PARADIGMS LOST: CULTURAL AND LEGAL IMPLICATIONS OF SEXUAL AMBIGUITY

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INTRODUCTION

For most people the question of their sex, gender, or sexual orientation (sexuality) never arises. They are identified as male or female at birth, socialized according to the cultural prescriptions in their society, and adopt the appropriate expressions of sexuality. In all societies, however, there are those for whom the standards are inappropriate, uncomfortable, or unacceptable. This paper deals with these people and the ways in which human societies have responded to them.

Legislation that addresses issues of sex and gender has usually failed to define these terms thereby throwing interpretatiosn onto the legal system which has, in the absence of a legislative history or guidance, used "common" interpretation of the term to guide its judgment. This has resulted in the conflation of the terms with legislation often specifying "sex" but judicial decisions referring instead to "gender."

The standard social science perspective views sex as a biological, ascribed characteristic that is usually identified at the time of birth on the basis of the appearance of the external genitalia. This sexual assignment is recorded on the infant's birth certificate and thereby becomes her/his legal sex. Gender, on the other hand, is a sociocultural, achieved construct, a behavior that is learned as a member of a particular society. Although rooted in biology (Shapiro,1998, p.248), gender systems are not determined by it.[1] The publication of Margaret Mead's *Sex and Temperament in Three Primitive Societies* (1935) demonstrated that what constitutes appropriate male and female behavior varies considerably among human groups.[2] The cultural importance of sex and gender is reflected in the fact that all societies make distinctions among people on these criteria. This is shown in contemporary American society in that the first question asked of new parents is the sex of their child. Societies differ, however, on the definition, number, and flexibility of these categories.

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[1]This is not to deny a biological influence on gender but to suggest that at the individual level gender development is a multi-factorial process.

[2]Recent criticisms of Mead's methods do not diminish the impact that this study has had on gender research.

DEFINING SEX

For most individuals, the assignment of sex is a straightforward task based on the appearance of the genitalia (external morphology, anatomical sex). However, what constitutes a male or female is based upon more than external anatomy. Equally valid criteria include chromosomal sex (46,XX = female; 46,XY = male) and gonadal sex (presence of testes or ovaries). Additional criteria are the presence or absence of seminal vesicles, prostate, uterus, or fallopian tubes (internal morphology). Other criteria are not apparent at birth, such as secondary sex characteristics that develop at the time of puberty (breast development and menses in females, voice changes in males and sexually dimorphic body hair patterns) and the child's evolving gender identity which develops in childhood and is reflected in choice of clothing, activities, etc. This "core gender identity" is often referred to as "psychological sex" and reflects the child's identification of itself as boy or girl. It is these developmental characteristics rather than invisible anatomical structures that signal the sex/gender of the child to others. In other words, we use gender to assume an individual's sex.

In most humans the various criteria on which sex assignment can be made are concordant; however, there are those where two or more may conflict. Traditionally known as hermaphrodites, the preferred term is now intersex, a much broader classification. True hermaphrodites have been defined on the basis of having both testicular and ovarian tissue that may be present as an ovotestis, an ovary and a testis, or some combination of the above. Chromosomally, true hermaphrodites are usually 46,XX although 45,X0 and 46,XY mosaic also occur. A uterus and vagina are present in eighty per cent of the cases and menstruation occurs although fertility is uncommon.[3] Most (75%) are raised as males although nearly all are infertile (Hermer, 2002, p.206). Pseudohermaphrodites are individuals whose chromosomal sex and external genitalia do not match, usually as a result of abnormalities in hormone production and/or reception. In such cases, the determination and assignment of sex is often difficult as the appearance of the external genitalia may be ambiguous.

The frequency with which intersex conditions occurs varies according to what is included in the definition. Most legal scholars have used Anne Fausto-Sterling's (2000, p.51) estimate of 1.7% of all births. Her definition of intersex includes "any individual who deviates from the Platonic ideal of physical dimorphism at the chromosomal, genital, gonadal, or hormonal level." Leonard Sax (2002) believes this definition is far too broad because it includes those who are physically indistinguishable from "normal" individuals and may exhibit no symptoms, thus creating confusion for both clinicians and patients. He maintains that intersex should be reserved for those conditions where the chromosomal sex is inconsistent with the phenotypic sex or where the phenotype cannot be classified

[3]Hermer (2002, 206, n38) states that twenty-one pregnancies have been reported in true hermaphrodites.

as male or female. He argues that of the ten conditions she cites, the five most common are not intersex conditions and if eliminated, the actual incidence of intersex (0.018%) would be less than two per ten thousand births. Sax would exclude Klinefelter syndrome, Turner syndrome, and late-onset adrenal hyperplasia from the intersex category. In particular, he notes the latter as accounting for 88% of the patients Fausto-Sterling categorizes as intersex even though they possess normal genitalia and females do not present clinically until their mid-twenties (usually as a result of fertility problems) and males present much later, if at all.

Chromosomal sex disorders included by Fausto-Sterling include Klinefelter syndrome which affects approximate one in every 500 to 1000 males who are born with two or more X chromosomes. Rarely recognized at birth although the testes and often the penis are smaller than in non-Klinefelter males, the condition becomes apparent at puberty with the development of breasts (gynecomastia). These individuals are often treated with testosterone to create a more masculine phenotype (Greenberg, 1999, p.283; Kelly, 1996, p.112). Turner syndrome affects roughly one in 5000 females. They usually have 45,XO chromosomes and although there are female external genitalia, ovaries are not present or exist only as "streak" (undifferentiated, non-functioning) gonads. Girls with this condition are often treated with estrogens at puberty to induce secondary sex characteristics (Kelly, 1996, p.112; Greenberg, 1999, p.284).

Although the numbers of individuals with chromosomal variations may be small, they are significant because people with these conditions would "fail" chromosome tests as they are neither XX nor XY and their status would be unclear should the courts establish a chromosome test as the standard for sex assignment. The most common causes of intersex conditions are hormonal conditions such as congenital adrenal hyperplasia (CAH), a genetic disorder that results in the accumulation of abnormal levels of androgens (often referred to as “male” hormones even though they also are present in females) in a genetic (46,XX) female fetus or infant with the result that external genitalia become masculinized (Kelly, 1996, p.117) although ovaries and internal female morphology are present. Some CAH infants have been designated male on the basis of genitalia. In other cases, where the genetic sex has been identified, the child may be treated surgically and hormonally to "normalize" her appearance. This condition occurs in about one of every 5000 to 15,000 births (Greenberg 1999, p.288).

Androgen insensitivity syndrome affects one in every 20,000 genetic males and can be either complete (CAIS) or partial (PAIS). Born with normally functioning testes, they exhibit a receptor defect that prohibits the processing of androgens produced by the testes. CAIS babies are usually identified as females at birth and there are no symptoms until puberty when menstruation fails to occur. Breast development follows a normal female pattern. Infants with PAIS exhibit a range of morphologies from nearly complete male genitalia to nearly complete female morphology depending upon the extent to which the receptors are able to process androgens (Greenberg, 1999,pp. 287-288; Kelly, 1996, p.116).

One of the more interesting hormonal disorders is 5-alpha-reductase

deficiency in which a 46,XY male appears phenotypically female at birth because of the body's inability to convert testosterone to the dihydrotestosterone needed for the development of external male genitalia. Assigned as females, they are socialized as such until puberty when secondary male sex characteristics develop with the descent of the testes, deepening of the voice, and growth of what had been identified as a clitoris into a small but functional penis. Most, though not all, change their gender identity at this time from female to male (Freund, 1985, p.287). Since 1961, over fifty families with this disorder have been identified in various parts of the world. Mendonca *et al.* reported (1996) on sixteen Brazilian children from ten different families who had the disorder. Sixteen had been raised as females but one had been raised as a male because two cousins and an uncle had been diagnosed with the condition. Only three maintained female identity once pubertal changes had occurred. Two had changed their identification to male before puberty and one had been raised as a male from birth. This outcome is similar to what has been documented in other reports; in a Turkish family four out of five switched gender identity and a Dominican Republic study indicated that this occurred in seventeen of eighteen (Mendonca *et al.* 1996).

Gilbert Herdt, following a suggestion by Carlton Gadjusek, documented this condition among the Sambia in New Guinea, a society that has very rigidly defined gender roles. Children with ambiguous genitalia are assigned by the attendant mid-wives as *kwolu-aatmwol* (in Neo-Melanesian the term for such individuals is *turnim-man*) which Herdt asserts represents a third sex category. Because this phenomenon has been known for a long time within the group, he feels it unlikely that children are wrongly assigned at birth.[4] Despite the existence of a third sex in this society, Herdt (1994, p.426) maintains that the Sambia have only two genders, masculine and feminine, and that *kwolu-aatmwol* are socialized toward a masculine direction (Herdt, 1994b, p.436).

For individuals with ambiguous genitalia born in the United States the standard medical practice has included early surgery to "normalize" the infant's genitals. This approach is based primarily upon the work of Dr. John Money, a psychologist at Johns Hopkins University in Baltimore, and his associates. Two assumptions form the basis of this intervention strategy. First, it was assumed that normal appearing genitalia are critical for an individual's psycho-social development. For males, penis size and the ability to urinate while standing are important criteria. Only those who will, as adults, be able to successfully penetrate females are assigned as males (Greenberg, 1999, p.272). As a result the infant phallus is evaluated on the basis of its "social potential" *i.e.* future size and sexual adequacy. To be medically acceptable as a penis, the phallus must be at least 2.5 cm long; a clitoris can be no longer than 0.9 cm to avoid surgical reduction despite the fact that normative ranges of infant phallic and clitoral size are unrelated to their size in adults (Preves, 2002). Where the penis is small (micropenis) or secondary male sex characteristics cannot develop (*e.g.* CAIS), the

[4]Compare this to the Brazilian family that raised their child as male despite genital ambiguity because of their awareness of the condition in the family.

decision is usually made to remove all vestiges of male external genitalia and raise the infant as a girl who will later receive female hormones and the surgical creation of a vagina. It should also be noted that surgical technology may also play a role in that it is easier to construct a vagina than a penis. This is often reduced to "it's easier to make a hole than a pole."

For females with clitoromegaly, surgical reduction often involved removal of erotic tissue, thus rendering the adult inorgasmic. Amazingly (from a 21st century perspective) surgeons extolling the benign nature of this surgery pointed to the complete sexual functioning of African women subjected to clitorectomy as part of native custom (Chase,1998, p.192). In both examples the surgical intervention was justified on cultural and cosmetic grounds rather than medical necessity. Kipnis and Diamond (1998, p.405) agree: "We question whether physicians should ever sacrifice the organic functionality of any child – Somali or American – on the altar of cultural expectation."

Secondly, it was assumed that an infant can be socialized into the proper gender role as long as this is started prior to the age of approximately two years. Justification for this rested on Money's report of the successful resocialization of an infant boy whose penis was ablated as a result of a botched circumcision. The child was surgically reassigned as a girl at the age of twenty-two months. What made this case particularly interesting from a scientific perspective was that the boy had an identical twin brother who could serve as a control in evaluating the success of the resocialization effort. For nearly two decades this case formed the basis for sex reassignment surgery in intersex and genitally traumatized infants as doctors assumed that a successful psycho-social development would ensue. It also served as an important justification for early surgery.

Tragically, the outcome of the "experiment" was significantly different from what Money reported. A follow-up on the case known in the literature as "John/Joan" (after the pseudonyms used by Money) by Milton Diamond and Keith Sigmundson (1997a) showed that the resocialization of Bruce Reimer as Brenda was a disaster as she rejected all attempts to turn her into a boy. From birth she had been the more assertive of the twins and continued to engage in typically male behavior, playing preferentially with her brother's toys and urinating from a standing position with predictably messy results. These behaviors made Brenda extremely unpopular among the girls, some of whom threatened to kill her if she tried to use the girls' bathroom at school. With few friends and responding aggressively to taunts, she was eventually expelled from school. Estrogen therapy that resulted in breast formation was especially distasteful to her and she compensated by overeating in order to mask this development. Annual visits to Johns Hopkins were also rejected. Increasingly the local doctors recognized that she was not making a successful adjustment and had begun to discuss among themselves the possibility of her returning to male status. Threats of suicide resulted in her father tearfully recounting the events of her infancy. Relieved that her belief that she was "really" a boy was accurate, she renamed herself David and announced that she would immediately begin living as a male.

Diamond was able to locate the now re-reassigned David Reimer who had

undergone phalloplasty, married, and adopted his wife's children from a previous relationship. Surprised that his case had been reported as successful, David Reimer spoke at length with reporter John Colapinto and the resulting article in *Rolling Stone* (1997) brought the case to the attention of the general public. Colapinto turned the article into a book (*As Nature Made Him: The Boy Who Was Raised as a Girl*, 2000) and the case became the basis for a NOVA television program (*Sex Unknown*, 2001). Suffering from depression and a marital breakup, David Reimer took his life in the spring of 2004 (Colapinto, 2004).

That this case received such prominence even before its deceptive basis was revealed is disturbing on several counts. First, generalization from a single case study is simply very poor science even if the unusual nature of the case made comparable studies difficult. Second, Bruce/(Brenda)/David Reimer was a typical 46,XY male with no discordant sex criteria other than as a result of surgical trauma. Therefore, his case is not useful for intersexed individuals where pre-, peri-, and post-natal hormonal environments are significantly different and where chromosomes may also be variant. Finally, there is the issue of misrepresentation of the case in the scientific and medical literature. It is unreasonable to hold physicians responsible for the accuracy of the research upon which they base their diagnoses and interventions. Nevertheless, they should have been aware of the tenuous validity of a single case.

GENDER IDENTITY

What is missing from the above discussion is a consideration of what has been called psychological sex, brain sex (Kelly, 1996), or core gender identity. How does a person's self-identification as girl/woman or boy/man occur? For Money it is primarily or exclusively a social construct resulting from early socialization whereas others (Reiner,1996, p.802; Kipnis and Diamond, 1998, p.404) suggest a significant hard-wired component, perhaps established by hormonal interactions in the prenatal period. Although at present there is no compelling evidence either way, it is logical to assume that something this complex is not reducible to a single factor and there is no reason to continue a false nature/nurture dichotomy.

Intersex children present a particular problem for either interpretation. How do parents socialize an intersex child? Even though medical protocols recommend raising a child unambiguously in the assigned sex (Wilson and Reiner, 1999, p.125; Diamond and Sigmundson, 1997b), is this possible knowing the child's history? Do parents over-emphasize the gender role of the assigned sex, demanding rigid adherence to cultural stereotypes? Unfortunately there are no long-term studies of parental reactions to intersexed children either by medical researchers or reports by parents themselves. One of the arguments put forth in favor of early surgery for children with ambiguous genitalia is that it increases the chances of parents bonding to a child they might otherwise see as defective. This is countered by the contention that surgery is therefore done to enhance the well-being of the parents rather than the patient, although the child may receive secondary benefits in terms of an improved relationship with the parents (Hermer,

2002, p.236). Fausto-Sterling's belief that intersexed children are being used as an experiment by scientists and doctors searching for a biological explanation of behavioral differences between males and females seems harsh. The alternative, to raise children as intersexed without any interventions, is also an experiment (Hermer, 2002, p.229). For adults such as Chase, Bornstein (1994) or Feinberg (1996), the choice of making a new path is precisely that, a choice, and they are aware of the price they could pay and the rewards they could earn.[5] For parents confronting the issue of how to raise their intersex infant, the problems are far more daunting and the costs involved will be paid by the child whose lifecourse they could set in an irrevocable manner. As Hermer, (2002, p.229) says, there is no "reasonably certain" answer.

Drawing inspiration from the gay and disability movements, individuals with intersex conditions have organized groups to address a variety of intersex conditions. These serve as focal points for the education of parents, support groups for intersexuals, and political action groups addressing medical issues, with a particular emphasis on eliminating genital surgery on infants and children except for medically necessary operations. By postponing surgery until the individual can give informed consent and choose her or his own path, they hope to avoid situations in which irreversible genital surgery has assigned an infant to a sex with which he or she does not identify. This also will permit the individual rather than the medical team to identify the relative importance of genital appearance and erotic function. The most visible of these organizations is the Intersex Society of North America (ISNA) founded by Cheryl Chase.

Political actions such as demonstrations at medical conventions resulted in only one immediate convert, Justine Schober, an Erie, PA urologist, among pediatric surgeons, urologists, and endocrinologists (Chase 1998, p.203). However, recent guidelines developed by Diamond and Sigmundson (1997b) are echoed by Schober's (1998) and Chase's (1998b, 1999) calls for a halt to cosmetic surgery on infants and children. They also point out that medical concerns about potential sexual functions in males have not been paralleled by similar concerns for females. "There is little evidence that a poorly functioning clitoris and vagina is [sic] any better than a poorly functioning penis, and there is no higher reason to save the reproductive capacity of ovaries over testes" (Diamond and Sigmundson, 1997b). Chase (1999) argues that a fundamental error in the traditional medical model of intersex is addressing it as a neonatal problem. Although medical personnel believe "normalcy" is a prerequisite for acceptance and happiness, intersexed people cannot be made totally normal so the emphasis instead should be in helping them come to terms with their differences. In particular she argues (1998, p.198) that preservation of genital sensation and erotic functioning is as important as reproduction and on this she has attempted to position cosmetic surgery on infants as analogous to female genital mutilation (FGM). In October 1996, when Congress passed the federal Prohibition of Female Genital Mutilation

[5]Feinberg (1980, p.2), who is transgendered, has stated "I am a very masculine woman....I am a woman. I am the way I am. It is a fine way to be" but also notes (1980, p.21) "I have lost more battles than I care to count. I could write a volume on the art of retreat. This is not an easy life. It is a struggle to survive. It is a fight."

Act, it specifically exempted medicalized clitorectomies performed to "correct" intersex conditions, even though the end result for the females involved was similar. Anti-FGM groups have tended to ignore ISNA; the leader of one group said they were "not concerned with biological exceptions" and another reported that their work was only in relation to FGM "that is performed as a harmful cultural or traditional practice on young girls," even though this would clearly include routine cosmetic surgery on American female infants (Chase, 1998, pp.204-205; Kessler, 1998, pp.80-81).

A major response to Chase and other activists is that today's surgery is far superior to that which they received and damage to nerves is avoided. Proof of this, however, will not be available for at least a decade and then only if follow-ups are done. Chase (1998b) points out that a similar claim that current prostate surgery does not affect sexual function in males are demonstrably false for many man. Additionally, if surgical techniques are improving rapidly, they become an important justification for postponing cosmetic surgery.

If gender identity is strongly influenced by hormonal or other biological factors, how does the developmental path in different types of intersexes vary from the usual? Is it possible to tease apart the various contributions? If gender identity is at variance with most or all biological criteria, does this reflect or define an intersex condition? If so, the number of intersexed individuals increases greatly and the definition of intersex expands. The next section of this paper deals with individuals whose gender identity is discordant with their genitalia and who have traditionally been excluded from the intersex category on the basis that psychological sex/gender identity is a social construct and therefore discordance represents a psychological/behavioral rather than an anatomical/medical condition.

TRANSSEXUALS

Transsexuals are important in any consideration of sexual ambiguity in part because legally all but two cases addressing issues of ambiguity have concerned transsexuals rather than intersexed individuals. As previously noted, if one accepts gender identity as primarily or exclusively biologically influenced, then transsexuals can be subsumed within the category of intersex despite the fact that most would not be considered intersexual on the basis of chromosomes, anatomy, or endocrine function.[6]

The incidence of transsexualism is hard to estimate and depends upon how one defines it. If only those individuals who complete sex reassignment surgery are included, the record is clearly biased towards those who can afford it or those in countries such as the United Kingdom (Dyer, 1999) it is where it is covered by national health insurance. This begs the question of those who have strongly identified as the other sex since childhood but are content to live in a body

[6]It should be noted, however, that many intersexed individuals are also recipients of hormone therapy. However, this is seen as therapeutic rather than volitional.

modified only by hormones.[7] There are also people such as Leslie Feinberg who use hormones to change their bodies but are clearly not transsexuals because they identify as neither male nor female. And what about Kate Bornstein, technically a MTF (male to female) transsexual because she has had both surgical and hormonal interventions, but who also identifies as neither male nor female (1994, p.4).

The available data is limited and non-comparable but can provide some indications of the numbers of people seeking surgical modifications. In the Netherlands, which has the most liberal policy toward transsexuals, sex reassignment surgery is available to anyone who has lived in the country for a year. Although initially the government was concerned about a potential invasion of "transsexual tourists" seeking surgery, the ratio of nationals to immigrants is seven to one. Between 1985 and 1993, 1200 patients underwent surgery at the Free University Hospital. Although there was an early surge in the number of applicants, by the mid 1990s, this averaged about 150 per year. Of these applicants, one hundred were offered some form or treatment and surgery was approved for eighty (Rogers, 1993). Hird (2002) estimates that there are approximately 5000 post-operative transsexuals in the United Kingdom as of 2002. The best statistics come from the Federal Republic of Germany where the Act on the Changing of First Names and the Determination of Sex Membership in Special Cases (Das Transsexuellen-Gesetz) took effect on 1 January 1981. The act provides the first clear indication of the number of people who are satisfied with steps short of surgery. It provides two options. The first or "small solution" contained in Article 1 provides for changing an individual's first name; the second or "major solution" in Article 8 is concerned with sex re-assignment. Either option requires favorable opinions from two mutually independent experts who must agree that the applicant's gender identity has existed for at least three years and is of a lasting nature. In order to be considered under Article 8, the applicant must be single, permanently incapable of reproduction, and have undergone sex reassignment surgery. Although the administration of hormones and reconstructive surgery do not require legal permission, castration must be approved by two physicians under the German Castration Act (Weitze and Osburg, 1996, p.411).

Weitze and Osburg (1996) reviewed all decisions handed down under the first ten years of this law, breaking them down into three non-mutually exclusive categories. The first included those who applied only for a change in first name, the second was those who applied for both a name change and a legal re-assignment of their sex, and the third those who initially applied for a first name change and later applied for the legal re-assignment of their sex. Because not all applicants were approved and those in the third group could also be included in the first group, the number of transsexuals is not equal to the number of applicants (Weitze and Osburg, 1996, pp.411-412). In the first ten years there were 1422 cases which reached the courts, 683 for first name changes and 733 for sex

[7]In no way is this intended to understate the effects of hormonal therapy which can be extremely striking and stressful but solely to suggest that this option should not remove them from the transsexual category.

reassignment. This is approximately 2.4 for every 100,000 people, or, if using only those approved under Section 8, 2.1 for every 100,000. The ration of MTF to FTM 9 (female to male) was 2.3 to 1; if only name change was considered it was 3 to 1 and if only sex reassignment was considered it was 2 to 1 (Weitze and Osburg, 1996, p.413). Most applications were approved (83% of those filed under Section 1 and 96% of those filed under Section 8) (Weitze and Osburg 1996, p.415). On the basis of their research they estimate (1996, pp.418, 423) that between twenty and thirty per cent of transsexuals will be satisfied with the "small solution." If their data can be extrapolated to other countries, using the number of sex reassignment surgeries to estimate the prevalence of intersex would result in an undercount.

A study by Herman-Jeglinska, Grabowski, and Dulko (2002) of Polish applicants for hormones and/or sex reassignment surgery indicated a ratio of 103 FTM to 29 MTF, a pattern which holds true in other formerly communist countries. This may reflect different social conditions from the west but definitely requires further exploration. A thirty-five item questionnaire administered to applicants asked them to rate themselves on a number of qualities. Items scored as masculine were such things as self-reliance, independence, and physical fitness; sensitivity to the needs of other, gentleness, affectionate were qualities identified as feminine. It would be interesting to determine if this reflects cultural differences or stereotypical attitudes on the part of the researchers. Either way it assumes the existence of two clearly defined and mostly non-overlapping categories.

Transsexuals are individuals whose core gender identity is different from their assigned sex. Under the *Diagnostic Services Manual IV (DSM-IV),* this condition is referred to as gender dysphoria. For transsexuals, however, what is dysphoric is not their gender (which is seen as their core identity) but their anatomical sex (Shapiro, 1991, p.250). The condition is marked by a strong conviction, beginning in early childhood, that they are really members of the other sex. This is frequently portrayed as "being a man trapped in a female body" or the reverse, "being a woman trapped in a male body." Their genitalia are a source of embarrassment or disgust and for many their ultimate goal is removal of the offensive anatomy. The intensity of this conviction is revealed in the following statement by Jan Morris (1974, p.169):

> Nothing will stop us, no fear of ridicule or poverty, no threat of isolation, not event he threat of death itself, ...If I were trapped in that cage again nothing would keep me from my goal, however fearful the prospect, however hopeless the odds. I would search the earth for surgeons, I would bribe barbers or abortionists, I would take a knife and do it myself, without fear, without qualms, without a second thought.

Fifteen years later Morris's attitude seemed to have mellowed and she was less accepting of a sexual and perhaps gender binary.

> The experience nevertheless made me feel that perhaps there was in the world at large, as there certainly was in me, an innate ennui with the whole system of progeneration. If people felt relieved to venture beyon the usual peripheries of male and female, did it perhaps means that all sexual orthodoxies, after so many million years of them, were becoming a bit of a bore? (Morris, 1989, pp.11-12)

Stoller (1975, p.248) and others (*e.g.* Prosser, 1998) have cautioned that reports of this early belief should be taken with a grain of salt as many candidates for SRS have read the relevant literature and have (re)created life histories that are designed to maximize their chances of approval for surgery (Stone. 1991, pp.291-292). Because one of the DSM-IV criteria is early onset, it is difficult to determine whether the life histories are the cause of the diagnosis or vice versa. Attempts to cure transsexualism with psycho-therapy have been unsuccessful and only surgery has resulted in improvement (Stoller, 1975). A five year follow-up of nineteen Swedish transsexuals (Bodlund and Kullgren 1996, 304) found that eighty per cent were satisfied with the outcome of their surgery with the best results coming from those where onset began before puberty and who had a homosexual orientation.[8] Outcomes were also consistently better in FTM transsexuals even though surgical results are not as positive (Bodlund and Kullgren, 1996, p.304). This may reflect the fact that they are more likely to establish stable partnerships and face fewer social restrictions in their new role.

It is important to distinguish transsexuals from transvestites even though (as will be discussed below) cross-dressing is usually required as a pre-requisite for sex reassignment surgery (SRS). Transvestites, unlike transsexuals, derive erotic pleasure from cross-dressing, identify as male, and are not dissatisfied with their genitals. Most identify as heterosexual and many are married and fathers. Because females, at least in the last half of the twentieth century, have had greater freedom of dress, transvestism is usually seen as a male disorder. For transsexuals, cross-dressing is done to put an outward reality on an inner conviction.

Meyerowitz (1998), reviewing the history of transsexualism in the United States as it has been reported in the popular press, states that the first attempts at a surgical change of sex occurred in the 1910s, although the earliest attempt was in 1902, when 28 year old Earl Lind convinced at doctor to castrate him. Females were also among the first to seek out such surgery; she notes that Alberta Lucille Hart convinced a doctor to perform a hysterectomy on her. These surgeries differ from contemporary SRS in that there was no attempt to create different anatomical structures but solely to remove those felt to be incorrect. The first published

[8]For doctors, homosexual orientation refers to attraction to someone of the same anatomical sex as the patient was assigned at birth, but since the patient perceives him/herself as the other sex, they would define this as a heterosexual orientation. This is only one of several contradictory definitions that plague comparative research on this topic.

scientific report dealing transsexual surgery appeared in 1931, when Felix Abraham reported on the castrations, penectomies, and creation of an artificial vaginas on two "homosexual transvestites" (Meyerowitz, 1998, p.162). Many future transsexuals first learned of the possibility of such surgery through the publication of the story of Lili Elbe who began life as the Danish artist Einar Wegener.

Contrary to the American stereotype that transsexual surgery was primarily sought out by males[9], Meyerowitz (1998, p.165) demonstrates that in the latter half of the 1930s, the most publicized transsexual surgeries were on female European athletes. In 1935, Belgian cycling champ Elvira de Bruyne became Willy de Bruyne; in 1936, British shot-put and javelin champion Mary Weston became Mark Weston and Czechoslovakian runner Zdenka Koubkova became Zdenk Koubkov. She notes that press coverage at the time reflected popular discomfort with female athletes and the assumption that they were "mannish," it not actually males. This marks the beginning of a continuing concern with the sex status of female athletes that does not have a parallel among male athletes even though chromosomal abnormalities such as supernumerary Y (XYY or XYYY) could also be construed as giving an unfair advantage to those individuals.

The term "transsexual" was first used by Dr. David Cauldwell, the question and answer department editor for *Sexology* magazine when he created the category "psychopathia transexualis" which he distinguished from homosexuality. Cauldwell also differentiated among gender (psychological sex), biological sex, and sexual orientation (Meyerowitz, 1998, pp.168-169).

Despite earlier reports, what most drew attention to sex change surgery (as it was then known) in the United States was the case of Christine Jorgensen, an American ex-GI from the Bronx who traveled to Denmark for two operations in 1952. (A final surgery to construct a vagina was done in New Jersey in 1953). The press feeding frenzy that followed the announcement made her a household name and provided for many transsexuals (especially males desiring to be females) hope that they too would be able to obtain surgery. Jorgensen (1967) reported receiving many letters from prospective patients as did her surgeons. Public figures who subsequently underwent SRS include writer James Morris, who became Jan Morris, and doctor/tennis player Richard Raskind, who became Renee Richards. Both joined Jorgensen in writing biographies focusing on their sex reassignment (Jorgensen, 1967; Morris, 1974; Richards, 1983). Prosser (1998, p.103), who is particularly interested in transsexual autobiographies as narratives, states that more than fifty have been published throughout the world between 1954 and 1996. He further suggests that "sexual inversion" as described by sexologists is not the homosexuality that is its usual interpretation, but transsexualism and that Radclyffe Hall's *The Well*, even though "foundationally yoked to lesbianism" is a transsexual narrative (1998, p.138). Jorgensen and Morris both report relatively normal and happy childhoods along with early convictions of being female.

[9] Garber (1989) reviews reasons for the emphasis on male (MTF) transsexuals outlined by Dr. Leslie Martin Lothstein, co-director of the Case Western Reserve Gender Identity Clinic.

Richards' childhood was marked by abuse (including forced cross-dressing) by his mother and his sister. His story fits Stoller's (1975) psychiatric description of the etiology of transsexualism which focuses on the critical role of the mother.

Because this type of surgery is not available on demand, centers which offer these treatments attempt to distinguish those who can most benefit from surgical intervention from those who may be transvestites, homosexuals, or suffering from other disorders. A 1995 survey by Peterson and Dickey of twenty-seven international clinics offering SRS received responses from nineteen (70%) which included all known government sponsored or university affiliated centers. All required applicants to live full time in the adopted gender role (known as the "real life" test) for a minimum of one year, more than half required a two year minimum. Seventeen required a period of observation of applicants for a minimum of three months, most required a one to two year period before approval. All excluded individuals with a history of continuing psychiatric instability or organic brain disorders evidenced by substance abuse, suicide attempts, criminal behavior, etc. Fourteen required applicants to obtain divorces if they were married before surgery would be approved.

The procedure outlined below is that followed by the Clarke Institute Gender Identity Clinic at the University of Toronto and can be considered relatively typical (Steiner, 1985). Those seeking SRS, upon being diagnosed as transsexuals, are expected to live in the adopted gender role for a minimum of one year before hormone treatment is initiated. An endocrinologist directs the hormone therapy. For both males and females this results in a redistribution of body fat and hair in sexually dimorphic patterns that will disappear within one to six months if hormones are stopped. Patients are informed that they will have to maintain hormone therapy for the rest of their lives. Males experience mild to moderate breast enlargement as well as a decrease in libido. Females receive an intramuscular injection of testosterone every two weeks that results in enlargement of the clitoris, cessation of ovulation and menstruation, and an increase in libido. After a year of hormone treatment, those who are employed and self-supporting, have no psychiatric disorder that would preclude understanding the impact of the desired surgery, are physically healthy, and unmarried are deemed eligible for surgery.

For males desiring reassignment as females (MTF), surgery entails a bilateral orchidectomy, amputation of the penis at the pubic symphysis and shifting the penile and scrotal skin to the appropriate anatomical position with the latter used to create the labia majora. A vagina is fashioned from inverted penile skin and skin grafts and kept open following surgery by the use of stents.

Females seeking reassignment as males (FTM) undergo mastectomy and elective hysterectomy. A phallus may be constructed from skin from the lower abdomen or thigh into which a removable prosthesis can be inserted to simulate erection and achieve vaginal penetration. Subsequent surgery can include insertion of testicular prostheses although Steiner (1985, p.338) states that few patients actually undergo this procedure.

Transsexuals are important in illuminating the meaning of gender in a

particular society. As Shapiro points out, transsexuals differ from non-transsexuals in that for them, it is gender that is ascribed and sex that has to be achieved. As a result, they illustrate to strong degree what it means to be a man or a woman, often behaving in stereotypical manners and conforming to very conservative models of gender roles. "While transsexuals may be deviants in terms of cultural norms about how one arrives at being a man or woman, they are, for the most part, highly conformist about what to do once you get there" (Shapiro, 1991, p.253). Jan Morris's pronouncement upon women (1974, p.153) "Her frailty is her strength, her inferiority is her privilege.." is a clear example of the fact that many MTF transsexuals haven't yet made it to the rearguard of the feminist movement and are still locked in the land of Father Knows Best. Their actions are more extreme than non-transsexual men and women but it is not clear whether this reflects their adoption of gender stereotypes or is an artifact of the need to impress their physicians of their suitability for surgery. This can be seen as a parallel to the tendency for candidates for SRS to tell similar life stories that conform to accepted medical criteria.

What is the outcome of transsexual surgery? Is the post-operative individual now redefined as a member of the other sex? Georges Burou, the Casablanca surgeon who made James Morris into Jan Morris and who pioneered sex reassignment surgery, stated " I don't change men into women. I transform male genitals into genitals that have a female aspect. All the rest is in the patient's mind" (in Raymond, 1979, p.10). Does this imply then that SRS can be seen as purely cosmetic surgery for individuals who have made the defining shift in their mental outlook? The prefix trans- implies a transitional stage between two static states. From a linguistic standpoint this suggests that the term transsexual should be limited to those individuals who desire to achieve anatomical simulation of the other sex from the time hormone therapy is initiated, during the "real life" test , and through the immediate post-operative period at the end of which, it would be assumed, they have "transitioned" into a new status. It seems, however, that the status of transsexual is a permanent one (Devor, 1997, p.48). In this it is analgous to marital status in that a divorced person does not return to "single"

status but instead occupies a third status of "divorced."[10] I shall examine the (often contradictory) ways that the legal systems of various countries and American states have attempted to address this issue in a subsequent section of this study.

Some of the most heated debates about the position of transsexuals have occurred within feminist and queer communities. Janice Raymond in *The Transsexual Empire: The Making of the She-Male* (1979, p.114) draws a line in the sand between women and "constructed women" arguing that woman is socio-

[10]I am grateful to Jenny Shen for providing this analogy.

politically defined as a result of oppression and that only those whose experiences have been shaped by these forces have the right to be called women. She is particularly fearful of the feminist and especially lesbian movement being co-opted by MTF transsexuals. For Raymond (1979, p.11), womanhood, although tempered by political experiences is, in the final analysis, reduced to chromosomes - and transsexuals fail the test. Shapiro (1991, p.159) states that this position is characteristic of recent feminist writing in which "there has been a somewhat unprincipled marriage of convenience between a social constructionist view of gender and an essentialist view of womanhood." Sandy Stone, the MTF head of Olivia Records was singled out for particular criticism by Raymond who felt that her assumption of a leadership position within a women's organization simply followed traditional patterns of male dominance. This perspective was supported by the refusal of the Michigan Womyn's Music Festival to not admit post-operative MTF transsexuals, claiming it was for "womyn-born-womyn" only (Prosser, 1998, p.71). Stone's response to Raymond, entitled *The Empire Strikes Back: A Posttranssexual Manifesto*, recognizes that MTFs do not share the social history of genetic females, nor do they support or reinforce a binary sex/gender dichotomy because within transsexual history "we can find a story disruptive to the accepted discourses of gender, which originates within the gender minority itself and which can make common cause with other oppositional discourses" (Stone, 1991, p.295).

Stone's willingness to make common cause with groups opposing the current gender system is echoed by many of those who see themselves as transgendered. Transgendered people deny the validity of a binary system of sex and gender but some see transsexuals who insist on SRS as reinforcing prevailing mutually exclusive categories. Instead, they prefer a society in which gender is no longer associated with sex or disappears altogether, something Lewins (1995, p.159) refers to as the hope option. Transgenders may move back and forth between genders, may use hormones to create specific body characteristics, or live as androgynous people. Transgenderism, rather than supporting the "either/or" position of transsexuals, emphasizes instead "both/neither", drawing upon postmodern ideas about fluidity (Roen, 2002; Epstein, 1990). In contrast to Janice Raymond, Leslie Feinberg (1996, p.117), a transgendered person, would welcome both MTF and FTM transsexuals in feminist and lesbian circles. In some respects, transgendered people have much in common with intersexed individuals. While the sex/gender ambiguity of the latter is forced upon them by biological conditions, in the former it is embraced eagerly and voluntarily. Cheryl Chase (1998, p.198) believes that for the time being it is necessary to raise intersex children unambiguously as boys or girls because society sees gender as a fundamental aspect of human life and while it would be nice to see gender differences eliminated, that is unlikely to happen in the near future. In the meantime, however, attempts should be made to make gender more flexible, permitting a far broader range of appropriate behaviors for males and females.

PART II: CROSS-CULTURAL PERSPECTIVES

The relatively rigid binary system of sex and gender in the United States[11] is not a universal pattern. Cultural definitions of gender vary among and within societies and over time. Even the numbers of genders and sexes are not constant. Perhaps because of the high cost involved (at least until insurance carriers began to cover sexual reassignment surgery), most of the people who have had this surgery are representatives of the middle or upper classes. Reports in the medical and scientific literature are almost exclusively from European and North American centers (Kuhnle and Krahl, 2002, is an exception). There has been little consideration of the role of culture in determining what is considered "normal" in terms of either anatomy or gender (Kuhnle and Krahl, 2002).

It may be that the concept of transsexual can only be found in societies where there is a binary system and normal is defined in terms of "either/or." If gender is rooted in the body, change in gender would have to necessitate a change in body. The preoccupation with external genital anatomy evidenced by transsexuals, even though it is invisible to the world at large and does not form the basis for gendered interactions, demonstrates this social construct. This is what differentiates between transsexual and transgendered people. Because transgenders deconstruct the connection between sex and gender, they are free to experience different gender roles without the obligation of modifying the body. This also permits them to escape rigidly stereotyped gender roles. It should be noted, however, that this does not mean that transgenders do not alter their bodies in a variety of ways, only that the reason for doing so is individual rather than social.

Intersexes represent another form of variation in which there are visible signs of ambiguity that are often present at birth. Within a binary system, medical personnel therefore have to uncover the person's "true" sex and use surgery as a means of "correcting" the defect so that the individual can be properly socialized. Although I have argued above that transsexualism is a culturally derived formulation of the modern west European tradition, intersex conditions, having a biological base, occur in all societies and the ambiguity they represent can be addressed in very different ways, including acceptance of the condition(s) as "normal."

In many societies there are individuals who perform roles that are, in whole or in part, at variance with their sex, yet they are not transsexuals in the American sense in that they do not identify as members of the other sex, nor do they necessarily feel the need to eliminate their genitals. The question then is whether these people are seen as representative of a third (or fourth, or fifth, etc.) gender or if gender is perceived as a continuum in which they may occupy intermediate positions but within a cultural formulation of "normal." Note

[11]Preves (2002) notes that this was not always the case in the European tradition as twelfth century theological and medical writers viewed sex as a continuum.

however, that normal does not imply high status or social approval. If they represent additional sex(es), what is/are the corresponding gender(s)? And if these "gender benders" represent additional genders, can it further be argued that intersexes represent additional sexes or intermediate locations on a continuum of sex? Do there have to be identical numbers of sexes and genders or does this simply imply a situation in which rigid distinctions remain and only the numbers have increased?

For insight into these and other issues, I turn now to considerations of systems of sex/gender as they are found in other societies. Perhaps the best known example of cross-gender behavior historically is the *berdache* role found in Native American societies. Europeans who encountered males who performed female roles and wore female dress interpreted them in exclusively sexual terms and applied the term "*berdache*" which is derived from the Persian *bardaj* and Arabic *bardag (*and then to *bardasso* in Italian, *bardaka* or *bardaje* in Spanish, and *bardache* in French) and refers to the receptive partner in homosexual male intercourse (Williams, 1986, p.9; Fulton and Anderson, 1992, p.603). Although a parallel situation was seen in women who assumed male roles and dress, this received less comment and tended to be included within the *berdache* category. This reflects a primary focus on male activities as more important and European concepts about gender stratification. Although unusual, it was at least understandable why females would want to be like males who occupied a superior social (and moral) position; the converse, that men would willingly take on an inferior status, was incomprehensible. That matrilineality (to the extent that it was understood by Europeans) might result in equal status for women and men (even if their tasks might be differentiated on the basis of sex/gender) was never considered.

Williams (1986, p.2) defines the *berdache* classification as including morphological males who don't fulfill the standard male role and often demonstrate non-masculine characteristics. Although traditionally viewed as effeminate, he proposes that androgynous would be a more accurate description. *Berdache* represented a recognized and accepted status where anatomical males took on some women's activities, remained asexual or took a passive role in intercourse with other males, were often seen as mediators between male and females, and might perform special ceremonial or ritual roles. Sabine Lang (1998, pp.9-10) agrees that the most important part of the definition is the taking up of activities and occupations of the opposite sex and she sees the *berdache* role as essentially a change in gender role rather than gender status and prefers the terms woman/man[12] to designate an anatomical male who assumes most or all elements of female gender roles and man/woman for an anatomical female who does the

[12]These terms are also used by Fulton and Anderson (1992), however, they reverse the order so that the anatomical sex precedes the gender role, *i.e.* their man/woman is equivalent to Lang's woman/man. In this paper I will follow Lang's terminology.

same with male gender roles. Although Williams (1986, p.82) puts a major emphasis on the aspect of homosexuality that (along with spirituality) he believes has received less attention than deserved, he agrees on the primacy of assuming alternate gender roles in defining *berdache*. Both agree that the status occupied by the person who adopts a gender variant pattern is not that corresponding to the gender role. Williams (1986, p.51), whose emphasis is on women/men, believes that the behavior patterns shown by these individuals is unique and individualized rather than strictly feminine and suggests that this was missed by early observers locked into a rigid binary system. Among the Zapotec, he suggests that the role represents a third sex (1986, p.82). Lang (1998, p.12) believes that the result is an ambivalent status that could also be construed as an alternate sex although she doesn't define it in this way. Others prefer the term "two spirit" to reflect the fact that the person is believed to have both female and male aspects although perceived as a third sex. Feinberg (1996, p.28) states that Spotted Eagle, a White Mountain Apache two-spirit had married a male two-spirit but following his death joined with a female partner. Apparently the first relationship was acceptable. I was told by Terry Tafoya, a Pueblo two-spirit, that a union between two two-spirits would be perceived as homosexual and unacceptable. There is obviously a lot of variation among those who today identify as two-spirit in terms of how issues of sex, gender, and sexuality are addressed.

Women/men and men/women had a wide distribution in native North America. Callender and Kochems (1983) find the woman/man category in 113 groups from California to the Mississippi Valley and Upper Great Lakes and Lang (1998, Map 1, pp.5-6) indicates 148 societies having either woman/man or man/woman. Certainly the four greatest concentrations are in the Prairies/western Great Lakes, northern and central Great Plains, lower Mississippi Valley; Florida and the Caribbean; the southwest, Great Basin and California; and scattered areas of the Northwest Coast, western California and Alaska (Williams, 1986, p.4). Long presumed to be absent in most areas of the northeast, Fulton and Anderson (1992, p.605, n 8) raise the interesting possibility that widespread epidemics (specifically they target smallpox, though others could have had equally devastating results) that first spread through this region may well have taken a far great toll on women/men, especially since they often have responsibility for burying the dead and therefore may have been at particular risk. Therefore, their absence from this region would be an artifact of conquest rather than a reflection of cultural differences. Williams (1986, p.4) notes a document found by Ray Fogelson indicating the existence of women/men among the Cherokee, an Iroquoian speaking group.

Both Williams and Lang review the roles of these individuals in different Amerindian societies and rather than provide a summary of each, it is more useful to examine the commonalities along them (albeit recognizing that not all the elements are present in every group). It seems that the woman/man or man/woman is viewed as having a long history, in some derived from the founding myth and in others clearly reflecting ancient patterns. These provide the roles with supernatural sanction. For example, among the Zuni, the *lhamana* (woman/man)

was created by the deities for a special purpose and would appear (linguistically at the very least) closely related to the katcina spirit *ko'lhamana* who mediated between hunters and farmers. Among the Mohave, the *alyha* (woman/man) may represent the original condition of humanity when women and men were not differentiated. Among the Navajos (*nadle* = woman/man and man/woman) and Arapahoes *(haxu'xan* = woman/man*)*, they were present from the beginning of creation and represent a supernatural gift (Williams 1986, pp.18-24). Religious sanction for alternate sex or gender roles would appear to be an important condition for social tolerance of sexual or gender minorities. This will be seen also in the *hijras* of India.

Religious significance is a critical factor in distinguishing men/women and women/men from those who engage in same-sex intercourse or assume partial or complete dress of the other gender. Some women/men function as curers, others as priests and shamans. Group members often believe that berdache status indicates visionary or dreamer powers. In some cases (Williams, 1986, p.25) the decision to become berdache is the result of a vision; but for most the assumption is that in choosing the role of woman/man a boy was acting out his basic character as supernaturally dictated. "It is in this power, based on the spiritual origins of berdachism and in the context of ceremonial leadership, in which the respected status of the berdache is rooted" (Williams, 1986, p.43).

Trexler (2002) strongly objects to the notion that those who assumed these roles had any choice in the matter despite the fact that the data accumulated by Williams based on the Human Relations Area Files and his fieldwork suggest

otherwise. His point seems to be that because most were children when the gender role shift occurred, they were pressured to do so for familial or social reasons. Numerous ethnographic reports indicate that Indian children had far more freedom from adult constraints than Euro-American children. Williams and Lang interpret this as meaning they would have the right to reject a gender assignment that they didn't want and in fact there are some reports of his. Trexler emphasizes what he sees as the inherent power differential based on age but this may reflect a contemporary American perspective. Even in those groups where children were tested by being asked to choose among tools typically used by each sex, he argues that this represents only an "exercise in parental or other adult authority" and visions, because they are interpreted by adults, serve the same purpose (Trexler, 2002). He notes (as do Williams and Lang) that in some groups, parents specifically chose to raise a child in the opposite gender. This was rarely if ever the first child and usually addressed a gender imbalance within the family. For example, among the Lache in Colombia, if a woman bore five sons in succession, the family would select one to assume female gender at puberty (Williams, 1986, p.46). This pattern seems most pronounced among the Inuit (Trexler, 2002), where the well-being of the family would be compromised it there were no sons to aid in the hunt. Among Inuit, the dominant pattern was to raise a daughter as a son

if none had been born. It has also been suggested that this served as an alternative to female infanticide. While it is important to note these exceptions, the bulk of the data suggests that they are just that. Trexler provides a service in reminding us that women/men and men/women were not always given high status and that it is important to beware of too romantic generalizations. However, he comes dangerously close to an *ad hominem* attack on Will Roscoe[13] when he decries his "...determination of find his homosexual present in the deep American past" (Trexler, 2002).

Even though women/men do not achieve the status of women in the societies in which they are found, Williams suggests that their status is directly related to that of women. Where women have high status, no shame is attached to female roles. Women/men differ from women, however, in that they have few demands placed on them by child care.[14] It is interesting to note that among the Iroquois, where female status is very high (Bilharz, 1995), women/men and men/women are not reported. My fieldwork (though not directed to this specific topic) did suggest that tolerance for gay and lesbian behavior today is limited.

Other important roles played by these individuals in native North America include participation, either as warriors or healers, in war parties. This was particularly true among the Cheyennes where women/men also led the Scalp Dance. Papago women/men also had an important role in a similar dance. Although closely related to the Papagos linguistically and culturally, the Tohono O'odham (Pimas) woman/man (*wi-kovat* = like a girl) received no respect and was believed to be the result of Papago witchcraft (Williams, 1986, p.18).

It is apparent that women/men and men/women are not analogous to American transsexuals as the assumption of the other status is impossible However, compare the following statement by Walter Williams (1986, p.84):

> "Berdaches seem to symbolize the original unity of humans, their differentiation into separate genders, and the potential for reunification as well. Ironically, by violating gender norms, berdachism enhances the society's definition of what is woman and what is man"

to objections raised by some feminists and transgenders to transsexualism as a confirmation of a hegemonic binary system.

Lang criticizes Williams for his emphasis on the role of sexuality among women/men (1998, p.11) and he clearly spends more time discussing male-male sexuality than he does men/women. Sexuality/sexual orientation, as we will see, takes on major importance in legal interpretations of sex and gender ambiguity and has received far less attention in anthropological research than it deserves. This

[13]See Roscoe's 1991 study of We'wha, a Zuni *lhamana*

[14]Women/men are often perceived as having special talents in education and dealing with children and can be parents since adoption is common in Indian societies. Children adopted by women/men tend to be older and therefore do not require the constant attention needed by infants and toddlers.

may result from the 1975 decision (subsequently revoked) by the executive board of the American Anthropological Association "not to endorse research on homosexuality across national borders" (Williams, 1986, p.13), an inexplicable and inexcusably parochial stance.

That the first Europeans to encounter women/men emphasized the sexual aspect of the role is demonstrated by the application of the word *berdache* to describe it. Clearly in their minds, this was the defining characteristic which provoked their moral outrage and contempt. Despite medical and psychological evidence to the contrary, in the popular mind transsexuals are often perceived as poorly disguised homosexuals, their gender deviance replaced by an even more negatively sanctioned moral deviance.

Similar opinions are used to dismiss the next two groups with institutionalized gender ambiguity.

The *hijras* of India define themselves as neither man nor woman (Nanda, 1999). Among the Crees, a woman/man is known as *ayekkwew* which translates as either "neither man nor woman" or "both man or woman," thereby showing strong parallels with both the *hijras* and modern transgenders (Epstein 1990, Roen, 2002). Nanda (1999, p.114) considers *hijras* to represent an alternative gender role but they differ in a number of ways from both transsexuals and women/men.

There are approximately 50,000 hijras, primarily in northern India (Nanda, 1999, p.38). The term is derived from an Urdu word meaning eunuch or hermaphrodite and carries the connotation of impotence resulting from a physical defect (Nanda, 1999, p.13). While some are intersexed (referred to as "born hijras"), most join hijra communities in their teens ("made" hijras), for a variety of reasons ranging from a desire to express a feminine identity, to poverty, domestic abuse, or prostitution. Living in the community does not however confer hijra status which is a gradual process and is attained only through surgical emasculation which usually follows after a period of about five to fifteen years. This is the core of hijra identity and is a religious obligation (*dharm)* (Nanda, 1999, pp.118, 115).

Like transsexuals, hijras report a history of childhood cross-gender behavior (Nanda, 1999, p.115) and Nanda (1999, p.19) suggests that the role attracts people with many cross-gender identities, attitudes, and behaviors. Because gender variation is deeply rooted in Indian society, the role can easily accommodate diversity. Also like MTF transsexuals, the removal of the penis and testes is required for entry into the new status; in the case of the hijra this represents a reclassification from impotent male to hijra. They differ, however, in that hijras make no claim to be women, only "like women." They are also "not men" because they have an imperfect or no penis. They cannot be women because they do not menstruate and are unable to have children. Their similarity to women is based on their dress and ornamentation, hair length, assumption of female names, and adoption of female behavior patterns. The latter are often a burlesque of traditional feminine behavior rather than the stereotypical behaviors seen in MTF transsexuals. Nanda reports (1999, p.15) that some hijras were raised as

women from birth and so may be genetic females or intersexes. The fact that they failed to develop secondary sex characteristics and to menstruate moved them from woman to hijra gender. One of the founders of the hijra is reported to have been a non-menstruating woman.

Like women/men and men/women, hijras gain some social status from their religious roles which involve fertility related rituals at marriage and the birth of a male child. The performers must be "real" hijras (*i.e.* emasculated or intersexed) and dressed in women's clothing. Their major devotions are to Bahuchara Mata, a version of the Hindu Mother Goddess who is important in the Gujurat region and associated with transvestism and transgenderism (Nanda, 1999, p.25). Unlike the major monotheistic religions with a male deity and institutional churches dominated by male clerics[15], Hindu deities are a remarkably diverse lot, with gods such as Shiva incorporating both male and female characteristics. Even though his symbol is a phallus, it always appears set in the *yoni*, a symbol of female genitalia. Both Vishnu and his avatar Krishna are sometimes portrayed as androgynous and Krishna's son Samba is a notorious homosexual and transvestite. In the Tantric School of Hinduism, the Supreme Being is hermaphroditic. Therefore, Hinduism provides a template for a multiplicity of sexes/genders. Ancient Hinduism actually taught that there was a third sex comprised of four categories: male eunuchs, castrated males, hermaphrodites, and female eunuchs (women who did not menstruate). Additionally, there is an important Muslim influence on hijras as well in the form of the eunuchs who guarded the harems, although unlike the hijras, they dressed as men and lived among women. A number of the major leaders of the hijras in cities like Delhi and Bombay are Muslim (Nanda, 1999, pp.20-21, 41).

Like women/men, however, the hijra claim to a special status based on ritual performance is diminished by the fact that many, if not most, earn their living from homosexual prostitution, even though this is considered deviant and stigmatized within the hijra community. Although some may earn three times the salary of a college professor, they have little control over their working conditions and are often exploited (Nanda, 1999, p.53).

Hijras are organized in communities that center around a *guru* and her *chelas* (disciples) and these take on many aspects of a family. *Chelas* who share a *guru* refer to each other as sisters and all take on the relatives of the *guru* as fictive kin. This greatly expands potential contacts, functions as an employment agency, and provides places to stay across India as hijras have the right to claim hospitality from their "kin." This network provides not only social support but economic security in time of illness and old age and may serve to attract those from very poor families. Nanda (1999, p.42) has noted that about half of the hijras come

[15]In the first chapter of Genesis the deity appears to have a dual male/female nature, perhaps a reflection of the inner-oriented religions encountered by Hebrew speaking tribes entering Canaan. This can be seen in the statement that humans were created in "our image, male and female." However, Jewish and Christian clerics instead focused upon the second creation story, Adam and Eve in the Garden of Eden, and interpreted it as demonstrating female duplicity and responsibility for the fall of man. See Sanday (1981, pp.215-231) for an extended analysis of Christian gender symbolism.

from scheduled castes (formerly known as untouchables). There is nothing comparable among women/men and men/women but the social support functions are paralleled by intersex groups such as the Intersex Society of North America and Androgen Insensitivity Syndrome Support Group.

In Brazil, Don Kulick (1998) has studied transgendered prostitutes known as *travestis*. Like MTF transsexuals and hijras, they assume female dress, names, and mannerisms but they do not believe they are women, but similar to hijras, are "like women." Their body modification is limited to secondary sex characteristics that they induce by means of massive consumption of female hormones (available over the counter) and injections of industrial silicone in the breasts, thighs, and buttocks. Although the body configuration they create appears grotesque by American standards, it mirrors, albeit in the extreme, Brazilian standards of beauty that emphasize large buttocks and thighs. They make no attempt to remove male genitals and are horrified and disgusted by the possibility of sex reassignment surgery. In their minds, God made them male and they should stay male - but they don't have to act masculine. They identify as homosexual males.

Kulick posits that in Brazil there are two genders that are defined not by any of the criteria outlined in the beginning of this paper, but by sexuality, specifically the role one takes in intercourse. Men are defined as penetrators, not-men are defined as penetrated. In this schema, women and *travestis* comprise a single gender (Kulick, 1998, p.229). Males who are penetrators in anal intercourse forfeit neither their maleness nor their masculinity and are not defined as homosexual; only males who are penetrated are homosexual. Like hijras, many, if not most *travestis*, make their living by homosexual prostitution and like hijras, are often seen as responsible for the spread of AIDS. Although they occupy a recognized status within Brazilian society, it is highly stigmatized and they are often victims of violence (Kulick, 1998, p.7). As Williams proposes for women/men, sexuality/sexual orientation is a critical dimension of their gender; in fact, it defines it.

Brazil is very tolerant of gender-bending as is seen most clearly during Carnival and female impersonators have prominent roles and high status. In the 1980s, Roberta Close, a *travesti* was usually acclaimed as the most beautiful woman in Brazil (Kulick, 1998, p.6). If one is to talk about gender as performance (Feinberg, 1996) or "doing gender," in Brazil one's sex is no handicap. This takes us back to Shapiro's statement about the feminist dilemma between social construction of gender (anybody can do it, *e.g.* genetic females, MTF transsexuals, *travestis*) and biological essentialism (it's the chromosomes, stupid!).

This then adds another dimension to the study of ambiguity - sexuality. If it is difficult to tease apart sex and gender, what happens when sexual orientation is added to the mix? We have already noted one difficulty in this regard. From a medical perspective, a transsexual seeking SRS who is attracted to a person of the same biological sex is defined as a homosexual transsexual, and is believed to have a better chance for successful readjustment. From the perspective of the transsexual, he or she is <u>not</u> homosexual because the basis is not anatomy but gender identity. Something similar can be seen among women/men and

men/women. Sue-Ellen Jacobs, Wesley Thomas and Sabine Lang have suggested that the term *berdache* be replaced by Two-Spirit because this best represents the "both/neither" that is at the heart of this gender. However, its scope has been expanded to include gays and lesbians who are not involved in the spiritual dimension or occupations that are outside traditional gender roles as well as other gender and sex variants. Like the term "queer" it has taken on a political meaning and has lost precision for social science. Nevertheless, in most cases sexual relationships between people of the same gender (man/woman and man/woman, woman and woman, man and man, woman/man and woman/man) are considered homosexual. But what they really are (if sex and gender are separated) is not homosexual, but homogendered relationships. So the binary sex/gender dichotomy takes on a third element and the syllogism becomes sex:gender:sexuality which gives us male:masculine/man:straight and female:feminine/woman:straight. If sexuality/sexual orientation is used to define (or contribute to) gender, then in Brazil we have male:not man:gay and male:man:straight. Using American stereotypes of gay men as feminine and lesbians as masculine, we could arrive at man:feminine(woman?):gay and woman:masculine(man?):gay. All of this may seem to be merely a mental exercise until we examine the legal definitions (more importantly, the judicial interpretations) of sex and gender and see how sexuality/sexual orientation has been infused into the debate.

PART III: LEGAL PERSPECTIVES

As it becomes more apparent that sex, gender (sex role, gender identity), and sexuality/sexual orientation have a multifactorial basis, a major difficulty arises in reconciling medical and biological concepts with social and legal concepts (Hucker, 1985, pp.393). The state has an interest in the sex of an infant as a way of establishing a means of social organization, preventing fraud, regulating privileges (*e.g.* voting rights prior to passage of the nineteenth amendment in the United States), promoting "morality" (prohibition of homosexuality and homosexual marriages), determining eligibility for military service, and establishing criteria for marriage (Epstein, 1990, p.101). Whether or not one accepts these as legitimate concerns of the state is moot. Most Americans hold many documents that proclaim their sex: drivers' licenses, passports, student identification cards, birth certificates, Social Security cards, etc.

Legal implications of sex reassignment have been briefly reviewed for Germany in a previous section of this paper. Justices at the 23rd Colloquy on European Law: Transsexualism, Medicine and Law found that transsexuals have full legal status only in those countries that hasve passed specific legislation. In all others they are dependant upon case precedent or administrative cooperation (Peterson and Dickey, 1995, p.147).

THE UNITED STATES

Sexual ambiguity issues have come to the attention of the legal system via transsexuals; to date there has been only one case in the United States, Wood v. C. G. Studio, (Greenberg, 1999) that considered issues of sex related to intersex individuals although it is likely that more will be heard. Because sex reassignment surgery had a much earlier development in Europe, the first cases relating to transsexuals appeared there and these early cases, along with judicial interpretations of Title VII of the Civil Rights Act, have provided direction for American judges. In the absence of federal legislation, state and lower courts have been relegated to confronting these issues without federal guidelines, creating the expected morass of inconsistent and contradictory decisions. As will be seen, the legal sex (as opposed to any biological definition) of a transsexual varies within and among jurisdictions.[16]

In Wood v. C. G. Studios (Greenberg ,1999, pp.322-325), the plaintiff had undergone surgery to "correct" her intersex condition prior to her employment by the defendant. She maintained she was terminated when her employer learned of this and she brought action claiming discrimination under the Pennsylvania Human Relations Act (PHRA).

The court determined that "sex" under the provisions of the PHRA included men discriminated against because of their sex and women discriminated against because of their sex, but excluded intersexed individuals. Relying upon Webster's Dictionary for its definition rather than medical evidence, the court ruled that there were only two sexes and Wood wasn't one of them.[17] As Greenberg (1999, p.323) notes, it is possible to interpret court decisions against transsexuals as a reflection of "the judiciary's tacit disapproval of people who "choose" to live outside traditional sexual norms. In Wood, the plaintiff chose to live within society's norms; she did not fit into the binary sex paradigm, so she chose reconstructive surgery so that she would be clearly a female." One might have expected the court to evidence greater sympathy for Wood than for transsexuals, though clearly this was not the case.

Most transsexual cases have revolved around domestic issues such as the validity of marriages contracted by post-operative transsexuals, child custody, spousal maintenance, etc. The major issue concerning the courts in marriages of transsexuals relates to the state's interest in prohibiting homosexual marriages. This involves two possible types of marriage: 1. where a male marries a post-operative MTF transsexual and 2. where a female marries a post-operative MTF transsexual. The logical conclusion is that if the post-operative transsexual is held to be a male (assigned sex at birth accepted as legal sex), then the first marriage is invalid but the second marriage is valid. Conversely, if the courts determine that

[16]Surveys of legal decisions can be found in Hucker, 1985, Green 1992, Eskridge and Hunter, 1997, Greenberg, 1999, 2000, Dunson, 2001, Frye and Meiselman, 2001, Walker, 2001, and Hong, 2002. Greenberg's (1999) article is most useful in that she provides medical summaries of intersex conditions that support her critiques of legal decisions.

[17]It is difficult to imagine the effect of this ruling on Wood and others with similar conditions (*e.g.* a person with Turner syndrome) as the court removed the possibility of an "Other" box to check.

the post-operative transsexual is female (assigned sex following surgery accepted as legal sex), then the first marriage is valid but the second is invalid. Because the United State Supreme Court acknowledges marriage as a fundamental right under the constitution, a transsexual cannot be denied the right to marriage and one of these marriages must be legal (Greenberg, 2000, pp.760, 762-763). The problem is that the courts cannot reach agreement on which one.

Many judges refer to the decision in Corbett v. Corbett as a precedent in dealing with transsexual legal cases even though it was heard in the United Kingdom. In 1960, George Jamieson had sex reassignment surgery in Casablanca and became April Ashley. He married Arthur Corbett who, although previously married, had homosexual affairs and a history of transvestism. They lived together for two weeks of their three month marriage. Arthur Corbett filed for divorce on the grounds that the marriage had not been consummated or April Ashley (nee Jamieson) was not a female and therefore the marriage was invalid as it was contracted between two people of the same sex.

Justice Ormrod, who was also a physician, ruled that April Ashley's true sex was male and she could not perform the "essential role of a woman in marriage" (precisely what this encompassed was not defined), therefore the marriage was invalid. For Ormrod, the determining criteria were anatomical: Ashley had XY chromosomes (chromosomal male), had testes prior to surgery and neither ovaries nor uterus (gonadal male), and, prior to surgery, had no external female genitalia (genital male). The judge stated that the law should adopt these criteria and, if all three are congruent, this determines the sex for purposes of marriage (Hucker, 1985, p.397-399; Green, 1992, pp.111-112).

A similar verdict was handed down in New York in 1974, when the courts held that a marriage between a FTM transsexual was invalid because it was contracted between two females (Frances B. v Mark B.). In this case, the "wife" discovered her "husband" had no penis and couldn't perform sexually and sued on the grounds that he was also a female. The court determined that an annulment would be justified on the basis of inability to consummate the marriage but since the defendant was, in fact, a female, it was invalid to begin with (Hucker, 1985, pp.399-400).

Two years later, a New Jersey court reached the opposite conclusion in M.T. v J.T. (Hucker, 1985, p.399). In this case the couple met and lived together prior to SRS but the relationship faltered and the suit was filed for maintenance and support. The defendant asserted that the marriage was invalid because both individuals were female. The New Jersey appellate court rejected an exclusively biological standard for sex determination and ruled that:

> For marital purposes if the anatomical and genital features of a genuine transsexual are made to conform with the person's gender, psyche, or psychological sex, then identity of sex must be governed by the congruence of the standards...Plaintiff has become physically and psychologically unified and fully capable of sexual activity consistent with her reconciled sexual attributes

> and gender and anatomy. Consequently, Plaintiff should be considered a member of the female sex for marital purposes. (in Hucker, 1985, p.399).

Two more recent cases have reasserted the position that transsexual marriages are invalid. The most important is Littleton v. Prange in which the Texas courts had to determine a post-operative transsexual's legal sex for marriage (Littleton v. Prange 1999). Christie Littleton, born Lee V. Cavazos, Jr. in 1952, began to identify as a girl by the age of three or four and even though a physician to whom her parents took her administered male hormones, she maintained a female gender identity. At the age of twenty-three she began psychological treatment in anticipation of sex reassignment surgery; two years later she had her legal name changed and began hormone therapy. At the age of twenty-seven she underwent breast construction and sex reassignment surgeries. She was permitted by Texas courts to amend her original birth certificate to reflect the change. She married Jonathon Littleton, who was aware of her medical history in 1989, and they lived together until his death in 1996.

Following Jonathon's death, she filed a medical malpractice suit against Dr. Prange under the Texas Wrongful Death and Survival Statute. Referring back to the Corbett decision, the defendant moved to get a summary judgment challenging her status as a proper wrongful death beneficiary and the motion was granted by the trial court and subsequently affirmed by the Texas Court of Appeals. Both sides stipulated that medical experts intended to testify that Christie was a transsexual and that this condition was likely the result of neuro-biological, genetic, and neonatal environmental factors, that MTF transsexuals were female psychologically and psychiatrically both before and after surgery, that Christie could function sexually as a woman, and that "medically" she was a woman (Greenberg, 2000, p.752).

The appellate court decided it had no authority to create a new law relating to transsexuals and that Christie's sex was purely a legal decision and it ruled two-to-one that she was male, despite the fact that no chromosomal evidence was submitted and other sex indicators were ambiguous. The majority opinion was written by Chief Justice Phil Hardberger with Justice Karen Angelini concurring. Justice Alma Lopez dissented. In his decision Hardberger averred there was only one issue, whether Christie Littleton was male or female and queried "...can a physician change the gender of a person with a scalpel, drugs and counseling, or is a person's gender immutably fixed by our Creator[18] at birth?" (Greenberg, 2000, p.753). In her dissent Lopez stated that the court could either establish guidelines for determining sex (which it was obviously loathe to do) or treat the issue as a question of fact to be determined at trial. Because Littleton had two birth certificates, each indicating a different sex, Lopez felt a summary judgment was inappropriate (Greenberg, 2000, pp.751-757). A petition for a writ of certiorari of

[18]The interjection of a "Creator" into the case suggests religion rather than science was a major factor in Justice Hardberger's decision.

the Littleton decision was denied by the United State Supreme Court in October 2002.

Phyllis Frye and Alyson Meiselman (2001, p.1042) who served as co-counsels in the case after the first appeal to the Texas Supreme Court point out that the Texas Department of Veteran's Affairs, nine years *before* the Littleton case, held that a veteran who changed sex and then married was entitled to additional vocational rehabilitation allowance because of the existence of a dependent spouse. Because the 4th Court also relied on the Defense of Marriage Act to test the validity of the Littleton marriage even though it was passed several months after Littleton died, they argue (Frye and Meiselman 2001, p.1095) that this is a violation of Article 1, Section 16 of the Texas Constitution which bans retroactive laws. They also note that Christie Littleton's sex and marital status would change as she moved not only through Texas but across the United States. In San Antonio where the case was heard, she is a single male; traveling to Houston and on federal property she is a female widow; going north to Kentucky she retains female widow status but reverts to single male status once she crosses into Ohio; heading east she is once again a female widow in New Jersey and Connecticut but regains single male status in Vermont (Frye and Meiselman, 2001, pp.1042-1043).

Another case calling for a determination of the sex of a transsexual concerns the estate of Marshall G. Gardiner who died intestate. Mr. Gardiner was a wealthy businessman and a widower with one son from whom he was estranged. In 1998, he and J'Noel, a college professor with a doctorate in finance and a MTF transsexual, were married in Kansas. J'Noel had undergone sex reassignment surgery in 1994, and her birth certificate (registered in Wisconsin) was amended to reflect the sex change. Her driver's license, passport, health documents and university records were also changed. Her husband was aware that his wife was a transsexual.

Following his death, J'Noel applied for letters of administration after Gardiner's estranged son, Joe, filed a similar petition. Joe responded by amending his petition to claim that he was the sole heir because the marriage between J'Noel and his father was void because they were of the same sex. The district court issued a summary judgment in favor of Joe which was appealed by J'Noel. The appellate court found no error in the Kansas court not giving full faith to the amended Wisconsin birth certificate but it reversed and remanded for the district court's determination as to the sex of J'Noel at the time the marriage license was issued. In doing so, the Court of Appeals rejected the reasoning of Corbett and the Littleton decision which was described "as a rigid and simplistic approach to issues that are far more complex than addressed in that opinion" and instead looked for guidance to the M.T. case (Supreme Court of Kansas, 2002). It also utilized Greenberg's 1999 article (incorrectly cited as 1992) and inquired specifically about what the implications would be for a person with Turner syndrome. The Kansas Supreme Court saw the difference in reasoning between the two lines of cases (Corbett and Littleton on one hand and M.T. and *In re Kevin* (to be discussed below)) resulting from the fact that the first treats a person's sex

as a matter of law and the second as a matter of fact.

In determining that the district court was correct in declaring J'Noel a male for the purpose of marriage, the Kansas Supreme Court (2002) utilized Webster's New Twentieth Century Dictionary definition of sex that states male is the sex that "fertilizes the ovum and begets offspring" and female is the sex that "produces ova and bears offspring." Writing for the court, Justice J. Allegrucci (Kansas Supreme Court, 2002) stated "A male to female post-operative transsexual does not fit the definition of a female. The male organs have been removed, but the ability to "produce ova and bear offspring" does not and never did exist. There is no womb, cervix, or ovaries, nor is there any change in his chromosomes. As the *Littleton* court noted, the transsexual still "inhabits...a male body in all aspects other than what the physicians have supplied." J'Noel does not fit the common meaning of female. Following this reasoning, women who have had hysterectomies, oophorectomies, or are infertile for a variety of reasons are not female and impotent males or those whose testes have been removed because of malignancy would not be considered male.

Although almost uniformly ruling against transsexual marriage, courts in the United States have been more favorably disposed to maintaining parental rights of transsexuals. In Colorado a court ruled against a father's attempt to regain custody of his children from his former wife, now a FTM transsexual, because the children were doing well (Eskridge and Hunter, 1997, p.1124; Hucker, 1985, p.401). A Minnesota court also upheld a custody award to a father diagnosed with gender dysphoria stating that there was no evidence that the child would be adversely affected. On the other hand, over a strong dissent, the Nevada Supreme Court upheld the termination of parental rights of a transsexual father, stating that it was "…strictly Tim Daly's choice to discard his fatherhood" (in Eskridge and Hunter, 1997, p.1124). This case differed from the others because there was evidence that the ten year old daughter strongly objected to visiting her father.

In re Kevin was heard in the Family Court of Australia in October, 2001, and concerned several issues related to both marriage and children. Kevin met Jennifer in 1996, and told her he was a transsexual. They began living together early in 1977, and Kevin had a total hysterectomy and bilateral oophorectomy in November. He decided not to have phalloplasty and is continuing hormone therapy. In October ,1998, he was issued a new birth certificate identifying him as a male and he and Jennifer were married. Jennifer became pregnant by in vitro fertilization and gave birth in November, 1999, and she and Kevin plan to have a second child in this manner. Kevin's transsexual history was known to the infertility clinic where Jennifer was treated and the doctors, nurses, and scientists decided that they should be considered a heterosexual couple who was infertile due to absent sperm production. The case was filed by Kevin and Jennifer seeking a declaration on the validity of their marriage. The Australian court ruled that the marriage was valid (Kansas Supreme Court, 2001).

There was a parallel case in the United Kingdom (X,Y,Z v. U.K.) In this case X was a FTM transsexual, Y was his female partner, and Z was their child born via assisted reproduction. X wanted to be listed as the father of Z even

though he was not the sperm donor. Under British law a biological male would have been recognized in this manner. The case was appealed to the European Court of Human Rights which held that X, Y, and Z constituted a family but the failure to recognize X as the father of Z was not a violation of Article 8 of the European Convention for the Protection of Human Rights as an interference with family right because there was no duty of member states to recognize as parents persons not biologically related to the child (Walker, 2001).

Despite the relatively liberal positions of New Jersey courts toward transsexuals, there have been exceptions. In 1976, the dismissal of a MTF teacher was upheld by the court which maintained that a transsexual teacher was likely to cause damage to the children in her care (Hucker, 1985, p.401).

Greenberg (1999) has summarized the opinions of courts in other countries which have, in general, held that the sex assigned at birth is the sex for purposes of marriage. Prior to the *In re Kevin* decision, and comparable to the Wood decision in Pennsylvania, Australian courts decided in a case in which the husband was a true hermaphrodite who had surgery to remove breasts, that he was neither male nor female. Implicit in this decision is that hermaphrodites may not marry (Greenberg, 1999, p.304). A Canadian court determined that a transsexual who identifies as male and has neither breasts nor internal female organs is a female for marriage purposes. In New Zealand a post-operative transsexual acquires her or his self-identified sex for marriage purposes. In Singapore the legal sex is that which appears on the birth certificate. Transsexual marriage is invalid in South Africa as the courts have held that a MTF transsexual has only the "artificial attributes" of a woman (Greenberg, 1999, p.307). Sweden has the most favorable climate for transsexuals. A potential candidate for sex reassignment surgery applies to a national board that appoints a special committee of experts in psychiatry, endocrinology and jurisprudence. If the application is approved, the board instructs the parish office to change their register entry on the individual's sex and authorizes other offices to make appropriate changes. The reassignment is incontestable in court and applies to all aspects of a person's life (Hucker, 1985, p.408).

The opinion on which future decisions will most likely rely was written by Judge Gerard J. O'Brien, Senior Circuit Judge for the Sixth Judicial Circuit in Florida in a custody case involving a FTM transsexual (Kantaras v. Kantaras, 2003). Michael Kantaras sued for primary physical custody of two children born to his ex-wife and adopted by him during the course of their marriage. The older was a born prior to their marriage and the second was a child conceived through artificial insemination during their marriage. In contesting the suit, Linda Kantaras argued that their marriage was illegal because Michael was really a female and therefore he could not legally adopt her children. The question the court focused on was "May Michael, born a woman, transition into a man, and, thereafter, enter into a marital relationship with a woman under the laws of Florida?" (Kantaras v. Kantaras, 2003, p.264). Refusing to accept the simplistic assertions of earlier decisions, Judge O'Brien stated (Kantaras v. Kantaras 2003, p.709) that "…in the opinion of this Court, the battle of the dictionaries is not an adequate substitute for

medical knowledge." For the first time in American courts there was testimony in open court by a wide range of specialists (surgeons, psychologists, endocrinologists, psychiatrists, etc.) on transsexualism. Drawing on this testimony as well as an exhaustive review of relevant U.S. and foreign legal opinions, O'Brien held that the marriage of Linda and Michael was valid under Florida law and granted custody of both children to Michael, stating (2003, p.725) "In summary, transsexuals appear to be none other than people with sex disabilities demanding full standing and the constitutional right to pursue happiness in the married state reserved for all heterosexuals."

Employment discrimination has been a particularly difficult problem, especially in terms of the meaning of "sex" as used in Title VII of the Civil Rights Act of 1964. This was added to Title VII in at attempt to sabotage passage of the bill but because there was no debate over its meaning, legislative intent is unknown (Dunson, 2001; Green, 1992, p.104). The first major case was filed in 1981, by Karen Ulane, a MTF transsexual who had been a pilot for Eastern Airlines and was not reinstated after her surgery. Ulane sued Eastern claiming protection under Title VII since the only thing that distinguished her present from former self was sex. Richard Green, a psychiatrist and lawyer, testified for the plaintiff that Ulane was a transsexual. A psychiatrist for the airline countered this, stating that because Ulane was a really a transvestite, surgery was an inappropriate therapy that would have a poor psychological outcome leading to emotional instability.[19] Allowing Ulane to continue as a pilot would put passengers at risk. The district court agreed with Ulane, stating that she was protected as a woman and as a transsexual under Title VII. The court said that "sex" included "sexual identity" because "sex is not a cut-and-dried matter of chromosomes" but is partly psychological (self perception) and partly social (perception by others) (Dunson, 2001). This decision was reversed by the 7th Circuit Court of Appeals which held that Title VII was for men and women, not transsexuals and that there was insufficient evidence to prove that she was discriminated against because of her gender (Green, 1992, pp.104-107). Essentially, the Circuit Court held that she was discriminated against because she was a transsexual and transsexualism was not protected under Title VII. Pennsylvania courts in the Wood case discussed above as well as courts in Connecticut and the District of Columbia have also interpreted Title VII to exclude transsexuals even though in other Title VII cases both the 7th Circuit and the Supreme Court interpreted sex as including stereotypes and other non-anatomical characteristics (Dunson, 2001).

In *Jane Doe v. Boeing Company* (1993), the plaintiff was hired by Boeing as an engineer in 1978. In 1984 she concluded that she was a transsexual and began hormone treatments in anticipation of sex reassignment surgery.[20] When

[19]She would also have had no grounds for appeal under the Americans with Disabilities Act of 1990, (ADA) (had it been in effect at the time of her case) which, because of objections by Sen. Jesse Helms, specifically excluded transsexualism and transvestism as recognized disabilities. At the same time Congress amended to Rehabilitation Act of 1973, to exclude transsexualism and transvestism (along with pedophilia and pyromania) as handicaps (Eskridge and Hunter, 1997, 1p.111)

[20]I am grateful to Dr. Helen Remick, Assistant Provost for Equal Opportunity at the University of Washington, for

she informed her employer and co-workers in 1985, that she was about to begin the "real-life" test, Boeing told her she was not to use the women's rest room nor dress in "feminine" clothing (defined as skirts, dresses, or frilly blouses). Unisex clothing such as slacks, non-frilly blouses, earrings, clear nail polish, lipstick, and foundation were acceptable. Doe's physicians indicated that this limitation on the expression of her feminine gender would not prevent her from qualifying for surgery. Anonymous complaints about her dress were received by Boeing and she was warned to conform to the unisex standards. When she added a strand of pink pearls to an outfit that had been defined by her supervisor as "acceptable" the previous day, she was dismissed.

Doe accused Boeing of violating Washington's Law Against Discrimination, claiming she was discriminated against because she was handicapped. The trial court ruled against Doe but was overturned by the appellate court which in turn was reversed by the state supreme court which held that to be handicapped under state law required first that the individual has an abnormal condition and that the employer discriminated against the individual because of that condition. The supreme court held that gender dysphoria was an abnormal condition but that Boeing did not discriminate against her because of it. She was dismissed not because she was a transsexual but because she violated the dress code.

States and municipalities have acted on their own to protect transsexuals and other sexual minorities. In 1975, Minneapolis passed the first law prohibiting discrimination against transgender people, amending the defintion of "affectional preference" in its local non-discrimination law to include "having or projecting a self-image not associated with one's biological maleness or one's biological femaleness." Although only three more new statutes were passed or old ones amended in the next quarter century, by August of 2000, thirty-three municipalities had passed similar provisions, eighteen by creating a new category and fifteen by amending an existing one (Dunson, 2001). Wisconsin, Minnesota, and Oregon interpret state discrimination laws as including transsexuals; Iowa does not (Eskridge and Hunter, 1997, p.1111). There has been considerable debate about which tactic to pursue. Dunson (2001) notes that it may be politically more feasible to simply expand an existing category than add another. On the other hand, this counters the legal efforts arguing that transsexuals and transgenders are already included within existent categories. He also indicates that if one follows Raymond's view that transsexuals accept gender stereotypes, it becomes hypocritical to ask for protection on the basis of violation of gender stereotypes.

New Jersey courts have held that transsexuals represent a protected class under the state's Law Against Discrimination, allowing a suit alleging sex discrimination by pediatrician Carla (nee Carlos) Enriquez against her former employer to proceed. Enriquez was fired as medical director for the West Jersey Center for Behavior, Learning, and Attention ten months after she began the

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directing me to this case.

transition from male to female. The Judges, Steven Lefelt, Michael King, and Francine Axelrod, held it was incomprehensible that the legislature would bar discrimination against homosexual, heterosexual, and bisexual persons and condone it against transsexuals (Gallagher, 2001).

Another issue faced by transsexuals is health care. A study by Kari Hong (2002) found that most private and public insurers exclude coverage (although a fourth of those interviewed by Hong indicated that they offered full coverage) for sex reassignment surgery and some used this to deny medical claims for none-SRS related treatments such as emergency room visits, routine physical exams, etc. for post-operative patients. A FTM patient with cervical cancer was rejected as a patient by more than twenty gynecologists on the grounds that other patients would feel uncomfortable with him in the waiting room.

ATHLETIC ISSUES

Although not technically legal, national and international athletic organizations have also been involved in determining the sex of athletes for eligibility. As previously noted, some of the earliest sex change procedures were done on female athletes. In 1980, the International Olympic Committee decreed that women athletes would be subject to chromosome tests to ensure that they were truly female. Apparent males were not subject to similar scrutiny. Prior to this they were subject to an examination of their external genitalia only. In 1985, Spanish hurdler Maria Patino was banned from competition at the World University Games because she failed the required chromosome test. Until the test she was unaware that she was chromosomally a male with Androgen Insensitivity Syndrome (Greenberg, 1999, p.273).

Probably best known in the United States is Renee Richards (nee Richard Raskind), a surgeon and tennis pro who was barred from competition in the U.S. Open which required her to submit to a chromosome test that, despite having been available for ten years, had never been used before. Both the United States Tennis Association and the World Tennis Association refused to sanction her play (Richards, 1983, p.343). Although she was initially told she could participate in the Italian Open Championship in Rome in 1977, once she arrived in Italy she was informed that she would have to take a chromosome test. Pressure from the World Tennis Association resulted in a similar requirement by French officials and a contract offered by the Cleveland Nets (World Team Tennis) was disapproved by the league (Richards,1983, pp.354-358). A lawsuit eventually permitted her to resume her professional tennis career but she returned to medicine in 1981.

From Richards' perspective (1983, p.344), the fact that she was a transsexual actually put her at a disadvantage. She still retained the skeletal structure of a male (on average heavier than that of a female) yet the estrogens she was taking reduced her muscle mass to female proportions. Furthermore, the idea than one would submit to such extreme surgery in order to win a tennis match seemed ludicrous. "How hungry for tennis success must you be to have your penis chopped off in pursuit of it?" (Richards, 1983, p. 345). Perhaps because there has

been no stampede of men trying to exchange their penises and testicles for Olympic gold medals, the International Olympic Committee in 1990, returned to the physical examination of genitalia to determine the eligibility of female athletes.

SUMMARY

The sex and gender ambiguity experienced by intersexes, transsexuals, and transgenders is reflected in the responses of the medical and legal communities and reflects that of American society at large. Popular culture has provided many examples of people whose gender seems ambiguous and flexible. The glitter-glam movement in rock music in the 1970s, with people such as Freddie Mercury and Queen, Elton John, and David Bowie[21] provided many with their first experience of what became known as "gender bending" and these people probably became role models for many who found contemporary sex and gender roles too restrictive. That many were also openly bisexual opened to question the rigid dichotomy of straight and gay as well.

If transsexualism is broadly defined in order to not restrict the term to those for whom surgery is an option (*i.e.* those living in industrial societies beginning in the latter half of the twentieth century) and to include those who chose to live much or all of their lives as members of another sex, it is clear that transsexualism is a phenomenon that has been found in many societies for millennia. Some individuals were fortunate to live in societies were there were roles that could accommodate their atypical behaviors, even though they might not have been highly valued. What appears to be happening now, however, is that these alternative or additional sex and gender roles tend to be disappearing into the dichotomies accepted by western industrial societies. The significant differences that set them apart from those who cross-dressed for erotic purposes, who took on another gender role for purposes of intrigue or espionage, or whose sexual orientation was not exclusively heterosexual have tended to be ignored and the groups subsumed into the category of gay or lesbian. Good examples of this are the appropriation of the *berdache* role by gay and lesbian North American Indians and the Thai *kathoey*. Buddhist origins myths described an independent third sex, sometimes identified as a hermaphrodite, known as *kathoey*, whose position was "a result of karmic fate, preordained from birth and thus beyond their capacity to alter." Therefore, they were to be pitied rather than ridiculed. As currently used, the term has become synonymous with gay man (Nanda, 2000, p.74). While the attraction of a traditionally valued (by many but certainly not all) role is understandable for people who have been victims of homophobia, it also deprives the role of its social, economic, religious, and cultural significance and ironically, in the case of the *berdache*, situates these individuals with the European conquerors who were also unable to see beyond what they imagined to be the sexual practices of these men. Jacobs and Cromwell, 1992, p.56) have noted that

[21]I have not included Michael Jackson in this list because his issues seem to go beyond sex and gender and indicate a profound discomfort with race as well.

the sacred nature of the Tewa *kwido*, traditionally viewed as a third gender, has been lost as the binary sex/gender/sexuality systems of the West have become predominant.

It is important to focus on the separation of sexuality from both sex identity and biological sex. From a purely linguistic standpoint, the confusion over what constitutes a "homosexual" and a "heterosexual" transsexual demands this. Furthermore it reinforces another binary system. The use of new terms to describe a person's sexual orientation seems long overdue. Milton Diamond and Keith Sigmundson (1997a) use the term androphilic to describe those who are attracted to males, gynecophilic for those who are attracted to females, and ambiphilic for those who are attracted to both males and females. While transsexuals are often homophobic (Shapiro, 1991, p.252), there are those who identify as gay or lesbian (Devor, 1997, p.448). Kate Bornstein, a MTF transsexual who considers herself transgendered as well, has a female partner who is in the process of becoming a FTM transsexual (Bornstein, 1994). This example clearly demonstrates the fluid nature of biological sex, gender (either as gender identity or gender performance), and sexual orientation.

The transgender movement, which deserves far greater attention than it has received in this paper, is attempting to break down the boxes into which people are pigeonholed on the basis of actual or presumed characteristics. Unfortunately, however, it has shown itself to be as exclusive and intolerant in many respects as the society whose values it rejects. This may represent the radical beginning typical of most social movements and it certainly doesn't represent all of those who see themselves as transgendered. On the other hand, an attempt to bring all sex and gender and sexual minorities under a single umbrella of "queerness" can also be seen as having a homogenizing effect that creates discord within the category as different groups jockey for leadership positions or stake out their exclusive turf.

Kulick (1998, p.230) notes another problem with thirdness in that "far from denaturalizing or displacing dichotomous systems of sex and gender, ... there is a real danger that ...[they] radically naturalize and reinforce traditional understandings of sexual dimorphism, by suggesting that individuals who do not fit the male-female binary fall outside it and transcend it, rather than disturb, blur, or reconfigure it." An echo of this can be seen in the statement cited earlier to Cheryl Chase that an anti-FGM group was not interested in "biological exceptions" and in the court's decision in the Wood case.

Whether the courts should adopt a uniform perspective on the legal status of transsexuals or the criteria to be applied in determining a person's legal sex (which might vary for different purposes) is an open question. In light of the shift to more conservative interpretations, a U. S. Supreme Court decision might not benefit transsexuals. On the other hand, the courts have held that all people have a right to marriage and therefore, as previously noted, one of the two possible marriages that could be entered by a transsexual *must* be valid. Thus at least some marriages currently held to be illegal would have to be recognized.

It is also important to note the reasons why transsexual marriages enter the legal system and the fact that there have been so few of them. The bottom line

appears to be financial. Only where a marriage has failed and there are significant potential financial liabilities or gains do the issues get raised in court. The Gardiner case demonstrates this clearly. It seems unlikely that Gardiner's estranged son would have resurfaced to contest his late father's marriage had he not been a millionaire. In *Littleton v. Prange*, Dr. Prange most likely consulted with Christie Littleton as the wife of Jonathon when he was under the care of the doctor. Only when she became involved in a wrongful death action (along with Jonathon's mother) did he seek to eliminate her as a plaintiff, which would likely limit any possible award of damages. The binary sex/gender/sexuality systems of the United States are well suited to the adversarial system of the courts in which one wins or loses. Other societies have recognized a broader range of variation in these areas reflecting the fact that there have always been those who did not fit easily or completely into one of two mutually exclusive categories.

Gilbert Herdt's (1994b, pp.444-445) summary is perhaps most useful:

> Gender identity is not entirely a social construction, and sexual variations are not merely an illusion of culture. The felt experiences of having a certain body, including the desires and strivings of the person socially identified with that body, combine to create a powerful ontology across the course of life. Surely, some elements of sex/gender development are internally motivated or hormonally time loaded in ways that can influence the outcome of such a life. However, we are reminded of the importance of social classification of sexual dimorphism and of the resistance to the creation of a third sex that is so enduring in Western culture.... We do not have to alienate human culture and history from biology to accept that, in some places and times, a third sex has emerged as a part of human nature; and in this way, it is not merely an illusion of culture, although cultures may go to extreme lengths to make this seem so. However, an illusion it would be to imagine that the answer to the problems of mistaken sex in human affairs can ever be solved without recourse to the work of culture and the study of individual desires

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