imbalance

Contrary to the two reasons for invalidating marriage contracted by transsexual people discussed above, the so-called mental imbalance quoted by most canonists concerns the situation both before and after the surgical procedure of sex readjustment. While sexual inconsistency and impotence can be verified only after the transsexual person decides to take irreversible steps to “adjust” his or her phenotypic sex to the one he or she feels affiliated with, mental imbalance, along with the consensual incapacity that is likely to result from it, often occurs independently of any medical procedures which, for various reasons, may not be conducted at all. The fundamental difference between the pre- and post-surgical mental condition of the transsexual person is that in the former case transsexualism, by definition, reflects a serious internal conflict and generates a mental disorder, the degree of which is assessed in the context of attempts made to surgically reassign the afflicted person’s sex. In the latter case, we are faced with certain *status quo* that is perceived by the affected person as an accomplished goal, which makes it possible to determine, to a moral

certainty, whether the prospective spouse, upon contracting marriage, satisfies the prerequisite of consensual capacity.

In the paragraph devoted to allowing marriage to be contracted by transsexual people before the surgery, opinions expressed by some authors were presented, implying that in such cases the right to marry should be seen as prevailing over the mental disorder as long as its symptoms do not unambiguously speak against the validity of the prospective marriage. When considering a case of the invalidity of marriage contracted by a transsexual person who has not undergone surgical sex reassignment, it is of key importance for the church court to assess the degree and nature of transsexualism of the prospective spouse upon entering into marriage [Huber 1998, 43]. This should make it possible to determine the validity of his or her marital consent, as it cannot be ruled out that in some transsexuals who have not undergone surgical procedures the gender identity disorder is, nonetheless, so severe that it has a destructive impact on all aspects of their lives, while other people experiencing a gender identity disorder can function properly without experiencing such a strong mental distress. In the former case, when adjudicating on the invalidity of marriage, the application of can. 1095, 2° of CIC/83 should be considered due to the serious dissonance between will and reason, or even the absence of internal freedom, which in some individuals may cause a grave lack of discretionary judgement [ibid.]. The problem of consensual incapacity, involving the inability to assume the essential marital duties for reasons of a mental nature (can. 1095, 3° of CIC/83), appears even more striking. This ability, necessary for granting marital consent, “is a general ability to offer oneself, and receive, as a man or a woman, in the matrimonial sense, in order to become husband and wife” [Góralski and Dzierżon 2001, 204]. In consequence, the consensual capacity of a person implies that he or she is capable of using his or her sexuality, thoroughly perceived as masculinity or femininity.

Living in a marital relationship which, according to the teaching of the Church, is “a partnership of their [the spouses’] whole life” (cf. can 1055 § 1), requires controlling one’s own sexuality²⁷. In the context of marital and

²⁷ The Pontifical Council for the Family stressed that “[c]hastity includes an apprenticeship in self-mastery which is a training in human freedom. The alternative is clear: either

family life, this sexual self-control is reflected in the ability to perform the assigned marital and family roles in a responsible and conscious way. This should start with efforts made to establish a community of life and love, which involves devotion to the other person in the spirit of mutual trust, and readiness to have children and to provide them with the adequate care and upbringing. In view of the above requirements, a transsexual person cannot be considered capable of controlling his or her own sexuality, even before surgical sex readjustment, as he or she experiences huge mental problems related to gender identity, together with related instability. This gives rise to a serious question of the ability to establish a harmonious and permanent partnership of conjugal life. Moreover, upon contracting marriage, the prospective spouses grant marital consent to each other, comprising their male or female sexuality perceived as a whole, and covering all the dimensions of human existence “in terms of being exclusive, procreative and lifelong” [Góralski and Dzierżon 2001, 43]. In consequence, a person who, upon entering into marriage, would display an importunate desire to fully readjust his or her body, will most likely not be able to assume the essential obligations of marriage in the procreative sense [Brzeziński 2014, 95-96].

Therefore, while declaring consensual incapacity and, consequently, the invalidity of marriage in the case of people who have undergone surgical sex reassignment appears relatively easy due to the occurrence of an undoubted and irreversible effect of a profound mental disorder, the matter of consensual capacity of those transsexuals who have contracted marriage without previously undergoing surgical procedures should be carefully considered in terms of the nature of the prospective spouse’s disorder at the moment of granting marital consent. The marriage contracted by such a person can only be declared invalid if consensual incapacity (as per can. 1095, 2^o or 3^o) is determined to a moral certainty.

man governs his passions and finds peace, or he lets himself be dominated by them and becomes unhappy. [...] To achieve this requires ability and an attitude of self-mastery which are signs of inner freedom, of responsibility towards oneself and others. [...] Such self-mastery involves both avoiding occasions which might provoke or encourage sin as well as knowing how to overcome one’s own natural instinctive impulses”, see: The Pontifical Council for the Family, *Guidelines for Education within the Family “The truth and meaning of human sexuality”*, Rome 1995 [Wróbel 2016, 128].

2.3.4. Fraudulent misrepresentation

The legislator in can. 1098 of CIC/83 has stipulated as follows: “A person contracts invalidly who enters marriage inveigled by deceit, perpetrated in order to secure consent, concerning some quality of the other party, which of its very nature can seriously disrupt the partnership of conjugal life”. There is no doubt that the gender identity disorder affecting one of the future spouses is a factor that can “seriously disrupt the partnership of conjugal life”. Invalidity can occur only if one of the spouses did not know about his or her partner being transsexual, and was misguided either by a fraudulent act of the prospective spouse or third parties, which has consequently led to contracting marriage. However, if the prospective spouse’s transsexuality was not concealed from the other spouse or he/she knew the truth from other source, the argument regarding misrepresentation cannot be invoked [Huber 1998, 41].

3. Conclusions

Nowadays, the capacity for contracting valid marriage by transsexual people evokes strong emotions, and it is hard to resist the impression that this matter is not always considered on its merits. The liberal trends which have recently grown in popularity try to convince society that the capacity to contract marriage or take other material life decisions is confined to privacy and no third parties can impose any pre-defined solutions. As a result, attempts are made to promote wider acceptance for certain types of behaviour which, objectively speaking, contradict the traditional moral, social, legal and cultural norms. In view of the aggressive offensive of the gender ideology, the Catholic Church, with all its openness to the latest achievements of natural and human sciences, needs to safeguard the moral order, and its reflection refers to the moral principles “founded on human reason illumined by faith and is consciously motivated by the desire to do the will of God [...]. The Church is thus in a position to learn from scientific discovery but also to transcend the horizons of science and to be confident that her more global vision does greater justice to the rich reality

of the human person in his spiritual and physical dimensions, created by God and heir, by grace, to eternal life²⁸.

By retaining the autonomy towards solutions typical of secular communities, the Catholic Church, in its teaching, has been stressing its duty to determine the capacity to contract marriage and start a family based on natural law, from which both these notions originate. The Church's negative assessment of the capacity to contract marriage by transsexual people does not stem from neglecting the objectively existing phenomenon, or from the intent to "punish" such people for their condition. The Church neither neglects transsexualism nor turns a blind eye on the suffering of people who experience a profound internal conflict and inconsistency between their birth-assigned sex and gender affiliation. Given the truth about man as a corporeal and spiritual being which has been spread for ages, it would be a false accusation to say that the Church is indifferent to mental problems which can cause much suffering and harm to the human spirit. Compassion and pastoral care, coupled with a careful moral assessment of people afflicted with various forms of mental disorders, which sometimes infringe upon moral norms, constitute the characteristics of the evangelical message invariably disseminated by the Church for two thousand years. However, even openness and mercy cannot lead to a concession to evil, nor do they allow random modifications to these legal notions that are grounded in the law of God, either natural or revealed. The good of the Church needs to be protected, not only as regards its individual members but also all believers who could suffer deep harm if people experiencing internal conflicts, and affected by personal identity disorders, were allowed to enter into marriage.

This is the key to interpreting the canonist efforts to take into consideration varied arguments against allowing transsexual people to contract marriage. Contrary to what the gender ideology seems to advocate, the problems faced by transsexual people cannot be solved through current therapies, even the most advanced ones, which often lead to an intensified internal conflict and mental imbalance, as noted in earlier in the study. In

²⁸ Congregatio pro Doctrina Fidei, Epistula ad universos catholicae Ecclesiae episcopos de pastorali personarum homosexualium cura *Homosexualitatis problema* (1.10.1986), AAS 79 (1987), p. 543-54, no. 2.

this context, the legal capacity of transsexual people to contract marriage cannot be assessed in a different way than presented above.

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Incapacity to Contract Marriage due to Gender Identity Disorders

Summary

The purpose of this study is to determine the impact of gender identity disorders on the person's capacity to contract marriage in the light of canon law. The starting point to the discussion is provided by the scientific concepts of human sexuality and gender identity disorders, viewed through the prism of the latest achievements of biological and psychological sciences, and confronted with Christian anthropology. The problem of the validity of marriage contracted by a person afflicted with gender identity disorders is also analysed in the study.

Key words: transsexualism, marriage, consensual incapacity, impotence, sex reassignment

Niezdolność do zawarcia małżeństwa spowodowana zaburzeniami identyfikacji płciowej

Streszczenie

Celem artykułu jest określenie wpływu zaburzeń identyfikacji płciowej na kanoniczną zdolność osoby do zawarcia małżeństwa. Punkt wyjścia stanowi naukowa koncepcja ludzkiej płciowości oraz zaburzenia identyfikacji płciowej widziane w świetle najnowszych osiągnięć nauk biologicznych i psychologicznych, a także skonfrontowane z antropologią chrześcijańską. W dalszej kolejności przedmiotem refleksji naukowej jest kwestia ważności małżeństwa osoby dotkniętej zaburzeniami identyfikacji płciowej.

Słowa kluczowe: transseksualizm, małżeństwo, niezdolność konsensualna, impotencja, zmiana płci

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