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I wish to thank a transgender lawyer who has been an inspiration and encouragement to me since I first came out—Phyllis Randolph Frye. Phyllis has been an encouragement to so many in the transgender community and has been a pioneering agitator and fighter for rights of transgender persons.

I also wish to thank my wife, Donna; my son, Jeremiah; and my sister, Dot for their support of me and encouragement to me.

I also wish to thank the many transgender, lesbian, and gay friends I have made since transitioning for their encouragement, acceptance and support and the many straight allies for their support and encouragement.

For any glory that comes of this labor, may it be to God.

Ally Windsor Howell
2015
FOREWORD

As I read the text of *Transgender Persons and the Law*, I felt gratified at how far transgender (TG) legal gains have come—as expressed in this book by Ally Howell—since 1992 when I created the first international TG legal conference in Houston. (Editor’s Note: Any scholar wishing to study the “roots” of TG legal activism can find all five volumes of the proceedings from the five international TG legal conferences at no cost at www.lliberatinglaw.com. Select Phyllis Frye from the Our Lawyers pull-down menu, and then click on Phyllis’s bio.)

Actually, my gratification goes further back, as I recall being fired as an engineer in 1976 and being told in 1978 by the Equal Employment Opportunity Commission after their investigation of my complaint that although my firing was discriminatory, it was not illegal in light of the 1977 federal appeals case *Holloway v. Arthur Anderson*, 566 F.2d 659 (9th Cir. 1977). This was the time in my life that I used my benefits through the G.I. Bill to go to law school. (In 1972, I was honorably discharged, but no less forced out of the U.S. Army as a First Lieutenant, Regular Army, when they learned that I cross-dressed in private.)

*Transgender Persons and the Law* is a very comprehensive text. All lawyers and lay activists dealing with this area of the law either in the courts or in legislative lobbying should read it. Ms. Howell covers the following areas of the law: (1) what is transgendered, (2) identification documents, (3) public facilities, (4) housing issues, (5) military and veterans issues, (6) family law, (7) school issues, (8) health care, (9) personal safety concerns, (10) keeping a job and getting a job, (11) immigration issues, and (12) criminal imprisonment issues. The appendices are extensive and thorough.

Obviously, there is much more work to be done in the area of TG legal gains. Much of that work is currently being done by or through such organizations as the National LGBT Bar Association, the National Center for
Transgendered Equality, Lambda Legal, the National Center for Lesbian Rights, Gay and Lesbian Advocates and Defenders, the Human Rights Campaign and the American Bar Association. I have close friends in all of these organizations, and I salute their efforts and gains.

In closing, thank you, Ms. Howell, for your encompassing snapshot of all of our legal gains a mere two decades after the roots were planted.

Phyllis Randolph Frye, J.D.
First out-of-the-closet transgender judge in the U.S. and
“Grandmother of the National TG Legal and Political Movement”
prfrye@aol.com
To paraphrase American playwright, performer, feminist, and activist Eve Ensler, transgender persons are immigrants into the world (read culture) of women and men. And immigrants are always hated, mistreated, and not appreciated when they first arrive.

Like other societies, the United States uses a binary system of gender in which being either male or female has great consequences. This binary system and its corollary system in which a “normal” society is made up of only couples comprising one man and one woman are the subject of much study and disputation. The most noticeable example of this is the rancorous public debate over same-sex marriages. Some say transgener persons, gays, and lesbians are not “normal.” But to quote my favorite twentieth-century philosopher Erma Bombeck, “‘Normal’ is just a setting on a clothes dryer.”

But there is also another debate about sex and gender, one that is not getting the same television and print media attention as the same-sex marriage debate. It centers on the issue of whether transgender persons are male or female for various legal purposes.
Most jurisdictions take the essentialist position that sex is fixed at birth—[that is,] by anatomy—and cannot be changed; only a small number of courts have recognized the complexity of the question and look to a person’s gender identity as a “primary determinant of legal sex,” and recognize a person who has transitioned into a different sex as having established [him- or] herself in that new condition. Thus, today a person’s legal sex could change by simply crossing from one state into another, and an incoherent collection of statutes and legal rulings determines “one of the most intimate and defining aspects of our lives—gender identity . . . our sense of ourselves as male or female.” Each judge may think he [or she] “knows” what sex is; the result is a system that, quite aside from the horrendous personal losses imposed on transgender people, is contrary to our conceptions of individual autonomy. “Can the law make something as central to our notion of selfhood as our sex depend on . . . where we reside . . . or [our] ability to afford surgery?” Such attitudes are related to an essentially historical view that there exist only two very fixed sexes. Though the long history of hermaphroditism and the laws dealing with it attest otherwise, twentieth-century courts and statutes all tend to reflect this view.

Even when courts have “recognized” a person’s new condition, far too often their obsession with anatomy leads them to require that in every case, extensive [and] invasive surgical interventions must have been undergone. For many, this project of achieving a perfect and acceptable appearance of the “other sex” is an ordeal that not only takes years and is prohibitively expensive but may involve “procedures that for some individuals are not only unnecessary but may cause permanent physical damage.” Relying on one’s gender identity rather than one’s sex would avoid this. The way to that goal, envisioned by more and more people today, is explored here.¹

We are not all born male or female as is commonly thought. If one asks experts at medical centers how often a child is born so noticeably atypical

in terms of genitalia that a specialist in sex differentiation is called in, the number comes out to about 1 in 1,500 to 1 in 2,000 births. But a lot more people than that are born with more subtle forms of sex anatomy variations, some of which won’t show up until later in life. Below we provide a summary of statistics drawn from an article by Brown University researchers.2  

The basis for that article was an extensive review of the medical literature from 1955 to 1998 aimed at producing numeric estimates for the frequency of sex variations. One should note that the frequency of some of these conditions, such as congenital adrenal hyperplasia, differs for different populations.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequency*</th>
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<tbody>
<tr>
<td>Not XX and not XY</td>
<td>1 in 1,666 births</td>
</tr>
<tr>
<td>Klinefelter Syndrome (XXY)1</td>
<td>1 in 1,000 births</td>
</tr>
<tr>
<td>Androgen Insensitivity Syndrome2</td>
<td>1 in 13,000 births</td>
</tr>
<tr>
<td>Partial Androgen Insensitivity Syndrome</td>
<td>1 in 130,000 births</td>
</tr>
<tr>
<td>Classical Congenital Adrenal Hyperplasia3</td>
<td>1 in 13,000 births</td>
</tr>
<tr>
<td>Late Onset Adrenal Hyperplasia</td>
<td>1 in 66 individuals</td>
</tr>
<tr>
<td>Vaginal Agenesis4</td>
<td>1 in 6,000 births</td>
</tr>
<tr>
<td>Ovotestes5</td>
<td>1 in 83,000 births</td>
</tr>
<tr>
<td>Complete Gonadal Dysgenesis6</td>
<td>1 in 150,000 births</td>
</tr>
<tr>
<td>Hypospadias (urethral opening in perineum or along penile shaft)</td>
<td>1 in 2,000 births</td>
</tr>
<tr>
<td>Hypospadias (urethral opening between corona and tip of glans penis)</td>
<td>1 in 770 births</td>
</tr>
<tr>
<td>Total number of people whose bodies are different from standard male or female</td>
<td>1 in 100 births</td>
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The term *gender* is a misunderstood one. It is often used as a synonym for *sex*, even though the two terms are different.

We are meaning-making animals. And among the meanings we create are the meanings of what breasts or vaginas mean, what penises mean, what broken wrists and uplifted pinkies mean, and what body hair or long blond hair mean. In effect, gender is a language, a symbolic language. Put another way, gender is a system of symbols and meanings, and the rules for access to these meanings, for strength and weakness, power and vulnerability, “masculinity” and “femininity.” . . . Gender, is then, more than a bit like standing a few inches from the Empire State Building—it is at once so close, so familiar, and yet so
overwhelming that it is difficult to conceptualize all at once or think about it clearly.³

To understand this identity issue, it is necessary to recognize that transsexualism is not a choice. It is now thought to be genetic in origin.⁴ Research increasingly shows that one’s gender identity has very little to do with one’s sex organs or genitalia.⁵

Gender variance is not new. It has been described throughout history and in many different cultures. Child development specialists used to believe that gender-typical and gender-variant behaviors were the result of the ways in which children were raised. Today, experts believe that the presence or absence of these behaviors is partly the result of the biological or genetic diversity among individuals. In other words, the genetic propensity for these behaviors is hard-wired in the brain before or soon after birth. Of course, the specific content of male and female roles has to be learned by all children, even though some children seem to be biologically predisposed toward manifesting some of the gender-role characteristics of the other sex. Some experts used to believe that gender variance represented abnormal development, but today many have come to believe that children with gender-variant behaviors are normal children with unique qualities—just as children who develop left-handedness are normal.

Although science has yet to pinpoint the causes, we know that gender-variant traits are not typically caused by parenting style or by childhood events, such as divorce, sexual abuse, or other traumatic experiences. Children do not choose to have gender-variant interests any more than other children choose gender-typical interests. Both

types of interests represent what comes naturally to each child. Gender variance is not caused by an emotional disorder. However, because of societal prejudice, children with gender-variant traits may experience ongoing rejection, criticism, and bullying, causing adjustment difficulties.\textsuperscript{6}

*Transgendered* and *transgender* have become umbrella terms. Whether to call persons “transgendered” or “transgender” is a matter of dispute among some in the community of transgender persons. For this work, the term “transgender” was chosen as it seems to have the widest use. Even when gender terms are being employed correctly, other terms elaborating on the concept are still widely misunderstood. For example, the terms include transsexuals; cross-dressers (also called transvestites); intersexed persons (also called hermaphrodites); drag queens (gay men who predominantly cross-dress for theatrical purposes); drag kings (lesbians who predominantly cross-dress for theatrical purposes); and an emerging group known as gender-variant persons, or gender queers or gender benders (persons who are either very androgynous in their appearance or who look like effeminate men or masculine women).\textsuperscript{7} Contrary to popular misconception, “the bottom line is that sexual orientation, being lesbian or gay, has nothing to do with gender identity, and they’re really parallel lines.”\textsuperscript{8}

The Diagnostic and Statistical Manual IV (DSM-IV), of the American Psychiatric Association (APA) contained a classification entitled “Gender Identity Disorder,” previously called “Gender Dysphoria.” This recognition by the APA made gender identity disorder a recognized medical condition and, thus, facilitates its recognition by the courts. Gender identity disorder has several diagnostic criteria:


\textsuperscript{7} See the Glossary of Transgendered Terms in Appendix 1 for definitions of these various terms.

WHO OR WHAT IS A TRANSGENDER PERSON?

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

In effect, the APA characterized transgenderism or gender identity disorder as both a medical and a mental disorder. Many in the transgender community contested this classification and argue that transgenderism should not be classified as a pathology. They note the parallel between this classification as a disorder and the prior listing in the DSM-I (1952), the DSM-II (1968), and the DSM-III (1980) in which homosexuality was listed as a mental disorder. It was removed in the DSM-III-R (1987), the DSM-IV (1994), the DSM-IV TR (2000), and the DSM-V (2012) after scientific developments challenging the previous paradigm of sexual orientation as a disorder were considered. Then, in 2012, the APA announced that the DSM-V which will be released in May of 2013 will delete the diagnosis of gender identity disorder. Instead, the DSM-V will again include a listing for “gender dysphoria” which is described as emotional distress from “a marked incongruence between one’s experienced/expressed gender and assigned gender.” This will allow for affirmative treatment and transition care without the stigma of disorder. In 2012, the APA also released new health guidelines for transgender patients, as well as a position statement.

affirming transgender care and civil rights. Both documents align with a new standard for respecting transgender people in the medical community.\textsuperscript{13}

Some have contended that gender identity disorder is a disability. Most in the transgender community do not want to be labeled as “disabled,” but others wish they could because of the difficulty keeping and/or obtaining employment once one comes out as transgender. The federal courts have rejected classifying gender identity disorder as a qualifying condition under the Americans with Disabilities Act.\textsuperscript{14} However, the Supreme Court for New York County, New York held that an MtF transgender minor in the custody of the state at a foster care facility was entitled to wear skirts at the facility because her gender identity disorder was a “disability” under the N.Y. Human Rights Law.\textsuperscript{15}

The foregoing criteria from the DSM for a diagnosis of gender identity disorder are all subjective in nature and are basically matters that are self-reported by the patient, as opposed to observed behavior in a clinical setting or results from a medical test. As a noted expert in the field of transgender medical care so eloquently put it:

\begin{quote}
[\textit{M}edicine has just gotten so high-tech, and there is so much science to it. . . . We want to know what’s the latest study. Well, there aren’t very many studies. There’s no way to do a test. We can’t draw blood, do an x-ray, do a PET scan, and prove that someone is transgendered. You just have to accept it. You have to accept the patient directing their own care, and that is often hard, and it’s probably the most challenging part, is to kind of get over ourselves and kind of let them be in the driver’s seat. So, don’t look for any test; there is nothing probably on the cover of Time Magazine about any part of the brain that’s going to give a good answer. Basically, we have to trust Popeye, and Popeye
\end{quote}

\textsuperscript{13} Beredjick, C., \textit{supra} note 11.

\textsuperscript{14} See, \textit{e.g.}, Myers v. Cuyahoga County, 182 Fed.Appx. 510, 2006 WL 1479081 (6th Cir. 2006)

\textsuperscript{15} Doe v. Bell, 194 Misc.2d 774, 754 N.Y.S.2d 846 (N.Y. Sup. Ct. N.Y. County 2003), and N.Y. Executive Law § 296, sub. 18(2).
WHO OR WHAT IS A TRANSGENDER PERSON?

says, “I am what I am,” and that’s just about as far as you can go in terms of making an accurate diagnosis, okay?16

Notwithstanding this disclaimer, there are recognized treatment standards of care,17 which bring transgender persons into the worlds of the mental health professionals and medical professionals. These standards provide that a person diagnosed with gender identity disorder should be under the care of a psychologist, psychiatrist, or both for evaluation and psychotherapy. Upon the recommendation of the psychologist or psychiatrist the person should begin hormone therapy under the supervision and care of a physician.18 For male-to-female (MtF) transgender persons, this would also be the time to begin facial and body hair removal by either laser treatments or electrolysis. Then the transgender person would begin cross-living in the opposite gender role full time. If the cross-living is successful for at least a year, transgendered upon the recommendation of the person’s psychologist or psychiatrist, the transgender person can seek gender reassignment surgery (also called sex reassignment surgery, GRS, or SRS). Many male-to-female transgender persons also seek and obtain plastic surgery to reduce the size of the Adam’s apple, feminize the face, and enlarge the breasts. The standards of care are advisory and provided as “clinical guidance” and specifically devised to be flexible, not a fixed step by step procedure and they should not be presented as any type of binding or fixed process. There are also other protocols, for example, the informed consent model, and some doctors use those protocols.

Sometimes, the terms transgender and transsexual can be confusing. However, for the purposes of this book, the word transgender will be used

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18. For male-to-female (MtF) transgendered persons, this involves taking estrogen and sometimes involves taking a testosterone suppressant. For female-to-male transgendered persons, this involves taking testosterone and an estrogen suppressant. Some MtFs have an orchiectomy (removal of the testes) and this obviates the need to take a testosterone suppressant.
exclusively to refer to transsexuals (defined in Appendix 1, “Glossary of Transgender Terms”). This choice is not designed to minimize, denigrate, or marginalize others under the transgender umbrella who are also denied equal civil rights. However, within the criminal justice system, it is only the transsexuals (preoperative, postoperative, and nonoperative) who seem to encounter significant problems related to their gender. Interestingly, in 2011, India and Nepal announced that they had decided to add a third gender to their upcoming censuses—for transgender persons. The announcement by Nepal’s Central Bureau of Statistics was in response to a landmark decision of the Nepalese Supreme Court on December 21, 2007, that directed the government to guarantee the rights of transgender, gay, lesbian and bisexual people.19

**Why Be Concerned about Transgender Persons?**

Despite popular belief that transgender persons are a small and insignificant group who choose to be the way they are, science suggests otherwise. Professor Lynn Conway of the University of Michigan estimates that 1 in 250 to 500 men are male-to-female transsexuals and that 1 in 2,500 people designated as male at birth have gender reassignment surgery.20 From an epidemiological point of view,21 the number of transsexual persons is statistically significant. Thus, transgenderism, for lack of a better term, is

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more common than the following conditions or diseases, which are better known and have large research budgets devoted to their study:

- Multiple sclerosis has an incidence of 91.7 per 100,000 people = *less than 1 per 1,000*\(^{22}\)
- Duchenne and Becker’s muscular dystrophy affects about one in every 3,500 to 5,000 newborn males = *less than 1 per 1,000*\(^{23}\)
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig’s disease) has an incidence of 1 per 100,000 persons = *less than 1 per 1,000*\(^{24}\)

Societal attitudes towards transgender persons, however, means that there are no telethons or foundations that exist to fund research to find better ways to assist transgender persons to live in the sex or gender that conforms to their inner gender identity.

Society does not understand what it is to be transgender. Remarkably, most transgender persons, especially those who are over thirty, also do not understand initially who and what they are. Dr. Lori Kohler, a transgender medical expert, has observed:

> So, in the past, being transgendered—it’s not like any of us grow up and say “Oh, I understand what that is.” It’s not even like someone who is transgendered grows up understanding what it means, and naturally having a language, and naturally being able to articulate their experience. But I think that the more we talk about it, the easier it becomes for younger people to realize what they’re feeling, and actually for their parents to be there and to be supportive of that, and to work with them.\(^{25}\)

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Dr. Kohler’s observation appears to be accurate based on my own experiences and observations as well as the life stories of transgender persons from two support groups which I have facilitated in Rochester, New York, and Montgomery, Alabama. However, because the main rule of those groups is that “what is said in the group stays in the group,” I am unable to discuss particulars and identities.

Dr. Kohler’s observation that it is easier for younger people now to come to terms with their true gender identity is equally astute. An encouraging example of what can happen when one comes out early in life is best demonstrated by the first-person account Mom, I Need to be a Girl,26 the story of a single mother whose son successfully transitions into her daughter with the help of her mother and her siblings.

Even though it is now easier for younger people to acknowledge and deal with their true gender identity, there are still major societal hurdles, if not roadblocks, to overcome. These include health care and mental health services, which are too often inadequate or nonexistent due to medical and mental health providers who share societal biases and medical and mental health providers who are unwilling to learn the proper treatment modalities for transgender persons. However, the major problem is that society values men more than women and places the societal rank of men above that of women.27

Professor Katherine Franke cogently analyzes the myths of sex, sexuality, and gender and their effects on society’s views:

26. EVELYN D. LINDENMUTH, MOM, I NEED TO BE A GIRL (Water Trook Pub., 1998). This book was originally published in soft cover format. But now, in a selfless gesture to share it with the world, it can be found on the web and downloaded for free. See http://ai.eecs.umich.edu/people/conway/TS/Evelyn/Mom_I_need_to_be_a_girl.pdf (last visited July 16, 2011). A copy is also in the author’s files.

27. This is generally based on the Christian Bible’s statement by St. Paul to the church at Ephesus when he said “Wives, submit to your husbands as to the Lord. For the husband is the head of the wife as Christ is the head of the church, his body, of which he is the Savior. Now as the church submits to Christ, so also wives should submit to their husbands in everything.” Ephesians 5:22–24. See also Becky L. Jacobs, PMS HAHA Acronym: Perpetuating Male Supremacy, 14 Tex. J. WOMEN & L. 1 (2004), and Christine M. Venter, Community Culture And Tradition: Maintaining Male Dominance In Conservative Institutions, 12 J.L. & RELIGION 61.
In the end, bodies end up meaning less in the fight for equality than the roles, clothing, myths, and stereotypes that transform a vagina into a she. “Analyzing the social processes that construct the categories we call ‘female and male,’ ‘women and men,’ ‘homosexual and heterosexual’ uncovers the ideology and power differentials congealed in these categories.”...

[T]he law assumes a natural and biological foundation of sexual difference, thereby distinguishing sexual differentiation from sexual discrimination. Upon examination, however, this assumption is revealed to be a fiction: gender norms, not pre- cultural biological facts, make up the difference that sexual difference makes. . . .

[I]n those circumstances in which people present a challenge to the intrapersonal unity of biological sex, core gender identity, and gender role identity, they find themselves legal outsiders, either suffering judicial punishment or being refused the rights and benefits afforded as a matter of course to people who conform to contemporary gender norms.28

Gender norms devalue qualities that are deemed feminine vis-à-vis those that are deemed masculine.29 Transgender persons discover a truth as they transition: in our society, women are valued less than men. Professor Mary Ann Case accurately describes this:

The man who exhibits feminine qualities is double despised, for manifesting the disfavored qualities and for descending from his masculine gender privilege to do so. The masculine woman is understandable; it can be a step up for a woman, and the qualities associated with masculinity are also associated with success. . . . So long as stereotypically feminine behavior, from wearing dresses and jewelry to speaking


softly or in a high-pitched voice, to nurturing children, is forced into a female ghetto, it may be continued to be devalued.  

And, as one study noted:

Transgender and transsexual people face a lifetime of inequalities and discrimination, despite often being amongst the most well educated members of society. As children, they can be bullied and abused for being gender different. As adults their families, friends and [neighbors] can reject them once their trans status is known, and they are very likely to experience assault and abuse at home, in the workplace and out on the streets. . . .

When they are seeking treatment to transition, they will start a medical process which reduces every aspect of their life and, in particular, their health down to the most minimal of issues, their trans mental health. Practitioners, at every level of medicine, ignore the trans person’s abilities to cope with ongoing crises that would destroy other people, their educational standing and the nature of the actual illness they are presenting with. The fact that some qualified nursing staff will insist on calling a person who has been transitioned for over 30 years in their former gender, is indicative of the level of ignorance that exists within our health services. 

Americans who identify as Lesbian, Gay, Bisexual, or Transgender (LGBT) report lower well-being than do non-LGBT Americans. Importantly, these differences hold true even after taking into account the effects of gender, age, race and ethnicity, educational attainment, state of residence, and population density. The disadvantage in overall well-being is more acute for LGBT women than for LGBT men. These findings are as part of the Gallup-Healthways Well-Being Index survey. Across all five elements of

31. Stephen Whittle, Lewis Turner, and Maryam Al-Alami, Engendered Penalties: Transgendered and Transsexual People’s Experiences of Inequality and Discrimination, EQUALITIES REVIEW, 77 (Manchester Metropolitan University, September 30, 2006).
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well-being, LGBT Americans—particularly LGBT women—trail their non-LGBT counterparts, even after taking into account possible differences in the demographic and geographic characteristics of LGBT and non-LGBT adults. These findings are consistent with research from UCLA’s Williams Institute, which shows that the LGBT population is at a disproportionate risk for poverty and food insecurity.32

Rates of food insecurity are higher for LGBT adults when compared with non-LGBT adults across several national surveys, and across gender, age, racial/ethnic, and education-level groups. After taking these factors into account, LGBT adults are 1.7 times more likely than non-LGBT adults to not have had enough money to feed themselves or their family in the past year. Certain sub populations within the LGBT community are particularly vulnerable to food insecurity or report relatively high rates of participation in SNAP. These include bisexuals, women, and people of color. More than a third (34 percent) of LGBT-identified women did not have money for food in the last year compared with 20 percent of non-LGBT women and 24 percent of LGBT men. And, while nearly 1 in 4 White LGBT adults (23 percent) experienced food insecurity at some point last year, the figure was more than 1 in 3 for African American LGBT adults (37 percent), more than 1 in 2 for LGBT Native Americans (55 percent), and more than three in four for Native Hawaiians (78 percent).33